Smoking, self-regulation and moral positioning: a focus group study with British smokers from a disadvantaged community

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Abstract

Smoking in many Western societies has become a moral as well as a health issue in recent years, but little is known about how smokers position themselves and regulate their behavior in this context. In this article we report the findings from a study investigating how smokers from an economically disadvantaged community in the East Midlands (UK) respond to concerns about the health impact of smoking on others. We conducted ten focus group discussions with mixed groups (by smoking status and gender; N = 58 participants) covering a range of topics, including smoking norms, self-regulation, and smoking in diverse contexts. We transcribed all focus group discussions before analyzing the data using techniques from discourse analysis. Smokers in general positioned themselves as socially responsible smokers and morally upstanding citizens. This position was bolstered in two main ways: "everyday accommodation", whereby everyday efforts to accommodate the needs of nonsmokers were referenced, and "taking a stand", whereby proactive interventions to prevent smoking in (young) others were cited. We suggest that smoking cessation campaigns could usefully be informed by this ethic of care for others.

Keywords

ethics / moral perspectives; focus groups; psychosocial issues; smoking cessation; vulnerable populations;

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Previously linked to glamour, style and celebrity, smoking has become a widely demonized practice over the past thirty or so years in many Western societies (Bayer & Stuber, 2006; Rozin & Singh, 1999; Brandt, 1998) – though there is more resistance in some societies, including some Mediterranean (Louka, Maguire, Worrell, & Evans, 2003) and Scandanavian countries (Helweg-Larsen, Tobias, & Cerbin, 2010). Smokers themselves have also undergone a transformation in media representations; in the UK, for example, smokers once depicted as attractive, successful executives are now construed as antisocial, irresponsible, irrational – and lower class (Graham, 2012). The deleterious health impact of smoking is well known, and tobacco consumption is recognised as the UK"s single greatest cause of preventable illness and early death, with more than 107,000 people dying in 2007 from smoking-related diseases (Peto, Lopex, Boreham, & Thun, 2010). In light of concerns about the effects of smoking on others (Teach, Crain, Quint, Hylan, & Joseph, 2006) and associated smoking bans, this paper is concerned with how smokers themselves respond to their 'immoral' status – and particularly any self-regulation that may result.

Although awareness of the health risks associated with smoking has contribruted to falling smoking rates in the UK and other countries, smoking among the most deprived groups has changed very little, resulting in these groups having much higher levels of smoking-related mortality and morbidity (Hiscock, Bauld, Amos, Fidler, & Munazo, 2012; Jarvis & Wardle, 2006). In England the proportion of 'manual' workers who smoke is 25% compared to 16% for those in non-manual occupations (Robinson & Lader, 2009). Research has shown that in these disadvantaged communities, stopping smoking is not a high priority, the norms are pro-smoking and smoking can often be an integral part of any positive social

capital that might exist in such environments (Author, 2001). Smokers in such communities are less likely to quit, to know other quitters or be ostracized for their smoking behavior; there are fewer local people who could support quit attempts (see Hiscock et al., 2012), and smoking cessation services might be limited and viewed with suspicion (Roddy, Antoniak, Britton, Molyneux & Lewis, 2006). Smoking prevalence and failed attempts at cessation have also been linked to living in stressful home and neighborhood environments featuring income instability, poor housing, run-down communities, high crime, lack of basic facilities and limited access to options for making healthy choices across a wide range of behaviors (Author, 2001). Although price is a key deterrent for never smokers and raising the price of cigarettes is widely regarded as an important policy initiative in reducing prevalence rates, in disadvantaged communities there is often access to and demand for local outlets ('fag houses') offering illicit, cheap tobacco which has been illegally imported to the UK and is of dubious provenance and typically more toxic than legal products (see Author, submitted). Nonetheless, even smokers living in areas where smoking is normative are not unaware of the health implications of smoking, and in fact most people living in disadvantaged neighborhoods do not smoke (Office for National Statistics, 2009). However, relatively little qualitative research has been conducted with low SES areas to determine the factors that are keeping smoking prevalence high, though psychological factors such as low self-efficacy or sense of agency have been implicated for smokers in these communities (e.g. David, Esson, Perucic, & Fitzpatrick, 2010).

For example, research indicates that smokers recognize the health risks – although they might minimize the danger and question some of the evidence (e.g. Oakes, Chapman, Borland, Balmford, & Trotter, 2004). Because great value is generally placed on personal choice and responsibility in most industrialized countries, especially in health and lifestyle domains (see Crawford, 1980; Lupton, 1995), smokers also invoke an individual right to

smoke when accounting for their smoking behavior – the right to make such unhealthy choices can be resolutely defended. However, as evidence about the harmful effects of passive smoking, especially on children (e.g. Teach, Crain, Quint, et al., 2006), has developed since the 1980s, and with that the emergence of anti-smoking legislation such as smoking bans in public spaces, the discourse of individual choice has become more difficult to sustain in a now more monitored and moralized context.

Contemporary concerns increasingly revolve around "private" environments such as the home and the family car, where parental smokers are increasingly targeted in attempts to prevent children from exposure to tobacco fumes and conditions such as asthma, and to discourage smoking initiation in adolescence. For example, some municipalities in the United States have proposed legislation to reduce or ban smoking in apartment buildings (King, 2010), while researchers in the Netherlands have advocated parental health education for those smokers living with children (Harakeh, Scholte, Vermulst, de Vries, & Engels, 2010). More than ever then, smokers are morally and legally bound to address the potential consequences of their smoking for nonsmoking friends, colleagues, family members and citizens generally (see also Poland, Frohlich, Haines, Mykhalovskiy, Rock, & Sparks, 2006).

