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The role of gender and social context for men's and women's smoking behaviour.

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Ce mémoire intitulé :

The role of gender and social context for men's and women's smoking behaviour.

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SUMMARY

Considerable population reductions in smoking prevalence have been witnessed in developed countries. However, despite population reductions, smoking has increasingly become socially stratified, a trend that emerges as particularly salient when examining smoking according to gender. The way the social context is gendered and shapes men's and women's smoking behaviour is critical in understanding gender disparities in smoking. The goal of this study is to examine how three elements of the social context are gendered and the way in which they differentially shape men's and women's smoking practices. The study includes 23 in-depth interviews with adult smokers living in Toronto and Montréal, stratified by socio-economic position and gender. Interviews were loosely based on themes related to the social context of smoking. Our results show that first, women express considerable dissonance between gender identities and smoking behaviour, whereas men's gender identities seem to reinforce smoking behaviour. Second, smoking was relevant for a woman's sense of physical attraction. The fear of weight gain during cessation also emerged as a significant factor only for women's smoking maintenance. Last, women suggest wanting, but not having control over smoking behaviour and cessation, while men express having control over smoking cessation, but with little urgency to do so. As elements of the social context are gendered and strongly shape men's and women's smoking behaviours, tobacco control initiatives ought to increasingly address the social construct of gender, as well as some of the inequalities inherent in gender norms, in order to further reduce the gender disparities in smoking.

KEY WORDS: gender, smoking, social context, social inequalities.

RÉSUMÉ

Des réductions considérables dans les taux de tabagisme ont été constatées dans les pays développés. Cependant, le tabagisme est devenu plus stratifié socialement, une tendance qui apparait lorsqu'on examine le tabagisme en fonction du genre. Comment le contexte social est influencé par le genre et comment il influence le tabagisme chez les hommes et les femmes est pertinent pour comprendre les inégalités dans les taux de tabagisme en fonction du genre. Cette étude a pour but d'examiner trois éléments du contexte social en considérant comment ces éléments sont influencés par le genre et façonnent le tabagisme chez les hommes et les femmes. L'étude portait sur 23 entretiens qualitatifs avec des fumeurs et des fumeuses adultes habitant Toronto et Montréal, stratifiés selon leur position socio-économique et genre. Les entretiens se basaient sur des thèmes reliés au contexte social du tabagisme. Nos résultats démontrent premièrement, que la majorité des femmes ressentaient un désaccord entre leurs identités et leur tabagisme alors que l'identité masculine semblait renforcer les pratiques tabagiques. Deuxièmement, le tabagisme était important pour l'attirance physique des femmes et l'appréhension reliée à un gain de poids était un facteur important dans la décision des femmes de continuer de fumer. Troisièmement, les femmes semblaient vouloir plus de contrôle sur leur tabagisme, alors que les hommes affirmaient qu'ils avaient le contrôle, mais qu'il n'était pas urgent d'arrêter de fumer. Les initiatives antitabac devraient mieux considérer l'effet du genre, ainsi que les inégalités de genre, afin de réduire les disparités tabagiques en fonction du genre.

MOTS CLÉS: genre, tabagisme, contexte sociale, inégalités sociales

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CHAPTER 1. INTRODUCTION

Tobacco use has been characterised as the "single largest risk factor for a variety of malignancies" (Emmons, 1999, p. 490) including cardiovascular disease, pulmonary disease, and a variety of cancers (Baker, Brandon & Chassin, 2004; Emmons, 1999) and is considered the "leading preventable cause of morbidity and mortality in developed countries" (Baker et al., 2004, p. 464). As such, cigarette smoking poses a substantial health risk to Canadians and is a significant concern for public health. Health Canada (2003) warns that half of all smokers will die from smoking-related diseases and that the continued use of tobacco results in an estimated 3 million smoking-related deaths per year worldwide (Baker et al., 2004; Emmons, 1999; Health Canada, 2003), including 45,000 deaths in Canada alone in 2005 (Health Canada, 2006).

As a result of public health and tobacco control efforts in Canada, the past five decades have seen considerable declines in smoking prevalence among Canadians, with smoking rates in Canada falling by almost one-half since 1985, from 35% to 19% (Canadian Tobacco Use Monitoring Survey (CTUMS), 2006). Since as recently as 1996, for age groups with the highest smoking rates, that is, young adults aged 15 to 19 and adults aged 20 to 24, smoking declines have also been considerable, namely, 12% and 10% respectively (CTUMS, 2006).

However, despite these relatively promising figures, Canadian population declines in smoking rates have not been unequivocally optimistic and smoking remains a ubiquitous practice. Currently 20% of men and 17% of women make up the 5 million Canadians (roughly 19% of the Canadian population) who still consider themselves smokers (CTUMS, 2006). In addition, despite the steady declines among younger smokers throughout the 1990s, smoking rates for 15 to 24 year olds have remained relatively stable since 2003, with total rates hovering around 20% (CTUMS, 2006; Health Canada, 2005). Furthermore, smoking has become increasingly concentrated among socially and economically disadvantaged populations. That is, those individuals with lower educational attainment, in working class occupations and with lower income levels are smoking more

and are experiencing smaller and slower decreases in smoking rates (Barbeau, Leavy-Sperounis & Balbach, 2004).

Alongside these smoking trends, the past five decades have also witnessed the traditionally large gap between men's and women's smoking undergo a considerable decrease, with women beginning to make up a significantly larger proportion of current smokers (Barbeau, Krieger & Soobader, 2004; Hunt, Hannah & West, 2004). Moreover, among some young smokers, the conventional gendered smoking trends have even begun to reverse (Barbeau, Leavy-Sperounis et al., 2004; Greaves, Jategaonkar & Sanchez, 2006; Hunt et al., 2004; National Strategy to Reduce Tobacco Use in Canada (NSRTUC), 1999). These changing smoking patterns among men and women are particularly critical as they have also resulted in corresponding gender transformations in the morbidity and mortality of smoking related illnesses (Payne, 2001).

An investigation into the role that gender plays in shaping men's and women's smoking behaviour is clearly important. Gender has been defined by Health Canada (2003) as the "array of socially constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis". As a major social influence, gender cuts across all populations, intersecting all aspects of our lives, influencing what we do, how we are perceived by others and how our identities are formed (Greaves & Barr, 2000). Gender also outlines for us the socially appropriate roles we take on and the type of activities that we pursue, including health behaviours such as smoking (Greaves & Barr, 2000). As such, despite the relatively optimistic population declines in overall smoking prevalence, the changes in smoking patterns according to gender and the gender disparities in smoking related illnesses that have developed require attention.

The objective of the current study is to examine the way in which the social construct of gender shapes men's and women's smoking behaviours. Specifically, through a comparative analysis of men's and women's narratives around smoking and the social context, this study aims to gain insight into the different ways in which the social context is gendered and how various elements of the social context differentially shape smoking behaviours for men and women. In addition, by examining the ways individual smokers

both reflect and reinforce common notions of gendered smoking behaviour, the gender inequalities witnessed in smoking patterns may be better understood and more successfully countered in tobacco control practices.

CHAPTER 2. LITERATURE REVIEW

2.1 Inequalities in smoking according to gender

In response to the first American reports in the 1960s decisively linking lung cancer to tobacco use, the past five decades have produced increasingly aggressive anti-tobacco public health campaigns in order to counter the serious health costs incurred by cigarette smoking (Ginsberg, 2005). Canadian smoking trends documented since the 1960s suggest that the decreases in smoking rates in Canada have in fact largely been due to the successes of the aggressive anti-smoking campaigns (Greaves & Jategoankar, 2006; Kirkland, Greaves & Devichand, 2003).

However, despite their overall success within the Canadian population, tobacco control efforts have not been equally effective in reducing and preventing smoking among all segments of the population (Poland et al., 2006). Unlike in the early 20th century when tobacco use primarily existed among men (and very few women) who occupied higher socioeconomic positions, smoking rates have begun to exhibit an increasingly steep social class gradient with smoking becoming concentrated among socially and economically disadvantaged populations (Crosier, 2005; NSRTUC, 1999; Poland et al., 2006). For example, reports have shown that by the late 1990s roughly 35% of women and 41% of men at the lowest income levels still smoked while only 18% of women and 22% of men at the highest income levels considered themselves smokers (Greaves & Jategaonkar, 2006).

Furthermore, women have begun to make up a considerably larger proportion of current smokers (Barbeau, Krieger et al., 2004; Gillies & Willig, 1997; Hunt et al., 2004; World Health Organization (WHO), 2003). Historically, smoking was considered a predominantly male behaviour with men's smoking rates consistently and considerably higher than those of women. In the past five decades, however, not only has the gender gap in smoking rates between men and women of all ages narrowed, but it is alarming to find that among some younger age groups the smoking trends according to gender have actually begun to reverse (Barbeau, Leavy-Sperounis et al., 2004; Crosier, 2005; Greaves et al., 2006; Hunt et al., 2004; NSRTUC, 1999; Rudy, 2005). For example, global examinations

of smoking patterns according to gender reveal that the decline in smoking has been significantly slower among women than that among men (Barbeau, Leavy-Sperounis et al., 2004; Crosier, 2005; Emmons, 1999; Greaves, 1996; Greaves & Jategaonkar, 2006; Greaves et al., 2006; Hunt et al., 2004; Payne, 2001). Specifically in Canada, over the 36-year period from 1965 to 2001, the percentage of men smoking decreased by 36%, from 61% to 25%, whereas the decrease in smoking rates among women during the same time period was only 17%, moving from 38% to 21% (Kirkland et al., 2003).

While aggregated smoking trends for men and women suggest that on average, men still have higher smoking rates than women, when smoking data are stratified according to age, a distressing trend comes to light: smoking rates for young women between the ages of 15 and 24 have begun to surpass those of young men of the same age (Gillies & Willig, 1997; Hunt, et al., 2004; Kirkland et al., 2003). This reversal of the traditional, male-dominated smoking prevalence patterns has been documented in a number of other developed countries, among them Austria, Canada, Denmark, England, France, Germany, Iceland, New Zealand, Norway, Scotland, Sweden and Switzerland (Greaves, 1996; Greaves et al., 2006; Health Canada, 2003; Hunt et al., 2004; Kirkland et al., 2003; Plumridge, Fitzgerald & Abel, 2002; WHO, 2001). Researchers in each of these countries have documented changing smoking patterns among young men and women over the course of the last decade and have found higher percentages of smoking among young women than young men.

The transforming distribution of smoking according to gender becomes particularly troubling when examining smoking's health consequences. While deaths due to lung cancer have been declining or levelling off for men in many developed countries, there has been a rapid increase in incidence and mortality due to lung cancer for women over the same time period (Payne, 2001). In fact, it has been calculated that since 1990, the number of lung cancer cases has increased by 17% in men but has jumped by 27% for women. Looking further back, it has been estimated that since 1950, mortality due to lung cancer has risen 197% for men, but 612% for women (Ginsberg, 2005). The increases in lung cancer rates among women have been linked to increases in women's smoking rates over the last five decades, as well as with more recent changes in women's smoking behaviour (Ginsberg, 2005; Payne, 2001; Popay & Groves, 2000). These changes in smoking patterns have led to

the need for increased research that examines the role gender plays in men's and women's smoking behaviour.

2.2 The biological and individual lifestyle perspectives

Biomedical research examining tobacco use has traditionally considered smoking as, first and foremost, a nicotine addiction (Laurier, McKie & Goodwin, 2000; National Institute on Drug Abuse (NIDA), 2001). This has led to a large body of research investigating the role of biology in tobacco addiction in order to help provide biological explanations for smoking initiation and to find better pharmacological treatments for smoking cessation (Batra, Patkar, Berrettini, Weinstein & Leone, 2003; Becklake, Ghezzo & Ernst, 2005; NIDA, 2001; Rodriguez et al., 2006; Vink, Willemsen & Boomsma, 2005).

For example, medical studies investigating the genetic and neurobiological determinants of nicotine dependence have proposed biological predispositions for tobacco addiction, and twin and adoption studies have been conducted to examine the heritability component of becoming a smoker (Batra et al., 2003; Vink et al., 2005; Zang & Wynder, 1996). The National Institute on Drug Abuse (NIDA, 2001), a major player in the dissemination of information regarding addiction and drug abuse in the United States, endorses this biomedical position towards tobacco use. They equate tobacco use with other serious addictions, writing that "addiction is characterized by compulsive drug-seeking and use, even in the face of negative health consequences, and tobacco use certainly fits the description" (NIDA, 2001).

Biomedical research that has examined gender and tobacco use has tended to focus on the sex-linked factors that influence differential health outcomes and differential smoking behaviours between men and women (Gough, 2006; Krieger, 2003; Payne, 2001). For example, in her review of sex, gender and causes of lung cancer, Payne (2001) discusses research in which men and women differ with regard to their biological vulnerability to developing lung cancer from smoking. Payne (2001) discusses a study by Hegmann et al. (1993), which found that the age at which one begins to smoke presents a different level of risk for men and for women, independent of the type of cigarette and the amount smoked.

Other medical studies have suggested that women are more vulnerable to some carcinogens in tobacco than men and that some sex-linked hormonal factors are the reason for this discrepancy (Ginsberg, 2005). A study conducted by Zang and Wynder (1996) discusses the difference between men's and women's metabolic activation and detoxification of lung carcinogens. The authors found that the risk for major lung cancer types is consistently higher for women at every level of smoking, and that this difference is most likely due to men's and women's differential susceptibility to tobacco carcinogens (Zang & Wynder, 1996). However, evidence in this area is mixed, and research is relatively limited regarding the question of whether it is the biological factors that differ between men and women that account for differential risk (Payne, 2001).

Although epidemiological research is concerned with gender differences in health, gender in this context is often still viewed as an individual's biological "sex" (Krieger, 2003). For example, in this body of research gender is operationalised as the variable "sex" and as a factor that must be statistically controlled for in order to remove it as a possible confound in the measurement of health differences between men and women (Denton, Prus & Walters, 2004; Emslie & Hunt, O'Brien, 2004; McKee, O'Malley, Salovey, Krishnan-Sarin & Mazure, 2005; Popay & Groves, 2000; Popay, Williams, Thomas & Gatrell, 1998; Stewart & McDermott, 2004; van Loon, Tijhuis, Surtees & Ormel, 2005; Westmaas & Langsam, 2005; Yoder & Kahn, 2003).

In addition to the pervasive biomedical view of tobacco use as nicotine addiction and the 'gender as sex' assumption in some epidemiological research, tobacco research in public health has predominantly conceptualised smoking as existing at the level of the individual, and as resulting from poor individual lifestyle choices (Frohlich & Poland, 2007; Laurier et al., 2000; Poland et al., 2006; Popay et al., 1998). This individual lifestyle approach to tobacco use is subscribed to by researchers in various fields of health research, including nursing, psychology, epidemiology, medicine and public health, the common denominator being that the cause for tobacco use rests within the individual.

Specifically, health research in psychology and psychiatry has investigated the psychological characteristics possessed by individuals who initiate and continue to smoke,

compared with the traits of individuals who do not smoke or who have successfully quit smoking (Baker et al., 2004; Gillies & Willig, 1997; McKee et al., 2005; Pierce, Distefan, Kaplan & Gilpin, 2005; Shepis & Rao, 2005; van Loon et al., 2005; Wagner & Atkins, 2000; Westmaas & Langsam, 2005). These studies tend to investigate individual psychological traits, including levels of negative affect and depression, stress and anxiety, impulsivity, sense of curiosity, motivation and self-efficacy, as well as the existence of various forms of psychopathology for their influence on smoking behaviour (Baker et al., 2004). The assumption is that, if the individual's psychological traits are properly targeted and the individual sufficiently motivated to change them, the individual will successfully quit smoking.

For example, McKee et al. (2005) examined the association between motivation to quit smoking and the differences in men's and women's perceived risks and benefits of smoking cessation and their cessation outcomes after treatment. The authors suggest that knowledge regarding motivation to quit and men's and women's perceptions of risks and benefits for quitting smoking should inform public health campaigns. They suggest that campaigns ought to be designed to increase motivation for cessation and to modify those beliefs that are associated with lowered treatment response (McKee et al., 2005).

Research conducted within the fields of health promotion, social epidemiology and public health has also tended to examine an individual's lifestyle choices as potential contributors to the risk of developing particular illnesses (Frohlich, Corin & Potvin, 2001; Popay et al., 1998). The lifestyle choices over which the individual is believed to have autonomy and which are targeted through health promotion interventions include level of exercise, nutritional habits, alcohol consumption and smoking behaviour. As such, when these lifestyle behaviours are performed poorly or incorrectly they are deemed risk factors for health. In order to address this, health promotion and tobacco control efforts have generally created health education programmes aimed at changing individuals' attitudes towards smoking behaviours (Frohlich & Poland, 2007).

2.3 Critique of the biological and individual lifestyle perspectives

The body of research examining the biological factors involved in tobacco use and addiction is critical for providing clues as to why any given individual smokes and for facilitating cessation through various nicotine replacement therapies. Medical research has also helped gain a better understanding of some of the possible sex-linked biological factors involved in men's and women's differential tobacco-related illnesses, which may be important to consider for tailoring smoking cessation programmes. However, these studies tell us little about how these factors contribute to the social distribution of smoking (e.g., along socioeconomic or gender lines), and they do little to enlighten us to changes in population smoking prevalence over time (Frohlich & Poland, 2007), such as the changing smoking patterns that have developed between men and women over the course of the last few decades.

The biomedical focus in research on smoking and addiction also raises important questions regarding the nature of an individual's ability to choose and his/her agency to act with regard to his/her own health behaviours (Gillies & Willig, 1997). Specifically, the biomedical approach reduces smokers to their biology, positioning smokers as victims of their tobacco addiction (perhaps even as slaves to their genes) (Poland et al., 2006). As this research omits the role of individual agency, it also ignores the way individual decisional acts interact with, and are shaped by, the particular social and cultural setting in which individuals find themselves.

The individual-focussed and lifestyle approach to health that is prevalent in public health research has also been criticised. For instance, Frohlich and Poland (2007) have suggested that the individual-level approaches to behaviour modification (e.g., McKee et al., 2005) are ineffective in helping people change their behaviours. They suggest that true changes in the health of the population must address the "fundamental causes" of the behaviour, that is, the mechanisms that create risk, such as the social context.

Furthermore, Frohlich et al. (2001) have suggested that by viewing lifestyle choices (e.g., amount of exercise, nutritional habits, alcohol consumption, smoking behaviour) as directly related to risk behaviours, the individual lifestyle approach to health reduces

lifestyle to a pathology. Considering lifestyle choices as risks for health also places the blame for possible health consequences (illness or need for medical care) on the individual, since it posits that health problems are due to poor lifestyle choices. The authors suggest that this manner of viewing lifestyle results in the study of health behaviours "independently of the social context, in isolation from other individuals, and as practices devoid of social meaning" (p. 784).

Moreover, while studies within the field of epidemiology acknowledge the importance of health differences between men and women, the studies often make no attempt to explain the reasons for the differences found. Williams (2003) argues that approaches in epidemiology that investigate race, class and gender are problematic as they "distil the effects of social and relational ideologies, structures and practices ... into the characteristics of discrete and self-contained individuals" (Shim, 2002 cited in Williams, 2003, p. 140). He suggests that epidemiology leaves unseen the social relationships of power and life chances that contribute to the disparities seen in men's and women's health (Shim, 2002 cited in Williams, 2003). Specifically with regard to gender, Chapman Walsh, Sorensen and Leonard (1995) have similarly argued that by omitting precisely those social influences that endow power and resources on the basis of gender, epidemiological research has left the important social processes involved in determining health "unidentified, unquestioned, and unexplored" (p. 149).

2.4 The social context of smoking

As smoking in particular has been acknowledged as a health behaviour that carries social and cultural meaning beyond its biomedical effects (Greaves, 1996; Michell & Amos, 1997; Plumridge et al., 2002; Shevalier, 2000; Wiltshire, Amos, Haw & McNeill, 2005), some health research concerned with tobacco use has examined the role of the social context for smoking and cessation, albeit in diverse ways (e.g., Baker et al., 2004; Dedobbeleer, Béland, Contandriopoulos & Adrian, 2004; Gilbert, 2005; Rice et al., 1996 Weden, Astone & Bishai, 2006). As such, a few examples may be useful before outlining the way the current study conceptualises social context.

Research conducted by Rice et al. (1996) examines the role of social support and social context variables as predictors of smoking cessation among a high-risk group of individuals with heart disease. In their study, social support for smoking cessation and several social context variables (age, education, marital status, gender and exposure to other smokers inside and outside of the home) are examined for their influence on an individual's chances of quitting smoking. The authors suggest that social support, gender (being male or female) and marital status influence smoking cessation among heart disease patients and that these factors ought to be considered in future interventions among such high-risk smokers. In this way, interventions arising from studies such as these are critical, as they address a group of smokers with an elevated risk of continued morbidity and mortality (Rice et al., 1996). However, this study does not address the larger question of why these individuals began to smoke or why they continue to smoke despite their illness. In addition, interventions based on a study such as this one remain relevant only for particular high-risk smokers (Frohlich & Poland, 2007) and therefore do little to change overall population rates of smoking.

Dedobbeleer et al. (2004) also examine the effect of both individual and social context factors on men's and women's smoking behaviours in Canada between 1978 and 1995. In their study, they examine the differential impact that cigarette prices, tobacco control legislation, newspaper coverage of tobacco issues, economic factors and social milieu had on men's and women's smoking rates (Dedobbeleer et al., 2004). The authors find that various contextual factors influence men's and women's smoking prevalence differently. They suggest the use of a "society and health" model for explaining smoking behaviour which includes influences on smoking from four distinct levels: the intrapersonal factors, the interpersonal relationships, the complex relationships with the community or organisations involved in smoking control, and the relationships with the larger social environment (Dedobbeleer et al., 2004).

