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The work presented in this thesis is, to the best of my knowledge and belief, original, except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

Zoi Triandafilidis
**Thesis by Publication**

In 2014 I was awarded a three-year funded Discovery Postgraduate Research Award to complete my thesis, as part of an Australian Research Council Discovery Project (DP130100723), titled *Young women’s construction and experience of cigarette smoking: A qualitative examination of the intersection of gender, social class and cultural identity*. The Chief Investigators on this project were Professor Jane Ussher and Professor Janette Perz. Within the project team, I contributed to the design of the project, and I was responsible for the collection and analysis of the qualitative data which is reported in the four published referred journal articles that form the central body of this thesis. The first draft of each article I wrote independently, with subsequent feedback and advice provided by my supervisors.

**Published Journal Articles Included in the Thesis**


**Conference Presentations Relevant to the Thesis**


Triandafilidis, Z. (2016, December). *“They wouldn’t see me as a good person, just because I smoke”*: *An intersectional analysis of young women’s experiences of smoking-related stigma*. Paper presented at the Society of Mental Health Research Conference, University of Sydney, Sydney.

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Abstract

The impacts of cigarette smoking on health are now well documented. Although overall rates of smoking in Australia have been declining for many decades, smoking remains a leading cause of death and disease. Research has begun to explore the ways in which smoking is experienced by young women, however, several gaps in this field of knowledge remain. There is a need for further research to help us understand the multiple, contradictory, and intersecting identity positions which shape young women’s smoking. Moreover, there is a need for research which adopts novel methodological approaches, such as participant-produced photography, and different theories such as poststructuralist and intersectionality theory, to further our understandings of the social context in which young women’s smoking is situated.

In this thesis I explore the ways in which young women smokers and ex-smokers construct and experience cigarette smoking. In order to do this, I situate my thesis in a social constructionist epistemological paradigm, and ask two research questions: “What discourses do young women draw on to construct their smoking?” and “What implications do young women’s discursive constructions of smoking have on their subjectivity, smoking practices, and interactions with anti-smoking campaigns and policies?” Data collection for this study took place between 2014 and 2015. Young Australian women aged 18 to 31, smokers and ex-smokers, took part in a three-stage qualitative study involving interviews, a participant-produced photography activity, and follow-up interviews. The data were analysed using discourse analysis, and intersectionality and poststructuralist theories.

The analysis of the data is presented in four referred journal articles. The first article examines young women’s smoking in relation to the performance of
femininity. In this article I found that young women’s smoking is implicated in both the doing and undoing of femininities, with participants’ experiences shaped by gender, social class, and sexuality. The second article explores the ways in which young women construct, experience, and negotiate smoking-related stigma. In this article, smoking-related stigma is shown to be shaped by various axes of identity; young women experience compounding layers of smoking-related stigma based on intersecting identity positions, such as gender, cultural background, social class, or whether they have children. The third article examines the ways in which young women make sense of smoking-related risk. This article highlights how young women draw on interpretative repertoires to position the risks of smoking in contradictory ways - as both acceptable and unacceptable. The fourth article discusses how young women construct their experiences of quitting smoking. This article shows how young women take up contradictory positions of responsibility and resistance, addiction and agency in relation to quitting smoking.

The conclusion, bringing together the findings from these four articles, argues that smoking takes up multiple, often contradictory meanings and functions in young women’s lives: feminine and unfeminine, a source of risk and a way of coping, an addiction and a choice. These findings have implications for the development of tobacco control responses which recognise young women’s agency and the complexity and contradiction that characterises their smoking, as well as acknowledging the multiple identities that shape their experiences with smoking.
Preface

While conducting research for this thesis, I have been an insider-outsider (Dwyer & Buckle, 2009). I am a 25-year-old woman, which makes me an insider among my participants. But, I am also an outsider, as I have never been a smoker and I have only ever smoked a handful of cigarettes in my life. Yet, smoking has been a regular feature in my life – my mother, who was a single parent, smoked; my brother smokes as a way of managing his schizophrenia; and my male partner smokes. My relationships have therefore led me to develop a vicarious understanding of some of the reasons why people smoke, as well as some of the difficulties they face in quitting.

When I tell people I research young women and cigarette smoking they often assume that I have a public health agenda – an experience that has also been described by other smoking researchers (see Dennis, 2016a). However, my background is in sociology, and my motivation for doing this research was the opportunity to critically analyse health discourse as it is experienced by young women who smoke. To reflect on my motivations, assumptions, and personal interest in researching young women’s smoking is to engage in reflexive analysis. Reflexivity is an important part of doing qualitative research and involves an examination of the impacts of both the researcher’s position and perspective, intersubjective dynamics between researcher and participant, and an evaluation of the research methods (Finlay, 2002; Stainton-Rogers & Willig, 2017). I have shaped this thesis, and this thesis has shaped me too. I position my subjectivity not as a problem, or a bias needing to be controlled, but rather, as an opportunity to further understand myself and the research process (Finlay, 2002). Throughout this thesis, I continue to critically reflect on the role I have played during the collection and analysis of data.
Chapter One: Constructions of Young Women and Smoking: An Introduction and Review of Existing Literature

This thesis explores young women smokers’ and ex-smokers’ constructions and experiences of cigarette smoking. In this thesis, I examine the discourses young women draw on to construct their smoking, and the implications these discursive constructions have for young women’s subjectivities, smoking practices, and interactions with tobacco control policies and campaigns. Situated within a social constructionist epistemology, I pose two research questions: “What discourses do young women draw on to construct their smoking?” and “What implications do young women’s discursive constructions of smoking have on their subjectivity, smoking practices, and interactions with anti-smoking campaigns and policies?” To answer these questions, I use poststructuralist and intersectionality theories to analyse how young women construct their experiences of smoking in interviews and photographs.

My analysis is presented in four published refereed journal articles, which explore young women’s smoking in relation to performances of femininity, negotiations of stigmatisation, understandings of risk, and experiences of quitting. This analysis tells a story of the complex and contradictory understandings young women have of their smoking. Through smoking, young women both do and undo performances of femininity, experience and negotiate smoking-related stigma, acknowledge the risks of their smoking but not their personal susceptibility, and position themselves as responsible and resistant, and as agents and addicts. I argue that it is only by understanding the complex and contradictory nature of young
women’s accounts of smoking that we can improve the support available to women to quit.

In this chapter, I examine existing research on young women and smoking, and explain how this thesis makes a novel contribution to this body of literature. The chapter has three sections. In the first section, I describe the broader context in which this thesis is situated. I discuss smoking prevalence and the tobacco control climate in Australia, the impacts of smoking on women’s health, and identify young women as an important group to target with specific smoking cessation interventions. I then examine changes in the social, cultural, and historical constructions of women’s smoking and explain the need for a social constructionist epistemological framework.

In the second section, I situate this thesis within existing knowledge on young women’s smoking, reviewing literature in four areas which reflect the focus of the articles I have written. Firstly, I examine smoking as a tool for performing identities and explore the way notions of smoking and femininity shape women’s experiences of smoking. Secondly, I review research on the stigmatisation of smoking, and the efficacy and ethics of the employment of stigma as a method of tobacco control. I then introduce the concept of intersecting stigma and examine women’s experiences of intersecting smoking-related stigma. Thirdly, I review studies on the social construction of smoking-related risk, focusing on how smokers understand smoking-related risk. Finally, I review research on quitting smoking, constructions of smoking in relation to concepts of addiction, choice, and willpower, and linear and non-linear conceptualisations of smoking cessation.
In the third and final section, I explain the need for further research on young women’s smoking that uses novel theoretical and methodological approaches. I then present my research aims and questions and provide an outline of how the thesis is structured.

**Smoking Rates in Australia: A Tobacco Control Success Story**

In Australia, the overall rate of daily smoking is 12.2%; this is one of the lowest smoking rates among Western countries (AIHW, 2017b; WHO, 2015). Across Australia, men continue to have a higher rate of daily smoking than women. However, in certain geographic regions this is not the case. In the Australian Capital Territory, for example, women smoke at a similar daily rate to men, and in South Australia the rate of daily smoking is higher for women than it is for men (AIHW, 2014b). While smoking rates in Australia have been declining since the 1970s (Greenhalgh, Bayly, & Winstanley, 2015), recently there has been a reduction in the rate of decline, with the 2013 and 2016 National Drug Strategy Household Surveys (NDSHS) showing no significant decline in the daily smoking rate during this period (AIHW, 2017c). This is concerning given that smoking remains the leading cause of preventable death and ill health in Australia (AIHW, 2011b), being responsible for 22% of the overall cancer burden and 80% of the lung cancer burden (AIHW, 2016).

Australia’s low smoking rates are often credited to advanced tobacco control policies – which make Australia one of the “front-runners for the title of world’s most successful smoking control nation” (Chapman, 2007a, p. 145). The tobacco control movement began in Australia in 1973, with the introduction of the first cigarette packet warning (Chapman & Carter, 2003). In the decades that followed,
cigarette advertising on television was phased out, quit campaigns began promoting the message that smoking is harmful, and restrictions on smoking in workplaces, hospitality venues and public places were enforced (Chapman, 2007b; Scollo & Winstanley, 2012). In the late 1990s cigarette taxes increased substantially, and then in 2013 an annual 12.5% tobacco excise increase began, which is proposed to continue through to 2020 (Department of Health, 2017). In 2012, Australia became the first country in the world to introduce plain cigarette packs; this worked to significantly reduce the appeal of smoking and limit the ability for tobacco companies to market cigarettes as a distinct product (Keane, 2014).

Despite the success of these policies in reducing overall smoking prevalence, rates of smoking among marginalised subpopulations in Australia remain high. Single parents, Aboriginal and/or Torres Strait Islander peoples, those who are homeless, who have poor mental health, who are in prison, or women who identify as lesbian, bisexual or queer, are often two to three times more likely to smoke than members of the general population (Australian National Preventive Health Agency, 2013; Mooney-Somers, Deacon, Richters, & Parkhill, 2015). These trends highlight the need to consider how smokers’ experiences may vary depending on their intersecting levels of social advantage.

During the last decade, rates of smoking among Australian adolescent girls and young women have been identified as an area of concern. The Australian Bureau of Statistics’ (ABS) (2009, 2013) national health surveys show that during 2007 and 2008, and 2011 and 2012, the rate of smoking among adolescent girls aged 15-17 years increased, while the rate of smoking for adolescent boys aged 15-17 years
decreased. Results from the 2010 National Drug Strategy Household Survey showed adolescent girls aged 12-17 years were more likely to smoke daily than adolescent boys (AIHW, 2011a), and the 2013 survey showed young women aged 25-29 years had the highest rates of daily smoking among women and smoked more heavily than men of the same age (AIHW, 2014b). The most recent 2017 survey showed that Australian adolescent girls initiate smoking at a younger age than boys (AIHW, 2017b). These trends suggest further investigation into Australian adolescent girls and young women’s smoking is warranted.

The Effects of Smoking on Women’s Health: Young Women as an Ideal Target for Intervention.

The concentration of smoking rates among young women is concerning given the significant health risks associated with women’s smoking. Smoking has been causally linked to numerous cancers, such as breast, lung, and stomach, as well as a range of cardiovascular and respiratory diseases (US Department of Health and Human Services, 2014). Compared to men, women face greater risks for developing some of these smoking-related diseases being more likely than men to develop lung cancer when smoking at similar rates (Zang & Wynder, 1996). Women also experience unique smoking-related health risks such as reproductive cancers, infertility, pregnancy complications, osteoporosis, and premature menopause (Ernst, Kaufman, Nichter, Samet, & Yoon, 2000; Samet & Yoon, 2001). For women using oral contraceptives, smoking is associated with additional risks such as adverse cardiovascular effects (Kroon, 2007). Smoking also has a negative impact on
women’s menstrual cycles and is associated with dysmenorrhea, menstrual irregularity, altered ovarian cycles, and hormone levels (Weinberger et al., 2015).

Much of the existing research on women’s smoking focuses on adult women (Graham, 1993; Greaves, 1996), adolescent girls (Haines, Poland, & Johnson, 2009; Macdonald & Wright, 2002; Michell & Amos, 1997), or is specific to smoking during pregnancy (Flemming, Graham, Heirs, Fox, & Sowden, 2013; Gould, McEwen, & Munn, 2011; Graham, Flemming, Fox, Heirs, & Sowden, 2014; Irwin, Johnson, & Bottorff, 2005; Passey, D’Este, & Sanson-Fisher, 2012; Siahpush, Borland, & Scollo, 2002). There is less research on women’s smoking during their late teens and 20s, who demonstrate unique smoking practices. For example, young women aged 25-29 years are more likely to smoke occasionally, compared to adolescent and older women (AIHW, 2017b). Young peoples’ smoking is often shaped by their experiences of a developmental period which is characterised by “considerable flux and transition” as they move between educational and occupational contexts (Wiltshire, Amos, Haw, & McNeill, 2005, p. 614). During their 20s is often the time young people’s smoking habits transition from experimental or recreational smoking to daily smoking; this therefore is an opportune time to provide interventions to prevent the development of lifelong smoking habits (Hammond, 2005). Significantly, if women stop smoking before the age of 30 years, more than 97% of the excess mortality attributed to smoking can be avoided (Pirie, Peto, Reeves, Green, & Beral, 2013). Therefore, increasing the support provided to young women to quit may help them to avoid the long-term health effects of smoking. Given young women’s unique smoking practices, and the benefits of
quitting at a young age, there is a need for further research which specifically examines the experiences of young women smokers in order to develop targeted interventions for this age group.

**Changing Cultural and Historical Meanings of Women’s Smoking in the West**

Cigarettes were originally considered to be an effeminate form of tobacco consumption as they were smaller and milder than cigars and pipes (Sobel, 1978). However, through branding and mass advertising, cigarettes began to be associated with masculinity (Goodman, 1993). With the development of manufacturing machinery in the 1880s, and the distribution of cigarettes during the Crimean and American Civil war, cigarettes became a popular form of tobacco consumption among men in the Western world (Sobel, 1978). During this time cigarettes were predominantly smoked by men. Throughout the first half of the twentieth century, smoking prevalence in Western countries grew substantially (Jha & Peto, 2014) with smoking among men increasing during the First World War. Cigarettes were freely distributed to soldiers for their therapeutic benefits, as they were said to “soothe the nerves”, “deaden loneliness”, and preserve “sanity” (Sobel, 1978, p. 86).

During the same period, smoking among women was often associated with lesbianism, prostitution, and the working-classes (Greaves, 1996). For instance, a woman smoking a cigarette was often used to denote lesbianism in erotic and pornographic imagery (Tinkler, 2006). Rates of women’s smoking increased significantly in the 1920s, as women’s smoking started becoming more acceptable (Chollat-Traquet, 1992). Cigarettes became a signal of the ‘modern’ woman, associated with jazz flappers and film stars (Elliot, 2006). Women’s smoking was
part of a broader movement towards gender equality, as it represented a woman’s right to occupy the same spaces as men, and to enjoy the same pleasures (Tinkler, 2006). Klein (1993, p. 117) describes how, by smoking, women defied traditional understandings of the submissive feminine by “actively giving herself pleasure instead of passively receiving it.” These examples of historical associations between smoking and women’s performances of gender, sexuality, social class, and women’s emancipation highlight the long and complex history of the relationship between women’s smoking, identity, and agency.

Capitalising on the idea that women’s smoking was a symbol of independence and emancipation, tobacco companies began marketing women’s cigarettes as “torches of freedom” (Amos & Haglund, 2000, p. 4). Tobacco companies also began to market “feminised” cigarettes to women; these were long, extra-slim, low-tar, light-coloured or menthol and promoted using fashionable gifts such as bags or underwear (Mackay & Amos, 2003). In cigarette advertising women smokers were represented as youthful, slim, modern, fashionable, and attractive to men (Jacobson, 1981). Tobacco companies also advertised smoking as a method of weight control which would allow women to achieve a slim body – a dominant representation of idealised femininity in Western culture (Amos & Haglund, 2000; Bordo, 2003). In 1930 the American Tobacco Company advertised Lucky Strike cigarettes to women as a way of “refraining from over indulgence” and maintaining a “modern figure” (see Figure 1). Cigarette advertising, women’s magazines, and medical professionals also recommended smoking as a way for women to manage caring and domestic responsibilities, such as housework or childcare (Tinkler, 2006).
These associations between smoking, thinness, and domesticity constructed women’s smoking as a marker of feminine “respectability” (Skeggs, 1997). Greater opportunities and fewer economic and social restrictions for women during the Second World War also contributed to a substantial rise in the number of women who smoked, which continued for several decades (Graham, 1993).

![Image](http://tobacco.stanford.edu)  

The “mixed messages” that surround women’s smoking.

Throughout the 1950s, information about the effects of cigarette smoking on health began to be made publicly available (Sobel, 1978). In response, anti-smoking groups and governments in Western countries worked to ban cigarette advertising and began disseminating individualised health promotion campaigns which worked to reposition cigarettes as a harmful drug, and smokers as addicts (Lupton, 1995). Information about the health effects of smoking, and the introduction of tobacco denormalisation strategies, led to smoking becoming increasingly stigmatised (Thompson, Pearce, & Barnett, 2007). Consequently, smoking prevalence began to decrease rapidly among men first, and then, more slowly among women (Lopez, Collishaw, & Piha, 1994; Morley & Hall, 2008). This led to a convergence in rates of women’s and men’s smoking in several Western countries (Hitchman & Fong, 2011), with little difference now noted in the number of young men and women who smoke, in a number of countries (Global Youth Tobacco Survey Collaborating Group, 2003).

Anti-smoking initiatives have set out to challenge the association between women’s smoking and femininity (Tinkler, 2006), through the construction of young women’s smoking as a health risk, a threat to social order, and a transgression of normative femininity (Jackson & Tinkler, 2007). Notions of smoking and feminine glamour were challenged in anti-smoking campaigns which presented visual archetypes of older women smokers as wrinkled and ugly due to their years of smoking. Meanwhile, non-smoking women were represented as beautiful supermodels such as Brooke Shields, Christy Turlington, and Tyra Banks (Haines-
In Australia, in 2014, young women’s smoking was the target of an anti-smoking campaign, featuring the 2009 Miss Universe Winner Rachael Finch (Figure 3). The campaign warned “If you smoke your future’s not pretty” and featured images of young women prematurely aged by the effects of smoking that included wrinkles, damaged grey hair and stained teeth. This campaign challenged the positive association between smoking and feminine beauty portrayed in cigarette advertising, but also reinforced the idea young women’s beauty is more important than their health (Haines-Saah, 2011).

However, despite regulations on cigarette advertising, smoking continued to be positively promoted through visual media such as films and television, and through tobacco industry advertising in women’s magazines (Jacobson, 1981), and women’s smoking continues to be represented positively as luxurious, glamorous, and fun in women’s magazines today (Kasujee, Britton, Cranwell, Lyons, & Bains, 2017). For instance, last year Kendell Jenner, one of the world’s most influential models posed with a cigarette for Love magazine (see Figure 2). This photograph highlights how young women’s smoking continues to be associated with celebrity, heterosexual appeal, and thinness. The juxtaposition of models as smokers in magazines and models as non-smokers in anti-smoking advertisements highlights the mixed messages that continue to surround young women’s smoking in a contemporary Western cultural context.
Two media stories exemplify the current ambiguous status of young women’s smoking in Australia, and how it plays out through visual mediums. In the first story, in May 2014, news outlets published photographs of 22-year-old Frances Abbott smoking with her boyfriend outside a party for an international luxury fashion label in Melbourne (Figure 4). Frances is the daughter of Tony Abbott, who was the Australian Prime Minister at the time. Tony responded, publicly denouncing his daughter’s behaviour and said “I don’t approve”. Tony described Frances as someone who “likes a social cigarette on special occasions” and said, “if you want to relax with a cig, it’s a free country” (Chesterton, 2014).

In the second story in July of 2014, Emily Scott, a 30-year-old Australian model, posted a “selfie” photograph of herself smoking on the social media platform Instagram (Figure 5). Emily deleted the photograph after she received criticism from followers who commented, “Nothing hot about this”, “Pretty poor role model. Gross” (Associated Press, 2014).
These two stories illustrate some of the contradictions surrounding young women’s smoking. Although the images of Frances and Emily smoking capture an association between smoking and glamour, fashion, and sexual attraction, the public responses to these events reveal the stigma that also surrounds young women’s smoking. These photographs, and the smoking and anti-smoking advertisements discussed throughout this section, highlight the pivotal role that visual imagery has in shaping our understandings of young women’s smoking – a relationship which researchers have begun to explore (see Haines, 2008; Tinkler, 2006).
The changing perceptions of women’s smoking throughout the twentieth century highlight the social and cultural specificity of meanings surrounding women’s smoking. For this reason, I adopt a social constructionist epistemological approach in this thesis (outlined in detail in Chapter Two). This approach allows me to consider how young women’s constructions and experiences of smoking are shaped by broader social and cultural discourses. In the next section I adopt this social constructionist lens and review existing literature on smoking and young women in relation to the performance of identity, negotiations of smoking-stigma, understandings of risk, and experiences of quitting.

**Cigarette Smoking and the Performance of Identity**

Within social constructionist and poststructuralist theoretical frameworks, cigarettes and smoking have been conceptualised as tools for constructing or performing identity (Banwell & Young, 1993; Gilbert, 2007b; Plumridge, Fitzgerald, & Abel, 2002; Scheffels, 2009). Within social constructionism and poststructuralism, identity is understood not as something you acquire, but as something you continually “do” (Butler, 1993, 2006). Identity performances are made up of “stylised acts” such as bodily gestures and movements (Butler, 1993; Lloyd, 1999) which are presented to others through social interactions. The term “performativity” is used to emphasise the repetition of these performances, which creates an illusion of a stable and fixed gender identity to the individual performer as well as those around them (Bradley, 2013). However, the on-going nature of these performances renders identity incomplete, and open to resignification and the possibility of being “undone” (Butler, 2004; Lloyd, 1999).
Among young women, smoking is often used to perform social identities that are valued by peers. In this context, smoking is an informal source of social currency (Cullen, 2010) and cultural capital (Haines et al., 2009) which allows them to gain approval and status (Gilbert, 2007a). Cigarettes have been conceptualised as a “prop” (Banwell & Young, 1993; Goffman, 1959; Scheffels, 2009), or a fashion accessory, which allows young women to project an image of autonomy and confidence (Wearing & Wearing, 2000).

Young women demonstrate unique social behaviours in relation to smoking such as sharing cigarettes and cigarette packets among friends, and smoking in groups (Amos & Bostock, 2007; Nichter et al., 2006). The desire to “fit in” socially is important for young women smokers, and smoking provides them with a sense of belonging, a way of connecting, bonding, and developing a network of friends (Seguire & Chalmers, 2000b) which can also lead them to continue smoking for fear of compromising friendships (Seguire & Chalmers, 2000b). Given that friendship is highly valued by young women (Griffiths, 1995), and social acceptance has important implications for their well-being (Hartup, 1996), young women’s smoking can be understood as adaptive and functional (Seguire & Chalmers, 2000b). For example, young Australian Aboriginal women, talking about how their smoking is tied to their Aboriginal identities and group membership, describe it as “a way of belonging, not of rebelling” (Passey, Gale, & Sanson-Fisher, 2011, p. 1).

Young women’s use of smoking in performances of social identity relates to their social positioning. For example, Michell and Amos (1997) found that young women who smoke are often at the top of the pecking order, demonstrate a high-level
of social skills, and project an image of high self-esteem. Girls at the bottom of the pecking order are seen to have poor social skills and low self-esteem, and smoking is seen to be a way to aspire to a higher social status (Michell & Amos, 1997). By demonstrating bodily competence in holding and ashing\(^1\) cigarettes, young women can acquire the status of a “real smoker”, and make distinctions between themselves and other, less experienced smokers (Haines et al., 2009).

For young women, smoking is thereby often a way of “performing coolness” (Banwell & Young, 1993; Plumridge et al., 2002). Young men construct “cool” social identities through physical activity and sport, which acts as a potential protective factor against taking up smoking (Fry, Grogan, Gough, & Conner, 2008; Michell & Amos, 1997; Plumridge et al., 2002; Wiltshire et al., 2005). Whereas, young women have fewer resources with which to position themselves as cool, as sport and exercise are often seen to be less feminine. This means they do not have this same excuse to refuse cigarettes and may experience greater social pressure to take up smoking (Banwell & Young, 1993; Fry et al., 2008).

Decades of tobacco denormalisation has worked to reconfigure smoking and smokers as “antisocial” (Keane, 2016), and smokers have become discursively and spatially relocated to marginalised spaces (Collins & Procter, 2011). These restrictions and regulations have reduced the social utility of cigarettes and made positive smoking social identities “difficult to perform” (Keane, 2014, p. 13).

\(^1\) The process of removing ash from a cigarette
The performance of femininity among young women smokers.

Smoking has also been conceptualised as a tool for young women to perform feminine gender identities, and a way of “doing gender” as an everyday practice (C. West & Zimmerman, 1987). For example, young women can be seen as constructing and performing femininity through the holding and ashing of cigarettes in a “showy” style (Gilbert, 2007b). Young women can also use smoking to subvert notions of femininity by adopting masculine smoking practices, such as dangling a cigarette in one’s mouth, to perform a butch lesbian or bisexual identity (Tinkler, 2006).

Feminist theory has also explored the construction of young women’s feminine identities through consumer culture (McRobbie, 2008). For example, young women purchase cigarettes in long, slim, lightly coloured packets (Gilbert, 2007b), and distinguish between cigarette brands which are suitable for “boys” and “girls” (Banwell & Young, 1993).

Smoking is used by young women to perform a central aspect of femininity – a thin body. A thin body is central to notions of idealised femininity and is seen to be a marker of feminine qualities such as heterosexual attractiveness, containment, and control (Bordo, 2003). Although the thin-ideal remains prevalent, women are also exposed to other body ideals such as “athletic” and “curvy” (Betz & Ramsey, 2017). Despite attempts to resist these ideals, women objectify their bodies (Betz & Ramsey, 2017). According to objectification theory, women’s internalisation of these ideals can influence feminine subjectivity and result in distress (Fredrickson & Roberts, 1997), and this distress is now normalised in Western societies (McRobbie, 2009).
The importance that young women place on being thin predicts future smoking (Honjo & Siegel, 2003), and body dissatisfaction is associated with increased odds of smoking initiation in both women and men (Howe et al., 2017). However, the use of smoking as a method of weight control is seen as “a specifically female thing to do” (Grogan, Fry, Gough, & Conner, 2009, p. 182). Body shame is a predictor of young women’s use of smoking to control weight, and those who smoke are more likely to report higher levels of objectified body consciousness (Fiissel & Lafreniere, 2006). Compared to women who smoke, women “never smokers” score higher on resistance to gender pressure scales – which suggests that feminist consciousness may serve as a protective factor against smoking (Zucker, Stewart, Pomerleau, & Boyd, 2005). These findings indicate that hegemonic notions of femininity contribute to women’s smoking, while the possession of power and the ability to be agentic may allow women to not smoke.

Nicotine contained in cigarettes has been found to reduce appetite (Mineur et al., 2011). Some research has suggested that young women take up smoking to reduce their appetite (Grogan et al., 2009), although other research questions how commonly this strategy is used by young women (Nichter et al., 2004). Women also report significant concerns relating to weight gain when quitting smoking, concerns which are often absent among men (Alexander, Frohlich, Poland, Haines, & Maule, 2010; Grogan et al., 2009). This discussion makes evident the importance of weight control in relation to young women’s smoking. However, there is an absence of research which considers young women’s smoking and weight control in relation to performances of feminine gender identities.
Young people’s accounts of their smoking are characterised by plurality and complexity (Ioannou, 2003), ambivalence and contradiction (Allbutt, Amos, & Cunningham-Burley, 1995), particularly for young women. Scheffels (2009) describes how young people have a “split vision” in relation to their smoking, where positive meanings associated with smoking being “cool” contradict the stigma that now surrounds smoking. For example, young women report smoking both enhances and compromises the ways in which they appear to others (Banwell & Young, 1993). Young women continue to see smoking as glamorous and fashionable (Gilbert, 2007a). However, they are also concerned about how smoking may compromise their appearance and their ability to attract men because of the impact of smoking on their skin, and the smell of smoke on clothing and bodies (Alexander et al., 2010; Amos & Bostock, 2007; Banwell & Young, 1993). Young women’s smoking is also considered to be simultaneously both sexy and “slutty” or “tarty” (Banwell & Young, 1993; Fry et al., 2008), while men’s smoking appears to reinforce their performances of hegemonic masculinity (Alexander et al., 2010; Nichter et al., 2006).

The contradictory constructions of women’s smoking, these “mixed messages”, can result in women experiencing significant dissonance between their gender identities and their smoking (Alexander et al., 2010). This begs the question; how do young women make sense of these contradictory representations of smoking as feminine and unfeminine? In the next section I consider how these changing perceptions of smoking have led to the stigmatisation of smoking, particularly among women.
**Tobacco Denormalisation and the Stigmatisation of Smoking**

The concept of stigma was popularised by Erving Goffman, who defined it as “an attribute that is deeply discrediting”, which reduces a person by “tainting” their identity (1986, p. 3). Much of the stigma associated with smoking relates to negative aesthetic markers, such as a stale smell, premature aging, stained fingers and teeth, and the perception of poor personal hygiene (Farrimond & Joffe, 2006). Smokers are often positioned as outcasts, polluters, anti-social (Farrimond & Joffe, 2006), excessive users of public health services, and an employment liability (Chapman & Freeman, 2008).

There are several ways in which the stigmatisation of smokers occurs (Wigginton, Morpheit, & Gartner, 2016). For instance, stigma is enacted interpersonally, as is the case when disapproval is expressed by family and friends (Stuber, Galea, & Link, 2008), or strangers (McCool, Hoek, Edwards, Thomson, & Gifford, 2013). Smokers also internalise stigma or self-stigmatise (Evans-Polce, Castaldelli-Maia, Schomerus, & Evans-Lacko, 2015; Ritchie, Amos, & Martin, 2010). A further way in which stigma is experienced by smokers is through broader social attitudes and structural policies. For example, some companies refuse to hire smokers (Stuber et al., 2008), or medical professionals might refuse to treat smokers (Pawlik, Olver, Storm, & Rodriguez, 2009).

In countries with advanced tobacco controls, such as Australia, anti-smoking legislation and tobacco denormalisation policies have increased smoking-related stigmatisation (Chapman & Freeman, 2008). Examples of this include, campaigns that use the notion of “passive” or “second-hand” smoking to position people who
smoke as a risk to others (Chapman & Freeman, 2008), and policies that legislate to remove smoking from public spaces (Bayer, 2008). Emerging evidence of the dangers of third-hand smoke has worked to further position smokers as a source of risk to others (Matt et al., 2011).

**Is stigmatisation an efficacious or ethical method of tobacco control?**

Citing the public health ethos of utilitarianism, arguments have been made to mobilise stigma as a tool for reducing overall tobacco consumption (see Bayer, 2008). Smoking stigma is reported to contribute to individual reductions in smoking and increased rates of cessation (Evans-Polce et al., 2015). Research has shown that rates of smoking are lower in areas where the public holds relatively unfavourable sentiments toward smoking (Kim & Shanahan, 2003). Although the denormalisation of smoking has led some smokers to quit, consideration must be given for those smokers who continue to smoke in an anti-smoking climate (Bell, McCullough, Salmon, & Bell, 2010).

Smokers are almost universally aware of smoking stigma and respond to it a variety of ways (Wigginton et al., 2016), usually either agreeing, disagreeing or challenging stigma (Evans-Polce et al., 2015; Hefler & Carter, 2017). Smokers also distance themselves from stigma by applying it to “other” smokers (Ritchie et al., 2010). Individually, smoking stigma can have negative implications for subjectivity and practices, resulting in feelings of shame, devaluation, guilt, embarrassment, and stress (Antin, Annechino, Hunt, Lipperman-Kreda, & Young, 2016; Evans-Polce et al., 2015). Smoking stigma can also lead to a loss of social status in public places, and smokers avoiding stigmatising environments (Ritchie et al., 2010).
Stigmatisation may lead smokers to conceal or keep their smoking status secret from family, employers, or health care providers (Antin et al., 2016) and/or limit their access to healthcare and inhibit smoking cessation efforts in primary care settings (Bell, Salmon, Bowers, Bell, & McCullough, 2010). For example, smoking-related stigma may lead cancer patients to delay seeking treatment (Chambers et al., 2012). Stigma may make smokers resistant to cessation, and stigmatised smokers often resume smoking after quitting (Evans-Polce et al., 2015).

Smoking-related stigma also has wider social implications and is involved in the production and reproduction of social class (Thompson et al., 2007). Widening socioeconomic differentials in smoking rates means smoking has become more commonly associated with unemployment, low socioeconomic status, and low educational achievement (Chapman & Freeman, 2008). Stigmatisation is less effective in reducing smoking amongst socially disadvantaged groups however (Bell, Salmon, et al., 2010). For example, higher socioeconomic smokers are more likely to challenge stigma, while lower socioeconomic smokers are more likely to internalise stigma and see themselves as outcasts (Farrimond & Joffe, 2006). The shaming of lower class, minority smokers may lead to a multiplication of stigmatisation for these groups, further isolating them, socially and geographically, and acting as demotivation for smoking cessation (Farrimond & Joffe, 2006; Graham, 2012; Scheffels, 2009). This contributes to what researchers term “smoking islands”, or the dual or multiplying stigmatisation of disadvantaged smokers (Graham, 2012; Thompson et al., 2007).
Examining stigma using an intersectional framework.

The studies reviewed above have examined the impact of smoking stigma on marginalised groups, but often focus on a single marginalised identity, such as gender or social class. Working within an intersectional framework, the concept of “intersectional stigma” allows us to develop a more comprehensive understanding of how smokers experience stigma. Intersectional stigma refers to the process by which identity and inequality work to multiply and compound the stigmatisation experienced by marginalised groups (Berger, 2010). The concept was originally used to analyse women’s experiences of multiplying stigma in relation to HIV, where the stigma of HIV was compounded by drug use, sex work, as well as gender, social class, ethnic and sexual orientation identities (Berger, 2010; Logie, James, Tharao, & Loutfy, 2011).

Intersectional stigma, also referred to as stigma layering, has been identified in women’s accounts of the overlapping stigma associated with mental illness (Mizock & Russinova, 2015), and the “constellation of stigmas” experienced by women who do dominatrix sex work (Levey & Pinsky, 2015). In relation to smoking, there is potential for the heightened stigmatisation of several conflated stigmatised and marginalised groups, such as smokers with a mental health diagnosis (Brown-Johnson et al., 2015), or poor, young, single mothers (Farrimond & Joffe, 2006; Goodwin & Huppatz, 2010). The next section explores experiences of intersectional smoking-related stigma among women.
Women’s experiences of intersecting smoking-related stigma.

Women experience higher levels of smoking-related discrimination than men (Antin et al., 2016; Brown-Johnson et al., 2015; Ritchie et al., 2010) and it is argued that women who smoke “rarely appear in a positive light” (Farrimond & Joffe, 2006, p. 487). In particular, young women’s smoking is seen to be “not as cool” as men’s (Nichter et al., 2006, p. 224). The stigmatisation of women’s smoking relates to the positioning of women’s smoking as unfeminine, as discussed earlier in the chapter, such as the perception that women’s smoking is unattractive, symbolic of a lack of control, and excessive sexuality (Antin et al., 2016). Women’s experiences of smoking-related stigma are also shaped by other intersecting identities which can compound the stigma associated with their smoking. For example, tobacco denormalisation policies may result in additional stigma for low income women (Greaves & Hemsing, 2009) and young working-class women face additional stigma for their smoking due to intersecting gender and social class identities, and notions of acceptable femininity and respectability (Scheffels, 2009).

Women’s experiences of smoking stigma are also shaped by culture. For example, the stigma associated with women’s smoking is amplified in an Asian context (Tan, 2013). In Indonesia, women who smoke are perceived to be morally flawed, while smoking among men is accepted and widespread (Barraclough, 1999). A similar double standard exists in Vietnam, where women’s smoking is seen to be inappropriate, while smoking among men is normalised (Morrow, Ngoc, Hoang, & Trinh, 2002). Among young Black women in the United States, experiences of
smoking and stigma can compound racial oppression and discrimination, and
reinforce smoking (Antin et al., 2016).

Women’s roles as mothers lead them to experience additional smoking-
related stigma. Women with children who smoke are often seen as bad mothers
(Hookway, Elmer, & Frandsen, 2017; Wigginton & Lee, 2013), largely due to the
negative health effects associated with smoking during pregnancy and second-hand
smoke exposure to children (US Department of Health and Human Services, 2014).
Mothers wear a disproportional amount of blame and social censure for parental
smoking (Farrimond & Joffe, 2006). This is compounded by the lack of medical
attention on the impact of men’s smoking on fertility and the health of the foetus, and
an absence of smoking cessation programmes targeted at fathers (Samet & Yoon,
2010).

Smoking during pregnancy has been described as smoking’s “greatest social
censure” (Tinkler, 2006, p. 215). Anti-smoking messages directed at pregnant
women are often foetus-centric and neglect women’s experiences of pregnancy and
motherhood (Oaks, 2000). These messages reinforce the notion that women are the
“moral guardians” of their children’s health (Madden & Chamberlain, 2004), and
little emphasis is placed on the woman’s own health, independent to her role as a
mother (Lupton, 1995). Problematically, the overwhelming focus on women’s
smoking during pregnancy has the potential to lead women to believe smoking
outside of pregnancy is less problematic, and to delay quitting until they become
pregnant (Jacobson, 1981). Also, the stigma surrounding smoking during pregnancy
leaves women’s experiences “untellable” which restricts their ability to seek support in relation to their smoking (Wigginton & Lafrance, 2015).

Smoking during pregnancy is more common among women experiencing social and economic disadvantage (Hiscock, Bauld, Amos, Fidler, & Munafò, 2012), such as lower education and lower household income (Martin et al., 2008). Existing research of public health discourses of maternal responsibility identifies the potential for women of colour, single mothers, and women living in poverty to be further marginalised and stigmatised for behaviours such as smoking (Bell, McNaughton, & Salmon, 2009). While previous research has identified the ways women’s identities intersect to shape and potentially amplify experiences of smoking-related stigma, more research is needed in this area; this is one of the aims of this thesis.

In this section I have discussed the stigmatisation of smoking, how it relates to social class, and reviewed research which looks at women’s experiences of smoking-related stigma in relation to gender, social class, culture and motherhood. I have highlighted how identities intersect to shape young women’s experiences of smoking stigma, and what impact this has on subjectivity and practice. As mentioned at the start of this section, much of the stigma associated with smoking relates to the perception smokers knowingly expose themselves and others to risk. The next section reviews literature on smokers’ knowledge of the health risks associated with smoking, and the way they make sense of these risks.

**Neoliberal Understandings of Smoking, Risk, Responsibility, and Gender**

Contemporary Western societies are increasingly defined by greater uncertainty and an increased preoccupation with identifying and managing risks,
such as smoking (Beck, 1992; Giddens, 1991). Current understandings of smoking and risk in Western societies have been shaped by neoliberalism and “healthism” discourse (Ayo, 2012). Neoliberalism broadly refers to a turn towards ideologies of individualism and choice, and the adoption of policies that promote a minimalised state and the deregulation of the market (Larner, 2000). In this context, a discourse of healthism posits that individuals are ultimately responsible for their own health (Greco, 1993); smokers are thereby positioned as autonomous and rational actors, and are expected to be calculative, and prudent, with respect to risk and danger (Lupton, 1995). It is expected that, once armed with the information about the risks, a “responsible smoker” will use self-surveillance and self-help to manage these risks and quit smoking. Smokers who choose to ignore or fail to avoid the risks and quit smoking are deemed ignorant, irrational, irresponsible, and lacking in self-control and will power (Lupton, 1995).

Constructions of smoking and risk are also gendered. For instance, young women’s smoking is represented in the media as being particularly dangerous and risky (Jackson & Tinkler, 2007). This, in part, relates to the health risks associated with second-hand smoke and smoking during pregnancy, and women’s primary roles in reproduction and child-rearing (Jackson & Tinkler, 2007), as discussed in the previous section on the stigmatisation of women’s smoking. Young women have been described as experiencing a “multiple burden of risk”, where risky activities such as smoking present a risk to their health, as well as a risk to their reputations as respectable women (Green & Singleton, 2006, p. 864). Additional research is needed
to understand how young women negotiate this multiple burden of risk in relation to smoking.

**Smokers’ understandings of smoking-related health risks.**

Most smokers are aware that smoking carries health risks such as lung cancer, heart disease and strokes (Siahpush, McNeill, Hammond, & Fong, 2006), but knowledge about how smoking uniquely effects women’s health is limited. For example, it has been reported that women have significantly less awareness of the health risks of smoking which are specific to them, such as osteoporosis (Roth & Taylor, 2001). Young women and men have also been reported to understand smoking-related risk differently. For example, girls perceive the mortality risk of smoking to be greater than boys but perceive the addictiveness of smoking to be less than what boys perceive (Lundborg & Andersson, 2008). This suggests that young women have unique understandings of smoking-related health risks. Young women smokers are also often dismissive of these risks, saying they have “heard it all before”, and “everybody’ knows about the dangers of smoking” (Banwell & Young, 1993, p. 381), and both young women and men position themselves as an “informed generation”, who are knowledgeable about the effects of smoking on health (Stjerna, Lauritzen, & Tillgren, 2004, p. 578).

Smokers, given their awareness of the potential health risks, must account for their continued smoking. However, understandings of smoking and risk are not considered in isolation but are interwoven with, and experienced alongside, other aspects of health. For example, smokers may compensate for the risks of their smoking by engaging in other health promoting behaviours, such as a “healthy” diet
Another way smokers make sense of their health risks is by constructing smoking as a “lesser evil” in relation to other “risky” activities such as alcohol and other drugs (Gough, Fry, Grogan, & Conner, 2009; Romer & Jamieson, 2001b). Anti-smoking campaigns are often ineffective at targeting young women, as they fail to consider the social context in which smoking takes place and the ubiquity of risk in young women’s everyday lives (Gilbert, 2005). There is a growing need then for further understandings around how social context shapes the way young women make sense of the risks of their smoking.