Recent studies have started to examine smokers' perceptions of morality in a context of heightened legislative and health-related concern for others affected by smoking. An interesting comparison between United States and Danish smokers by Helweg-Larsen, Tobias, and Cerbin (2010) found the former group to be much more mindful of and responsive to the needs of nonsmokers compared to their Scandinavian counterparts, who largely placed the onus on nonsmokers to act when they smoked in their presence. Nonetheless, all smokers did report some self-regulation, most notably in relation to children, universally portrayed as innocent, pure and undeserving of exposure to health-damaging fumes. Such efforts around children do not imply that consumption will decrease; indeed, it is

possible that smoking might well be maintained if smokers see themselves as morally responsible – smoking sensitively around/away from others but smoking nonetheless.

Studies to date have mainly focused on negotiating smoking in public. Some recent qualitative research has begun to look at how smokers account for smoking in the home environment. For example, Holdsworth and Robinson's (2008) study of maternal smoking at home in a disadvantaged community where smoking was normative highlights complexities and difficulties in restricting smoking because of space constraints, prevailing discourses of normative mothering, and favourable social comparisons with other smoking mothers. In their study, for example, some mother's experienced tension between smoking at home (but away from children) and attending to young children who may be crying in another room; here there is a conflict between caring for self (smoking is perceived to have a calming influence) and caring for children by being co-present and soothing which may lead on some occasions to smoking around children. Any guilt experienced by mothers was partially assuaged through social comparisons with other smokers perceived as less caring e.g. through not making efforts to regulate smoking around children. In these ways smoking mothers attempted to resist stigmatisation of (working class) smokers within public health discourses. Research by Bottorff, Kalaw, Johnson, Chambers, Stewart, Greaves, and Kelly (2005) considered the meanings attributed to smoking within couple relationships, identifying supportive and critical constructions within and between different couples and across situations. For example, in couples where both partners smoked, smoking was often conducted jointly and signified intimacy and unity, whereas in couples where one partner only smoked arrangements were negotiated to accommodate smoking opportunities, with the non-smoking partner attending to children for example while the other partner smoked out of sight as a courtesy. In some of these couples, the non-smoking partner expressed disapproval

on a regular basis, issuing repeated requests to quit, while the smoking partner made efforts to smoke in private and conceal evidence of smoking.

Moralization around smoking is an important topic which requires further investigation. Building on recent research on the social and moral dimensions of smoking noted above, our qualitative research reported here draws on discussions with smokers (mothers, fathers, young people) situated within an economically deprived community with a prevalence rate of 43%, more than twice the national average for England (21%). Understanding the place and meaning of smoking in such communities is important because of the high prevalence rates and attendant health risks. We already know that pro-smoking norms within disadvantaged communities contribute to high prevalence rates and risk minimisation (e.g. Graham, Inskip, Francis & Harman, 2007), but we know little about smokers' responses to contemporary moralized discourse on smoking. We set out to understand how smokers in disadvantaged areas oriented to and positioned themselves and others in relation to discourses of moralization. In our study we wished to address questions such as:

- To what extent do smokers recognise and accept moral imperatives around smoking?
- In what ways do smokers adjust or reduce their smoking in the presence of others?
- How do they perceive themselves and other smokers in terms of moral status?

Given our interest in the accounts provided by smokers themselves in relation to others potentially affected by smoking, we deployed qualitative methods involving focus groups with smokers and non-smokers in a deprived urban community with high smoking rates. In foregrounding participant accounts, our work contrasts with much theory-driven health research on smoking informed by models such as the Theory of Planned Behaviour (e.g. Conner, Sandberg, McMillan, & Higgins, 2006) and Social Identity Theory (e.g.

Stewart-Knox, Sittlington, Rugkasa, Harrisson, Treacy, & Santos Abaunza, 2005). While Theory of Planned Behavior variables such as perceived behavioural control, and Social Identity Theory work on within-group and between group processes, have contributed greatly to our understanding of smoking behaviours, inductive, qualitative research complements such work by highlighting the often complex, fluid and social aspects of smoking phenomena emphasised by smokers themselves.

Rather than test the power of causal factors or restrict our focus to particular social identification processes, in this article we attend to the ways in which smokers (and non-smokers) dynamically worked up, negotiated and debated accounts of self-regulation, ethical conduct and self-positioning with friends and acquaintances in a social (focus group) context. This social focus is in line with the contemporary emphasis on the social context of smoking within the field of tobacco control research (see Paul, Ross, Bryant, Hill, Bonevski, & Keevy, 2010), although again our work is not structured by prevailing theoretical frameworks (e.g. Poland et al., 2006; Unger Cruz, Shakib, Mock, Shields, & Baezconde-Garbanati, 2003). Our research builds on our previous qualitative research with young smokers (Author, 2008), and can be situated within a growing tradition of qualitative health research within Psychology (e.g. Lyons & Chamberlain, 2006). Ultimately, rich, "insider" accounts derived from intensive qualitative analysis can prove valuable in informing the design of more effective smoking cessation interventions, in this case incorporating local perceptions and actions with regard to smoking around others.

Method

The focus group data presented here derives from a wider study on smoking in a deprived urban area in the East Midlands of England with a high smoking prevalence of 43% (Nottingham City PCT, 2008). The neighborhood is characterized by high unemployment and

low income, and smoking is a key reason why people in this part of the city die on average 10 years younger than those in wealthier areas. Given the challenges in living within such a disadvantaged community, it is likely that social support for smoking is high while support for quitting is limited (see Hiscock et al., 2012).

The project was funded by NHS Nottingham City and entailed conducting interviews and focus groups with community residents and key informants (e.g. local retailers, community health professionals and service providers) in two waves, the first concerned with identifying prevailing norms around smoking and health, the second concentrating on smoking cessation and harm reduction interventions. The 10 focus groups featured here were conducted with community residents in the first wave: 58 participants in all, with each group mostly featuring a mix of smokers, ex-smokers and nonsmokers (only one group comprised smokers only; see Table 1). The rationale for mixed groups was to mimic naturally occurring peer groups which would feature a mix of smokers and nonsmokers.

