Pollution, Peril and Poverty: A British Study of the Stigmatization of Smokers

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ABSTRACT

This paper considers the symbolic, experiential and institutional basis of the stigmatization of British smokers, particularly in the context of the higher rates of smoking in lower socio-economic status (SES) groups. Interviews based on a free association task were conducted with 40 smokers and non-smokers from higher and lower SES groups. Thematic analysis identified several areas of stigmatization of British smokers by non-smokers: identification of negative aesthetic ‘marks’ of smoking and of smokers as ‘polluters’ who harm others; the display of direct and indirect social disapproval; and the association of smokers with out-groups such as single mothers. Higher SES smokers tend to challenge the ‘facts’ on which this stigmatization is based, whereas lower SES smokers internalize the stigmatized aspersions. Recent British Tobacco Control campaigns, which play on the negative aesthetic of the smoker and the ‘peril’ which they represent, may exacerbate stigmatization. This may have de-motivating effects on lower SES smokers for reasons explored in the paper. Copyright © 2006 John Wiley & Sons, Ltd.

Key words: smokers; socio-economic status; stigmatization; tobacco control

INTRODUCTION

There is a strong linear relationship between smoking rates and socio-economic disadvantage (Jarvis & Wardle, 1999). Sixteen percent of men and 15% of women in managerial or professional jobs smoke, whereas the rates are 36% for men and 34% for women in manual work and are higher amongst the unemployed (Lader & Meltzer, 2004). The ‘smoking gap’ between socio-economic status (SES) groups contributes to significant differences in health outcomes; a far greater proportion of lower SES individuals suffer smoking-related illnesses and mortality (Jarvis & Wardle, 1999). The entrenched smoking norms amongst lower SES groups have made them the target for the tobacco industry and Tobacco Control interventions alike (Barbeau, Leavy-Sperounis, & Balbach, 2004).

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Qualitative research with lower SES smokers has tended to focus on how smoking functions to offer stress-relief and pleasure in the context of structural disadvantage (e.g. Bancroft, Wiltshire, Parry, & Amos, 2003; Graham, 1993). However, less attention has been paid to in-depth exploration of the stigmatization of lower SES smokers, the potential for which is high given that poverty itself is a stigmatized condition (Furnham & Gunter, 1984). This paper aims to rectify this gap.

Theorizing the stigmatization of health behaviours

Stigma is a mark of social disgrace that arises within social interaction (Goffman, 1963). It disqualifies bearers of the mark from full social acceptance. The extent to which an action such as smoking and the people associated with it are likely to be stigmatized depends upon a number of characteristics. Firstly, a stigma is more likely to be attached to a condition deemed to be the bearer’s responsibility. Secondly, stigma is increased when the condition threatens other people. Thirdly, greater stigma tends to be attached to conditions that are readily apparent to others and deemed aesthetically displeasing (Jones et al., 1984).

Although the ‘marking’ of a person as stigmatized occurs within inter-personal relationships, it cannot be divorced from broader social processes. What may be a stigmatizing characteristic in one era may not be in another (Dovido, Major, & Crocker, 2000). Furthermore, the process of stigmatization is an ideological one. Parker and Aggleton (2003) argue that ‘stigma is linked to the working of social inequality’ (p. 16) which serves to reproduce existing power relations. Crawford (1994) has illustrated this in the context of ‘health’ as a pre-eminent social value in Western society. He suggests that the bifurcated division of society into the ‘healthy’ (who almost invariably tend to be middle-class) and the ‘unhealthy’ (who almost invariably do not) functions to legitimate middle-class social dominance and ‘fitness to rule’. The stigmatization of the ‘unhealthy’ is an active social process; risky behaviour is associated with and projected onto ‘Other’ already stigmatized out-groups, for example gay and foreign people in relation to HIV/AIDS. Crawford’s work raises two interesting questions in the context of this paper; whether smokers are associated with already stigmatized out-groups and how the current institutional context might challenge or legitimate such stigmatization.