Although young people acknowledge the general risks of smoking, these risks are said to be reinterpreted at the individual level (Stjerna et al., 2004), and they distinguish between their own smoking behaviours, and those of others (Allbutt et al., 1995). Smokers may adopt self-exempting beliefs, which work to deny a personal vulnerability to the negative health effects of smoking (Chapman, Wong, & Smith, 1993). For example, many smokers believe they have a lower risk of developing lung cancer than the average smoker (Weinstein, Marcus, & Moser, 2005).

When young adults start smoking, they often position their smoking as temporary, underestimating the addictiveness of tobacco and overestimating their ability to quit (Romer & Jamieson, 2001a). Consequently, they see themselves as immune to the risks faced by long-term smokers (Denscombe, 2001; Gough et al., 2009). For young women, this immunity is compounded by their high rates of non-daily, social, or very light smoking; this may lead them to believe their smoking is not addictive and does not carry the significant risks associated with heavy smoking (Li, Holahan, & Holahan, 2015; Schane, Glantz, & Ling, 2009b). There is a need for
further research on occasional smoking as it makes up a significant portion of young women’s smoking behaviour, and presents a challenge to traditional binary categorisations of smokers and ex-smokers or non-smokers (Keane, 2016).

Focusing on the perceived benefits of smoking is another way smokers account for the health risks associated with smoking (Gough et al., 2009; Helweg-Larsen, Tobias, & Cerban, 2010). The pleasures of smoking, in part, relate to its temporal effects (Keane, 2002). The act of smoking creates a sense of time and space as it is “not considered doing anything, but neither is it doing nothing” (Keane, 2002, p. 107). Smoking also symbolises a “letting go” of control, and a release from the pressure to conform to health norms (Scheffels & Schou, 2007), particularly for women who are subject to strict health expectations (Alexander et al., 2010). For example, engagement in smoking, without parental approval, can provide a sense of pleasure for young women (Banwell & Young, 1993) and offer symbolic adult status for young women struggling to gain autonomy and independence at home and at work (Daykin, 1993). Additionally, women see their smoking as benefiting them socially, providing them with support, comfort, companionship, and offering both predictability and consistency (Greaves, 1996).

Smoking is also positioned by women as helping them to emotionally manage negative feelings, such as stress and anxiety (Copeland, 2003; McDermott, Dobson, & Owen, 2006; Seguire & Chalmers, 2000b; Torres & O’Dell, 2016), and boredom (Banwell & Young, 1993; Haines, 2008), as well as helping to elicit positive feelings (Greaves, 1996). Hilary Graham’s (1993) seminal research, carried out in England in the 1980s, found women used smoking to cope with experiences of stress, unstable
housing, being reliant on benefits, sole caring of children, limited community support, and poor mental and physical health. More recent research has shown smoking continues to be used as a way of coping with adversity, with some women using smoking to mediate psychological distress brought on by adverse childhood experiences (Strine et al., 2012). Moreover, for young smokers, the social and psychological benefits of smoking are immediate, and may thus outweigh what are perceived to be long-term risks (Hoek, Hoek-Sims, & Gendall, 2013).

The use of smoking as a way of coping may be more common among women, with studies showing young women may be more likely to use smoking to manage depressive symptoms than young men (Liss-Levinson, 2010). For young Aboriginal women, experiences of marginalisation can contribute to present orientated pleasure seeking through smoking (Passey et al., 2011). These studies indicate emotional coping is an importance component of young women’s smoking, which is often compounded by experiences of poor mental health and cultural marginalisation.

The studies reviewed in this section highlight young women’s unique experiences and understandings of smoking risks, and the need for further investigation. Given the known health risks of smoking, the responsible smoker is expected to make attempts to quit. In the next section I examine research on constructions of quitting smoking, women’s experiences of quitting, and understandings of addiction, choice, agency, willpower, and what is means to be an “ex-smoker”.
Constructions of Quitting Smoking

Given the known risks of smoking, it is unsurprising that more than half of those who smoke report they are interested in quitting (Babb, Malarcher, Schauer, Asman, & Jamal, 2017), and most have made attempts to quit, cut down or reduce the harm associated with their smoking (AIHW, 2014b). The cost of smoking and the effect of smoking on health are common reasons smokers give for wanting to quit (AIHW, 2014b). However, other smokers are less interested in quitting, and position their smoking as unproblematic and “no big deal” (Farrimond, Joffe, & Stenner, 2010; Scheffels & Schou, 2007), citing enjoyment and relaxation as reasons for not wanting to quit (AIHW, 2017a). For “proud smokers”, those who positively evaluate smoking and adopt positive smoking identities, quitting is often a low priority (Farrimond et al., 2010), with many smokers reporting that they feel they “ought” to quit rather than “wanting” to (Uppal, Shahab, Britton, & Ratschen, 2013). This suggests the way individuals position themselves in relation to smoking has implications for their quitting practices.

The process of stopping or “quitting” smoking has become medicalised and commodified, which has resulted in the development of a range of psychological interventions and pharmacological treatments that assist with quitting smoking (Chapman & MacKenzie, 2010). These treatments include, but are not limited to, pharmacotherapies, such as nicotine replacement therapy (NRT) in the form of patches, sprays, gums, inhalers and lozenges, medications such as Champix, counselling, and group interventions (McEwen, Hajek, McRobbie, & West, 2006). It has been argued the medicalisation of smoking cessation has contributed to an
absence of research into the most common way smokers prefer to quit – unassisted (Morphett, Partridge, Gartner, Carter, & Hall, 2015; A. L Smith & Chapman, 2014).

In Australia, the most common activities used by smokers to help them quit or cut back are; going cold turkey (sudden and abrupt cessation), discussing smoking and health at home, and using nicotine gum, patches or an inhaler (AIHW, 2017a). There has also been a partial de-medicalisation of smoking cessation, with the advertising of over-the-counter NRT products, which construct quitting as an everyday practice (Keane, 2013). Therefore, the smoker is now positioned as both an addict in need of medical intervention, as well as a rational consumer, responsible for quitting (Keane, 2013). Despite acknowledging the stressful life circumstances that maintain their smoking, smokers often view themselves as individually responsible for quitting (Pateman et al., 2016), a view which is reinforced in smoking cessation campaigns (Frohlich, Mykhalovskiy, Poland, Haines-Saah, & Johnson, 2012). This positioning means that people who continue to smoke are often stigmatised and seen to be making morally questionable choices (Frohlich et al., 2012).

Women’s experiences of quitting smoking.

Some studies, particularly those conducted in clinical settings (Bohadana, Nilsson, Rasmussen, & Martinet, 2003), show that women have less success with cessation (P. H. Smith et al., 2015), however, other, population-based studies, show there is little difference in cessation rates among women and men (Jarvis, Cohen, Delnevo, & Giovino, 2013). Men often express less urgency to quit smoking but report having greater agency over their smoking; in contrast, women express a greater sense of urgency to quit, but less agency in doing so (Alexander et al., 2010).
Compared to men, women are more responsive to non-nicotine factors that relate to smoking, such as smoking cues, and the physical sensation of smoking (Allen, Oncken, & Hatsukami, 2014). This finding relates to research which shows that women tend to have more success with non-nicotine medications and behavioural interventions, compared to nicotine replacement therapies (Allen et al., 2014).

Socialising with other smokers and alcohol consumption are common causes of relapse among smokers (Burton, Hoek, Nesbit, & Khan, 2015). Women face unique barriers in quitting smoking. They include income instability, stress, and a lack of psychosocial support (Lacey et al., 1993; Stewart et al., 2011). The use of smoking to control weight and trait anxiety are predictors of relapse among women following a quit attempt, but not for men (Westmaas & Langsam, 2005). Women with less social and economic resources also face additional barriers in quitting and have less chance of successful smoking cessation (Amos, Greaves, Nichter, & Bloch, 2012) as quitting requires access to resources such as rewards to substitute the benefits of nicotine, and healthier sources of stress-relief (Jensen, 1994). The influence of an immediate social network, such as partners, family and friends, is less effective in helping women reduce their smoking compared to men whose quit attempts are more positively supported by these social influences (Westmaas, Wild, & Ferrence, 2002). However, social support seeking is negatively associated with smoking on the day men quit but the opposite relationship is reported by women (Westmaas & Langsam, 2005). These studies highlight the differing effects of social support on women’s quit experiences.
Young women smokers also report unique cessation experiences. Young women often express feelings of regret and negativity in relation to their smoking (Seguire & Chalmers, 2000b); while describing the need to quit – they often position this as a future event (Moffat & Johnson, 2001). Like most smokers, the cost of tobacco, physical fitness, and information about the health hazards are the most common reasons given by young women for wanting to quit (Villanti, Bover Manderski, Gundersen, Steinberg, & Delnevo, 2016). However, despite being highly motivated to quit, young women often report a sense of hopelessness in relation to the difficulty of quitting (Copeland, 2003). They report significant social, emotional, and physiological “costs” incurred for quitting smoking (Seguire & Chalmers, 2000a). These include the loss of a desired image, a way to bond with others, the loss of a method of relaxation and stress reduction, and the potential for nicotine withdrawal (Seguire & Chalmers, 2000a).

Young women may also face unique barriers in quitting that relate to the effects of their menstrual cycle on smoking withdrawal symptoms (Perkins, 2001). For these reasons young women are often reluctant to engage with smoking cessation programmes, saying they prefer to quit on their own, or with the support of a friend (Weiss et al., 2010), or family (Seguire & Chalmers, 2000b). The tendency for young people to not see themselves as addicted to smoking, and to perceive nicotine replacement therapy and cessation supports as more suited to older, addicted smokers may explain this preference (Amos, Wiltshire, & Haw, 2006). It also emphasises the influence of addiction and choice discourses on young smokers’ quit attempts.
**Addiction, choice, agency, and willpower.**

The tobacco industry constructs smokers as free-willed individuals exercising consumer choice, who have the willpower to quit smoking at any point in time (C. White et al., 2013). Conversely, public health discourse often constructs the smoker as a non-agent, as a passive victim of tobacco addiction (Macnaughton, Carro-Ripalda, & Russell, 2012). This construction of the smoker as an addict may lead non-smokers to be more empathic and non-judgemental towards smokers (McCool et al., 2013). Smokers may take up the position as “addicts” (Farrimond et al., 2010), often describing their addiction to smoking as psychological and habitual, rather than biological (Uppal et al., 2013; Wigginton et al., 2016).

However, despite the popularity of brain disease models of addiction, the concept of choice in relation to quitting holds strong with smokers. This may lead smokers to often rejecting the notion of addiction, instead positioning themselves as “in control” of their smoking (Farrimond et al., 2010; Scheffels & Schou, 2007). Many young people reflect this position, describing their smoking as a “personal choice” (Denscombe, 2001). Young people’s reluctance to describe themselves as “full-fledged” addicted smokers, leads them to describe smoking in relation to other aspects of dependence, such as socialising, pleasure, empowerment, and emotions (J. L. Johnson, Bottorff, et al., 2003).

Despite their opposing constructs of smokers, both the tobacco industry and public health bodies also position quitting smoking as a matter of self-discipline, self-control, and willpower (C. White, Oliffe, & Bottorff, 2013). Consequently, only smokers “committed” to cessation are deemed worthy of support (Wigginton et al.,
2016, p. 8). These attitudes are reflected in the accounts of young people, who view willpower as an effective quitting strategy (Amos et al., 2006). In relation to smoking, willpower is constructed as a masculine trait, with men often positioned as being more in control of their bodies, and therefore better able to control their smoking than women (C. White et al., 2013). This relates to a broader understanding of agency as a trait often associated with masculinity (Conway, Pizzamiglio, & Mount, 1996).

These gendered notions of willpower, agency and quitting are evident in the accounts of young people; while young women describe self-motivation as important to their cessation success (Seguire & Chalmers, 2000b), young people perceive young men as being “in control” of their smoking, and young women as “out of control” (Nichter et al., 2006). Similar accounts of gendered agency are given by smokers themselves, with women expressing a lack of agency over their smoking and men describing having agency and the ability to quit smoking (Alexander et al., 2010). This gendered agency in relation to smoking is then reinforced by smoking research which explores women’s vulnerability to taking up smoking and difficulties with smoking cessation, which Keane (2002, pg. 106-7) argues has constructed women “as motivated by lack, while leaving the male smoker unmarked and unproblematised.”

These contradictory concepts of indulgence, agency, control, addiction and abstinence, are evident in smokers’ accounts of smoking and quitting (Hughes, 2009; Nachtigal & Kidron, 2015), particularly among women who smoke (Gillies & Willig, 1997). For example, teenage girls offer contradictory accounts of
“invincibility” and being in control of their smoking, and of unanticipated addiction (Moffat & Johnson, 2001); postpartum women’s stories of smoking relapse likewise include contradictory notions of control and willpower, vulnerability and addiction (Bottorff, Johnson, Irwin, & Ratner, 2000). Further research is needed to examine the negotiation of these contradictory discourses among young women who smoke.

**Linear and non-linear pathways to “becoming” an ex-smoker.**

Smoking cessation is often conceptualised within linear stages of change models which refer to precontemplation, contemplation, and preparation stages (DiClemente et al., 1991; Villareal, 2003). Within this model the individual is conceptualised as either a smoker or an ex-smoker with the understanding that “every cigarette smoked confers the status of a smoker” (Keane, 2013, p. 193). While readiness to quit is an important phase in this model, it has been challenged by the increased success associated with spontaneous quit attempts (R West & Sohal, 2006).

Conversely, other research conceptualises smoking identities as being “nomadic”, rather than linear, and has used Deleuzo-Guattarian poststructuralist theorising to argue for an understanding of quitting smoking as an embodied practice of becoming rather than being an ex-smoker (Thompson, Pearce, & Barnett, 2009). This non-linear understanding of smoking cessation helps to account for the high relapse rates among smokers attempting to quit long term (Ockene et al., 2000). This prior research highlights the utility of a poststructuralist approach in understanding smoking and non-smoking identities as fluid, and open to reconstitution. Moreover, as most smoking research examines the perspective of current smokers or non-smokers (Keane, 2016), the inclusion of the experiences of ex-smokers in future
research is needed to better understand the non-linear process of smoking and quitting.

This section has revealed young women’s experiences of smoking and quitting to be distinctly shaped by discourses of addiction, choice, agency, and willpower. I argued that a poststructuralist approach is a useful way of understanding both smokers and ex-smokers’ experiences of smoking and quitting. This argument is continued in the next section, where I maintain the need for further research on young women’s smoking which utilises innovative theoretical and methodological approaches, including poststructuralism, social constructionism, intersectionality, and visual methods.

**Utilising Innovative Theories and Methods in the Study of Young Women’s Smoking**

Existing research on women’s smoking has been subject to several theoretical and methodological critiques. Firstly, within the smoking literature, notions of sex and gender are often conflated, and identity is often quantified and reduced to fixed, categorical variables, such as “male” and “female” (Bottorff et al., 2014; Wigginton, 2017). A social constructionist epistemology, poststructuralist theory and qualitative methods can help to address these limitations. Social constructionism allows for the acknowledgement of multiple truths and selves (Burr, 2015), while a poststructuralist approach allows for a more complex understanding of identity as fluid and multiple (Weedon, 1997). These approaches have proven to be an effective way to critically study young women’s smoking as they allow for the examination of complexity, nuance, and contradiction (Gilbert, 2007b; Haines et al., 2009). Given these factors, I
adopt a social constructionist epistemology and draw on a poststructuralist theoretical approach in this thesis – which I explain in detail in Chapter Two.

Gender-specific research helps to provide a better understanding of epidemiological trends in smoking and informs gender sensitive tobacco control interventions (Ernster et al., 2000). However, and as identified earlier, research on women’s smoking largely fails to consider how gender intersects with other axes of social and economic disadvantage (Amos et al., 2012; Bottorff et al., 2014; Wigginton, 2017). A small body of research has examined intersections of gender, ethnicity, social class, sexual orientation, and age in relation to smoking using both quantitative (Aguirre et al., 2016; Bilal et al., 2015; Corliss et al., 2014), and qualitative methods (Antin et al., 2016; J. Douglas, 2014; Liss-Levinson, 2010). Jenny Douglas’ (2014) doctoral thesis used an intersectional approach to examine young African-Caribbean women’s experiences of smoking, and concluded that intersections of race, ethnicity, culture, and religion are imperative to understanding how young women experience smoking. Given the established importance of considering intersecting identities in relation to young women’s smoking, I adopt an intersectional approach in this thesis.

Existing analyses of women’s smoking are often criticised for being devoid of social and political context (Wigginton, 2017). Semi-structured interviews are a widely used and diverse research method that allows for an exploration of the personal and social contexts that shape individual experience (McIntosh & Morse, 2015). Semi-structured interviews are “epistemologically versatile” and compatible with a range of qualitative and quantitative methods (McIntosh & Morse, 2015, p.
10) such as visual methods, which also provide researchers with an opportunity to contextualise experiences (Pink, 2003).

Researchers have examined visual representations of women’s smoking in a historical context (Tinkler, 2006), in tobacco industry advertising (Anderson, Glantz, & Ling, 2005), and in anti-smoking campaign advertising (Oaks, 2000). However, fewer studies have analysed women’s visual representations of their smoking. One exception is Haines’ (2008) use of participant-produced photography, which helped provide critical insights into female adolescent tobacco use. Given the proven utility of participant-produced photography methods in Haines’ thesis, and within critical health psychology (Papaloukas, Quincey, & Williamson, 2017; Radley, 2011), I incorporated this method into my thesis research design to complement the semi-structured interview data.

In summary, this thesis draws on social constructionist and poststructuralist theories, intersectionality, interviews and participant-produced photography to further understandings of how young women construct and experience their smoking in relation to their performances of femininity, negotiation of stigma, understandings of risk, and experiences of quitting. In this thesis, the term ‘young women’ is used to refer to women aged 18-30 years, who are experiencing a significant period of identity development, characterised by instability, transition, and uncertainty (Denscombe, 2001). This target age range was selected because of the rates of smoking among this cohort and their status as an ideal target for intervention – as discussed earlier in this chapter.
Thesis Aim and Research Questions

With this thesis, I aim to explore young women smokers and ex-smokers’ constructions and experiences of cigarette smoking. To achieve this aim, I asked the following research questions:

1. What discourses do young women draw on to construct their smoking?
2. What implications do young women’s discursive constructions of smoking have on their subjectivity, smoking practices, and interactions with anti-smoking campaigns and policies?

Structure of the Thesis

This thesis contains seven chapters. In this first chapter, I have introduced the topic of young women and cigarette smoking. I have examined the Australian tobacco control context, identified impacts of smoking on women’s health, and highlighted the need to target young women in smoking interventions. I explored the shifting meanings of women’s smoking in Western countries and argued that a social constructionist epistemology allows for an understanding of how changing social and cultural discourse shapes women’s smoking. I then reviewed existing literature on smoking and young women, focusing on smoking and performativity, the stigmatisation of smoking, constructions and experiences of smoking-related risk, and of quitting smoking. Finally, I explored and justified the use of a social constructionist epistemology, poststructuralist and intersectionality theories, and participant-produced photography methods to inform this research on young women’s smoking, and stated my thesis aim and research questions.
In Chapter Two I describe the theoretical, epistemological and methodological approaches used in this research. I then explain the design of the study, the recruitment procedure, as well as participants’ demographics, and provide pen portraits for further context. The three qualitative stages are then outlined: interviews, photography activity, and follow-up interviews. I discuss the socially constructed nature of the interview and photography data, and participants’ reflexive engagement in the study. Finally, I discuss the two steps involved in the discourse analyses of the data and pause to reflect on how I influenced this process.

Chapters Three, Four, Five, and Six of the thesis contain four published journal articles. In these articles I analyse the research findings and discuss these findings in relation to existing empirical and theoretical understandings of young women’s smoking. Chapter Three, *Doing and undoing femininities: An intersectional analysis of young women’s smoking*, considers the discursive repertoires young women use to position themselves in relation to discourses of smoking and femininity, and how these relate to broader cultural discourses associated with smoking in public health and popular media. These findings reveal young women’s experiences and negotiations of discourse surrounding smoking and femininity are shaped by intersecting social class and sexual identities.

Chapter Four, *An intersectional analysis of women’s experiences of smoking-related stigma*, looks at young women’s experiences of the stigmatisation of smoking. The analysis considers how young women negotiate smoking-related stigma, and how experiences and negotiations of smoking-related stigma are shaped by intersecting identities, including gender, cultural background, social class, and
mothering. The findings highlight the negative implications of smoking-related stigma and the potential for women to experience compounding levels of stigma.

Chapter Five, *‘It’s one of those "It’ll never happen to me" things’: Young women’s constructions of smoking and risk*, explores how young women make sense of the risks associated with smoking. The analysis explores dominant interpretative repertoires in young women’s accounts of the risks of their smoking, and how their use of these repertoires allows them to position the risks of smoking as both acceptable and unacceptable, and position anti-smoking messages as ineffective. This analysis highlights the complexity and contradictions in how young women understand and respond to smoking-related risk, and how these responses relate more broadly to discourses of respectable femininity.

Chapter Six, *Young Australian women’s accounts of smoking and quitting: A qualitative study using visual methods*, examines the ways in which young women construct and experience quitting smoking. The analysis reveals the discourses the young women drew on in their accounts of quitting, and how these relate to the contradictory positions they assumed as responsible and resistant, addicted and agentic. This analysis identifies implications for young women’s subjectivity, and their engagement with tobacco controls and cessation support.

Chapter Seven is the conclusion to the thesis. In this chapter I return to my original research aims and discuss the overall findings from the four articles. I consider the implications of these findings for tobacco control policy and interventions. The strengths and weaknesses of the study are reviewed, and recommendations for future research are made.
Chapter Two: Theoretical Approach and Research Methods

In the Introduction chapter, I asked the question: how do young women construct and experience cigarette smoking? In this chapter, I outline the theoretical approach, the methods, and methodological framework used to answer this question. In the first half of the chapter, I discuss my epistemology, social constructionism, and the theoretical approaches I use in the thesis, poststructuralism and intersectionality. I explain how these theories shaped the way I researched and analysed young women’s smoking. I then explore the notion of subjectivity in relation to positioning theory, the concepts of language and discourse in relation to Michel Foucault’s scholarship, and Judith Butler’s theory of gender performativity. Finally, I outline my intersectional theoretical approach, and explain how this helped me explore the impact of multiple identities on young women’s smoking.

In the second half of the chapter, I describe the research methods. I begin by giving an outline of the recruitment procedure and the 27 smokers and ex-smokers who participated in the study. For each participant, I have written a pen portrait, a brief written description of the person’s age, cultural and ethnic background, sexuality, social class background, if they had children, and smoking status. I then explain the research procedure, which involved three stages: stage one featured interviews, stage two was a photography activity, and stage three involved follow-up interviews. I discuss the socially constituted nature of participants’ interviews and photographs, and comment on how participants reflexively engaged in the study. Finally, I describe the first and second steps of the discourse analysis I carried out, briefly reflect on how I influenced the analysis, and conclude the chapter.
Theoretical Approach

This thesis is grounded in social constructionist epistemology. Social constructionism, detailed in the following section, is a “broad church” which consists of a number of strands and underpins a number of theories (Lock & Strong, 2010a, p. 6). In my analysis chapters I draw on two different theoretical frameworks that sit within a constructionist perspective to analyse the data: intersectionality and poststructuralism. The relationship between my epistemology and the theoretical frameworks I draw on in my analysis is shown in Figure 6. In Chapters Three and Four I draw on intersectionality as the analytical framework, as my aim is to examine how different social categories intersect and shape young women’s performances of feminine identities, and experiences of smoking stigma (Warner, 2008). In Chapters Five and Six I use a poststructuralist framework, as my intention is to examine the multiplicity and fluidity of participants’ subjective experiences of smoking-related risk and quitting (Weedon, 1997).

Figure 6. Epistemology and theoretical frameworks in the thesis.
Social constructionism: Rejecting a fixed reality.

Social constructionism is a theoretical approach which rejects essentialism, individualism, and realism, and acknowledges multiple truths, realities, and selves (Burr, 2015). Social constructionism is concerned with how meanings and understandings are produced through social interactions and located in time and space (Lock & Strong, 2010a). These meanings or understandings are also known as “constructions”, and these different ways of thinking allow for different types of action. Social constructionism sees language as central to the way in which we understand our social world, and language and other symbolic systems are seen to both constitute and be constituted through discourse (Burr, 2015).

The term “discourse” is used by social constructionists as a way of understanding how language shapes what we can think, say, do, and have done to us (Burr, 2015). Discourse is articulated through a range of forms, including images, texts, and practices (G. Rose, 2016). Burr (2015, pp. 74-75) defines discourse as “a set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events.” Discourses can become so dominant they become taken for granted “truths”, and it is not uncommon that discourse is “appropriated in the interests of the relatively powerful” (Burr, 2015, p. 89). The use of a social constructionist epistemology in this thesis allows me to conceptualise young women’s smoking as being culture bound; embedded within a particular social and historical context (Willig, 2000). This means young women’s constructions of their smoking are shaped by broader systems of knowledge and values in society. Moreover, through understanding young women’s constructions of
smoking, femininity, health, and quitting, I can identify the power implications that results from their discourse.

**Poststructuralism: A theoretical turn to subjectivity and language.**

Poststructuralism initially formed part of a broader turn towards the study of culture in the arts and humanities (Bonnell & Hunt, 1999). Poststructuralism fits within a social constructionist epistemology but has a specific focus on how meaning is constituted through language and discourse and the power relations inherent in this process (Weedon, 1997). As a theoretical movement, poststructuralism sought to disrupt taken-for-granted truths about social life that structuralist theorists had sought to establish (Dillet, Mackenzie, & Porter, 2013; J. Williams, 2005). Structuralist theorists conceive of language as having fixed, agreed upon meanings, and focus on developing a method for identifying the signs in everyday practice that make up our reality (Dillet et al., 2013). For poststructuralism, the focus is more ontological, and meaning is seen to be always contestable (Burr, 2015).

As with social constructionism, poststructuralism abandons the notion of a single reality or truth and recognises a “plurality of meanings” (Gavey, 1989, p. 462). Poststructuralist theorists have reconceptualised subjectivity as being multiple, fluid, and constituted and reconstituted through language and discourse (Weedon, 1997). These conceptualisations of subjectivity, language and discourse are essential to the analysis in this thesis, allowing me to understand how young women’s experiences of smoking shape, and are shaped by their discursive accounts of smoking. In particular, the terms “subject” and “subjectivity” are poststructuralist concepts I use
to refer to how young women in the study understand themselves and others (Weedon, 1997).

In this thesis I employ a post-structuralist understanding of “experience”; one which challenges its authority and questions its position as “the origin of our explanation” (Scott, 1991, p. 780). This understanding of experience is informed by the work of Joan Scott, who explains (1991, p. 780), “[experience is] that which we seek to explain, that about which knowledge is produced.” Poststructuralism has often been criticised for its determinism, yet Cosgrove (2000) argues that by incorporating the study of experience, poststructuralist researchers are able to conceive of individual agency and resistance. Therefore, young women’s experiences of smoking can be understood as both constituted by and constituting meanings of gender, health and risk (Cosgrove, 2000, p. 249). This dynamic process between discourse, subjectivity and lived experience is what Foucault (1979) termed “subjectification”. Dorthe Staunaes (2003) argues that the subjectification process be unpacked using analytical tools, such as intersectionality, a concept I return to in the final section below, as I outline the ways in which I utilise post-structuralism in this thesis.

**Understanding subjectivity using positioning theory.**

Within a post-structuralist theoretical framework, positioning theory has been developed to examine how language and discourse produce “subject positions” within social interactions (Davies & Harré, 1990). Positioning theory has partial origins in the concept of a “role”, which was popular in social psychology in the 1950s and 1960s (see Goffman, 1959). Bronwyn Davies, Rom Harré and colleagues
were critical of the fixed and permanent nature of a role, and the lack of consideration for the context in which interactions takes place. This led them to develop the concept of a subject position, which is more context specific, and can be accepted, challenged, defended, taken up and discarded within a given interaction (Lock & Strong, 2010a). Within these interactions a moral framework exists which dictates the rights, duties and obligations of individuals within a given context (Lock & Strong, 2010b). The notion of positioning has been utilised by many post-structuralist feminist researchers, including Wendy Hollway (1984), who used it to examine the construction of subjectivity in the context of heterosexual relationships, and Jane Ussher (2011) who drew on positioning theory to analyse constructions of women’s distress as “madness”.

Positioning theory is compatible with the epistemology and theoretical approach of the thesis. Positioning theory has been categorised as a type of micro social constructionism as it focuses on the construction of subjectivity in everyday interactions (Burr, 2015). Davis and Harré’s (1990) work is often positioned within feminist poststructuralism, as it is concerned with how discursive practices produce subjectivity. Drawing on positioning theory in this thesis allows me to explore the multiple, contradictory subject positions young women smokers take up or are assigned. In my analysis, the use of positioning theory allows me to explore how young women position themselves in relation to other smokers, as well as in relation to broader social and cultural discourses of smoking.
Foucault, language and discourse.

In this thesis I draw on the work of Michel Foucault, whose interest in how language mediates our social world has led him to be closely associated with the poststructuralist movement. Foucault is best known for his theorising on power, subjectivity and discourse, through his historical case-studies on madness, medicine, prisons, and sexuality (Foucault, 1975, 1978, 1979). Foucault (1972, p. 193) was interested in how “a certain ‘way of speaking’” can convey meaning and coined the term “discursive formations” to refer to the way in which statements, objects, and concepts are ordered and positioned. Foucault studied the process by which language produces knowledge, looking at how this knowledge has the power to produce reality. As such, Foucault’s work is central to a poststructuralist analysis of the constitution of young women’s smoking through language (Tonkiss, 1998).

However, it is important to note that Foucault’s micro-level theory of power has been criticised for its neglect of structural inequalities, such as social class, ethnicity, and gender (Henderson, 2015). Foucault’s work also inadequately addresses the issue of agency – offering an “over-determinist view of the subject” (McNay, 2000, p. 9). To address these limitations, this thesis incorporates the work of Judith Butler and feminist theories of gender performativity, as discussed below, to conceptualise women who smoke as having the capacity for autonomous action.

Butler and gender performativity.

Feminist scholars Candace West and Don Zimmerman (1987) first introduced the phrase “doing gender” to describe the social construction of gender identities in everyday routines and practices. The notion that gender is something that one does
has been developed further by Judith Butler, a poststructuralist feminist scholar. Butler (1993) developed the theory of gender performativity to capture the idea that performative speech acts produce our understandings of gender (Osborne, 1996). An example of a performative speech act is the naming of bodies at birth as “girls” and “boys” which produces an understanding of gender as a binary. According to Butler’s theory of performativity, gender is created and re-created within social situations – an ongoing process which is made up of stylised acts such as bodily gestures and movements (Butler, 1993, 2006). Understandings of gender as “durable but not immutable” (McNay, 2000, p. 2), allow space for agency and resistance in the “undoing” of normative understandings of gender (Butler, 2004).

In my analysis, I draw on Butler’s theory of gender performativity to better understand how smoking performances are used by young women to construct and produce identities. However, the work of Butler and other Anglo-feminist theorists has been criticised for privileging gender at the expense of other positions of disadvantage (Namaste, 2009). In response to these criticisms, intersectionality theory has been developed from the activism and scholarship of Black feminists, as an approach to understanding the intersection of multiple marginalised identities.

**The multiplicity of identity and intersectionality theory.**

Frustrated with the “elision of difference in identity politics” (p. 1242), Black feminist Kimberlé Crenshaw (1991) coined the term “intersectionality” to describe how identities, such as “woman” and “Black”, intersect to compound experiences of marginalisation. Given its origins, intersectionality research has a strong social justice focus, where research findings are often used to address issues around social
marginalisation and exclusion (Hankivsky & Cormier, 2009). Intersectionality is an approach which has several adaptations and interpretations across disciplines (S. Cho, Crenshaw, & McCall, 2013; Marecek, 2016), and it has been conceptualised as a theory, concept, methodology, and heuristic (Lewis, 2013).

An intersectional analysis can be broadly characterised by an interest in how sameness and difference relate to power (S. Cho et al., 2013). Intersectionality is based on the premise that our social identities are mutually constitutive, an idea which challenges traditional understandings of inequality and identity as being the sum of distinct social positions (Christensen & Jensen, 2012; Warner, 2008). Intersectionality focuses on the point at which different social categories meet (Platt, 2011), allowing us to gain insight into how identity positions come together to provide “instances of both opportunity and oppression” (Warner, 2008, p. 455). Therefore, an intersectional approach can be used to examine intersections of privilege, as well as marginalisation (Else-Quest & Hyde, 2016).

In this thesis I adopt a method of intersectionality outlined by Staunaes (2005), which is based on a poststructuralist and social constructionist understanding of the subject as agentic, but also as constrained by available discourse. This approach allows me to consider how social categories “saturate, tone, overrule, and support one another” at their intersection (Staunaes, 2005, p. 155). For instance, I explore how young women negotiate the intersection of mothering, working-class, and smoking identities. However, in adopting an intersectionality approach one faces a number of “theoretical dilemmas” (Walby, Armstrong, & Strid, 2012). The

For those doing intersectionality research, the challenge “is to read categories simultaneously” (Staunaes, 2005, p. 155). One of the challenges I face in this thesis, is how to identify distinct identities, such as sexuality, or culture, whilst still recognising the intersection of these identities also shapes how they operate (Walby et al., 2012). When doing intersectionality research, it is therefore important to be cognisant of which social identities are included for analysis, and which are not, as it is not possible to include all identities in the analysis (Warner, 2008) – I reflect on this difficulty further in Chapter Seven. Reflexivity is also important to intersectionality research, and critical reflections have been included throughout the thesis, as outlined in the preface.

Having discussed my epistemology and the theoretical approaches I draw on in this thesis, the remainder of the chapter outlines the methods I used to research young women’s smoking.

**Research Methods**

**Design.**

This study has a three-stage qualitative design. Working within a social constructionist epistemology, qualitative methods were employed as they help to contextualise human experience (Burr, 2015). Stage one of the study involved semi-structured interviews with 27 women. Eighteen of the women chose to go on to stage two, which was a participant-produced photography activity, where participants took
photographs of their experiences with smoking. Those same eighteen women then participated in stage three – follow-up semi-structured interviews where they discussed their first interview, their photographs, and their participation in the study. Two types of discourse analysis were conducted: discursive psychology (Potter & Wetherell, 1987), and Foucauldian discourse analysis (Ussher & Perz, 2014; Willig, 2008a). This research design allowed me to consider how young women discursively construct and experience smoking, and how these constructions and experiences are shaped by intersecting identities.

**Recruitment.**

Several methods were used to recruit participants (see Appendices A and B). Participants were recruited through online advertising on the social media platform, Facebook, during August and September of 2014. Participants were also recruited through flyers, which were posted on university and TAFE college noticeboards, and handed out at train stations and university classes. Snowballing methods were also useful in recruiting (Braun & Clarke, 2013), and participants and colleagues were encouraged to pass on the study information within their personal social networks.

The recruitment materials stipulated that participants had to be young women aged 18 to 30 years old. The recruitment materials also specified that participants could be smokers or ex-smokers, but had to have smoked at least 100 cigarettes, which is the definition of “smokers” and “ex-smokers” given by the Australian Institute of Health and Welfare (AIHW). The inclusion of both smokers and ex-smokers allowed for a consideration of young women’s experiences of smoking and of quitting.
The recruitment materials directed participants to an online survey run through the Survey Monkey website (see Appendix F). In this survey participants answered a series of demographic questions, as well as some brief questions on their experiences of smoking. Participants were asked, “What is your cultural or ethnic background? (e.g., Anglo-Australian, Chinese)”, and given a free-form response text box. Several participants chose to classify themselves as “Australian”, a trend reflected in broader population studies where participants have preferred to refer to their nationality or citizenship, in place of race or ancestry (Stevens, Ishizawa, & Grbic, 2015).

Participants were also asked “How would you describe your social class background? (e.g. working class, middle class, upper class)”, and again, wrote their answers in a free-form response text box. As previous researchers have noted (Huppatz, 2010), participants’ self-identified social class positions were at times inconsistent with their survey responses to questions about education, occupation, and income. This inconsistency is demonstrative of the limitations of self-identification as an accurate measure of social class, but is also beneficial in highlighting the subjective nature of social class. This question was added to the survey after one participant had already completed her interview – therefore, I estimated her social class background based on her own and her parents’ levels of education and income.

The survey was designed to help screen potential participants and ensure the selection of a diverse sample for further involvement in the study. A total of 197 women completed the survey, 95 women gave their contact details, and indicated
that they were interested in participating in the study. From this list of 95, I used
maximum variation sampling to select 49 young women across different social class
backgrounds, sexualities, cultural backgrounds, and status in relation to children
(Glesne, 2016). These identities were selected due to the influence they have on
smoking behaviours, as discussed in the previous chapter. In line with an
intersectional theoretical approach, the selection of participants who identified as
lesbian, working-class, or non-Anglo helped to make women with less social power
more visible (Warner, 2008).

I contacted these 49 women and sent them a copy of the Participant
Information Sheet (see Appendix C) and a consent form for stage one of the study
(see Appendix D). Of the 49 women, 27 women agreed to participate in stage one of
the study and all were instructed their participation was voluntary, and that they were
able to withdraw from the study at any time without reason. The 27 participants
signed consent forms either physically or electronically – depending on whether the
interview was conducted face-to-face or by telephone. The study attrition which took
place from recruitment through to the final stage is shown in Figure 7.

95 survey respondents registered interest in the study
49 survey respondents were contacted
27 stage one interviews were conducted
18 stage two photography activities were completed
18 stage three follow-up interviews were conducted

Figure 7. Study attrition.

During the recruitment process and the three stages of the study, I kept a
spreadsheet to record interactions with participants. When participants’ details were
entered into the spreadsheet, they were assigned pseudonyms to maintain their anonymity. These pseudonyms have been used to refer to participants for the entirety of this thesis, and in the published articles. Participants were given a $30 supermarket gift card as reimbursement for their time participating in each of the three stages of the study.

Participants.

From the 27 women who participated in stage one of the study, 18 were smokers, and 9 were ex-smokers. These women ranged in age from 18 to 31 years and had a mean age of 24 years. The women had starting smoking regularly between the ages of 13 and 24 years (average age was 16 years) and had been smoking for between 2 and 16 years (average length of 7 years). Most participants were living in New South Wales at the time of their first interview (85%), and two participants lived in Queensland, one in South Australia, and one in Western Australia. The demographics of the 27 women who participated in stage one are included in Table 1. Eighteen of the 27 women from stage one chose to go on to stages two and three. These 18 women also ranged in age from 18 to 31 years but had a slightly lower mean age of 23 years. The demographics of the 18 women who participated in stage two and three are included in Table 2.
### Table 1. Stage one participant demographics

<table>
<thead>
<tr>
<th>Demographics (n=27)</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Smoking status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoker (n=13)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15+ cigarettes/day</td>
<td>4</td>
<td>22</td>
</tr>
<tr>
<td>&lt;15 cigarettes/day</td>
<td>10</td>
<td>56</td>
</tr>
<tr>
<td>Non-daily smoker</td>
<td>4</td>
<td>22</td>
</tr>
<tr>
<td>Ex-smoker (n=9)</td>
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<td></td>
</tr>
<tr>
<td>15+ cigarettes/day</td>
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<td>11</td>
</tr>
<tr>
<td>&lt;15 cigarettes/day</td>
<td>5</td>
<td>56</td>
</tr>
<tr>
<td>Non-daily smoker</td>
<td>3</td>
<td>33</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>7</td>
<td>26</td>
</tr>
<tr>
<td>No</td>
<td>19</td>
<td>70</td>
</tr>
<tr>
<td>Pregnant</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>Social class</strong></td>
<td></td>
<td></td>
</tr>
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<td>Working class</td>
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<td>44</td>
</tr>
<tr>
<td>Middle class</td>
<td>13</td>
<td>48</td>
</tr>
<tr>
<td>Upper middle class</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td><strong>Cultural/ethnic background</strong></td>
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<td></td>
</tr>
<tr>
<td>Anglo or “Australian”</td>
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<td>63</td>
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<tr>
<td>Other</td>
<td>10</td>
<td>37</td>
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<td>Heterosexual</td>
<td>18</td>
<td>67</td>
</tr>
<tr>
<td>Bi-sexual</td>
<td>7</td>
<td>26</td>
</tr>
<tr>
<td>Lesbian</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 10 (School Certificate or equivalent)</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>Year 12 (Higher School Certificate or equivalent)</td>
<td>9</td>
<td>33</td>
</tr>
<tr>
<td>Tertiary diploma/trade certificate/TAFE</td>
<td>8</td>
<td>30</td>
</tr>
<tr>
<td>University degree or higher</td>
<td>6</td>
<td>22</td>
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</tbody>
</table>

### Table 2. Stage two and three participant demographics

<table>
<thead>
<tr>
<th>Demographics (n=18)</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Smoking status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoker (n=13)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15+ cigarettes/day</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>&lt;15 cigarettes/day</td>
<td>6</td>
<td>46</td>
</tr>
<tr>
<td>Non-daily smoker</td>
<td>5</td>
<td>38</td>
</tr>
<tr>
<td>Ex-smoker (n=5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15+ cigarettes/day</td>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td>&lt;15 cigarettes/day</td>
<td>3</td>
<td>60</td>
</tr>
<tr>
<td>Non-daily smoker</td>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>6</td>
<td>33</td>
</tr>
<tr>
<td>No</td>
<td>11</td>
<td>61</td>
</tr>
<tr>
<td>Pregnant</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td><strong>Social class</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working class</td>
<td>6</td>
<td>33</td>
</tr>
</tbody>
</table>
Middle class 11 61  
Upper middle class 1 6

**Cultural background**

Anglo or “Australian” 12 67  
Non-Anglo 6 33

**Sexuality**

Heterosexual 11 61  
Bi-sexual 6 33  
Lesbian 1 6

**Education**

Year 10 (School Certificate or equivalent) 3 17  
Year 12 (Higher School Certificate or equivalent) 5 28  
Tertiary diploma/trade certificate/TAFE 6 33  
University degree or higher 4 22

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**Pen portraits.**

The following pen portraits contain demographic information given by participants about their age, cultural and ethnic background, sexuality, social class background, if they had children, and smoking status.