INSERT TABLE 1 ABOUT HERE

Community residents were recruited via posters and advertisements in prominent local retailers and community venues inviting interested people to contact the research team. In addition members of the team frequently visited a local community centre in a bid to recruit face-to-face and raise awareness of the project. Individuals who expressed an interest in participating either by telephone or face-to-face were sent/given a project information sheet and consent form with a pre-paid envelope for posting. Focus group participants were awarded a £25 shopping voucher for their time.

All research strands (interviews, focus groups) followed relevant ethical guidelines (e.g. British Psychological Society) and the study was approved by both university and medical Research Ethics Committees in February 2009. All potential participants were briefed about the project in advance, advised of their rights, reassured about confidentiality and anonymity, and invited to sign a consent form. Focus groups were conducted in local community centers, facilitated by two members of the research team each time, with discussions lasting up to two hours each.

Topics covered in the focus group sessions included:

- knowledge and values around smoking and quitting;
- perceived benefits and costs of smoking and quitting;
- sources of cigarettes, both legal and illegal (it is well known that residents in economically deprived areas can access cheap sources of tobacco illegally imported to the UK from 'underground' sources ['fag houses']);
- views about current tobacco control legislation (e.g. smoke-free), and views about potential future legislation (e.g. generic packaging);
- role that smoking plays in daily life and in connection with other relevant behaviors such as diet, alcohol consumption and physical activity;
- suggestions for reducing smoking.

Focus groups have proved invaluable in discerning prevailing group/community norms around a given phenomenon, and have been used to good effect in our previous work on young people and smoking (e.g. Author, 2009; Roddy et al., 2006). Since we were interested in smoking as a social, community-based phenomenon, affecting friends, family

members and neighbors, we were interested to examine how smoking-related behaviors were defined and defended during interactions with peers – hence our decision to employ focus groups rather than, say, individual interviews. Focus groups allow insights into shared values and group dynamics, highlighting concerns, issues and debates in vivo, often with minimal researcher input or direction as participants discuss issues with each other (see Wilkinson, 2004). Focus groups can therefore be viewed as more 'naturalistic' than one-to-one interviews, especially if conducted with friends and neighbors (rather than artificially constructed groups), as is the case in the current research. Of course no research method is perfect, and in focus group situations some individual voices may be relatively suppressed while others dominate; as well there may be lots of overlapping talk, and the presence of the researcher, even if she/he adopts a minor role, may inhibit certain accounts and encourage others. For example, our research project had a smoking cessation agenda, and this may have prompted much discourse about quitting, health consequences and positive self-presentation (we did indeed witness such discourse, but the accounts presented were complex and dynamic, as we demonstrate in our analysis and discussion sections).

All focus groups were fully transcribed and then analyzed from a discourse analytic perspective (Wetherell, 1998). The transcripts were initially read closely and without specific hypotheses in mind – a 'bottom-up' approach to qualitative data analysis focusing on participant accounts in response to researcher questions (e.g. on attitudes to quitting) and in response to each other's accounts. Initially, all 'objects' (e.g. smoking; cigarettes; fag houses) and subjects (e.g. children; nonsmokers; other smokers) mentioned in the discussions were itemized; then, the various constructions around each object and subject were identified (e.g. smoking as pleasure; children need protection). Next, all constructions were studied to identify links, a process culminating in generation of fewer, higher level constructions, or 'discourses' (e.g. 'addiction'; 'government hypocrisy'; 'smoking as a moral issue'). These

discourses referred to a number of different topics, and given the size and richness of the dataset, team members concentrated on different topics. The focus on moralization here was one such topic, and all relevant extracts were then subjected to further detailed analysis, with particular attention to discursive resources and practices deployed in the text. For example, we considered relevant repertoires (resources) which inform participant talk (e.g. "smoking as unhealthy"; "children as vulnerable", and so forth) and the strategies (practices) used to position self and others in particular ways (e.g. emphasizing self-regulation in the presence of others; constructing other smokers as worse, and so forth). The first author presented a preliminary analysis to the team, all of whom had read and analyzed the transcripts independently, and there was much discussion about analytic content, organization and presentation before the final discourse patterns were agreed. We settled on two major interconnecting patterns tied to moralization which we have termed "everyday accommodation" and "taking a stand".

Results

Although presenting data from mixed focus groups (i.e. smokers, nonsmokers, exsmokers), we focus mainly on accounts provided by smokers as they focused much of their talk on smoking with others. The issue of smoking in the presence of others was raised by the researchers but also came up spontaneously in the discussions, with smokers attending to issues of responsibility and consideration of others - unprompted by researcher or nonsmokers in the group - by presenting themselves (and their smoking) as reasonable and sensitive to the presence of nonsmokers. The discussions did not feature overt conflict or disagreement between smokers and nonsmokers; as friends and neighbors, our participants were familiar with each other and favored consensus and shared values. Our smokers positioned themselves as ethical smokers in two main ways:

Everyday accommodation: references to various regular, modest concessions made to nonsmokers so that they were not exposed to cigarette smoke.

Taking a stand: references to instances of active intervention by smokers designed to discourage or prevent (young) people from having access to cigarettes.

