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'I think that it's a pain in the ass that I have to stand outside in the cold and have a cigarette': representations of smoking and experiences of disapproval in UK and Greek smokers

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Smoking and disapproval in Greece and the UK

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Biographical notes

Pinelopi Louka is a research student at the University of Westminster. Her thesis is concerned with the relationship between moralization of smoking and smokers' representations of smoking.

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Marcia Worrell is a Senior Lecturer in Psychology at Roehampton University. Her main interests are in the application of qualitative methods to a range of questions of identity in psychology.

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Abstract

Smokers in Greece and the UK are habitually exposed to different levels of social disapproval. This qualitative study explored the accounts of smoking and disapproval offered by 32 UK and Greek smokers. Accounts were framed with reference to a highly moralized construction of smoking. Participants were sensitive to social disapproval of their smoking. While disapproval from those close to them was accepted, disapproval from the general public was not. Two discursive repertories 'smoking works for me now' and 'the struggle to quit' were identified as resources that participants drew upon to enable continued smoking while acknowledging the health issues. While there were many similarities in the accounts provided, there were important differences that seem to reflect the different 'smoking worlds' inhabited.

Key words: Smoking, moralization, qualitative, discourse, disapproval

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Introduction

As the health risks associated with smoking have become clearer, smoking has become the subject of intense moralisation, at least in so far as Western, English-speaking countries are concerned (e.g. Rozin, 1999; Goldstein, 1991). Within these contexts health is seen as the responsibility of the individual and something over which control should be exercised (e.g. Brandt, 1997); thus placing individuals under a duty to be healthy (Blaxter, 1997) that is violated by smoking. Greater awareness of the health risks of smoking and increasing concern about the effects of passive smoking has fuelled support for smoking restrictions in public places.

Anti-smoking measures and smoking restrictions are public expressions of disapproval of smoking and a desire to protect vulnerable populations and non-smokers from exposure to smoke. Across the EU there is variation in the degree of anti-smoking measures imposed, though increasingly smoking policies are being harmonised (for example, health warnings must be in large black and white text and cover at least 30% of the front of a cigarette packet). Anti-smoking measures do seem to be reliably associated with reductions in cigarette consumption, smoking rates and smoking related mortality. For example, Norway, Finland and Iceland all introduced advertising bans which were followed by reductions in smoking rates (UK Department of Health, 1998). In April 2004 the Republic of Ireland implemented a ban on smoking in workplaces that had contributed to a 7.5% decline in cigarette sales within 6 months (BBC News, 9 September, 2004). Local measures too, particularly workplace smoking bans, contribute to

declines in cigarette consumption and smoking prevalence (e.g. Chapman, Borland, Scollo, Brownson, Dominello, Woodward, 1999).

Although there is an observed decline in smoking associated with the introduction of anti-smoking measures, what remains unclear are the mechanisms underlying this. Certainly the opportunities to smoke in public are reduced but this is unlikely to readily account for the observed reductions in smoking. What is more likely is that the attitudes of general public towards smoking (or official perceptions of these attitudes) must undergo some change before anti-smoking measures can be successfully implemented and accepted. However it is also probable that anti-smoking measures and associated disapproval of smoking affect perceptions of, and cultural norms around, smoking in the general public (Nyborg & Rege, 2003; Parry & Platt, 2000). These in turn may affect the ways in which smokers view their own smoking behaviour.

The purpose of this study was to explore the representations of smoking held by smokers who are habitually exposed to different levels of smoking restrictions. We focused on UK and Greek smokers as these two EU countries differ both in terms of smoking rates and anti-smoking measures enforced. The adult UK smoking rate is approximately 25% (Lader & Meltzer, 2003) and this rate, according to data provided by WHO (2002), is around the European average. By contrast, Greece not only has the highest level of adult smokers in the EU, estimated at 45%, (Eurobarometer 2003) but also the highest proportion of heavy smokers (Eurobarometer, 2003; Koumi & Tsiantis, 2001). The UK and Greece also differ in terms of the range of anti-smoking

measures that are enacted as well as the general smoking etiquette (WHO 2002, Eurobaromenter, 2003).