**Smokers.**

Jessica was 22 years old and identified as “Aussie”, bi-sexual, and middle class. She usually smoked about 20 cigarettes a day.

Sarah was 28 and identified as being English-Australian, bi-sexual, middle class, and had a child. She usually smoked about 10 cigarettes a day.

Jennifer was 26 and identified as Anglo-Australian. She was heterosexual and middle class. She usually smoked about five to eight cigarettes a day.

Megan was 26 years old and identified as having an English background. She was heterosexual and middle class. She usually only smoked about three days a week.
Rachel was 21 years old and identified as Slovakian and Aussie. She was heterosexual and middle class. She usually smoked about 8 to 12 cigarettes a day.

Vanessa was 22 years old and identified as Aboriginal. She was heterosexual and working class. She usually smoked about seven cigarettes a day.

Kalika was 19 years old and identified as Greek Australian. She was lesbian and middle class. She usually smoked about two days a week.

Lisa was 26 years old and identified as Anglo-Australian. She was heterosexual, working class, and had two children. She usually smoked about 15 cigarettes a day.

Sinta was 19 years old and identified as Indonesian and Spanish. She was heterosexual and middle class. She usually smoked about three cigarettes a day.

Shayma was 19 years old and identified as Iraqi, Assyrian and Canadian. She was heterosexual and middle class. She usually smoked about seven cigarettes a day.

Tara was 24 years old and identified as Anglo. She was heterosexual and working class. She usually smoked at least seven cigarettes a day.

Shannon, was 23 years old and identified as Anglo-Australian. She was bisexual and upper-middle class. At the time of the first interview Shannon usually smoked about two days a week. In the months between the first and second interview Shannon had broken up with her boyfriend, and at the time of the second interview said she was smoking “quite heavily”.

Caitlyn was 21 years old and identified as New Zealand Australian. She was heterosexual, working class, and had a child. She usually smoked about 15 cigarettes a day.
Hannah was 25 years old and identified as Lao and Maltese. She was heterosexual and working class. She usually smoked about 15 cigarettes a day.

Chelsea was 20 years old and identified as Anglo Celtic Australian. She was bi-sexual and working-class. She usually smoked about one day a week.

Briana was 18 years old and identified as being Aboriginal-Lithuanian. She was heterosexual, working-class, and had a child. She usually smoked about 10 cigarettes a day.

Danielle was 30 years old and identified as being Australian. She was lesbian and upper-middle class. She usually smoked about 10 cigarettes a day but was attempting to quit at the time of her interview.

Brittany was 21 years old and identified as being Australian. She was bi-sexual and middle class. She usually smoked about 10 to 15 cigarettes a day.

Ex-smokers.

Olivia was 18 years old and identified as Anglo-Australian. She was bi-sexual and middle class. She used to smoke four times a week and had stopped smoking for two weeks at the time of our first interview, classifying her as an “ex-smoker”. However, at the time of the second interview, several months later, Olivia had started smoking again.

Stephanie was 27 years old and Anglo-Australian. She identified as heterosexual, lower-middle class, and had two children. She used to smoke about 25 cigarettes a day and had quit smoking two months prior to the study.
Gemma was 25 years old and identified as Italian. She was heterosexual and middle class. She used to smoke about six cigarettes a day and had quit two months prior to the study.

Jing was 24 years old and identified as Chinese. She was heterosexual and middle class. She used to smoke about five cigarettes a day and had quit one year prior to the study.

Courtney was 21 years old and identified as Australian. She was heterosexual, working class, and was pregnant. She used to smoke about eight cigarettes a day and had quit six months prior to the study.

Paige was 30 years old and identified as Anglo Australian. She was heterosexual. She did not specify her social class background. She used to smoke about 10 cigarettes a day and had quit three months prior to the study.

Julie was 31 years old and identified as Peruvian. She was heterosexual, working class, and had a child. She used to smoke about three days a week and had quit two years prior to the study.

Emily was 21 years old and identified as Australian. She was bi-sexual, working-class, and studied full-time. She used to smoke about four cigarettes a day and had quit 18 months prior to the study.

Ashlee was 21 years old and identified as Australian. She was heterosexual, had three children, and studied full-time. She described her social class background as middle class, but also spoke about having to scrape together money to buy food. She used to smoke about 10-12 cigarettes a day and had quit one year prior to the study.
**Research procedure.**

Ethics approval was awarded for this study from the University of Western Sydney Human Research Ethics Committee in November 2013 (see Appendices J and K). Data collection for the study took place between April 2014 and March 2015.

**Stage one: Interviews.**

During stage one of the study, participants were invited to participate in a one-on-one interview. Participants living within Sydney were offered the choice of participating in either face-to-face or telephone interviews. Six participants opted to do face-to-face interviews, which were conducted in private rooms on university campuses across Sydney. The remaining 21 interviews were conducted over the telephone due to geographical constraints or out of convenience for the participant. The length of the interviews ranged between 25 to 90 minutes, with most interviews lasting around 40 minutes. With the participants’ permission, all the interviews were recorded using an audio recorder, and the recording then sent for professional verbatim transcription. Before beginning the interview, I reminded participants that what they said would be confidential, and data would remain anonymous. I also advised participants not to answer any questions which made them uncomfortable, and to let me know if they wanted to pause or stop the interview or if they wished to withdraw from the study altogether. I conducted 25 interviews and two interviews were conducted by an Honours student working on the wider ARC project.

The interviews were semi-structured, meaning they were made up of a small number of open-ended questions and conducted in a conversational style (Willig,
A semi-structured style of interview allowed participants to take a leading role in constructing the story around their smoking (Graham, 1984). The interview questions were structured around three main themes: participants’ experiences with smoking, quitting, and representations of smoking in the media. The interview schedule included open-ended questions, such as “Can you tell me about when you first began smoking?” The use of open-ended questions helped to place the focus on the participants’ narratives and experience, and created a less formal interview environment (Willig, 2008b). Questions were followed up with prompts, such as “Do you remember the first cigarette you smoked?” These prompts were used to elicit further information from participants. The interviews ended with a closing question asking participants: “Is there anything else about your experiences smoking cigarettes that you would like to talk about or you think we haven’t covered?”

The interview schedule was piloted during the first three interviews. Following the transcription of the three interviews my primary supervisor and I read through the transcripts and discussed how the interview schedule might be improved. As a result of this, an opening question was added at the beginning of the schedule: “Tell me about your experiences with smoking.” This broad question aimed to put participants at ease and helped develop rapport between myself and participants (DiCicco-Bloom & Crabtree, 2006), and “yield spontaneous, rich descriptions” of participants’ experiences (Kvale, 2007, p. 61). The final interview schedule for stage one can be found in Appendix G.
**Stage two: Photography activity.**

In qualitative health research, arts-based methods have begun gaining recognition in recent years (Boydell, Gladstone, Volpe, Allemang, & Stasiulis, 2012; Fraser & al Sayah, 2011; Harrison, 2002). A range of arts-based methods exist, including theatre, photos, poetry, drawing, and dance (Boydell et al., 2012; Fraser & al Sayah, 2011), and these methods are most commonly used to generate and disseminate knowledge (Fraser & al Sayah, 2011). The use of arts-based methods presents both opportunities and challenges, particularly in relation to the flexibility of arts-based methods compared to the structure of traditional methods, and differing concepts of truth, accuracy, impact, and value in academic research (Boydell et al., 2016). Given the proven merit of using arts-based methods, a photography activity was included in the research methodology. I detail some of the opportunities and challenges of this method in the remainder of this chapter, and in conclusions I make in Chapter Seven.

After participating in stage one, the interview, participants were told about stages two and three of the study. Of the 27 women who participated in stage one, 18 chose to continue with the study. These women received a set of instructions about stage two of the study, a photography activity in which they used their mobile phones and/or digital cameras to take photographs of their experiences with smoking (see Appendix H). The instructions invited participants to imagine they were taking photographs for an exhibition titled “Smoking through the eyes of young women”. They included a series of prompts to guide participants in what they might photograph, such as “a place where you like to smoke”. Participants had the freedom
to photograph whatever they felt was important to their experiences of smoking with the prompts provided as a stimulus to help direct participants towards aspects of their smoking related to the research questions and aims of the project.

Participants took on average three weeks to take photographs and submitted a total of 157 images. The images were mostly photographs, but also included screen shots, and images they had created themselves or downloaded from the internet. Participants were instructed to upload an explanatory caption with their photographs. However, many participants appeared to find this process difficult, and less than half of the photos were returned with captions. For example, when I asked Jing (24, ex-smoker), for whom English was a second language, how she might caption one of her photographs, she said: “I cannot say the title, but I can describe to you.” For participants such as Jing, their photographs often captured detailed stories and complex experiences, which were not easily described in a couple of words or one sentence.

Several ethical considerations relate specifically to the use of arts-based methods, such as photography (Boydell et al., 2012). Participants who took part in stage two signed a second consent form which related specifically to the use of their photographs (see Appendix E), giving permission for non-identifying photographs to be included in publications and presentations. Again, these consent forms were signed either physically or electronically – depending on whether participants did a face-to-face or telephone interview. The University of Western Sydney ethics board stipulated that participants were not to take photographs that identified people which some participants found challenging. For example, Lisa (26, smoker) said, “that was
probably the hardest part, because instinctively when you take a photo, [you] take a photo of a person, not an object.” Despite being instructed not to, participants submitted several photographs with identifiable people in them. To manage this, I used photo editing software to blur any identifying features (see Figure 8). This software helped to maintain the anonymity of participants, but, as Tinkler (2013) notes, important data was lost in this process, such as facial expression. This process highlighted tensions between paternalism and agency, where the desire to protect participants’ anonymity was at odds with acknowledging participants’ anonymity and their desire “to be seen as well as heard” (Wiles, Coffey, Robinson, & Heath, 2012, p. 41).

*Figure 8.* Photograph with identifiable features blurred.

*Contextualising participants’ photographs.*

A critical approach to visual methodology involves a consideration of the conditions in which participants’ photographs were produced and distributed (G.
Rose, 2016), and an acknowledgement that the photographs were produced within the context of the study (Radley, 2011). For instance, participants in the study spoke about how some photographs were accidentally deleted, and how photographs were often staged, rather than being candid. Harrison (2002) offers the following reflections on the use of visual methods in qualitative health and illness research:

The conventionality of photographic practice will mean that both existing and elicited photographic records will encompass only selected social occasions, particular people and places, and that they will be framed or composed utilising some aesthetic principles. These areas require evaluation within such data. If we wish to ask respondents to produce a visual diary or journal of their illness career, for example, then we need to be aware that illness is not a typical subject for everyday photography.

As Harrison suggests, and as has been noted in previous photovoice research (Guell & Ogilvie, 2013), participants in this study were unable to capture the entirety of their experiences of smoking in their photographs. One participant, Rachel (21, smoker), expressed this frustration, saying, “There’s some things that you can’t really take a photo of.” In addition to the difficulty they experienced in omitting identifying faces, participants spoke about how their ability to take photographs was restricted in terms of the time available to them. However, as previous researchers also have noted, this led participants to be creative in their photo-taking (Tinkler, 2013). Participants commonly used symbolism in their photographs to communicate their experiences, as has been noted in previous research using similar methods (Frith & Harcourt, 2007). For example, Ashlee (21, ex-smoker), took a photograph of a
medical helicopter to represent the relationship between smoking and her health (Figure 9). She said, “I really couldn’t take a photo of lungs or you know…so I thought, you know, a medical helicopter would suffice.”

![Image](image-url)

*Figure 9. Participants’ use of symbols and motifs in their photographs.*

Participants were able to use symbolism in their photographs as they knew they would have the opportunity to explain their meaning in their follow-up interview. Megan (26, smoker) spoke about how this influenced the way in which she took photographs for the study:

> I did it all in the space of, like, six hours, my brain was thinking about it and I could just start to make the association with my relationship with smoking and what I thought about it. And, I’d be like, ‘Oh yeah, that’s a good idea. How can I, like, demonstrate that photographically?’ But, I’ll be able to explain.

Megan’s account highlights how participants’ photographs should not be individually analysed as direct representations of their experiences, but are better understood in
The context of participants’ interviews (Haines-Saah, Oliffe, White, & Bottorff, 2013).

**Stage three: Follow-up interviews.**

All 18 women involved in stage two of the study participated in stage three. Following the completion of the photography activity, a follow-up, one-on-one, in-depth, semi-structured interview was scheduled at a time convenient to the participant. The follow-up interview schedule can be found in Appendix I. This interview comprised of three parts. At the beginning of the follow-up interview, participants reflected on their first interview. This task was facilitated by a review of the first interview transcript; a copy of which had been emailed or mailed to them beforehand. This allowed participants to reflect on the accounts they gave in the first interview. I had also read the transcripts and discussed them with my primary supervisor, which allowed me to ask specific follow-up questions and clarify anything that was unclear in the first interview (Morse, 1991).

The second part of the follow-up interview focussed on the photography activity. Participants were asked about their experiences of taking photographs before discussing each photo and its caption, one-by-one. Participants were directly involved in the process of analysing their photographs. For example, they were asked questions such as, “Tell me about your reasoning for what you included in the photo?”

The third and final part of the follow-up interview was spent asking participants about their thoughts on being involved in the research project and whether there had been any changes to the way they felt about smoking (the
responses are summarised in the later section of this chapter which looks at participant reflexivity). Four of the interviews were conducted face-to-face, and the remaining 14 were conducted over the telephone. The length of the stage one and three interviews ranged between 25 and 90 minutes and took 45 minutes on average. All interviews were recorded using an audio recorder.

During my first five follow-up interviews I also piloted a visual probe activity. This activity involved showing participants images of five recent anti-smoking campaigns and seven recent anti-smoking policies and asking their thoughts and opinions on each of them. This activity generated some interesting responses from participants, however through conversations with the project team, it was decided this activity, in addition to the discussion of the photographs in the follow-up interview, was too onerous for participants and so it was removed for the remaining 13 follow-up interviews.

The amount of time between participants’ first interview and their follow-up interview ranged between three weeks to five and a half months, with the average time being 11 weeks (see Figure 10). The use of follow-up interviews allows you to observe changes over time (Morse, 1991), and “to capture temporal and spatial dynamics that shape individual narratives” (Ryan, Rodriguez & Trevena, 2016). In the weeks and months between when I first interviewed the women and when their second interview took place, their private and public landscapes had continued to evolve. Taxes on cigarettes continued to rise, and new regulations on smoking in public places began to be enforced. The women also experienced personal changes; some had ended intimate relationships, lost loved ones, and/or experienced physical
and mental health events. In response to these events, their smoking took on new meanings, and they adopted different discursive positions, both within interviews and across them.

Figure 10. Time between participants’ interviews

The use of follow-up interviews also allowed me to create familiarity and build rapport with participants (Morse, 1991). Participants often seemed more comfortable discussing their experiences of smoking in their follow-up interviews. For example, participants spoke about smoking during her pregnancy, and their experiences of abusive relationships and grief and loss. These examples also highlight the emotional nature of some of the interviews, and the way in which participants told stories of their smoking as it related to broader experiences of love, loss, and struggle. As one participant, Shannon (23, smoker), commented, “I remember talking about smoking, but we talked about so much more at the same time.” The emotional intensity of the follow-up interview was also shaped by the incorporation of participants’ photographs, which were often personal, capturing intimate scenes at home with friends or family (Guest, 2016). The incorporation of
photographs in the follow-up interview also allowed participants to focus on a particular point in time, to concentrate their thinking, and provide more detailed reflections about their smoking (Tinkler, 2013). In addition to the benefits, the use of follow-up interviews was also challenging, as it meant maintaining contact with participants over a longer period, and several participants were only willing to commit to a one-off interview.

The socially constructed nature of the interviews.

The interviews were a social interaction which were shaped by the physical context in which the conversations took place. Most of the interviews were conducted over the telephone due to participants’ geographical location and for the convenience of the participant. The use of telephone interviews is often beneficial when discussing sensitive or potentially embarrassing topics (Novick, 2008; Trier-Bieniek, 2012). As discussed in the previous chapter, smoking is a stigmatised behaviour (Stuber et al., 2008), particularly, smoking during pregnancy (Wigginton & Lafrance, 2015). Perhaps for this reason, I noticed that participants generally provided richer accounts in the telephone interviews.

A smaller number of interviews were conducted face-to-face. These interviews had the benefit of allowing for non-verbal communication through facial expressions and gestures. For example, participants demonstrated the way in which they held their cigarettes to me, and another young woman showed me a scar on her hand, where she had deliberately burnt herself with a cigarette. It is possible these experiences might not have been shared, had we not met face-to-face.
Reflecting on the interview dynamics.

Within a social constructionist paradigm, research data is seen to be co-constructed (Finlay, 2002). The data collected during the interviews was shaped by the interviewer and interviewees’ assumptions of one another, and the power dynamics between researcher and participant (Finlay, 2002). The intersubjective dynamics varied from participant to participant, but I tried to create a friend-like relationship with my participants; making sure I was chatty and used humour to build rapport. Participants often asked me about my smoking experiences. When asked my experiences with smoking I disclosed I was a non-smoker and had only smoked a handful of cigarettes in my life. I also often said my partner was a smoker, hoping to present myself as being both naïve to their experiences, and non-judgemental. This reciprocity allowed me to share some information with participants, and slightly offset the unequal amount of disclosure in the interview – which is said to be part of ethical research practice (Crow, 2012). Self-disclosure is also said to help humanise and equalise the relationship between the researcher and participant, and to put the participant at ease (Reinharz & Chase, 2001).

Despite my efforts, I was aware the unacceptability of smoking in society permeated our conversations. Participants appeared to feel pressure to conform to social expectations and norms around smoking and health, often making asides and clarifications. The following extract of my conversation with Courtney (21, ex-smoker) conveys some of the embarrassment participants often expressed around their smoking:

*And you were around 14/15 when you started [smoking]*?
Yes… (laughs). As bad as that sounds. Participants also acknowledged they were conscious about how they came across in the interaction. For example, Megan (26, smoker) said “I sound like an alcoholic in these interviews.” This self-awareness was amplified by their readings of the transcripts from their first interviews.

Participants recognised the socially constructed nature of the interviews. Reading the first interview transcripts led some participants to realise inconsistency in their accounts. Some participants commented they had misrepresented their experiences, not been “truthful”, or contradicted themselves in what they had said. For example, Courtney (21, ex-smoker) said, “I thought my views on smoking were kind of straight down the line, but I kind of changed my mind a lot, even when I was reading it back.”

Reflexive journaling helped me be more aware of my motivations, assumptions, and biases during the research (Finlay, 2002). For example, being a New Zealand migrant has shaped my role as a researcher, as I was unfamiliar with some Australian cultural nuances I had to seek clarification from others on participants’ use of terms such as “wog”, “bogan”, and “derro”. Being the same gender as my participants potentially made them feel more at ease, and for “woman to woman” talk to take place (Reinharz, 1992), for example, talking about topics such as menstruation or weight concerns. Moreover, being of a similar age to most of my participants perhaps allowed for more informal generational talk to happen.

I recognise my education was a potential barrier when communicating with participants. Only six out of the 27 women I interviewed had also completed a
university degree. To help mitigate these educational differences, I was very conscious of the language I used when speaking with participants, and positioned myself as a student, rather than a researcher, to make myself more relatable to the young women I spoke to who were studying at university. My efforts to reduce the power asymmetry between myself and participants appeared to have been successful, given most participants gave detailed and personal accounts of their experiences with smoking.

**Participants’ reflexive engagement in the study.**

In qualitative research, the emphasis is often placed on the reflexivity of the researcher, rather than participants (Koelsch, 2013). However, it is important to reflect on the meaning and experience of the interview for both the interviewer and the interviewee (Willig, 2008b). The acknowledgment of participant reflexivity is consistent with a social constructionist epistemology, and an understanding of knowledge as being actively constructed (J. A. Smith, 1994). Increasing opportunities for participant reflexivity allows for more collaborative research, that is potentially more empowering and less exploitative (Enosh & Ben-Ari, 2016), particularly for women, whose speech is more often silenced (Reinharz & Chase, 2001).

The act of taking photographs led participants to be reflexive, and to reconsider their daily lives (Pilcher, Martin, & Williams, 2015). Aspects of the follow-up interview also aimed to engage participants in reflexive practice, including asking them to comment on the transcript of their first interview, provide interpretations of their photographs, and reflect on their experiences of participating
in the study. These aspects also aimed to actively engage participants in a collaborative analysis of the study data (Jenkins, Woodward, & Winter, 2008).

Participants reflected on how their participation had helped them to better understand or be more aware of their smoking. For example, Kalika (19, smoker) commented:

I said ‘I only smoke when I am socialising and not very much even then’ but I actually smoke a lot more than I thought I did, like if I am socialising I will chain smoke the entire time so I have sort of realised that maybe I am a little bit more dependent on smoking than what I thought I was.

Kalika’s account shows how interviews can operate as a “vehicle of reflexive thought”, allowing participants to gain new understandings of themselves and others (McCabe & Holmes, 2009, p. 1523). For the women who had quit smoking, their participation often gave them a sense of validation. As Julie (31, ex-smoker) explained, “It was a good experience. It’s like a little journey. I get to revisit and see how strong I was to give up something that was so addictive and socially accepted in a sense.”

Previous smoking research that has used novel methods, such as voice recordings, has also reported these methods increase participants’ awareness of their smoking practices (Burton et al., 2015).

Several participants described their participation in the study as “enjoyable” while several commented the interviews had “felt a bit like a counselling session”. For example, Chelsea (20, smoker) spoke about how her participation in the research gave her an opportunity to disclose to her father about her smoking:
I went to see my dad and we caught up and it was quite recently after we had the first interview. And because the topic was on my mind, I started talking to him about my participation in your research, and I was quite honest with him, and it was quite nice, and he didn’t take it poorly. He just shared with me some experiences of people he knew who smoked socially and yeah, didn’t shun me, it was actually quite nice, and I feel like we bonded over being able to be open about it.

For some participants, and in contrast to Chelsea’s experience, this reflexive engagement was quite confronting. Lisa (26, smoker) gave the following account,

It’s certainly been a bit of an eye-opener, like the different questions that you’ve asked…to actually stop and think and sort of have to ask that of myself has been sort of a little bit confronting in a way, to actually consider my behaviour and whether or not I’m actually okay with it. Like, obviously I just accept the fact that I smoke but when I’m actually having conversations around the various reasons why I smoke, and why I make that choice, it really sort of makes me think twice about whether or not I am actually okay with the choices that I’m making.

These feelings of discomfort among participants has been noted by other researchers when conducting repeat interviews, and it is an important ethical issue to be mindful of when using these methodologies (Ryan et al., 2016).

Some participants spoke about how their increased awareness did not change the way they thought about smoking, or their smoking practices, while for others,
participation in the study offered a sense of hope in relation to quitting smoking. For example, Shayma (19, smoker) said,

I’ve just had more of a belief that I can [quit] compared to before. Before I was just like, “na, it’s not going to happen. That’s just who I am.” But more and more, I’m like, you know what, maybe I can, and maybe I will one day.

Other participants were more reluctant to engage in reflexive analysis (Enosh & Ben-Ari, 2016). Age may also have been a factor as a lot of the younger participants were less descriptive in their accounts and did not appear to have the same vocabulary, or ability to be reflexive about their smoking.

Given the emotional engagement required for this type of reflexive analysis (Reinharz & Chase, 2001), it was important to recognise any signs of distress amongst participants during both the interviews and my contact with participants during the photography activity. I did not notice any signs of abnormal discomfort or distress during any stage of the study. Independent health service material was made available to participants, in the form of telephone numbers, for the New South Wales (NSW) Quitline and the Cancer Council Helpline.

**Analysing the data.**

The data collected for this thesis were analysed using discourse analysis, focusing on how meaning is constructed through talk, text, and imagery (Tonkiss, 1998). When it comes to doing discourse analysis, “there are no recipes or formulae” (Gavey, 1989, p. 467). The analysis I conducted, involved two steps. The first step was the thematic organisation of the data through transcription, coding, and creating
summaries. In the second step, I identified discourses, using two methods of discourse analysis: discursive psychology and Foucauldian discourse analysis.

Although there are many ways to analyse discourse (see Wetherell, 2001), discursive psychology and Foucauldian discourse analysis have been identified as the two dominant approaches (Willig, 2008b). In this section I discuss the two approaches, and how I drew on each approach to answer different research questions.

Discursive psychology is associated with the works of Jonathon Potter and Margaret Wetherell (Potter & Wetherell, 1987; Wetherell & Potter, 1988), and largely focuses on how speakers use discursive or linguistic resources to construct meaning during social interactions. These linguistic resources are often referred to as “interpretative repertoires”, examples of which include terms, metaphors, figures of speech, visual images, and modes of explanation (Edwards, 2004; Wetherell & Potter, 1988). Repertoires can be contradictory, and they function differently depending on the context in which they are used (Burr, 2015). Discursive psychology is best suited to the analysis of the performative qualities of interpretative repertoires in everyday discourse (Willig, 2008b). In Chapter Three I use discursive psychology to analyse the performative qualities of young women’s use of discourse in their accounts of doing feminine gender identity in their daily lives. In Chapter Five I use it to analyse young women’s accounts of smoking and risk in their everyday lives, and how these discourses allow young women to perform respectable femininity.

Another common discourse analytic approach is Foucauldian discourse analysis (Willig, 2008a). Foucauldian discourse analysis focuses on the way discourse relates to broader social processes of legitimation and power, and the
subject positions available to, and taken up by different groups of people (Willig, 2000). This analysis focuses on the discursive resources available to speakers, and how discourse constructs subjectivity and power relations (Willig, 2008b). Therefore, Foucauldian discourse analysis seeks to understand the social context in which discourse is situated, and how this relates to institutions of social control and power (Tonkiss, 1998). In Chapter Four I use Foucauldian discourse analysis to analyse young women’s constructions and experiences of smoking-related stigma and to explore how young women draw on different discursive resources to negotiate stigma, and how this relates to power. In Chapter Six I use it to explore young women’s experiences of smoking and quitting and to examine the subject positions made available to young women through discourses of responsibility, addiction, and choice.

Although discursive psychology and Foucauldian discourse analysis are distinct approaches, with several notable differences (Holt, 2011; Ussher & Perz, 2014), they are compatible, as demonstrated in previous research (see Rapley, 2004; Sims-Schouten, Riley, & Willig, 2007; Wetherell, 1998). By drawing on both approaches in the thesis, I analyse young women’s smoking discourse on both a micro and macro level – in their interview accounts, and in relation to wider social and institutional discourses and practices (Holt, 2011; Sims-Schouten et al., 2007). In the next section I explain the first step of the analysis: transcription, coding, and summarising of the data.
The first step of analysis: Transcription, coding, and summarising.

The first step in analysing the data was the transcription of the interviews. The interviews were transcribed verbatim by a professional transcription company, and included non-verbal expressions, such as laughs and sighs. I then integrity checked the transcripts, by listening to the audio recordings, checking for errors, and making corrections where necessary. During my integrity checks I anonymised the transcripts, removing any names, places, and identifying information. This process helped me become more familiar with the data prior to analysis (Braun & Clarke, 2006). As I familiarised myself with the data, I began making notes about some of the concepts or common themes that appeared in the data.

Extracts from interview transcripts included in the analysis chapters are subject to several transcription conventions. To improve readability and sense, words have been included in square brackets “[]”, and filler words, such as “um” and “yeah” have been removed. Three periods “…” are used to indicate removal of irrelevant talk from the beginning, middle, or end, of a quote.

Following transcription, I began coding: a process which allowed me to organise my data into themes, as detailed below. I uploaded all the interview transcripts and photographs into NVivo 10, a computer software programme that allows for the compilation, management, and coding of qualitative data. An integrative approach was taken to data analysis, where the data from the nine women who participated in just the stage one interview, and the 18 women who participated in all three stages of the study, were analysed together. By integrating multiple data components during analysis, I was able to build stronger, more useful conclusions.
Bazeley, 2011). Analysing participants’ combined narratives helped to illuminate recurring themes and ideas, as well as shifts and changes (Thomson & Holland, 2003).

I then selected three interview transcripts and one set of photographs, and went through each transcript, line-by-line, and each photograph, and identified first order codes, which capture both semantic and latent content. Semantic themes operate at an explicit level, on the ‘surface’, while latent themes are on an interpretative level, and recognise underlying ideas and concepts (Braun & Clarke, 2006). For example, “cost of cigarettes” or “smoking at work” are first order codes which capture semantic themes, while “smoking as a performance”, and “smoking as resistance” are first order codes which capture latent meaning. My initial codes were reviewed by my primary supervisor, who provided me with feedback.

Once I had finished first order coding, I read through the codes identifying similarities and differences between them and organising them under thematic higher order codes. The first order codes, “smoking to fit in” and “smoking to manage emotions” for example, were subsumed under the higher order code “reasons for smoking”. This process of creating higher order codes led to the development of an initial coding framework, which organised the data into thematic areas. The framework was reviewed by my supervisors and the broader project team, and was refined through the renaming, collapsing, removal, and separating out of codes. For example, the first order code, “smoking and partners”, was collapsed from the higher-order code “smoking in relation to other people”, to separate and distinguish participants’ experiences of smoking in relation to their partners. Using this revised
coding framework, I then coded the remaining interviews and photographs. While coding the remaining data I made some additional minor changes to the organisation and naming of codes. The final coding framework is included in Table 3.

The development of the coding frame was inductive, as it was based on the data, rather than any pre-existing theoretical or analytic interest (Braun & Clarke, 2006). However, it is not possible to entirely separate the researchers’ preconceptions from this process (Braun & Clarke, 2006). For example, I created the code “smoking as a performance”, which is a code that may not have been created by a researcher who had not adopted a constructionist epistemological stance.

Table 3. Final coding framework

<table>
<thead>
<tr>
<th>The practicalities of smoking</th>
<th>First experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessing cigarettes</td>
<td></td>
</tr>
<tr>
<td>Amount smoked</td>
<td></td>
</tr>
<tr>
<td>Cost of cigarettes</td>
<td></td>
</tr>
<tr>
<td>Holding, ashing, blowing</td>
<td></td>
</tr>
<tr>
<td>Smoking accessories</td>
<td></td>
</tr>
<tr>
<td>Times when smoking</td>
<td></td>
</tr>
<tr>
<td>Cigarette types or brands</td>
<td></td>
</tr>
<tr>
<td>Reasons for smoking</td>
<td>Smoking to fit in</td>
</tr>
<tr>
<td>Smoking to manage emotions</td>
<td></td>
</tr>
<tr>
<td>Smoking as time-out</td>
<td></td>
</tr>
<tr>
<td>Smoking as cool</td>
<td></td>
</tr>
<tr>
<td>Smoking as enjoyable</td>
<td></td>
</tr>
<tr>
<td>Smoking as normal</td>
<td></td>
</tr>
<tr>
<td>Smoking as resistance</td>
<td></td>
</tr>
<tr>
<td>Associations with smoking</td>
<td>Smoking, alcohol and partying</td>
</tr>
<tr>
<td>Smoking and other drugs</td>
<td></td>
</tr>
<tr>
<td>Associations between smoking and other things</td>
<td></td>
</tr>
<tr>
<td>Smoking in relation to other people</td>
<td>Smoking and parents</td>
</tr>
<tr>
<td>Smoking and partners</td>
<td></td>
</tr>
<tr>
<td>Smoking and children</td>
<td></td>
</tr>
<tr>
<td>Smoking and socialising</td>
<td>Social smoking</td>
</tr>
<tr>
<td>Smoking in different spaces</td>
<td>Smoking at work</td>
</tr>
<tr>
<td>Smoking at home</td>
<td></td>
</tr>
<tr>
<td>Smoking at school/university</td>
<td></td>
</tr>
<tr>
<td>The acceptability of smoking in different spaces</td>
<td></td>
</tr>
<tr>
<td>Understandings of smoking</td>
<td>Smoking as a performance</td>
</tr>
</tbody>
</table>
Once I had coded all the data, I went through and summarised the content of each code. In these summaries I identified recurring and distinct ideas within and across participants’ accounts. For example, within the data coded as “smoking and other drugs”, I noted the idea “cigarettes are a safer alternative to other drugs”. For each of these ideas, I referenced quotes from participants’ interviews or photographs, using an asterisk to signify quotes that were particularly illustrative. The coding summaries helped to further organise my data and helped with the second step of the analysis – identifying discourses. A sample coding summary is included in Table 4.
Table 4. Coding summary sample

<table>
<thead>
<tr>
<th>Smoking and other drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Smoking as leading you to try other drugs (Jennifer, Lisa)</td>
</tr>
<tr>
<td>• Smoking and drugs as having the same fun, risk-taking associations (Jennifer, Lisa, Shannon)</td>
</tr>
<tr>
<td>• Smoking marijuana as leading you to smoke more cigarettes (Jennifer, Lisa, Shannon), or less (Shannon, Tara)</td>
</tr>
<tr>
<td>• Mixing tobacco with marijuana (Shannon, Shannon), which is easier with rollies (Shannon)</td>
</tr>
<tr>
<td>• Cigarettes as a safer alternative to other drugs (Rachel, Sinta), less addictive (Stephanie), but more addictive long-term (Stephanie*)</td>
</tr>
<tr>
<td>• Smoking cigarettes as treated less severely than other drugs (Stephanie), and has less stigma (Stephanie*)</td>
</tr>
<tr>
<td>• Cigarettes as being less acceptable than alcohol and other drugs (Shannon, Shannon)</td>
</tr>
</tbody>
</table>

Participants talked about the relationship between smoking and other drugs in different ways. Some participants positioned cigarettes as a safer, more acceptable form of drug taking, while others positioned cigarettes as a dangerous drug that can lead you to try other drugs. Some participants smoked more when taking drugs, others smoked less.

Participants talked about how cigarettes are thought of in a similar manner to other drugs i.e. associated with fun and risk-taking.

Lisa’s photograph shows how smoking cigarettes takes place in the same environment as other drug taking.

Shannon’s photo shows how she associates the fun of taking drugs and smoking cigarettes together.

The second step of analysis: Identifying discourses.

The second step of the analysis involved the identification of discourses in the thematically coded and summarised data. In Chapters Three and Five, I analysed the data using discursive psychology. I was interested in how participants drew on interpretative repertoires to position themselves in relation to discourse.

Interpretative repertoires were identified through a process of reading and viewing segments of the data and identifying patterns of discourse (Wood & Kroger, 2000). I studied the variations, inconsistencies, and differences in the language used in participants’ accounts of their smoking (Wetherell & Potter, 1988), as well as the
effect of these discursive resources (Holt, 2011). For example, when coding the data, I identified the phrase, “it won’t happen to me”, as reoccurring. When examining participants’ use of this phrase, I noted how it allowed participants to be dismissive of, or distance themselves from the health risks of smoking. See Table 5 for an example of how discourses were identified in Chapter Three.

Table 5. Examples of discourse in Chapter Three

<table>
<thead>
<tr>
<th>Discourse</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigarettes and smoking styles as gendered</td>
<td>Participants differentiated between “a feminine way” and a “guy’s way” of smoking</td>
</tr>
<tr>
<td>Smoking as controlling weight</td>
<td>Participants spoke about smoking providing an “oral fixation”, and said nicotine was a form of “appetite control”, and that they “replaced food with smoking”</td>
</tr>
<tr>
<td>Smoking as a sexual tool</td>
<td>Participants spoke about the association between women’s smoking and heterosexuality, drawing parallels between smoking, women’s mouths, and heterosexual sex</td>
</tr>
<tr>
<td>Smoking as compromising appearance</td>
<td>Participants spoke about how smoking damaged their skin, nails, and teeth, saying “if I didn’t smoke, I wouldn’t be getting all wrinkly”</td>
</tr>
</tbody>
</table>

In Chapters Four and Six I analysed data using Foucauldian discourse analysis. I used a series of theoretically informed questions to guide this process (Holt, 2011): ‘What discourses are drawn on by young women to construct their experiences of smoking?'; ‘What subject positions are made available to young women by these discursive constructions?'; ‘How do young women negotiate these subject positions?'; and ‘What are the implications of these subject positions for young women – particularly in relation to power?’ Following the identification of discursive constructions, I then considered the functions of these discourses, the subject positions they made available, and the implications of these discourses for
individual subjectivity and practice (Ussher & Perz, 2014). For example, the “smokers as bad mothers” discourse, a widely accepted “truth” (Wigginton & Lee, 2013), made the subject position of irresponsible and “bad mother” available to women who smoked, while for women who had quit smoking, the position of responsible, and “good mother” is made available.

The photographs were analysed alongside the interview data. As with the interviews, the analysis of the photographs involved paying close attention to detail, complexity, and contradiction within images, across images, between images and interviews, and comparing participants’ images with broader social and cultural discourse (G. Rose, 2016). Participants’ photographs were not positioned as representations of a “truth” or “reality”, but as representations of participants’ experiences of smoking, produced within the context of the study (Pilcher et al., 2015). When analysing participants’ photographs, I asked questions such as: ‘Who is the assumed audience?’, ‘What is the photograph trying to tell or persuade the viewer of?’, and ‘What is invisible, what is not seen?’.

A reflexive pause.

It is important for me to be reflexive about how I influenced the data analysis process. As Stainton-Rogers and Willig (2017, p. 7) note “[themes do not] somehow magically ‘emerge’ from the data, as if there were no human meaning-making going on”. During the coding and analysis phases I wrote notes in my reflexive journal. We also had discussions in the broader project team, about how our own identities and experiences shaped the way each of us interpreted the data. For example, my own lived experiences of social class, which were situated in a New Zealand cultural
context, were different to that of my primary supervisor, who was raised in England. These differing experiences led my primary supervisor and I to debate the different ways in which social class shaped the experiences of the young women in the study. My primary supervisor had also smoked for a period in her life, while I have not. Our differing experiences with smoking also contributed to our debates about how we might interpret participants’ accounts. These discussions helped me to recognise that multiple interpretations of the data were possible, and that my own interpretations were shaped by my own lived experiences.

**Conclusion**

In this chapter I have detailed the epistemological and theoretical approaches I draw on in this thesis, and the research methods utilised. In the next four chapters I present the findings from my analysis, which are published as journal articles. The subsequent chapter, Chapter Three, is the first analysis chapter, and contains a journal article, *Doing and undoing femininities: An intersectional analysis of young women's smoking*, which examines young women’s smoking in relation to their performances of femininity.
Chapter Three: Doing and Undoing Femininities: An Intersectional Analysis of Young Women’s Smoking.

This chapter contains the journal article *Doing and undoing femininities: An intersectional analysis of young women’s smoking*. This article uses an intersectional approach to explore young women’s constructions and experiences of smoking in relation to their performances of femininity and other intersecting identities. This article is also included in Appendix L.

Abstract

Previous research has found that young women’s smoking relates to their performance of feminine gender identities. Using an intersectional approach, we explore in this study how young women’s smoking is implicated in the doing and undoing of femininities, as well as other intersecting identities. Discourse analysis was used to examine interviews and a photography activity conducted with young women, both current and ex-smokers. This analysis revealed four culturally dominant repertoires: “cigarettes and smoking styles as gendered,” “smoking as controlling weight,” “smoking as a sexual tool,” and “smoking as compromising appearance.” Young women’s experiences and negotiations of discourse surrounding smoking and femininity were shaped by intersecting social class, and sexual identities. These findings can be used to inform the development of smoking cessation interventions which recognise the diversity in how young women perform femininity.

Introduction

Widespread social disapproval meant that historically women in Western cultures were much less likely than men to smoke cigarettes (Waldron, 1991). Currently, in much of the Western world, this gender gap is not as large, and in some countries, women are smoking just as much, if not more than men (Ng et al., 2014). In Australia the percentage of women who smoke daily is 11.2%. Although this is lower than the overall percentage of men, in certain parts of Australia, women are smoking at similar or higher rates than men (AIHW, 2014b). Australian women are most likely to smoke daily between the ages of 25 and 29. In recent years there have
been increases in the mean number of cigarettes smoked per week by women between the ages of 18 and 29 (AIHW, 2014b). Trends such as these have led to calls for research which adopts a gendered perspective in understanding smoking (Sieminska & Jassem, 2014). A gendered perspective helps to provide insight into the specific reasons why young women smoke, and the difficulties they have with quitting, information which can then be used to inform the development of targeted health education material.

Gendered research carried out in a Western context has shown that women are more likely than men to be negatively affected by smoking-related stigma (Evans-Polce et al., 2015), more likely to report being dependent on cigarettes, and to have lower expectations and less positive experiences with cessation (Sieminska & Jassem, 2014; US Office on Smoking and Health, 2001). In addition to the general health risks associated with smoking, young women face additional risks related to pregnancy outcomes and contraindications with oral contraceptives (Ernster et al., 2000).

Research on women’s smoking often draws on the concepts of gender and gender identity. Gender has been conceptualised in feminist scholarship as a constructed identity, which is neither stable or coherent (Bradley, 2013). Several theorists have examined the way in which gender is enacted on an individual level. For example, West and Zimmerman (1987) use the notion of “doing gender” to imagine gender as a routine, everyday practice. Similarly, Butler (1993, 2006) describes gender as an on-going performance, made up of stylised acts. Within feminist theory, gender identity has been reconceptualised as “durable but not
immutable” (McNay, 2000, p. 2), allowing space for agency and the resistance of gender norms. Butler (2004) uses the phrase “undoing gender” to describe the process by which normative conceptions of sex and gender are routinely undone.