Everyday Accommodation

Throughout the focus group (FG) discussions and often spontaneously, smokers presented themselves as sensitive to nonsmokers in various ways. There was much talk of making a range of concessions to nonsmokers, a series of accommodations which smokers themselves regarded as modest or unexceptional, -- the kind of consideration for others expected of any citizen, smoker or not. For example, self-regulation was practiced in the homes of nonsmokers and also in smokers" own homes when receiving a nonsmoking visitor. The extended extract below indicates how our smokers build up consensual understandings of proper behavior in the presence of nonsmokers, in doing so positioning themselves as responsible subjects -- and nonsmokers as potentially vulnerable:

> **Participant (P) 4 [smoker]:** See if I visit my family who don't smoke I wouldn't dream of smoking in their house.
> **P2 [smoker]**: I don't
> **P3 [smoker]**: No we wouldn't.
> **P4 [smoker]:** Even if they said you could.
> **Interviewer (I):** Oh that was what I was going to ask [name] how you feel?
> **P4**: The answer is no I wouldn't.
> **P2**: I've got a lot of respect for that. I know I'm the same. I wouldn't do it to people
> **P4**: I can go to my sister and one of my brothers don't smoke but I wouldn't dream of going into their house and lighting a cigarette up.
> **P2**: No I wouldn't.
> **I**: So your own home because you two are both smokers it's fine?
> **P4**: Now if anyone comes to visit us I'm very funny about lighting a cigarette up.
> **P2**: I am. I'm like that with my friend who comes.
> **I**: Are you, in your own home?
> **P3**: Yeah.
> **P4**: And that's weird. If somebody comes to our house that don't smoke I do not smoke in front of them.
> **P3**: and I have a special fan as well and that cost me £200 about 15 year ago and it's brilliant. I switch that on and it clears my living room as quick as that [clicks fingers].
> **P2**: I could do with something like that in the kitchen.

I: What's the thinking behind this? Is it because you don't smoking, you know, it's smelly?
P4: I just feel guilty that ... yeah because I feel guilty that that person doesn't smoke and I'm actually smoking in front of them and giving them.
P1 [smoker]: Yeah that's it.
P2: You do don't you? Yeah, inflicting it on them.
P1: Then you might as well not
P3: Bad vibes really isn't it?
P4: Exactly and I'll say to [name] now go outside and just, if you want a quick fag, just go outside while we've got company.
P3: I go outside in the back garden.
P2: Yeah I'm like that
P4: So I do not smoke in front of people who don't smoke.
I: How long have you sort of felt like that? Is that a result?
P4: All the time.
I: Oh have you?
P3: Yeah all the time.
P4: Yeah.
I: You've always been conscious of that?
P4: Always done that yes.
I: Okay right.
P2: You're like that ...
P1: Even when I smoke in the street and there's someone behind me, if someone's behind me I'll move to the side. I think it's horrible if someone did that to me.

(Extract 1, Focus Group [FG]2)

This mixed gender FG comprised seven participants and features five smokers, one exsmoker and one nonsmoker – and one married couple who both smoke. The extract begins with an emphatic declaration of smoking restraint from P4, reinforced with an extreme case formulation ("never"; see Pomerantz, 1984) and a reference to "dream" which consigns the very idea of smoking in front of nonsmokers to the realm of the unreal. This sentiment is echoed by others before P4 proceeds to underline the point further by asserting a refusal to smoke even when granted permission by nonsmoking others; not smoking in such inviting circumstances is implicitly construed as heroic self-discipline. The position is then clarified for the interviewer whereupon P2 presents smoking as an offence to others which should be avoided ("I wouldn't do it to people").

P4 then moves from nonsmoking others in general (people) to particular nonsmokers siblings (his siblings), thereby rendering the smoking sacrifice as real, personalised and tangible. Others reproduce this commitment before the interviewer enquires about smoking in their own homes. Here, P4 rejects the interviewer's assumption of unproblematic smoking at

home (“its fine”) and continues with the theme of self-regulation, this time with respect to nonsmoking visitors to his home (“I’d be funny about…”), further indicating concern for others and likely hesitation and discomfort if he were to smoke around visitors.

P2 endorses this account with a second example citing a friend, which prompts the interviewer to register surprise -- and possibly doubt -- by invoking home as a personal space (“your own home”). While P3 responds in the affirmative, P4 picks up on the interviewer’s implication that the situation might be counter-intuitive (“weird”) before reiterating his statement about not smoking in front of guests. P3 then cites personal investment in a “special fan” deemed to be efficient in removing smoke from a domestic room (“brilliant... clears room like that”). In the context of the previous turn and the general theme of consideration for others, P3”s example can be read as an orientation to other’s needs: if she does smoke at home in front of others, the fan is perceived to neutralise the potentially damaging smoke. P2 endorses this item as a useful device for the kitchen (smoking around food was also regarded as taboo, as we discuss below).

With the interviewer probing further about motivations behind at-home restraint, P4 introduces the notion of guilt, not just about smoking per se but about the possible harm that can result (“giving them”). Agreement from others is forthcoming, highlighting a moral code (P2: “you don’t do you?”) and implying unpleasant and perhaps unhealthy consequences (“inflicting it on them”). With such attendant angst, not smoking is presented as simpler (P1: “you may as well not”), while P3 reiterates the tension associated with smoking at home in front of others (“bad vibes”).

Repairing outside is then mentioned as another form of self control and respect for others; here, the woman in a married couple (P4) recounts encouraging her husband (P3) to smoke outside when with visitors. P3 endorses his wife’s account while P2 also claims to smoke outside at home; here the claim is about type of person rather than the actual

behaviour ("I'm like that"), suggesting incorporation of a moral character who cares for others. When the interviewer infers that such practice might be recent, say as a result of increased anti-smoking legislation, our participants rebut the inference by emphasising a longstanding commitment to sensitivity around nonsmokers ("always done that" and so forth). This assertion foregrounds personal choice and standards over external forces and invocations. The scope for upstanding concern for others is then widened to public spaces beyond the home when P1 points to moving away from others in the street to avoid passing smoke on to unsuspecting others. The special nature of this action is signalled by "Even…", and empathy is conveyed with imagining being the victim of passive smoking while in public ("…horrible if someone did that to me").