While Dedobbeleer et al. (2004) aim to be inclusive of both individual and social context variables in order to explain which variables are most important for smoking and cessation, they do not explain how and why the particular social factors are differently important for men and women. They also do not answer the question of why smoking is socially distributed according to the particular gender patterns they found in their study.

Furthermore, Williams (2003) criticises this understanding of social context that operationalises context and individual behaviour separately, the way it is typically done in epidemiology. He argues that by making a strong distinction between context and individual behaviours as independent levels of analysis in multilevel modelling, the qualities of relatedness and connectedness between the 'levels' are lost (Shim, 2002 cited in Williams, 2003). Williams (2003) suggests that taking into account the relationship between social structure, context and individual agency will allow for a better understanding of health behaviours.

Considering this, the current study aligns itself with the conceptualisation of social context as it is discussed by Poland et al. (2006), by Frohlich, Potvin, Chabot and Corin (2002) and by Frohlich et al. (2001). In Poland et al.'s (2006) examination of social context and smoking the authors suggest that smoking is a collective social practice and that the concentration of smoking among particular subgroups of the population (e.g., those in lower socioeconomic positions) and the changing smoking patterns (e.g., those between men and women) is not a random occurrence. They argue that the unequal distribution of smoking is tied to the way societies are organised and therefore also to the social practices of those living in that particular society.

It is further helpful to refer to Frohlich et al.'s (2002) collective lifestyles approach in order to understand how social behaviours such as smoking are shaped by social forces such as gender. The collective lifestyles approach is especially useful since, by taking what the authors call "social practices" and "social conditions" into account, it prevents a "reductionist and individual-centred perspective" of health behaviours (Abel, Cockerham, & Nieman, 2000 in Frohlich & Poland, 2007, p. 54).

Social practices are defined by Frohlich et al. (2001) as the "routinized and socialized behaviours common to groups" (Frohlich & Poland, 2007, p. 55). These social practices (socialised behaviours) are formed by structural opportunities and constraints, which the authors define as "any form of human action or interaction insofar as they are recognised as reverberating with features of power relations" (Frohlich et al., 2001, p. 785). Smoking can be understood as a social practice as it is a social behaviour replete with associations

regarding power relations and is a behaviour expressed and distributed according to structural opportunities and constraints (e.g., smoking bylaws and social norms).

Frohlich et al. (2001) go on to describe social conditions. They suggest that social conditions are the "factors that involve an individual's relationship to other people" (p. 785). They propose that social conditions include social structures of society, including, for example, gender, race or socioeconomic status. Furthermore, the authors suggest that the relationship between the social conditions that individuals experience (e.g., gender) and their social practices (e.g., smoking behaviour) is experienced as a "collective lifestyle" and that this relationship may shape individuals who are taking part in the experience in similar ways. In this way, men's and women's distinct experiences of smoking can be considered to consist of distinct "collective lifestyles".

In order to further position gender with respect to our conceptualisation of the social context, the current study draws on several researchers who have investigated the role of gender and health behaviours. For instance, Courtenay's (2000) constructionist perspective of gender suggests that men and women behave the way they do because they adapt concepts about femininity and masculinity from the culture in which they live. As Courtenay (2000) highlights, gender does not consist of two static categories, the masculine and the feminine. Rather, he argues that gender is a "dynamic, social structure" (p. 1387) in which "a set of socially constructed relationships ... are produced and reproduced through people's actions" (p. 1387) and in social relationships with other people (Courtenay, 2000). Gender thus does not reside in the individual men and women, but in the social transactions that can be defined as gendered.

With regard to health Courtenay (2000) specifically argues that since health behaviours like smoking are social acts, they are, like other social practices, a means for demonstrating elements of gender identity. He maintains that health behaviours are used in interactions in the "social structuring of gender and power" (p. 1390) and that performing health behaviours thus becomes a way for men and women to perform gender (Courtenay, 2000). Bottorff et al. (2006) have based some of their smoking research on the theoretical premise of Courtenay's (2000) work. The authors similarly suggest that a constructivist theory of gender hypothesizes that men's and women's health behaviours, specifically their

smoking behaviours, are influenced by dominant cultural ideals of femininity and masculinity (Bottorff et al., 2006).

Furthermore, Courtenay (2000) argues that men and women are not passive in accepting a socially prescribed role, nor are they exclusively socialized by the particular culture in which they live (Courtenay, 2000). Rather, men and women are also agents in constructing and reconstructing the dominant norms of masculinity and femininity and that agency is "central to constructionism" (1388). Courtenay (2000) thus argues that both the social context and the individual's active and creative agency are involved in reproducing health behaviours along gender lines. That is, individuals are not simply conditioned by their socio-cultural surroundings to take on gendered health behaviours, but are active agents in constructing the norms (e.g., masculinity and femininity) which are reflected in health practices such as smoking.

In a similar way, Popay and Groves (2000) suggest that the relationship between the "experience and action of individual human beings... as creative agents acting on and shaping the world around them... and structures of power and control within which they are embedded" (p. 73) must be considered in order to better understand men's and women's gendered experiences of health behaviours and illness (Popay & Groves, 2000; Popay et al., 1998). These authors also argue that, by qualitatively examining the social context in which individuals live, they may tap into a "shared cultural understanding" (Popay & Groves, 2000, p. 77) of what it is to be a man or a woman, which sheds light on the "gendered representations" (p. 77) of experiences and provides insight into the way experiences and behaviours such as smoking are gendered.

By considering the way gender and social context shape smoking behaviour, the current investigation addresses gender inequalities, which have a bearing on gendered smoking patterns. In addition, by discussing the practice of smoking with individual men and women, we are further able to consider the behaviours and experiences of smokers that reproduce the gendered influences and constraints they perceive with regard to their smoking.

2.5 Gender and health behaviour: Performing gender

The premise that has driven much research concerning gender inequalities in health is the finding that men tend to have higher rates of mortality and shorter life expectancies than women, but that women experience greater morbidity from various illnesses throughout the lifespan (Annandale, 1998; Carpenter, 2000; Denton et al., 2004; Denton & Walters, 1999; Hunt, 2002; Kirkland et al., 2003; Macintyre, Hunt & Sweeting, 1996; Oliffe & Mroz, 2005; Popay & Groves, 2000). While this "women are sicker but men die quicker" hypothesis (Walters, 2004, p. 5) has produced much gender and health inequalities research, the findings have also been debated. For example, some research has found that the direction and magnitude of health differences between men and women depend upon the symptom examined and that the excess illness for women applies to instances of minor illnesses and symptoms of psychological distress (Denton et al., 2004; Macintyre et al., 1996; Popay & Groves, 2000).

Another body of research, also typically included under the heading of gender and health research investigates men's and women's health behaviours (e.g., eating patterns, physical activity and smoking behaviour) rather than focusing on gender inequalities in morbidity and mortality. This research examines the way in which gender is expressed through the enactment of health behaviours, as well as the way in which gender shapes various health patterns. The current study is included within this second body of research.

Examinations of gender and health behaviours are important, as health behaviours are critical determinants of health and illness. Considering the way health behaviours are gendered may thus provide clues concerning the gender disparities in morbidity and mortality previously mentioned (Courtenay, 2000; Denton et al., 2004; Denton & Walters, 1999; Mahalik, Burns & Syzdek, 2007; WHO, 2003). As Courtenay (2000) persuasively argues, "unlike the presumably innocent effects of wearing lipstick or wearing a tie, the use of health-related beliefs and behaviours to define oneself as a woman or a man has a profound impact on one's health and longevity" (p. 1388).

2.5.1 Masculinity and Health

Hegemonic masculinity is defined as the "dominant constructions of masculinity, which influence men's identities and practices, including health practices" (Gough, 2007, p. 327). Studies of masculinity and health behaviour have consistently shown that the adoption of such a hegemonic masculine gender identity is associated with numerous health-damaging beliefs and health-risk behaviours (Bottorff, Oliffe, Kalaw, Carey & Mroz, 2006; Courtenay, 2000, 2003, 2004; Courtenay & Keeling 2000; Gough, 2006; Gough, 2007; Oliffe & Mroz, 2005; WHO, 2001). These typically masculine health-related beliefs and practices include a disregard for danger, beliefs of invulnerability and denial of weaknesses, emotional and physical control, the appearance of being strong and robust, the perception of resilience, and the dismissal of care in the face of illness (Bottorff et al., 2006; Courtenay, 2000, 2003; Gough, 2006; Oliffe & Mroz, 2005; WHO, 2003). The association between masculinity and health damaging beliefs and behaviours has been blamed, in part, for the link between masculinity and mortality (Courtenay, 2004).

Hunt et al. (2004) have reported that higher expressions of masculinity in both men and women have been associated with an increased risk of poor health behaviours. Emslie, Hunt and Macintyre's (2002) study of smoking and drinking habits among men and women in similar employment positions also found that both men and women with higher expressions of masculinity (measured through a sex role inventory) had a greater likelihood of being smokers and of drinking heavily. Furthermore, in a review examining health-risk behaviours among men and women, Courtenay (2003) found that men of all ages were more likely than women to perform a variety of behaviours increasing the risk of illness, disease and death such as increased alcohol and tobacco use, engaging in risky sports and the refusal to seek health care, among others.

Other research has also found that conventionally masculine ideals of reason, autonomy and control emerge in response to prescriptive health promotion initiatives and thus become barriers to health behaviours such as healthy eating (Emslie, Ridge, Ziebland & Hunt, 2006; Gough & Connor, 2006; Robertson, 2006; Wetherell & Edley, 1999). Research conducted by Gough and Connor (2006) suggests that for men to preserve their sense of autonomy, individual agency and control over their food and health choices, they reject health information sources in the media, in advertising campaigns and in scientific

studies, viewing these as "misleading, ideological, even hysterical" (p. 391). Rather, men were in favour of being "sensible and balanced in forging one's own path" (p. 391).

This is consistent with the suggestion that masculine gender stereotypes dictate men's risk behaviours resulting in the dismissal of health needs, avoidance of preventive health activities and, to varying degrees, a rejection of typically feminine health ideals and behaviours, all in order to enact their manhood (Courtenay, 2000; Courtenay, 2004; Mahalik et al., 2007). An especially forceful rejection of health-promoting behaviours was found among men who felt subordinate or who felt they had less power than other men (Backhans, Lundberg & Månsdotter, 2007). These men tended to exhibit compensatory health behaviours that were 'hypermasculine', that is, behaviours that were increasingly dangerous, in order to regain a sense of power or control (Backhans et al., 2007).

Similarly, as emotional expression and the release of emotions (e.g., through crying) are linked to, and are socially acceptable forms of, femininity, masculinity has also been found to be associated with obligatory control over one's emotional and physical state and over one's health in general (Courtenay, 2000; Emslie et al., 2006). In a study regarding men's attitudes towards health, Robertson (2006) found that both exerting control over one's health behaviours as well as the release from control over health are important for men and had to be negotiated in order to maintain a dominant masculine identity. In this way, both caring too much about one's health (too controlled) and caring too little about one's health to the point of excess (too much release indicating lack of control) called into question their masculine identity of being in control (Robertson, 2006).

Interestingly, men seem to differ from women with regard to the way in which they discuss having control over their own health (Courtenay, 2000, 2003; Denton et al., 2004; Yoder & Kahn, 2003), although research here is not consistent. For example, agency, defined as the "part individuals play in exerting power and producing effects in their lives" (Courtenay, 2000, p. 1388), is a quality that has typically been associated with men (Yoder & Kahn, 2003). Men have also been found to perceive, more often than women, that they have control over their lives (Denton et al., 2004; Robertson, 2006). However, other studies have found that men believe less strongly that they have control over their future health or that their individual activities contribute to their improved health (Courtenay, 2003).

It seems clear that the preservation of a hegemonic masculinity figures strongly into men's help-seeking practices. This is discussed by Moynihan (1998) in a paper examining theories of masculinity. She suggests that men's "façade of control and stoicism" (Moynihan, 1998, p. 1074) in the face of health threats is the cost of what she calls the "heavy burden of maintaining what we have been led to believe is 'the making of a man'" (p. 1074). Furthermore, O'Brien, Hunt and Hart's (2005) research on masculinity and health practices found that men are often reluctant to seek help for health unless it is for the purpose of restoring or protecting another more valued instance of masculinity (e.g., preserving masculine-type employment as a fire-fighter, or maintaining sexual performance).

2.5.2 Femininity and Health

Set in contrast to masculine health beliefs and behaviours, feminine health behaviours have typically been defined by greater care for health and by the enactment of more health-promoting behaviours (Backhans et al., 2007; Gough, 2007; Lupton, 1995; Madden & Chamberlain, 2004). As such, health itself is generally considered to be a characteristically feminine concern and is thus viewed primarily as belonging to the woman's social domain (Backhans et al., 2007; Gough, 2007; Lupton, 1995; Madden & Chamberlain, 2004). In fact, as Backhans et al. (2007) suggest, health promoting behaviours are constructed as "forms of idealised femininity" (p. 1894) and it has been suggested that it is for this reason that women tend to be viewed as carrying the most responsibility for health (Courtenay, 2000, 2003, 2004; Lupton, 1995).

Gough (2007), who investigated men's health representations in the media, supports this. He suggests that health behaviours such as eating healthy foods, shopping for food and cooking have traditionally been "feminised", and that women have thus been relied upon and held responsible for advice and support with regard to food and healthcare (Gough, 2007; Gough & Conner, 2006).

Madden and Chamberlain (2004), who examined health messages in the media that specifically target women, have similarly suggested that dominant gender views regarding

women and their health provider roles are reinforced by media representations of health and nutrition. Madden and Chamberlain (2004) found that women's magazines habitually depict women in the health-provider and mother role and as necessarily knowledgeable about health. They argue that the media frames women as the "moral guardian(s)" (p. 592) of their own and their family's nutritional health. However, interestingly, the messages present conflicting responsibilities for women and mothers as well. For example, the authors suggest that while women ought to be 'morally' responsible for the upkeep of their family's health (with nutritious foods), women must also ensure their family's happiness (providing more exciting, and perhaps less healthy, foods), all the while making sure they maintain their own feminine physical appearance (Madden & Chamberlain, 2004).

In addition to their own health-promoting behaviours then, women have also been considered most often responsible for regulating the health of their partner, family and children (Courtenay, 2004; Courtenay & Keeling, 2000; Lupton, 1995; Madden & Chamberlain, 2004; O'Brien et al., 2005). As Lupton (1995) argues:

> Women are expected to regulate the diet of their partners and offspring according to the dictates of health guidelines, to monitor their partner's weight and exercise habits, to ensure the cleanliness of their children, to make sure that their children are vaccinated and to desist from smoking and alcohol consumption while pregnant and even afterwards (p. 119).

Considering this, it is not surprising that being a woman has been viewed as "the strongest predictor of preventive and health promoting behaviour" (Courtenay, 2000, p. 1386). Research examining gender and health has found that women tend to be more aware of health issues, perform more health promoting activities, have healthier lifestyles and make more frequent health care consultations, when compared to men (Courtenay, 2000; Hunt, 2002; O'Brien et al., 2005), although the gender difference for consultations is debated and may depend upon the severity and type of symptoms examined (Koopmans & Lamers, 2007; Wyke, Hunt & Ford, 1998). More specifically, a review cited by Courtenay (2000) found that women are more likely than men to perform a range of health-promoting behaviours and that they generally have better exercise habits, are less likely to be overweight, are on average less likely to consume alcohol and to smoke cigarettes, and are more likely to consume vitamin supplements (Courtenay, 2000, 2003, 2004; Lupton, 1995).

Specifically with regard to women's control over their health, Gillies and Willig's (1997) research on women's smoking revealed that among some women, the ability to regulate their smoking behaviour in the face of tobacco addiction was a demonstration of self-discipline, temperance and restraint. In this way, the perception of having agency or control in matters surrounding health, and the way in which this is expressed in health behaviours, may be indicative of one's femininity.

While men's and women's health behaviours are often viewed in opposition to one another, a note worth mentioning with regard to research in gender and health is the fact that the assumed duality of gender (male – masculine, female – feminine) is a simplification of the variability in men's and women's gender identities (Carpenter, 2000; Hunt, 2002; Popay & Groves, 2000). For example, in their research on quality of health care, Jackson et al. (2004) argue that a gender-based diversity analysis recognises that there are not only differences between men and women, but that neither women nor men make up a homogenous group, and that important differences exist within each group. Many other researchers similarly suggest that, while some relatively consistent gender differences do exist with regard to health, it must be cautioned that blindly accepting a duality in gender can be constraining, if not altogether false (Annandale & Hunt, 2000; Chapman Walsh et al., 1995; Courtenay & Keeling, 2000; Emslie et al., 2004; Gough, 2006; Macintyre et al.,1996; Walters, 2004).

2.6 The gendered cigarette

Among the many gendered health behaviours, one that is remarkably so is smoking. Greaves and Barr (2000) argue that "gender affects our behaviours regarding smoking, our cultural and social experiences of tobacco advertising, our smoking behaviours and interpretations of smoking" (p. 10). Hunt et al. (2004) and Morrow, Ngoc, Hoang and Trinh (2002) suggest that research conducted on gender and smoking behaviour must recognize that men and women begin to smoke, and decide whether or not to quit smoking, all within a particular social context and that "gender is a major – but dynamic - influence" (Morrow et al., 2002, p. 688; Hunt et al., 2004). Bottorff et al. (2006) also maintain that men's and women's behaviours are "influenced by dominant cultural ideals of femininity and

masculinity" (p. 3098) and that smoking is a social behaviour used to demonstrate these gendered identities. It is thus not surprising that the connection between gender, cigarette smoking, and the marketing of cigarettes to men and women based on gender has a long history (see Vitz & Johnston, 1965).

Tobacco advertisements have long promoted cigarette consumption among men and women by associating smoking with the ability to reflect masculine identities, as well as to enhance gender identities appealing to women (Hunt et al., 2004; Vitz & Johnston, 1965). Hunt et al. (2004) suggest that female gender identity has been associated with different images of tobacco consumption throughout the 19th and 20th centuries in response to the social changes in gender roles in society. For example, the authors refer to Elliot (2001), who wrote that a woman smoking in Victorian times symbolised a rejection of the ideal feminine norms and behaviours and that the cigarette was thus a tool used by middle class women to tackle these ideals. In their research on the marketing of tobacco to women, Amos and Haglund (2000) also describe the change from the late 19th century, when smoking among women was associated with "loose morals and dubious sexual behaviour" (p. 3), to a time fifty years later when smoking had become socially acceptable and even desirable (Amos & Haglund, 2000). The authors suggest that the new social roles adopted by women during the first and second world wars, including traditionally male roles, behaviours and styles, opened up the possibility for the cigarette to become a symbol of emancipation or what the authors call the women's "torch of freedom" (p. 5) (Amos & Haglund, 2000).

The substantial increase in smoking among women during this time is also evidence of the way in which the tobacco companies were capitalising on the changing gender roles and social attitudes towards women (Amos & Haglund, 2000). The tobacco companies had replaced the original symbols of loose morals associated with women's smoking with new symbols. They thus repositioned smoking as "not only respectable but sociable, fashionable, stylish and feminine" (Amos & Haglund, 2000, p. 4). Greaves (1996) describes these changes in social developments succinctly by saying "women's smoking as it relates to gender has moved from a symbol of being *bought* by men (prostitute), to being *like* men (lesbian/mannish/androgynous), to being *able to attract* men (glamourous/heterosexual)" (p. 22, emphasis in the original).

Tobacco use has also been a means for men to represent and reinforce the culturally dominant images of masculinity and male gender norms. For example, in late 19th century Canada, smoking was an activity almost exclusively accepted for men and it symbolized the transition from boyhood to manhood, a rite of passage that brought men of various types together, forming a type of gender solidarity (Rudy, 2005). Smoking was also a means for men to express their distinction and social class (Rudy, 2005). For example, refraining from smoking under certain conditions, notably when in the presence of women, was a means for men to show restraint and control and smoking was, as such, a way of accentuating the differences between genders (Rudy, 2005). While the views of masculinity promoted by cigarette smoking changed over the course of the 20th century, from the cigarette as an indication of refinement and upper class status, to the cigarette as reinforcement of the virile and outdoors man, cigarette advertisements have almost always projected the image of the smoking man as independent, assertive, strong and powerful (Zucker, Stewart, Pomerleau & Boyd, 2005).

In this way, tobacco advertisements have historically performed a type of gender-based analysis by capitalising on men's and women's changing and variable gender roles and by evolving with these changes, making it possible for cigarettes to appeal to both feminine as well as masculine identities (Chapman Walsh et al., 1995).

2.7 Gender and men's and women's smoking behaviour

The enactment of gender as a set of social behaviours is illustrated in a definition cited by Jarrett Rudy in his historical work "The Freedom to Smoke: Tobacco consumption and identity" (2005). Here gender is "an identity instituted through a *stylized repetition of acts* ... and must be understood as the mundane way in which bodily gestures, movements, and enactments of various kinds constitute the illusion of an abiding gendered self" (Rudy, 2005, p. 13). Health behaviours, in particular smoking behaviours, consist of such 'bodily gestures, movements, and enactments' that represent and reflect gender. As such, an examination of gender becomes central in the understanding of men's and women's health and smoking behaviours.

The relationship between gender, identity and smoking emerges prominently in research conducted on smoking during adolescence and an important body of research examining gender and smoking behaviour has been conducted with adolescent girls and boys (Amos & Bostock, 2007; Amos, Gray, Currie & Elton, 1997; Ioannou, 2003; Lloyd, Lucas & Fernbach, 1997; Lucas & Lloyd, 1999; Michell & Amos, 1997; Nichter et al., 2006; Nichter, Nichter, Vuckuvic, Quintero & Ritenbaugh, 1997; Plumridge et al., 2002; Scheffels & Schou, 2007; Stjerna, Lauritzen & Tillgren, 2004; Wiltshire et al., 2005). Adolescence is a critical time for smoking, since cigarettes hold particularly important messages with regard to feminine and masculine identities, and because these meanings shape decisions as to whether or not to begin or continue to smoke (Chapman Walsh et al., 1995; Nichter et al., 2006; Stjerna et al., 2004; Wearing, Wearing & Kelly, 1994). As Wearing and Wearing (2000) suggest, the social and cultural factors surrounding smoking for young adolescents hold much greater persuasive power to encourage adolescents to smoke than the "threat of probable health effects 30 years away" (p. 50) has in discouraging them from smoking.