A number of studies have focussed specifically on the relationship between young women’s smoking and gender identity. Young women have given accounts of constructing feminine gender identities through purchasing long, slim cigarettes and lightly coloured cigarette packets, and through the holding and ashing of cigarettes in a showy style (Gilbert, 2007b). A small proportion of young women report using smoking as a conscious dieting strategy (Nichter et al., 2004), allowing them to maintain the feminine ideal of a slim body (Bordo, 2003). As well as constructing femininity, young women have also spoken about how smoking can compromise their femininity, citing the smell of smoke on their clothing and bodies as one such example (Amos & Bostock, 2007). Scheffels (2009, p. 482) uses the phrase “split vision” to describe this type of tension, where smoking is seen to serve both positive and negative functions.

Young women’s constructions of their smoking as both feminine and unfeminine correspond with broader Western cultural constructions of smoking and femininity, which continue to shift across time and space (Butler, 2006). In the early twentieth century, women’s smoking was often seen as a symbol of prostitution (Greaves, 1996), but as women took up smoking in larger numbers, it also came to be seen as a source of liberation and emancipation (Greaves, 1996; Tinkler, 2006). Cultural shifts in women’s smoking transformed it from a “mannish” practice, associated with lesbianism, into a way for heterosexual women to attract men, a shift
reflected in portrayals of women’s smoking as glamorous and feminine in tobacco marketing material (Greaves, 1996, p. 22). However, these representations have been challenged over the past fifty years by anti-tobacco messaging, which has worked to reposition women’s smoking as unfeminine and unattractive (Bottorff et al., 2014; Haines-Saah, 2011).

Cultural constructions of women’s smoking are also shaped by intersecting identities, such as social class and sexuality. Throughout history, the consumption of cigarettes has often been marked by distinct socioeconomic differentials. In Australia, smoking has become “a badge of unemployment, low socioeconomic status and low educational achievement” (Chapman & Freeman, 2008, p. 27). Among women, lower education and household income levels are associated with higher rates of smoking, a trend which is most visible during pregnancy (Huang & Ren, 2011). Sexuality is another important intersection in understanding women’s smoking. In parts of Australia, lesbian and bisexual women are approximately twice as likely to smoke as the general population (ACON, 2015). Researchers exploring the relationship between smoking and sexuality found that smoking and sexual orientation identities intersect, and shape how lesbian and bisexual women develop their self-concept (Comfort, 2012). These studies point to the need to study women’s smoking and identity from an intersectional lens.

Despite calls from researchers for a greater consideration for identities which intersect with gender (Bottorff et al., 2014), there is no previous research that has looked at the intersection of social class, sexuality and gender in young women’s constructions of smoking within a Western context. The present study addresses this
gap in the research literature by adopting an intersectional approach, to answer the research question: how does gender intersect with social class and sexuality to shape young women's constructions and experiences of smoking? A further aim of this paper is to extend existing research on the contradictory constructions of women’s smoking (Greaves, 1996; Haines-Saah, 2011), by exploring how young women negotiate a split vision in relation to their smoking and its ability to both do and undo femininities. We look to advance current quantitative and epidemiological research which positions women’s identities as singular or fixed, by adopting a qualitative methodology, which allows for a more complex understanding of identity as fluid and multiple.

**Method**

**Participants.**

Twenty-seven young women, smokers and ex-smokers, between the ages of 18 and 31 (mean age = 24) took part in the study. The target age range (18-30 years) was selected as it encompasses a time period when women are most likely to be daily smokers (AIHW, 2014b). Eighteen of the women were current smokers, with most of these women smoking less than fifteen cigarettes a day (56%). The nine ex-smokers who participated in the study had quit smoking sometime between two weeks and two years. Most of the women who participated in the study identified as Anglo Australian (63%), with the remaining women identifying with Aboriginal Australian, Asian, American, European, Middle Eastern, and Pacific Island cultural backgrounds. When presented with the following categories, the majority of the
participants identified as being from working-class (44%) and middle-class (48%) backgrounds, while (7%) identified as being upper-middle class. Most of the women described themselves as heterosexual (67%), or bi-sexual (26%) and a smaller number identified as lesbian (7%). At the time of the study, over a quarter of the women had children (26%), and one woman was pregnant.

**Procedure.**

Participants were recruited through the distribution of flyers at train stations, undergraduate university tutorials, tertiary education campus noticeboards, as well as online advertising on social media. Participants were purposively selected in order to include young women from a variety of social class, and sexual identity backgrounds. This approach is used in intersectional research to ensure that women with identities which carry less social power and status, such as working-class, or lesbian, are made visible (Warner, 2008). Participants took part in a three staged study: 1) in-depth, semi-structured interviews, 2) a photography activity, and 3) follow-up, in-depth, semi-structured interviews. The stage one interview explored participants’ experiences with smoking, quitting, and their perceptions of smoking in the media. Participants were asked questions such as: “What were your reasons for starting to smoke?” which were followed up with prompts, such as, “Do you feel your reasons for smoking are any different now?” In the second stage participants took photographs of their experiences with smoking for an average period of three weeks. Participant-produced photography also offers first-hand insight into how young women construct and visualise their smoking (Haines-Saah, 2011). Participants submitted a total of 157 images, which were mostly photographs, but
also included images they had downloaded or created themselves. During the follow-up interview participants were asked about their first interview, their photographs, and their experiences of being involved in the study. The follow-up interview also gave the interviewer an opportunity to clarify any issues raised in the first interview. An example of the types of questions participants were asked during their follow-up interview is: “Tell me about what it was like taking photographs of your experiences with smoking.” In order to answer the question of how gender, social class and sexuality intersect, we asked participants questions about their experiences of smoking in the context of everyday life in order to avoid presenting identities such as “woman” or “lesbian” as discrete entities (Bowleg, 2008; Christensen & Jensen, 2012). The interviews for stages one and three lasted 45 minutes on average. The majority of interviews were conducted by the first author, a young woman, had only smoked a handful of cigarettes in her life and would be classified as a non-smoker.

The process of combining multiple research methods, such as interviews and a photography activity, is referred to as “methodological triangulation”, and it is said to enhance the quality of qualitative research by providing “a more complete picture” and allowing for “higher level interpretations of the data” (Farmer, Robinson, Elliott, & Eyles, 2006, p. 390). We also used a technique called investigator triangulation, where the perspectives of the four authors were brought into the coding and analysis process. The four authors range in age, have different sexualities, social class backgrounds, and theoretical and disciplinary experiences. As with the first author, the other authors were all non-smokers, although one of the authors could be classified as an ex-smoker as she had spent some time socially smoking in the past.
Reflexively interrogating these subjectivities was another way the integrity of the study was increased. For example, reflexive journaling allowed the first author to become self-aware of her motivations, assumptions, and biases as a non-smoker who is doing smoking research (Finlay, 2002).

Twenty-seven women participated in the first stage of the study, and eighteen of those women went on to participate in the second and third stages. Due to geographical constraints, 35 out of 45 interviews were conducted over the phone, with the remaining 10 interviews done face-to-face at university campuses across metropolitan Sydney. Participants gave informed consent to participate in the study, and gave permission for non-identifying photographs to be included in publications and presentations. Ethics approval was granted by Western Sydney University Human Research Ethics Committee.

**Theoretical framework and analysis.**

In our analysis, we drew on a number of theories which sit within a social constructionist paradigm. This epistemological positioning grounded our understandings of smoking and identity as socially constituted in time and space (Burr, 2015). Our analysis is based on a social constructionist understanding of gender as being done or undone through routine, everyday practices, and stylised acts (Butler, 1993, 2004, 2006; C. West & Zimmerman, 1987). This understanding of gender is combined with an intersectional approach, a perspective which looks at how multiple categories of identity intersect and interact (Christensen & Jensen, 2012). We adopt what intersectionality researchers refer to as a both/and approach, where we acknowledge both an overall, or ‘master’ category, and the points of
intersection where this category meets other identities (McCall, 2005; Warner, 2008, p. 458). In our analysis we look at how our master category, gender, shapes experiences of smoking, as well as how these experiences are further shaped by intersections with social class or sexuality.

We adopted a method of discourse analysis developed by Potter and Wetherell (1987) which allowed us to consider how young women’s understandings of smoking and identity “are constituted in and through discourse” (Wood & Kroger, 2000, p. 2). In preparation for analysis the interviews were professionally transcribed and then integrity checked by the first author, at which point participants’ names were replaced with pseudonyms. The process of integrity checking allowed the first author to listen and re-read the interview and photography data. Having become familiar with the interview and photography data, a coding frame was developed through consultation between the researcher team. The data were coded by the first author, and checked by the second author. The coding summaries were reviewed by the research team, beginning an iterative process of reading and interpreting segments of data, and identifying discursive patterns (Wood & Kroger, 2000). We drew on positioning theory (Davies & Harré, 1990) to help us examine the ways in which participants took up, or were assigned, subject positions in relation to their smoking, and the ways in which these subject positions allowed women to both do and undo feminine identities. We also used the concept of ‘discursive footwork’ to help us make sense of how young women positioned themselves in relation to discourses of feminine smoking. The term ‘discursive footwork’ refers to the way people negotiate challenges to their identity by aligning themselves with a defensible
position (Goffman, 1981). Through this process we came to identify four sets of terms, metaphors, and figures of speech that participants used to construct their accounts, what Wetherell and Potter (1988) call “interpretative repertoires.”

This paper explores the four interpretative repertoires participants used to construct their experiences of smoking and the performance of femininities: “cigarettes and smoking styles as gendered,” “smoking as controlling weight,” “smoking as a sexual tool,” and “smoking as compromising appearance.” We examined the ways participants drew on these discursive repertoires to position themselves in relation to discourses of smoking and femininity, looking at how these relate to broader cultural discourses associated with smoking in public health and popular media. Participants’ age and smoking status has been added in parenthesise in order to help contextualise their quotes.

Findings

**Cigarettes and smoking styles as gendered.**

Young women in the study spoke about cigarettes and different styles of smoking as being gendered, and how the practice of smoking is used to perform feminine identities. Participants differentiated between “a feminine way” and a “guy’s way” of smoking. A masculine style of smoking was described as “aggressive”, “rude” and “powerful”. Men were said to be more perfunctory in their smoking, taking less time to smoke, often holding the cigarette between their thumb and forefinger, and concealing it in their palm. A feminine style of smoking was said to be “dainty”, “elegant” and “posh”. Women were said to take their time smoking,
holding their cigarettes between their middle and fore fingers, away from their body in a showy, open fashion. For example, Danielle (30, smoker) spoke about the way she smokes in these terms,

The way that I smoke is very social. Fingers out, and my wrists are showing and I’m chatting with my hands. Sometimes guys smoke like, it’s almost enclosed in their palm…their body language suggests that they’re sneaking a cigarette. It’s not like that, it’s very open and chatty and – I don’t want to say feminine, but that’s the word that’s coming to mind.

In her account, Danielle positions her smoking as a performance, where she gestures with her body (fingers, wrists, palms) in order to communicate a feminine gender identity (Butler, 2006). Danielle also talks about how this feminine way of smoking is “very social”, drawing our attention to one of the reasons why young women take up, and continue with smoking (Gilbert, 2007a; Haines et al., 2009). A number of participants took photographs capturing this feminine way of smoking (Figure 11), where cigarettes were often featured alongside other markers of femininity, such as nail polish, or sitting with crossed legs (Figures 12 and 13).
Figure 11. A feminine style of smoking, where the cigarette is held in an open palm, away from the body.
Figure 12. A photograph of a woman holding a cigarette shows another marker of femininity, nail polish.
Figure 13. A photograph of a woman holding a cigarette shows another marker of femininity, crossed legs.

These gendered styles of smoking intersected with the performance of class and sexual identities. In participants’ accounts, a woman adopting a masculine style of smoking was associated with a “butch” lesbian identity. For example, Kalika (19, smoker) said, “I’m around a lot more butch women and they hold their cigarettes a very masculine way, like between two fingers like that [gestures with her thumb and forefinger]”. Within a heterosexual matrix, binary understandings of sex, gender, and sexuality mean that women displaying masculine behaviours may be identified as
lesbian (Butler, 2006). Performing smoking may therefore serve as a means of outwardly positioning a woman’s sexual identity. For example, Danielle (30, smoker), spoke about smoking as a way for her and her partner to take up butch/femme identities in their lesbian relationship. While Danielle talked about smoking in an “open”, “feminine way”, she said her partner smoked “the guys’ way”, doing more of a “hiding thing”. She said,

I think for me I would, hope pitting myself as the femme fatale with red lipstick and it’s all very sexy and sultry. But, for my partner, who’s quite masculine I think, she would be in that more Fight Club role where it’s cool and it goes with the image.

By smoking in a “feminine way”, Danielle positions herself as a “femme fatale”, while her partner uses a masculine style of smoking seen in the film Fight Club to perform a butch identity. In this account, smoking can be seen as a subversive act, as it allows these women to take up butch-femme roles, undoing gender by disrupting dominant constructions of femininity as heterosexual (Butler, 2006). Women’s masculine smoking styles were open to being interpreted in other ways, however. Some participants described women’s adoption of a masculine style of smoking as representative of a lower class position. As Stephanie (29, ex-smoker) said,

That way of holding a cigarette [between the thumb and forefinger] looks really, really shingly and cheap. It doesn’t make you look classy.

Yes. And, why do you think that is that way for a woman?

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2 Italics are used to indicate the interviewer’s speech
I suppose I see it as being a more refined, a more classy type. I think it’s something that some of us need to aspire to and, it just looks really horrible, especially for a woman.

Stephanie differentiates between “classy” and unclassy ways of smoking, and in doing so, indicates how smoking might be conceptualised as a classed practice of “distinction” (Bourdieu, 2010, p. 223). Stephanie said that women “especially” should “aspire” to be “classy”. This reference to aspiration suggests a class hierarchy and reinforces the privileged status of a middle-class femininity (Skeggs, 1997). This narrative therefore illustrates one way in which gender and class intersect – through doing femininity in the social practice of smoking.

Participants also gave accounts of how femininity was performed and represented through the types of cigarettes participants consumed. The women in the study talked about how cigarettes containing herbal or menthol flavouring were “girls” cigarettes’ (Jing, 24, ex-smoker), and how “cigarette cases”, “slim cigarettes”, and “long cigarettes”, were “more feminine” (Danielle, 30, smoker). What is more, as was the case for smoking style, the consumption of certain types of cigarettes was seen to signify a classed femininity. For example, Jessica (22, smoker) talked about how cigarettes in “a white packet with a gold trim” were “sophisticated”. Another woman, Jing (24, ex-smoker), talked about the packaging of the “women’s” cigarettes she used to buy in China, saying, “it looks elegant and looks expensive”. Finally, Tara (24, smoker) gave an account of her sister providing her with “not as strong” cigarettes during high school, as the “harsh” ones were seen to signify a lower social class. These examples show how individuals might be “driven” to adopt
the styles and objects of consumption that are perceived to be the more sophisticated
tastes of the affluent (Storr, 2002, p. 32). As with Stephanie’s account of different
ways of smoking, the accounts of different types of cigarettes exemplify the way in
which class intersects with femininity, and how consumer culture has emerged as a
new mode of gender performance (McRobbie, 2007).

**Smoking as controlling weight.**

Within modern Western culture, the creation of a thin body is a significant
marker of an idealised (hetero) feminine identity (Bordo, 2003). A number of
participants spoke about using smoking to control their weight, and thereby perform
femininity. For example, women spoke about smoking providing an “oral fixation”
(Jennifer, 26, smoker), saying nicotine was a form of “appetite control” (Lisa), and
that they “replaced food with smoking” (Gemma, 25, ex-smoker). One participant,
Shannon (23, smoker), said,

> I realised that when I binge ate I didn’t smoke during it. So, I was like,
> ‘What’s going on there? Maybe if I smoked during that place where I binge
eat, then I wouldn’t binge eat, I’d just smoke instead, and that’s fine, right?

Because then I’m thin, right? And, that’s where everything’s good.

Through smoking, Shannon is able to control her binge eating and create a thin body.
This leads Shannon to rationalise the implicit health risk of smoking as “fine”,
because she is able to socially profit from being thin, saying “that’s where
everything’s good”. Shannon’s position is supported by an obesity health discourse
where thinness is seen “as a universal good” (Rich & Evans, 2005, p. 346).
Conversely, other participants were reluctant to admit to using smoking as a weight control strategy. For example, Megan (26, smoker) said,

I think a lot of people still use ciggies as a replacement to food because there are a lot of super slim people that live around here.

Is that something that you’ve had personal experience with?

I have done in the past. I had an eating disorder for about three years when I was younger, around the time I started smoking, but I didn’t at that time specifically use smoking as a replacement for food. But I have, definitely, in the past every now and then said “I’m not going to have that meal and I’m going to have a cigarette instead”.

Megan initially distances herself from the use of smoking to control weight by applying this strategy to others. It is only when she is probed that she talks about having done this herself in the “past”, when she was “younger”. Megan’s reluctance could be explained by a desire to present herself as resistant to cultural discourses associated with thinness, and to distance herself from what has been positioned by other young people as an “immature weight-control strategy” (Grogan et al., 2009, p. 182).

Putting on weight was a concern in the accounts participants gave of past or future quit attempts. For instance, Shannon (23, smoker) talked about becoming “depressed” when quitting smoking: “I just found whenever I quit I would start eating more, and that would make me really depressed, because then I thought I was getting fat, and then I hated it, so then I’d smoke.” Weight management was also a reason for women to go back to smoking. Jing, an ex-smoker who had quit smoking...
one year ago, talked about an old photograph (Figure 14) she submitted as part of the study, saying that it showed her looking “really skinny…because of smoking”. She said, “I may think if I want to lose weight, maybe I can go back to smoking.”

Figure 14. “When I see the old photo of me, I think I am so slim because of smoking.”

However, when asked about whether or not she would go back to smoking, Jing said “I also think being too slim is not beautiful, so maybe now is also good.” Jing talks about how an expanded definition for what is considered “beautiful” for a woman means she does not have to take up smoking again. This account suggests that less
restrictive ideas of what constitutes feminine bodies gives young women more space in which to choose not to smoke.

**Smoking as a sexual tool.**

A number of participants in the study gave accounts of using their smoking as a tool for performing their sexuality. Within these accounts they spoke about the construction of women’s smoking as sexy: “it’s kind of like sexy for the women to be smoking” (Olivia, 18, smoker). Participants also spoke about the association between women’s smoking and heterosexuality, drawing parallels between smoking, women’s mouths, and heterosexual sex. For example, Shannon (23, smoker) said: “It’s like you have a small penis between your fingers that you’re constantly fellating.” Lisa (26, smoker) remembered smoking when she was younger, and this being part of her discovery of her sexual attractiveness. In her account she talks about accessing cigarettes and alcohol by befriending older men:

The association with smoking is, sort of becoming sexually aware, like realising that these older men would do me favours because they found me sexually attractive, becoming aware that I had a little bit of power…awareness that I wasn’t a child anymore and my friend calls it the ‘power of the pussy’; how women can use the fact that men would like to have sex with them, to manipulate them horribly.

Lisa talks about how her smoking helped her to explore the “little bit of power” her sexual attractiveness offers. In her account, smoking forms part of Lisa’s transition from “child” to sexual woman, and is part of her negotiation of contradictory discourses where she is expected to be both “sexually aware”, and responsible in
using her sexual power (Renold & Ringrose, 2011). Her description of herself as manipulating men “horribly” suggests critical self-positioning, with the acquisition of cigarettes central to her failure to perform responsible feminine sexuality.

A number of women in the study discussed the ways in which the performance of smoking is used to attract potential sexual partners. Megan (26, smoker) talked about how smoking allows people to go into a space that is more conducive to conversation, saying, “a lot of the time that’s how you meet attractive men.” Smoking was also said to be a way for women to attract other women. Brittany (21, smoker) talked about first trying smoking in order to impress a girl she “had a huge crush on.” Kalika (19, smoker) also spoke about this idea of smoking to attract other women:

That’s how you meet lesbians. You go outside for a smoke and then that’s when you can talk to them and yeah it plays a massive part in that…when you see someone smoking I think that it sort of makes them appear as somewhat rebellious and seductive.

This construction of smoking as playing a “massive part” in meeting potential lesbian partners is a potential explanation for why young, single, lesbian woman, such as Kalika, might chose to smoke.

In their accounts, the women often drew attention to the contradicting discourse surrounding smoking and sexuality. For example, Megan (26, smoker) took a photograph of a Google image search showing glamorous Hollywood film stars smoking. She spoke about this photograph, saying, “it sounds really gross, but sometimes when you’re all made up, and you’ve got your lippy on and stuff and you
have a cigarette, you feel very glamorous and beautiful, like the women in the photos.” In her account we see Megan qualifies her experience of smoking as “glamorous and beautiful” by saying it “sounds really gross.” Other women challenged the very construction of women’s smoking as a way of being sexual. For example, Julie (31, ex-smoker), describes a photograph (Figure 15), she took, saying:

I just don’t think it looks sexy, it looks trashy, a cigarette hanging out of your mouth, it just looks really trashy, but that’s one of my favourite photos out of all of them because it’s not sexy it’s gross.

In her account Julie is able to affirm her position as an ex-smoker by challenging the construction of women’s smoking as sexy and reinforcing the stigmatisation of smoking as “gross”. Also, by using the term “trashy”, Julie reinforces the idea that the way in which women smoke is indicative of social class.

Figure 15. “That’s one of my favourite photos out of all of them because it’s not sexy it’s gross.”
Some of the women spoke about using their smoking as a tool for negotiating potentially compromised sexualities. For instance, Shannon (23, smoker) says,

I lost my virginity when I was 13…And, it was just a big odd thing about me that everyone knew…And, I guess, smoking for me became another thing that I could call my own, and that was mine. Because, that’s the thing, once you, like, “Oh, she’s not a virgin anymore,” and then all of a sudden you want to have all these other things on you, you know what I mean? Because, you’re like “I can be crazy in all sorts.” You know, so I just piled them on.

In the account she offers, Shannon uses smoking as a way to position herself as in control, in the face of the stigma she perceives after losing her virginity at a young age. By actively embracing what she describes as a “crazy” feminine subject position, outwardly signified by her smoking, Shannon is able to position herself as subversive rather than a social or sexual outcast (Lees, 1993). In another example, Lisa (26, smoker) said,

I’d had a massive night and did the walk of shame thing and went to this picnic and my friend’s boyfriend was making fun of me, saying that because of, you know, quite dressed up and whatnot, that I looked like I was out of Mad Men, and laughing, saying how I’m such a bogan but for some reason with a cigarette in my hand I’d become really elegant.

Lisa is made “fun of” for being “bogan” or lower class, and her “walk of shame” could potentially have led to a loss of reputation with her being labelled a slag (Bale, 2011). Yet, through her smoking she is repositioned as “elegant”, embodying feminine respectability. In both of these examples, smoking is said to help these
young women to negotiate the limited boundaries of respectable female sexuality, allowing them to avoid stigma, and to take up a position of sexual agency and empowerment.

**Smoking as compromising appearance.**

Many of the women in the study also talked about smoking compromising their physical appearance, and as a result, disrupting their performance of femininity. Participants spoke about how smoking damaged their skin, nails, and teeth, saying, “my teeth are quite yellow…and my complexion is grey” (Tara, 24, smoker), and “if I didn’t smoke, I wouldn’t be getting all wrinkly” (Lisa, 26, smoker). Lisa took a photograph (Figure 16) of her teeth to show “how damaged they are.” The photograph that Lisa took bears resemblance to a smoking cessation image that was featured on cigarette packets in Australia at the time of the study (Figure 17). The similarity between the two images highlights the way in which a discourse of health and smoking cessation campaigns might shape the way women make sense of their smoking (Haines-Saah, 2011), and their bodies.
Figure 16. “My bottom teeth and how damaged they are.”

A compromised appearance, and a spoiled feminine identity, had negative implications for participants’ subjectivities. For instance, Tara (24, smoker) said, “I feel really ugly; it [smoking] makes me feel disgusting.” Another participant, Danielle (30, smoker), said, “I’ve been told that it is not attractive, and I look very unattractive when I smoke, which was hard for me because as a girly girl, that’s kind of very important.” Finally, Courtney (21, ex-smoker), said:

I remember when I used to be getting my eyebrows done and the lady would turn around and say to me, “You smoke.” And, I wouldn’t have even smelled like cigarettes, or had one, and I’d be like, “How can you even tell?” And, she goes, “You can see it in your skin.” And, I hated it. I hated the fact that she could see my skin was through smoking.

In an effort to avoid a compromised appearance, participants spoke about the various ways in which they worked to manage the physical impact of their smoking. For example, Ashlee (21, ex-smoker) said, “I used to have to bleach my fingers to get the nicotine stains off”, while Tara (24, smoker) talked about using whitening toothpastes to remove yellow stains from her teeth. For some women, the impact of smoking on their appearance was a source of motivation for them to quit. For instance, Lisa (26, smoker) said,

I’ve noticed lately that I’m starting to age and it terrifies me and I don’t want to be old, my teeth are getting really very bad, I’m getting all wrinkly, I’m getting the smoker’s wrinkles, you know, the vertical lines on the lips, I’m too vain to be comfortable with that, so I will eventually quit because I don’t know, vanity, I guess, (LAUGHS) will prevail.
Although Lisa talks about “eventually” wanting to quit smoking because of the impact it has on her appearance, she has little discursive space in which to rationalise this, evidenced by her laughter, and positioning of herself as “vain”. This lack of footing for women to be concerned about their appearance was also evident in other accounts where participants qualified concerns about the impact of smoking on their appearance, saying, “It sounds stupid” (Shayma, 19, smoker), or “I feel really shallow” (Olivia, 18, smoker). This limited space for footwork relates to the lack of entitlement women have to be openly concerned about their appearance, where women’s concerns about appearance are often interpreted as being narcissistic or vain (Fredrickson & Roberts, 1997). Yet, the fact that a women’s physical appearance has an influence on how she is viewed and treated in society means that this concern for appearance is actually often a strategic way for women to improve their social and economic prospects (Fredrickson & Roberts, 1997).

Participants structured their discourse in order to distance themselves from other women whose appearances are seen to be compromised from smoking. For example, Megan (26, smoker) talked about her mother’s genetics protecting her appearance from the impacts of smoking, saying, “there are genetics that weigh into these things as well. My mum’s been a smoker since she was 18, and she still looks like she’s only 35.” Emily (21, ex-smoker) distanced herself from a smoking cessation campaign that focuses on the impacts of smoking on appearance, by positioning it as being more relevant to other women more concerned about their appearance:
I am still a very natural person; I don’t wear makeup, doing my hair takes about five minutes. But I have friends who spend nearly two hours on their makeup and you know, if they’re being told that smoking is going to do whatever to their appearance, then they’re probably going to listen because they value their appearance that much.

Emily is able to distance herself from smoking cessation messaging which portrays a type of idealised femininity she does not aspire to (Haines-Saah, 2011). Participants also positioned the effects of smoking on appearance as only being a concern for “older” women. For instance, Briana (18, smoker) said, “When you smoke cigarettes it ages you, dramatically. It wouldn’t age me now, but as I went on I’m sure it would.” When discussing the effects of smoking on age and appearance, the participants often gave examples, or spoke about people in their 60s, 70s, or 80s, implying that the effects of smoking on appearance can only be seen with lifelong smoking.

Other women shifted between resisting and reinforcing the notion that smoking is unattractive and unfeminine. For example, Tara (24, smoker) said, Apparently, your skin rejuvenates itself every 35 days...So that’s why I try to tell myself, like maybe wrinkles and stuff, won’t go, they might fade a bit, but I just feel like, I’ve been smoking for seven years full-time now. I have to stop now before it does serious damage. It’s probably done a lot of damage already. So, the biggest reason obviously is that like an illness and yeah, like what motivates me, but obviously I guess, feeling, like I’m 24, but I feel like I look 30, even though people tell me I look 18.
Tara acknowledges that smoking affects her skin, saying her smoking has “probably done a lot of damage” and that she feels older, but then contradicts this by saying it is not “serious damage”, and that she is told she looks younger. This cycling between confirming and denying that smoking compromises her appearance and femininity is symptomatic of a split vision of smoking.

**Discussion**

In this study, we examined photographs and interview accounts, in order to understand how young women, both current smokers and ex-smokers, construct smoking in relation to gender, social class, and sexual identities. The ways in which women use smoking to both do and undo femininity can be understood in relation to Bartky’s (1990) concept of “disciplinary practices”, a feminist adaptation of Foucault’s theory of disciplinary practices and the production of the docile bodies. Bartky (1990, p. 65) describes three disciplinary practices which help construct feminine bodies:

- Those that aim to produce a body of a certain size and general configuration;
- those that bring forth from this body a specific repertoire of gestures, postures, and movements; and those directed toward the display of this body as an ornamented surface.

The first of these practices, the production of a body of a certain size, relates to the women’s accounts of using smoking to control their weight, and maintaining the thin body shape that is central to traditional notions of idealised femininity (Bordo, 2003; Ussher, 1997). As this study, and others (Fiissel & Lafreniere, 2006; Grogan et al., 2009; Zucker et al., 2005), have shown, weight is a concern for women who smoke,
making women more reluctant to quit smoking, and more likely to take up smoking again once they have quit. Comparing the consequences of being overweight (such as reduced economic and social opportunities (Fredrickson & Roberts, 1997), with the health risks of smoking, women are able to rationalise their smoking, and reject a discourse of health. The idea of women using cigarettes to manage their weight has been reinforced through cigarette advertising and popular media (Tinkler, 2006), and as a result, the association between smoking and weight control are common among women, yet almost absent amongst men (Paul et al., 2010). Previous research has shown that women who have higher levels of body shame are more likely to use smoking as a weight control method (Fiissel & Lafreniere, 2006). This suggests that cultivating a more body-positive culture among young women may reduce the number of incentives for them to take up smoking, as well as making it easier for them to quit.

The second of Bartky’s disciplinary practices refers to the construction of femininity through gestures, postures, and movements, as seen in participants’ descriptions of feminine ways of smoking being open and expressive with the body. These types of movements work to undo traditional notions of femininity, where women were expected to constrict their movements, and limit the amount of space they occupy (Bartky, 1990). This undoing of traditional femininity was shown to intersect with performances butch or femme lesbian identities. This association between smoking and the construction of sexual identities provides explanation for the report that among lesbian women “to be a lesbian is to be a smoker” (Comfort, 2012, p. 212). This finding, combined with the role of smoking in attracting a sexual
partner, may also help to explain the higher rates of smoking among lesbian and bisexual women, a propensity that contributes to health disparities between LGBT communities and the general population (ACON, 2015; Fish, 2009).

Bartky’s final disciplinary practice is the production of femininity through the regulation of women’s bodies as ornamented surfaces. In order to produce a feminine body women must maintain an attractive, youthful appearance, ensuring that the surface of their bodies “betray no sign of wear, experience, age” (Bartky, 1990, p. 69; Skeggs, 1997). Although women are expected to maintain attractive, feminine bodies, this work rarely garners them power, and their behaviour is often positioned as vain or trivial (Bartky, 1990). As has been noted in previous research (Grogan et al., 2009), the women in this study used ‘othering’ as a discursive technique to displace the stigma of smoking and aging onto older women. Grogan et al. (2009, pp. 179-180) note the “interesting tension” between young women taking up smoking as a way to appear more mature, but then having to later manage the negative physical signifiers of aging associated with smoking, such as wrinkles. This is yet another example of the conflicting functions that lead young women to develop a split vision of their smoking.

By conceptualising young women’s smoking in relation to these disciplinary practices, we can consider the subjective and practical implications this might have for identity development and smoking behaviours. If a young woman is able to adopt feminine gestures, postures, and movements when smoking, or is able to use cigarettes as a weight control strategy, her smoking helps her to discipline her body and achieve feminine identities. However, if she is unable to manage the impact of
smoking on the surface of her body, she may then be positioned as unfeminine and face stigmatisation as a result. These tenuous gender performances were shown to be inseparable from class and sexuality performances. Negotiating the feminine/unfeminine, the classy/unclassy, and the heterosexual/butch elements of their smoking is what leads these young women to feel conflicted about the function their smoking serves and to develop a split vision, and may lead to ambivalence about quitting (Scheffels, 2009).

Some participants rejected traditional notions of femininity and instead of using their smoking to discipline their bodies, they used it to undo gender by performing non-normative femininity. This resistance was exemplified by the women in the study who used their smoking to shift the boundaries of acceptable feminine heterosexuality. However, Budgeon (2014) warns that this type of resistance may be limited, and does not always translate into real social change in gender hierarchies. Tinkler (2006, p. 149) also draws our attention to the fact that it is usually only women with a higher class status who have this “leeway” to use their smoking to challenge dominant constructions of femininity.

Smoking cessation campaigns have reproduced the idea that smoking is unfeminine through images such as the “ugly older woman smoker”, and the “model non-smoker” (Haines-Saah, 2011, pp. 193, 196). These campaigns are often designed in response to studies which show that women are conscious of the impact of smoking on their appearance (Gilbert, 2005). For example, the 2014 Queensland State Government quit smoking campaign shows the aging effects of smoking on Rachael Finch, winner of Miss Universe Australia 2009, and is titled, “If you smoke,
your future’s not pretty.” Campaigns such as this perpetuate young women’s anxieties around appearance, reinforce the notion that a woman’s value and worth is tied to her ability to maintain her appearance, create negative stigma for women who smoke, and encourage young women to prioritise appearance over health (Haines-Saah, 2011). As noted in this study, these campaigns present a type of idealised hetero-femininity which for many socially and economically marginalised women is unachievable or undesirable, and can lead them to disengage with smoking cessation messages (Haines-Saah, 2011). Although these campaigns may be deemed a ‘success’ in terms of their potential to make some women quit smoking, they can also have the opposite effect, as well as potentially compounding the levels of smoking-related stigma experienced by women (Triandafilidis, Ussher, Perz, & Huppatz, 2016). Based on the findings from this study, we recommend an increase in women-centred smoking cessation programmes that build confidence, work to reduce the stigma young women experience around their smoking, acknowledge the impact of social and economic structural factors, and tackle young women’s ambivalence around their smoking (Greaves, 2015).

Some smoking cessation interventions have recognised the split vision young women have of their smoking. For example, the “Smoke Free, Still Fierce” campaign is designed to empower lesbian, bi-sexual, and queer (LBQ) women to be “fierce” and to “break-up” with cigarettes (ACON, 2016). The campaign acknowledges the split vision that LBQ women experience, as well as the influence of multiple experiences and identities, saying, “smoking can be a complex, love/hate relationship, enmeshed with identity, mental health and social connections.” The
campaign video offers young women alternative ways (aside from smoking) to perform their gender identity, showing women using clothing, hairstyles, and body language to embody both normative and non-normative femininities. The findings from this study highlight the need for approaches such as this, which offer positive gender representations, acknowledge the function of smoking for young women and recognise social context in which it takes place.

One of the strengths of this study is the in-depth qualitative approach used to investigate young women’s experiences of smoking and the performance of identities, in both smokers and ex-smokers. By including a photography activity, as well as two semi-structured interviews, participants were able to actively engage with the research process and reflect on accounts of their smoking. The use of an intersectional approach allowed for a consideration of how young women’s constructions and experiences of smoking and femininity are shaped by identities beyond gender. We are aware that while gender, social class, and sexuality were made visible, other categories of identity remained invisible. In the future, researchers could explore experiences of smoking and the performance of femininity in relation to other intersecting identities, such as age and ethnicity.
Chapter Four: An Intersectional Analysis of Women’s Experiences of Smoking-related Stigma

This chapter contains the journal article *An intersectional analysis of women’s experiences of smoking-related stigma*. This article uses an intersectional approach to explore how young women experience and negotiate discourses of smoking-related stigma. This article is also included in Appendix M.


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Abstract

In this article we explore how young women encounter and counter discourses of smoking-related stigma. Twenty-seven young Australian women, smokers and ex-smokers, took part in interviews, and a sub-sample of 18 took photographs to document their smoking experience, and took part in a second interview. Data were analysed through Foucauldian discourse analysis. Four discourses were identified: “smoking as stigmatised”, “the smoking double standard”, “smoking as lower class”, and “smokers as bad mothers”. The women negotiated stigma in a variety of ways, shifting between agreeing, disagreeing, challenging, and displacing stigma onto ‘other’ smokers. These experiences and negotiations of smoking-related stigma were shaped by intersecting identities, including gender, cultural background, social class and mothering, which at times, compounded levels of stigmatisation. It is concluded that tobacco control measures should consider the negative implications of smoking-related stigma, and the potential for women to experience compounding levels of stigma.

Introduction

From the second half of the twentieth century, rates of women’s and men’s smoking in Western countries began to converge, and in some countries women now smoke just as much, if not more than men (WHO, 2008). In the past decade in Australia, young women have reported a higher rate of daily smoking than their male counterparts (AIHW, 2008, 2011b). In addition to the well-established risks of lung cancer and heart disease, there are a number of other health risks linked to cigarette smoking which are unique to women, such as reproductive cancers, iatrogenic
consequences, and contraindications with oral contraceptives (Ernster et al., 2000). Previous research has explored a range of key psychological and social aspects of gendered smoking (Greaves, 1996), such as how women use smoking to construct feminine identities (Amos & Bostock, 2007; Gilbert, 2007b) and the role of smoking in social group identities (Amos & Bostock, 2007; Gilbert, 2007a; Michell & Amos, 1997). The impact of poverty and social deprivation (Graham, 1987, 1994; Graham, Inskip, Francis, & Harman, 2006), and the role of mothering and caring work (Graham, 1987, 1994) have also been examined. This research has drawn attention to the impact of tobacco denormalisation on women’s experiences of smoking-related stigmatisation.

Stigmatisation refers to the process by which a person’s attributes or behaviours taint their identity or discredit them socially (Goffman, 1986). Research looking at the stigmatisation faced by smokers has found that smoking-related stigma is enacted through social interaction and self-stigmatisation, as well as wider social attitudes and structural policies (Bell, McCullough, et al., 2010; Brown-Johnson et al., 2015; Farrimond & Joffe, 2006; Kim & Shanahan, 2003; McCool et al., 2013; Ritchie et al., 2010; Stuber et al., 2008). Smokers are almost universally aware of the negative stigma associated with smoking, and although most smokers agree with this stigma, they also disagree, challenge, or only attribute stigma to other smokers (Evans-Polce et al., 2015). For those who do self-stigmatisate their own smoking behaviour, the consequences are negative feelings of shame, guilt and embarrassment (Evans-Polce et al., 2015). It is these feelings that many anti-smoking campaigns aim to elicit, in an attempt to reduce smoking behaviour (Chapman & Freeman, 2008).
However, many individuals continue to smoke regardless of such campaigns, and therefore, have to live with the consequences of smoking-related stigma.

Smoking-related stigma has been examined in relation to a number of different identity categories, such as young adults (Scheffels, 2009), social class (Farrimond & Joffe, 2006; Graham, 2012) and mothers (Oaks, 2000; Wigginton & Lafrance, 2015; Wigginton & Lee, 2013). This research shows that stigma is experienced differently across social groups. For example, smokers from higher socioeconomic groups are more likely to challenge smoking-related stigma, and lower socioeconomic smokers more likely to internalise it, which might mean lower socioeconomic smokers are less likely to engage with anti-smoking campaigns and to quit smoking as a result (Farrimond & Joffe, 2006). These studies focus largely on the relationship between smoking-related stigma and a singular identity position, but often discuss the influence of intersecting identities. For instance, Scheffels (2009) focuses on experiences of smoking-related stigma among young women and men, noting that young women can face further stigmatisation as a result of their gender and social class identities, with regards to notions of acceptable femininity and ‘respectability’. The compounding layers of stigmatisation faced by these young women, suggests the need for further research on women’s experiences of smoking-related stigma which adopts a multidimensional view of identity.

Arguments for the mobilisation of stigma in tackling smoking rates are often framed in public health debates by utilitarian ethics of “the most good for the greatest number of people” (Bayer, 2008; Silva, Smith, & Upshur, 2013, p. 411), as social stigma and tobacco denormalisation policies are often associated with falling
smoking rates (Chapman & Freeman, 2008). However, in Australia smoking is no longer a widespread behaviour. The daily rate of smoking has fallen to 12.8%, having almost halved since 1991 (AIHW, 2014b; V. White, Hill, Siahpush, & Bobevski, 2003). The highest rates of smoking in Australia are now concentrated among society’s most marginalised groups: single parents, Aboriginal and/or Torres Strait Islander peoples, people with poor mental health, people who are homeless, and people in prison (Australian National Preventive Health Agency, 2013).

Australia is internationally recognised for its advanced tobacco control legislation and was the first country in the world to introduce plain packaging of cigarette packets. This legislative environment has contributed towards growing anti-smoking public sentiment, and the stigmatisation of smoking and smokers (Chapman & Freeman, 2008). Researchers have raised concerns about the impact of smoking-related stigma on individual smokers, as well as on wider social disparities. Although some studies have noted positive individual outcomes resulting from smoking-related stigma, such as smoking cessation, increased intentions to quit, and a decreased risk of taking up smoking again after quitting, smoking-related stigma has also been associated with negative outcomes, such as social isolation and stress, resistance to smoking cessation, and taking up smoking after quitting (Evans-Polce et al., 2015).

Thomson, Pearce, and Barnett (2007, p. 515) coined the term “smoking islands” to describe a wider social process of “othering” that can result from smoking-related stigma, warning against the ways in which smoking-related stigma can be implicated in the production and reproduction of social class. In this article we look to contribute to the debate about concerns associated with the ethics and efficacy of
smoking-related stigma as a tobacco control strategy, by exploring young women’s experiences of smoking-related stigma, and the implications it has for their subjectivity and smoking practices, using an intersectional theoretical framework.