In the British context, health promotion and legislation are unequivocal about the dangers of passive smoking. This is evident in the ‘Second-hand smoke is a killer’ Tobacco Control campaign (DOH, 2005a), proposed legislation in the form of the ban on smoking in enclosed public spaces in the Health Bill (Health Bill, 2006) and, most visibly, in the warnings on cigarette packets such as ‘smoking seriously harms you and others around you’ (The Stationary Office, 2002). Stangor and Crandall (2000) have argued that ‘peril’, or a universal motivation to avoid threat, lies at the root of all stigmas. This threat can be material and tangible, such as to one’s health and/or symbolic, such as a threat to one’s worldview or moral values. How is the smoker, identified as a threat at an institutional level, seen by smokers and non-smokers?

Discourses about stigmatized health threats are related strongly to notions of morality. Rozin (1999) has argued that smoking in the US constitutes a textbook example of the process of moralization whereby what was once considered a ‘preference’ is now considered a ‘moral violation’. He argues that this has lead to the widespread stigmatization of US smokers (also see Goldstein, 1991; Kim & Shanahan, 2003).
Qualitative research in the British context has revealed many smokers report experiencing social disapproval. For example, Parry, Thompson, and Fowkes (2002) found that one of the most prominent themes when interviewing older smokers with arterial disease was the social change of smoking from the socially acceptable behaviour of their youth to an unacceptable one. A sense of isolation followed from this social disapproval and restriction. A comparative qualitative interview study with Greek and UK smokers found that UK smokers are exposed to a highly moralized construction of smoking. Smoking is held to be a legitimate target for public health intervention and restriction, which UK smokers themselves tend to accept. For Greeks, whose core model focuses on the rights of the individual, these restrictions can be construed as ‘racism’ against smokers (Louka, Maguire, Evans, & Worrell, 2006).

Two studies have investigated smoking-related stigma within specific groups in the British population. Chapple, Ziebland, and McPherson (2004) have shown that lung cancer patients feel stigmatized because of the association between their disease and smoking. The fear of being held causally responsible, and thus blamed, leads many of them to conceal it. Concealing the stigma of smoking is also a prime concern for women smokers within the British Pakistani and Bangladeshi communities. Within that community, it is a widely accepted male activity, consonant with notions of masculinity (Bush, White, Kai, Rankin, & Bhopal, 2003).

This study reported in this paper explores SES differences in the construction of smoking-related stigma in a sample of British smokers and non-smokers from higher and lower SES groups.

METHODS

Procedure

The traditional semi-structured interview has been criticized for its use of the ‘how?’ ‘when?’ and ‘why?’ question and answer format, which can produce intellectualized data (Holloway & Jefferson, 1997). A method that prioritizes reason-based explanation might hide the symbolic, emotional and experiential material in which stigmatizing discourses are contained. Therefore, this study used a novel combination of methodologies. Participants initially completed two ‘conceptual maps’ of their images of smokers and non-smokers. Each ‘map’ comprised a grid of boxes which participants had to fill with words and pictures (see Lloyd & Lucas, 1998). The aim was to elicit participants’ spontaneous ‘first thoughts’ concerning smokers and non-smokers. In line with psycho-dynamic tenets, first thoughts are assumed to reflect highly salient, visceral and symbolic material that may not be accessible at a conscious level (Joffe & Lee, 2004). Having generated free associations, the first part of the interview involved participants in expanding on their associations.

Following from this, an ‘episodic’ interview (Flick, 1997) was conducted, to elicit narrative as well as abstract data. Participants were asked to relate stories, experiences or ‘episodes’ from their lives concerning smoking and smokers. The interviewer probed those issues raised spontaneously. The only semi-structured questions posed were: ‘how do you think smoking is thought of nowadays?’ and ‘which groups of people do you associate with being smokers?’
Sample

Forty participants between 20 and 60 years of age were selected using an *a priori* sampling frame, which varied by socio-economic and smoking status. ‘Higher’ and ‘Lower’ SES was derived using the NS-SEC 2000 classification (Rose & Pevalin, 2001) using a median split between the eight categories. ‘Smokers’ were defined as regular smokers who currently smoke more than one a day. ‘Non-smokers’ were defined as those who do not currently or have never smoked more than one a day (Royal College of Physicians, 2000).