Comparative investigations of gender and smoking among adolescents have found striking differences in the reasons why boys and girls take up smoking and the role smoking plays in identity formation (Lloyd et al., 1997; Lucas & Lloyd, 1999; Michell & Amos, 1997; Nichter et al., 2006; Plumridge et al., 2002; Stjerna et al., 2004; Wearing & Wearing, 2000; Wearing et al., 1994). For example, while smoking has been found to be particularly important in forming a 'cool' identity among both young girls and boys, smoking is particularly significant among young girls for determining "pecking order, style, image and social identity" (Michell & Amos, 1997, p. 1867).

Comparative studies examining smoking among adolescents found that smoking did not carry the same social significance for boys and girls (Michell & Amos, 1997; Wearing et al., 1994). For instance, Wearing et al.'s (1994) research has suggested that while teenaged males have varied opportunities for adventurous leisure activities with which to form their identities, girls of the same age do not have the same options and often turn to smoking as a leisure activity with which to identify. Michell and Amos (1997) provide support for this finding. In their research, Michell and Amos (1997) found that the largest group of smokers among teenaged girls was the group identified as the 'top' girls, that is,

those girls, who were considered by their peers to be good-looking, popular, stylish and 'cool'. However, the authors did not find the same trend among the 'top' boys of the same age (Michell & Amos, 1997). Rather, they found that the 'top' boys could identify with activities other than smoking, and that for some the desire to be cool through smoking cigarettes conflicted with their wishes to be fit and sporty (Michell & Amos, 1997).

Similarly, Plumridge et al.'s (2002) study concerning smoking refusal among adolescents suggests that young girls have fewer options than boys for maintaining a high social status of 'cool' when refusing to smoke. Consistent with Michell and Amos' (1997) earlier work they found that boys have alternatives to the "smoker cool" (p. 173) through physical activity, while smoking refusal for girls is associated with accepting an inferior status (Plumridge, et al., 2002).

In another comparative study of 18 and 19 year old college men and women, Nichter et al. (2006) found that the meanings attached to smoking remained important and differentiated for men and women. Their study revealed that smoking, specifically among women, was associated with gender identity and physical attraction, but also that elements of contradiction, control and agency emerged as important. For example, the authors found that women's smoking sometimes carried a negative valence in that it was viewed as unattractive and a sign that women lacked control (Nichter et al., 2006). In fact, some of the male participants in their study suggested that women were expected to "have more control of themselves" than men, and that women should be able to refrain from smoking (Nichter et al., 2006, p.224). However, this was dissonant with the simultaneously accepted and even positive image that smoking held for girls when out with their friends at a party. In this particular situation, smoking was a sign of possessing agency and displayed a desirable and outgoing personality (Nichter et al., 2006). For young men, on the other hand, smoking contrasted less with their identities and was more frequently viewed as a sign of manliness, as a symbol of possessing a cool and relaxed demeanour, and as an indication of being in control (Nichter et al., 2006).

A recent Canadian study comparing adult men's and women's smoking prevalence quantitatively examined the differential impact that cigarette prices, tobacco control legislation, newspaper coverage of tobacco issues, economic factors and social milieu had

on men's and women's smoking rates (Dedobbeleer et al., 2004). The authors found that men were dissuaded from smoking when cigarette prices increased and they smoked fewer cigarettes when more stringent smoking bans were introduced (Dedobbeleer et al., 2004). Women's smoking rates, on the other hand, were unaffected by the change in price and they did not reduce the number of cigarettes smoked with the introduction of more restrictive smoking regulations (Dedobbeleer et al., 2004). This study further supports the findings suggesting that smoking has different meanings for men and women.

Several studies have also investigated smoking exclusively among girls. These studies find that smoking contains particularly strong messages for young girls about femininity, identity, the body and sexuality (Lucas & Lloyd, 1999; Wearing & Wearing, 2000). For example, Lucas and Lloyd (1999) report that smoking among girls is an important element in gaining group membership and is strongly associated with attractive social representations, such as a "passport to an exciting and popular lifestyle" (Lucas & Lloyd, 1999, p. 654). In their discussion of smoking as a fashion accessory, Wearing and Wearing (2000) maintain that smoking for girls is one way in which to resist gender stereotypes, in particular the "prissy, confining 'good girl' images" (p. 47).

A number of studies have investigated the gendered aspects of the social world and the role they play for adult women's smoking (Gilbert, 2005; Graham, Francis, Inskip & Harman, 2006; Greaves, 1996; Greaves & Barr, 2000; Greaves & Jategaonkar, 2006; Greaves et al., 2006; Nichter et al., 2006; Wearing & Wearing, 2000). Results from these studies echo the findings from studies conducted with young adult women, highlighting the prominence of identity, control and agency, and conflict for shaping women's smoking behaviour.

For example, Lorraine Greaves, a leading scholar in the field of women's tobacco use, has examined the social meanings tied to smoking among adult women (Greaves, 1996; Greaves & Jategaonkar, 2006). Her book "Smoke Screen: Women's Smoking and Social Control" (1996) investigates the lives of 35 Canadian and Australian women who smoke and the meanings they associated with their cigarette smoking. Through interviews with the women smokers, Greaves (1996) explores the significance that smoking has for adult women and outlines the role smoking plays in women's lives. From the interviews, Greaves

(1996) identifies five emergent themes with regard to women and their smoking behaviour. These themes include: 1) smoking as a way for women to organize their social relationships, that is, as a means of equalising power, or as a way to bond with others or put distance between themselves and others; 2) smoking as a way to create particular feminine images, for example, as independent, as stylish, to mark one's difference, as symbols or rituals, and for weight control; 3) smoking as a means to control emotions, by reducing negative feelings and tension, enhancing positive feelings or to limit emotional responses; 4) smoking as a source of emotional support, conferring elements of predictability and controllability; and lastly, 5) smoking as a way of negotiating identity (Greaves, 1996).

In the theory Greaves (1996) develops of women's smoking, the dissonant nature of smoking, as well as its association with control and agency, emerge prominently. Greaves (1996) writes that smoking for women acts to mediate the "discrepancies between emotional states and cultural and social expectations" (p. 107). While smoking carries important social meanings for women, these meanings are continually changing, and are thus troublesome for women in that they create contradictions in women's lives. For example, Greaves (1996) suggests that smoking is both empowering and disempowering for women, and can be a means of demonstrating agency, but can also represent a burden. In this way, quitting smoking is not only difficult due to dependence on cigarettes, but also potentially represents a "loss of part of the equipment of being female" (Greaves, 1996, p. 106). Greaves (1996) thus writes that smoking is:

> an important means through which women control and adapt to both internal and external realities. It mediates between the world of emotions and outside circumstances. It is both a means of reacting to and/or acting upon social reality, and a significant route to self-definition (p. 107).

Gillies and Willig (1997) also conducted research on the constructions of smoking, addiction and control for adult women smokers. The authors found that women's regulation of smoking behaviour in the face of tobacco addiction was a demonstration of self-discipline and restraint. However, the authors suggest that the sense of control applied only to the women's ability to moderate smoking behaviour, not their ability to quit smoking, for which some felt they lacked agency (Gillies and Willig, 1997). The authors note that when discussing smoking cessation and nicotine addiction, some women expressed a lack of agency to quit, but also maintained that smoking for them was a personal freedom and a

choice (Gillies and Willig, 1997).

In a more recent Australian investigation of women's subjective interpretations of their cigarette smoking and of anti-smoking campaigns, Gilbert (2005) also reports that themes surrounding conflict, control and identity, as well as the emotional importance of smoking, emerge in her interviews. For example, Gilbert (2005) found that women smoked to control their psychological state, to deal with difficult life situations and as part of female identity formation. Some of the young women she interviewed suggested that smoking served to calm their emotions and to provide "relief, some sort of inner peace" (Gilbert, 2005, p. 235). The emphasis on the social meaning of smoking among these women also functioned as a critique of the anti-tobacco campaigns being headed in Australia at the time. According to Gilbert (2005) the campaigns that specifically focussed on the medical risks of smoking were deemed limited because, as one respondent suggested, there are "other things in life, which are considered more important than medical issues" (Gilbert, 2005, p. 235).

The role of smoking with regard to the body, both in terms of body image and body weight, has been found to be particularly significant in the lives of adolescent girls and adult women. For instance, it has been found that among girls the use of cigarettes in specific bodily positions may project elements of gender identity and status, such as autonomy, confidence and assertive sexuality (Wearing & Wearing, 2000).

In addition, several studies have found that cigarette smoking among women is used as a means to lose or maintain body weight, and some studies have found that women may in fact have lower cessation rates than men due to concerns about weight gain (Austin & Gortmaker, 2001; Chapman Walsh et al., 1995; Crisp, Sedgwick, Halek, Joughin & Humphrey, 1999; Greaves, 1996; Honjo & Siegel, 2003; Wagner & Atkins, 2000; Westmaas & Langsam, 2005; Wiseman, Turco, Sunday & Halmi, 1997; Zucker et al., 2005). For example, Honjo and Siegel (2003) conducted a study of women's smoking and weight control and found a strong association between the level of desire young girls had to control their weight and their smoking status. That is, the girls who most strongly valued thinness were four times more likely to have become established smokers after four years than those girls who least valued thinness. Since physical appearance has steeper

consequences for women than for men (Chapman Walsh et al., 1995) and gender norms require women to maintain, at all cost, thin bodies, Honjo and Siegel's (2003) study results are not surprising. This research is particularly relevant in light of the current preoccupation among North American and European women with the desire for a thin body and the attempts to control weight through various health-damaging means (Olmsted & McFarlane, 2003).

While the relationship between women's smoking and weight control has been found in many studies, not all research is consistent with these findings and not all have found that this practice is exclusive to women (Clark et al., 2004; Nichter et al., 2004). For example, Nichter et al. (2004) examined smoking and weight control among teenaged girls and found little evidence of the use of smoking as a weight control strategy among the study participants. In addition, a recent study conducted by Clark et al. (2004) examined weight concern among male smokers. The authors of the study found that, similar to many women smokers, an increased desire to lose or control weight was negatively related to the men's motivation to quit smoking (Clark et al., 2004).

Few studies have been conducted exclusively on men's smoking behaviour (Courtenay, 2000; Emslie et al., 2004), perhaps because, as some suggest, smoking may generally be a "less gendered phenomenon" amongst men (Hunt et al., 2004, p. 246). However, more recent interest in men's health has prompted gender and health research on smoking to include investigations of men and of masculinity (Bottorff et al., 2006; Emslie et al., 2002; Hunt et al., 2004; O'Brien et al., 2005). Research conducted with men is important in light of findings suggesting that on average, men in most age groups have higher levels of smoking than women, and therefore continue to experience greater risks to their health (International Network of Women Against Tobacco (INWAT) Europe, 1999).

For example, some research has suggested that men and boys smoke in order to demonstrate their masculinity, male assertiveness and control (Chapman Walsh et al., 1995; Nichter et al., 2006). Others have found that, on average, men are more likely to find themselves in situations that are supportive of smoking, in tobacco-promoting environments, and that, when belonging to certain male social groups, men tend to experience pressure to smoke and consume alcohol in order to be part of these masculine

cultures (INWAT Europe, 1999). In addition, men do not face the same social stigma for smoking as women do, and may therefore feel less conflict with regard to their smoking and a reduced urgency to quit smoking (INWAT, Europe, 1999).

In order to examine the way in which men's smoking behaviours are gendered, Bottorff et al. (2006) conducted a study examining men's smoking behaviours set within the context of their partner's tobacco reduction or cessation during pregnancy. The authors maintain that the socially constructed, hegemonic masculine gender identity is not consistent with health-promoting behaviours, and that changes to health behaviours, such as reducing or quitting smoking, may require men to reject some of the typically accepted masculine health ideals (Botorff et al., 2006). A particularly interesting element of the study was therefore that these men were being confronted with a new social situation in which their gender identity was changing considerably: they were becoming fathers. The authors found that during the phase of transition into fatherhood there were strong links between expressions of masculine gender identity and smoking behaviour (Botorff et al., 2006). For example, there was a tension between the practice of smoking and the new role of becoming a 'family man', there was a significant perceived loss of freedom to smoke in the new life situation as a father, and there was considerable resistance to begin living a smoke-less life (Botorff et al., 2006).

While the results of Bottorff et al.'s (2006) study suggest that men have a strong resistance to quitting smoking when becoming fathers, the authors also suggest that social and cultural shifts that re-define male roles in relation to childcare and family life may influence smoking behaviour by offering men a "respite from the 'pathology of masculinity'" (p. 3105), where masculinity and health are generally not compatible. In this way they argue that cultural and societal changes, as well as new social roles for men, may lead to new definitions of masculinity and affect men's health-promoting behaviours (2006).

As such, a large body of research has demonstrated the important role that identity formation and issues of the body play for adolescents who smoke. In addition, a slightly smaller body of research has revealed the dissonant nature of smoking for women, specifically with regard to identity, the body, control and agency. However, very little

research (especially qualitative) has comparatively analysed adult men's and women's smoking behaviour to investigate the role that gender and elements of the social context continue to play for men's and women's smoking behaviour.

In addition, perhaps because smoking in adulthood is regarded as somewhat calcified, and the remaining adult smokers are considered to be addicted to cigarettes and unable to quit smoking, there is a dearth of research investigating the role of gender and the social context for adult male and female smokers. However, as is evidenced by the narrowing gap between men's and women's smoking rates and the more quickly decreasing smoking rates among men compared with women over the past decades (Greaves & Jategaonkar, 2006; Greaves et al., 2006; Kirkland et al., 2003), the gendered social context is clearly important for adult men's and women's smoking behaviour.

For this reason, we consider it important to attempt to fill the gap in the research literature and to investigate the way gendered elements of the social context shape smoking among adult men and women. This is particularly relevant to gaining a better understanding of the social reasons why some adult men and women continue to smoke, in the face of general population smoking declines for adults. In addition, this will allow us to further investigate the unequal smoking distributions along gender lines, in order to more effectively respond to these inequalities in tobacco control programmes.

2.8 Research Questions

First, the current study examines how men and women smokers' gender identities shape the perceptions they have of their own and others' smoking behaviours and how this influences the way they talk about their experience of smoking. For example, we ask whether the practice of smoking emerges as conflicted with regard to women's and men's gender identities. Second, this study explores the way in which considerations of the body, including weight control, body image and the physicality and health effects of smoking, figure into men's and women's narratives. For example, we ask whether body image and weight concerns play a larger role in determining the smoking behaviour and prospects for cessation for women than for men. Last, this study explores whether men's and women's

expression of control and agency over their smoking behaviour is gendered, and whether gender has played a role in their attempts at, and experiences of, cessation.

Three propositions arise from the research questions. First, we expect to find, in both men's and women's narratives, that feminine gender identity is more dissonant with smoking behaviour than is masculine gender identity. As a corollary, we propose that this may at once provide encouragement for women wishing to quit smoking, but may also have a negative and stigmatising effect on other women smokers. Second, we expect to find that concerns over weight gain and body image are predominantly expressed by women smokers, and that this may function as a deterrent to smoking cessation. Last, we expect to find that masculine gender identity is more often associated with expressions of control over smoking behaviour, and with greater agency in the ability to quit smoking, than is a feminine gender identity.

Comparatively analysing men's and women's narratives around smoking practices will provide insight into the ways in which gender, as an element of the social structure, differentially influences elements of the social context and shapes men's and women's smoking behaviours. It will also allow an examination of the way in which individual smokers both reflect and reinforce notions of gendered smoking behaviour, potentially leading to a greater understanding of the inequalities witnessed in smoking patterns according to gender.

CHAPTER 3. METHOD

3.1 Study Design

The current study was exploratory in nature and involved the combination of qualitative interview data from two study phases. The first study phase consisted of interviews for the research project "The Social Context of Smoking: Laying the Conceptual and Empirical Foundation for a Theoretical Toolkit in Tobacco Control Research" led by co-principal investigators K. Frohlich (Université de Montréal) and B. Poland (University of Toronto). This study received ethical approval in October 2004 from the "Comité d'éthique sur la recherche chez les êtres humains de la Faculté de médecine", Université de Montréal (project number: CERFM 58 (04) 4#134). As part of this study, 17 in-depth qualitative interviews were conducted with adult smokers in the Greater Toronto Area in late 2005 and early 2006. Themes explored in these interviews related to several elements of the social context deemed important for smoking practices including collective lifestyles, the body, identity, place, pleasure, power and control. Throughout the remainder of this document this study will be referred to as the first study phase.

Given the recognized importance of gender for smoking in the literature, and the conspicuous references to gender revealed in the narratives of the first study phase (although gender was not explicitly examined in the interviews), a second research project entitled "Gender, social context and smoking behaviour" was initiated by me, Ms. Alexander, as an off-shoot of the first research project. This study received ethical approval in July 2006 from the "Comité d'éthique sur la recherche chez les êtres humains de la Faculté de médecine", Université de Montréal as a 'sub-study' of the first research study (project number: CERFM 58 (04) 4#134). As part of this second study phase, an additional six interviews were conducted in Montréal, in the autumn of 2006 in order to further investigate and refine the initial findings concerning gender. For the remainder of this document, this study will be referred to as the second study phase.

The 23 qualitative interviews that ensued from these two study phases were combined for the final analyses to examine the way in which the social context and smoking

behaviours are shaped by gender. This combination was considered appropriate, as the samples were deemed similar enough to one another, such that gender would shape smoking in similar ways for men and women in Montréal and Toronto.

3.2 Methodological Approach

The views expressed by participants in the qualitative interviews with regard to smoking practices represent multiple subjective accounts of smoking, granting us a glimpse into the ways in which the social world is gendered and how this may shape men's and women's smoking behaviours (Pyett, 2002). As such, a firm and objective answer to the questions: 'how does gender influence smoking behaviour?' and 'why do men and women smoke?' is not expected and is even an irrelevant aim of this study (Sayer, 2000). However, it is nevertheless assumed that important themes can be uncovered by speaking with men and women about their everyday smoking experiences. For example, according to Popay and Groves (2000) it is through narrative accounts that individuals express the multiple "social locations" or social roles which they inhabit and through which they provide information regarding the socially and culturally "proper thing to do" and "proper time to do things" (p.77) which shape gendered behaviours. They suggest this is particularly important when attempting to gain a better understanding of the way in which experiences of the social context are gendered and how these are manifest in individuals' health behaviours. (Popay & Groves, 2000).

In addition, it is precisely by focusing on the everyday accounts of the participants' smoking experiences through qualitative interviews, and by acknowledging the meanings that are attached to these experiences, that the relationship between men's and women's sense of agency and the social structures surrounding them can be explored (Popay & Groves, 2000). Popay and Groves (2000) argue that people's discussions of their experiences are a means to "(re)construct their sense of who they are in the context of the social and material world" (p.77) and by doing this illuminate the subjective relationship between identity, agency, and social structures.

The discussions with men and women smokers, and the themes emerging from our conversations with them, have therefore been treated as relevant forms of knowledge which may subsequently be used to guide the creation of health promotion and tobacco control interventions wishing to take into account the variability, subjectivity and socially meaningful nature of smoking practices.

3.3 Inclusion Criteria

Inclusion criteria for participants of both study phases were identical. Participants had to be current smokers and have smoked within the last 30 days; have smoked for a minimum of 10 years; be 19 years of age or older (the age at which it is legal to purchase tobacco products in Ontario, a criterion maintained for the Montréal interviews to ensure consistency with participants interviewed in Toronto); and have lived at least three of the 10 years they have been smoking in Canada, a period deemed sufficient to establish familiarity with the social context of smoking in Canada. Participants also had to have a solid enough basis in English to follow the interview. This criterion was maintained for the Montréal interviews in order to be consistent with the Toronto interviews and also because English is the researcher's mother tongue. Conducting the interviews in English facilitated interview communication and the researcher's ability to put the participants at ease throughout the interview.

3.4 Sample

For the purposes of the first study phase a maximum variation sample of 17 participants was recruited. This was done in order to achieve as much difference in perspectives and experiences of smoking as possible, and had the aim of achieving variation with regard to socioeconomic position and gender. Specifically, the researchers sought a balance in the number of men and women smokers falling into two socioeconomic "categories": a "working" class of smokers, that is, individuals, who have not completed post-secondary education, who are employed in a manual or clerical profession and who are possibly financially unstable; and a second "professional" class of smokers, that is, individuals, who have completed post-secondary education, who hold knowledge-economy

type work, and who possibly own property. The selection of interview participants according to these criteria is particularly important for this study as "class", age and gender are significant for the way in which the social context is experienced.

The 17 participants included six male and 11 female smokers. A sample size of 17 was deemed sufficient to generate enough rich information from men and women smokers in order to achieve theoretical saturation of the data. That is, with this sample size enough information emerged with regard to the themes of interest for the first study phase. The imbalance in the number of men and women smokers was due to increased access to female smokers during the initial data collection phase. This was not assumed to bias the research results as sampling was continued until enough rich information was collected for both men and women.

The sample for the second study phase consisted of an additional six participants including three women and three men. Since the sampling procedures for these participants were identical to those of the first study phase and attempts were made to ensure as much variation in terms of "class" categories and age as is possible for a sample size of six, the second sample can be considered a subset of the population from which the first sample was chosen.