While specific situations where consideration for others are described, references to a more general set of ethical principles were also common:

> **P2 [smoker]:** You still have standards when you're smoking, you know what I mean, if like someone's having their dinner or anything, you wouldn't smoke in front of them.
>
> [lines omitted]
>
> **P5 [smoker]:** If you're in a strangers house, a guest or something you'd ask if it was okay or something like that, do you know what I mean?
>
> **P7 [smoker]:** Yeah [most agree].
>
> **P1 [smoker]:** There is an etiquette still isn't there?
>
> **P2**: Yeah.
>
> **P1**: I mean a lot of people who if they don't smoke won't let you smoke in their house so you'll stand in the garden or what not.

(Extract 2, FG6)

This all-men FG featured eight men, with six smokers, one ex-smoker and one non-smoker. P2 explicitly attends to the issue of moralization by invoking "standards", here attributed to all smokers via the generic footing "you" (rather than, say, a personal pronoun),

and reinforced with a concrete example around self-imposed regulation when others are eating. P5 then contributes another instance of concern for others: asking permission to smoke when in another's home rather than assuming that smoking is allowed. The term "etiquette" is then deployed by P1, which frames the issue in terms of politeness (rather than morality), with the "still" implying that smokers have always shown good manners, that concern for others is not simply a recent development. Adhering to nonsmokers" wishes is then reiterated with another example where smokers are depicted as prepared to venture outside should smoking be frowned on in another's house. No conflict or tension is reported with respect to nonsmokers" preferences – smoking control or moderation is deemed to be the right or polite course of action.

In terms of smoking in public places, debates concerning boundaries, rights and responsibilities were common. For example, one participant distinguishes between deliberate and unintentional projection of smoke on to others:

> **P5 [smoker]:** Some people do it deliberately just because they think it's funny, but say you do it by accident, like I've done it to people by accident, I've been talking to them and I've blown my smoke in their face and I know it's horrible, it's disgusting, I hate it, really hate. So I do think they do have a right to do it [object] because it is their health as well, second hand smoke is just as bad as smoking a fag but I don't think, especially in a public place that is an open public place, that there is that much of a big deal about it unless somebody is standing really close to you and deliberately blowing it in your face.
>
> (Extract 3, FG4)

This FG featured four women, two of whom were smokers, and one man who smoked (P5). Here, it is acknowledged that not all smokers behave considerately; in fact, "some people" might intentionally blow smoke over others. Moreover, they do it for "fun", and can thus be construed as malicious and immoral. In contrast, the speaker positions himself as an ethical smoker, horrified by unwittingly ("by accident") generating smoke toward others on prior occasions. This account is augmented by detail (Potter, 1996), with reference to actual activities (e.g. talking) and specific, visible aspects (face), as well as strong emotional terms

formulated in a three-part list-like fashion ("horrible, disgusting, hateful"" -- see Jefferson, 1990), emphasizing the morally transgressive nature of smoking directly in front of (innocent) others. The nonsmoker's right to protest is then underlined, with passive smoking validated as a serious danger to health, here equated to actually smoking.

Having established his credentials as a sensitive smoker appalled at the prospect of placing others at risk, the potential for offending others when smoking in public is minimized (no "big deal"), at least in "open" spaces away from other people. The smoker's right to public smoking is thus reinforced while presenting himself and smokers like him as socially caring. This right is only eschewed with reference again to the maligned unethical smoker who intentionally smokes over others nearby.

The issue of smokers' rights was picked up in all the discussions, with many participants drawing on a repertoire of smokers as disproportionately demonized and excessively restricted. However, even when such opinions were expressed in a forthright manner, the effects on others were usually debated:

> **P4 [smoker]:** You know when I get up in the morning, and I smell the smoke in my flat, I can literally be sick, 'cause I don't like the smell of it. All me windows are open, spraying.
>
> **P2 [smoker]**: But I agree with that, because I've got children.
>
> **P4**: But the thing is, they've stopped smoking on buses. They've stopped smoking on trains. They've stopped smoking on aeroplanes and boats. But why stop smoking on something that I've bought, I drive? Why should they stop me from smoking in my car when it's mine?
>
> **P5 [smoker]**: Yeah, but why should the children that are in there [name], why should they inhale your cigarette smoke?
>
> **P4**: But then that's the same, you sitting in your front room and having a fag, and your children are in the house.
>
> **P2**: I think, you know you're writing this down [to interviewer]?

I: Yes.

P2: My own personal view is, if you're a smoker, they are taking away that person's.

P4: Identity.

P5: Taking liberty.

P2: No, you're going in places like, into shops or wherever you're going, on a bus. You wouldn't dream of lighting up if it's other people. They're taking away your common sense. They're saying to you, 'you're a smoker, you're an idiot.' Can you understand what I mean?

I: But ... the bus driver.

P5: I mean I would not smoke where little children are.

P2: That's right. You wouldn't get on a crowded bus and light up.

P4: Well you're not allowed in the first place nowadays.

P3 [never-smoker]: You respect the other people wouldn't you?

P4: That's right, yes.

P2: I mean they're bringing all these laws in. They're treating the smokers like idiots.

(Extract 4, FG1)

This all-women FG featured three smokers and two nonsmokers. This extract begins with an acknowledgement concerning the foul nature of stale smoke in the home environment – the smell of smoke was often labeled disgusting within the groups, by smokers and nonsmokers alike. Strategies to extricate smoke are then mentioned (opening windows, using room freshening products). The next speaker (P2) locates such activities as other-centered rather than personal, in this case with regard to her children (an especially powerful category connoting innocence, purity and so forth, as we discuss below). P4 then responds by recognizing smoking prohibition in public transport contexts (another list for emphasis: buses, trains, aeroplanes and boats) before introducing an exception: private means of transport i.e. his car. Personal pronouns are emphasized (I've bought; I drive; me; my; mine)

to heighten the contrast with the public sphere, and with the anonymous "they" perceived to impose unnecessarily draconian restrictions on smoking.