Participants were obtained from the Camden and Islington Smokers’ Clinic database (Department of Epidemiology and Public Health, UCL) and the Research Participation Database of the Psychology Department, UCL. After ethical approval was obtained, interviews were conducted and recorded with consenting participants, either in UCL’s Psychology Department or in participants’ homes.

Analysis

A coding frame was developed using the transcripts and applied systematically to all interviews using the Atlas-ti qualitative analysis software. A thematic analysis (Joffe & Yardley, 2004) was then undertaken.

FINDINGS

The thematic analysis revealed several main themes, one of which was the stigmatization of smokers. The three key aspects of stigmatization are presented here: the metaphor of pollution, the experience of social disapproval and the identification of the smoker with the ‘Other’. In each section, the non-smokers’ constructions are presented first, followed by those of the smokers. SES differences are discussed where pronounced.

The metaphor of pollution

*Non-smokers.* Non-smoking participants associate smokers with a strong negative aesthetic. This comprises two aspects, smell (e.g. ‘reek’, ‘pong’, ‘stink’, ‘stale’, ‘old’) and negative appearance (‘stained yellow fingers’, ‘grey, dry, wrinkly skin’, ‘brown teeth’). This negative aesthetic links smokers to connotations of premature aging, poor health and decay. It also functions as a negative ‘marker’ or ‘sign’ by which smokers can be distinguished within the population.

This sense of embodied dirt and decay is linked to a metaphor which non-smokers use extensively; smoking as pollution. Smoking is described by them as a ‘dirty’ or ‘filthy’
habit, cigarette butts as ‘rubbish’ and cigarette smoke as ‘polluting’ or ‘toxic’. The smoker is dirtied by this association; several non-smokers see smokers as lacking in cleanliness and engaging in poor self-care.

The pollution metaphor is also used to explain passive smoking as ‘contamination’. Passive smoking is represented by non-smoking participants as an ‘invasion’ of personal and spatial boundaries and a contravention of a ‘right’ not to be affected by the actions of others. In terms of assessing the risk posed by passive smoking, non-smokers tend to feel it is less risky than if they personally smoked, but that it does increase the risk slightly. Any reason-based risk assessment of such ‘contamination’ is accompanied by very strong emotions. Participants report ‘disgust’, ‘dislike’ and feelings of physical sickness in response to ‘being polluted’. The following extract, for example, reveals this participant’s previously unarticulated fear of bodily contamination, which underpins her dislike of passive smoking:

When I am standing behind someone and the smoke is coming in my face, I don’t really think about the health side of it at all, really, I think oh god, that’s been in your body, I don’t want it in mine now. I think it’s dirty. It’s not just smoke, it’s second-hand smoke cos it’s been down your lungs, in your mouth and now it’s coming into my body. I never said that before.
Participant 25, (non-smoker, lower SES female)

Moral judgement is particularly harsh for those who ‘contaminate’ those who are perceived to be innocent and vulnerable, such as young children or babies.

Smokers. Smokers certainly show awareness of the negative aesthetic associated with their social group. However, a strong group-based difference exists in this regard. Higher SES smokers do not tend to personally identify themselves with the negative appearance. They distance themselves from it by associating it with ‘older’ or ‘heavier’ smokers. Higher SES smokers also tend to use the pollution metaphor to their advantage to mitigate any perceived blame, by arguing that pollution caused by their personal smoking is equivalent or of lesser impact than other types of pollution. They also point out that they are demonized for their polluting behaviour in a way that other polluters are not:

Yeah, ok, it is a disgusting habit and it’s smelly and everything, but so is belting out crap from cars and I don’t drive, so I’m sure more crap comes out of people’s cars driving to work than the sort of crap I put in the atmosphere. Being a smoker is a habit that you have to hide, whereas driving a car that is a horrible polluting thing, that’s fine, that’s ok.
Participant 37 (smoker, higher SES female)