At the time the reported study was conducted (January to April 2002) the UK and Greece differed considerably in terms of anti-smoking measures applied. Successive UK governments have applied tobacco tax increases exceeding the level of inflation, with the effect of producing cigarettes that are among the most expensive in Europe (Joossens & Raw, 1998). This stands in marked contrast to Greece where tobacco prices were considerably lower than the EU average (Joossens & Raw, 1998; WHO, 2002). Furthermore, no tobacco advertising restrictions were in operation in Greece, while in the UK all major means of tobacco advertising had been prohibited. Unlike the situation in the UK, in Greece smoking was permitted in many public buildings and designated non/smoking areas in cafes and restaurants were relatively rare. While there was, and remains, considerable support for smoking restrictions within the UK (Lader & Meltzer, 2003) smoking restrictions are least likely to be respected in Greece (Eurobaromenter, 2003). Since 1998, the UK government has funded a large number of 'stop smoking' campaigns and associated services. No such publicly funded services were available in Greece at the time of the study[1]. In June 2002 the Greek government announced new anti-smoking measures (implemented between June and December 2002). Despite these changes, when compared to Greece, smoking is still subject to more restrictions and sanctions in the UK and quitting is much more heavily promoted. It is also the case that smokers in the UK are more likely to experience public or social disapproval than their Greek counterparts.

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In this qualitative study we set out to examine the ways in which smokers in the UK and Greece understand and account for their smoking. In particular we were interested in the ways in which moralised constructions of smoking informed these accounts and the ways in which participants both experienced and talked about the levels of disapproval that their smoking behaviour engendered

Methodology

Participants

Convenience samples of 10 smokers were recruited in the UK (London and surrounding area) and 11 smokers in Greece (Athens and surrounding area). Both samples were intentionally demographically similar to facilitate comparison between the samples from the two countries. We focused on relatively young smokers who were unlikely to have experienced any smoking-related illness. Participants were all relatively well educated and were either students or young professionals. Recruitment initially took place via university notice-boards and thereafter through snowballing. The Greek sample consisted of 6 men and 5 women who were aged between 23 and 28 years (mean=24.54, Sd=1.75). The UK sample comprised 5 men and 5 women aged between 19 and 37 years (mean=25.2, Sd=6.37). A further group of 11 Greeks studying in the UK, consisting of 5 men and 6 women aged between 20 and 24 years (mean=22.45, Sd=1.36) was recruited in order to explore the experience of being a smoker in two different smoking environments.

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Data Collection and Analysis

The data were collected via a combination of semi-structured interviews and focus-groups. The semi-structured format of the interviews provided a consistent framework for addressing the questions pertaining to our study at the same time as affording flexibility to pursue respondents' viewpoints in depth. The focus groups were conducted in order to gain insight produced by the interaction between participants about their experiences of smoking. An advantage using focus groups in our research is that it drew out participants' experiences and reactions to smoking in ways that may not have been illuminated by or are complementary to, other methods (Gibbs, 1997), including the semi-structured interviewing approach we adopted in this study. Focus groups, comprising 3 smokers, were conducted across each of the 3 groups of participants. Participants were invited to take part in either an individual interview or a focus group.

The questions explored participants' representations of their own smoking, perceptions of society's view of smoking, experiences of disapproval and the effects of this. Greek smokers resident in the UK were also asked to compare their experiences of smoking and disapproval in both countries.

The interviews and focus groups took place in a location of the participants' choice. Typically this was on university premises or the participants' own homes. Detailed information about the study, including the ethical framework guiding the research, was given out to all participants before seeking their agreement to participate. Each chose their own pseudonyms, which appear in our analysis. All interviews were conducted in either English of Greek by the first author (a Greek-English bilingual). The

interviews were audiotaped and verbatim transcripts produced in the language the interview was originally conducted (either in English or Greek). After an initial analysis the Greek transcripts were professionally translated into English and back translated into Greek. All of the transcripts were read and re-read by the research team in order to identify themes running across and between the interviews and focus groups. Each theme was coded and the codes reviewed, refined and entered on to Atlas Ti where further indexing took place and analytic categories were created. Atlas Ti is specialist software package designed to assist with the categorization and analysis of qualitative textual, graphical and audio data (LTSN 2000).

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Results

Acceptability of smoking.