The private status of the car is then challenged by P5 who introduces children into the equation and problematizes their exposure to cigarette smoke. The response is to equate the car with the home, thereby implicating P5 in a similar "offence" with children present. The discussion is then picked up by P2 who proceeds to emphasize the perceived erosion of smoker's rights and liberties – but couched carefully within a repertoire which highlights concern for potential victims of passive smoking in public areas. This aspect is strongly emphasized -- "I wouldn't dream of lighting up if it's other people" -- and this portrayal of the conscientious smoker is presented as at odds with the perceived legislative view, where smokers are reportedly constructed as "idiots", with no capacity to deploy "common sense" (implicitly linked to consideration for others). The favored image of ethical smokers is then reiterated by others, again invoking "little children" as an obvious moral boundary, as well as smoking in public spaces (e.g. on buses), and generally citing "respect for others". The view that the authorities fail to recognize smokers" capacity to act responsibly is then repeated, and implicitly underlined by the dominant moral view of smokers hitherto presented.

At the same time, across the focus group discussions there was criticism of other smokers, especially parents, who were seen to smoke in front of children, for example in public at youth football matches ("their dads are drinking and smoking at 10 o'clock in the morning next to a football team": FG8), with particular hostility reserved for young single mothers who are seen to prioritise smoking over the welfare of their children ("the voucher is supposed to be for baby milk...they're buying fags with it", FG2). This focus on those adult smokers regarded as irresponsible, neglectful and immoral might in part be designed to deflect attention away from our participants" smoking, and to imply that, by contrast, any smoking partaken is practiced with care and sensitivity for others, especially children. Such

social comparison with "deviant" smokers further serves to consolidate our smokers' positioning of themselves as ethical.

Taking a Stand

As well as presenting various instances of everyday accommodation, and criticising retail outlets and local 'fag houses' for selling cigarettes to minors, many of our smokers also provided examples of a commitment to smoking prevention in others, especially the young, often citing personal interventions. The protection of children was seen to extend beyond the family home, incorporating the local community. For example, a strictly enforced age limit on purchasing cigarettes is praised in situ:

> **P2 [smoker]:** You see a lot more kids outside the shops asking to get fags than you ever have, haven't you.
>
> **P1 [smoker]:** Even I get ID-ed sometimes. Even for Rizlas or something like that.
>
> **P3 [smoker]:** Yeah, you've got to be over 25 haven't you? It's 25 unless you've got ID. I always go with you don't I, 'cos you've always got yours on you.
>
> [everyone talking at once]
>
> **P1**: It's good though, I've said to the person 'oh it's good that you do that' because I don't want my little brother coming in here, I've actually said that because I worry about it.

(Extract 5, FG3)

This FG comprised six smokers, four women and two men. These young (twenty-something) respondents discuss the growing presence of younger children loitering around local shops and petitioning adults to purchase cigarettes for them. Age 25 is cited and deemed potentially problematic in terms of our participants being served – but in spite of this potential downside in relation to their own consumption, the limit is supported in the context of deterring smoking in younger children. P1 specifically mentions a younger sibling, and his

ethical stance is worked up through recounting a concrete intervention on his part: commending a retailer for a strong stance and thus protecting his younger brother and other children in the area. Filial responsibility is amplified by the use of emotional language and the first person pronoun ("I worry about it"), highlighting investment in the issue. In terms of both affect and action, P1 has firmly established himself as an ethical smoker who is concerned about young people accessing cigarettes and damaging their health.

Smokers themselves also report actively taking a stand and not ceding to requests from younger people to purchase cigarettes on their behalf:

> **P3 [smoker]**: But the thing is you'll still have that individual that will go in with for 14 year old kid and buy some fags or buy a can of beer.
> **I:** I know. I've had adults said they'd do that.
> **P3**: Yeah, you've still got the idiot that's going to do that.
> **P2 [smoker]**: Yeah people asking you to get, I've had kids come to me and say 'can you get me some fags please?' I say no 'I blimin ain't'.
> **P3**: No [P4 agrees].
>
> (Extract 6, FG2)

This mixed gender FG comprised seven participants and features five smokers, one exsmoker and one nonsmoker. Other adults who purchase cigarettes or beer for children are denounced ("idiot"). The age of the children in question is made relevant, in this case 14, but in other stories younger children have been mentioned (e.g. "I don't think it's right because some of them look about seven" [P1, FG4]). The extremely young age foregrounded in these extracts serves to stress the scale of the transgression. P2 evidences his stance by reporting a typical instance, using reported speech, where he presents himself as refusing a request from a minor in emphatic terms. Support for this position is forthcoming from other participants. In this way our smokers can view themselves – and can be viewed by others – as responsible citizens. This point is explicitly alluded to in our next extract:

> **I**: Do you think the fact that the government put up the age of sale of cigarettes because it used to be 16.
> **P3 [smoker]:** No they're hanging outside.
> **P2 [smoker]:** Well you still get kids come up to you and say go to the shop for us. Yeah go to the shop for us.

P4 [never-smoker]: Do you?

P3: They hang outside and say right get me a packet of 20 like, you can take a couple out for yourself.

I: And do you?
P1 [smoker]: No.
P3: No.
P4: No I don't.
P5 [smoker]: Even I don't do that, I just walk.

P3: It's the same as with anything. It's the same as with a beer.

P4: I aint getting copped a big great fine for someone.

P3: No.

P1: They're going to get their hands on them one way or another aren't they?
P2: Just because you smoke you've still got standards, you know what I mean?

(Extract 7, FG6)

This all-men FG features eight men, with six smokers, one exsmoker and one non-smoker. Our participants are unanimous in their reported disinclination to buy cigarettes for young people, a stance that extends to other prohibited items such as beer. In this matter a degree of self-interest is asserted by P4 (avoiding a fine), while P1 implicitly questions the effectiveness of refusal with a fatalistic suggestion that children will obtain cigarettes by other means. But P2 returns us to perhaps the key message from our focus groups on the topic of moralization: despite risking their own health and wellbeing, smokers nonetheless can be regarded as ethically principled.