Higher SES smoking participants also tend to argue that the health risk for passive smokers is relatively low, both in comparison to their own personal risk and in general. Lower SES smokers, on the other hand, seem to be more accepting, both of the negative aesthetic in which their habit is couched and their status as a ‘risk’ to others. All of the lower SES smokers in the sample volunteer the information that their smoking poses a risk through passive smoke, and many go on to identify this level of risk as reasonably high. A few think the risk associated with smoking is equal or higher for non-smokers than smokers, suggesting the internalization of their identity as polluters:

Non-smokers I think, from what I’ve read and seen on the TV, the effects of smoking are more serious for a non-smoker inhaling it, secondary smoke, than someone who smokes.
Participant 19 (smoker, lower SES female)
The experience of social disapproval

**Non-smokers.** Non-smokers identify smokers as part of a minority group whose behaviour is ‘anti-social’ and ‘unacceptable’. This is seen as having intensified in recent years, making smokers a stigmatized group. Non-smokers use terms such as ‘outcast’, ‘persecuted’, ‘lepers’, ‘under-class’ and ‘blacklisted’ to describe smokers’ status in society.

The extent to which non-smokers report that they themselves are personally tolerant or disapproving of smokers varies considerably. Few non-smokers mention showing direct disapproval of smokers by challenging them face-to-face. Rather, they argue that smokers’ status as a stigmatized minority is reinforced by the segregation of public places into smoking and non-smoking zones. According to non-smokers, there are clear spatial norms in which it is ‘not acceptable’ to smoke. These are primarily in enclosed spaces such as public transport where the physical ‘risk’ of contamination is high, or in one’s personal space. There is a particular sense of disgust concerning smoking around food/in restaurants, which may reflect more symbolic contamination fears. Considerable social disapproval is shown to those who transgress these spatial (and moral) boundaries. Although non-smokers mention benefits of being in the ‘smokers’ club’, such as opportunities for bonding, these are outweighed by social disapproval. Indeed, such social disapproval is displayed openly by many non-smoking participants, indicating the social acceptability of such beliefs:

If you go to a restaurant you have to be separated, segregated from other people. I feel they are kind of judged, and if they were coming to a person like me who really is against smoking, unfortunately before they have even opened their mouths, that’s a strike against them.

Participant 39 (non-smoker, lower SES female)

**Smokers.** Smokers’ sense of the social disapproval they face varies as a function of socio-economic group. Higher SES smokers see themselves as part of a very small, and ever shrinking, minority group, although they rarely use derogatory terms such as ‘outcasts’ or ‘lepers’. For them smoking has become an activity to be concealed in many contexts, such as from family members. Few higher SES smokers have ever been directly challenged about their smoking behaviour. Rather their concern is the negative perceptions their smoking status might create:

I don’t like the fact that you are automatically always, you do get stereotyped as a smoker and people have their list of, you know, things . . . they just automatically make certain associations. If you smoke, I think people see you as being, not off the straight and narrow, but I do think that people class you differently, they kind assume it’s a bit naughty and I think it had a kind of selfish aspect.

Participant 2 (smoker, higher SES female)

By way of contrast, lower SES smokers tend to perceive themselves as part of a larger minority or even majority group within their own social milieu. Despite seeing themselves as living within a context where there is a ‘mix’ or ‘balance’ of smokers and non-smokers, many more label themselves as ‘outcasts’ when compared with the higher SES smokers. This may indicate their acceptance of this status. They also detail many more instances of indirect social disapproval directed at them: from the looks of strangers in public places to family members who ‘hate’ them smoking. Lower SES smokers also tend to report more

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2Social disapproval can broadly be divided into two categories: ‘indirect’ in which the smoker is not directly challenged (e.g. seeing no smoking signs, being in an environment where smoking is perceived as unacceptable) and ‘direct’ in which the smoker is directly confronted by a comment or action.
direct challenges to their smoking behaviour as they take it out into social contexts in which non-smoking is the norm:

After I had my hysterectomy, I was bringing my catheter bag and my drips and my morphine to walk half a mile to get outside a side door to have a cigarette and this surgeon came in the morning, me and a few other people had been standing in the doorway where it was strictly you couldn’t smoke, but I thought it’s early and no one will notice and the surgeon came in and the way he spoke to me and looked at me, with disgust that I was smoking and said ‘you shouldn’t be smoking here’.
Participant 19 (smoker, lower SES female)