All participants in this study felt that public perceptions of smoking were largely dependant on place and time. British participants reported that, in their experience, most people in the UK tended to hold negative and disapproving views of smoking, which contrasted to their perception of a greater tolerance of smoking 10 or more years ago. Both Greek and British participants attributed the changes across time and the variations between places to shifts in social norms and attitudes brought about by education and anti-smoking measures and legislation.

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> *'I think the fact that once upon a time the government couldn't stop you…um…I mean a few years ago there were advertisements on the telly of women smoking saying how great it was for you and how wonderful it was and now people are saying it's not good for*

you and you have lots of establishments stopping people from smoking. Social norms do play quite a big part in people's attitudes and behaviours.   Maybe that's the reason why people now are more negative about smoking than they used to be and also lots more people now are aware of the risks and damages that are done…um…advertising per se is a lot more in your face about smoking [pause] You didn't have such graphic accounts of what would happen to you 10 years ago, so yeah, I think the part that organizations play in negatively showing smoking has had quite an impact on people's positive attitudes to not smoking.' (Claire UK F, lines 171-186)

All participants spontaneously compared attitudes in their countries of residence to attitudes in other countries, particularly the USA, where smoking was perceived to be extremely unacceptable, and southern European countries, where it was felt that a more liberal attitude prevailed. Greek participants living in the UK stressed that marked differences in attitudes towards smoking in the UK affected them to the extent that they felt very uncomfortable about smoking in the UK. Many referred to cultural attitudes towards smoking and anti-smoking legislation as being akin to a 'racism' in the sense that they were felt to be highly discriminatory. Again this was generally explained in terms of governmental promotion of anti-smoking education and anti-smoking measures.

'*Um…I believe that maybe the campaign the anti-smoking campaign that they did in England was more effective than those of other countries, in a sense that it made anti-smokers to be more*

> *against smoking and against smokers as well. Thing that I am against, I mean I am against this racism(sic) because everyone, smokers, non-smokers and anti-smokers have certain rights with regards to their choices.* '(Legend, Greek in UK M, Focus Group, lines 250-255)

The participants' talk about public perceptions of smoking appeared to reflect the different moral contexts they inhabit, to the extent that they all perceived a clear, causal link between anti-smoking education and measures and public attitudes. On the one hand, UK participants expressed strong support for designated smoking areas and public smoking restrictions, citing the importance of clean air for non-smokers. Greek smokers in the UK, on the other hand, emphasized that, at the same time as respecting these measures, they also felt that they as smokers were discriminated against in the UK. For UK participants, there was a clear tension between respecting non-smokers' rights to clean air and smokers' rights to smoke. Participants stressed that they need to be respected too and were very unwilling to put-up with disapproval when smoking in a designated area or in their own homes. Greek participants in Greece, in contrast, felt that smoking restrictions were fundamentally unfair as they interfered with the smoker's free choice and legal right to smoke. These participants all expressed concern about the (then) impending anti-smoking legislation in Greece. The issue of passive smoking was not raised; these smokers emphasized that any risks of smoking applied only to those who smoked. Again, these differences do seem to reflect the different cultural narratives around smoking in Greece and the UK. Most participants, both Greek and UK, talked of feeling frustrated by government

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hypocrisy around taking tobacco revenue while passing measures to make smoking more difficult.

> '*I think it's a pain in the ass that I have to stand outside in the cold to have a cigarette and because of the way the government is pushing cigarettes and because they are readily available. I don't think that non-smokers have the right to complain about someone's smoke if the government is quite prepared to take the tax off you and is quite prepared to sell them to you and you are free to choose if you want to smoke or not. Then by the same token you should at least in some ways be vindicated, you know.*' (Claire, UK F, lines 233-240).

All participants had experienced some level of disapproval of their smoking and were highly motivated to avoid this.   Two important sources were identified and differentiated: intimates and the general public. Disapproval from intimates (family members, partners and close friends) made participants feel guilty and bad about their smoking. This level of disapproval was more likely to be accepted however, as it was understood to reflect and be motivated by concern for the participant.