Intersectionality challenges the idea that identity is additive, instead focusing on the interaction of multiple social categories, and how this relates to power and oppression on an individual and structural level (Christensen & Jensen, 2012). S. Williams and Fredrick (2015, p. 384) argue that an intersectional approach allows us to develop “a more complete understanding of the experience of stigma”. The concept of ‘intersectional stigma’ draws on intersectionality theory to consider the way in which stigma is compounded by axes of identity and inequality (Berger, 2010, p. 24). This concept was originally used to understand how women with HIV can experience multiple layers of stigma resulting from their illness, their status as drug users or sex workers, as well as their gender, social class, ethnic and sexual orientation positions (Berger, 2010; Logie et al., 2011). The concept of intersecting stigma, also referred to as stigma layering (Lekas, Siegel, & Leider, 2011), has also been used to explore women’s experiences of mental illness (Mizock & Russinova, 2015), and dominatrix sex work (Levey & Pinsky, 2015). A similar concept, ‘multiplying stigmatisation’, has been used by researchers to discuss the potential for smoking-related stigma to further isolate already socially disadvantaged groups (Farrimond & Joffe, 2006; Graham, 2012; Scheffels, 2009). These studies also noted that compounding smoking-related stigma is often experienced by women. For instance, Farrimond and Joffe (2006) point out the combined stigmatisation faced by poor young single mothers who smoke. Although this existing research has shown
the potential for women to experience multiplying smoking-related stigma, we are yet to fully make sense of how these intersecting identities shape women’s experiences of smoking-related stigma, and the impact this has on subjectivity and smoking practices. In this article we address the question of how women experience and negotiate smoking-related stigma, adopting a social constructionist, intersectional theoretical framework. The research questions were as follows:

**Research Question 1:** How do young women construct and experience cigarette smoking stigma?

**Research Question 2:** How do young women negotiate smoking-related stigma?

These questions explore the ways in which young women experience and actively construct, reproduce and negotiate cultural discourses associated with smoking-related stigma.

**Methods**

**Design.**

In this article we present findings from a study of young women’s constructions and experiences of cigarette smoking. Young women, either current smokers, or ex-smokers, were involved in in-depth, semi-structured interviews. Participants were then invited to participate in a photography activity and a follow-up interview. This combination of visual and interview methods helped generate insight into the social context in which smoking takes place (Haines, Oliffe, Bottorff, & Poland, 2010). We conducted a Foucauldian discourse analysis, drawing on an intersectional framework and positioning theory to understand how women’s
smoking is shaped by multiple identities and discourses. Discourse analysis, intersectionality and positioning theory all sit within social constructionism, a theoretical approach which critically questions taken-for-granted understandings of our social world (Burr, 2015).

**Participants.**

In order to participate in the study, the young women had to have smoked at least 100 cigarettes in their lives (a classification used by the Australian Institute of Health and Welfare (AIHW) (2014b) to define smokers). These women were both current smokers (67%), and ex-smokers (33%) (although, one of the ‘ex-smokers’ had started smoking again by the time of her second interview). Of the 18 women who were currently smoking, most smoked less than fifteen cigarettes a day (56%), with the remaining women either smoking 15 or more cigarettes a day (22%), or not smoking on a daily basis (22%). Participants ranged in age from 18 to 31 years, with an average age of 24 years (in Australia the legal age for purchasing tobacco products is 18). Participants were purposively selected from a variety of cultural, social class, sexuality, and mothering backgrounds. Most of the women (63%), identified as Anglo Australian, with the remaining women identifying with Aboriginal Australian, Asian, American, European, Middle Eastern, and Pacific Island cultural backgrounds. When given the following prompts, the participants identified as being from working-class (44%), or middle-class (48%), and upper-middle class (7%) backgrounds. The highest level of education completed by participants ranged from three years of secondary school (15%), five years of secondary school (33%), tertiary diploma/trade certificate (30%), and university
degrees or higher (22%). When asked to describe their sexuality, most of the women selected heterosexual (67%), or bi-sexual (26%), with a smaller number selecting lesbian (7%). Over a quarter of the women had children (26%), and one woman was pregnant at the time of the interviews.

Participants were actively recruited by handing out flyers at train stations and at the start of undergraduate university tutorials. Passive recruitment methods included putting up flyers at tertiary education campuses, and online advertising on Facebook. A brief online survey collected demographic information on the age, culture, social class, sexuality, and childbearing status of potential participants to ensure the selection of a sample which included “multiple categories” of identity (Christensen & Jensen, 2012, p. 110). 197 women completed the survey, and 49 were contacted for the stage one interview, with 27 women accepting the invitation. Eighteen (67%) of those women opted to continue on with the second and third stages of the study. Participants were given a $30 (AUD) supermarket gift card as reimbursement for their time participating in each of the three stages of research. Ethics approval from the University Human Research Ethics Committee was granted. Participants received an information sheet and signed a form offering informed consent, either physically or electronically.

Procedure.

Stage one.

During the first three stage one interviews a semi-structured interview schedule was piloted, to examine the utility of the questions, the flow of the interview, and any questions that may have been omitted. Following the pilot testing,
a broad opening question was added to the beginning of the interview: “Tell me about your experiences with smoking”. This exploratory opening question, and a semi-structured style interview were used to encourage participants to play a leading role in constructing the story around their smoking (Graham, 1984). The interview covered participants’ experiences with smoking, quitting, and their perceptions of smoking in the media. Participants were asked questions such as, “Can you tell me about when you first began smoking?”, and “Have you ever tried to stop smoking?” The interview focussed on smoking in the context of everyday life, in an effort to avoid positioning identities such as, ‘smoker’, ‘woman’ or ‘mother’ as distinct entities (Bowleg, 2008).

**Stage two.**

In the second stage of the study participants took photographs of their experiences with smoking. Participants submitted a total of 157 images: mostly photographs, but also screenshots, and visual designs participants had created themselves. Participants took on average three weeks to complete the activity, using their own personal digital cameras or mobile phones to take the photographs.

Previous research has shown that visual methodologies are an effective tool for engaging with young people (Tinkler, 2013). By analysing young women’s visual accounts alongside their verbal narratives, we were able to explore more of a multidimensional, multisensory understanding of their experiences (Del Busso, 2011).
Stage three.

Once participants had completed stage two of the study, a second semi-structured interview was scheduled for a convenient time for the interviewer and participant. Before the interview participants were sent a copy of their interview transcript from stage one and told that they would be given an opportunity to talk about their accounts. At the start of the interview, participants had the chance to be reflexive, commenting on, and being asked follow-up questions about the narratives they provided during their first interview (J. A. Smith, 1994). The participants were then asked about their experiences of taking photographs, before going through and describing each photograph they submitted and their reasons for taking it. The final part of the interview was spent asking participants about their experiences of being involved in the research project and whether there had been any changes to the way they thought about their smoking. Data from this final part of the interview were used to evaluate the effectiveness of the study design for engaging with young women, and is not included in the findings for this article. Some of the questions participants were asked during the follow-up interview included: “Tell me about what it was like taking photographs of your experiences with smoking.”; “Talk to me about how you have found the experience of being involved in this research project?”

The geographical diversity of the sample meant that most (78%) of the stage one and two interviews were conducted over the telephone, with the remaining ten interviews done face-to-face at university campuses across metropolitan Sydney. As well as allowing for a geographically diverse sample, telephone interviews can aid in the discussion of topics that are sensitive or potentially embarrassing (Novick, 2008).
The nature of smoking as a stigmatised activity, particularly in contexts such as smoking during pregnancy, makes it a sensitive topic (Wigginton & Lafrance, 2015). The use of face-to-face interviews allowed for a different type of interaction, where interviewer and participant were able to use facial expressions and body language to communicate. For example, several women used gestures during face-to-face interviews to show the way in which they held cigarettes. However, as reported in previous research (Parton, Ussher, & Perz, 2016), participants generally provided richer accounts in phone interviews. This was most pronounced during follow-up interviews where the physical distance between interviewer and participants meant that photographs were unable to just ‘speak for themselves’, which then led participants to provide fuller descriptions and interpretations of those images. The interviews lasted on average 45 minutes, and were recorded using an audio recorder. The interviews were professionally transcribed, and participants were assigned pseudonyms to maintain anonymity. The data were collected between April 2014 and March 2015.

**Analysis.**

A Foucauldian discourse analysis was conducted, focussing on how meaning is constructed through talk, text, and imagery (Tonkiss, 1998). Foucault (1972, p. 193) was interested in discourse, and how “a certain ‘way of speaking’” can convey meaning. Interested in the relationship between language and the socio-historical construction of reality, Foucault used the term ‘discursive formations’ to refer to the way in which statements, objects, and concepts are ordered and positioned. This analysis also drew on positioning theory (Davies & Harré, 1990), as a way of
understanding the multiple, contradictory subject positions participants took up or were assigned. Positioning theory fits within a social constructionist approach, and helped in making sense of accounts where participants positioned smoking and smoking-related stigma as both positive and negative, or positioned smokers as ‘other’ to their own selves. The analysis followed the steps of Foucauldian discourse analysis outlined by Ussher and Perz (2014) and Willig (2008a). In accordance with this method, the analysis began with the reading and re-reading of the interview transcripts, and the viewing and re-viewing of the photographs. This occurred when Triandafilidis carried out integrity checks of the transcripts, and reviewed the stage one interviews and stage two photographs before conducting the follow-up interviews, as well as further reading of transcripts, viewing of photographs, and discussions among the research team. A subset of interview transcripts were coded by Triandafilidis and Ussher, capturing both semantic and latent content (Braun & Clarke, 2006). Following this process a coding frame was then able to be developed. The coding frame was used to structure the coding into thematic areas such as ‘anti-smoking campaigns and policies’. Using NVivo 10 software, data were organised within this framework through an on-going process of collapsing and combining codes. For example, the code “smoking and partners” was collapsed, and made a sub-code of “smoking and other people” to separate out data that pertained to women’s experiences of smoking in relation to their partners. Data within each code were summarised, with the aim of identifying discursive constructions. The photographs were analysed as part of participant’s overall narratives, and offer insight into the material setting in which participant’s experiences with smoking took
place (Radley, 2011). In this article we present four of the discursive constructions that relate to smoking-related stigma: “smoking as stigmatised”, “the smoking double standard”, “smoking as lower class”, and “smokers as bad mothers”. We considered the way in which participants negotiated and positioned themselves in relation to these discourses, the impact of taking up stigmatised subject positions on subjectivity and smoking practices, and how these discourses relate to those available in public health and popular media.

Findings

**Smoking as stigmatised.**

The “smoking as stigmatised” discourse encompasses the stigma of smoking in relation to moral identity. Many of the women interviewed gave accounts of how their smoking was stigmatised and could compromise their moral status. For example, Shayma spoke about her relationship with her colleagues at the pharmacy where she works, saying, “They wouldn’t see me as a good person, just because I smoke.” Brittany said, “People would be like, “did you know that’s bad for you”, or “seriously, you’re a smoker?” as if like they thought you were a cool person, and now you’re awful.” For Shayma and Brittany, their smoking means they are no longer seen as “good” people, and are repositioned as “awful”. This is what Goffman terms ‘moral stigma’, where stigmatised behaviour, such as smoking, leads to “blemishes of individual character” (Goffman, 1986, p. 4). Brittany went on to talk more about the impact of smoking-related stigma on her identity, saying,
I used to be really worried about people judging me because I had a pretty severe social phobia and I got treatment for that about a year ago, but for ages I was still worried about people judging me for smoking. Earlier this year I went to the hospital for depression and after that I just smoked heaps all the time, and I didn’t really care about people, and their response to it. So, it was probably having less anxiety and also the depression of not caring what other people think and not caring about anything.

Brittany’s account reveals the way in which smoking-related stigma and the judgement of smokers can lead to anxiety and worry, especially when intersected by mental health issues, such as a social anxiety disorder, where a person has a heightened awareness of social judgement and criticism.

One of the ways in which smoking is seen to blemish an individual’s moral character is through ideas of dirt and disgust. Participants spoke about being explicitly told, or being made to believe that they, or their smoking, were “disgusting” (Sarah, Megan, Stephanie, Gemma, Lisa, Caitlyn, Tara) or “dirty” (Vanessa). Danielle said, “I’ve had a couple of comments that it stinks”. Some participants agreed with the idea that smoking is dirty and disgusting. For instance, Sarah described the ashtray she photographed (Figure 18), saying, “I hate the smell, yuck. I hate the look of an ashtray as well, they always look so dirty and yuck…But for some reason, it’s just not enough to make me stop.” Even though Sarah applies the stigma of smoking being dirty to her smoking, she claims it does not impact on her ability to quit.
Another way in which smoking compromises identity is through notions of addiction and choice. Participants talked about the stigma of being addicted to smoking. Lisa said, “Even if it’s acceptable to smoke, it’s still not acceptable to need a cigarette.” Lisa’s account suggests that it is the lack of control, or the “need” to smoke that is stigmatised. Participants used a number of techniques to avoid being seen as addicted to smoking. Stephanie talked about monitoring her smoking by thinking to herself, “I really feel like one now, like, how long’s it been? Will it look bad if I have another one when I’ve only just put one out?”, while other participants would say to others, “I’m not addicted” (Sarah). However, even when smoking was
positioned as a choice, participants still experienced stigma. For instance, Megan said, “There’s just a bit of like free-willing stigma attached to smoking, that people think you’re free to give up at a moment’s notice.” Both these notions of addiction and choice had negative implications for women’s subjectivities. Stephanie described the feeling of being addicted to smoking as “embarrassing”, and when Caitlyn’s smoking was positioned as a choice, within her control, but she was still unable to quit, she said, “it makes me feel down on myself.”

**Negotiating the stigma of smoking.**

Participants responded to the “smoking as stigmatised” discourse in a number of ways. Jennifer, a current smoker, positioned this stigma as positive, saying, “It sways you not to smoke, which is a good thing.” By accepting the negative judgement of smoking, Jennifer might be able to avoid accruing further smoking-related stigma (Wigginton & Lafrance, 2015). In contrast, some women disagreed with smoking-related stigma and the negative impact it has on identity, positioning it as a barrier to quitting, saying, “It’s really hard to quit if you’re stressed and worried about people judging you.” (Brittany). Several of the women in the study tried to negotiate smoking-related stigma by avoiding being identified as a smoker. For instance, Gemma and Shayma both talked about not wanting cigarettes to “define” them. Sarah used the phrase “closet smokers” to describe people who were able to ‘pass’ as a non-smoker by concealing or managing the visibility of their smoking (Goffman, 1986).

In an effort to maintain a positive sense of subjectivity some women would hide their smoking from others, or only smoke around particular people or social
groups. For instance, Shayma talked about only telling her close friends that she
smokes. A number of participants talked about preferring to smoke with other
smokers, or preferring to have relationships or friendships with other people who
smoke. For instance, Emily said, “I spent more time with the people who didn’t care
than the people who did, simply because I didn’t want to listen to it, because it made
me feel guilty that I was doing something wrong.” In this account Emily talks about
spending more time with people who did not care about her smoking, highlighting
how smoking-related stigma can lead women to become isolated from a wider anti-
smoking population, as they seek out groups of “dedicated smokers” who continue to
smoke, and are resistant to anti-smoking sentiment (Scheffels, 2009, pp. 481, 483).

A number of women took up subject positions as ‘considerate smokers’ to
distance themselves from ‘other’ less considerate smokers. Participants described
behaviours that helped characterise them as considerate smokers, such as moving
away from others when smoking, asking permission to smoke, and not smoking
around children. For example, in her account Hannah said,

When I see parents with little kids, and they’re holding their kid and they
have a cigarette in their other hand. Yeah don’t like that either. If I really
think about those types of smokers, nah, it’s just really inconsiderate.

By distinguishing herself from “those types of smokers”, Hannah positions herself as
a considerate smoker. Hannah is what Scheffels (2009) terms a ‘negotiating smoker’,
where she manages her identity by distancing herself from smokers who are
stigmatised. By following the rules of considerate smoking dictated by different
social fields, and condemning the actions of other “inconsiderate” smokers, Hannah
is able to negotiate the stigma directed towards smokers and avoid taking up a stigmatised subjectivity. Fewer participants, such as Shannon, wanted to be identified as a smoker. Shannon said, “as a young girl I just always desired to smoke, and I wanted to be a smoker”, adding that this was “probably very embarrassing”. In Shannon’s admission we see the impact of stigma on subjectivity, whereby one is embarrassed to identify as a smoker.

**The smoking double standard.**

“The smoking double standard” discourse examines the stigma of smoking in relation to gender identity, as well as the intersection between gender and culture. A number of the participants referred to a smoking double standard in their accounts, where men’s smoking practices were seen as more acceptable, or desirable, and women’s smoking as less acceptable or desirable. In the following extract Sinta discusses this double standard, saying, “I do sometimes hear a lot of guys saying, ‘It’s the most ugly thing, if I ever see a girl smoking’, and things like that, while they probably smoke as well.” Several participants said the smoking double standard reflected their partner’s desire to control them, rather than a concern for their health or well-being. For example, Shannon talked about having an ex-partner whose friends smoked, but who “hated” her smoking. Shannon described this double standard as “more of a controlling thing”, saying, “He wanted me to be a certain idea he had about what a girlfriend was and what a woman was and she wasn’t a smoker, I guess.” These accounts highlight how the smoking double standard operates as a form of power and control, both within individual intimate relationships, as well as
Participant’s accounts revealed that the smoking double standard is shaped by intersecting cultural identities. For example, Sinta spoke about how women’s smoking is increasingly stigmatised in Indonesian culture compared to Australian Western culture. She said:

But I don’t think it’s as bad as maybe you know, when I do go to Indonesia I would never be caught dead smoking in front of my family, even though all the men smoke. I still wouldn’t just, like the culture and out of respect for my family.

Another woman, Jing, spoke about the smoking double standard in the context of her home country China, saying, Chinese men “don’t like girls smoking.” Finally, Shayma talked about the smoking double standard that exists between her and her male partner who smoked occasionally, relating this to their “wog” culture. In Australia, the term ‘wog’ was traditionally used as a racist slur toward people from Southern European, Turkish or Lebanese backgrounds, although in recent times younger generations have begun to reclaim the word through ethnic humour (Tsolidis & Pollard, 2009). Shayma said: “So in our culture, it’s pretty much unacceptable for women to smoke.” In these examples Sinta, Jing, and Shayma are all faced with compounding stigma due to their gender and cultural identities, which then had implications for their subjectivities and practices. For example, Sinta said she “would never be caught dead smoking” around her family. Shayma talked about hiding her smoking from her parents and others in her community. Shayma’s photographs show...
her having to clean traces of cigarette ash from her car (Figure 19), having to throw away a cigarette when she thought someone she knew might see her smoking (Figure 20), and pretending to take a shower so that she can smoke when she is at home with her parents (Figure 21). Shayma’s photographs position smoking as something needing to be contained or covered up, reinforcing the discursive positioning of her smoking as unacceptable, for herself, and other women in her culture.

*Figure 19. The ash in Shayma’s car.*
Figure 20. A cigarette Shayma had to throw away.

Figure 21. Shayma pretending to take a shower so she can smoke.
Jing spoke about how the stigma associated with “the smoking double standard” was further amplified by other cultural expectations associated with her gender, saying, “I can’t stand the looks of my boyfriend because he needs to marry me. Girls of my age who are Chinese, they have to marry within two years.” Jing, who had quit smoking for one year at the time of the interviews, said her decision to quit smoking was partly due to cultural pressure for her to get married, and the fact that her boyfriend wanted her to quit smoking. Jing’s boyfriend’s tolerance for her smoking declined as their relationship became more established, perhaps reflecting the diminishing appeal of partner’s risk-taking behaviours in long-term relationship contexts (Sylwester & Pawłowski, 2011). This was one of the few examples in the study in which exposure to smoking-related stigma contributed to sustained smoking cessation.

**Challenging the smoking double standard.**

Several of the women who took part in the study talked about wanting to challenge the double standard that exists between women’s and men’s smoking, and wanting to say “fuck you” to men who tried to regulate their smoking. For example, Lisa talked about an ex-boyfriend who “smoked like a chimney”, but would get “so angry” with her smoking, saying, “I kind of get a bit, like, “fuck you, I can do what I want.” Another woman, Danielle talked about her reaction to her boss and friend commenting that her smoking was “very unfeminine”:

I think a part of me…wanted to say, ‘Fuck you, I’ll smoke whenever I want to smoke.’ But, it did actually impact me and it kind of made me want to stop. And, I did for a little while there.
In another example, Shayma spoke about challenging her boyfriend, who was an occasional smoker, by saying to him, “A cigarette doesn’t define me. I’m not going to lose some self-respect just because I’m smoking”. The stigma Danielle experiences has an “impact” on her, and helped her to quit smoking short-term. Whereas, Shayma becomes more resistant to the idea of quitting, going on to say, “I don’t like to be told what to do.” These examples highlight the complexity of women’s experiences of smoking-related stigma, where although Danielle and Shayma challenge the stigma directed toward them, it has different outcomes for their subjectivity and smoking practices.

**Smoking as lower class.**

The “smoking as lower class” discourse focusses on the stigma of smoking in relation to class identity, as well as the intersection between gender, class and cultural identities. Participants’ narratives revealed how smokers are ‘othered’, with smoking positioned as a sign of poverty, struggle, and a lack of education. For instance, Sarah, a single mother, said, “It’s my outlet and it’s really the only one that I have. I can’t go and buy myself new clothes every day and do all those things, so I smoke.” Courtney, who identified as being working-class, talked about her partner who worked in construction, and the smoking culture among construction workers, saying, “It’s definitely got to do with their habits, ways of life and what they do, like, struggle.” Both Sarah and Courtney position smoking as being an “outlet” to help manage “struggle” in their lives. While Sarah and Courtney position themselves or their partners within this discourse, some participants distanced themselves from it by ‘othering’ smokers. For instance, Chelsea said,
I used to think the people that I saw when I was in high-school who smoked, they were not very cool. They were very poor, didn’t come from very good backgrounds, they would have teen pregnancies. They didn’t know any better. It was kind of like they were lower people.

Here, Chelsea acknowledges the stigma associated with smoking being “lower” class, but distances herself from it by applying this stigma to an ‘other’, “they” who “didn’t know any better”. In another example, Jing, an ex-smoker, also distances herself from ‘other’ smokers by saying,

The traditional Chinese thinking is smokers are really not high educated, but I’m a student now and in the future, I hope my profession will be a university lecturer…If I’m smoking it’s not at my level.

Here Jing compares her educational capital with that typically associated with smokers, ‘othering’ them. This discursive technique helps affirm Jing’s identity as an ex-smoker, and might mean she is less likely to take up smoking in the future.

However, Jing went on to challenge the construction of smoking as a signifier of lower social class in Australian culture, by commenting on the association between smoking and social class within a Chinese context. She said,

I think people in Australia are more tolerant than people in China because actually when in China, if they are smoking, people will say she is not in a good profession. She is not well educated or her family’s education is not good. But here in Australia…there’s many well-dressed women and they are also managers, they also smoke.
This example illustrates how the construction of smoking as lower class is culturally bound. Jing is able to minimise the stigma that exists in Australia by comparing it to the harsher judgement she would receive in China. Similarly, Sinta challenged the idea that smoking signifies a lack of intelligence, by saying, “I know so many smart amazing people that occasionally might have a cigarette or always smoke or whatever it is, so I don’t think it is a judgement or it should be a judgement on a person.” Sinta challenges the idea that smokers lack intelligence by individualising smokers and offering examples of smokers not worthy of this negative judgement. However, by individualising smokers Sinta implicitly agrees with this discourse, implying that there might be ‘other’ not such “smart amazing people” deserving of stigmatisation.

Some women spoke about their efforts to avoid being positioned as lower class. For example, Tara talked about her sister controlling the brand of cigarettes she smoked during high school, saying,

> After a while, she forced me to change to Winfield Sky Blue, which is the lower, not as strong [cigarettes]. She’s like “Winnie Blues are derro, you need to change to not as derro cigarettes and not be so harsh and strong.

As well as being “derro”, (an abbreviation of derelict, inferring homelessness, see Gibson, 2013), smoking high strength cigarettes is generally positioned as masculine (Dewhirst & Sparks, 2003). Therefore, Tara’s sister works to protect them from the intersecting stigma of being unfeminine, lower class women. Other women repositioned the stigma of smoking being lower class to their advantage, by using smoking as a tool for creating or maintaining social capital. For instance, Lisa spoke
about using smoking to maintain relationships with her childhood friends who were not “particularly bright” and whose lives had gone “separate ways”, now occupying different social positions to her own. She said, “we had different friends and different interests and things like that, but we’d still all hang out and smoke cigarettes.”

Another participant, Shannon, spoke about how the stigmatisation of smoking helped her to mask her middle-upper class, Anglo-Australian background, helping her to initiate social interactions with people from different social backgrounds. She said,

If I’m smoking, people who would normally write me off because of the way that I look, feel happy to engage with me because I’m there and I’m smoking and working-class people or indigenous people or whatever, you can have a moment in the space where for whatever reason…that shared commonality of enjoying a cigarette allows you to just be.

In referring to this “moment in the space”, Shannon acknowledges the power of smoking to transcend social barriers as temporal, and spatially limited. A final example of smoking being used as a tool for social mobility lies in Stephanie’s account of taking up smoking when she went from a “really strict” private school to a state school. She said, “going from one end of the scale to the other end of the scale. You’re going to do anything to fit in.” Possessing a certain amount of cultural capital: Lisa with her intelligence, Shannon with her middle, upper class Anglo-Australian background, and Stephanie with her private schooling, these women have the power to tactically repurpose the stigma of smoking being lower class to create and maintain social capital (de Certeau, 2011).
**Smokers as bad mothers.**

The “smokers as bad mothers” discourse considers the stigma of smoking in relation to mothering identities, as well as the intersection between gender, mothering and social class identity. In many participant accounts, women with children who smoked were positioned as ‘bad mothers’, further evidence of the stigmatisation of women’s smoking. Participants spoke about the idea that women were responsible for their children’s health, and that women who smoke are irresponsible mothers. For example, Stephanie said, “I don’t think you can light up a cigarette anywhere without people going, ‘But, you have children. You can’t be smoking.’ Or ‘Let’s try setting a good example for your children’.” In another example, Briana takes responsibility for her son’s future smoking habits, saying, “If your parents do it you think it’s okay. So I don’t want him to get into it either. So that’s another reason to quit.” Here, the idea that women are responsible for their children’s health provides Briana with an incentive to quit smoking.

Participants drew on medical discourse in making themselves responsible for the effects of their smoking on their children’s health. An example of this is where Lisa talked about being responsible for her daughter’s asthma, saying, “smoking’s a respiratory thing, asthma is respiratory, it’s sort of logical to assume that I’ve caused or at least had the disposition and I’ve triggered it by insisting on smoking while pregnant and breastfeeding.” In another example, Ashlee refers to medical discourse surrounding ‘third hand smoke’, a term which describes the residual chemical residue found in the air, or on surfaces such as furniture or clothing, after tobacco smoke exposure (Winickoff et al., 2009). This notion of third hand smoke is invoked
by Ashlee when she describes how her doctor made her responsible for her son’s bronchiolitis, saying, “My daughter gets croup, and my son gets bronchiolitis, so the doctor said that’s because you’re smoking, even though I’m smoking outside, they could still smell it on my clothes.” Ashlee described this interaction with her doctor as making her “feel terrible”, illustrating the negative implications of internalising the stigma of being an irresponsible mother who smokes.

Smoking during pregnancy is subject to severe scrutiny in national health campaigns (Oaks, 2000), which was reflected in participant’s accounts of the surveillance and stigma of mothers who smoke when pregnant. For instance, Stephanie said,

It makes you look like a really shitty mum. With my first I was in hospital…And, they’re not going to wheel a heavily pregnant woman downstairs so she can have a cigarette. And, I wasn’t going to ask because can you imagine the look on the nurse’s face? But, it is done, because the lady beside me used to go downstairs for cigarettes all the time, but I wouldn’t because I’d be a little bit more self-conscious of the way people look at me.

Stephanie focuses on how smoking would make her “look like a real shitty mum”, imagining “the look” the nurse would have given her, and how other people would “look” at her. This language illustrates the monitoring and surveillance that pregnant bodies, such as Stephanie’s, are subject to (Finerman, Sanders, & Sagrestano, 2015; Wetterberg, 2004). Just as Stephanie observed other women, and was aware of being observed herself, likewise, Lisa spoke about how she applies the stigma of smokers
being bad mothers to other women, as well as having this stigma applied to herself, saying, “I’d probably look down on parents who smoke, a little bit, so I assume other people will look down on me.” These examples demonstrate the way in which women are both “judged and judge” against discourses of ‘good mothering’ (Goodwin & Huppatz, 2010, p. 1), applying smoking-related stigma to both themselves and others.

Participants also spoke about the construction of smokers as bad mothers in relation to social class. Stephanie refers to the construction of “low class” mothers in the media, saying, “It’s so so socially unacceptable to smoke a cigarette with a child... if you want to portray somebody as low class, you want to portray somebody as not caring, that’s the perfect way to do it.” This notion of “caring”, which Stephanie raises, relates to self-sacrifice and being child focussed, which are traits associated with respectable middle-class mothering (Hays, 1996; Skeggs, 1997). Therefore, woman who have children and continue to smoke, are seen to be bad mothers, as well as occupying a lower social class. In another example, Danielle discusses the intersection between smoking, mothering and social class, saying, It’s extremely frowned upon, and I think you could actually be abused if you were smoking and you were pregnant. At my auntie’s wedding…there was a heavily pregnant woman who is a second cousin of mine, and she was standing there with a –a glass of wine in her hand and a cigarette in the other, it was horrible. It was really quite unattractive. Very, very unattractive and I don’t want to sound like a snob or anything, but it seems quite low – bogan. You know, low socio-economic, a bit – just a bit redneck, I think.
Danielle’s account draws attention to an additional source of stigma, where pregnant women who smoke are not only seen to be of a lower social class, which she describes as “bogan” or “redneck”, but also “unattractive”. This focus on appearance serves as a visual distinction which helps to class mothers, where a lack of care for appearance is seen to signify a lack of care for children (Goodwin & Huppatz, 2010).

**Negotiating a ‘bad mother’ identity.**

Some women challenged the stigma of smokers being bad mothers by focusing on how their smoking helped them in their roles as caregivers, a rhetorical technique which has been found in prior research on working-class mothers (Graham, 1987, 1994). For example, Sarah talked about how smoking allowed her to take time out from her sole parenting duties:

Every hour, every whatever, I’ll sneak outside and I’ll sit down and I’ll have a smoke and it’s kind of like I’m collecting my sanity…Yeah, so obviously I don’t get to have a smoke every hour or whatever, it’s when I can, you know, if you’re sitting quietly watching TV or something, then I can actually sneak out and have one. But yeah, that would be my reasoning for smoking now, like that five minutes, I can sit down, have a smoke, relax and you know, collect my thoughts or sanity or whatever you want to call it.

Another participant, Ashlee, said, “You go out for a cigarette and I’d shut the house up so the kids couldn’t come out, and then, it was sort of like me time.” In these accounts these women challenge the discursive positioning of women who smoke as bad mothers by offering examples of how smoking supports them in their caring duties, and how they protect their children from second-hand smoke exposure by
going outside. While she challenges this stigma, Sarah also applies it to herself, talking about having to “sneak” outside, implying that she is embarrassed by her behaviour, and that it needs to be hidden.

Quitting smoking presents women with an opportunity to repair a spoiled identity as a bad mother (Wigginton & Lafrance, 2015). Ashlee, an ex-smoker, repositions the stigma of being a bad mother in her account of her photograph (Figure 22), where she said, “Yeah, that’s me and my kids. I can actually run around with the kids now and not struggle for breath.” In her photograph and verbal account, Ashlee positions herself as an active, involved and caring mother “now”, she has quit smoking, helping her to reclaim a ‘good mother’ identity. When asked about her reasons for selecting this photo, Ashlee said, “I was just thinking of reasons why I quit, and reasons why it was good for me to quit”. Here we see that the desire to be a good mother might help affirm Ashlee’s decision to quit smoking and decrease her risk of taking it up again.
Figure 22. Ashlee playing with her children.

Discussion

This article has demonstrated that young women experience and negotiate smoking-related stigma in a variety of ways. These findings highlight the complexity of the stigma faced by women who smoke, and the need to recognise the way in which different identities shape their experiences and negotiations of it. The “smoking as stigmatised” discourse explored how the idea of dirt and disgust comprises smoker’s identities. This physical disgust can translate into a moral disgust (Tyler, 2013), which is especially problematic for women, whose bodies are seen to be indicative of morality (Haug, 1987). The positioning of smokers as physically and morally disgusting is part of ‘othering’, or what Tyler (2013) terms
social abjection, which serves to legitimate state control and regulation of cigarettes and those who consume them. The “smoking as stigmatised” discourse also highlighted the implications of smoking-related stigma for people with mental health concerns, who report twice the rate of smoking than the general Australian population (Australian National Preventive Health Agency, 2013). Previous research has shown that women experience intersecting layers of stigmatisation as a result of mental health problems (Mizock & Russinova, 2015), meaning that smokers who also suffer mental illness are subject to compounding levels of stigma relating to their smoking as well as their mental illness. The discussion of addiction and choice showed how women who smoke can experience additional shaming as a result of the social stigmatisation that comes with being positioned within neurobiological models of addiction (Buchman & Reiner, 2009). Finally, participant’s negotiation of a stigmatised smoking identity through the positioning of smokers as considerate and inconsiderate corresponds with previous research on young women’s smoking (Lennon, Gallois, Owen, & McDermott, 2005).

The “smoking double standard” discourse captured the way in which women’s smoking is judged differently to men’s, how this serves to regulate femininity, and is amplified by intersections of culture and age. This discourse highlights the unequal treatment of men’s and women’s smoking, with women experiencing greater levels of discrimination for their smoking than men (Brown-Johnson et al., 2015), where women who smoke are seen as “tainted”, while men are positioned as “macho” (Bush, White, Kai, Rankin, & Bhopal, 2003). The regulation of women through the smoking double standard forms part of a wider patriarchal
culture where women’s bodies and behaviours are surveyed and disciplined to fit within boundaries of idealised femininity (Ussher, 1997). A double standard can also be seen in women’s experiences of quitting smoking, where women may face additional pressures during cessation with regards to weight gain and the maintenance of a thin ‘feminine’ body (Sánchez-Johnsen, Carpentier, & King, 2011). The “smoking as lower class” discourse considered how smoking is associated with poverty, a lack of education, and struggle. These findings corroborate previous research which has shown that women’s smoking is sustained by material and social disadvantage (Graham, 1994). There was also evidence that cultural background shapes women’s experiences of smoking-related stigma, with class-related stigma intensifying in some cultural contexts. Although differences in experiences of smoking-related stigma among cultural groups has been established in previous research (Stuber et al., 2008), future research might further explore how intersections of social class and culture shape women’s experiences of stigma. These findings also suggest that access to cultural capital allows some women to be ‘cultural omnivores’, where they have the power to socially profit from engagement in a wide range of cultural activities, including smoking (Warde et al., 2005). This analysis contributes to an existing body of literature which highlight the social and cultural benefits young women can derive from their smoking (Gilbert, 2007a, 2007b; Haines et al., 2009).

Finally, the “smokers as bad mothers” discourse explored the stigma that surrounds women who have children and smoke. These accounts demonstrated the way in which women are made responsible for the impacts of smoking on children’s
health. This responsibilisation might be part of the process by which women are more readily reprimanded for parental smoking (Farrimond & Joffe, 2006; Oaks, 2000), adding to the bias they face in the healthcare system (Burgess, Fu, & Van Ryn, 2009). The responsibilisation of mothers is also seen in public health responses to the consumption of alcohol and other drugs by women during pregnancy (Jos, Perlmutter, & Marshall, 2003). Although women in the study attempted to challenge smoking-related stigma by focussing on how their smoking helped them in their roles as mothers, they continued to self-stigmatised, which suggests that although mothers can adopt techniques to manage or avoid stigma (Burgess et al., 2009), they are unable to escape it entirely. As previous research has shown (Lennon et al., 2005), this analysis showed that the stigma surrounding ‘smokers as bad mothers’ and the desire to be a ‘good mother’ can serve as motivation for women to quit smoking. However, it is important to note that mothers unable to quit smoking experience significant levels of guilt and shame (Nichter et al., 2008), which can create emotional distance between the mother and child (Tan, 2016). Furthermore, high rates of postpartum relapse among women who have quit smoking (Meernik & Goldstein, 2015), may be reflective of the temporary motivation that stigma offers to mothers.

These findings highlight the complexity in how women respond to smoking-related stigma. While participants accepted smoking-related stigma, by internalising it or adopting stigmatised subjectivities, they also negotiated it, by challenging it, distancing themselves from it or repositioning it to their advantage. By challenging, distancing, or repositioning stigma, these women actively resisted this process of
‘being made abject’ (Tyler, 2013). Being stigmatised or self-stigmatising had negative implications for participants’ subjectivities, associated with reports of anxiety, distress, and embarrassment. Stigma also impacted on smoking practices, leading women to hide their smoking, or to stop smoking, either temporarily or long-term. This study provides further evidence for the demotivating effect of stigma (Farrimond & Joffe, 2006), as smoking-related stigma led some participants to become more resolved in their smoking, and to seek out communities of smokers. Although a number of participants reported that the internalisation of smoking-related stigma was a motivation for quitting smoking, only one woman said this stigma led to successful, long-term cessation. Where participants reproduced or aligned themselves with discourses of smoking-related stigma we witness the power of social stigma as a form of biopower, helping to govern and regulate health behaviour (see Foucault, 1988; N. Rose, 1996; Thompson et al., 2007). Where participants were able to use this stigma as motivation to quit smoking, or continue not smoking, we witness the success of stigmatisation as a public health approach, and where participants resisted being made abject, we see how forms of governmentality can be contested. It is important to also consider the biological basis of nicotine addiction, to which women are uniquely susceptible (Benowitz 2010), and the role this plays in women’s continued smoking when faced with smoking-related stigma.

Although there were similarities across participants, these women’s experiences of smoking-related stigma were shown to be uniquely shaped by various axes of identity. Participant’s accounts revealed that women experience
compounding layers of smoking-related stigma based on intersecting identity positions, such as gender, cultural background, social class, or whether or not they have children. This intersecting stigma was often also applied to women occupying an already ‘othered’ identity position. These findings are in line with previous research which has explored experiences of multiplying smoking-related stigmatisation (Farrimond & Joffe, 2006; Graham, 2012; Scheffels, 2009; Thompson et al., 2007). This article has helped to grow this body of knowledge by focusing on women’s negotiation of stigma and drawing attention to the negative impact multiplying smoking-related stigma can have on subjectivity and practice. Although this study has explored a number of axes of intersections, future work is needed to continue to understand intersections of other identities, such as disability, sexual identity, and age. The sample for this study contained women from a range of social class backgrounds; however, one of the limitations was that over 50% were from middle or upper class backgrounds. As rates of women’s smoking is highest among lower social class groups, future researchers might also consider studying women’s experiences of smoking-related stigma within a larger sample of women with lower social class backgrounds.

These findings have implications for the development and design of anti-smoking responses. In Australia attention is now turning toward reducing disparities in smoking rates, and managing the impact of smoking-related stigma on already marginalised populations (Australian National Preventive Health Agency, 2013). As other researchers have noted (Graham, 2012; Graham et al., 2006; Kandel, Griesler, & Schaffran, 2009), tobacco control attention and funding could be better directed
into policies which “engage directly with social inequalities” (Graham, 2012, p. 95), working to improve the material and social wellbeing of those populations most likely to smoke. This would mean a turn toward tobacco control interventions which address the social context in which smoking takes place, by working to reduce the social and structural inequalities in income, education, and health care which frame the lives of the majority of women who smoke. By targeting certain groups of women, interventions can address specific economic and social barriers to quitting. Anti-smoking rhetoric in the media, as well as that which is used by healthcare professionals, can avoid reinforcing smoking-related stigma by focussing on the positive aspects of quitting smoking.
Chapter Five: ‘It’s One of Those “It’ll Never Happen to Me” Things’: Young Women’s Constructions of Smoking and Risk

This chapter contains the journal article ‘It’s one of those “It’ll never happen to me” things’: Young women’s constructions of smoking and risk. This article uses a poststructuralist theoretical approach to explore how young women position the risks of their smoking. This article is also included in Appendix N.

Abstract

In this article, we examine how young women make sense of the risks associated with smoking cigarettes. We recruited young women smokers and ex-smokers living in Australia in 2014 and 2015 to participate in semi-structured interviews and a participant-produced photography activity on young women’s experiences of smoking and smoking-related risk. We analysed the data using discourse analysis to examine how young women positioned themselves in relation to smoking-related risk, and how this was shaped by discourses of health, risk and femininity. We identified four dominant interpretative repertoires: ‘the risks of smoking are self-evident’, ‘it’s not going to happen to me’, ‘smoking as a lesser evil’ and ‘smoking to cope with stress and emotion’. Through our analysis, we found that by drawing on these repertoires, participants were able to position the risks of smoking as both acceptable and unacceptable. Participants also made use of several of these repertoires to position antismoking messages as ineffective. We place these findings in the context of broader health and risk discourses surrounding young women’s use of smoking to reinforce and subvert representations of ‘respectable’ femininity. We identify ways in which public health approaches could and should be developed to recognise the complexity and contradiction inherent in young women’s lay accounts of smoking-related risk and situate smoking risks in the context of young women’s everyday lives.

Introduction

The risks of smoking, particularly for young women, are well established. Despite this, young women continue to smoke cigarettes. In this article, we examine
the way young women position themselves in relation to smoking-related risk and how this positioning shapes the way young women engage with anti-smoking discourse. Our findings have implications for our understandings of how young women’s ‘risky’ health behaviours relate to notions of ‘respectable’ femininity.

**Young women’s experiences of smoking and risk.**

Despite significant declines in smoking prevalence in major industrialised countries, smoking among specific groups, such as young women, continues to be problematic. For example, in Australia, young women begin smoking at a younger age than young men (AIHW, 2017b). The major health risks associated with smoking are all-cause mortality, death from cancer and circulatory and respiratory diseases (Iversen, Fielding, & Hannaford, 2013). Young women smokers experience additional health risks which relate to their use of oral contraceptives, their fertility and pregnancy outcomes (Ernster et al., 2000). Young women who smoke also have an increased risk of developing breast cancer, although it has been shown that young women have limited knowledge about this risk (Bottorff et al., 2010). Public health campaigns often rely on stereotypical representations of gender and femininity to communicate messages about smoking risks, such as breast cancer (Haines, Bottorff, et al., 2010). These studies highlight the need for additional research on young women’s perceptions of the risks associated with smoking, in order to improve the policy and programmes targeted at them.