The identification of the smoker with the ‘Other’

Non-smokers. Many non-smokers associate smokers with a number of specific out-groups. One particularly salient group is the older smoker. The primary connotations within this image are poor health, heavy addiction and the poverty smoking might cause. However, older smokers are not generally held responsible for their smoking, which is seen to have started when they were young and ‘didn’t know better’; they are therefore not morally censured for continuing to smoke. At the other end of the age spectrum, very young ‘immature’ teenage smokers are censured. They are perceived to be concerned with the ‘coolness’ of smoking and thus associated with weakness as they ‘give in to peer pressure’.

Women smokers are also a salient group throughout the interviews of non-smokers, and they rarely appear in a positive light. Many non-smokers mention that young teenage girls smoke more than boys nowadays. Another highly salient female is the ‘smoking mother’. The smoking parents who are identified are, without exception, mothers:

There is a Croatian girl upstairs that I have known for years and years and I saw her downstairs smoking for the first time and I had no idea that she smoked and it really shocked me and I was quite surprised with that, as it didn’t go with her, I didn’t think it went with her image cos she’s a mother and stuff and I think it’s important that they are a good role model, I don’t really like smoking mothers for a start.
Participant 26 (non-smoker, higher SES male)

Smokers are also linked, particularly by higher SES non-smokers, with working-class groups and social disadvantage. A variety of terms are used, such as ‘poor council house tenants’, ‘lower class benefits kind of image’, ‘low income’, ‘poor’, ‘working-class’ and ‘unemployed’. One aspect of this identification concerns the ‘lack of intelligence’ of smokers in light of their disregard for health messages. The other is lack of responsibility with money and a lack of control over their lives in general.

The association between stigmatized out-groups and smokers coheres in the form of the ‘poor young single mother who smokes’. This combines several stigmatized groups: the ‘immature’ youth, the poor, females and smokers. This confounding of marginalized groups may augment the strength of the negative associations:

It’s all linked, the less well-off people are, the more likely they are to smoke and damage their own or their children’s lives. If the children are unborn, for example the mother’s smoking has an effect and it affects the money that can be spent for food.
Participant 8 (non-smoker, lower SES male)

Smokers. Higher SES smokers tend to make similar, though far fewer, associations between smoking and social out-groups. However, they are careful to distinguish
themselves from these ‘types’ of smoker. For example they make positive social comparisons between themselves as young and unaffected by smoking and those who are not, such as the older smoker. They thereby distance themselves from this negative social identity. Half of the higher SES smokers make a connection between smoking and lower social status. However, it lacks the moral dimension of the non-smokers’ construction. Furthermore, not all their associations are negative. Higher SES smokers also mention young ‘trendy’ affluent smokers as a group with whom they, often in terms of positive self-identification, associate smoking.

Lower SES smokers make the fewest associations between out-groups and smokers. No lower SES smoker in the interviews made an association between social disadvantage and being a smoker. This may reflect that they do not wish to identify themselves (as members of this group) with the attendant negative connotations.

DISCUSSION

The results suggest that British smokers are identified via a negative aesthetic marker, consisting of smell and appearance. Like all stigmatized marking, they are not assessed merely at a cognitive level, but emotionally too (Jones et al., 1984). Non-smokers report repulsion, dislike, irritation, sickness and, most often, disgust in the face of them. This concurs with Rozin (1999) theory that moralized entities are often subject to disgust. It is interesting to note that the free association conceptual map technique used in this study allows the expression of this visceral emotion which underlies the stigmatization of smokers.

Disgust is linked conceptually to the ‘peril’ of smoking through the metaphor of ‘pollution’. As mentioned, the concept of threat has been argued to underpin all stigmas (Stangor & Crandall, 2000). At its heart, the construction of smoking as pollution identifies smokers as contaminators who invade the personal space and physical bodies of others. This status as a source of ‘peril’ marks smokers out as legitimate targets for stigmatization and moral judgement, particularly those who are perceived to harm ‘innocents’ (Louka et al., 2006; Rozin, 1999).