> '*All this disapproval makes me guilty and uncomfortable because at the end of the day I know they are right. They care about me so anything they say is for my own good. I don't get upset with them I might if there was someone else you know a stranger who just criticized my smoking but not them. I feel uncomfortable and bad as a person and I feel guilty as a smoker 'cause I know they are right and I should stop'.* (Samantha, UK F, lines 87-92)

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These feelings stood in contrast to those engendered by disapproval from strangers. Most participants reported experiencing disapproval from the general public, generally in the form of looks, coughs etc. but also negative comments, which made them feel alienated and ostracized. This was felt to reflect an unfair stigmatizing judgment of them as a person based solely on their smoking behaviour rather than their personal characteristics. Greek participants rarely reported experiencing disapproval in Greece, however many had experienced it in other countries. Greek participants resident in the UK and UK participants all reported some kind of experience of this disapproval in the UK. This gave rise to feelings of anger in many participants, particularly when they were in places, like pubs, where smoking is permitted.

> '*I think you get it more in pubs or restaurants when you are smoking next to someone and they are making noises and start coughing and even talk out loud about it and it makes you uncomfortable because you can't go anywhere else, but on the other hand you are saying to yourself 'Fuck you, I am smoking anyway, this is a pub for God's sake', you know.*' (Jack, UK M, lines 136-141).

Accounts of own smoking.

All participants demonstrated their awareness of the health consequences of smoking and sought to explain their current smoking against this backdrop. Participants' talk demonstrated a firm acceptance of the moral obligation to be healthy and an awareness that this was violated, or could be seen to be violated, through smoking. When taken together, the moralization of smoking and the duty to be healthy provide an imperative to quit smoking. Participants

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in this study however drew upon two major discursive repertoires 'Smoking works for me now' and 'The struggle to quit' to account for their continued smoking in light of acknowledged health consequences and pressures to quit.

'Smoking works for me now'

Twenty-seven participants (5 UK, 22 Greeks) utilized this discursive repertoire when discussing their own smoking. These accounts were linked to the perception that there was still time to enjoy smoking and that consideration of the longer-term consequences of smoking could be postponed. This was particularly apparent in the case of Greek smokers.

> '*I like to smoke too much to think about it in a negative way…um…you know when you are doing something that you like it is what counts and not what it will cause you. You don't even want to think about that, what matters is your priority. For me, the fact that I like to smoke comes first and since I haven't experienced any health consequences I am OK with that. Later on when I am older I would like to cut down for medical reasons but not now or in the near future because I am pleased with my smoking.*' (Marmo, Greek in Greece F, lines 20-27)

> '*I feel great. I don't intend to quit. I am aware that it [smoking] is bad but my priority, at least for now, is that I like to smoke.*' (Marlborova, Greek in UK F, lines13-14).

At the same time as reiterating what our Greek participants had said, the UK smokers also tended to add that they felt guilty, stupid or bad for smoking, even while stressing their enjoyment of it.

> '*Cause I enjoy it [smoking] too much…We all need to have a habit of some sort, mine just happens to be smoking (laughs) at least that's what I say to stop myself feeling guilty'* (Emma, UK F, lines 39 and 43-45).

All the participants who used this discursive position drew on the notion that 'Smoking is not the problem, lifestyle is' in order to explain their smoking in light of their acceptance of an obligation to be healthy. This comprised two discourses, healthy lifestyle and control of smoking.

A healthy lifestyle

By drawing on holistic constructions of health (e.g. diet, exercising, and avoiding drinking), many of the participants argued smoking should not be considered in isolation from wider lifestyle issues and that an engagement with these healthy practices could counterbalance the effects of smoking on health. A major difference in the way the healthy discourse was deployed amongst our sample was that UK participants tended to argue that an otherwise healthy lifestyle could *ameliorate* the effects of smoking while Greek participants went further to argue that a healthy lifestyle could actually *negate* the effects.

> '*I was never really worried about the outcomes of smoking, I mean health based, cause I have kept myself fit and I believe I have read research somewhere saying how, if you keep yourself fit, you can counteract the effects of smoking'*. (Peter, UK M, lines 45-48).

'*I don't think I could quit [pause]. I could try and do other things to protect my health but I would never give up smoking because I like it [pause] what I mean is that if you are careful about what you eat, if you exercise, if you are careful in your way of life then you can do a little sin like smoking.*' (Fox, Greek in UK M, lines 43-47).