In addition, the purpose of the current study was not to explore the differences between the samples based on location, but rather to investigate and further refine the understanding of the role gender and the social context play in the practice of smoking. As such, while the Montréal smokers may differ somewhat from those in Toronto, the two samples were selected in such a way as to be considered to belong to similar subsets of the population. The three male and three female participants were purposefully selected for this second study phase to be representative of the entire study sample, but also to ensure that they would provide additional rich information regarding gender and smoking behaviour in order to add to the gender-related themes that had emerged from the first phase analyses.

3.5 Recruitment and participant management

Participants interviewed as part of the first study phase were reached during two recruitment stages. A first group of participants was recruited through posters displayed at a downtown Toronto deli. This deli was originally selected because at the time of recruitment it contained an enclosed smoking room next to the main eating area and because preliminary observations suggested that a wide cross-section of smokers frequented the deli throughout the workweek. Individuals interested in participating contacted the research assistant, who then provided them with additional information regarding the study and arranged a time and place to conduct the interview, if they wished to participate. However, after the first 5 participants were recruited this way, it became apparent that the sample was relatively homogeneous and included only working class women between the ages of 30 to 60 years. For this reason, and to ensure the desired heterogeneity of the study sample, the remaining participants were recruited using purposeful sampling based on the personal networks of the project researchers. As such, smokers belonging to the personal networks of the researchers were contacted to ask if they were interested in participating in a study about smoking. If they agreed, a research assistant contacted them in order to further inform them about the research and to arrange an interview time and location. Using this method, an additional 12 smokers (six male and six female) were recruited. A total of 17 interviews were conducted with participants living in the Greater Toronto Area.

The additional interviews conducted as part of the second study phase were recruited in Montréal, Québec in autumn 2006. Because participant recruitment using personal networks was successful for achieving a maximum variation sample in the first study phase, the six additional participants for the second study phase were similarly recruited through personal networks. To this end, friends and acquaintances of the researcher and her supervisor who smoke were contacted and asked if they were interested in participating in a study about smoking. Those interested in participating were contacted to set up a convenient date, time and place for the interview to be conducted.

3.6 Data Collection

3.6.1 Interviews

Interviews conducted as part of both study phases were one-to-one in depth narrative interviews lasting between 30 to 90 minutes and were held in a location agreed upon by both the interviewer and participant. Interviews were guided by open-ended questions, thus allowing the participant to determine the direction and focus of the discussion. The interview guide used for the original 17 interviews of the first study phase was based on several themes related to the social context (see Appendix A). To ensure consistency, the interview guide for the second study phase was similar to that followed for the first study phase. However, a few additional questions and probes focusing on gender were added based on themes that had emerged as relevant and worthy of further investigation during initial readings of the original 17 transcripts (see Appendix B). The final interview guide was reviewed and validated by the researcher's supervisor and a research assistant from the original research team.

Prior to the interviews of both study phases, care was taken to explain the study and the study's aims to each participant. Importantly, it was made explicit that the study's aim was not to convince the participant to quit smoking. In addition, each participant was assured that participation in the study was voluntary and confidential, and that any responses given during the interviews would be reported anonymously through the use of a pseudonym when data are reported and published. Each participant was also notified that he or she could stop the interview at any time without penalty and that any portion of the interview could be designated as 'off the record', which would subsequently be omitted from the transcript. Informed consent was obtained from all participants before beginning the interview, and all participants were provided with a personal copy of the written consent form on which details of the study were again presented (see Appendix C). Before beginning each interview recording, general demographic information including age, sex, and occupation was collected from each participant (see Appendix D). After the interview, participants received a compensation of $30.00 in recognition of their time and contribution to the research project.

3.6.2 Audio-recordings and transcripts

All interviews conducted for both studies were digitally audio-recorded. For the first study phase the interviews were transcribed verbatim from the audio-recordings by a professional transcriber. To ensure the participants' privacy and to prevent the participants' names and other identifiable information from being disclosed, the audio-recordings were only made available to the professional transcriber and to the research assistants involved in the interviewing and analysis of the interview material. For the six additional interviews of the second study phase, the interviewer alone had access to these voice recordings, as only she was involved in the transcription and analysis process. To ensure the same quality for the six transcripts of the second study phase as for the 17 interviews transcribed in the first study phase, the same transcription styles, procedures and guidelines were followed. As such, verbatim transcription was supplemented with non-verbal contextual descriptions in those cases where the written transcript text was insufficient or when additional descriptions would provide relevant information regarding the interviewer-participant interaction. Examples include interjections of laughter, longer pauses or unusually quiet, loud or emotional speech. Short explanations were given in cases where it was important to indicate that a participant was paraphrasing or mimicking or in cases where some speech elements of the conversation were difficult to hear or decipher.

For both study phases electronic transcripts were verified for typographical errors. In addition, the anonymity of the participants was ensured as the interviewers reviewed all transcripts and took care to exclude any information that could potentially disclose the participant's identity.

3.6.3 Field and analytical notes and researcher journal

Throughout the data collection for both study phases interviewers took field notes during each of the 23 interviews in order to describe any details not captured by the recording and thus not available in the transcripts. These notes included comments about body language, non-verbal information, facial expressions, descriptions of the interview setting and the overall tone of the interview, as well as any initial impressions the interviewer had in relation to the interview. In addition to the field notes taken by

interviewers of the first study phase, I also made analytical notes during preliminary readings of the 17 transcripts from study phase one. This was done in order to keep track of ideas and observations regarding gender and also served as a guide in the selection of themes relevant to gender, as well as in the formulation of the interview guide for the second study phase.

Furthermore, throughout the data collection for the second study phase, the researcher also kept a personal journal. This was done for several reasons. First, the journal was used to describe the data collection process in detail, keeping track of the dates and times of the interviews and any other significant events occurring during data collection. Second, the journal was used to reflect on the difficulties and successes encountered during the data collection process. Third, the journal kept track of any reflections on the data collected, questions that arose throughout the process, and discussions with the research supervisor.

3.6.4 Data Management

Data for both study phases had several sources all of which required specific care and organization. First, the audio-recordings of interviews conducted as part of both study phases, as well as all electronic versions of verbatim interview transcripts (Microsoft Word format) were saved on the personal computers of the researchers and were password protected. As mentioned above, other than minor data cleaning performed by the interviewers to ensure the participant's anonymity, the transcripts were in their original verbatim format.

Field and analytical notes taken by the interviewers throughout the 23 interviews have been used to supplement the audio-recordings and the transcripts. The field and analytical notes are also in electronic format and are saved on the researcher's personal computer together with the audio-recordings and the electronic transcripts. The personal journal kept by the researcher during the second study phase is also kept in a filing cabinet in the home of the researcher. Printed copies of the interview transcripts from both studies are also kept in a filing cabinet in the home of the researcher.

CHAPTER 4. DATA ANALYSIS

The current analysis includes data collected during two research phases: data from the first study phase ("The Social Context of Smoking: Laying the Conceptual and Empirical Foundation for a Theoretical Toolkit in Tobacco Control Research"), and data from the second study phase ("Gender, social context and smoking behaviour"). While interviews from both studies were combined and analysed together, the procedures for the coding and data analyses will be described separately.

The coding and analysis for interviews from both study phases followed time-honoured procedures outlined by Taylor and Bogdan (1984) for combining "thick description with thick interpretation". These procedures include reading and re-reading the data (familiarisation), keeping track of themes, hunches, interpretations and ideas using memos (an initial coding), and looking for emerging themes to construct typologies of key phenomena (analysis). Tesch's (1990) description of qualitative data analysis are also referred to here because her method of organising and analysing qualitative data is clear and helpful in structuring the explanation of the procedures used in the current study.

4.1 "De-contextualization" of data of the first study phase

In her description of qualitative data analysis, Tesch (1990) suggests that once researchers have become familiar with the interview data through repeated readings of the transcripts, analysis ought to begin with a "de-contextualisation" of the data. This process involves the segmenting of interview data into relevant text portions, each segment able to stand and contain meaning on its own (Tesch, 1990). In order to organise and categorise the text segments, Tesch (1990) suggests developing what she calls an 'organizing system'. In the creation of an 'organizing system' Tesch (1990) outlines several basic methods for proceeding. These include constructing the organising system around the research questions, basing the organising system on the research instruments or on a related study's research categories, or constructing the organising system from the data themselves. For the development of the organising system, both study phases followed a procedure that combined several of these suggested methods.

For the first study phase the interview guide was organised around themes relating to the seven elements of the social context of smoking (collective lifestyles, the body, identity, place, pleasure, power and control). As such, the seven social context themes were used as a rough guide in the development of the 'organizing system'. However, due to the open-ended nature of the interviews it was also critical to be receptive to new information emerging during the interviews. In this way, the interview data themselves and any new emerging information were also relied upon in the creation of the 'organizing system'.

Four members of the original research team (the two co-principal investigators of the original project, a research assistant and I) performed several readings of the interviews in order to identify meaningful text segments and come up with additional themes related to the seven elements of social context. Specifically, each team member performed separate readings and preliminary coding of seven selected interviews, four of which were identical for each member and three of which were unique to each member. Each team member then identified a set of 15-20 'tags' or themes emerging from the interviews and relating to the social context. There was much overlap between the suggested 'tags' and after discussion, 20 'tags' were maintained (Appendix E). Although it was not the focus of the first study phase, gender did emerge as a prominent theme in these interviews regarding smoking and social context and as such, a gender 'tag' was included among the 20. In this way, both the original interview guide, as well as new information emerging from the interviews, helped organise the interview material into a well-defined 'organizing system'.

In addition, and also as part of the "de-contextualization", Tesch suggests that interview data be sorted and subsequently coded. The 17 interview transcripts were thus entered into the qualitative research package, Atlas.ti (version 5) and coded using the 'tags' developed within the organising system. In order to ensure analytic rigour and transparency in the coding process an audit trail was maintained throughout the coding process and coding involved several investigators. The Atlas.ti software facilitated a closeness to the data throughout the coding process by keeping a list of all coded text segments available in the margin and interactively linked to the original transcript files and by allowing these coded text segments to remain visible for other researchers. In addition, each interview was coded twice by two research assistants; each research assistant first coded one half of the

interviews and then re-coded the other half of the interviews. This ensured that both research assistants possessed a common understanding of the codes and coding methods and that all interviews were coded consistently.

4.2 "De-contextualizing" and coding of the second study phase data

The "de-contextualization" of the interview data from the second study phase was similar to that of the first study phase. As the second study phase followed a similar interview guide as the first, and was similarly examining elements of the social context of smoking, the same organising system was used to categorise the text segments of the six additional interviews. However, the interviews conducted during the second study phase also investigated topics specifically relating to gender. As such, during the readings of transcripts from the second study phase, particular attention was paid to meaningful text segments that emerged with regard to gender. For example, this included explicit references to gender such as mention of a 'girly way to smoke' or a 'masculine way to smoke'. However, the transcripts were also read using gender as a lens through which to analyse men's and women's discussion of their smoking behaviour, specifically with regard to three elements of the social context: "identity formation", "considerations of the body" and "control and agency". Through multiple readings of the transcripts, three new and more detailed 'tags' related to gender were developed (masculine smoker, feminine smoker and attraction and smoking) and were added to the original 'organizing system' that had been developed for the first study phase (Appendix F).

Again all interview transcripts were entered into the qualitative research software package Atlas.ti and were coded using the new organising system. An audit trail was again maintained throughout the coding process, although only I was involved in the coding of the additional six interviews. However, as I had also been involved in the coding of the original 17 interviews, I coded the six interviews of the second study phase in a consistent way with the coding of the original interviews.

4.3 Re-coding of first study phase interviews

In order to combine and analyse all 23 interviews from both study phases for themes relating to gender and the social context of smoking, the original 17 interview transcripts were re-coded using the new organising system developed during the readings of the six additional interviews. As such, each segment of text that had originally been 'tagged' as a lens for gender in the original 17 interviews was re-coded using the new, more detailed gender codes. In this way all 23 interviews were coded consistently with regard to gender and could be combined for a larger analysis of gender, social context and smoking behaviour.

4.4 "Re-contextualizing" the data and data analysis

Finally, Tesch (1990) suggests that before beginning data interpretation, one must assemble together all meaningful textual segments belonging to the same category or code. For the current analysis, Atlas.ti also facilitated the 're-contextualization' of the interview data by allowing the creation of reports. Reports involve the creation of new files in which all segments of text that have been given the same code are assembled into one document. In this way, each code report includes all interview segments from the 23 interview transcripts relevant to a particular code.

In addition, as a further 're-contextualization' of the data, the three elements of the social context that had been elaborated in advance as part of the research question ("gender identity", "considerations of the body" and "agency") provided a larger 'skeleton' of themes around which the textual material could be organised and under which several related codes could be grouped. However, as Tesch (1990) suggests, themes should be viewed as flexible between one another, so that the richness of information in the transcripts is not lost by forcing codes into particular themes. For example, as considerable overlap exists between text segments included under "gender identity" and "considerations of the body", meaning would be lost if text segments were rigidly assigned to one theme or the other. Atlas.ti was again useful in maintaining flexibility between themes, as one segment of text could be assigned more than one code or could be coded entirely or only in part by several different codes, thus permitting the text to belong to more than one theme.

All code reports were finally printed and loosely grouped under one of the three main social context themes ("gender identity", "considerations of the body" and "agency") for interpretation. For the analysis of gender with regard to each of the three themes of social context, the textual code reports belonging to each theme were read once again and similarities and differences between the interviews were identified and analysed.

4.5 The use of primary and secondary data: A caveat

Given that the use of secondary data in qualitative research is uncommon, and that it has been the source for debate (Heaton, 2004), it is important to address the use of secondary data that was collected during the original research phase for the project "The Social Context of Smoking: Laying the Conceptual and Empirical Foundation for a Theoretical Toolkit in Tobacco Control Research".

Heaton (2004) suggests that there are a few epistemological issues to be resolved in the use of secondary data, two of which are relevant for the current discussion. First, Heaton (2004) proposes the problem of 'data fit'; that is, whether the pre-existing research data from the first study phase can legitimately be used for research purposes for which they were not originally collected. In this case, the problem would surround whether the original interview data could be used to investigate gender when gender was not the original focus of the study. While the focus of the first study phase was on elements of the social context other than gender, gender was known to be important to smoking behaviour and mention of gender in the original study interviews was thus followed up. In addition, the interview guide for the second study phase interviews was created based on the preliminary readings of the first interviews and the data collection and analysis methods were also similar in both study phases.

A second concern regarding the use of secondary data is the problem of not having "been there" during the first data collection; in other words, it addresses how the relatively distant relationship of the researcher to the data affects interpretation of the material (Heaton, 2004). Taylor and Bodgan (1984) also suggest that, in qualitative research, data collection and analysis is an ongoing process, and it typically does not include a "division

of labour" between data collectors and data coders, as is often the case in quantitative research. It is therefore possible that the secondary data analysis of the 17 original interview transcripts risks suffering from a loss of richness and detail with regard to the information normally obtained during interviews. However, a few strategies have compensated for this difficulty. First, all audio-recordings from the interviews and all field notes taken before, during and after the first study phase interviews were available to me. This in itself will add to the richness of the interviews, with regard to subtleties in the voices, non-verbal information and information regarding interview setting and 'feel'. Second, the researcher of the current study has had frequent and ongoing contact with the interviewers of the first study phase. In this way, the interviewers were able to fill in any additional information concerning their roles in the interview, their general feelings about the process and anything that they might have contributed to the interview themselves. Lastly, as previously mentioned, the researcher for the second study phase was also part of the research team involved in the creation of the original organising system and in the coding of the first 17 interviews. This allowed for a familiarity and closeness to the original data throughout the data collection process.

CHAPTER 5. RESULTS

Running Head: GENDER, SOCIAL CONTEXT, SMOKING BEHAVIOUR

To be submitted to: Social Science and Medicine

"This ancient, ancestral feeling of controlling fire … it's something that's part of men, that keeps man grounded on the earth … women don't have that need of the relationship with fire"

The role of gender and social context for men's and women's smoking behaviour.

by

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KEY WORDS: gender, smoking, social context, social inequalities.

Abstract

Over the past five decades there have been considerable population declines in smoking across developed countries. Despite these declines, smoking has become an unequally distributed practice, a finding that emerges as particularly salient in investigations of gender and smoking. Since gender plays a large role in shaping health behaviours such as smoking, examining the role of gender for men's and women's smoking may be critical to better addressing disparities in smoking. The current article examines expressions of gender that emerged during 23 in-depth interviews with men and women with regard to smoking practices. Interviews were loosely based on themes related to the social context of smoking and were analyzed specifically with regard to three themes: *identity*, *the body* and *individual agency*. All participants were living in Toronto or Montréal and were stratified by socio-economic position and gender. Our most striking finding is that smoking is particularly conflicted for women, but not for men. This finding emerged across the three social context themes; 1) while women expressed dissonance between smoking and their identities, men's smoking emerged as more consistent with theirs; 2) smoking shaped women's body image in a significant, yet contradictory, way. Smoking was particularly relevant for women's sense of physical attraction, and the fear of weight gain during cessation was a significant factor in women's smoking maintenance. The concern for the body was virtually absent in the interviews with men; 3) with regard to agency over smoking and cessation, women suggested wanting, but not having control over smoking behaviour and cessation, whereas men expressed having control over smoking cessation, but felt little urgency to do so. Tobacco control initiatives ought to increasingly address the gender inequalities inherent in the health discourse regarding tobacco-related practices, and in tobacco control itself, in order to further reduce gender disparities in smoking.

Introduction

Over the past five decades there have been considerable population declines in smoking prevalence across developed countries, including a 17% decrease in smoking prevalence in Canada alone between 1985 and 2006 (Canadian Tobacco Use Monitoring Survey (CTUMS), 2006; Greaves & Jategoankar, 2006; Greaves, Jategoankar & Sanchez, 2006). This is particularly significant for public health, as tobacco use is considered the "leading preventable cause of morbidity and mortality in developed countries" (Baker, Brandon & Chassin, 2004, p. 464) and is the "single largest risk factor for a variety of malignancies" (Emmons, 1999, p. 490), including cardiovascular disease, pulmonary disease, and a variety of cancers (Baker et al., 2004; Emmons, 1999).

Despite the overall population declines, smoking has become an unequally distributed practice, a finding that emerges as particularly salient in investigations of gender and smoking behaviour (Barbeau, Leavy-Sperounis & Balbach, 2004; Greaves & Jategaonkar, 2006; Kirkland, Greaves & Devichand, 2003). For example, smoking has become increasingly concentrated among socially and economically disadvantaged populations, and women have begun to make up a considerably larger proportion of these smokers (Barbeau, Krieger & Soobader, 2004; Crosier, 2005; Gillies & Willig, 1997; Greaves & Jategaonkar, 2006; Hunt, Hannah & West, 2004; National Strategy to Reduce Tobacco Use in Canada (NSRTUC), 1999; World Health Organization (WHO), 2001). Recent examinations of smoking patterns in several developed countries reveal that smoking rates among women have been declining at a slower rate than among men (Greaves & Jategaonkar, 2006; Hunt et al, 2004), with Canadian numbers indicating a 36% decrease for men compared with a 17% decrease for women between 1965 to 2001 (Kirkland et al., 2003). In addition, in several countries, smoking rates for young women between the ages of 15 and 24 have either caught up to, or have begun to surpass, those of young men of the same age (Gillies & Willig, 1997; Hunt et al., 2004; Kirkland et al., 2003). Population declines in smoking rates have thus not been unequivocally optimistic.

The gender inequalities in smoking prevalence are especially critical to consider as the changes in smoking patterns among men and women over the past decades have already resulted in a serious gender disparity in the morbidity and mortality of smoking related

illnesses. For example, while deaths due to lung cancer have been declining or levelling off for men, there has been a rapid increase in incidence and mortality due to lung cancer for women (Payne, 2001). In fact, it has been estimated that since 1950, mortality due to lung cancer has risen by 197% for men while it has risen by 612% for women. Even since as recently as 1990, lung cancer cases have increased by 17% in men, but have jumped by 27% in women (Ginsberg, 2005; Payne, 2001; Popay & Groves, 2000). As such, despite sizeable population-level declines in smoking prevalence, the disparities in smoking rates that have developed according to gender require further attention.

Health Canada (2003) defines gender as the "array of socially constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis". Gender cuts across all populations, intersects all aspects of our lives, influences how we are perceived by others, how our identities are formed, and it outlines for us the socially appropriate roles we take on and the type of activities that we pursue, including health behaviours such as smoking (Greaves & Barr, 2000). By examining the social context of men's and women's smoking, the current article investigates the way in which elements of the social context are gendered and how these differentially shape men's and women's smoking behaviour.

Review of relevant literature

Epidemiological, medical and health promotion research examining tobacco use has traditionally considered smoking as, first and foremost, a nicotine addiction (Ginsberg, 2005; Laurier, McKie & Goodwin, 2000; National Institute on Drug Abuse (NIDA), 2001). This research has typically investigated the role that biology plays in tobacco addiction in attempts to find explanations for continued tobacco use among some individuals, and to find better pharmacological treatments for smoking cessation (Baker et al., 2004; Lupton, 1995; Lynch, Kaplan & Salonen, 1997; Poland et al., 2006; Popay, Williams, Thomas & Gatrell, 1998). Furthermore, tobacco research has generally conceptualised smoking as an individual-level behaviour that principally results from an individual's poor lifestyle choices (Laurier et al., 2000; Poland et al., 2006; Popay et al., 1998; see examples Denton, Prus & Walters, 2004; McKee, O'Malley, Salovey, Krishnan-Sarin & Mazure, 2005; Shepis & Rao, 2005; Westmaas & Langsam, 2005).