Although the threat may be material, it is filtered through moral and symbolic lenses. Douglas (1966) has pointed to the importance of purity laws, ascribing who is ‘dirty’ and ‘clean’, as a way of controlling the physical and social body. This is very much in evidence in the unwritten social rules of smoking revealed by the sample. They relate to smoking in personal and confined spaces and near to food, which is often subject to purity norms. The non-smoking and smoking participants identify and defer to these norms, at least in public, even if they privately contest them. This may reflect an acceptance by smokers of their identity as modern-day polluters who have to be contained.

The level of acceptance, however, differs according to the SES of the smoker. Higher SES smokers tend to minimize the risk they present to others and compare their polluting behaviour favourably with that of other polluters such as car drivers. This functions to distance them from an undesirable social identity. On the other hand, the lower SES smokers tend to identify with the norm that they present a great risk to others. This acceptance of their ‘danger’ to others may indicate an internalization of the ‘spoiled’ smoking identity.

Social disapproval and the disruption of social interaction also differ qualitatively between the lower and higher SES smokers. Lower SES smokers report wide-ranging direct and indirect social disapproval, while higher SES smokers report only a limited
degree of the latter. Initially, this finding seems counter-intuitive. Higher smoking rates in the lower SES groups mean smoking is more normative. However, as lower SES smokers move out of their own social milieu into a wider, non-smoking one, their normative behaviour becomes stigmatized.

These results also provide support for Crawford’s contention that risky health behaviours are projected onto social out-groups. In the interviews, smokers are associated with the old, the unhealthy, women and the working-class/disadvantaged. Identification of such groups (often in combination) is particularly common amongst higher SES non-smokers, who benefit in terms of fortifying their social status as ‘healthy’. It could be argued that the identification is rooted in material circumstances rather than projection; greater numbers of working-class individuals, for example, smoke (Lader & Meltzer, 2004). However, the material level does not account for the finding that poor smoking mothers, in particular, are demonized for ‘harming their children’. Men smoke more than women do (Lader & Meltzer, 2004) and the risks to children of either parent smoking are similar, apart from during pregnancy.

The increasing stigmatization of smokers has not taken place in a vacuum. The government aims to close the smoking gap as a mechanism for reducing health inequalities (The Stationary Office, 1998). Yet, the stance taken in its health promotion and legislation may be exacerbating stigmatization of smokers. For example the Department of Health’s Tobacco Control campaign ‘Ugly Smoker’ (with slogans such as ‘You smoke, you stink’ and ‘Smoking makes your teeth minging’) aims to target young women’s concerns about attractiveness by playing on the stigmatizing marks and negative aesthetic discussed in this paper (DOH, 2005b). In addition, the Government’s passive smoking initiatives represent an uncritical acceptance of the notion that smokers represent a significant health threat to all others at all times, despite scientific controversy and reservations about the proportionate nature of legislation (The Stationary Office, 2006).

Stigmatization of smokers may be functional if one’s goal is to reduce overall smoking rates—an unfavourable smoking climate encourages quit rates at both an individual and a state level (Kim & Shanahan, 2003). However, from an ethical perspective, marginalization and stigmatization are considered retrograde within other health promotion arenas, such as AIDS/HIV prevention (Bayer & Stuber, 2006). Furthermore, stigmatization may not be equally motivating across socio-economic groups. Smoking rates remain as high as ever in lower SES groups despite growing stigmatization. Unlike higher SES smokers, the study has shown that lower SES smokers tend to internalize stigmatization rather than challenge it or change their behaviour to avoid it. Current health promotion campaigns that focus on the ‘peril’ smokers represent, and the disgust they engender, may push higher SES smokers into quitting, but fail to engage the already stigmatized (often multiply) disadvantaged smoker. They are thus more likely to perpetuate smoking inequalities than remove them.

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3A ‘minger’ is a colloquial British term used by young people for an ugly disgusting woman, thus ‘minging’ in this context means unattractive and repulsive.
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