Some of our participants went beyond mere refusal to purchase cigarettes for minors, citing more proactive interventions:

I: So youngsters, where do they get their cigarettes from? Do they go to shops and buy them, or do they tend to get them off?

P1 [smoker]: They get them ... that you're on about, probably ... they've got older groups.

P2 [smoker]: I've seen children outside asking an adult that's going in. If the person's got no scruples, yeah, no problem.

P5 [smoker]: I wouldn't.

P1: I got my son, when he lived at home, I got my son and I dragged him in the Spar shop. I says 'don't sell him cigarettes' and he started going barmy at me.

P3 [never-smoker]: Sorry, just a little thing that we used to do years and years ago. I know my dad did it, because we were told not to smoke. My mum didn't smoke, my dad did smoke. My dad chuffed away good style, but he said, even then he said, 'don't start it', and then he'd find out one of the younger lads had got some cigarettes, so he'd say, 'oh you want to smoke?', and he would make them sit there and smoke a packet till he was turned green, and he'd stop.

(Extract 8, FG1)

This all-women FG featured three smokers and two nonsmokers. The immorality of buying cigarettes for children is again highlighted ("no scruples"). While P5 merely voices her refusal stance, P3 proceeds to illustrate this position with a personal story involving her son. The effort undertaken is emphasised ("dragged him"), as is the directness of his demand addressed to the retailer ("don't sell him cigarettes"), leaving little room for doubt. The resistance (and possible humiliation) of the son is then referenced ("barmy"), again emphasising personal cost but also the importance of steering children away from the lure of cigarettes.

Another dramatic intervention is described by P3, this time in relation to her father's initiative with boys reputedly interested in smoking. Although she is not a smoker, her story takes up the perspective of her father, a smoker, and reinforces the support for tough methods of discouraging smoking within the focus groups among smokers and non-smokers alike. The form of aversion therapy presented might well be regarded as extreme today, but it is firmly located in the past ("years and years ago") and judged to be effective ("he'd stop"), a bottom line argument which is difficult to counter (Edwards, Ashmore, & Potter, 1995). The father's status as a smoker is made relevant, perhaps inviting us to view his efforts to deter the young as issuing from a position of experience and authority. Details (e.g. "turned green") and

reported speech add weight to the story, and the intervention is supported by the speaker e.g. through the initial footing ("we used to do").

In general, a commitment to smoking prevention in relation to others was also displayed across all discussions, particularly (again) in reference to children. There was widespread support for early health education initiatives, and strategies for engaging the young were enthusiastically volunteered. A popular suggestion, for example, entailed exposing children (and parents) to graphic images of smoke-damaged lungs. Such enthusiastic advocacy of direct and dramatic interventions with young children, presented across all focus groups, positions our smokers as mindful of the health of others even while their own choices and habits might damage their own health.

Discussion

Our data suggest that smokers in our focus groups perceive themselves to be judged and marginalised within wider society – notwithstanding their more accepted status within a local community context where smoking prevalence is high. Such negative constructions of smokers are rejected, and our participants resolutely position themselves as considerate smokers in various ways. We distinguished between two forms of moral practice -- "everyday accommodation" and "taking a stand". In the former category, smokers described a range of strategies to minimise the circulation of smoke toward others, including smoking in selected rooms or spaces, retiring outdoors, opening windows, using extraction devices, and so on. The second category encompasses more proactive displays, where our participants described interventions which reinforced legal and moral codes around smoking, such as refusing to purchase cigarettes for young people, actively discouraging young people from smoking, and advocating direct, graphic anti-smoking initiatives with primary school age children. With these accounts our smokers present themselves as upstanding citizens committed to

protecting others, especially children, and implicitly undeserving of judgment because of their smoking behaviour.

That smokers go to such lengths to describe routine and special efforts toward caring for others in a community context where smoking is normative indicates the power of moralization discourse around smoking in the UK compared to some other European countries (see Louka et al., 2003). It is interesting that the vast majority of everyday actions recounted by our participants referred to smoking in a different way rather than stopping smoking e.g. smoking in different places away from others rather than choosing not to smoke at all. In other words, moralization discourse had not yet penetrated to the extent that smoking prevalence was significantly affected, hence smoking rates have remained consistently higher in disadvantaged communities compared to more affluent areas (Hiscock et al., 2012). Nonetheless, smokers construct themselves as caring and considerate, acutely aware of the effects of their smoking on others around them. Clearly, health promotion initiatives around smoking need to take care not to construe smokers as ignorant or insensitive (see Botelho & Fiscella, 2005), and could perhaps draw positively on this ethic of care for others in their midst - whilst providing scientific evidence of the ineffectiveness of some of the strategies these smokers employ. As other has noted, interventions in deprived neighborhoods need to work from a non-judgemental standpoint where local discourses and complexities are understood, and where community members can be enlisted to support smoking cessation (see Holdsworth & Robinson, 2008).

Our smokers reject explanations of smoking maintenance which exclusively focus on biological addiction or personal pleasure; instead, smoking is construed as something which is practiced with some degree of thought and sensitivity concerning its potential effects on others, especially children. While local community norms obviously help to sustain high

consumption by individuals, co-existing norms stressing politeness and decency toward neighbours work to regulate smoking in social situations. According to participant accounts, such ethical standards pre-date the current moralization discourse around smoking and health: they are historically and locally situated.