Although some epidemiological research is concerned with gender differences in smoking, gender in this context is still often operationalised as an individual's biological "sex" and is viewed as a factor that must be statistically controlled for to remove it as a possible confound in the measurement of health differences between men and women (Emslie & Hunt, O'Brien, 2004; Krieger, 2003; Popay & Groves, 2000; Popay et al., 1998; Stewart & McDermott, 2004; Westmaas & Langsam, 2005; Yoder & Kahn, 2003). Furthermore, Williams (2003) suggests that approaches in epidemiology that investigate social factors including race, class and gender are problematic as they also "distil the effects of social and relational ideologies, structures and practices ... into the characteristics of discrete and self-contained individuals" (Shim, 2002 cited in Williams, 2003, p. 140). In this way, while epidemiological and medical research has allowed for the examination of differences between men's and women's health status at the individual biological level, it has often omitted the role that the social construct of gender plays in shaping smoking behaviour (Hunt et al., 2004; Williams, 2003).

The inclusion of gender as a social influence, as opposed to a biological identifier, is important for investigations concerning the social inequalities in smoking. This is particularly the case since research suggests that smoking is a social behaviour that carries social and cultural meaning beyond its bio-medical effects and that smoking is shaped by various elements of the social world, specifically gender (Greaves, 1996; Michell & Amos, 1997; Plumridge, Fitzgerald & Abel, 2002; Poland et al., 2006; Shevalier, 2000; Wiltshire, Amos, Haw & McNeill, 2005).

For instance, Courtenay (2000) maintains that male and female gender is socially constructed, "produced and reproduced through people's actions", and that health behaviours such as smoking, like other social practices, are a means of demonstrating elements of female and male gender identity. The way a cigarette is held, the way it is smoked and even the particular brand of cigarettes smoked hold meaning regarding gender. Research conducted on smoking must therefore recognise that individual men and women begin to smoke, and decide whether or not to quit smoking, all within a particular social context and that "gender is a major – but dynamic - influence" within the social context (Hunt et al., 2004; Morrow, Ngoc, Hoang & Trinh, 2002).

The Social Context of Smoking

Several researchers have suggested that when investigating health behaviours such as smoking, we must not only examine individual experiences and actions, but also the social structures in which we live (Poland et al., 2006; Popay and Groves, 2000; Williams, 2003). In their discussion of the social context of smoking, Poland et al. (2006) view smoking as a collective social practice. They argue that the concentration of smoking among particular subgroups of the population (e.g., those suffering from mental illness, homeless individuals, young women) is not a random distribution, but rather that it is tied to the way in which societies are organised, and is therefore tied to the social practices of those living in the particular society (Poland et al., 2006). The authors identify several dimensions of the social context as critical to the practice of smoking, including power relations, the physical and social elements of the body, identity formation, collective lifestyles, desire and pleasure, and "smoking as an activity rooted in place" (Poland et al., 2006, p. 59). They suggest that social structures such as race, class and gender cut across these social context dimensions.

As is evidenced by the disappearing gender gap in smoking rates and the more quickly decreasing smoking rates among men compared with women (Greaves & Barr, 2000; Greaves & Jategaonkar, 2006; Greaves et al., 2006; Kirkland et al., 2003), the gendered social context appears to be particularly important for adult men's and women's smoking behaviour. Furthermore, Courtenay (2000) argues that both the social context and individual agency are involved in reproducing health behaviours along gender lines. That is, individuals are not simply conditioned or socialised by their socio-cultural surroundings to take on gendered health behaviours, but are also active agents in constructing the norms (e.g., masculinity and femininity), which are reflected in health practices like smoking.

For example, Popay and Groves (2000) have suggested that the relationship between the "experience and action of individual human beings ... as creative agents acting on and shaping the world around them ... and structures of power and control within which they are embedded" (p. 73) must be considered in order to better understand men's and women's gendered experiences of health behaviours and illness (Popay & Groves, 2000;

Popay et al., 1998). The authors argue that, by qualitatively examining the social context in which individuals live, they may tap into a "shared cultural understanding" (p. 77) of what it is to be a man or a woman. They suggest that this sheds light on the "gendered representations" (p. 77) of experiences and provides insight into the way experiences and actions such as smoking are gendered.

As such, the current investigation addresses gender as an element of the social structure, which has a bearing on, and shapes, inequalities in men's and women's smoking patterns. In addition, by interviewing smokers about their experiences and smoking behaviours, the study also addresses men's and women's sense of agency over smoking behaviours that reproduce the gendered social influences and constraints existing with regard to the practice of smoking.

Gender and smoking behaviour

The enactment of gender as a set of social behaviours is illustrated in Jarrett Rudy's (2005) historical work "The Freedom to Smoke: Tobacco consumption and identity". He refers to the definition of gender as "an identity instituted through a *stylized repetition of acts* ... understood as the mundane way in which bodily gestures, movements, and enactments of various kinds constitute the illusion of an abiding gendered self" (Rudy, 2005, p. 13). Smoking behaviours consist of precisely such "bodily gestures, movements, and enactments" that reflect gender.

The relationship between smoking behaviour, gender and identity has emerged prominently in comparative investigations of smoking among adolescents. These studies have found striking differences in the reasons why boys and girls take up smoking and the role smoking plays for gender and identity formation (Lloyd, Lucas & Fernbach, 1997; Lucas & Lloyd, 1999; Michell & Amos, 1997; Nichter et al., 2006; Plumridge et al., 2002; Stjerna, Lauritzen & Tillgren, 2004; Wearing & Wearing, 2000; Wearing, Wearing & Kelly, 1994). For example, Wearing and Wearing (2000) have found that for girls, smoking contained particularly strong messages about femininity, identity, their bodies and sexuality, and that smoking could project images such as autonomy, confidence and a resistance to less desirable images such as the "prissy, confining 'good girl' images"

(Wearing & Wearing, 2000). Amos and Bostock (2007) similarly found that, for girls, smoking was a means of constructing a gender identity which rejects the more traditional 'good girl' images, whereas for boys, smoking functioned to exhibit a 'cool' identity, but that smoking also clashed with boys' other identities of being fit and sporty.

The role of smoking for the establishment of a feminine or masculine identity remains important and differentiated in young adulthood. In another comparative study of 18 and 19 year old college men and women, Nichter et al. (2006) found that smoking among women was associated with gender identity and physical attraction, but that elements of contradiction, control and agency also emerged as significant. For instance, the authors found that while smoking among women was considered unattractive and indicative of lacking control in some situations, smoking was considered desirable and could function as a sign of individual agency and of possessing an outgoing personality among friends or in a party setting (Nichter et al., 2006). Conversely, smoking among college-aged men was seen predominantly as a sign of manliness and of coolness and as a symbol of possessing a relaxed demeanour and of being in control (Nichter et al., 2006).

Other studies have highlighted the prominence of identity, control and conflict for shaping women's smoking behaviour in particular (Gilbert, 2005; Gillies & Willig, 1997; Graham, Francis, Inskip & Harman, 2006; Greaves, 1996; Greaves & Barr, 2000; Greaves & Jategaonkar, 2006; Greaves et al., 2006; Nichter et al., 2006; Wearing & Wearing, 2000). For example, Greaves (1996) has illustrated the relationship between smoking and identity, control and conflict, suggesting that smoking carries important social meanings for women but that these meanings are continually changing and thus create contradictions in women's lives (Greaves, 1996). Greaves argues that smoking is both empowering and disempowering for women and can be a means of demonstrating agency, but can also represent a burden.

Similarly, Gillies and Willig's (1997) research on women's smoking revealed that women's ability to regulate their smoking behaviour in the face of tobacco addiction demonstrated discipline and restraint. However, the authors suggest that the sense of control applied only to the women's ability to moderate smoking behaviour, not their ability to quit smoking, for which some felt they lacked agency (Gillies and Willig, 1997).

The role of smoking with regard to the body, both in terms of body image and body weight, has also been found to be particularly significant in the lives of adolescent girls and adult women (Austin & Gortmaker, 2001; Crisp, Sedgwick, Halek, Joughin & Humphrey, 1999; Honjo & Siegel, 2003; Wiseman, Turco, Sunday & Halmi, 1997; Zucker, Stewart, Pomerleau & Boyd, 2005). Importantly, it has been found that women may in fact have lower cessation rates due to concerns about subsequent weight gain (Chapman Walsh, Sorensen & Leonard, 1995; Honjo & Siegel, 2003; Zucker et al., 2005). While not all research suggests that this is consistently true or that it is an exclusively female behaviour (Clark et al., 2004; Nichter et al., 2004), the body of research linking smoking and weight control among women is critical, as concern over physical appearance has been found to be more significant for women than for men (Chapman Walsh et al., 1995) and gender norms require women to maintain, at all cost, thin bodies (Bordo, 1993).

Few studies have been conducted exclusively on adult men's smoking behaviour (Courtenay, 2000; Emslie et al., 2004), perhaps because, as some suggest, smoking may generally be a "less gendered phenomenon" amongst men (Hunt et al., 2004, p. 246). However, recent interest in men's health has prompted research examining gender and smoking behaviour to include men and investigations of masculinity (Bottorff, Oliffe, Kalaw, Carey & Mroz, 2006; Courtenay & Keeling, 2000; Emslie, Hunt & MacIntyre, 2002; Hunt et al., 2004; O'Brien, Hunt & Hart, 2005).

For example, Bottorff et al. (2006) examined male smokers whose partners were expecting a child. The authors found that during the phase of transition into fatherhood, strong links between expressions of masculine identity and smoking behaviour existed and that masculine gender identity had been socially constructed in opposition to health-promoting behaviours. They suggest that changes in health behaviours such as quitting smoking required a corresponding rejection of masculine ideals (Bottorff et al., 2006).

While a considerable body of research has demonstrated the role of gender for smoking among adolescents, and another body of research has revealed the dissonant nature of smoking for women with regard to elements of the social context, there is a dearth of research (especially qualitative) that has comparatively analysed adult men's and

women's smoking behaviour to investigate the role that gender and elements of the social context play in creating unequal smoking distributions along gender lines. For this reason, in order to begin to fill the gap in the research literature, the current article will comparatively analyse the way gendered elements of the social context shape smoking among adult men and women.

The article examines expressions of gender that emerge in men's and women's narratives of their smoking practices, and how these varied by three aspects of social context: identity (i.e., masculine and feminine), the body (i.e., body image and weight) and individual agency (i.e., the part individuals play in exerting power and producing effects in their lives, Courtenay, 2000, p. 1388). As such, three research questions are pertinent to understanding the role of gender and the social context for smoking behaviour. These include: 1) how do men and women smokers' identities shape their perceptions of their own and others' smoking behaviours?; 2) how do considerations of the body, including weight control and body image, figure into men's and women's narratives?; 3) and, how does gender shape men's and women's experiences of agency over their smoking behaviour?

Method

The current study was exploratory in nature and involved the combination of qualitative interview data from two phases. The first phase consisted of 17 in-depth interviews conducted with adult smokers in the Greater Toronto Area. Themes explored in these interviews related to several dimensions of the social context of smoking. Given the recognised importance of gender for smoking behaviour in the literature, and the fact that this first study did not explicitly examine the role of gender for smoking, the second phase was initiated as an off-shoot of the first. As part of the second phase, an additional six interviews were conducted in Montréal to further investigate gender. A total of 23 qualitative interviews were combined for the final analyses to examine the way in which the social context and smoking behaviours are shaped by gender.

For both study phases a maximum variation sample was recruited and a balance was sought in the number of men and women falling into two socioeconomic categories: a "working" class of smokers who had not completed post-secondary education, who were

employed in a manual or clerical profession and who were possibly financially unstable; and a second "professional" class of smokers who had completed post-secondary education, who held knowledge-economy type work, and who possibly owned property. Participants included current smokers who had smoked within the last 30 days, who had smoked for a minimum of 10 years, who were 19 years of age or older, and who had lived at least three of the 10 years they have been smoking in Canada (a time deemed sufficient to establish familiarity with the social context of smoking in Canada). Each participant provided written informed consent and received a $30 honorarium for their participation in the study.

The 17 participants interviewed as part of the first phase were contacted during two recruitment stages. The first five participants were recruited through posters displayed at a downtown Toronto deli. After the first 5 participants were recruited, it became apparent that the sample was saturated and relatively homogeneous and included only working class women aged between 30 and 60. Given that variation based on gender, age and socioeconomic status (SES) was desired, the remaining participants were recruited through purposeful sampling based on the personal networks of the project researchers. The six additional interviews conducted as part of the second study phase were held in Montréal, Québec in autumn 2006 and participants were also recruited through the personal networks of the researchers. The 23 participants included nine male smokers and 14 female smokers (see Appendix A).

All interviews were one-to-one narratives lasting between 30 and 90 minutes, held in a location agreed upon by both the interviewer and participant, and were digitally recorded. Interviews were guided by open-ended questions allowing the participant to determine the direction and focus of the discussion. The first 17 interviews followed an interview guide organised around themes relating to several dimensions of the social context of smoking.[1] The six additional interviews followed a similar interview guide, but included, as well, a few additional probes around gender.[2]

To begin the analysis, four members of the research team, including the two co-principal investigators of the original project and two research assistants, performed

[1] Please contact second author for a copy of the first interview guide.
[2] Please contact first author for a copy of the second interview guide.

multiple readings of the original 17 interviews and identified a set of 15-20 'tags' relating to the social context of smoking. The 17 interview transcripts were then entered into the qualitative research package, Atlas.ti (version 5) and coded. In order to ensure analytic rigour and transparency in the coding process, an audit trail was maintained throughout the coding process. In addition, each interview was coded twice by the research assistants. This ensured that both research assistants possessed a common understanding of the "tags" and coding methods and that all interviews were coded consistently. The coding of the six additional interview transcripts followed the original coding scheme. However, particular attention was paid to meaningful text segments emerging with regard to gender. As such, three new and more detailed 'tags' related to gender were developed and added to the original coding scheme (masculine smoker, feminine smoker, attraction and smoking) to create a new coding scheme. These interview transcripts were also entered into the qualitative research software package, Atlas.ti (version 5).

Finally, in order to combine and analyse all 23 interviews for themes relating to gender, the original 17 interview transcripts were re-coded using the new coding scheme. The three social context dimensions elaborated as part of the research questions (i.e., identity, the body and perception of agency) provided a framework around which the interview material was organized and analysed. Finally, for the analysis of gender with regard to the three social context dimensions, textual reports were created for each dimension and were analysed in order to compare the similarities and differences between the interviews.

Findings

Identity and smoking behaviour

Gender identity and smoking behaviour were strongly linked to one another in our interviews with adult men and women. A key finding of our study was that most women expressed dissonance between their smoking behaviour and their identities, creating considerable conflict for them, whereas smoking among the men was not as dissonant with their identities, and thus did not create conflict for them in the same way.

One of the ways in which conflict emerged for the women interviewed was with regard to their identification with health, with their requirement to exhibit health knowledge, and with their general rejection of unhealthy behaviours. Women frequently discussed their health behaviours as central to their lives and as figuring into their identities, all of which conflicted considerably with their smoking behaviour.

For example Jennifer, a former model in her early 30s, provided a striking example of a woman who defines herself in large part through her health behaviours. She discusses her healthy habits at length, mentioning that she goes to the gym, does yoga and is very concerned about what she puts into her body. For instance, she says "I don't eat processed foods...I'm very concerned about chemicals and yucky food". Her identity as a healthy woman is therefore in direct conflict with her smoking behaviour. This conflict is most evident when Jennifer discusses what it is like for her to be a smoker. It immediately becomes clear that her smoking is a source of shame, guilt and marginalisation.

> "It's absolutely horrific. It is. I feel so ostracised. I feel like I'm a bad person. I feel like I'm a lazy person. I don't know what else to say because that would pretty much sum it up. Like I live on the margin and I feel doubly oppressed as a smoker being a quote unquote healthy person, a person who otherwise takes care of herself in other parts of her life. I feel like everybody's always-- Like all of that's discounted because I smoke... I think about it every second that I smoke... And every time I have a cigarette I feel disgusting. Like, I feel embarrassed." (early 30s, female, graduate student)

Several women also strongly identified with their roles as mothers and caretakers, which also emerged as dissonant with smoking. For example, Shelley, a 42 year old legal secretary and mother of two, suggests that being a health conscious mother is important to her. She says that she has recently decided to spend more time taking care of her girls' health with "swimming one night, gymnastics one night, weight loss group one night", as she feels they may be getting "a bit chubby". In this way Shelley presents herself as a responsible and health conscious mother who makes sure she and her girls stay healthy and fit through various health promoting activities. However, her "good mother" identity comes into conflict with her smoking behaviour, and this emerges particularly in her discussion of smoking cessation. While Shelley acknowledges her responsibility of being a good role model for her children, she expresses the dilemma between her obligation to quit smoking (the children "should be the reason") and the feeling that in the end she should be quitting for herself. Shelley seems to vacillate back and forth on this issue.

> "The last couple of months actually they have been: 'Mom, you should quit you know, you shouldn't smoke.' And a couple of times they've found twigs in the backyard and said: 'Mom, I'm going to smoke just like you.' It still hasn't hit home enough to make me want to quit... I think in the back of my head with having kids, you know, it's there, you know, I want to be around for the rest of their lives you know...I know in my head that I should quit, but I'm just not at that stage in my life to want to do it and I think I have to do it for myself as opposed to, but, my children should be the reason, but it's just not there yet." (early 40's, female, clerical)

A third identity that emerges as dissonant with smoking is that of the young, educated woman. Rachel, a self-identified lesbian in her late 20's, is a graduate student in a health-related field. While Rachel feels that smoking is consistent with some of her identities, that is, when she is part of the "queer community" or in some work situations, she also experiences a sense of dissonance with regard to her smoking behaviour when she considers her identity as a young, educated woman studying in the health field. Rachel suggests that this identity seems to require her to be non-smoking, and she says that "in an academic setting and in a government setting it is absolutely awful being a smoker."

Rachel discusses having to manage the physical effects of smoking on her body in order to avoid negative judgment from university professors and colleagues at a health conference. She describes the elaborate process she undergoes to be able to smoke in her hotel room without smelling of smoke.

> "I took off all my clothes, I wrapped a towel around me like this, I opened one of the shower caps ... I put all my hair under the shower cap and there was like little vents -- So I lied down on the ground like this ... I had the cigarette in the ashtray and I actually put the cigarette so the smoke part was outside...I got on the ground like this and that's how I smoked. ... Then I sprayed myself. Well I don't really have perfume but I kind of you know --. I brushed my teeth again, chewed some gum and that kind of thing." (late 20's, female, graduate student)

Rachel also criticises the double standard she sees applied to the acceptability of women's smoking compared with men's, which she experiences in discussions with her partner's family.

> "When her brother-in-law was smoking...nobody would ever say anything to him. Nobody would ever be like, you know, you really shouldn't be smoking. But me, I'm a young student, I'm a girl... and for some reason they are hard on me for smoking.... Her dad kept going on and making these implications that ...I'm doing this terrible thing to my body, how could I, you know, be in (name of health graduate program)." (late 20's, female, graduate student)

With regard to the men, the identification with a hegemonic masculinity, while not apparent in all interviews, emerged strongly in some interviews with men smokers. Hegemonic masculinity is defined as the "dominant constructions of masculinity, which influence men's identities and practices, including health practices" (Gough, 2007, p. 327). In our study, this included identification with being a tough, 'straight talking' man who is resilient in the face of health risks and who is not too concerned about the health effects of smoking. Men's smoking behaviour did not seem to conflict with these identities. In fact, in some cases, smoking seemed to support the expressed hegemonic masculinity. The men's narratives were thus for the most part free of dissonance with respect to identity and smoking.

Both Christophe, a 30 year old working as a television camera man, and Philippe, who is in his mid 30s and works as a design instructor and dj, characterise the tough, 'straight talking' man when they discuss their smoking. For example, when describing their preferred choice of cigarettes, both men indicate that the physical sensation of "pain" or a particular "presence" from the nicotine is required for them to properly enjoy the smoking experience. Philippe says that he could smoke almost any type of cigarette, "as long as it's strong enough". He says he hates smoking a cigarette that doesn't make him "feel like something, pain or anything". According to him only women and "grandmas" smoke light cigarettes "thinking that it's gonna be better for their health". Christophe similarly suggests that smoking light cigarettes is "so bad... you feel like you're puffing air" and that "there has to be something, there has to be a presence."

Similarly, some men who identify with the tough, risk-taker identity are able to rationalize or distance themselves from the negative effects of their smoking. For example, while George, a lawyer in his mid 30s, admits that he should quit smoking, he suggests that his concern for health exists only because "other people tell him" that smoking is unhealthy, not because he is genuinely concerned about his health.

Jim, a postal worker in his mid 50s, best typifies the tough, risk taking man. He is a man who is unconcerned about the health risks of smoking, maintaining that "there is

nothing they can throw at me now that'll phase me... not even the big C." In his interview, Jim frequently mentions that he has survived numerous serious illnesses throughout his life and despite his knowledge of the risks associated with smoking, he says he will do what he wants and will likely always continue to smoke.

> "I'm fully aware of the consequences. You know a lot of people are in denial. I'm not you know. But I'm going to do what I want." (mid 50s, male, mail sorter)

In some of the interviews with men, the hegemonic masculine gender identity seems not only to be consistent with smoking behaviour, but smoking seems to emerge as an enhancement of the dominant masculinity. This is illustrated by Philippe who describes the way in which smoking enhances and "goes well with" the male smoker. He says that for a man:

> "Smoking is a bit more rough. It's more aggressive, he's inhaling in another way, it gets smoke into him ... I think guys smoking, it's like a machine ... it goes well with the guy, the image we have of fire and stuff like that." (mid 30s, male, dj and design instructor)

Tony, a part-time student in his late 20s who identifies as a gay man, describes the way in which he views the stereotypical, tough, heterosexual male smoker, and the way in which smoking can be an enhancement of this type of masculinity.