Western societies are characterised by growing uncertainty and an increasing preoccupation with identifying and managing risk, particularly in relation to health and illness (Giddens, 1991). Knowledge of the health effects and addictive nature of
cigarettes has contributed to a widespread cultural construction of smoking as a risky behaviour (Lupton, 1995). Understandings of smoking and risk in Western societies are shaped by neoliberal discourses of ‘healthism’, where health is seen to be a matter of individual responsibility, and behaviours such as smoking are considered to be an internally imposed risk resulting from poor personal lifestyle choices (Petersen & Bunton, 1997). Individuals are positioned as agentic, rational and responsible actors, who, when equipped with knowledge about the risks of smoking, will work to avoid these risks by quitting smoking (Lupton, 1995; Miller & Rose, 2008). Smokers who do not quit are at risk of experiencing stigma as a result of their continued smoking (Triandafilidis et al., 2016).

Public health campaigns often draw on a traditional biomedical model of health and risk communication, treating smokers as rational consumers who need to be informed about smoking-related risks identified in medical and scientific research (Gilbert, 2005). These campaigns tend to present an individualised view of health, where smokers are positioned as a risk to themselves and others (Lupton, 1995). However, research has shown that exposure to risk discourses does not always lead to successful smoking cessation and, in some instances, can be counterproductive, leading smokers to develop a sense of helplessness or resentment and may make them more resistant to quitting (Bond, Brough, Spurling, & Hayman, 2012). Smokers often resist the construction of smoking as risky by casting doubt over the validity of smoking risk information (Peretti-Watel, Halfen, & Grémy, 2007) and by adopting self-exempting beliefs which work to deny their personal vulnerability (Chapman et
al., 1993). For example, smokers rate their personal risk of lung cancer as less than that of the average Australian smoker (McMaster & Lee, 1991).

Researchers have found that age influences the way smokers engage with smoking-related risk discourses. Young adult smokers are more likely than older smokers to underestimate the risk of developing disease as a result of smoking (Lee, 1989). They also contest the validity of the link between smoking and illness (Gough et al., 2009) and minimise the risks of smoking in relation to other risky behaviours, such as alcohol and other drugs (Jamieson & Romer, 2001). Young adults are able to present themselves as being invulnerable to the risks of smoking by positioning their smoking as a temporary practice (Gough et al., 2009), and arguing that the impacts of smoking on health are only associated with long-term smoking (Denscombe, 2001).

Young adults are more likely than older adults to be non-daily or social smokers, and to hold the belief that non-daily smoking does not carry significant risk, which minimises their perception of risk (Schane, Glantz, & Ling, 2009a). Young adults are also likely to underestimate the addictiveness of tobacco and overestimate their ability to quit (Romer & Jamieson, 2001b). Although young adults are often dismissive of the risks when they first begin smoking, once they take up regular smoking, as their awareness of risk increases, as does their intentions to quit (Romer & Jamieson, 2001b). This suggests that young adults have a distinctive experience of smoking-related risk, which must be better understood in order to provide smoking cessation support to this age group.

Emphasising the perceived benefits of smoking is another way smokers mediate their perceptions of smoking-related risk (Gough et al., 2009; Helweg-
In her study of young women smokers, Gilbert (2005) uses the phrase ‘risk profiling’ to describe how young women justify the risks of their smoking in relation to the benefits. A number of researchers have shown that women position their smoking as a way of coping and being resilient. For example, young women talk about using smoking to suppress or reduce negative feelings, to numb emotions or to elicit positive feelings (Haines, 2008). They argue that smoking provides support, comfort, companion-ship, as well as offering predictability and consistency (Greaves, 1996). The idea that smoking is a way for women to manage emotions, stress and loneliness has been reinforced through both television and film (Tinkler, 2006). Among young women specifically, smoking is said to be a way of constructing identity and negotiating social relationships (Cullen, 2010; Gilbert, 2007a, 2007b; Haines et al., 2009; Triandafilidis, Ussher, Perz, & Huppatz, 2017a), as well as managing anxiety (Copeland, 2003), relieving boredom (Banwell & Young, 1993; Haines, 2008) and coping with stress (McDermott et al., 2006).

Commentators have used a range of social and psychological theories, such as cognitive dissonance theory to understand the ways in which individuals negotiate smoking-related risk. McMaster and Lee (1991) have used cognitive dissonance theory to examine the rationalisations and distortions of logic which smokers use to manage the dissonance between their smoking and their belief that smoking is risky. However, these theories often conceptualise the decision to smoke as rational, conscious and independent of social, cultural and material influences. Alternatively, smoking can be conceptualised within a poststructuralist analytical framework, where language and discourse are seen to shape meaning and influence subjectivity.
Poststructuralist theories have gained popularity among those researching young women’s smoking (Gilbert, 2007b) and have been used in a study of young women’s perceptions of risk in relation to anti-smoking campaigns (Gilbert, 2005). In this article, we use poststructuralist theory, to better understand how young women position themselves in relation to smoking-related risk, in the context of social and cultural discourse associated with health, risk and femininity.

**Methods**

In this article, we report on findings from a multimodal qualitative research study, which involved both interview and participant-produced photography data. Previous research has shown that smokers and ex-smokers understand risk differently, with former smokers having higher awareness of smoking-related risk than current smokers (Weinstein, 2001). Therefore, we draw on the perspectives and experiences of both smokers and ex-smokers in this article.

**Design.**

This study involved three qualitative elements. We started with telephone and face-to-face interviews with 27 young women. Following those interviews, 18 of these women chose to participate in a photography activity, where they were invited to take photographs of their experiences of smoking. Follow this, we re-interviewed all 18 of the women to follow up issues that arose in the first interview and to discuss their photographs.

We used interviews as they enabled us to explore in-depth the participants’ experiences of smoking. We used semi-structured interviews to direct the
conversation towards women’s experiences of smoking and risk, while enabling participants to redefine this topic and generate new insights into these experiences (Willig, 2008b). We also included a participant-produced photography activity in the research design, to provide another mode of communication, and a fuller account of participants’ experiences. The photographs helped us to situate participants’ experiences of smoking-related risk within the contexts of their everyday lives (Robertson, Gifford, McMichael, & Correa-Velez, 2016). The ‘everydayness’ of participants’ photographs also helped to elicit greater depth and detail in the follow-up interviews (Pilcher et al., 2015). By triangulating inter-view and photography methods, we were able to explore the ‘convergence, complementarity, and dissonance’ in young women’s accounts of risk in relation to their smoking (Farmer et al., 2006, p. 378).

**Participants.**

We recruited 27 young adult women, aged 18–31 (average age, 24) for the first stage of our study. We used flyers to advertise the study and invite young women to talk to us about their experiences of smoking and quitting. These flyers were distributed at train stations, university classes, tertiary education campus noticeboards and through social media advertising. To take part in the study, participants had to meet the Australian Institute of Health and Welfare’s (AIHW, 2014b) definition for smokers, which is having smoked at least 100 cigarettes in their lives. We recruited 18 women who currently smoked (67%) including 4 who smoked 15 or more cigarettes a day (22%), 10 who smoked less than 15 cigarettes a day (56%), and 4 who only smoked occasionally (22%). The remaining nine women
(33%) defined themselves as ‘ex-smokers’ who had quit smoking prior to commencement of the research. Participants’ length of cessation ranged between 2 weeks and 2 years.

Seventeen of the women were Anglo Australian (63%), while the remaining women identified as being from Aboriginal Australian, Asian, American, European, Middle Eastern and Pacific Island cultural backgrounds. When asked to describe their social class background, 12 participants identified as being from working-class backgrounds (44%), 13 from middle-class backgrounds (48%) and 2 identified as having an upper-middle class background (7%). Eighteen women described themselves as heterosexual (67%), seven as bisexual (26%), and two women identified as lesbian (7%). One woman was pregnant at the time of the study, and seven of the women had children (26%). All of the women were living in Australia at the time of the interviews. A total of 27 women participated in the first stage, with 18 women opting to continue on to the second and third stages.

**Procedure.**

In the first round of interviews, we invited the women to talk about smoking, quitting and representations of smoking in the media. We started the interview by asking ‘Tell me about your experiences with smoking’. This broad, opening question was intended to put participants at ease and build rapport, as well as allowing them to set the agenda for the interview (DiCicco-Bloom & Crabtree, 2006). During the interviews, we asked participants open-ended questions such as, ‘Can you describe what it feels like to smoke cigarettes?’ The use of open-ended questions helped to
create a focus on narrative and experience and establish a less formal interview interaction (Willig, 2008b).

Following the interviews, we invited participants to take photographs of their experiences of smoking. We asked them to imagine they were taking photographs for an exhibition titled ‘Smoking through the eyes of young women’. We gave participants some prompts to guide them. For example, we suggested that participants might like to photograph ‘a place where you like to smoke’. Participants took on average 3 weeks to complete the photography activity, submitting 157 images in total. Participants had the freedom to take photos of aspects of their experiences which they felt were important to them, while the prompts worked to direct participants towards topics which were relevant to our research questions.

We then followed up the photographs with a further round of interviews. In these interviews, we invited the participants to talk about their first interviews, their photographs and their experiences of being involved in the study. We asked them questions such as ‘What does this photograph mean to you?’ and ‘Tell me about what it was like taking photographs of your experiences with smoking’. In this interview, we asked participants to provide interpretations of their first interviews and their photographs and encouraged them to collaboratively contribute towards the analysis of their data (Jenkings et al., 2008).

The initial and follow-up interviews took 45 min on average. Given that some of the participants lived some distance from the institution hosting the research, most of the interviews (35 out of 45) were telephone interviews. Researchers have observed (Trier-Bieniek, 2012) that interviewees often provide rich accounts in
telephone interviews, especially when discussing stigmatised behaviours, such as smoking. We gave all participants an information sheet and all participants provided written agreement to take part in the study. The study was granted full ethical approval by Western Sydney University Human Research Ethics Committee. All the interviews were conducted between April 2014 and March 2015. In this article, we use quotes from the interviews but have replaced participants’ names with pseudonyms. We include the age and smoking status of participants to help contextualise quotes.

**Analysis.**

We used poststructuralism, positioning theory and discourse analysis to analyse the interviews and photographs. Poststructuralism is a theoretical approach which challenges structuralist notions of the subject as fixed or contained and conceptualises identity as being multiple and fluid (Weedon, 1997). This theory allowed us to consider young women as capable of maintaining multiple, contradictory subjectivities, such as ‘smoker’ and ‘responsible and risk adverse’. The terms ‘subject’ and ‘subjectivity’ are used in poststructuralist theory to refer to the way individuals are understood by others and the way they understand themselves, through discourse (Weedon, 1997). The term discourse refers to ‘a set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events’ (Burr, 2015, pp. 74-75).

We explored subjectivities and subject positions using positioning theory, examining how language and discourse produce multiple ‘positions’ within social interaction, and considering individuals’ negotiation of these positions (Davies &
Harré, 1990; Lock & Strong, 2010b). Using positioning theory, we were able to consider how participants positioned themselves in relation to social and cultural discourses around femininity, health and smoking-related risk.

We used Potter and Wetherell’s (1987) method of discourse analysis as it focuses on the construction of discourse through linguistic resources, such as ‘interpretative repertoires’ (Wetherell & Potter, 1988). Interpretative repertoires are a ‘culturally shared tool kit of resources’ that include metaphors, tropes or figures of speech that speakers can draw on to construct accounts (Burr, 2015, p. 69). For example, researchers have identified peoples’ use of the phrase ‘everything in moderation’ to make sense of conflicting health advice in relation to diet and heart disease (Lupton & Chapman, 1995).

In preparation for the analysis, we used the services of a professional transcriber to produce text versions of all the interviews, which we checked for accuracy. Triandafilidis and Ussher coded a subset of the interview transcripts and identified both semantic and latent themes in the data (Braun & Clarke, 2006). These themes were discussed with Perz and Huppatz and a coding frame was developed, which Triandafilidis then used to code the remaining interviews and photographs. This was a dynamic process, with codes continually being collapsed and combined. Participants’ photographs were coded alongside their interviews in order to identify key themes in the images (G. Rose, 2016). Following coding, the data within each code were read and reviewed and commonalities and differences within coded categories summarised. Using these summaries, we were able to identify patterns in the data through an iterative process of reading, viewing and analysing each segment
of data (Wood & Kroger, 2000). We paid particular attention to the detail of language used and to the variation, inconsistencies and differences in how participants constructed smoking-related risk and negotiated and resisted subject positions associated with smoking and risk (Wetherell & Potter, 1988). For example, after several readings of the data coded in the category ‘smoking and health’, we identified the phrase ‘it’s not going to happen to me’ as reoccurring in participants’ accounts. Having identified this repertoire, we then examined the implications of this talk.

We used Rose’s (2016) Discourse Analysis I to analyse the photos. We paid close attention to detail, complexity and contradiction, both within the photographs, between the interview accounts and the photographs and between participants’ photographs and broader social discourse on smoking and risk. For instance, we considered how participants’ photographs compared to representations of smoking in tobacco advertising and anti-smoking campaigns. When we looked at participants’ photographs, we did not seem them as representations of any specific truths or reality about young women’s smoking, but rather as representations of participants’ experiences with smoking made visible to the researchers within the context of the study (Pilcher et al., 2015).

Findings

The risks of smoking are self-evident.

Participants in the study positioned themselves as knowledgeable about the risks associated with their smoking, describing the risks of smoking as self-evident:
‘we’re not stupid, we do know’ (Jessica, 22, smoker); ‘it’s a lot of common knowledge . . . everyone knows it’s bad for you’ (Sinta, 19, smoker). Rachel (21, smoker) said:

You’ve got warning signs all over a packet of cigarettes. You’ve got signs everywhere. You’ve got restrictions everywhere. You pay extra tax as a smoker. And you’ve also got the ads that were on TV for a long time. Yeah, obviously we know it’s bad for us. What have I been living under a rock this whole time?

Another young woman, Briana (18, smoker), represented herself as knowledgeable about the risks of smoking in an image she submitted for the photography activity (Figure 23). She created the image by compiling photographs of health warnings on her cigarette packet, with text and emojis, which warn that smoking ‘kills’, is a ‘dirty habit’ and ‘damages your gums and teeth’. In her account of the image, she commented

I’m sure back when my mum started smoking they didn’t have as much knowledge about it as they do now. They didn’t think it was as bad as it actually is. Now the statistics on it show that smoking is pretty much the number one killer when it comes to dirty habits.

In her photograph and account, Briana took a position as knowledgeable about the health risks of smoking and distanced herself from other, less knowledgeable smokers from previous generations. Drawing on this repertoire, these young women were able to take up positions as rational, knowledgeable, risk-aware and health-
conscious, in an attempt to maintain a responsible identity and minimise further judgement for their smoking.

Figure 23. “Smoking is pretty much the number one killer when it comes to dirty habits.”

‘It really has no impact on smoking’: Knowing the risks and continuing to smoke.

Taking up subject positions as knowledgeable and rational in relation to the risks of smoking meant that participants had to draw on particular discursive strategies to manage their inconsistent smoking subjectivities. One strategy participants used to cope with this dissonance was to position themselves as
indifferent to information about the risks of their smoking. For example, Kalika (19, smoker) asserted that ‘regardless of all the people that were saying it’s really bad and it’s carcinogenic and whatever, that didn’t really influence me that much’. In particular, participants positioned themselves as indifferent towards anti-smoking messaging. For instance, Stephanie (27, ex-smoker) said,

> We know its negative effects, but, it really has no impact on smoking. I don’t think you’re going to get somebody that’s seen the ads on TV and knows what’s going on to say, ‘When I saw the ad and it really hit home, so I just quit that day’.

Another participant, Shayma (19, smoker), took a close-up photograph of a cigarette packet (Figure 24). She described the photograph, saying, ‘I just took that to show that I’m not annoyed by that packaging . . . it’s just a toilet, it’s not even disgusting, it doesn’t annoy me at all’. In both her photograph and account, Shayma took up a position of indifference, showing herself to be unaffected by her exposure to the graphic health warning. Other participants positioned themselves as defensive and defiant. Shannon (23, smoker) described a friend who would tell her how ‘bad’ her smoking was, saying ‘it just made me want to smoke more. I wanted to smoke in her face’. Another woman, Sinta (19, smoker), said,

> I’ve heard a lot of times even when I am out in a social setting, you know, ‘that’s not really good for you’, ‘that’s going to give you cancer’, or ‘that’s so disgusting, that stinks’, and sometimes I’ll just pull it out and be like, ‘I’m going to have my cancer stick’ just so I nip it in the bud.
By describing her cigarette as a ‘cancer stick’, Sinta claimed that she was able to ‘put up a shield’ and take up a defensive subject position in response to warnings about the risks of smoking. These accounts captured these young women’s attempts to reconcile their knowledge about the risks of smoking with their continued smoking and to make sense of these apparently contradictory positions by being unaffected or resistant to information about smoking risks.

‘It’s not going to happen to me’.

Another way participants minimised the dissonance between their smoking and their knowledge of smoking-related risks was to take up a position as personally
immune to risk, using the repertoire that the negative effects of smoking were ‘not going to happen’ to them. As Kalika (19, smoker) observed, ‘you just think that it’s not going to happen to you, you’re not going to get lung cancer, you will be fine’. Another woman, Sarah (28, smoker), said ‘everyone that I know, is like “it’s not going to happen to me”’. Participants gave a number of different explanations for why they thought the risks of smoking were not pertinent to them. Some participants talked about not physically seeing the effects of smoking on health: ‘you just think to yourself, “it’s not going to happen to me” because you don’t actually see it every day’ (Kalika, 19, smoker). Talking about her parents, older sister and other family members who smoke, Briana (18, smoker) noted, ‘they don’t look like they have any health problems or anything, so I just thought, they can do it, I can probably do it as well’. Another woman, Sarah (28, smoker), stated, ‘All of my friends smoked, some of them heavily, through their pregnancies, and their kids are spot on’. These accounts highlight how young women can prioritise material evidence and embodied knowledge over official risk discourses, and how an absence of observable health consequences allows some young women to dismiss claims regarding the risks of smoking. Conversely, participants also drew attention to visible smoking risks. Chelsea (20, smoker) captured visible evidence of the health effects of her smoking in a close-up shot of an ashtray (Figure 25). She described the photograph, saying, ‘kind of like a graveyard of cigarettes. Maybe there’s a metaphor there for the health impact?’ Chelsea’s photograph is reminiscent of anti-smoking advertisements which often use ashtrays to symbolise the health risks of smoking. For instance, one of the graphic health warnings featured on cigarette packets at the time of the study shows
an ashtray, with the slogan ‘Quitting will improve your health’ (Figure 26).

Chelsea’s photograph and account highlight how young women might draw on anti-smoking imagery to make sense of the health risks and potentially challenge a position of immunity to risk.

*Figure 25.* “A graveyard of cigarettes.”
Other women avoided being positioned as ‘at-risk’ by locating their smoking within a context of an otherwise healthy lifestyle. Sinta (19, smoker) said that smoking is ‘probably my only bad, or detrimental habit that I have’, and Shannon (23, smoker) told us when she took up smoking she ‘started to do lots of exercise’ and started reading things like, “‘Can you be a healthy smoker?’” and “Can you supplement all the vitamins you lose from smoking by doing all these other things?’” By taking up other ‘healthy’ lifestyle practices, Shannon worked to challenge the discourse that smokers are unhealthy and presented herself as seeking healthiness.
through self-knowledge and self-improvement, repositioning herself as responsible for her health. Participants also distanced themselves from other ‘at-risk’ smokers, such as ‘heavy’ smokers: ‘maybe because I was never a heavy smoker, I never thought that sort of thing would happen to me’ (Gemma, 25, ex-smoker); ‘I have to be smoking a deck [a packet of cigarettes] a day for something bad to be happening to me, so that’s why I’m not that worried’ (Shayma, 19, smoker). Some participants described the risks of smoking as only applying to older, life-long smokers, positioning themselves as being too young to experience negative health effects: ‘I don’t really care about the health risks because the majority of people who smoke and get cancers are probably a lot older than 21’ (Brittany, 21, smoker).

The ‘it’s not going to happen to me’ repertoire was also used by participants to position anti-smoking messaging as ineffective. For example, Paige (30, ex-smoker) said,

You watch it on TV and because I haven’t been smoking for as long as they have for instance, they’re a mother with four kids and they’re in their late 40s and you think, well, I’m not in my late 40s and I don’t have four kids and I probably didn’t smoke as much as you, so it’s not going to happen to me. By associating poor health outcomes with heavy, older and life-long smokers who are responsible for the health of their children, Paige minimised her perception of her own personal risks. Paige went on to describe how her perceptions of anti-smoking messaging shifted, depending on her desire to quit or continue smoking: ‘I found that unless I wanted to quit, I wasn’t really paying attention to any of that. A little bit of, like, that’s not me, it’s never going to affect me syndrome’. Another woman, Sarah
(28, smoker), gave a similar account of her responses to anti-smoking messages. She said, ‘even on the cigarette packets when you see the photos, [you think] “it’s not going to happen to me”’. Sarah took a photograph of a packet of cigarettes and lighter (Figure 27). She described the photo saying, ‘I don’t even know what that picture is on the packet. I wouldn’t have even taken notice of it obviously’. The out-of-focus cigarette packet shown in the photo reinforces Sarah’s account of being able to distance herself from the graphic health warnings about the risks of smoking.

Olivia (18, ex-smoker) offered a different account, saying that anti-smoking campaigns challenged a ‘it’s not going to happen to me’ repertoire, and her resulting perceptions of immunity. She said,

I think they’re quite effective. Every time I saw one it would remind me that I had to stop because I didn’t want to keep going and just think nothing would happen to me because you could see by all like the images and stuff, that stuff does happen.

This account highlights how challenging the belief that ‘it’s not going to happen to me’ may help young women who are in the process of quitting smoking.
Figure 27. “When you see the photos, [you think] ‘it’s not going to happen to me.’”

**Smoking as a lesser evil.**

Another way participants minimised the inconsistency between their smoking and their knowledge of its risks was to position it as ‘lesser’ in relation to the multiple risks or ‘evils’ they were exposed to in their lives. For example, Lisa (26, smoker) spoke about the risks she was exposed to growing up in a remote, low socio-economic town which she described as ‘a horrible little place’ with ‘massive problems’, such as welfare dependence, drug and alcohol issues and domestic and family violence. Talking about smoking within this context, she said,
It doesn’t really matter if a child is smoking, because there’s definitely more horrible things that people are doing. If your 14-year-old daughter is smoking cigarettes, then that’s probably not so bad because her 15-year-old friend is about to have a baby, so it’s a lesser of two evils sort of thing.

Smoking was also positioned as a lesser evil than poor mental health. For example, Brittany (21, smoker), articulated her concerns about the risks of smoking in relation to her experiences of depression: ‘I’ve gone through a lot of stuff and I don’t think smoking is that bad compared to a lot of the other stuff I’ve had to go through’.

Brittany explained how a ‘smoking as lesser evil’ repertoire was reinforced by other people in her life: ‘because everyone knew that I had depression, they weren’t going to hack on me for my smoking, because I had bigger issues that were more important’. By situating the risks of smoking among other, more harmful evils, young women are able to minimise or dismiss the risks of their smoking. Here, young women accept this position of ‘at-risk’ but position this state of risk as not being primarily attributable to smoking.

Alcohol was an ‘evil’ many participants discussed in relation to their smoking. For example, Vanessa (22, smoker) compared the risks of smoking to alcohol saying, ‘I don’t think smoking is as bad as alcohol’. Jessica (22, smoker) described a photograph (Figure 28) she took when she was ‘drinking and hanging out with friends’. She described her interactions with one friend that night, saying,

Every time I lit up a cigarette she’d just go, ‘smoking kills, smoking kills,’ blah, blah, blah, and in the end, I was just like, ‘yeah, you know what else kills, drinking so much’.
The acceptability and ubiquity of alcohol is shown by its overwhelming presence in the photo, and the comparative unacceptability or unpopularity of smoking, which is not visible in the image. In her photo and her account, Jessica draws our attention to the potential difficulty of positioning the risks of smoking as lesser in a social context where the risks of alcohol are more normalised. Another woman, Chelsea (20, smoker), rationalised the risks of her smoking by stating that it was consistent with the risks associated with her alcohol consumption. She said, ‘Oh well, I’m drinking [alcohol] and that’s a bad thing for my body, I may as well smoke as well’.

Chelsea’s account of her health is fatalistic, suggesting that negative outcomes resulting from her alcohol consumption are unavoidable, and therefore, the consequences of her smoking are irrelevant.

Participants were often fatalistic when comparing the risks of smoking to other ‘evils’. For example, Sarah (28, smoker) used fatalistic talk when discussing her health:

I don’t think I’m going to die from [smoking]. I have diabetes now so, if I’m going to die, it’s going to be something else, not smoking two or three smokes a day.

Sarah went on to position risk as a normal part of her life, saying, ‘People will say “why are you smoking, you can get this and get that” and it’s like, yes, but you can also walk outside and get hit by a bus tomorrow as well’. Courtney (21, ex-smoker) also drew on notions of fatalism, positioning her health outcomes as being random or a matter of chance. Courtney said, ‘someone who doesn’t smoke, trains all their life, can die of a heart-attack at 30, 40. My mum had her heart-attack at 45, and she’s
never smoked a day in her life’. These young women exploited the ecological fallacy inherent in smoking-related risk research, where the statistic (and risk) applies to a group and not to specific individuals. This allowed participants to frame the risks of their smoking as a matter of chance rather than certainty. The fatalistic talk used by these women works to imply that their health is beyond their control.

![Image](image_url)

*Figure 28. “Drinking and hanging out with friends.”*

Participants also spoke about the risks of quitting smoking, at times positioning smoking as a lesser evil in relation to these risks. For example, one participant, Tara (24, smoker), spoke about having a history of being suicidal and spending time in hospital with mental health issues. She spoke about her experiences with the smoking cessation drug Champix, saying that when she used it she had ‘bad dreams’, and got ‘really emotional’, ‘paranoid’, ‘delusional’ and ‘became suicidal’. Tara said that she did not want to use Champix and ‘risk that happening again’. 
Another participant, Sarah (28, smoker), spoke about continuing to smoke during pregnancy to avoid the risk of another miscarriage:

The specialist said, ‘we want you to give it up, but you have that chance of miscarrying again’. So, my brain is here, there and everywhere thinking ‘what am I going to do?’ But at the end of the day, I chose to continue having those few cigarettes because I didn’t want to have a miscarriage.

Sarah used the medical authority of her specialist and her risk of miscarriage to rationalise her decision to smoke during pregnancy. This positioning helped to protect Sarah’s subjectivity, as she was able to align herself with dominant medical risk discourse and avoid taking up a stigmatised position as a ‘bad mother’.

**Smoking to cope with stress and emotion.**

Participants gave accounts of how smoking helped them to cope with stress and manage negative emotions, a strategy which enabled them to manage the dissonance between their positions as smokers and as ‘risk aware’. One participant explained this by saying: ‘[smoking] is a way to move through that emotion and to pass the time while you’re waiting for those feelings to subside’ (Chelsea, 20, smoker). Some women said smoking gave them the time or space to think things through. For example, Lisa (26, smoker) spoke about the stress of being ‘horribly broke’. She described her smoking at that time saying it was ‘more of a crutch than a choice . . . it was like, “I can’t deal with this, I’m just going to sit and have a cigarette and breathe deeply for a moment”’. While smoking allowed some women the time and space to work through problems, others used it as a distraction from their
problems. For example, Brittany (21, smoker) spoke about using smoking to help manage her depression:

With my depression, sometimes there will be short episodes where I’ll get really down ... with smoking I think it’s a bit of a distraction because it makes you feel relaxed . . . I kind of went to rely on that because it would be a quick convenient way rather than actually dealing with it. I know it’s not the healthiest way.

Another participant, Shannon (23, smoker), explained,

it’s better for your health to stop doing it. But, you can always come up with arguments, like, ‘well, it’s better for my mind at this moment to keep on smoking’.

In both Brittany and Shannon’s accounts, we can see how the benefits of smoking in terms of coping with negative emotions are seen as exceeding the costs of smoking with regards to other aspects of health, providing an incentive to continue smoking.

Participants positioned their smoking as a form of social support: ‘it’s something to keep you company’ (Shannon, 23, smoker); ‘it’s like a little friend in your pocket’ (Julie, 31, ex-smoker). Brittany (21, smoker) spoke about how time spent alone smoking allowed her the space she needed to reflect on her problems after her mother died:

I spend a lot of time just talking to myself about my problems because there’s no-one there and, because my mum passed away. Sometimes I just talk to her, and just like bitch about my life.
These accounts highlight how objects such as cigarettes have symbolic value, providing young women with both social and familial connections. Several women spoke about how smoking helped when they were bored. Lisa (26, smoker) said, I’m a stay-at-home mum, so I really get quite intensely bored . . . I really have nothing to do, so I tend to just sit and read a book and have a cuppa and smoke cigarettes.

Smoking was also said to provide a ‘stability or reliability’ (Jennifer, 26, smoker). The regularity that smoking offered was particularly important to one woman, Shannon (23, smoker), who talked about how smoking helped her to manage her bipolar disorder: ‘every single low is a depression, and every single high is being manic, and [smoking] was just something stable about me’.

Participants spoke about how they used smoking to ‘manage stress’. Stephanie (27, ex-smoker) spoke about how smoking was an ‘awesome stress relief’, saying, I work almost full-time, I have two little kids and I do it all by myself, and smoking was a buffer . . . it’s a coping mechanism. The more stress I had, the more I smoked.

Stephanie shared a photograph she had taken of a Christmas tree (Figure 29). In many cultures, Christmas is seen to be a time of relaxation and family; however, Stephanie described it as ‘very stressful’. Stephanie said, ‘last year was the first year I missed out on Christmas morning with my kids in four years. It was like, where’s the Malibu and the cigarettes now’. Stephanie’s account illustrates how stressful situations might act as a potential trigger for relapse among women who have quit...
smoking. The contrast between Stephanie’s photo and her account highlights how stressful triggers to smoke may, at times, be invisible to others.

Another woman, Briana (18, smoker), also a single mother, offered a similar account:

   I smoked during pregnancy, and I know I shouldn’t of. I did quit, and then my son’s father broke up with me and I was under a lot of stress, and I actually picked up smoking again, and continued it throughout my pregnancy until the end.... It just honestly made me feel a lot better when I had a cigarette, especially if I was thinking about all the stuff I was going to have to do by myself now that I was a single mother about to raise a baby on my own.

These accounts illustrate how some of the women in our study positioned smoking as a way to manage the stress and additional caring responsibilities associated with single motherhood. These accounts work to challenge the discourse that smoking mothers are uncaring and selfish, by positioning smoking as helping these women to perform their caring duties.

Along with stress management, some of the women positioned smoking as a way of helping to manage a range of different emotional states. Emily (21, ex-smoker) spoke about using smoking to manage anger: ‘I found that if I was getting extremely angry, I’d have a cigarette and I’d calm down’. Others described smoking as having helped them to manage grief. Courtney (21, ex-smoker) talked about smoking as a way of coping when she lost a partner to suicide: ‘when he committed suicide I just went into a deep depression, [it was] just alcohol and cigarettes
basically, and [I] didn’t really talk to anyone’. For other participants, smoking was a way to cope with low self-esteem. For example, Jennifer (26, smoker) compared smoking to self-harm, saying,

You know it’s bad for you but it’s kind of like self-harming. If you feel bad about yourself you don’t really care that it’s damaging, it feels good and that’s what you want for that point in time.

Another woman, Chelsea (20, smoker), said,

If I’m home alone, I’ll have, this sounds really awful and very sad, but I’ll have some wine and then go for a walk and have some cigarettes because I either hate my life or hate my body, so it’s just a way to destroy it a little bit, it’s not taking very good control of your body, but you’re making the decisions of what’s going into your body, even if it’s bad.
These accounts illustrate the way in which smoking can be conceptualised as an abstract form of self-harm. As both Jennifer and Chelsea explained, smoking provided them with a way of coping when they felt ‘worthless’ or ‘hated’ themselves or their bodies. By attempting to ‘damage’ and ‘destroy’ their bodies, these women adopted attitudes and behaviours that did not align with a healthism discourse and the
pursuit of good health, while firmly expressing bodily agency and autonomy. Unlike Jennifer and Chelsea’s acts of self-harm, Shannon (23, smoker) positioned her smoking as more of a ‘reward’ or a ‘comfort’ – an act of self-care:

When I’m seriously depressed, I don’t smoke, it’s almost like smoking’s a reward . . . if I’m smoking that means that it’s ok, if I’m not smoking at all it means something is seriously wrong or I’m feeling really bad because I don’t even want to give myself that small comfort of smoking.

Shannon took a photograph (Figure 30) of herself as she was starting to feel better after a period of depression, saying, ‘the process of being outside and the availability of letting myself have a cigarette is already starting to make me feel better’. For Shannon, smoking acted as external, material evidence of her improved internal mental well-being, physically signifying her ability to manage her depression. Shannon’s positioning of her smoking as an effective way of coping was reinforced in the positive representation of smoking in her photo, where she showed herself to be openly smoking in public.
Discussion

The findings from our study have highlighted how young women took up positions as knowledgeable about the risks of smoking on health. This meant that they must then account for the risks involved with their smoking by drawing on repertoires that discounted this knowledge, positioning themselves as personally immune, minimising this risk in relation to other ‘evils’ and emphasising the benefits of smoking. These findings highlight the complexity in young women’s subjective negotiation of smoking, as they take up multiple and contradictory positions in relation to its associated health risks. These findings are relevant to understanding how young women both exercise agency but are constrained in their ability to engage
in risk-taking behaviour as a way of reinforcing and subverting discourses of respectable femininity.

The repertoire ‘the risks of smoking are self-evident’ worked to align young women with dominant health discourse which positions smoking as risky (Lupton, 1995). Using this repertoire, the women in the study positioned themselves as knowledgeable about the risks of their smoking and responsible for their health. However, young women also used this repertoire to disengage from anti-smoking messages, positioning such messages as ineffective, and themselves as defensive, defiant and indifferent. Similar responses to anti-smoking messages have been noted in a study of university students who smoke (Wolburg, 2006). However, as the current study and others have shown (Goszczyńska, Knol-Michałowska, & Petrykowska, 2016), individuals not only acknowledge the risks of smoking but also believe that these risks are not applicable to themselves. As noted in previous research (Wigginton & Lafrance, 2014), acknowledging the risks of smoking means that women must then account for the reasons why they continue to smoke and construct alternative risk-adverse subjectivities, to avoid being positioned as irrational, and to protect themselves from blame from themselves and others.

One way in which participants minimised the perceived risks of smoking was through the use of a ‘it’s not going to happen to me’ repertoire. The sense of invulnerability, or unrealistic optimism identified in participants’ accounts, has also been found in a previous study of young smokers (Denscombe, 2001). These findings show that a young adult’s sense of immunity to risk is affirmed by the lack of immediate harmful consequences from smoking and their limited experiences of
ill health. Participants also spoke about the lack of physical evidence for the effects of smoking on their health, a finding which may be explained by a tendency among young women to place greater importance on the externally visible effects of smoking on health, such as the impact of smoking on the skin (Gilbert, 2005). The notion of the ‘at-risk’ smoker being an older man, who has smoked for many years, has been reinforced in tobacco education literature (Shevalier, 2000). Thompson, Pearce, et al. (2009) warn that identity struggles can arise as people who smoke are unable to position themselves within binary understandings of ‘healthy’ and ‘unhealthy’. The way in which participants situated their smoking within a context of an otherwise ‘healthy’ lifestyle has also been noted in several studies (Gilbert, 2005; Haines-Saah et al., 2013). In doing this, young women challenge ‘either/or’ binaries of smoking as healthy/unhealthy.

Another technique used to minimise the perceived risks of smoking was the positioning of smoking as ‘a lesser of two evils’. Young smokers today are situated within a world characterised by uncertainty and doubt (Denscombe, 2001), leading some young women to position their smoking as just one of many evils that they are exposed to within their increasingly risky lives (Denscombe, 2001). Researchers have explored this strategy by which smokers can downplay the risks of their smoking by relating it to other sources of risk (Heikkinen, Patja, & Jallinoja, 2010; Thompson, Barnett, & Pearce, 2009) and we found that the young women in our study related the risks of their smoking to the risks of other social and health issues and their alcohol consumption. Fatalism and determinism were central to young women’s accounts of smoking-related risk. Similar discursive strategies have been
reported by Wigginton and Lafrance (2014), in their analysis of luck language in women’s accounts of smoking during pregnancy. These strategies may allow women to make sense of the risks of their smoking and the limited control they have over their health, as well as helping them to save face and avoid blame for their smoking (Keeley, Wright, & Condit, 2009). Further education is needed to challenge the perception that smoking cessation during pregnancy is riskier for the infant than continued smoking, as studies have shown that maternal smoking cessation has been shown to reduce adverse infant outcomes (Batech et al., 2013).

Finally, participants drew on the ‘smoking to cope with stress and emotion’ repertoire in order to convey the benefits of their smoking. In line with the findings of other researchers (Banwell & Young, 1993; Greaves, 1996; Haines, 2008), the young women in our study gave accounts of using smoking to manage a range of emotions, such as anger and boredom. Women have greater social pressure to regulate emotions, and smoking offers a way to limit, delay or communicate ‘unfeminine’ feelings such as aggression, directness and assertiveness (Greaves, 1996). Young single mothers in the study positioned their smoking as a way of managing stress, which suggests that the stresses of sole caring continue to impact on women’s health (Graham, 1987). However, nicotine is a stimulant and researchers have concluded that smoking is more likely to act as a stressor than a stress relief, as Jarvis and Wardle (2006, p. 233) note ‘there is no good evidence in humans that [smoking] ameliorates [stress or adverse moods] other than through withdrawal relief’. This conclusion is strengthened by studies which show that people report significant decreases in stress following smoking cessation (Taylor et al., 2014). At
the same time, stressful life events have been shown to have a greater impact on women’s ability to quit, compared to men (McKee, Maciejewski, Falba, & Mazure, 2003), further highlighting the need to reduce young women’s exposure to environmental stressors, and to increase the mental health and stress management support available to those who smoke.

The women in our study also described how smoking provided them with a sense of control over their bodies, a finding which has been noted in a number of previous studies of women’s smoking (Graham, 1993; Greaves, 1996; Haines, 2008). This sense of control is particularly appealing to young adults, who tend to have limited authority in their own lives (Denscombe, 2001). By taking up this position, these women challenge public health discourse which constructs smokers as lacking self-control (Lupton, 1995). Yet, young women report that in addition to smoking making them feel in control, they also feel controlled by their smoking (Health Canada, 1996), highlighting the contradictory functions smoking can play in young women’s lives. In contrast to previous research (Weinstein, 2001), our analysis identified little difference in how smokers and ex-smokers drew on these repertoires. This could in part be explained by the ubiquity of these repertoires, not only in relation to smoking-related risks but also in health discourse more broadly (Heikkinen et al., 2010).

Conclusion

In this article, we have shown that young women have ways of managing their knowledge of smoking risks and are able to reposition these risks as acceptable. By positioning their smoking as a way to cope, young women resist being positioned
as at-risk. This is what C. Brown (2011) terms a ‘both/and’ position, where the speaker both reinforces and rejects dominant discourse. In taking up a both/and position, participants are able to position the risks of smoking as both acceptable and unacceptable and themselves as both at-risk and safe. In doing this, these young women challenge dominant public health discourses which position smoking as an activity, which carries few benefits and which has significant financial, social and health-related costs (Lupton, 1995).

Young women’s constructions of smoking-related risk relate to wider risk discourses surrounding young women and femininity. Young men are socially perceived to actively engage in risk behaviours as ‘risk-takers’, while young women are more often represented as passive recipients of risk and to be ‘at-risk’ (Mitchell, Crawshaw, Bunton, & Green, 2001). Young women can challenge these representations by participating in risky behaviours such as smoking and other leisure activities (Green & Singleton, 2006). By engaging in risky behaviours, young women are also able to disrupt dominant discourses of feminine respectability and notions of the ‘caring self’ (Green & Singleton, 2006; Skeggs, 1997). However, young women are also constrained by discourses of respectable femininity, evidenced by their efforts to reframe their risky behaviour as acceptable, responsible and caring (Mitchell et al., 2001). Our findings contribute to a broader understanding of young women’s subjectivities as complex and contradictory, capable of individual agency but also constrained by structural conditions.

Many anti-smoking campaigns operate on the premise that knowledge about the risks of smoking will lead to behaviour change (Thompson, Barnett, et al., 2009).
The findings from this study highlight the need for broader, more inclusive understandings of health and well-being. Anti-smoking messaging needs to move away from discourse which positions people and practices within binary understandings of risky/safe and healthy/unhealthy and understand that young women see themselves as engaging in a range of practices which both contribute to and help manage risk (Haines-Saah et al., 2013). As with other commentators (Duff, 2003; Heikkinen et al., 2010), we would suggest that public health messages move away from ‘expert’ risk discourses by acknowledging young women’s lay accounts of risk and the presence of everyday risks. The Triggers campaign (Quit Tasmania, 2015) released in Tasmania, Australia, in 2015 is an example of a campaign which helps to situate smoking within a range of different everyday social contexts. The advertisement depicts smoking in relation to alcohol consumption and stress. Campaigns such as this, which situate smoking in the context of everyday life, may help young women to identify and challenge their own understandings of smoking and risk, something previous campaigns have, at times, failed to do (Weinstein, 2001). Tobacco control interventions need to go beyond just presenting information about the risks of smoking. Young women need greater support in relation to mothering, domestic labour, wage disparities and their mental health.
Chapter Six: Young Australian Women’s Accounts of Smoking and Quitting: A Qualitative Study Using Visual Methods

This chapter contains the journal article Young Australian women’s accounts of smoking and quitting: A qualitative study using visual methods. This article uses a poststructuralist theoretical approach to explore how young women construct and experience smoking and quitting. This article is also included in Appendix O.