This analysis helps to develop the Theory of Planned Behaviour concept of subjective norms in smoking (e.g. Conner et al., 2006) by highlighting two sets of norms within the dataset, and the wider community ("prosmoking" and "care for others") and their multiple and complex impacts on smoking-related behaviour (smoking, but not in front of children, or not in the family home, or only in certain pre-designated zones, and so forth). Thus 'subjective norms' can be viewed as a set of (sometimes conflicting) ideals which circulate within a community setting and which inform member's accounts of public practices, whether health-related, controversial or otherwise. In addition, we would say that Social Identity Theory factors are not especially relevant in our data because, if anything, our smokers displayed a strong investment in themselves as morally upstanding individuals more so than as part of a coherent peer group of fellow smokers united by a love of tobacco. Our intensive analysis does add depth and complexity to work on the social context of smoking (e.g. Paul et al., 2010) by demonstrating the various strategies and positions smokers report deploying when accounting for smoking -- and self-regulation -- in different social situations.

Critical reflections

Reflecting on our study, we must consider the research context itself as a moralization site, where participant smokers might have felt that their behaviour, were problematized by the research team. The manifold self-positioning as ethical smokers evident in the focus group discussions could then, in part, be understood as responses to a research agenda perceived as anti-smoking: prosmoking stances and stories might therefore have been

intentionally withheld for fear of being judged. Our sense, however, is that our participants in the focus group discussions appeared largely at ease and were often forthright in providing their accounts, and we regard the data as approximating naturalistic interactions that would occur between community residents. For example, in another article based on the same study we highlight potentially controversial positions, such as explicit support for the purchase of illicit cigarettes from local 'fag houses' (Author, under review.); purchasing cheaper (and more toxic) cigarettes from unauthorised sources highlights the importance of price for smokers in disadvantaged communities, and supports the view that raising the price of tobacco further could prove effective in discouraging smoking (see Hiscock et al., 2012) – although clearly the illegal sale of imported cigarettes would also need to be addressed. Exploring the issue of quitting intentions further would also be useful in the context of self-regulation and moralization.

It must also be noted that the more proactive interventions (showing graphic images, refusing to buy cigarettes and so forth) were typically advocated for other people rather than the speakers themselves, thereby absolving themselves from exposure to their proposed smoking cessation initiatives. Often this point was oriented to by participants as something to be accounted for, and typically references to age and experience were invoked to warrant their exemption (as in "I'm too old/too far gone" for any new policies to work on me). However, it could be postulated that a charitable focus on others, especially children, works as a strategy to deflect attention away from one's own smoking and any attendant exhortations about responsibility and change. Consequently, an ethical smoking identity is to some extent compromised by such self-exception, although it must also be stressed that frequently the researcher's questions and the discussions were deliberately focused on other people, rather than directly challenging smokers about their own behaviours and intentions.

As well, our smokers spontaneously spoke of other smokers in the community, mainly in negative terms. The condemnation of other, worse smokers– for example those who smoked in front of children, purchased cigarettes for children, or sent their children to the shops for cigarettes – could also function to deflect attention from our participant's smoking and any criticism thereof (see also Holdsworth & Robinson, 2008). These demonised others therefore make a useful comparison group and help our smokers to claim a more respectable status.

Our study constitutes an initial examination of how smokers in one low SES community orient to moralization discourse. We are not trying to generalise to all such communities, but we have taken care to document the context of the study beyond quantitative indicators such as high smoking prevalence. For example we have noted the use of 'fag houses' where cheap, illegal cigarettes can be purchased, a concern that children especially are not exposed and do not take up smoking, and a process of social comparison where 'other' smokers are castigated as more irresponsible. More research is required to study the relationship between smoking, self-regulation and moralization in other disadvantaged neighbourhoods – and also in more affluent communities. In addition, research which directly investigates smokers' various and complex responses to moralization is required, in the UK and elsewhere, given that different cultures express different levels of moralization (Helweg-Larsen et al., 2010; Louka et al., 2003). Our focus group methodology yielded rich and complex data which illuminated 'mundane moralities' (Holdsworth & Robinson, 2008) or 'lay normativity' (Sayer, 2005) around smoking. As mentioned earlier, focus group discussions are inevitably informed by group dynamics, researcher presence and project agenda, and it would be useful to complement our data with, say, individual interview accounts where personal and biographical repertoires around smoking and morality could be gleaned. In addition, moralization discourse tends to be associated with particular groups, such as maternal

smokers (Holdsworth & Robinson, 2008), and more work is required to examine responses to moralization by these and related subgroups (e.g. fathers; grandparents; family friends). Further research could also interrogate health promotion texts: smoking cessation services and materials could be analysed for moralization discourse, and smokers invited to discuss their reactions and suggest alternative interventions; indeed, we intend to raise this matter with a smokers' panel who contribute to our research projects. Perceived effects of moralised versus neutral stop smoking initiatives on smoking prevalence and attitudes to quitting could also be examined. Other health-related practices widely judged to be deviant could also be studied in this way, such as "unhealthy" eating practices and heavy alcohol consumption. At another level, policymakers and health promotion agencies need to discuss the relative merits and shortcomings of adopting a moralistic stance to marginalised sections of society.

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Table 1: Focus group composition

Group number	Participants
FG1	5 women (3 smokers, 2 exsmokers)
FG2	4 women (2 smokers, 1 exsmoker, 1 nonsmoker), 3 men who smoke
FG3	4 women, 2 men, all smokers
FG4	4 women (2 smokers, 2 nonsmokers), 1 man who smokes
FG5	4 women (3 smokers, 1 exsmoker), 3 men who smoke
FG6	8 men (6 smokers, 1 exsmoker, 1 nonsmoker)
FG 7	5 men (4 smokers, 1 exsmoker), 1 woman who smokes
FG 8	5 women (1 smoker, 1 exsmoker, 3 nonsmokers), 1 man, nonsmoker
FG9	4 women (3 nonsmokers, 1 smoker)
FG10	4 women (1 smoker, 2 exsmokers, 1 nonsmoker)