> "I think for a typical male it does factor into his identity as a man... It's like you can see it when certain men smoke. The way they hold their cigarette... clasping it ...their stance, the way they will flick ashes, it's done in a very manly way, just almost like beating their chests with their hands... it's a whole look, it factors into this testosterone, that's how I view it. The majority of men that I see who smoke, smoke in a specific way, almost like a dog peeing and marking its territory. Like it's very, it's just assertive." (mid 20s, male, student)

Men's discussion of smoking is thus not only characterised by an absence of dissonance between smoking and their gender identities, but also at times, by the ability for smoking to function as an enhancement of the dominant form of masculinity.

Smoking and the Body

Smoking was closely tied to gender expression and was significant for the representation of certain images of the body. For many women, smoking was implicated in body image in contradictory ways such that smoking played a role in constructing physical

attractiveness, but also had the ability to take away from the positive feminine images. Importantly, while women were aware of the negative impacts of smoking on the body, smoking was still considered a means for some women to control body weight. In this capacity, smoking again created a considerable amount of conflict for women.

Body image and physical attraction

An important finding of this study was the salience of smoking for body image and physical attractiveness in interviews with women, while this theme was almost entirely absent in the interviews with men. For some women, smoking had the power to both enhance, as well as detract, from their body image and physical attractiveness, and thus carried ambivalent messages.

For example, the interview with Jennifer best illustrates the ability for cigarettes to differentially affect the body image aesthetic. On the one hand, Jennifer emphasises her preference for smoking the girly, pretty and "long cigarettes", suggesting that these make her feel "glam" and "fabulous". She contrasts these with the "short stubby", "tough guy" cigarettes, which she says she would never smoke. For Jennifer, the aesthetic effect of smoking the long, glam cigarettes seems to be a reflection of her preferred body image as the girly, "thin and pretty" woman as opposed to the "short and stubby" tough guy. Jennifer's discourse is reminiscent of 1960-70s cigarette advertisements targeting women ("Virginia Slims is made long and slim, just for you", *in* Greaves, 1996), associating the slimmer, longer cigarettes with women's desire for a slim body.

However, Jennifer also feels embarrassed about her smoking and, like many of the women interviewed, goes to some lengths to hide it. For example, a second aesthetic effect that smoking has on the body, and which Jennifer is concerned about, is the smell cigarettes leave on hair and clothing. While both men and women mention disliking the cigarette smell, for women the smell of cigarettes on the body is viewed as particularly repellent and as significantly able to detract from a woman's aesthetic appeal. As such, despite the ability of certain "glam" cigarettes to enhance Jennifer's body image, smoking also threatens her physical attractiveness. The cigarette smell on her body is clearly not consistent with her ideas of feminine aesthetic appeal.

> "Yeah smoking is an anomaly in my life for sure. It's very bizarre...I'm like a very girly girl preener... I like bathing. I think bathing is really important. I have like two showers a day. I don't know ... I'm very-- I like to be really clean. Smoking makes me feel really dirty." (early 30s, female, graduate student)

For Jennifer to maintain a sense of feminine aesthetic, special care and elaborate management is thus required to mask this smell after smoking.

> "When I have a cigarette I wash my hands, I brush my teeth or hope to God that my clothing doesn't reek, which is another reason why I go out and hide... I feel really neurotic about that ... I never used to wear perfume. I wear perfume now. I think maybe it's because I feel like that maybe it'll help cover up the smell of smoke."

Consistent with the concerns some women have regarding the negative impact of cigarettes on body image and on aesthetic appeal, several women also expressed considerable concern for the physical impacts of smoking on the body, especially those that have negative aesthetic effects. These include yellowing teeth, stained fingers and changes to skin complexion. For instance, Jennifer suggests that she chooses cigarettes that will not aesthetically affect her body or make her look like a smoker.

> "I smoke certain types of cigarettes that don't stain your fingers. So you can see my fingers don't look like a smoker's. I don't have any nicotine residue or yellow nails or any of that."

Furthermore, references to the ambivalent meanings that smoking carries for women's body image and physical appeal are made by both men and women. Tannis, a student in her mid 20s, laments the fact that smoking in the past had functioned as an accessory to a woman's physical attractiveness, whereas today, for a woman to be physically attractive, she is required to be non-smoking.

> "My co-worker was like 'oh, it's so unattractive to see a woman smoke'. And it used to be so hot man, the fifties, like fuck! ... I'm thinking in the fifties if I was smoking, white like this, curvy and like, I would, I'd be the bomb! Nineties, two-thousand - no, it's like, you have to be waif, tanned brown and non-smoking." (mid 20s, female, student)

Quite in line with Tannis' statements regarding women smokers, Philippe suggests that women's smoking carries ambivalent messages and has the power to both enhance and detract from their aesthetic appeal. On the one hand, Philippe says that smoking can enhance a woman's femininity and physical appeal:

> "It can be very sexy, in a way, women and smoke, but not always. It depends on the woman, it depends on the situation." (mid 30s, male, dj and design instructor)

However, while Philippe suggests that some images of women smoking are sexy, he also suggests that smoking is inconsistent with femininity. Philippe's ideal, stereotyped image of a feminine woman includes bodily manifestations that contrast with smoking.

> "You know a woman is in general very elegant, has these gestures and then has smoke coming out of her mouth, it's like ooof! Sometimes it can be weird."

Considering the significance of physical attraction and body image for many women, it is perhaps not surprising that some women interviewed perceived the aesthetic impacts of smoking as equally important to the health effects. For example, when Cindy, a lawyer in her mid 30s, discusses the negative consequences of smoking, both the health and aesthetic impact of smoking seem to be given equal weight.

> "I don't want to get cancer. It would be very unfortunate. Um, and, you know, I don't want to age prematurely. I don't want any of that stuff." (mid 30s, female, lawyer)

Similarly, Anna, an actor in her early 40s, considers the health and aesthetic impacts of smoking on her body with equal concern, saying "I'm sure I'd be healthier... I'd probably have a better complexion".

We see, therefore, that for several women interviewed there is a strong and conflicted association between smoking, body image and physical attraction. This finding is also striking, as it contrasts considerably with men's interviews, which were characterized by an almost complete absence of concern for aesthetics and body image.

Body weight

A preoccupation with body weight and weight loss existed in most interviews with women, but not in the interviews with men. Importantly, it was revealed that smoking cigarettes played a significant role in several of the women's attempts to control their weight. This was particularly evident during discussions of smoking cessation when a number of women expressed anxiety over weight gain, and felt they would have to "fill the void" from not smoking with food.

For instance, Carmen, a medical secretary in her early 30s, resists quitting smoking, since during previous quit attempts food had become a replacement for cigarettes.

> "I ate. And I ballooned up...that's why I guess I'm scared to stop again because I'm scared that that weight's going to come back on." (early 30s, female, clerical)

In a similar way, Eva, a receptionist in her early 40s and mother of two, mentions that she has been dieting for a few years. She suggests that for her, cigarettes function as a dieting aid and that "instead of eating and snacking when I'm watching TV, I grab a cigarette." Eva's preoccupation with weight gain is striking and she suggests that quitting smoking for her would be equivalent to death. The gravity of her weight concern, and its link to her smoking, emerges particularly strongly when she is asked about quitting.

> "I don't want to gain that weight back. I'd rather smoke and die, than be fat again. Seriously." (early 40s, female, clerical)

Beverly, a gardener in her early 40s, also suggests that her lifelong concern about her weight is a main motivator in her continued smoking.

> "It was always frustrating to be heavy and in quitting smoking I got heavier and I guess a lot of times I equate the two together...I'd try and quit for a couple of days and you could see the pounds creep up. You know nope, nope, that's not working... keep smoking and that way I don't eat." (early 40s, female, gardener)

In fact, smoking cessation and weight gain are so closely tied to one another for Beverly that when asked if she could ever see herself as a non-smoker, she says she can only imagine Beverly the non-smoker as "big Bessie".

For Cindy, smoking seems to be particularly strongly linked to body size and weight. She illustrates this relationship by describing a past experience of quitting smoking and her consequent weight gain. In this passage, she expresses the importance of her body size for her sense of identity, thus linking smoking and body weight to her identity and personality.

> "I was always a very small person and that was part of me... but I wasn't anymore...I didn't wear a size 2, I wore a size 10, or even bigger than that at one point. I just felt very unattractive... like totally unattractive. ... I guess up until then a lot of my sense of confidence was based on the way I felt like my body looked. ... I couldn't base it on that anymore. ... It was a really difficult time for me because I had to try to find things that I liked about myself other than my physical appearance because ...I didn't like it any more... I didn't lose the weight until I started smoking again." (mid 30s, female, lawyer)

Importantly, the strong link between smoking and the body, in terms of managing a positive body image, physical appearance and body weight, emerges exclusively in the

interviews with women. The prevalence of this link among the women demonstrates the way gender norms surrounding the body may shape women's smoking behaviour.

Agency

The way in which the perception of agency over smoking is gendered has important consequences for men's and women's smoking and was especially evident in discussions of cessation. For example, many women expressed a sense of urgency to quit smoking and the desire for more control over the cessation process, yet they also tended to express having little agency over their smoking behaviour and cessation. This emerges most prominently in the interview with Jennifer. She describes herself as being 'obsessed' with her smoking and discouraged by her quit attempts, as having no will-power to quit smoking, and as being afraid of failing if she tries to quit again.

> "I mean some individuals choose to smoke and probably don't think about it very often, but I think about it every second that I smoke. Yeah. I'm obsessed with the fact that I'm a smoker. Literally obsessed with it... I'm really scared now... I want to quit so badly right now, but I have no idea how to go about it. I can read as much literature as I possibly can and fill out as many quit smoking program booklets as I possibly can, but it doesn't make it any easier." (early 30s, female, graduate student)

Jennifer's lack of agency with regard to cessation is particularly distressing for her because she feels that she has control, and exerts agency, over many other areas of her life.

> "It's weird because with everything else I have the willpower... with cigarettes it's like, I really want it, like right now, I really want it. I'm getting sweaty. I really want a cigarette... I can't talk myself out of it. It will stay in my head... I can't just sort of shut if off ... that voice that's saying smoke, smoke, smoke, smoke. It's horrible."

The lack of agency over smoking cessation is also expressed by Leslie, a mother in her late 30s working as a hair stylist. Leslie is a smoker for whom "you can't make a coffee strong enough and you can't make a cigarette strong enough" and she says that her addiction to cigarettes "takes over" other basic needs like eating. When the topic of smoking cessation arises Leslie suggests that she does not have the will-power or the strength to quit. As she explains, quitting smoking would require her to be physically restrained.

> "You know I can't do it. I'm sorry, but I can't. I don't have the will-power or I don't have the strength. I just can't. I go absolutely insane... I could quit if you locked me in a room where I didn't have to talk to anybody."

Some women perceive a lack of agency over smoking behaviour precisely because smoking cigarettes is so closely tied to their body weight. For example, Beverly, who mentions that the pounds "creep up" when she tries quitting smoking, suggests that she feels controlled by cigarettes, since to not be fat, she has to continue to smoke.

> "[smoking] controls the fact that well yeah, you know, if I don't want to be big and fat then I'll keep smoking, right. And it's like, I might have just kicked your butt, yeah. I'm not going to be big and fat and quit smoking."

In contrast to the women, most of the men interviewed expressed far less urgency to quit smoking and also felt they had agency over their smoking behaviour and future cessation. George, a policy analyst in his mid 30s, exemplifies this attitude. When asked about his plans to quit smoking George's response is non-committal, does not convey any urgency to quit smoking, and is even somewhat humorous.

> "I: Have you tried quitting?
> P: Not really, no. I'm not really a quitter. Ah, yeah it's more something I think about at night and then sort of by the time I'm actually at work, you know, half way through my work day- oh fuck, I was going to stop smoking, right. No. It's more like that." (mid 30s, male, policy analyst)

George also comes across as relatively unconcerned about his smoking behaviour. He suggests that he can moderate his smoking behaviour, that he can abstain from smoking when it is required, and that he can choose which cigarettes he does and does not want without experiencing much discomfort. He expresses a laid back attitude toward his smoking and conveys a sense of agency over his smoking patterns. George suggests that he smokes the precise amount he wants to and does not feel driven to smoke.

> "Increasingly for me I want to smoke, and I want to smoke until the very moment that I'm satisfied with it, and then I'm not real eager to keep doing it. And often that can be, like, just four or five drags and then I'll just throw it out, or walk away, or brush it out. And not really for any other reason than I think, you know, I wanted that part of it and now that I've had it, that's good."

When men discuss the potential for quitting smoking, unlike many of the women, they also express a greater sense of agency in their ability to do so. While George is not planning to quit smoking (he is, after all, "not really a quitter"), he suggests that if he were to quit, it would require a sort of "mind shift". However, he is also quick to add that he

does not want to "make too much" of his plans for cessation and does not deliberate too much on the best way to quit smoking.

> "It is probably the central mind shift that has to take place. Like I think that's really the key thing. And other times I realize, you know, shut up...Like either quit or don't, right... I think that people make a lot of it... It's very true that, you know, part of what is addictive about smoking is the familiarity of routine, and a big part of not smoking is becoming comfortable and familiar with some other routine. But you know, I don't want to make too much of it."

In a similarly laid back manner, Rick, a mechanic and father of two in his early 40s, suggests that quitting smoking for him would not involve a lot of planning. Rather, for him it would primarily involve "putting his mind to it" and saying "that's it, end of it, drama's over". This expression of agency over smoking and cessation also echoes Jim's discussion of his previous cessation experiences. Jim suggests that when he has quit smoking in the past he was in complete control, and that his success lay only in the ability of his mind to control his body.

> "... a Friday night on September 10th, 1978, I had my last cigarette. And I never smoked for eight years and I had absolutely no withdrawal... Just mind control. That was it. I never had one bit of withdrawal. Nothing... But see, your mind controls your body... That's all it is, is mind power, will-power." (mid 50s, male, mail sorter)

As such, men's and women's sense of agency over their smoking differs by gendered expectations of behaviours. This difference also has implications for the sense of conflict expressed with regard to their smoking. The women interviewed generally feel increased urgency to quit smoking and express wanting to have control over the smoking cessation process. Despite the intense desire to quit smoking, however, women seem to feel they have less agency to do so, which creates a considerable amount of conflict for them. On the other hand, the men interviewed did not as frequently mention the desire to quit smoking, but when the subject of cessation arose, men generally expressed having agency over their smoking behaviour and cessation. This assurance of control seems to go hand in hand with the reduced amount of conflict overall expressed in the interviews with men when compared to women.

Discussion

Our interviews explored the way in which three dimensions of social context: identity, the body and agency are gendered and shape smoking behaviour. The findings from our study support previous research examining gender and smoking, emphasising gender as critical to the way in which smoking behaviours are enacted (Amos & Bostock, 2007; Batten, 1993; Bottorff et al., 2006; Greaves, 1996; Greaves and Tungohan, 2007; Ioannou, 2003; Nichter et al., 2006; Wearing & Wearing, 2000; Wearing, Wearing & Kelly, 1994). In our study, gender was found to be central to both men's and women's smoking and was particularly evident when smoking was used as a vehicle to manage gender identity or to convey gendered attitudes towards health.

Importantly, the findings from the current study also expand on this body of gender and smoking literature that has, for the most part, focussed on adolescent smoking. By comparatively analysing smoking among adult men and women, our study demonstrates that gender and social context remain important for differentially shaping the smoking practices of adult smokers. Our findings also begin to shed light on current disparities in smoking rates between men and women and point to implications for tobacco control.

A particularly important theme emerging from our findings is that smoking poses a considerable amount of conflict for some women, but does not for men. In fact, a general sense of contradiction and anxiety defined many of the women's discussions of their smoking behaviour and appeared with regard to all three elements of the social context. This finding is consistent with Greaves' (1996) research with adult smokers in which women viewed smoking as grounds for feeling "guilt, tension, contradiction and as reason for self-castigation" (Greaves, 1996; p 37). Greaves (1996) also found that women struggled to unify their identities and lives with their smoking behaviour. As evidenced in our interviews, being knowledgeable about health issues and being committed to health behaviours was central to women's lives and identities. However, this 'healthy woman' identity seemed to create conflict for women when considering their smoking behaviour.

In addition, several women in our study voiced the pressure that they felt as mothers to be non-smoking. This is not altogether surprising since Lupton (1995) has also suggested that health campaigns in general, and tobacco control efforts in particular, have placed the responsibility for health on women "in their roles as wives and mothers, with little concern

for women's own health status" (p. 119). Greaves (1996) also suggests that a "foetus centred" approach to smoking cessation has commonly been used in tobacco control efforts. This approach focuses on the woman's primary role as mother, caretaker and role model for her children as the main motivation for cessation (Greaves, 1996). She criticises this approach, suggesting that it puts pressure on women to quit smoking for the sake of their children alone and that it tends to increase the sense of guilt among smoking mothers, rather than focussing on the mother's health or the role that smoking and cessation play in the lives of these women.

Furthermore, Madden and Chamberlain (2004) argue that women are viewed as the "moral guardians" (p. 592) of their children and their partner's health. An unhealthy practice such as smoking thus may have the potential to cast a shadow on women's moral position. Some of the women interviewed seem to suggest that by smoking they are not meeting the standards of femininity which seem to require young, educated, health-conscious and responsible women to be non-smoking. In this way, smoking among these women seems to emerge as a transgression of what Lupton (1995) calls women's "health imperative". The sense among these women that they are committing this health transgression may help to explain the considerable amount of conflict they expressed in their interviews.

Men's interviews, on the other hand, provided a contrast to those of the women, primarily because their discussions of smoking were much less characterised by conflict. Rather, most men discussed smoking in a more relaxed manner and the interviews were largely defined by a lack of concern regarding smoking and health risks, or by any real urgency to quit smoking. A particularly noteworthy finding emerging from men's interviews was the ability of cigarette smoking to enhance characteristics associated with a hegemonic masculine identity. Bottorff et al. (2006) suggest that smoking for men is a means to reproduce gendered identities and is a way to "express their youthful and indestructible masculinity" (p. 3100). This is illustrated by some of the men in our study who suggest that smoking functioned as an accessory to masculine identity, including toughness, resilience to pain and a lack of concern about health and smoking risks (Gough, 2007). While not all men interviewed were entirely unconcerned about their smoking behaviour, the contrast between the men's and women's interviews regarding smoking and

health is consistent with literature linking hegemonic masculinity to men's rejection of health concerns (Courtenay, 2000; Gough, 2006; Gough, 2007; Mahalik, Burns & Syzdek, 2007; Moynihan, 1998; O'Brien et al., 2005; Robertson, 2003).

Furthermore, the men in our study seemed to receive more social approval to smoke than the women did. This is not altogether surprising. For example, Nichter et al.'s (2006) study of the gendered dimensions of smoking among college youth also indicated that there were far fewer social constraints and negative associations connected with men smoking than with women smoking (Nichter et al., 2006). In this way, without the dissonance between smoking and gender identity, and with no pressing need to adjust smoking behaviour in order to be more consistent with the dominant masculine identity, the level of conflict regarding smoking is not expected to be the same among men as among women.

The extent to which smoking impacts women's body image and sense of physical appeal is particularly striking in the interviews. For example, smoking was considered to both positively and negatively affect women's body image. Cigarettes were sometimes referred to as accessories to body image, but could also threaten attractiveness by conveying an unattractive "smoker" look. Some women were also considerably concerned with the aesthetically damaging physical effects of smoking cigarettes such as yellow teeth, stained fingers and wrinkling skin. Smoking thus required careful management for women to maintain an attractive body image, an activity which also seemed to provoke anxiety. The preoccupation among most women with smoking's aesthetic effects and its impact on body image can be understood in light of the fact that the desire to be physically attractive is a socially prescribed goal for women (Greaves, 1996; Madden & Chamberlain, 2004; Zucker et al., 2005). In fact, tobacco control campaigns have explicitly appealed to women's anxiety regarding the requirement to maintain a youthful, attractive body by presenting images of old, wrinkled (and therefore undesirable) smokers in order to incite women to quit smoking, or to prevent young girls from beginning to smoke (Greaves, 1996; Lacroix & Auger, 2007; Lupton, 1995).

Furthermore, several women in our study give aesthetic and health concerns equal weight in their decision of whether or not to quit smoking. In some cases the aesthetic concerns even seem to override those for health. The reasons for quitting smoking thus

become complicit in what Madden and Chamberlain (2004) call the "feminine beauty discourse" (p. 593). That is, quitting smoking, like other health behaviours, is not primarily done for health reasons, but more importantly "as a means through which to manage ... one's physical appearance" (2004, p. 593).

Considering this, it is also not entirely surprising that the area in which most anxiety and conflict regarding the body emerged was in women's discussions of weight management during smoking cessation attempts. In our study almost all the women expressed fear of weight gain associated with quitting smoking and suggested that potential weight gain was a deterrent to smoking cessation. This is particularly relevant given the preoccupation among North American and European women with a thin body and weight control (Bordo, 1993; Olmsted & McFarlane, 2003; Zucker et al., 2005).

As a striking contrast to the women, few men in our study discussed smoking with regard to the body. That is, men did not tend to express concern regarding smoking and their own body image or body aesthetics, and they did not show concern over weight gain during smoking cessation. This may be relevant on the one hand, since discussion or admission of concerns regarding the body, and especially bodily aesthetics, is not a socially prescribed or accepted masculine behaviour (Conner, Johnson & Grogan, 2004). On the other hand, the lack of concern for the body may also be due to the fact that men are generally resistant to the social pressures that cause body image dissatisfaction in women (Conner et al., 2004).

Given the difficulties women have in reconciling conflicting desires and obligations surrounding smoking, their identities, physical attraction and body weight, as well as the overall conflict that characterises many of the women's discussions of smoking, it follows that women might express less agency over their smoking behaviour. Both Walters and Charles (1997) and Doyal (1995) suggest that the anxiety and conflict that women experience is a response to the "contradictory and demanding reality of so many women's daily lives" (Walters and Charles, 1997, p. 1729) and that their anxieties concerning their multiple roles and responsibilities "reflect feelings of powerlessness and the contradictions women face in their lives" (p. 1729). As such, the inability for women to resolve their smoking behaviour with their lives, and the resulting anxiety this creates, may also

contribute to women's lack of agency regarding smoking cessation.