Abstract

**Background:** Although the overall rate of smoking in Australia continues to decline, the rate of decline has begun to slow. Rates of smoking among young women in Australia have been a particular concern, which has led to the development of targeted public health campaigns. Poststructuralist theory has successfully been used in research to explore the way in which young women experience smoking. However, there is an absence of poststructuralist analysis of young women’s experiences of quitting. This study aims to address this gap.

**Methods:** We carried out 27 interviews with young Australian women smokers and ex-smokers. Eighteen of those women then participated in a photography activity and follow-up interviews. A Foucauldian discourse analysis of the data was conducted.

**Results:** Through our analysis, we identified three discourses: ‘The irresponsibility of smoking: Quitting as responsible’, ‘The difficulties of quitting: Smoking as addictive’, and ‘Making a decision to quit: Smoking as a choice’. In relation to these discourses, participants took up contradictory positions of responsibility and resistance, addiction and agency. Taking up these positions had implications for young women’s subjectivity, and the way they engaged with tobacco controls and cessation support.

**Conclusions:** The analysis highlights the complex and contradictory nature of young women’s experiences with smoking and quitting. The study’s findings are considered in relation to the improvement of tobacco control policies and cessation support programmes targeted at young women.
**Background**

Growing public awareness of the negative health implications of smoking, and the erosion of “smoking-positive cultures” have contributed to declining rates of smoking in Australia for over fifty years (Chapman & Freeman, 2008, p. 25). However, recently the rate of smoking decline has slowed (AIHW, 2017c). Considering that smoking remains one of the leading causes of preventable death and disease (AIHW, 2011b), a decrease in the rate of smoking decline is worrisome. Rates of smoking among young women are an area of particular concern. In Australia, young women are taking up smoking at a younger age than men (AIHW, 2017b). Smoking among young women is associated with negative health outcomes, including increased mortality rates, death from cancer, circulatory, respiratory and other diseases (Iversen et al., 2013). Compared to men, women are at an increased risk for certain smoking-related diseases, due to factors such as oral contraceptive use (Samet & Yoon, 2010). However, if women quit smoking before the age of 30 they can avoid more than 97% of the excess mortality risk associated with continued smoking, which indicates that young women should be a target group for intervention (Pirie et al., 2013).

Research on smoking cessation has primarily focused on adult smokers, which has resulted in a lack of awareness of young peoples’ experiences of quitting (Backinger, Fagan, Matthews, & Grana, 2003, p. iv49). Young women are aware that smoking is risky, and are highly motivated to quit, but often report a sense of hopelessness in relation to the difficulty of quitting (Copeland, 2003). Some young women are concerned about the social, emotional, and physiological ‘costs’ of
quitting smoking (Seguire & Chalmers, 2000a). These costs include the loss of the perceived benefits of smoking, such as social advantages and a method of weight control (Lennon et al., 2005). It has also been reported that that young women are reluctant to engage with smoking cessation programmes, preferring to quit on their own, or with the support of a friend (Weiss et al., 2010). These studies highlight the need for further research which focuses on constructions and experiences of smoking cessation among young women, in order to better understand barriers to quitting, and to allocate tobacco control resources more appropriately. This is the aim of this paper.

Smokers’ experiences of quitting are shaped by prevalent social and cultural discourses surrounding health and wellbeing. In wealthy neoliberal western countries, a prevailing ‘healthism’ discourse maintains that the pursuit of good health is an individual’s responsibility (Lupton, 1995). Rational, responsible smokers are expected to maximise their health and avoid risk by complying with tobacco control policies and making attempts to quit smoking (Fernández, 2016). The majority of smokers appear to assume this position of responsible, health-seeking citizen, by saying they are interested in quitting (Babb et al., 2017) and making attempts to quit or cut down (AIHW, 2014b). However, the process of quitting smoking can be difficult. Few quit attempts are successful (R. West & Fidler, 2011), and most smokers make multiple attempts to quit before achieving long-term cessation (Cooper, Borland, & Yong, 2011). At the same time, many smokers also challenge these health imperatives, expressing resentment and resistance towards quitting smoking (Frohlich et al., 2012). By maintaining a smoking identity, smokers risk
being positioned as irrational, and experiencing the negative social stigma applied to those who smoke cigarettes (Stuber et al., 2008).

In the 1980s researchers began to identify nicotine and tobacco products as dependence-producing. Neuroscientists have developed a brain disease model of addiction, where nicotine is shown to activate brain pleasure centres – establishing a neurological basis to addiction (Dackis & O'Brien, 2005). Smoking dependence also relates to the context in which smoking takes place, smoking rituals, and sensory stimuli such as touch, taste and smell (Zwar et al., 2014). Characteristics of nicotine dependence include smoking soon after waking, smoking more than ten cigarettes a day, and a history of withdrawal systems with previous quit attempts (Zwar et al., 2014), while withdrawal from nicotine is associated with negative psychological and physiological effects, such as irritability, frustration, anger, anxiety, difficulty concentrating, increased appetite, restlessness, depressed mood, and insomnia (American Psychiatric Association, 2013). These findings led to the inclusion of tobacco use disorder and tobacco withdrawal in the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association (APA), and the International Classification of Diseases (ICD) of the World Health Organisation (WHO) (Henningfield & Benowitz, 2004). These physiological and psychological conceptualisations of smoking and addiction have contributed to the medicalisation and commodification of smoking cessation (Keane, 2002), and the development of a range of psychological interventions, such as counselling, and group interventions (McEwen et al., 2006). In Australia, health professionals advise pharmacotherapy for smoking cessation, such as nicotine replacement therapy (NRT), varenicline, and
bupropion, as well as non-pharmacological supports, including group or individual counselling, cognitive and behavioural coping strategies, written information, and telephone counselling (Zwar et al., 2014).

Most smokers stop smoking without formal help, either by cutting down, or quitting abruptly, also known as quitting ‘cold turkey’ (Chapman, 2007b). However, smokers who are more nicotine-dependent are more likely to use pharmacotherapy and seek behavioural support to assist in quitting (Cooper et al., 2011). Health professionals in Australia are instructed use the 5As approach: ask patients about tobacco use, assess their willingness to quit, advise quitting, offer assistance, and arrange to follow-up with patients (Zwar et al., 2014). This approach draws on cognitive theories, such as the stages of change (SOC) model, which is based on the assumption that smokers are rational and coherent, who make gradual steps towards quitting (DiClemente et al., 1991). However, these theories assume that the attitudes and beliefs shared by smokers are expressions of stable underlying cognitive structures, an assumption challenged by discourse analysts, who argue that understandings of smoking behaviour are complex and contradictory, shaped by a range of environmental and social factors (Gillies & Willig, 1997; J. L. Johnson, Bottorff, et al., 2003).

Counter to cognitive theories of smoking cessation, discourse analysts have sought to examine the way smokers position themselves in relation to cultural discourses of smoking and addiction. For example, adopting a subject position as an addict can provide a causal explanation for the continuation of a seemingly irrational behaviour such as smoking (Lupton, 1995). This subject position is enabled by
tobacco control campaigns which construct smokers as powerless against their addictions, and position young adult smokers in particular, as addicts who lack self-control, discipline and willpower (Frohlich et al., 2012). However, many young adults resist this construction, instead positioning themselves as ‘in control’ of their smoking, constructing their smoking as a choice rather than an addiction (Scheffels & Schou, 2007). Young adults are often reluctant to describe themselves as having a ‘full-fledged’ addiction to smoking, and are more likely to identify with ‘weaker’ forms of dependence, such as being socially or emotionally dependent on cigarettes (J. L. Johnson, Bottorff, et al., 2003). Contradictory discourses of smoking and quitting are also evident in the accounts of adult smokers, who draw on notions of indulgence and control, addiction and abstinence, to account for their continued smoking and inability to quit (Morphett, Carter, Hall, & Gartner, 2016; Nachtigal & Kidron, 2015). Poststructuralist theory can provide an explanatory theoretical framework for these contradictions, conceptualising smoking identities and practices as fluid and non-linear, associated with multiple, complex subject positions (Thompson, Pearce, et al., 2009). Poststructuralist theory allows us to recognise that young women can move between ‘smoker’ and ‘non-smoker’ identities, and that the transition from ‘smoker’ to ‘ex-smoker’ is a process of becoming rather than being (Thompson, Pearce, et al., 2009).

Whilst poststructuralist theory has been used to inform explorations of contradictory constructions in young women’s accounts of their smoking (Gilbert, 2005; Triandafilidis, Ussher, Perz, & Huppatz, 2017b), these studies have not considered how young women’s constructions of smoking relate to their experiences
of quitting. The present paper is necessary to improving our understandings in this area. Empirical findings from a qualitative study of young women smokers and ex-smokers are analysed using a poststructuralist approach, in order to address the following research questions: How do young women smokers and ex-smokers construct quitting and continued smoking? How do young women smokers and ex-smokers position themselves in relation to discourses of quitting and continued smoking?

Methods

This study draws on data from a broader qualitative study which aimed to explore young women’s constructions and experiences of cigarette smoking. The study was made up of three stages. In the first stage, 27 young women smokers and ex-smokers participated in exploratory semi-structured interviews. Eighteen of those women opted to participate in the second and third stages: a photography activity and follow-up interviews. The triangulation of different qualitative methods allowed us to understand young women’s experiences of quitting in a way that would not be possible through interview accounts or photographs alone. The study was carried out in metropolitan New South Wales. However, the majority of interviews (n=35) were conducted over the phone, allowing us to recruit participants living interstate and regionally. The data were analysed using Foucauldian discourse analysis and positioning theory.

Procedure.

Participants were recruited through the distribution of flyers at train stations
and university campuses, which asked, “Are you a young woman who currently smokes cigarettes, or an ex-smoker?” The study was also advertised on social media, with the message: “3 stage study of women’s experiences of smoking and quitting”.

These two different messages were used to recruit women who might identify as a ‘smoker’ or an ‘ex-smoker’, as well as women who might not identify as ‘smokers’ or ‘ex-smokers’, but see themselves as ‘smoking’ or ‘quitting’. During the first stage of the study participants engaged in interviews which explored their experiences with smoking, quitting, and representations of smoking in the media. Eighteen of those women then chose to go on to stage two of the study, a photography activity, where they were invited to take photographs of their experiences with smoking. The process of taking photographs helps participants to reflexively engage with their smoking practices in the context of their everyday lives (G. Rose, 2016). The photography activity drew on elements of a photovoice study, a method which actively engages participants in the research process, allowing them to share their ‘voice’ (Wang, 1999). We also drew on elements of a photo-elicitation study, where the discussion of photographs in the context of an interview allows for the elicitation of rich, in-depth data (Harper, 2002). This combination of photography methods has proven successful in previous qualitative studies of women’s health (see C. M. Johnson, Sharkey, & Dean, 2011). Participants took on average three weeks to complete the activity and submitted 157 photographs. The 18 women from stage two of the study then went on to the third stage, a follow-up interview. Following their first interview, participants were sent a copy of their interview transcript. During the follow-up interview participants were given an opportunity to reflect on their first interview,
and the interviewer was able to ask follow-up questions. During the follow-up interviews, participants also discussed their photographs, and their experiences of the photography activity. The stage one and stage three interviews ranged between 25 and 90 minutes, and were audio recorded.

**Analysis.**

Poststructuralism refers to a school of thought that emerged in the 1960s and 1970s which challenged traditional understandings of language, meaning and subjectivity (Weedon, 1997). A poststructuralist approach considers subjectivity as multiple, and as constituted and reconstituted through language and discourse (Gavey, 1989). In doing poststructuralist analysis there is an opportunity to be transformative, not only through the deconstruction of current ways of knowing, but also in the development of strategies for change (Davies et al., 2006). Foucauldian Discourse analysis was used to examine the discourses of smoking and quitting available to young women (Willig, 2000), and positioning theory allowed us to consider the subject positions made available through these discourses (Davies & Harré, 1990). Positioning theory also provided a way of conceptualising young women as capable of taking up, resisting, and repositioning, multiple, often contradictory subject positions, such as ‘smoker’ and ‘ex-smoker’, ‘addict’ and ‘agent’.

We followed a style of Foucauldian discourse analysis outlined by Ussher and Perz (2014). The first step of the analysis involved reading transcripts and viewing the photographs. This process began when the first author integrity checked the professional transcriptions made from the interview audio recordings. The data
were read and viewed again and a coding frame was developed, allowing us to code
the interviews and photographs together using NVivo, a qualitative data analysis
software program. This software allowed us to do an integrated analysis of the data,
and identify the similarities and differences across the interviews and photographs
(Moran-Ellis et al., 2006). The coded data were then summarised, and these
summaries were read by all four authors, allowing us to identify dominant smoking
and quitting discourses. Having identified these discursive constructions, we were
then able to examine the function of these constructions, the subject positions
available to participants, and implications of these positions for participants’
subjectivity and smoking practices.

The triangulation of research methods often requires the privileging or
weighting of a particular data set which is better suited to the research questions
(Farmer et al., 2006). Given the close relationship between discourse and verbal
language, and the study’s aim to explore young women’s discursive constructions of
quitting and continued smoking – the interview data were given priority during
analysis. The photographs were analysed alongside the interview transcripts, and
helped to provide further insight into the materiality of participants’ experiences
(Radley, 2011). As with their interview accounts, participants’ photographs were not
considered to be a direct representation of reality, but rather, another account of their
experiences of smoking and quitting produced within the context of the study
(Pilcher et al., 2015).
Results

The sample was made up of 27 young women aged between 18 and 31. Participants reported that they started smoking regularly between the ages of 13 and 24 years, and the average age of regular smoking was 16 years. Participants had been smoking for between two and 16 years, for an average length of seven years. Eighteen of the participants were current smokers. Of those participants who smoked, most smoked less than 15 cigarettes a day (56%), with a smaller number smoking 15 or more cigarettes a day (22%), or not smoking on a daily basis (22%). The remaining nine participants had quit smoking at the time of recruitment. Participants’ length of cessation ranged from two weeks to two years. By including both ‘smokers’ and ‘ex-smokers’ in the sample we were able to bring together their experiences, and deconstruct binary understandings of smoking and non-smoking.

Most of the sample said they were Anglo Australian (63%), and the remaining women identified as being from Aboriginal Australian, Asian, American, European, Middle Eastern, and Pacific Island cultural backgrounds. When asked about their social class background, most participants described themselves as working-class (44%) and middle-class (48%), and a smaller number identified as upper-middle class (7%). Participants mostly characterised themselves as heterosexual (67%), and bi-sexual (26%), with a smaller number identifying as lesbian (7%). At the time of the study, one participant was pregnant, and seven others had children.

During our analysis, we identified three dominant discourses in participants’ accounts of quitting: ‘The irresponsibility of smoking: Quitting as responsible’, ‘The difficulties of quitting: Smoking as addictive’, and ‘Making a decision to quit:
Smoking as a choice’. Participants’ names have been replaced with pseudonyms, and their smoking status is provided in parenthesis to contextualise quotes.

**The irresponsibility of smoking: Quitting as responsible.**

Most participants discursively constructed smoking as irresponsible, and quitting as a way of being responsible. In positioning smoking as irresponsible, participants spoke about the impact of smoking on their health, the financial cost of their smoking, and the impact of smoking on partners, parents, friends, and children. For example, Caitlyn (smoker) said she wanted to quit smoking because, “It makes me sick, and it’s expensive.” Gemma (ex-smoker) said she quit because she was “Wanting to save money and wanting to be healthy.” Jing (ex-smoker) explained why she wanted to remain a non-smoker: “My boyfriend doesn’t want me to smoke. If I go back to smoking he will be very angry and won’t marry me.” Briana (smoker) spoke about her chances of developing a smoking-related illness, saying, “I don’t want to have to put my family through that because of a stupid decision I made.” In describing her continued smoking as a “stupid decision”, Briana implicitly positions her smoking as a choice, and herself as responsible for the negative health outcomes and impact on her family that result from her continued smoking.

Participants’ status as ‘smokers’ or ‘ex-smokers’ had implications for their positioning of self and subjectivity. For participants who had not quit, the irresponsibility associated with their continued smoking was described as having negative implications for their subjectivity. For example, Sarah (smoker) spoke about her inability to quit smoking during pregnancy, saying, “I hated myself, and I still hate myself for it today.” Conversely, participants who had quit smoking were able
to take up a position of responsibility. For example, Ashlee (ex-smoker), a single mother with three children, said she took a photograph of money (Figure 31) to represent the savings she had made since quitting smoking. Ashlee positions herself as financial responsible after quitting smoking, saying, “I’m not scraping through to get bread or milk anymore, I’ve actually got money there. And I actually have a savings account open as well now.” Lisa (smoker), reported that a past quit attempt made her feel “self-righteous”, saying, “I was somehow a better person because I was not addicted to it… I think I was just proud of myself… like ‘I’m a better person now because I’m not smoking cigarettes.’” Lisa’s account highlights how adopting an ‘ex-smoker’ identity allows young women to adopt a more positive sense of self, and avoid the negative stigma of an ‘addicted smoker’ identity.

*Figure 31.* “I’ve actually got money now” (Ashlee, ex-smoker).
In negotiating discourses of responsibility, a number of participants took up a position of resistance in relation to quitting smoking. For example, Rachel (smoker) explained, “You get told what to do almost all the time and it's like that one small way of going against what everyone is telling you to do.” This position of resistance had implications for the way participants, such as Rachel, responded to tobacco control measures. She said,

Right before the price goes up or right before a new ad campaigns starts, I'll see that and I'll be like, “You know what? I'm going to keep smoking just to be stubborn.”

Although Rachel takes up a position of resistance, she also adheres to discourses of responsibility, by then saying, “I definitely intend to quit before I decide to start a family.” In a similar vein, participants spoke about intending to quit when they were older. For example, Jessica (smoker) said, “I haven’t actually really tried [to quit] because I don’t want to…I’ll try and quit when I’m 30 and see how I go.” By purporting that they “intend to quit” in the future, young women, such as Rachel and Jessica, can position their current smoking as temporary, and distance themselves from a fixed identity as a ‘smoker’.

Other participants distanced themselves from the stigma of a smoking identity, and demonstrated responsibility, by saying they would “cut back” or only smoke “a few cigarettes a day”. For example, Sarah (smoker) said, “I do want to quit, but it doesn’t bother me if I continue to have a few cigarettes a day.” Shayma (smoker), said, “I basically know that I’m just someone that probably won’t stop smoking. I’ll probably cut back.” Occasional smoking allows young women to
demonstrate a sense of agency and control over their smoking. By cutting down their smoking, but not quitting, young women can simultaneously take up positions as responsible and resistant.

**The difficulties of quitting: Smoking as addictive.**

Accounting for the difficulty in quitting smoking, participants constructed their smoking as an addiction. For example, Hannah (smoker) said, “Quitting cigarette smoking is like trying to quit heroin. It’s similar because it’s such a strong drug in a way.” By situating smoking within a wider drug discourse, Hannah can take up a position as an addict, and can account for her continued smoking. Another participant, Danielle (smoker), said, “It’s an addiction, it’s not really a choice. I would love to stop if it was that easy, but it hasn’t seemed to be so far.” Danielle positions herself as an addict who lacks “choice”, which again, helps to account for an inability to quit smoking. This position of addiction was also assumed by Stephanie (ex-smoker), when she was trying to quit smoking:

I was always one of those people that would say, “I’m definitely not addicted, I can quit whenever I want, I just don’t want to.” And, when you do try and quit you realise you’re kind of really addicted to them.

Stephanie’s account suggests that acknowledging a lack of control over smoking, and taking up a position as an addict, may be necessary in taking up an ‘ex-smoker’ identity. However, this is not necessarily a comfortable or easy position for a smoker to find herself in. Stephanie went on to talk about the “embarrassment” she felt at being addicted to smoking, highlighting how the stigma associated with addiction can negatively impact on subjectivity.
Several participants who had quit smoking continued to position themselves in relation to discourses of addiction. For example, Gemma (ex-smoker) said,

I do miss it. If someone offered me a cigarette without any repercussions or me guaranteed not to get addicted, I’d probably take it, but, I know that if I did have another cigarette I’d start smoking again.

Stephanie (ex-smoker) offered a more fatalistic account of her addiction, saying, “If I start smoking again, I will probably continue smoking until the end. So I’m determined not to start smoking again.” These accounts highlight how young women construct quitting smoking as an on-going process, and addiction as having no fixed end point. Constructing smoking as an addiction might prevent young women who have quit smoking from resuming smoking practices. Conversely, some participants resisted being positioned as an addict. For example, Rachel (smoker) said, “I don’t really have an addictive personality and I wouldn’t consider myself addicted to cigarettes.” In this account, Rachel constructs addiction as being a quality of a personhood that is different to her own, which allows her to avoid the stigma associated with being positioned as an ‘addict’.

Addiction discourse was used in participants’ accounts of tobacco control measures, with varying effects. For example, Shayma (smoker) said she took a photograph (Figure 32) of a sign advising of an increase in government taxation on tobacco because it made her “pissed” and “angry”. She explained,

Back then it was really cheap and people would easily get addicted because it’s very cheap and you can afford it. But now, people are finding it really hard to afford them, so it’s kind of like “I’m going to buy it anyway, but I
can’t afford it. What can I do? I’m addicted to it, I need it.” I feel like it’s kind of cheating in a way…Not that I’m anyone suffering from that, but there are a lot of people that are.

Figure 32. “When I saw that sign it just made me angry” (Shayma, smoker).

Drawing on addiction discourse, Shayma is able to position taxation on tobacco as unethical and as “cheating”. Sarah (smoker) spoke about the graphic health warnings on cigarette plain packaging, saying,
It’s not going to work; it’s not going to stop people from smoking. Seeing a picture doesn’t stop your whole body, and your whole brain being tricked into, “I’m not addicted anymore.”

Sarah draws on a neurological explanation of addiction which locates the source of addiction within the body, allowing her to position external stimuli, like the graphic health warnings on cigarette packaging, as ineffective in treating her smoking addiction. Conversely, Emily (ex-smoker), said,

I didn’t like having cigarettes that had big pictures of cancer and all that sort of stuff on them. I thought it was gross and you know, “what if I looked like this”, and yeah, my brain decided it just didn’t want to smoke anymore.

Emily also draws on a neurological explanation for her smoking, but, in opposition to Sarah, positions graphic health warnings as effective in helping her “brain” to not want to smoke. Sarah and Emily’s contrasting accounts highlight how addiction discourse can have differing effects on the way young women construct the impact of tobacco control measures on their ability to quit.

**Addiction as a social and psychological ‘habit’**

In their accounts of quitting, participants challenged the idea that their addiction was only physiological by emphasising the habitual aspects of their smoking. As Sarah (smoker) explained, “I’m addicted to the habit rather than the craving I think.” In their accounts of smoking being a habit, participants positioned their smoking as “mental”, “psychological”, and subconscious. For example, Courtney (ex-smoker) took a photograph of a cup of tea (Figure 33), which she described as a “trigger”. She said, “If someone says, ‘Oh, do you want a coffee or a
tea,’ I go, ‘Yeah.’ And, then in my head I’m like, ‘[I] should light a cigarette.’ And, then I’m like, ‘No I don’t smoke.’” In her account, Courtney positions her ability to disrupt her smoking habits as a psychological process located in her “head”. Like Courtney, many other participants spoke about how their smoking habits were paired with other habits and addictions, such as alcohol and coffee. For example, Shannon (smoker) said “it’s really hard to drink [alcohol] and not smoke”, and Tara (smoker) said “cigarettes are really good with drinks, like coffee. I find that every night before I go to sleep, I look forward to a coffee and a cigarette in the morning.”

Figure 33. “Having a cup of tea makes me want a smoke” (Courtney, ex-smoker).
Participants gave accounts of how the habitual nature of their addictions rendered nicotine replacement products ineffective. For example, Shannon (smoker) said, “I’m not a fan of the nicotine patches and things like that…I think a lot of the hard work in it, particularly when you’re younger, is mental and social.” Brittany (smoker), spoke about using a nicotine inhaler, saying,

I wanted a cigarette, even though I had the nicotine, I still got that kind of nice feeling of relaxation but it was the actual cigarette, like lighting it and stuff. I like the act of smoking.

In place of nicotine replacement products, participants emphasised the need for mental strength and willpower when quitting, saying “It’s just all a mental thing. It comes down to how strong your willpower is” (Tara, smoker). Willpower was said to involve “using the mind” to “move past”, “distract” or “forget about” cravings. A lack of willpower was seen by participants as being a barrier to quitting smoking. For example, Hannah (smoker) said, “I feel like I don’t have enough willpower to quit.” Another woman, Caitlyn (smoker), said, “I just need to get the willpower and give up.” In contrast to Hannah’s account, Caitlyn constructs willpower as a non-fixed quality, and something you can “get”. This construction allows young women smokers, such as Caitlyn to take up a position of agency in relation quitting smoking.

Participants spoke about the gendered nature of smoking addiction, contrasting their own habitual addictions to men’s physiological addictions. For example, Megan (smoker) spoke about how her father was “physically addicted” to smoking, while her and her mother were “situationally addicted”, and smoked in response to “environmental factors”. Another participant, Sarah (smoker),
distinguished between her and her male partner’s addictions, saying, “His body is addicted to the ingredients of the smokes, like an actual cigarette, whereas I think me, personally, I’m more addicted to the five minutes of peace and relaxation.” This gendered construction of addiction had implications for how participants understood their experiences of quitting. For example, Julie (ex-smoker), spoke about her husband being much more physically addicted to cigarettes, saying, “He has smoked probably 100 thousand more smokes than what I have. I guess it is so much easier for me to let it go.” The positioning of habitual addictions as “easier” to overcome may result in women, such as Julie, experiencing greater pressure to quit, or feeling less entitled to support.

**Making a decision to quit: Smoking as a choice.**

In contrast to their accounts of addiction, participants constructed smoking as a choice, and emphasised the importance of making a decision to quit. For example, Megan (smoker) spoke about how being “badly addicted” to smoking made it hard to quit, but went on to say “ultimately it’s someone’s choice [whether they smoke]”.

Another participant, Courtney (ex-smoker), said, “When you’re an adult you have the choice and the freedom to [smoke]…unless they want to [quit], they won’t do it.” In her account, Courtney draws on the liberal discourse of freedom to reinforce the construction of smoking as a choice, and the importance of deciding to quit. Sarah (smoker) also emphasised the importance of making a decision to quit, saying, “I think people have to want to give it up and if they don’t want to give it up…it’s not really going to happen.”
The construction of smoking as a choice, and quitting as a decision had implications for subjectivity, allowing participants to develop a sense of agency and optimism around quitting. For example, Chelsea (smoker) takes up a position of agency in relation to her smoking, saying, “If I really don’t want to [smoke], I’m sure I could stop”. This optimism is also evident in the following comment from Rachel (smoker):

As cliché as it sounds I'm sure I could quit if I really wanted to. I want to do it on my terms. I don't want to do it as in I'm giving in to everyone constantly telling me not to smoke.

In stating that quitting needs to be on her “terms”, Rachel is positioning herself as needing to be agentic, and in control of the quitting process. Another participant, Shayma (smoker), spoke about quitting, saying, “The idea that I’ve done it once makes me feel good because I know I can do it again.” Shayma’s account illustrates how a position of agency and a sense of optimism can reinforce a positive sense of self, where Shayma can “feel good” about her past quit attempts, and motivated to make future quit attempts. Another participant, Lisa (smoker), said,

I can’t continue, and I can’t afford [cigarettes]. They’re going up at a phenomenal rate. Like for a month, I do not have enough money…to justify smoking. It’s ludicrous. So I will quit and I know that I can, it’s just a matter of actually having that little spurt to do it.

Lisa takes up a position of agency, saying she “can” and “will” quit, but indicates she requires something further to prompt her. Lisa’s account highlights that despite constructing quitting as a choice, and herself as agentic in relation to smoking, she
may need further motivation or support to quit. However, in another account given by Lisa, she describes a loss of optimism and agency:

The first time [I quit] I kind of had the optimism that you know, “tomorrow I won’t be a smoker, tomorrow I won’t want a cigarette.” Whereas now I know that that doesn’t actually really go away for a very, very long time.

This account from Lisa highlights how the sense of optimism that results from the construction of smoking as a choice, may diminish with multiple quit attempts.

By constructing smoking as a choice, participants were able to dismiss tobacco control messages. Again, talking about graphic health warnings on plain cigarette packaging, Sarah (smoker) said, “I don’t think any picture will…you have to want to quit, you have to want to do it.” A similar response was given by Jessica (smoker), who said, “I don’t think the packages will have anything to do with people’s decisions…if they’re going to smoke, they’re going to smoke.” Sarah and Jessica’s accounts show that the construction of smoking as an individual choice can lead young women to be dismissive of population-level tobacco control interventions.

The construction of smoking as a choice had implications for how participants approached quitting. Participants favoured quitting ‘cold turkey’, without any assistance, as it was seen to be demonstrative of “strength”, agency and control over smoking. For example, Courtney (ex-smoker) gave the following account of quitting cold turkey,
It’s a bit empowering to turn around and say “well I didn’t use anything I just stopped”, it makes you feel good about yourself that you can just quit like that.

The positive impact of this sense of agency is also evident in Jessica’s (smoker) account,

When you use a programme or stuff like that, I feel like you haven’t got the strength to maintain it, whereas if you go cold turkey, you’ve done it all and you’ve got the strength, and yeah, it’s going to be a struggle, but you’ve achieved it, so you feel like, “wow, I did that by myself, I can do it. I don’t need help”.

Courtney and Jessica’s accounts suggest that the sense of agency gained from quitting cold turkey has positive implications for subjectivity, leading them to “feel good” about themselves. However, Courtney and Jessica’s assertions, “I didn’t use anything” and “I don’t need help”, reinforce a discourse of individualism, which may negatively impact on young women’s willingness to seek support when quitting smoking. This discourse of individualism was also evident in Megan’s (smoker) photograph of Band-Aids at her feet (Figure 34). She explained this photograph by saying,

I put the Band-Aids on the ground to kind of push the idea that, this is something I need to heal within myself. I’m not going to get better at this unless I stop the smoking and heal the damage I’m doing to my lungs, and like stop further damage that I’m doing…there’s a hope that I can get the
balls to say that I want that more than the cigarette with my wine and my beer.

In talking about her need to “heal within” herself, Megan positions herself as personally defective, and individually responsible for the damage she is doing to her body. Megan’s account of needing to “get the balls” in order to stop smoking relates to gendered discourse which positions men as having greater agency and control over their bodies.

Figure 34. “Cigarette Wars, A New Hope” (Megan, smoker).
Discussion

Public health initiatives, such as graphic health warnings on cigarette packets, often target individual smokers, reinforcing the notion that smokers are individually knowledgeable and responsible for the risks of their smoking (Courtwright, 2009). Participants in our study took up positions of responsibility by reiterating the irresponsibility of smoking, and expressing their desire to quit, a finding consistent with previous research (J. M. Brown, 1996; Moffat & Johnson, 2001). The cost of smoking and the impact of smoking on health were the two main reasons for wanting to quit or change their smoking behaviours, supporting previous research (AIHW, 2014b; Villanti et al., 2016). The responsibility participants took for both their own health, and the effect of their ill health on others, could relate to the unique material and discursive pressure put on women to be primarily responsible for health and to care for others (Lupton, 1995). Similar findings have been identified in other research, which show that women are twice as likely as men to report feeling pressure to quit smoking, saying this pressure mainly comes from children and other family members (Royce, Corbett, Sorensen, & Ockene, 1997). This study also provides further evidence that tobacco control policies, such as taxes and health warnings, are successful in prompting cessation, and discouraging regular smoking among young people who are experimenting with smoking (Chaloupka, Yurekli, & Fong, 2012). However, despite being motivated to quit, some young women require additional support with the process of cessation (Guillaumier et al., 2014), highlighting the need for comprehensive approaches to tobacco control which
incorporate both population-level interventions and additional supports targeted specifically at young women.

Young women in this study also expressed resistance towards quitting, positioning quitting or cutting down smoking as a future event. Young people often perceive few short-term negative health effects as a result of smoking, which can produce a sense of invulnerability, allowing them to delay quitting until they are older (Slovic, 2000). This sense of invulnerability is also affirmed by the construction of smoking as a temporary, youthful phenomenon, which young people can take up and then quit when they chose to (Gough et al., 2009). Tobacco control programmes and policies targeted at women often focus on smoking during pregnancy or women’s roles as mothers, and “represent women as adversaries of their babies-to-be” (Oaks, 2000, p. 64), which may explain the accounts of young women in this study who construct quitting as happening in the future when they plan to ‘start a family’. By positioning quitting as a future event, young women acknowledge the need to quit smoking, which allows them to maintain a position of responsibility. By cutting down their smoking and adopting an identity as a social smoker, young women are able to move between the subject positions of ‘smoker’ and ‘non-smoker’. Adopting an ‘in between’ identity (Thompson, Pearce, et al., 2009, p. 574), young women are able to retain the socially beneficial aspects of their smoking, while avoiding the stigma experienced by habitual smokers. This indifference towards quitting smoking represents a form of passive resistance to the imperative of health (Katainen, 2006).
This study found that addiction discourses and a position as an addict have varying implications for young women smokers and ex-smokers. Participants in this study both adopted and resisted positions as an addict – similar to a previous study of Australian smokers (Wigginton et al., 2016). Addiction discourses alleviate some responsibility for smoking behaviours, allowing young women to defend their smoking and account for the difficulties they face in quitting (Gillies & Willig, 1997). This finding is consistent with previous research which has found that the concept of addiction may allow women who smoke during pregnancy to maintain a ‘good mother’ identity (Wigginton & Lee, 2014). However, a position as an addict attracts stigma, and has negative implications for young women’s subjectivity, as previous research has also identified (Triandafilidis et al., 2016). Neurological explanations of nicotine addiction, which locate the problem of addiction within the individual as opposed to the cigarette, can also lead to feelings of fatalism, hopelessness and disempowerment (Morphett et al., 2016).

Young women in this study differentiated between the physiological, and the psychological or habitual aspects of addiction, a finding consistent with previous research (Amos et al., 2006; Gillies & Willig, 1997). Positioning themselves as habit-addicted, rather than nicotine-addicted, allows smokers to contextualise their smoking as a social practice that forms part of their everyday lives (Wigginton et al., 2016). Young women positioned their addictions as more psychological, and men’s as more physiological, which could relate to a broader gendered discourse that constructs women as more emotional, and men as more logical (Ussher, 1997). This discursive positioning correlates with data that show that women are generally more
sensitive than men to the non-nicotine factors that relate to smoking, such as smoking cues, and positive sensorimotor effects, leading them to have greater success with non-nicotine medications and behavioural interventions, compared to nicotine replacement therapies (Allen et al., 2014). These findings suggest that it is important that smoking cessation programmes targeted at young women present a comprehensive view of addiction, and offer social and psychological interventions, such as counselling, alongside pharmacological treatments for nicotine addiction.

Discourses around smoking being a choice are prevalent among health care workers (J. L. Johnson, Moffat, & Malchy, 2010), the tobacco industry (Griffin, Szmigin, Bengry-Howell, Hackley, & Mistral, 2013), in tobacco control messages targeting young people (Frohlich et al., 2012), and has been reported in previous studies of young smokers (J. L. Johnson, Lovato, et al., 2003). Therefore, it is seen to be important that smokers ‘really want to quit’ (Morphett et al., 2013). The emphasis young women place on decision making in relation to quitting smoking may lead them to think they must put serious thought and planning into quitting. This focus may prevent young women from making spontaneous quit attempts, which may be more successful than planned attempts (R West & Sohal, 2006). Smoking cessation research, policy and practice has concentrated on pharmaceutical and behavioural interventions, despite most smokers reporting that unassisted quitting is their preferred method, and unassisted quitting being the method with which they have the most success (A. L Smith & Chapman, 2014). The use of pharmacological cessation aids sit at odds with ideas of individual choice, willpower and control, which may explain smokers’ preference for going ‘cold turkey’ (Morphett et al., 2015). Tobacco
control programmes and interventions targeted at young women need to acknowledge the value of unplanned, un-medicated cessation, but at the same time, allow space for those women who need further cessation support. As noted in previous research (Wiltshire, Bancroft, Parry, & Amos, 2003), young women draw on notions of willpower to understand the control they have over smoking. Young women who position themselves as lacking willpower may be reluctant to attempt quitting, highlighting the importance of cessation support that gives young women a sense of power over their smoking. One participant constructed agency in relation to quitting as masculine, a finding which relates to research where men report greater agency over cessation (Alexander et al., 2010). These findings provide further evidence for the need to improve young women’s sense of agency and power, specifically in relation to their smoking, as well as more broadly. The use of narrative therapy has been suggested as an intervention which may help smokers to make sense of these contradictory positions of addiction and agency (Wigginton et al., 2016). Through a process of externalising smokers’ unsuccessful quit attempts, and reconstructing the way they identify with smoking (Haring, 2013), narrative therapy may help young women, such as those who participated in this study, to develop a sense of agency and power in relation to quitting smoking. This therapy could also incorporate dual process theories of smoking cessation, which integrate contradictory notions of spontaneity and preparation in their model of successful cessation (Andrea L. Smith, Carter, Dunlop, Freeman, & Chapman, 2017).

Young women’s optimism towards quitting, where they underestimated their chances of becoming addicted to smoking, and overestimated their ability to quit, has
been found in previous research on young smokers (Weinstein, Slovic, & Gibson, 2004; Wolburg, 2009). Optimism also plays an important role in quitting, as self-efficacy and feeling able to quit are key to successful cessation (Thompson, Barnett, et al., 2009). However, as findings from this study, and others have shown (Wolburg, 2009), realising the difficulty in quitting may also be an important part of the quitting process. Cessation supports and health campaigns need to foster optimism among young women smokers, by positioning quitting as an attainable goal (Parry, Fowkes, & Thomson, 2001). However, they also need to be careful not to present the benefits of cessation as being immediate, or ignore the physical and psychological challenges of quitting (J. M. Brown, 1996). The best approach for communicating this contradictory message of optimism and difficulty, should be the subject of further research.

**Strengths and limitations.**

This study is one of the first on young women’s experiences of smoking and quitting to take such an innovative theoretical and methodological approach. The use of qualitative interviews, a photography activity, and follow-up interviews allowed the researcher time to build trust with the women and actively involve them into the production and analysis of data, which helped to increase the credibility of our research (Oakley, 1981). The triangulation of different qualitative methods added variation to the data, which allowed for a more nuanced analysis to take place (Tracy, 2010). The use of discourse analysis and poststructuralist theory allowed us to examine young women’s adoption of dominant discourses of smoking and quitting, as well as their resistance of them (Gavey, 1989). However, the
The triangulation of interview and photography data also presents several challenges. For instance, decisions relating to the privileging of one data set above another is a challenging aspect of the triangulation process (Farmer et al., 2006). The prioritisation of the interview data in this analysis lead to a more limited consideration of the photographs. This limitation could be addressed by future research which places more emphasis on visual analyses of young women’s experiences of smoking and quitting.

The nature of qualitative research means that findings are not generalisable to a wider population, but findings can be transferred to other settings (Merriam & Tisdell, 2015). The transferability of findings to young women of different cultural backgrounds may be limited due to the large proportion of Anglo-Australian women in the sample. Passey, Gale, and Sanson-Fisher’s (2011) research has highlighted the importance of socio-cultural context in understanding experiences of smoking among Aboriginal women in Australia. Future research could look more closely at culture and ethnicity, and how these identities might shape young women’s constructions and experiences of quitting, in order to develop interventions which are specific to culturally-diverse young women. The findings of the study are also limited to the majority heterosexual sample of women. Bi-sexual and lesbian women have expressed interest in tailored smoking cessation interventions (Sanchez, Meacher, & Beil, 2005), and such interventions have begun to be developed in Australia (ACON, 2016). Further qualitative research on young bi-sexual and lesbian women’s experiences of smoking and quitting could support the continued development and evaluation of such interventions. Limitations also surround the applicability of these
findings to young women who are pregnant. Previous research has shown that pregnant and non-pregnant women have distinct experiences of smoking cessation (Buja et al., 2011). Although this study included women’s experiences of smoking and quitting during pregnancy, these women made up less than a third of the original sample, which limits the transferability of our findings to this group.

**Conclusions**

The findings from this study add new insight into the complexity and contradiction of young women’s quitting experiences. These findings align with the contradictory depictions of smokers inherent in tobacco control and tobacco industry agendas. For instance, while smoking is portrayed in tobacco control campaigns as a dangerous, risky and addictive habit, cigarettes have also been advertised as a source of pleasure and enjoyment, and a form of emancipation for women (Tinkler, 2006).

Findings from this study are relevant to the development of individualised interventions, and important to the evaluation of current public health approaches to smoking. The complexity of these issues calls for a comprehensive approach to young women’s smoking, where population-level policies, such as taxation, are delivered alongside local interventions targeted specifically at young women (Backinger et al., 2003, p. iv51). Interventions targeted at young women need to offer flexibility and variety, allowing women to take control and make their own decisions regarding cessation (Greaves, 2015; Minian, Penner, Voci, & Selby, 2016).