Control of smoking

A majority of the Greek smokers who adopted the 'Smoking works for me now' position spoke of the importance of being in control of their smoking. Control of smoking was a key way in which these participants understood, explained and justified their smoking. While all acknowledged that smoking was potentially harmful, this was qualified by the extent to which the individual could be seen as being in control of their behaviour. This was reflected in the importance of having a 'limit'. Most Greek participants spoke of having a limit, typically a pack of cigarettes a day. If smoking is kept within these limits then it is seen to be under control. A number of Greek participants developed this to question whether smoking is as harmful as it is portrayed to be.

'*I don't think that smoking is as harmful as people believe it to be. I know many people who smoke, my age, but also older than me and they are fine. I believe that smoking in general is harmful only when you overdo it. But still I don't think that smoking on its own can cause something, it has to some something else as well such as heredity or one's general lifestyle*'. (Angel, Greek in UK M, lines 16-21).

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In the quote above, Angel links together the sub-themes of control and lifestyle. Quitting is also resisted through pointing to hereditary factors. These are seen to be beyond the control of the individual and therefore providing a warrant to continue smoking as the effects are beyond the control of the individual.

For the Greek participants control was exercised through internal comparisons, in particular keeping smoking within self-defined limits. UK smokers, on the other hand, spoke of being 'safe'. This safety was defined in terms of how much they smoked in relation to other people. UK participants all understood their smoking with reference to other people and compared their cigarette consumption and/or general lifestyle to those of other smokers.

> '…*But as I said I do not consider myself to be a heavy smoker… um…a heavy smoker for me would be someone who smokes around 30 to 40 cigarettes a day. I know people who as soon as they get up in the morning light a cigarette*.' (Peter UK M, lines 20-23).

Quitting.

The smokers who used this 'smoking works for me now' discursive repertoire all defended their smoking in the here and now. Of the 27, only 9 (5 Greek, 4 UK) expressed a firm desire or intention to quit in the future. Although this may be related to the participants' relative youth research does suggest that younger smokers may have more favourable attitudes towards quitting (e.g. Kviz et al. 1994) and the 'common sense' belief that young people feel immortal does not seem to be supported by the available evidence (see Henley & Donovan, 2003).

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The 5 Greek smokers tended to present quitting as something that they would be able to do, unproblematically, at the 'right time' and this is probably related to the fact that smoking, for them, is not problematicised in the present. However, at the time of interview, smoking was seen to be too useful, or too much a part of their lives, to consider quitting.

> *'I control this habit and I hope that in the future when I overcome my youth egoism, apart from the starting reason…um…by my youth egoism I mean the idea that nothing will happen to you, then I will be able to reduce it and ultimately quit. Of course that doesn't mean that because its consequences are evident in the long-term to say that because they aren't evident in let's say 30 years from now to quit in 29 years from now [pause] I have a mental timetable that I believe when some circumstances…um…life circumstances are generally more firm and finalized as now they are somewhat vague and are not as I want to them to be then I won't need cigarettes as a way out…um…I believe that then I won't even need it and I will quit as it is a means of a way out [pause] that's the way I see it as a means of a way out and nothing else'.* (Conan Greek M, lines 80-91)

The 4 UK participants who intended to quit also talked of the 'right time' to quit, which, again, was not now. However, unlike the Greek participants who adopted this position, they tended to problematicise quitting and anticipated difficulties in doing so. Many used discourses of addiction to stress how difficult it would be. This, we would suggest, is because smokers in the UK have come to understand smoking as a highly problematic activity. Moreover the tension between the current positive aspects of smoking and the potential

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long-term negative aspects of smoking, addiction and attempting to quit was more evident in the UK responses.

The remaining 18 participants (17 Greek, 1 UK) used the discourse 'smoking is not the problem, lifestyle is' to undermine the widely accepted view that smoking inevitably damages health to actively resist quitting. The 17 Greeks talked of the future as being unpredictable and they might be offered 'a chance to quit' but might not. Most, however, they did intend to reduce their cigarette consumption as they age, citing health as a reason. Crucially though, quitting would be contingent on actually experiencing a health problem and/or being told to do so by a doctor. This position, as articulated by these Greek participants, enables the view that the chances of smoking-related harm are quite low if lifestyle is otherwise good, so that if and when illness strikes then, and only then, should quitting be considered.