In addition, considering the gendered "moral' (Lupton, 1995) requirement for women to be in control of their health (and therefore be non-smoking), the practice of smoking could also be interpreted as a sign of irresponsibility, of lacking control, and ultimately as a transgression of their moral health requirement. This transgression would function to further increase women's sense of anxiety over smoking and also their urgency to quit smoking. Considering this, it is not surprising that the women in our study express wanting more control over cessation, as cessation would allow them to maintain the desired gender identity. However, this may also explain the increased sense of anxiety that emerges when women suggest not actually having agency over the cessation process.

One way to understand the seeming incongruity between women's increased desire to control their smoking and their decreased sense of agency over the ability to do so, comes from Lupton's (1995) discussion of health promotion practices and the paradox of what she calls a "control and release" cycle. Lupton (1995) suggests that by putting pressure on individuals to exert control over their health practices such as smoking, some health promotion efforts may in fact be intensifying the desire for the 'forbidden' health behaviour. Katainen (2006) similarly maintains that if health promotion messages regarding smoking are too severe, individuals are likely to rebel and ignore them. Smoking among women in our study can be understood as a behaviour that is particularly 'forbidden' and at odds with most feminine health expectations. However, smoking may also be considered desirable as it is also a release from, and perhaps rebellion against, these strict health expectations that women generally encounter.

The lack of conflict experienced by men with regard to smoking, and the absence of urgency among men to quit smoking, seems to afford men a greater sense of agency over their smoking behaviour and over future cessation. Lupton's (1995) discussion of the "control and release" paradox could also provide an alternative understanding of men's sense of agency with regard to smoking cessation. Since men receive less pressure from health promotion efforts to be non-smoking, and because men do not experience the same contradiction and anxiety with regard to their smoking behaviour as women do, smoking for men may not be experienced as a 'forbidden' desire with the same intensity as it is

experienced by women. In this way, despite men's reduced urgency to quit, smoking is less conflicted for men and may be easier to disassociate from in future attempts at cessation.

When considering gender and social context with regard to their ultimate impact on smoking, the dissonance that women express, as well as the resulting urgency they feel to quit smoking, could be considered advantageous in terms of increased smoking cessation. However, while this sense of urgency may lead some women to attempt, and others to succeed at quitting smoking, Greaves (1996) suggests that more pressure on women and increased urgency to quit smoking would more likely induce guilt and lead women smokers to feel even more stigmatised, rather than lead to successful smoking cessation.

In addition, the increased dissonance for women concerning smoking may only function as a cessation aid for those who have the means to follow smoking cessation programmes, while further marginalising those women who do not. This has been supported by Lupton (1995), who has suggested that health promotion campaigns are advantageous primarily for those individuals from the middle classes who typically take up the messages and act upon them. This is also consistent with recent research on social context, socio-economic status (SES) and smoking which has suggested that higher SES smokers are more likely to adapt positively to tobacco control messages, while lower SES smokers felt more in conflict with tobacco control messages and rejected the possibility of smoking cessation (Frohlich, Poland, Mykhalovskiy, Alexander & Maule, in preparation).

In contrast to the women, the lack of conflict experienced by men with regard to smoking, coupled with greater social approval of male smoking, might suggest that men ought to have consistently higher and perhaps increasing rates of smoking. While this might provide an explanation for the continued overall higher rates of smoking among men compared with women, smoking trends over the past five decades have shown larger decreases in smoking for men compared with women. This overall reduction in men's smoking compared with that of women's is likely due to the fact that tobacco control efforts have been more effective at reaching male smokers than female smokers (Greaves & Barr, 2000).

Conclusion

Our study results show that the investigated elements of the social context are gendered and shape adult men's and women's smoking in distinct ways. Tobacco control ought to target these gendered elements in order to more effectively address gender inequalities as these may be contributing to the disparities in smoking rates existing between men and women. In particular, women's concern over their bodies and the social sanctioning of men's smoking seem to be areas of considerable importance for tobacco control. Addressing these concerns requires a comprehensive understanding of gender and smoking. Acknowledging the role of gender and social context in the lives of smokers, while not appealing to smokers' anxieties and resorting to health-damaging tactics, is required in order to reduce smoking rates in a more just and equal manner (Greaves and Jategoankar, 2006; Lacroix & Auger, 2007).

Appendix A – Demographic Information

Participants	Gender	Age	Occupation	Family	Study phase
1 Stephen	M	Early 30s	Industrial mgmt	Lives with partner (gay), no children	1
2 Rachel	F	Late 20s	Graduate student	Lives with partner (gay), no children	1
3 Jennifer	F	Early 30s	Graduate student	In a relationship but lives alone, no children	1
4 Beverly	F	Early 40s	Gardener	Married, four children	1
5 Rick	M	Early 40s	Mechanic	Married, two children	1
6 Leslie	F	Late 30s	Hair stylist	Married, two children	1
7 George	M	Mid 30s	Policy analyst	Married, one child	1
8 Roberto	M	Early 30s	Lawyer	Married, no children	1
9 Sean	M	Late 20s	Lawyer	Married, no children	1
10 Beth	F	Late 20s	Lawyer	Engaged, lives alone, no children	1
11 Cindy	F	Mid 30s	Lawyer	Divorced, lives with a friend, one step-child	1
12 Jim	M	Mid 50s	Mail sorter	Single, no children	1
13 Sandra	F	Mid 50s	Clerical	Divorced, three children	1
14 Louise	F	Early 60s	Clerical (law)	Single, lives alone, no children	1
15 Carmen	F	Early 30s	Clerical (med)	In a relationship but lives alone, no children	1
16 Shelley	F	Early 40s	Clerical	Married, two children	1
17 Eva	F	Early 40s	Clerical	Married, two children (grown)	1
18 Tony	M	Late 20s	Student	Single (gay), lives with roommates	2
19 Florence	F	Mid 20s	Student	In a relationship, lives alone, no children	2
20 Tannis	F	Mid 20s	Student	Single, lives alone, no children	2
21 Christophe	M	Early 30s	TV cameraman	Single, lives alone, no children	2
22 Anna	F	Early 40s	Actor	In a relationship, lives with partner, no children	2
23 Philippe	M	Mid 30s	DJ and design instructor	In a relationship, lives with partner, no children	2

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CHAPTER 6. LIMITATIONS AND DISCUSSION

6.1 Limitations

The findings of the current study have to be considered in light of several limitations. First, a potential limitation concerns the two study phase samples. The 17 interviews for study phase one were conducted in Toronto while the six interviews for study phase two were conducted in Montréal. This fact could comprise a drawback with regard to the difference in the social context of smoking between the two cities. For example, in Toronto a law prohibiting smoking in restaurants, bars and in most public spaces had been in place since June 2004, one to two years before the Toronto interviews were held. In Montréal, on the other hand, city bylaws still permitted smoking in bars, some restaurants and other public spaces until May 31, 2006 (when the ban on smoking in all public spaces went into effect). The Montréal interviews were held only four to six months after this law went into effect. These differences in the smoking context of the two cities may have affected the way in which the social context shaped participants' smoking behaviour and the way the social context of smoking was discussed in the interviews.

In addition, cultural differences between the two cities may have an influence on the way health concerns are normally perceived and in the way health behaviours, including smoking, are enacted. For example, both the men and women smokers in the Montréal sample were generally less concerned about their smoking behaviour than were the smokers living in Toronto. In fact, smoking for the Montréal participants seemed to communicate a less negative image in general than it did for Toronto participants. It is therefore possible that the cultural differences between Montréal and Toronto influenced the attitudes our participants had concerning health-related topics, and that this difference emerged in discussions of smoking behaviour. However, since the study was not comparative in nature and because we aimed for a diversity of participants within each sample, the assumption was made that the social context would be similar enough in both cities that the smokers could have originated from the same sample. In this way, it is possible that the influence of the particular city may have had a less important impact on smoking behaviour than the elements of social context that we were examining (i.e., gender, identity, the body, agency).

The second limitation concerns gender in particular. The interview guides used in the two cities were not identical and only the interview guide used for the Montréal interviews included specific probes for gender. It is therefore possible that the two interview guides differentially shaped discussions of the way the social context is gendered with regard to smoking. In order to address this concern, it is relevant to note that while the differences in the interview guide used in Toronto and Montréal may have led to some differences in the way gender and smoking was discussed, smoking is a health behaviour that is particularly gendered, and in our study, gender emerged equally significantly in the interviews with smokers from both cities. It may thus be possible to conclude that neither the differences between the social context of smoking in Toronto and Montréal, nor the differing interview guides, were significant enough to create true differences in the way smokers discuss gender and the social context of smoking.

The third limitation concerns the inclusion of the first 17 interviews of study phase one into the final analysis (which included all 23 interviews) and was previously mentioned as a caveat in the use of primary and secondary data. Since these 17 interviews were not conducted by me, it is possible that the study may have suffered from a loss of detail with regard to the information normally obtained while conducting interviews. However, as mentioned in the section "The use of primary and secondary data: A caveat" we attempted to compensate for this through several strategies. First, the audio files from the original 17 interviews and all field notes taken throughout the interview process were made available to me. This added to the understanding of the interviews, with regard to subtleties in the voices, non-verbal information and information regarding interview setting. Second, throughout the final analysis performed on all 23 interviews I was in frequent contact with the interviewers of the first study phase. In this way, they were able to fill in any additional information concerning their roles as the interviewers, their general feelings about the interview process, and anything that they might have contributed to the interview themselves.

A last potential limitation is the fact that in discussions of gender and health the participant's gender may affect the themes emerging in the discussion. For example, for the current study it is important to consider that the dominant masculine prescription for not

discussing, or overly expressing, matters concerning health may have led to an under-representation of men's actual concerns for health (Bottorff et al., 2006, Courtenay, 2000; Lupton, 1995; Oliffe & Mroz, 2005). Oliffe and Mroz (2005) have addressed the difficulties involved in interviewing men about health issues. The authors suggest that men may resist engaging in discussions about their own health since the topic is not typically within the male domain. They also suggest that men typically feel the need to have control over situations such as interviews, and that they generally express stoicism and self containment in interview settings (Oliffe & Mroz, 2005).

In addition, it may also be important to note that the interviews for the current study included in each case a female interviewer, and that this may also have affected, and perhaps even muted, the topics men were willing to discuss regarding their smoking and health. It is thus important to acknowledge that men may be more concerned about their health and more eager to quit smoking than they were able to address in an interview situation.

6.2 Discussion

Our study set out to examine three propositions that were based on the three dimensions of social context investigated in our interviews. First, with regard to identity, we expected to find that feminine gender identity would be represented as being more in conflict with smoking behaviour than masculine gender identity. This was confirmed by our study results, since most women's identities seemed to conflict considerably with their smoking and most women we interviewed struggled to unite their identities with their smoking behaviour. This conflict did not emerge in the interviews with men.

Second, we expected to find that concerns over weight gain and body image were predominantly expressed by women smokers, and that this would function as a deterrent to smoking cessation. This proposition was overwhelmingly supported by our findings. Almost all the women interviewed expressed a fear of weight gain associated with quitting smoking and their body weight was a major consideration in determining their smoking behaviour. Women were also considerably concerned about their body image and how this

was affected by their smoking behaviour. It was striking to note that concerns over weight and body image were almost non-existent among the men

Last, we also expected to find that masculine gender identity would be associated with a greater sense of agency over smoking and cessation than feminine gender identity. Our findings also confirmed this proposition. Not only did men express having more control over their smoking, but they also expressed much less urgency regarding their smoking cessation. This provides a considerable contrast to the women in our study who discuss smoking cessation with a particularly large amount of conflict and with a reduced sense of agency over their ability to quit smoking.

Considering the findings across all three elements of the social context, one dominant theme that emerges is the general sense of anxiety and contradiction that defines women's discussions of their smoking behaviour and the considerable amount of conflict that smoking poses for women. The fact that a sense of conflict with regard to smoking is expressed almost exclusively by women smokers is consistent with Madden and Chamberlain's (2004) research regarding healthy eating messages in women's magazines. They have suggested that health and healthcare concerns are typically feminized in the media and that concerns and responsibilities surrounding health are thus predominantly seen as belonging singly to the female domain (Madden & Chamberlain, 2004). Unhealthy behaviours such as smoking are therefore generally considered unacceptable for women and may create considerable anxiety and conflict among women who smoke.

In view of the conflict expressed by women smokers, specifically regarding their identities and bodies, it is particularly problematic that tobacco control campaigns have often tended to manipulate young women's concerns over their physical appearance in order to incite them to quit smoking or to prevent them from beginning to smoke. Both Lupton (1995) and Greaves (1996) criticise past tobacco control campaigns in Britain, Australia and Canada which have attempted to instil women with a fear of smoking by presenting images of old, wrinkled (and therefore undesirable) women.

While Lupton (1995) and Greaves (1996) are referring to campaigns from over a decade ago, current tobacco control efforts continue to target women's concerns over

physical attraction for smoking cessation. For example, the age progression software *April*® (www.aprilage.com) was developed in order to "demonstrate[s] how one's face can change with age due to smoking, obesity and sun exposure". With fear inspiring headings such as "Scared to smoke" and "The ugly truth" the *April*® website boasts of the usefulness of the software as a smoking prevention and cessation tool. They suggest it provides a means for youth to witness, and come to fear, the negative aesthetic effects that will result as a consequence of smoking (e.g., increased wrinkles, dulling skin tone, quicker aging).

In addition, despite the fact that the messages conveyed by *April*® primarily concern physical appearance and aesthetics and all but ignore the health consequences of smoking, the software has recently been exhibited as a "Smoking Simulation Software" at various Canadian health conferences (e.g., Ontario Tobacco Control Conference December, 2006, www.otcconference.com and International Union for Health Promotion and Education (IUHPE) World Conference, June 2007, www.iuhpeconference.org/). Given the significant social pressures for girls and women to maintain youth and beauty, these means of reducing smoking are especially troubling and run the risk of propagating gendered beauty ideals most directly among young girls and women (Greaves, 1996; Lacroix & Auger, 2007; Madden & Chamberlain, 2004).

Furthermore, women's concern for body image and body weight is important to consider, as it may be a factor contributing to the slower overall decreases in smoking rates among women and to the comparatively elevated smoking rates among some cohorts of young girls (Toll & Ling, 2005). For instance, a recent article by Lacroix and Auger (2007) suggests that targeting women's physical appearance for smoking cessation and prevention increases women's anxieties over physical beauty. They further maintain that these campaigns may in fact have paradoxical effects on smoking behaviour (Lacroix & Auger, 2007). Lacroix and Auger (2007) argue that a focus on beauty in tobacco control may not only reinforce women's preoccupation with physical appearance and increase anxiety surrounding the body, but that the focus on body aesthetics may paradoxically discourage cessation through the commonly held belief that quitting smoking will result in weight gain (Lacroix & Auger, 2007).

While women's sense of conflict surrounding smoking was a considerable theme emerging from our study, the contrast between the interviews with men and women points to a second important theme which concerns the men smokers. The interviews with men were striking primarily because men's discussions of their smoking behaviour were characterized by so little conflict. In fact, men discussed their smoking in a surprisingly relaxed manner. Men's interviews were largely defined by a lack of concern regarding their smoking and its risks to health, and none of the men expressed any real urgency to quit smoking. Most important, however, was the fact that smoking not only emerged as consistent with male identities, but that smoking was in fact positively associated with masculinity.

The social approval of male smoking expressed in our study and the ability of smoking to complement a hegemonic masculinity is consistent with previous work discussing masculinity and smoking (Bottorff et al., 2006; Nichter et al., 2006). In fact, the connection between masculinity and smoking in our study may also have historical roots. Jarrett Rudy discusses the social sanctioning of smoking among men as an historical phenomenon in his book "Freedom to smoke: Tobacco consumption and identity" (2005). Rudy writes that in the early 1900s the association between masculinity and smoking was a way for gender boundaries to be delineated in the public sphere. He suggests that smoking for men was considered a type of initiation, "nothing less than a rite of passage to manhood" (p. 14), whereas smoking among women put their moral character into question. Rudy also suggests that the positive association between smoking and masculinity was reinforced by "shared standards of respectability and etiquette" (p. 14), standards which were reflected in various depictions of social life including newspapers, comics, fiction and poetry writing at the time (Rudy, 2005). In this way, smoking was not only acceptable among men; in some social settings it was seen as socially desirable. The idea of smoking as a complement to a masculine identity seems to have persisted among current smokers.

In light of the themes emerging in our study, when considering the role of gender and social context with regard to their ultimate impact on smoking cessation, men's and women's smoking has to be considered separately. The social context surrounding men seems to be overwhelmingly supportive of smoking behaviour. The lack of conflict experienced by men, coupled with greater social approval of male smoking, might therefore

suggest that men would take up smoking to a greater degree than women, and that men would be less likely to decrease their rates of smoking than women. However, it seems that it is perhaps this lack of conflict concerning smoking and the absence of urgency to quit smoking that may afford men a greater sense of agency over their smoking behaviour and consequently over cessation.

This is supported by McKee et al.'s (2005) research which has distinguished between men's and women's smoking cessation. The authors report that men less accurately remember difficulties of past withdrawal when having quit smoking, and that men tend to minimize the negative symptoms associated with cessation compared with women smokers. The authors suggest that this is reflected in men's increased success rates once they do attempt to quit smoking (McKee et al., 2005).

In contrast to the men, the conflict that women express regarding their smoking behaviour, as well as the resulting urgency women feel to quit smoking, could be considered advantageous in terms of increased smoking cessation. However, while this sense of urgency may lead a large number of women to attempt, and some to succeed at, quitting smoking, Greaves (1996) suggests that more pressure on women and an increased urgency to quit smoking would more likely induce guilt and lead women smokers to feel stigmatized, rather than lead to successful smoking cessation.

In addition, Greaves and Barr (2000) report that, compared with men, women generally have less confidence in their ability to quit smoking, perceive more barriers to abstinence and that women anticipate more negative consequences related to quitting smoking. McKee et al. (2005) have also found that women tend to report lower self-efficacy in their ability to resist smoking, specifically in situations in which they perceive negative affect. In this way, women's perception of lacking agency may in part explain their reduced quit rates and increased relapses to smoking when compared with men (McKee et al., 2005), and may also explain their increased sense of anxiety regarding cessation.

A Note on Gender Diversity

While the current study found striking and consistent gender differences in the smoking practices of men and women, a note regarding diversity within gender is necessary. Walters (2004) suggests that although some relatively consistent gender differences do exist with regard to health, falling into gross gender stereotypes can be constraining, if not altogether false (Annandale & Hunt, 2000; Chapman Walsh et al., 1995; Courtenay & Keeling, 2000; Emslie et al., 2004; Gough, 2006; Macintyre et al., 1996; Walters, 2004). Furthermore, Gough (2006), when specifically discussing men's health research, argues that a major problem is the tendency to refer only to stereotypical representations of gender, while excluding a whole spectrum of male identities.

For instance, one exception among the male participants in our study illustrates the need for diversity in gender and health research. Stephen, a gay man in his early 30s, did not subscribe to the hegemonic masculine identity, and he explicitly mentioned contradictions in his life with regard to smoking. As such, much like the women we interviewed, Stephen suggests that smoking cigarettes impacts his body image and his sense of physical attractiveness and that this provides a certain amount of conflict for him.

In the context of Robertson's (2006) research on lay men's understandings of health, Stephen's narrative is not altogether surprising. Robertson (2006) argues that "the rise of HIV/AIDS, and the association of gay men with (stereotypically) feminine characteristics ... combined to legitimate, and perhaps even make a moral requirement, caring about health issues for gay men" (p. 183). In this way, perhaps similar to the women in our study, Stephen may also feel 'morally' bound to demonstrate certain health concerns and behaviours and may feel increased conflict with regard to his smoking.

A further note regarding gender diversity in health research comes from both Robertson (2006) and Greaves and Jategaonkar (2006). These authors highlight the importance of considering sexual diversity when examining health behaviours. This is especially critical for tobacco control, since studies have found that sexual orientation influences both concerns over body image as well as smoking behaviour. Furthermore, tobacco companies have been targeting gay and lesbian populations in ways that are markedly different from the tactics used to market cigarettes to straight men and women,

potentially adding another layer to the already existing gender inequalities in smoking (Conner et al., 2004; Greaves & Jategaonkar, 2006).

CHAPTER 7. CONCLUSION

7.1 Suggestions for tobacco control

The particularly striking finding that women smokers experience substantial conflict with regard to their bodies suggests that smoking and the body is an important area of future research for tobacco control. This is particularly the case, since the anxiety experienced by women with regard to smoking has historically been exploited by the tobacco industry, particularly in their association of smoking, women's physical appeal and concerns regarding body weight (Amos & Haglund, 2000; Toll & Ling, 2005). By specifically targeting younger female smokers, and by emphasising the role of smoking for feminine ideals and for weight control, these industry tactics may have helped create the trend of increasing smoking among younger women (Toll & Ling, 2005). Furthermore, the positive association between masculinity and smoking is also an area tobacco control must consider. Greaves (1996) has argued that the tobacco industry has long been using gender based analyses to differentially market cigarettes to men and women and that tobacco companies have typically "react(ed) to the diversity of contemporary women far more comprehensively than do health promotion agencies" (p. 28).

In order to counter the gender inequalities in smoking, tobacco control must gain an equally comprehensive understanding of gender and smoking as the tobacco industry has had. That is, tobacco control must create campaigns that specifically acknowledge the role of gender and social context in the lives of men and women smokers. However, this must be done without resorting to other health-damaging tactics and, in the case of women, without appealing to women's anxieties over their bodies. This consideration is particularly important, since tobacco control tactics which have focused on women's concerns around beauty to enforce smoking cessation have merely propagated the gendered beauty ideals among women, and have increased women's sense of anxiety and conflict surrounding their smoking (Lacroix & Auger, 2007). Especially considering Greaves and Tungohan's (2007) call for tobacco control to transform gender relations rather than exploit or accommodate them, it is particularly clear that tobacco control campaigns focusing on physical appearance fall miserably short of this request.

In addition, the theme emerging in our study concerning the positive association between smoking and masculinity and men's general lack of urgency to quit smoking could in part provide an explanation for the overall higher smoking rates for men compared with women. However, this does not entirely explain men's smoking rates; it does not account for the larger smoking declines for men compared with women over the past few decades or for men's lower smoking rates in some age categories. One explanation for the smoking trends among men suggests that men and women have historically received different pressures from health promotion and tobacco control (e.g., Lupton's (1995) "control and release" paradox) and that traditional tobacco control campaigns were more successful at reaching and targeting male smokers than women smokers.

For example, while the traditional tobacco control campaigns attempted to reach the entire population of smokers, they tended to focus on middle-aged men (Shevalier, 2000) and did not acknowledge the gendered social context of smoking for women as distinct from that of men's. Rather, it was assumed that the specific motivations influencing individuals to smoke were shared by all smokers and that anti-smoking interventions would have an equally important effect on all smokers, men and women alike (Greaves and Barr, 2000). It is thus possible that traditional anti-smoking campaigns have only been able to counteract the positive association between smoking and masculinity among some cohorts of men (e.g., middle-aged men), leading to quicker decreases in smoking among these men compared with other groups of men and with women in general.

Given the narrowing gender gap in smoking rates between men and women and the reversal of traditional smoking trends between younger girls and boys over the past few decades, Greaves and Jategoankar (2006) have suggested increased gender based research and analysis in tobacco control, and the creation of more gender sensitive programmes and policies for tobacco cessation. They also suggest that these efforts specifically address smoking among young girls and women (Greaves & Jategoankar, 2006).

On a larger social scale, it has also been suggested that tobacco control ought to aim for social change by targeting the gendered social pressures for men and women and by addressing the social inequalities in men's and women's lives which may be creating

resistance to cessation among men and women. While this is a large feat, in their studies of men's smoking, Bottorff et al. (2006) have found that social and cultural shifts that re-define male roles in relation to childcare and family life may in fact have an influence on men's smoking behaviour. They suggest that these new male roles may make masculinity and health behaviours more compatible. Similarly addressing social and cultural shifts that define female roles may lead to new ways to address tobacco prevention and cessation among women as well (Mahalik et al., 2007).

Last, tobacco control must not only address the differences between men and women, but also the diversity among men and women in order further reduce inequalities in smoking (Hunt et al., 2004). Hunt et al. (2004) maintain that tobacco interventions and future smoking prevention programmes ought to specifically address and counter "the varied and complex ways in which cultural constructions of gender roles and idealized images have been reinforced and modified by the tobacco industry" (p. 248).

7.2 Conclusion

Through discussions with men and women about their smoking behaviours, the interviews for the current study explored the way in which three dimensions of social context: identity, the body and agency, are gendered and shape smoking behaviour. Our study demonstrates that smoking is particularly shaped by elements of the gendered social context and leads to different smoking behaviours for men and for women. We found that smoking for women is especially conflicted with regard to the elements of the social context examined, while smoking for men was relatively free of conflict. In particular, women's concern regarding smoking and their body weight as well as the positive association between smoking and masculinity seem to be obstacles to smoking cessation and are thus areas of prime importance for future tobacco control research.

Gender inequalities in smoking behaviours are particularly critical for public health to consider, since the changes in smoking patterns documented among men and women over the past few decades have already resulted in gender disparities in the morbidity and mortality of smoking related illnesses. That is, largely due to the changing smoking patterns

among men and women, including increases in women's smoking and greater declines in smoking among men, cases of lung cancer have increased by 17% in men and by 27% in women since 1990 (Ginsberg, 2005). This is a particularly troubling gender inequality in health. The findings from our study, which outline the importance of gender and social context for men's and women's smoking patterns and smoking cessation, may provide a better understanding of how to counter these gender inequalities in health. It is a challenge for tobacco control to target the gendered elements of the social context (identity, body and agency) in future interventions in order to reduce smoking in a more gender sensitive, and therefore more just, manner.

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APPENDICES

Appendix A - Interview Guide for First Study Phase

Preamble
We're really interested in how smoking fits into people's lives, how perhaps it becomes part of who you are and how you live.

'Grand tour' question:
What's it like to be a smoker these days? Can you tell me about that?
Probe for examples/stories to illustrate what people are saying

Power relations:
Can you give me some examples of where your smoking has come up as a topic of conversation?
Where someone you live or work with has made an issue about the fact that you smoke?
Any situations where you hide your smoking?

Place:
With all the restrictions on smoking, where do people smoke these days? Where do you and your friends smoke?

Pleasure:
What cigarettes do you enjoy the most? Which do you enjoy the least?
How use smoking (timing) – when.

Identity:
Can you picture yourself as a non-smoker?

Body:
Do you ever notice the way that someone is smoking? What did you notice about it?
Ever conscious of the way you're smoking?
Ever experiment with smoking a different way?

Brands:
What brand do you smoke? What does that brand say about you? Have you always smoked that brand?
Are there some brands you really don't like or would never want to be seen with?

Tobacco control:
Do you think that people who work in tobacco control have certain images or stereotypes about smokers? (who smokers are, what they're like)

What do you think tobacco control could be doing better?

Appendix B – Interview Guide for Second Study Phase

Preamble
We're interested in finding out about the role that smoking plays in people's lives – so I am interested in how smoking became a part of your life and a part of who you are.

General questions:
Can you tell me what it's like to be 'a smoker' these days?
Probe for stories/examples to illustrate – (what is it like? Can you explain?)
Specifically in terms of work, school, friends?

Power Relations:
Can you give me some examples of where smoking has come up as a topic of conversation? (family or friends) …examples of where someone you live or work with has made an issue about the fact that you smoke?

Pleasure/Enjoyment:
When, where and with whom do you most enjoy smoking? What do you like/enjoy OR dislike/not enjoy about smoking?
Have you ever tried to quit?
What was that like? Can you tell me about that?
Why want to or not want to quit?

Identity:
Can you picture yourself as a non-smoker?
Do you feel smoking has become a part of your 'identity'? How?
Have there been social situations where 'being a smoker' was beneficial/ disadvantageous for you?
Are there situations in which you hide your smoking? Why?
How would you (or can you) describe a 'typical male smoker' or a 'typical female smoker'? (attributes, behaviours, concerns)
Do you think there are differences between men and women smokers?
Where do you think these ideas come from?

Brands:
What brand do you smoke? What does it say (if anything) about you?
Do you identify people who smoke certain brands of cigarettes with anything in particular? (men - women)
Are there brands you really don't like or would never want to be seen with?

Body:
Do you ever notice particular 'ways' or 'manners' that certain people smoke, the way they hold the cigarette? What do you notice? (meaning?)
Is this different for men and women?
Are you ever conscious of the way you're smoking?
How is your smoking related to the way you feel about your body? (affect health - image)?

Encounters:
Have you had any encounters with people about your smoking (friends, family, strangers) that stand out to you?
Do you get the impression that people perceive/ react to or even judge men's and women's smoking differently?
Have you come across situations where you feel you were pressured differently because you are a man/woman?

Tobacco Control/Health Promotion:
What are some anti-smoking messages that you have seen/ received/ remember?
What do you think about those messages?
Do you think that people whose job it is to reduce smoking have certain images or stereotypes about smokers? Specifically re: male and female smokers?
What do you feel current messages are saying to men and women smokers? (are men and women targeted differently?)
What do you think Tobacco Control groups could be doing differently - to target men and women more effectively?

Appendix C – Research Consent Form

Université de Montréal

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Title of research project:
"The Social Context of Smoking: Laying the Conceptual and Empirical Foundation for a Theoretical Toolkit in Tobacco Control Research"

Subtitle of the research project:
"The influence of gender and the social context on smoking behaviour"

Sponsor/Funding:
Canadian Tobacco Control Research Initiative (CTCRI)
Canada Graduate Scholarship Master's Award (CIHR)

Investigators:
Katherine Frohlich, Ph.D., Department of Social and Preventive Medicine, University of Montréal
Stephanie Alexander, graduate student, Department of Social and Preventive Medicine, University of Montréal

Background & Purpose of Research:

What is this study about?: This is a research study about the social context of smoking and the way in which gender* might influence smoking. We are curious about how smoking fits into the everyday lives of those who smoke and how smoking may be different for men and for women.
*Gender here means a set of socially constructed roles and relationships, personality traits, attitudes, behaviours, values, and the relative influence that society ascribes to the two sexes in different ways (Health Canada, 2000)

Why are we doing this study?: We believe that smoking is about more than nicotine dependence, and that smoking becomes part of the everyday lives of people who smoke in many different ways. Also, different trends in smoking rates have recently developed according to gender and this is why I am interested in finding out the different experiences and understandings men and women smokers have. The goal of this research is to talk to smokers and see how they feel the social context around them influences their smoking behaviour. We feel that there are important parts of smoking that the health and research community are not sensitive to, and as a result, a lot of the work they do overlooks some of the main reasons why people continue to smoke.

What will the results of this study be used for?: The thoughts and feelings that you as a smoker share with me will not only help test our research team's ideas, but we also hope that the results of this study will show other people who work in tobacco health and research how they can be more sensitive and helpful to smokers in the future.

Eligibility:

- To participate in this study you must:
- Have smoked for at least 10 years
- Be a current smoker (smoked within the last 30 days)
- Be 19 years of age or older
- Have been in Canada at least the past three years
- Have a solid enough basis in English to follow the interview
- Be a resident of the City of Montréal

Procedures:

Who will participate in this study?: Up to six people (3 men, 3 women) meeting the eligibility criteria will participate in this study.

What will I have to do?: If you want to be a part of this study you will agree to an interview that will last between 45-90 minutes. The interviews will be recorded using a digital recording device.

Where will this happen?: The interviews will take place at a location agreed upon by you and the interviewer. If smoking is not allowed on the premises at this location, you will be offered breaks during the interview to go outside to smoke.

What questions will I be asked?: In this interview we are interested in talking to you about:

- What you like/dislike about smoking
- What 'function' smoking has in your life
- Smoking and your 'identity'
- Non-smokers and your smoking behaviour
- Smoking and the way you feel about your body
- Tobacco Control and Health Promotion messages

Will someone try to get me to quit smoking?: NO. You should know that this study is an interview study ONLY. There is no "quit-smoking" part of this study, but if you like, you can tell us about your feelings and experiences with trying to quit in the past or present.

Voluntary Participation & Early Withdrawal:

What happens if I change my mind?: Your participation in this study is voluntary. This means that you can decide to stop the interview at any time, with no penalty to you. During the interview you also have the right to: 1) stop the recording device and speak "off the record"; 2) not to answer any questions, or change your answer to any questions; 3) to stop the interview or leave.

Risks/Benefits:

Are there any risks to me if I participate?: The risks associated with participation in this study are minimal to none, as this research study is an interview only. One potential *inconvenience* to you is the time involved. You may feel uncomfortable answering certain questions about smoking or discussing personal issues. Please understand that you do not have to answer any questions that you do not want to.

Are there any benefits to me if I participate?: Other than a compensation (see below), and perhaps the pleasure of sharing your experiences, there will be no direct personal benefit from participating in this study. However, participating will give you an opportunity to talk about some of the reasons why you smoke and your views on smoking in general. The insights that you provide may also benefit society by allowing others involved in tobacco research, policy and practice, to better understand the experiences of smokers.

Privacy & Confidentiality:
How will my privacy be protected?: All information you provide during this study will be kept in strict confidence. In order to make sure your information is correct the interviews will be recorded and then typed. The digital recordings and written copies will only be used by the research team. No other person will see them. Recordings of the interviews will be destroyed two years after the completion of the study and all typed interviews will be stored in a filing cabinet in the apartment of the researcher in Montréal, to which only she has access. Your interview will be given a code number and name and your real name will never be used on the recording or the written copy of the interview. The information you share during the interviews will be presented in such a way that it will be impossible for other people to recognize you. Transcripts and interview material will be destroyed 2 years after the completion of the research project (Summer 2009).

Publication of research findings:
What happens if the results of the study are published?: No names or information that might identify you will be used in any publications or presentation resulting from this study. All responses will be reported anonymously through "code names" and your real name will not be used.

Compensation:
Will I be compensated?: In recognition of your time and contribution, you will be compensated with $30.00 at the end of the interview.

Dissemination of findings:
Can I find out about the results?: If you would like to know about the results of this study and how the interview information is being used, you can get information by contacting the research team at any time following your participation (phone numbers provided below).

Contact person:
The persons who may be contacted about the research are:

Stephanie Alexander (Interviewer), who may be reached at telephone number [redacted], or
Dr. Katherine Frohlich (Co-Principal Investigator), who may be reached at telephone number (514) 343-6430.

For any ethical problems regarding the conditions of your participation in this study, you may contact the University of Montréal Ombudsperson at the telephone number (514) 343-2100.

Copy of informed consent for participant:
You are being given a copy of this informed consent to keep for your own records.

Administrative information
The original copy of the consent form will be stored in a filing cabinet in the apartment of the researcher in Montréal, to which only she has access.

Participant's consent:
By signing below I agree that:

- Any questions I have asked about the study have been answered to my satisfaction.
- I have been assured that no information will be released or printed that would disclose my personal identity and that my responses will be completely confidential.
- Any risks or benefits that might arise out of my participation have also been explained to my satisfaction.
- I understand that my participation is completely voluntary
- I further understand that I can withdraw from the study at any time without explanation.

I hereby consent to participate.

Name of Participant	*Signature*	*Date*
Name of person who obtained consent	*Signature*	*Date*

Investigator's declaration:
By signing below, I hereby certify that:
I have clearly explained to the participant the terms of the present consent form.
I have clearly explained to the participant that he/she may withdraw from the study at any time without explanation.

Name of Investigator	*Signature*	*Date*

Administrative Information :
The original form will be kept at the home of the researcher and a signed copy of the form will be provided to the participant This project and the current consent form have received ethical approval by the CERFM on July 26, 2006: Reference number: CERFM 58(04)4#134 (sub-study)
Date of the version of the current form: July 27, 2006

Informations de type administratif :
L'original du formulaire sera conservé au domicile du chercheur et une copie signée sera remise au participant Le projet de recherche et le présent formulaire de consentement ont été approuvés par le CERFM le 26 juillet 2006 : No de référence : CERFM 58(04)4#134 (sous-étude)
Date de la version du présent formulaire : 27 juillet 2006

Appendix D – Demographic Information

Participants	Gender	Age	Occupation	Family	Study phase
1 Stephen	M	Early 30s	Industrial mgmt	Lives with partner (gay), no children	1
2 Rachel	F	Late 20s	Graduate student	Lives with partner (gay), no children	1
3 Jennifer	F	Early 30s	Graduate student	In a relationship but lives alone, no children	1
4 Beverly	F	Early 40s	Gardener	Married, four children	1
5 Rick	M	Early 40s	Mechanic	Married, two children	1
6 Leslie	F	Late 30s	Hair stylist	Married, two children	1
7 George	M	Mid 30s	Policy analyst	Married, one child	1
8 Roberto	M	Early 30s	Lawyer	Married, no children	1
9 Sean	M	Late 20s	Lawyer	Married, no children	1
10 Beth	F	Late 20s	Lawyer	Engaged, lives alone, no children	1
11 Cindy	F	Mid 30s	Lawyer	Divorced, lives with a friend, one step-child	1
12 Jim	M	Mid 50s	Mail sorter	Single, no children	1
13 Sandra	F	Mid 50s	Clerical	Divorced, three children	1
14 Louise	F	Early 60s	Clerical (law)	Single, lives alone, no children	1
15 Carmen	F	Early 30s	Clerical (med)	In a relationship but lives alone, no children	1
16 Shelley	F	Early 40s	Clerical	Married, two children	1
17 Eva	F	Early 40s	Clerical	Married, two children (grown)	1
18 Tony	M	Late 20s	Student	Single (gay), lives with roommates	2
19 Florence	F	Mid 20s	Student	In a relationship, lives alone, no children	2
20 Tannis	F	Mid 20s	Student	Single, lives alone, no children	2
21 Christophe	M	Early 30s	TV cameraman	Single, lives alone, no children	2
22 Anna	F	Early 40s	Actor	In a relationship, lives with partner, no children	2
23 Philippe	M	Mid 30s	DJ and design instructor	In a relationship, lives with partner, no children	2

Appendix E – Tags and Definitions – Study Phase 1

Tags	Definition
BODY	**Overt or implicit** *statements, memoing about...* Effects of smoking on body: (a) health - "Taking care" of one's body, body "projects", shaping of the body, weight, gain/loss (b) enjoyment - physicality of smoking: mannerisms, physical sensation of (c) look of smokers (e.g., effects of smoking on the body, stained fingers) Links to gender, identity, pleasure, addiction
GENDER	**Overt or implicit** *statements, memoing about...* Weight, gain/loss of, attitudes about weight "drinking with guys", "male thing", "tough guy cigs" Gender roles seen in smoking, typing (of selves, others) Allusions to/instantiations of masculinity/ femininity and health/ smoking (e.g., male risk taking, resilience, self-sufficience, less concern for health; female greater concern and care for health). Links to identity, body, power, brand (health promotion)
HEALTH PROMOTION	**Overt or implicit statements** *coding, memoing about...* Internalization of HP messages, policies Reactions, resistance to health messages (e.g. 'aware of consequences') Bargaining, trade-offs, "balancing act" (e.g., 'healthy aside from smoking') Lay evidence, theory, anecdote, perception of risk, mythology Relating / comparing to other (health) issues Links to tobacco control, power, identity
IDENTITY	**Overt or implicit** *statements, memoing about...* Own and others' identities, related to smoking (e.g. sexual orientation, gender, religion, functional alcoholic) Self as smoker, non-smoker (positive and negative views) Health, healthfulness (e.g. 'health freak') Competence, control, responsibility. Distinction: self from other smokers (class, types of smokers) Signs and symbols of own identity Links to gender, body, power, brand

POWER	**Overt or implicit** *statements, memoing about...* Sense of "powerlessness" Relations between people (at home, work) Interactions, negotiations around smoking Social control, formal regulation of smoking Rebellion, resisting authority Links to gender, identity, tobacco control, choice/agency
Addiction discourse	Craving, withdrawal Junkie, "fix"
Starting smoking	Age, reasons, memories Regret
Cessation	Reasons to quit (health, pressure/coercion) Barriers, obstacles (cues, symptoms) Withdrawal, relapse, preparation for, expectations Experience with, strategies, aids used Definitions of (degrees of abstinence)
Place	Specific places (home, work, etc.), and people in them Interactions occurring in places Public place: surveillance, control. Exclusion, removal, separation from –(hiding?) Architecture, liminality, boundaries between space Contamination, purification – aesthetics Links to identity, power, tobacco control
Brand	Light, mild Packaging Taste (novelty, disgust) Shape (length, colour, filter) Purchasing (access, cost)
Pleasure	Play, fun (vs. work, obligation) Having fun with smoking, playfulness Enjoyment of smoking Luxury, relaxation Lack of pleasure, displeasure Variability with time, place, company Stress reduction
Control/Choice/Agency	Of participant speaking only Control of smoking behaviour Personal control vs. social control Control over space Fatalism, hope/optimism Spirituality 'Worldview' of illness (maybe 'identity' too)

Community	Smokers as community Belonging, sociability, being part of Isolation, removal, separation Sharing smokes Formal groups (work, school, church) Informal groups (friends, 'arts' community, gay community) Smoking alone
Encounters re: smoking	Public and private Accommodating, antagonistic "Rude" Anticipation of
Personal health	Status, conditions Mental health Death Health behaviours, habits other than smoking (nutrition, exercise, sleep, etc.)
Smoking behaviour	Smoking with, when, while Consideration, accommodation Compensation Adaptation to restrictions, public and private Routine, ritual, habit, compulsion vs. special, treat Mannerisms Changes over time, variations of (by age, situation, etc) Disruption of (intentional and unintentional)
Hiding, concealing	From authorities, loved ones, colleagues, etc. Sneaking Revealing, 'coming out' Washing hands, wearing perfume Smoking out of sight
Stigma	*Overt statements about...* Perceptions of smoking, smokers – changes over time Social acceptability Moral judgment (morality, stupidity, responsibility) Marginalization Types of smokers Pressure not to be associated with smoking Career implications Symbols of (smell, yellow fingers)
Tobacco control	Specific messages, price, access, place, etc. How taken up, responded to, resisted "Rights" discourse Government – control, hypocrisy, distrust Suggestions for tobacco control Effects on social activity, smoking patterns Perceptions of risk, mythologies re: smoking Lay evidence, theory, anecdote Changes over time

What smoking does for me	Relaxation, relieve stress, come down Relieve boredom, kill time Take a break, escape Mark time, events Celebrate, reward self Resolve problems Social lubricant Meditate, "talk to God" Utility – needing it

Appendix F –Tags and Definitions – Study Phase 2

GENDER coded for all these	Definition
Masculine Smoker	Based on question of what a 'stereotype male smoker' is. What people say of male smokers. What smoking does for male smokers. Male smokers pressured differently.
Feminine Smoker	Based on question of what a 'stereotype female smoker' is. What people say of female smokers. What smoking does for female smokers. Female smokers pressured differently.
Attraction and Smoking	Any mention of sexiness, attractiveness, appeal and smoking or cigarettes. The function cigarettes can have for one's sexuality. Cigarettes (smoking) as enhancements to or from sexuality.