> '*Um…as I think about it now I want to continue to smoke but you never know what happens in the future. If I don't have a health problem I would like to smoke around 10 cigarettes a day but if my doctor advises me to quit I will quit.*' (Alexis, Greek in Greece M, lines 58-61).

The 'smoking works for me now' discursive repertoire allowed smokers to defend their smoking while acknowledging the associated health risks. Those who adopted this position stressed that they knew about the health risks and were sensitive to the possibility that their position be read as an 'excuse'. They moved to disclaim this by emphasizing that their talk reflected their 'true' beliefs. This position clearly prioritizes the positive aspects of smoking in the here and now over any potential negative consequences in the future.

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Participants were effectively presenting a cost-benefit analysis. For those who did not intend to quit the costs of smoking are acknowledged, but the current benefits outweigh potential future costs as participants still have time to smoke. On the other hand, those who do not have a firm intention to quit drew upon the discourse 'smoking is not the problem, lifestyle is', to actively undermine and question the hegemonic position that smoking is inevitably bad and always incompatible with health. In this way the benefits of smoking outweigh the costs, which are seen to be unpredictable and certainly not inevitable.

The struggle to quit

The second discursive repertoire we identified '*the struggle to quit'* was adopted by 5 of our participants (4 UK, 1 Greek). These smokers expressed the desire to quit smoking but felt unable to do so. All had made numerous attempts to quit and, while some expressed optimism that they would eventually succeed, they presented quitting as very difficult and problematic endeavor. These participants also drew on discourses of control, but unlike participants who drew on the 'smoking is right from me now' repertoire, presented their smoking as being largely outside their control, drawing on discourses of addiction, both physiological and psychological, to do so.

> '*I don't like smoking now because I am nearly 30 and it's doing irreparable damage to my health I have broken capillaries everywhere I am unfit. I want to have children in the near future, these are all factors that I want to stop smoking cause I'm actually damaging my body and because I cannot stop smoking I perpetually beat myself up about how weak I am how you know it's*

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not a big deal and I should be able to stop smoking but I think I underestimate how addictive it is, not just the nicotine but the whole psychological aspect of smoking, you know the social alleviation of pressure [pause] I hate it and I wish I could stop smoking. I don't like the way my clothes smell I don't like the way my breath smells and the way my fingers get discoloured…um…I have tried to quit and I will again in the future to make me feel better about myself.' (Claire UK F lines 58-68).

Unlike many of those adopting the 'smoking works for me now' position, these smokers felt that time is running out and that they must stop soon in order to avoid or minimize irreparable damage. Interestingly there was no difference in age between participants drawing on this position and those associated with the smoking works for me now repertoire we identified. What differed was their perception of the time available to them to safely smoke, so that the benefits of smoking were outweighed by the costs. This was particularly striking in the responses of the women adopting this position, who spoke of having to quit before having children. One UK participant combined both the 'quitting is a struggle' and 'smoking works for me now' positions. Although feeling negatively about her smoking, she argued that she had a choice in the present time and her choice was to continue smoking. This element of choice, however, would be removed at the time she decides to become a mother.

'…I will quit when I want to have children cause I don't want to be a smoking mother'. Then [when she becomes pregnant] I don't think

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I have a choice…um…now I have choices that's why I continue to

smoke.' (Mary, UK F, lines 123-126).

The 'quitting as a struggle' position stressed the negative aspects of smoking and the current and/or potential effects on health. These participants felt that the time for smoking had run out. The fact that they continued to smoke was explained in terms both of personal weakness and the tenacity of the tobacco habit.

Discussion

The findings reveal important similarities and differences in the accounts of own smoking offered by these Greek and UK smokers. These accounts seem to reflect the different social realities around smoking that the participants experience. All the accounts were framed in reference to a highly moralised construction of smoking. Acceptance of a moral obligation to be healthy was evident in all responses though was expressed in different ways in the accounts of smoking provided. Participants all initially acknowledged that smoking was harmful and then sought to explain or justify their smoking in the light of this. Two discursive repertoires, 'smoking works for me now' and 'the struggle to quit,' enabled participants to continue smoking while acknowledging the health issues. These repertoires can be broadly read as cost-benefits analyses whereby current and future costs of smoking are evaluated and set against the benefits in the here and now. This was closely linked to perception of time for most participants. Many felt that they still had time to smoke, while for those adopting the 'quitting is a struggle' position time was running out. These perceptions were not related to participants' actual

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age, but rather to their sense of where they were in their lives. This was particularly apparent in the case of those women participants who were considering having children within the next few years. For these women smoking and motherhood were incompatible.

UK and Greek responses also differed. These differences almost certainly reflect the different 'smoking worlds' inhabited by these smokers. Smoking was and is subject to greater levels of moralisation and disapproval in the UK than in Greece. Our findings suggest that this gives rise to different engagements with the duty to be healthy and pressures to quit. Greek participants (both in Greece and the UK) were more likely to actively resist quitting. Some Greek participants offered a construction of health that could include smoking as part of a generally healthy lifestyle. These participants had access to a greater range of cultural narratives that enabled some of them to challenge received wisdom that smoking is inevitably harmful.

The UK smokers were much more likely to express a firm intention to quit. Interestingly, despite this, with the exception of the small number of Greek smokers who adopted the 'quitting is a struggle' position, Greek smokers presented quitting as relatively unproblematic while the UK smokers were concerned that quitting would be extremely difficult and their talk of quitting drew heavily on discourses of addiction. Again we suggest that this reflects differential exposure to cultural narratives around smoking: UK smokers inhabit a cultural context where smoking is construed as a highly problematic activity. In addition UK smokers have considerably more exposure to anti-smoking health education campaigns that are usually informed by discourses of addiction. As Gillies (1999) notes 'This dominant

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construction of cigarette smoking as a physiological addiction is, in many respects, disempowering and negative' (p.81).

Certainly these findings do suggest a relationship between perceptions of smoking and the moralisation of smoking. While the relationship between anti-smoking measures and public attitudes towards smoking is unclear, it is important to acknowledge that the smokers in this study perceived a direct causal link between them. Moreover UK participants all accepted that smoking was a legitimate target for intervention and regulation. The Greek participants were more likely to offer an individualistic construction of smoking whereby the smoker exercises his or her legal choice and right to smoke. Smoking was presented as a matter of individual freedom and therefore an area of concern for the individual rather than society. Regulation and control of smoking were matters for the individual smoker and not the state or members of the (non-smoking) general public. The UK smokers' support for restrictions was based on their acceptance of the need to protect others from their smoke, which reflects the emphasis of much recent public health education. In contrast, Greek smokers tended to emphasise that smoking was a risk for the smoker only, and not for other people; which enabled them to challenge the need for smoking restrictions.

These findings suggest that acceptance of smoking restrictions does seem to be related to exposure to them, supporting Nyborg & Rege (2003). However all participants in this study, both Greek and British, expressed a view that smokers had compromised enough and yet were still subject to disapproval even when 'keeping the rules'. They resented centrally imposed restrictions while smoking remains a legal habit and smokers are heavily

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taxed. Greek participants in particular felt that the Greek government did little to promote non-smoking or educate people about the dangers of the smoking. This does suggest that government led restrictions are more likely to be accepted if accompanied by evidence of a real commitment to tackling smoking.

The findings also suggest that exposure to social disapproval has an impact on the ways in which smokers feel about their smoking as well as their smoking behaviour. Smokers are influenced by disapproval both emotionally and behaviourally and are highly motivated to avoid it, though the impact depends on the source of disapproval and the smoker's perceptions of it. Two important sources were clearly identified: intimates and the general public. Disapproval from intimates, such as family members was accepted and understood in terms of concern while disapproval from the general public was not accepted and was understood as a stigmatising judgement. The accounts of 'public' disapproval suggest that all our participants perceive the general public in the UK to have highly moralised constructions of smoking. The act of smoking was seen to signify the smoker as 'immoral' and this positioning was actively resisted.

In conclusion, these findings demonstrate that smokers are highly sensitive to moralised constructions of smoking and health. They also suggest that cultural narratives around smoking do influence the ways in which smokers understand and talk about their smoking. Social disapproval of smoking has powerful effects on smokers, though these effects are very much dependent on the source of the disapproval. Disapproval and restrictions are accepted if smokers consider than these are motivated by

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concern for them, rather than a discriminatory judgement of one aspect of their behaviour. Further research is needed to explore the relationship between social disapproval of smoking and actual smoking behaviour.

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Footnote

[1] It should be noted however a limited programme was introduced in

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