Tobacco control messages need to challenge existing public health discourse that suggests smokers are solely responsible for their health, or have complete control over their smoking behaviours. However, it is also important that these
messages do not also remove young women’s sense of agency, as this study has shown that a lack of agency in quitting can result in experiences of disempowerment and/or an inclination to resist quitting. It is imperative that programmes and policies targeting young women seek to intervene earlier than pregnancy and motherhood, as many women in Australia are now delaying having children until their 30s (Australian Bureau of Statistics, 2016). The focus of these programmes and policies could be directed towards improving young women’s mental health, given their reports of increasing levels of psychological distress (Bailey et al., 2016), and the bi-directional relationship between smoking and poor mental health among young women (Leung, Gartner, Hall, Lucke, & Dobson, 2012). As previous researchers have argued (Kirkland, Greaves, & Devichand, 2004), it is our recommendation that in order to impact cessation rates among young women, we must improve the social and economic environment in which they are situated. The similarity in accounts of young women ‘smokers’ and ‘ex-smokers’ in this study, affirms the need for tobacco control responses which conceptualise smoking and non-smoking as non-binary, non-linear practices, and quitting smoking as being more of a process of recovery and relapse (Nachtigal & Kidron, 2015; Thompson, Pearce, et al., 2009).
Chapter Seven: Making Sense of the Conflicting Functions of Young Women’s Smoking: Conclusions and Reflections

In the preface I noted that in conducting this research I have often encountered the assumption that my research is orientated around public health objectives, such as the reduction of tobacco-related harm through smoking cessation. Foucault conceptualises these objectives as “biopower”; mechanisms which seek to manage and discipline the population in order to produce healthy citizens, with health ‘interventions’ a form of regulation (Foucault, 1994; Gastaldo, 1997). In this thesis I have adopted a critical position in relation to public health, with the aim of broadening current understandings of how smoking is discursively constructed and experienced by young women. As other critical tobacco-related researchers have expressed, my intention is that the findings from this thesis will “provide alternative and critical views which could help public health move towards a more humanistic, nuanced view of the person” (Macnaughton et al., 2012, pp. 456-457). I do not reject public health’s ambition to improve health and extend life through prevention of smoking related illness, but in this thesis, I argue for more empathetic tobacco control responses and a “preventative” approach, which seeks to reduce smoking among young women by improving their material and social wellbeing. As other critical scholars have demonstrated (see Thompson et al., 2007, pp. 514), it is possible to “be broadly sympathetic with anti-smoking strategies”, while remaining critical of them.

As a researcher investigating smoking, presumed to be driven by a public health agenda, I am often asked the question “why do people smoke”. I struggle to
answer this question succinctly as my intention in this thesis has not been to discover the “truth” of young women’s smoking, but rather to explore some of the fragments and contradictions that comprise young women’s smoking subjectivities. My motivation for doing this research is expressed in the following quote from Deborah Lupton (1995, pp. 160-161):

The point is not to seek a certain ‘truth’, but to uncover the varieties of truth that operate, to highlight the nature of truth as transitory and political and the position of subjects as inevitably fragmentary and contradictory.

The importance of disrupting a unitary truth of young women’s smoking was made clear to me when I was approached by a young woman around my age after I had presented my thesis research at a conference. She said my research resonated with her as she had previously been in an abusive relationship with a partner who disapproved of her smoking. She explained that, despite knowing the potential health risks, smoking was a small act of resistance that gave her a sense of agency in a situation where she felt otherwise powerless. This woman’s story captures an essential outcome of this thesis – the complicating of our understandings of young women smokers and ex-smokers, through a discussion of some of the contradictory functions of smoking.

I began this thesis by examining the fragmented and contradictory cultural constructions of women’s smoking. In my review of existing literature on young women and smoking I noted that young women use smoking to perform femininity and social relationships, and experience smoking-related stigma which is compounded by gender, social class, culture and motherhood. The literature I
reviewed also showed young women have unique experiences and understandings of smoking risks, and their experiences of smoking and quitting are distinctly shaped by discourses of addiction, choice, agency, and willpower. The review of the literature identified the need for further research on young women’s smoking drawing on a social constructionist epistemology and poststructuralist theory to examine complexity, nuance, and contradiction in young women’s smoking. The review also identified intersectionality as a theory which would allow for a consideration of how intersecting identities shape young women’s smoking, and the method of participant-produced photography to provide further insights into how young women visually construct their smoking.

This lead me to pose two research questions: ‘What discourses do young women draw on to construct their smoking?’, and ‘What implications do young women’s discursive constructions of smoking have on their subjectivity, smoking practices, and interactions with anti-smoking campaigns and policies?’ To answer these questions, I conducted a three-stage qualitative research study of young women smokers and ex-smokers aged 18 to 31 years. I analysed 45 interviews and 157 photographs, using discourse analysis, intersectionality and poststructuralist theory, and my findings were reported in four published journal articles.

In this chapter I discuss my findings; I consider the implications for tobacco control, examine the strengths and limitations of the research, make suggestions for future research, and conclude the thesis.
Young Women’s Contradictory Accounts of their Smoking

My overall findings from this thesis demonstrate that for young women smoking has conflicting functions. The analysis of young women’s interviews and photographs shows smoking is constructed in complex and contradictory ways, and oppositional subject positions are adopted. For instance, for some young women in the study smoking was a disciplinary practice which helped them to construct a feminine body (Bartky, 1990), yet they also described how it occludes the maintenance of an attractive and youthful appearance. Disrupting hegemonic discourses of idealised femininity (Ussher, 1997), young women in the study demonstrated agency in their use of smoking to perform non-normative femininity, such as butch/femme lesbian identities. However, participants’ ability to resist gender norms and subvert discourses of respectable femininity were constrained (Budgeon, 2014) as it was the women with greater social and cultural capital who had the power to use smoking to challenge dominant representations of femininity (Tinkler, 2006).

In the analysis of smoking-related stigma, contradictory accounts of smoking were also provided by young women in the study who described internalising, adopting, challenging, distancing, and repositioning stigmatised smoking subjectivities. Smoking stigma served as a form of biopower which governed and regulated young women’s behaviour (Foucault, 1988; N. Rose, 1996), yet they also had the power to contest and reposition stigma. Contradiction was also evident in young women’s positioning of the health risks of their smoking, as they framed themselves as both at-risk and risk-adverse. Although many young women in the
study resisted the imperative of health (Lupton, 1995) and expressed resistance towards quitting smoking, they also continued to rationalise and account for their ongoing smoking. For instance, young women positioned their smoking as a ‘lesser evil’ than poor mental health, drinking alcohol, and the risks associated with quitting smoking. Similarly, in their accounts of quitting smoking, young women took up contradictory positions in relation to discourses of responsibility and resistance, addiction and choice. Young women drew on these contradictory discourses to position tobacco control measures as both effective and ineffective, and to account for the ways in which they approached quitting.

The use of poststructuralist theory in the analysis of young women’s accounts of risk and quitting smoking allowed for an understanding of young women as having multiple and complex subjectivities, and as being capable of taking up contradictory positions as at-risk and risk-adverse, responsible and resistant, addicts and free-agents. Using this theoretical positioning I was able to identify the social and cultural benefits of young women’s smoking in addition to the stigma and health risks, and avoid “moral and dualistic positionings” of smoking and health (Dennis, 2011, p. 25). These findings complement existing research which has used Bourdieusian and poststructuralist theory to analyse the social and cultural benefits of teenage girls’ and young women’s smoking (Gilbert, 2007a, 2007b; Haines et al., 2009). Using a poststructuralist lens, I was also able to conceptualise young women smokers and ex-smokers as both regulated by, and resistant of smoking-related discourse.
Women’s complex negotiation of smoking discourse has also been identified in previous research, particularly in relation to smoking during pregnancy (Wigginton & Lafrance, 2014). For instance, Scheffels’ (2009) study of young smokers has found the construction of smoking identities is marked with considerable contradiction, what they term a ‘split vision’, as smoking is seen to symbolise freedom, courage, and individuality, as well as being stigmatised, immoral, and undistinguished. The present study has furthered our understandings of smokers’ understandings of this ‘split vision’ by introducing Brown’s (2011) concept of the both/and position, which conceptually allows for young women to both reproduce and resist dominant discourse in relation to smoking and health. This conceptualisation allows us to recognise young women’s agency and power, as well the impact of oppressive discourse and social relations on their constructions and experiences of smoking.

Rethinking Tobacco Control Responses: Recognising Young Women’s Agency and Multiplicity

The findings from this thesis have implications for the development and design of tobacco control measures targeting young women. In this study young women took up contradictory positions in relation to graphic health warnings on cigarette packets, saying these images both challenged and reinforced a “it’s not going to happen to me” repertoire. This active negotiation of meaning is similar to that identified in previous smoking research (see Dennis, 2011; Gilbert, 2005). For example, Dennis (2016a, pp. 86-87) describes one sixteen-year-old woman who, afraid of giving birth to a large baby, smoked cigarettes sold in packets which
contained the health warning, “Smoking reduces the birthweight of your baby”.

Dennis’ case study highlights how young women reconstruct public health knowledge in ways that are not internally consistent or rational and shows how the risks of smoking are contextualised and understood in relation to other risks, such as child birth (Dennis, 2011). Alongside Dennis’ research, the findings from this thesis highlight the need for policy makers and public health professionals to recognise that young women are not passive in receiving health messages, but rather actively negotiate and even resist anti-smoking discourse. Therefore, during the design of anti-smoking messaging, greater consideration needs to be given to how such messages are actively interpreted by consulting further with young women smokers.

As identified in this thesis, and in the previous example from Dennis’ research, smoking is a practice best understood in the context of everyday life, particularly in relation to other health behaviours (Blue, Shove, Carmona, & Kelly, 2016). It is interesting to note that the negotiation of contradictory discourse identified in this thesis is similar to that identified in previous health research, such as women’s constructions of food and “healthy” eating (Churruca, 2016; Madden & Chamberlain, 2004). For instance, Lupton and Chapman (1995) discuss the paradox of wanting to eat “good” food for health reasons and wanting to eat “bad” food for comfort and pleasure. Keane (2002, p. 109) describes this paradox as a “tension between living in the present and protecting and improving one's future”, saying, “Striking the balance is perhaps a question of taste, rather than truth.” Keane challenges this notion of a single or fixed truth around what it means to be healthy and to live a good life. Tobacco control responses targeting young women need to
avoid reproducing these truths through binary concepts such as healthy/unhealthy and risky/safe, and instead, recognise the complex subject positions young women occupy.

For example, this study identified similarities in the constructions and experiences of young women who were smoking and those who had quit. Some young women negotiated divisions between smoker, ex-smoker, and non-smoker identities by adopting what Thompson, Pearce, et al. (2009) term an “in between” identity, which allowed them to avoid the stigma associated with habitual smoking but retain the social benefits. This finding provides further support to researchers who have previously argued that smoking and non-smoking are non-binary and non-linear practices, and that quitting smoking should be conceptualised as a process of recovery and relapse (Nachtigal & Kidron, 2015; Thompson, Pearce, et al., 2009). This conceptual shift is particularly important for young women given their high rates of social or occasional smoking (McDermott, Dobson, & Owen, 2007), and the significant health risks associated with this type of low-intensity smoking (Inoue-Choi et al., 2017). It is important that anti-smoking messages and health care practitioners avoid using binary labels which focus on identities such as “smoker” or “ex-smoker”, and instead draw on language such as “young women who smoke cigarettes” or “young women who have previously smoked cigarettes”.

Allowing for multiple and intersecting identities in our responses to young women’s smoking.

The findings from this thesis have also illustrated some of the ways in which young women’s experiences of smoking are shaped by intersecting identities. For
instance, some heterosexual young women used smoking as a tool to control their weight and sexually attract men, while some lesbian young women used masculine and feminine styles of smoking to perform butch and femme identities and to sexually attract women. Intersecting identities of culture, social class, and motherhood were also shown to shape young women’s experiences of smoking-related stigma. Women from Indonesian and Chinese cultures, women from lower socio-economic backgrounds, and women who were pregnant or had children spoke about experiencing compounding smoking-related stigma. Previous research has also shown that adolescent girls and women’s smoking is influenced by intersecting gender, race, ethnicity, culture, religion, sexuality, and social class identities (Antin et al., 2016; J. Douglas, 2014; Liss-Levinson, 2010). The findings from the discourse analysis reported in this thesis provides a novel contribution to this growing area of research, by providing insight into how meaning is constructed at the intersection of different identities. Future research on young women’s smoking could continue to draw on intersectionality theory to explore smoking in relation to other axis of identity, such as disability, given the higher rates of smoking among people with disabilities (Armour et al., 2007).

The intersecting nature of young women’s identities has implications for how they are conceptualised in public health and tobacco control responses. For instance, Australian general practitioners are given guidelines on how to support smoking cessation among “populations with special needs”, such as pregnant and breastfeeding women, adolescents and young people, and people with mental illness (Zwar et al., 2014). Future guidelines and training given to health professionals could
benefit from adopting an intersectional approach, and acknowledging how multiple identities and experiences intersect, and potentially compound the challenges young women experience in relation to smoking and quitting.

The findings from this thesis also show that young women encounter a gendered double standard in relation to smoking, where they experience additional stigma in relation to notions of smoking being unfeminine – a phenomenon which has been identified, but not explored in-depth in previous research (Brown-Johnson et al., 2015; Bush et al., 2003). As noted throughout this thesis, anti-smoking campaigns often perpetuate negative stereotypes about women (Haines-Saah, 2011). For instance, campaigns often reinforce traditional gender roles by focusing on women’s smoking during pregnancy, or second-hand smoke exposure to children, which results in the shaming of those women who continue to smoke (Greaves & Tungohan, 2007). These campaigns reinforce normative conceptualisations of femininity through images of non-smoking models and generate stigma through the portrayal of “ugly older women smokers” (Haines-Saah, 2011). The findings from this thesis emphasise the need for anti-smoking campaigns which avoid stigmatising young women who smoke by adopting positive smoking cessation messages.

In Chapter Three I discussed a recent positive smoking cessation campaign in Australia which conveyed some of the complexities surrounding young women’s smoking. The Smoke Free, Still Fierce campaign was developed by ACON, an Australian health promotion organisation specialising in lesbian, gay, bisexual, transgender and intersex health (Figure 35). This campaign was developed following an online survey they conducted of lesbian, bisexual and queer women who smoke
(Mooney-Somers et al., 2016). The advertisement featured both normative and non-normative femininity and acknowledged the ‘split vision’ young women often have of their smoking, saying “smoking can be a complex, love/hate relationship” (ACON, 2016). The advertisement showcased healthy ways in which to perform femininity and lesbian, bisexual, and queer identities, such as through clothing, hairstyles, and body language. This type of campaign which seeks to support rather than stigmatise smokers could be adopted to target other groups of young women, such as those from different cultural or social class backgrounds.

*Figure 35. Smoke free, still fierce.*

**The need for a ‘preventative’ approach in addressing young women’s smoking.**

Findings from this thesis can be understood in relation to previous research which has argued that tobacco control resources would be better directed towards improving the material and social wellbeing of those groups most disadvantaged in society – which are the groups most likely to smoke (Graham, 2012; Graham et al., 2006; Greaves, 2014; Kandel et al., 2009; Siahpush et al., 2002). Women who have
the most success with smoking cessation are those in circumstances that support lifestyle change, as women faced with personal and structural difficulty and disadvantage are limited in their ability to undergo health-behaviour change (Graham, 1993). This was evident in this study, where young women positioned their smoking as a lesser evil to other risks, such as domestic and family violence. There is a need to reduce structural inequalities that relate to continued smoking, such as education, housing, heavy caring responsibilities, and social isolation (Graham, 1993; Greaves, 2014). This “preventative” approach to tackling smoking rates, that seeks to improve women’s position in society has been advocated by both Australian health groups and the World Health Organisation (Department of Health, 2014; Samet & Yoon, 2010).

In this thesis I found that young women position their smoking as a way of coping with stress and negative emotions. This finding is not surprising given young women report high levels of psychological distress (Bailey et al., 2016), and poor mental health has a bi-directional relationship with smoking – meaning smoking is both a predictor and product of poor mental health (Leung et al., 2012). Therefore, increases to funding for mental health services for young women and men in Australia may have indirect implications for young women’s smoking (Department of Health, 2018). Other issues such as low socio-economic status and relationship stability indirectly impact young women’s smoking. Other indirect methods to address young women’s smoking could then be the elimination of the gender pay gap (Cassells, Duncan, & Ong, 2017), given the association between socioeconomic disadvantage and increased smoking rates and increased difficulties in quitting
Research also shows women experiencing intimate partner violence are more likely to smoke (Caleyachetty, Echouffo-Tcheugui, Stephenson, & Muennig, 2014), therefore, women smokers could benefit from increased efforts to combat domestic violence – given that intimate partner violence is also the greatest health risk factor for women aged 25-44 years in Australia (AIHW, 2018). These policy interventions have the potential to support women to not smoke, and to improve their health and wellbeing more broadly.

**Methodological Strengths of the Thesis**

This thesis has several strengths which have bearing for those conducting future research. The study reported in this thesis employed a large sample size for qualitative research (van Rijnsoever, 2017), which allowed for an in-depth and broad understanding of young women’s smoking (Glesne, 2016). This breadth of understanding came from the recruitment of participants of different cultural and social class backgrounds, and sexualities. While many previous studies of young women’s smoking have focused solely on current smokers (see Gilbert, 2007b; Haines et al., 2009), the experiences of both smokers and ex-smokers are included in this thesis. By analysing the experiences of smokers and ex-smokers I was able to consider how smoking subjectivities are adopted by young women both when continuing and quitting smoking.

The findings from the study have been strengthened by the research design which involved an innovative, in-depth qualitative approach. Qualitative methods provide an opportunity to study tensions and contradictions in data (Willig, 2008b), and offer greater insight into participants’ subjective experiences than quantitative
measures (Cuc, Sobell, Sobell, Ruiz, & Voluse, 2014). The use of repeated
interviews allowed me to build trust with participants (Lyons & Chamberlain, 2006),
and the collection of data across three time periods increased the richness of the data,
and the subsequent analysis (Davidson & Tolich, 2003). The participatory design
allowed participants to be actively involved in the production and analysis of data,
which increased the credibility of the findings (Oakley, 1981). The use of qualitative
methods, particularly photography, helped to provide insights into the context of
young women’s everyday lives where smoking takes place, highlighting the
relationship between smoking and other health behaviours. Future research could
continue to employ innovative methodologies to further explore this relationship
between smoking and other health risks, such as alcohol consumption.

The combination of interviews and a photography activity is a form of
methodological triangulation which helps provide “a more complete picture” of
young women’s experiences of smoking (Farmer et al., 2006, p. 390), by
illuminating variations and nuances (Tracy, 2010). The follow-up interviews, in
which participants discussed their photographs, contained rich narratives and “thick
description”, both of which contribute to the integrity of the findings (J. Cho &
Trent, 2006; Guell & Ogilvie, 2013). By distinguishing between initial and
subsequent interviews, and participants who engage at different stages of a study,
future researchers can conduct comparative analysis and reflect more deeply on how
these methodological variations influence the depth and detail of the data.

The inclusion of the photography activity forms part a broader trend towards
using visual research methods which has been influenced by the growth of the visual
in contemporary culture (G. Rose, 2014), and a growing recognition of arts-based methods in research (Boydell et al., 2016). The incorporation of a participant-produced photography activity is a further strength with regards to the dissemination and translation of research findings. The incorporation of participants’ photographs into the journal articles and conference presentations listed at the start of this thesis, helped to generate greater interest, provided a humanising effect, and contributed to a poststructuralist “decentring of the authority of the author” (Harper, 2002, p. 15).

The use of arts-based methods also often carries benefits to participants (Boydell et al., 2012). In this study, the participatory and in-depth nature of the interviews and photography activity allowed participants to reflect on their smoking in the context of their lives. Previous research on smoking has suggested this type of reflexive engagement, where participants are able to identify their cues for smoking, their feelings, and need for cigarettes, could have therapeutic benefits in helping smokers to quit (Jacobson, 1981; J. L. Johnson, Lovato, et al., 2003). J. L. Johnson, Lovato, et al. (2003) have suggested that hearing their own story, as well as the stories of others, may help young people to see different possibilities in relation to their smoking, or to reaffirm a non-smoking identity and maintain behaviour change (Parry et al., 2001). Future research could employ a longitudinal research design to assess the potential for these methodologies to support young women to quit smoking.

Another strength of this thesis was the use of investigator triangulation, and the consideration of different interpretations of the data during analysis. Variations in age, sexuality, social class, and theoretical and disciplinary backgrounds between me
and my supervisors strengthened the analysis, as I was able to interrogate the data from a range of different perspectives (Farmer et al., 2006). However, this process was challenging as it required us to reflexively interrogate our values, beliefs, knowledge, and biases, and to challenge one another to avoid projecting any personal thoughts and beliefs onto participants’ accounts.

**Limitations of the Thesis and Suggestions for Future Research**

Limitations of the research pertain to the sample recruited to participate in the study. The majority of participants were Anglo-Australian and considering culture and ethnicity have been shown to be important determinants of women’s smoking experiences (see J. Douglas, 2014; Passey et al., 2011), the findings outlined in this thesis may not be transferable to specific cultural contexts. Most of the women in the sample were also heterosexual, and findings may not be transferable to women who are lesbian, bi-sexual, or queer – who have been identified as having distinct experiences with smoking (Comfort, 2012; Mooney-Somers et al., 2016; Remafedi, 2007). Many participants were not pregnant and had no children, therefore, findings might not be relevant to women who are pregnant or have children. Future research should look to further explore the specific needs of young women smokers of different cultural backgrounds, sexualities, and young women who are pregnant or have children.

Limitations also surround the use of interviews as a research method. In Chapter Two I discussed the socially constructed nature of the research interviews and reflected on how my interactions with participants shaped the data collected. The interviews provided a context in which discursive constructions of the self were
produced through a dynamic and collaborative process of *story making* (Presser, 2004). However, the stories that were able to be told, and the subjectivities that the young women were able to take up, were constrained by the context in which the interviews took place. These constraints relate to “participants’ ability to reflectively discern aspects of their own experience and to effectively communicate what they discern through the symbols of language.” (Polkinghorne, 2005, p. 138). These limitations were discussed by participants when I asked them to reflect on their participation in the study. For instance, Shayma (19, smoker) spoke about challenges she faced expressing herself during the interview:

Sometimes I just didn’t know what else to say and stuff, because I’m really bad at like expressing myself. I remember with the first interview, you kept on asking for examples and I’m really bad at giving examples, and I’d constantly be like, “I don’t know” or I’d use the same example constantly.

Similar frustrations were shared by Brittany (21, smoker) when she read the transcript from her first interview. She said, “I did read it, and honest to God, all I could think was I do not make sense…But I kind of understood what I was saying but my English was really bad.” These quotes highlight the difficulty participants faced in having to communicate their lived experiences using language.

The use of participant-produced photographs sought to mediate this by providing another way for participants to communicate their experiences with smoking, which also afforded them a greater sense of authority over the research process (Brown, Worrall, Davidson, & Howe, 2013). There were several instances where participants used their photographs to communicate issues they had not
discussed in their interviews. For example, Briana (18, smoker) took a photograph of a baby card and clothing which she titled “Something that has promoted me to quit”. (see Figure 36). In her first interview, Briana had only spoke about her son once, and did not mention smoking during pregnancy, yet with this photograph she was able to communicate the importance of her son in relation to her experiences of smoking.

Figure 36. “Something that has promoted me to quit"
The findings from this research are limited to the socio-cultural and historical context in which they have been produced. The study reported in this thesis was designed and conducted between early 2014 through to early 2015. The benefit of this was that I was able to capture young women’s initial responses to the plain cigarette packaging which was introduced in late 2012. However, since this time, several developments have occurred in relation to the social, moral, and political atmosphere of smoking (Dennis, 2016b). These include the growing conversation around third-hand smoke (Dennis, 2016b), and the continuing debate around the safety of electronic cigarettes and harm reduction (Chapman, 2013; H. Douglas, Hall, & Gartner, 2015; Rahman, Hann, Wilson, Mnatzaganian, & Worrall-Carter, 2015).

Some researchers have argued for a harm reduction approach (Graham et al., 2014), while others maintain the view “there is no safe level of smoking and that quitting completely is the only way to genuinely reduce risk of harm” (Keane, 2013, p. 192).

Some evidence shows electronic cigarettes could be used to help smokers to quit (Bullen et al., 2013; Thirlway, 2018), however, the identification of a positive relationship between electronic cigarette use and cigarette experimentation among young people (Best et al., 2017) has contributed towards the construction of electronic cigarettes as a “gateway” to “harder” and more harmful forms of nicotine consumption, namely cigarettes (Bell & Keane, 2014). Although electronic cigarettes provide a similar sensory experience to cigarettes, Keane (2014) argues they are a unique commodity and have different discursive meanings to cigarettes. There is a need for further research which examines young women’s discursive constructions of electronic cigarette use.
The data analysed in this thesis is situated in an Australian cultural context and the findings discussed have broader relevance for other Western countries with similar tobacco climates, such as Canada, the United States, and the United Kingdom (Dennis, 2016a). However, given much of the existing research on women’s smoking is situated in a Western context (Bottorff et al., 2014), there is a need for further research in poorer countries where rates of smoking among women are increasing (Amos & Haglund, 2000), and women continue to be exposed to second-hand smoke and exploited through tobacco production (Amos et al., 2012; Greaves, 2007).

Final Reflections

This thesis has explored the discourses young women use to construct their experiences of smoking. Building on existing research, I adopted a social constructionist epistemology and poststructuralist and intersectionality theory to analyse the accounts given by young women smokers and ex-smokers in interviews and a photography activity. The findings from my discourse analysis show that young women construct and experience their smoking as having conflicting functions, and they are both regulated by and resistant of smoking-related health discourse. Therefore, the findings from this thesis suggest the need for greater acknowledgement of the contradiction and conflict that characterises young women’s smoking through the development of tobacco control responses that recognise young women’s agency and the multiplicity of their identities.
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Retrieved from www.racgp.org.au
Appendix A: Recruitment Materials - Flyer

Young Women and Cigarette Smoking Study

Are you a young woman who currently smokes cigarettes, or an ex-smoker?

**What is the study about?** At the University of Western Sydney we are researching young women’s experiences of smoking or quitting.

**Who are we looking for?** Women aged 18-30 who smoke daily, weekly or monthly OR ex-smokers who smoked at least 100 cigarettes before quitting.

**What is required?** Completion of a brief 10 minute online survey. You also have the opportunity to participate further in the study if you wish. All information you give us is confidential.

You can find out more about the study and complete the survey online at:


[www.facebook.com/womensmokingresearch](http://www.facebook.com/womensmokingresearch)

If you want more information about the study or you prefer a paper copy of the survey please contact us on:

☎ 02 4620 3606 or 1800 057 141

✉ youngwomenandsmoking@uws.edu.au

This study has been approved by the University of Western Sydney Human Research Ethics Committee (Study ref: H10426).
Appendix B: Recruitment Materials – Facebook Advertisement

Research into Young Women and Cigarette Smoking
Sponsored

3 stage study of women’s experiences of smoking and quitting. $30 available for each stage

Young Women and Smoking
WWW.SURVEYMONKEY.COM
Appendix C: Participant Information Sheet

Young women’s experiences of cigarette smoking: a qualitative examination of the intersection of gender, class, cultural and sexual identity:

Participant Information Sheet

Invitation

We would like to invite you to take part in a study about cigarette smoking. The researchers on the study are Professor Jane Ussher, Associate Professor Janette Perz, Dr Kate Huppatz, Dr Christine Metusela, Zoi Triandafilidis (PhD student) and Jasmine Sproule (Honours student) from the University of Western Sydney. To help you decide if you want to take part, it is important for you to understand why the research is being done and what it will involve.

What is the purpose of the study?

This study is designed to help us learn more about your experience of cigarette smoking or quitting, and to understand how gender, sexuality, social class, and cultural identity shape smoking.

How is this study being paid for?

The study is being sponsored by the Australian Research Council: DP130100723

Who can become involved in the study?

Women aged between 18-30 who are currently smoking daily, weekly or monthly or ex-smokers who have smoked at least 100 cigarettes in their life, but are no longer smoking.

What will I be asked to do?

If you decide to participate in the study you will take part in three stages:

Stage one: An individual semi-structured interview will be conducted with you by a member of the research team. This interview aims to explore your experiences of smoking, experiences of quitting, your perceptions of anti-smoking campaigns, and how smoking forms part of your everyday life.

Stage two: You will be sent an email detailing instructions on a four-week photography activity where you will take photographs of your experiences with smoking cigarettes. You will be given a list of written cues guiding you to take photos or find images on the themes of the research (e.g. something that reminds you of smoking, your favourite cigarettes, what ex-smokers do instead of smoking). You are also free to take additional unprompted smoking-related photos.

A member of the research team will follow up with you after two weeks. After a total of four weeks you will be asked to submit your photographs via email.

Stage three: Following your participation in the photography activity, you will take part in another individual semi-structured interview to examine your experience of the research process and allow you to discuss any changes in your experience of smoking after having taken part in the research. Both interviews will be audio-recorded and transcribed with your consent.

How much of my time will I need to give?

Each individual interview will last for about one hour. The duration of the photography activity is four weeks. You are invited to add to your cultural probe activity at times convenient to you.
What are the benefits / positives?
This study will provide the research team with an understanding of the experiences of young women smokers and ex-smokers. This understanding will aid in the development of targeted anti-smoking campaigns and assist in reducing the prevalence of smoking for young women. The knowledge generated from this project will benefit young women smokers, the next generation of children, health educators, the Australian government, and the overall health and economic wellbeing of Australians.

Will taking part in this study cost me anything, and will I be paid?
Participation in this study will not cost you anything. If you take part, you will be reimbursed for your time and reasonable travel expenses to the amount of $30, for each of the three stages of the study.

Will the study involve any discomfort for me? If so, what will you do to rectify it?
Talking about your smoking experience may be an uncomfortable topic for you. If you decide to take part in the study, we will do whatever we can to make sure you feel safe and comfortable. You do not have to answer any questions that make you feel uncomfortable and you can stop the interview or the cultural probe activity at any time. If you feel any distress from participating in the study you can talk to the research team or contact NSW Quitline on 13 7848 or Cancer Council Helpline on 13 11 20.

What will happen with the results?
We plan to present and discuss the results with other organisations interested in young women and cigarette smoking, however, you will not be identified in any publication of the research. Data collected across the three stages of the project, including the social networking site, will be used in the results. However, the data will be based on aggregates, patterns, and similarity of themes and will not reveal the identity of any specific individual. Whenever we present or discuss the results, including potential future research, your name will not be mentioned and no one will know that you participated in the project.

Can I withdraw from the study?
If you decide you want to take part in the research project, you will be asked to sign a consent form. All of the information you provide is confidential and will be securely stored for a period of five years. Participation is voluntary. If you decide not to be involved, it will not affect you in any way and it will not affect the relationships you have with any of the organisations involved. You can change your mind and quit the study at any time and you don’t have to give any reasons if you don’t want to.

Can I tell other people about the study?
Yes, you can tell other people about the study and give them the researchers’ contact details if they would like to participate or would like information.

What if I require further information?
If you would like to participate, would like to know more about the study or experience any problems while taking part in the study, please contact a member of the research team on 02 4620 3606 or 1800 057 141 or c.metusela@uws.edu.au.

What if I have a complaint?
This study has been approved by the University of Western Sydney Human Research Ethics Committee (Study ref. H10426). If you have any concerns about the conduct of the study, or your rights as a study participant, you may contact the Ethics Committee through the Research Ethics Officer on 02 4736 0229 or humanethics@uws.edu.au.

This information sheet is for you to keep and thank you for taking the time to consider this study.
Appendix D: Consent Form – Interviews

Young Women and Cigarette Smoking: Consent to Participate in Research

1. I acknowledge that I have read, or have had read to me, the Participant Information Sheet relating to this study. I acknowledge that I understand the Participant Information Sheet. I acknowledge that the general purposes, methods, demands and possible risks and inconveniences which may occur to me during the study have been explained to me by __________________________ (“the researcher”) and I, being over the age of 18 acknowledge that I understand the general purposes, methods, demands and possible risks and inconveniences which may occur during the study.

2. I acknowledge that I have been given time to consider the information and to seek other advice.

3. I acknowledge that refusal to take part in this study will not affect me in any way.

4. I acknowledge that I am volunteering to take part in this study and I may withdraw at any time.

5. I acknowledge that this research has been approved by the University of Western Sydney Human Research Ethics Committee.

6. I acknowledge that I have received a copy of this form and the Participant Information Sheet.

7. I understand that the interviews will be digitally recorded and transcribed.

8. I understand that my identity will not be disclosed to anyone else or in publications, presentations or potential future research. Data collected from the three stages of the project, including the social networking site, will be used in the results. However, the data will be based on aggregates, patterns, and similarity of themes and will not reveal the identity of any specific individual.

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Appendix E: Consent Form – Photography Activity

Young Women and Cigarette Smoking: Consent to participate in research for non-identifiable photographs

1. I acknowledge that I have read, or have had read to me, the Participant Information Sheet relating to this study. I acknowledge that I understand the Participant Information Sheet. I acknowledge that the general purposes, methods, demands and possible risks and inconveniences which may occur to me during the study have been explained to me by __________________________ (“the researcher”) and I, being over the age of 18 acknowledge that I understand the general purposes, methods, demands and possible risks and inconveniences which may occur during the study.

2. I acknowledge that I have been given time to consider the information and to seek other advice.

3. I acknowledge that refusal to take part in this study will not affect me in any way.

4. I acknowledge that I am volunteering to take part in this study and I may withdraw at any time.

5. I acknowledge that this research has been approved by the University of Western Sydney Human Research Ethics Committee.

6. I acknowledge that I have received a copy of this form and the Participant Information Sheet.

7. I understand that the interviews will be digitally recorded and transcribed.

8. I understand that my identity will not be disclosed to anyone else or in publications or presentations.

9. I agree to non-identifying photographs from my visual probe activity to be included in publications or presentations.

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Appendix F: Survey Questionnaire

Young Women and Cigarette Smoking

Introduction

As part of the Young Women and Cigarette Smoking Study being conducted by the University of Western Sydney we are interested in your experiences of smoking. Women smokers and ex-smokers aged between 18-30 years are invited to take part in this study. The study has been approved by the University of Western Sydney Human Research Ethics Committee (Study ref: H10426).

Instructions:
- Taking part in the study is voluntary.
- Information you provide is confidential.
- The survey will take about 10 minutes to complete.
- Please do not exit the survey before completing as you cannot return to the incomplete parts after exiting.
- If you are interested in participating in the three stages of the research project, with a $30 reimbursement voucher available per stage, you can leave your contact details on the last page.
- Use the previous and next buttons at the bottom of each page to move between pages.

If you have any questions, please contact us on: Tel: 02 4620 3606; Email: youngwomenandsmoking@uws.edu.au

Your participation in this study is greatly appreciated.

Questions about your smoking history and smoking status

1. What is your current age?
2. What age were you when you began smoking regularly?
3. Why did you begin smoking?
4. Are you currently a smoker?
   - Yes
   - No
5. What is the usual number of cigarettes you smoke in a day?
6. On average, how many days in a week do you smoke cigarettes (0-7)?
7. On average, how many of the last 30 days did you smoke cigarettes (0-30)?
8. What best describes your pattern of smoking?
   - I smoke mostly on my own
   - I smoke mostly with other people
   - I smoke as much on my own as I do with other people
9. What brand(s) of cigarettes do you smoke?
   - Winfield
   - Dunhill
   - Benson and Hedges
   - Peter Jackson
   - Longbeach
   - Horizon
   - Marlboro
   - Alpine
10. Have you always smoked that brand/those brands?
   - Yes
   - No
   - If no, what other brands?

11. What was the usual number of cigarettes you used to smoke in a day?

12. On average, how many days in a week did you used to smoke cigarettes (0-7)?

13. On average, how many days in a month did you used to smoke cigarettes (0-30)?

14. What best describes your pattern of smoking?
   - I smoked mostly on my own
   - I smoked mostly with other people
   - I smoked as much on my own as with other people

15. What brand(s) of cigarettes did you smoke?
   - Winfield
   - Dunhill
   - Benson and Hedges
   - Peter Jackson
   - Longbeach
   - Horizon
   - Marlboro
   - Alpine
   - Other (please specify)

16. Did you always smoke that brand/those brands?
   - Yes
   - No
   - If no, what other brands?

17. For what reason(s) did you quit smoking?

18. What age were you when you quit smoking?

19. What do you think about plain cigarette packaging?

20. Did plain packaging lead to any of the following? (Tick all that apply)
   - An increase in your smoking
   - A decrease in your smoking
   - Made no difference
   - Affected the brands you bought
   - Made you consider quitting
   - Made you quit
   - Other (please specify)

General questions about you

21. What is your Australian postcode?

22. If you live overseas, please specify what country you live in:

23. What country were you born in?

24. What is your cultural or ethnic background? (e.g., Anglo-Australian, Chinese)

25. Are you currently in an intimate relationship?
26. How long have you been in your current relationship?

27. Which best describes your living situation?
   - I live alone
   - I live with my partner
   - I live with my parents
   - I live in a shared household
   - Other (please specify)

28. Which best describes your sexual identity?
   - Heterosexual
   - Lesbian
   - Bi-sexual
   - Other: I identify as ...

29. Do you have any children?
   - Yes
   - No
   - If Yes, what are their ages?

30. If you are in paid employment, what is your occupation?

31. On average, how many hours of paid work do you do a week?

32. On average, how many hours of unpaid/volunteer work (including domestic duties) do you do a week?

33. Please select the income bracket below that best applies to you
   - >$80,000 per year
   - $61,000 to $80,000 per year
   - $41,000 to $60,000 per year
   - $21,000 to $40,000 per year
   - <$20,000 per year
   - Nil income
   - I prefer not to answer

34. What kinds of activities do you enjoy doing in your free time?

35. What is the highest level of education you have completed?
   - Less than Year 10
   - Year 10 (School Certificate or equivalent)
   - Year 12 (Higher School Certificate or equivalent)
   - Tertiary diploma/trade certificate/TAFE
   - University degree or higher

36. What is the name of the last high school you went to and what Australian State was it in (if applicable)?

37. Are you currently studying? (e.g., School, TAFE, University, Course)
   - Yes, full time
   - Yes, part time
   - No
   - If Yes please specify what you are studying

38. What is/was your parents’ occupation?

   Father:  
   Mother:
39. Please select the income bracket below that best applies to the combined income of your parents
   - >$141,000 per year
   - $121,000 to $140,000 per year
   - $101,000 to $120,000 per year
   - $81,000 to $100,000 per year
   - $61,000 to $80,000 per year
   - $41,000 to $60,000 per year
   - $21,000 to $40,000 per year
   - <$20,000 per year
   - Nil income
   - I don't know
   - I prefer not to answer

40. What is the highest level of education completed by your parents?

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<th>Less than Year 10</th>
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<th>Year 12 Higher School Certificate or equivalent</th>
<th>Tertiary diploma/trade certificate/TAFE</th>
<th>University degree or higher</th>
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41. How would you describe your social class background? (e.g. working class, middle class, upper class)

Final comment and further contact

42. If you are interested in participating in an individual interview and further two research stages for this project please provide us with the following contact information. All information you provide is confidential. There is a $30 reimbursement voucher for participation in each of the three stages, $90 in total.

Name
Address
Phone (daytime)
Email

43. What are your preferred days and times for contacting you by phone?

44. Please provide any feedback or comments you wish to make in the comment box below.

You have completed the survey once you click on the Done button below.

If you have any further questions about the study, please contact us on Tel: 02 4620 3606 or Email: youngwomenandsmoking@uws.edu.au

Thank you for participating in this survey. It is much appreciated!
Appendix G: Stage One Interview Schedule

Experiences of smoking
To start off with, can you tell me a bit about your experiences of smoking cigarettes?
Can you tell me about when you first began smoking?
Prompts: do you remember the first cigarette you smoked?
What were your reasons for starting to smoke?
Prompts: do you feel these reasons for smoking are any different now?
Can you describe what it feels like to smoke cigarettes?
Prompts: where do you mostly smoke, with whom, and when?
Can you describe to me the way in which you smoke?
Prompts: holding and ashing, what types of cigarettes do you smoke? do you have any thoughts on how men and women hold/ash their cigarettes?
What do you think about people who smoke?
Prompt: What reactions have people had to your smoking? How do you think smoking is thought of nowadays?

Quit attempts
(Smokers)
Tell me about your thoughts on quitting smoking.
Prompt: do you think you’ll always smoke?
Have you ever tried to stop smoking?
Prompts: how many, why did you attempt to stop smoking (e.g. family pressure, health reasons), how did attempting to stop smoking make you feel? how would you know if someone was ‘addicted’ to smoking?
(Ex-smokers)
Tell me about your attempts to stop smoking.
Prompts: why did you stop smoking (e.g. family pressure, health reasons), how many times did you stop, what was it like, how did you go about it, why do you think they weren’t successful, did you use any social media, or quit apps?
Tell me about how you gave up smoking.
Prompts: when did you give up, why did you give up smoking, what worked, why did it work?
Media images of smoking and anti-smoking

What do you think about images that promote smoking, such as TV shows, movies or pictures of celebrities?

What do you think of anti-smoking messages and campaigns?

Prompts: TV, cigarette packs, posters, impact on own smoking.

Tell me what you think about plain packaging of cigarette packs.

Prompts: has it changed the way you smoke? effects on purchase of cigarettes/brand choice?

Anti-smoking campaigns targeted at women often focus on the effect smoking has on your appearance. What do you think of this approach?

Closing question

Is there anything else about your experiences smoking cigarettes that you would like to talk about or you think we haven’t covered?
Appendix H: Stage Two Photography Activity Instructions

Thank you for your participation in stage one of the Young Women and Cigarette Smoking study. I would like to invite you to take part in the following activities over the next four weeks as part of stage two of the study.

Photography activity:

Imagine you are taking photographs for an exhibition titled “Smoking through the eyes of young women”. You can take photographs using a camera phone or digital camera, or any other device you might have access to. If you don’t have access to any of these devices, please let me know and I will provide you with a digital camera to use for the study.

Here are some prompts for things you might photograph;

- An object that reminds you of smoking
- A place that reminds you of smoking
- Your favourite brand of cigarettes
- Something that makes you want to have a cigarette
- Something that makes you feel like quitting or that has made you to quit
- How you think smoking is thought of nowadays

These are just some suggestions; please take any other smoking-related photos that come to mind. There are no restrictions around how many images or photographs you wish to share.

We ask you to please not take any identifiable photos of yourself or other people.

You can complete the photography activity at any time convenient to you. At the end of the four weeks all photographs should be uploaded and submitted, either via email to z.triandafilidis@uws.edu.au or in a personal message to the research Facebook account (www.facebook.com/youngsmokingresearch).

When uploading photographs please label each one with a caption explaining what the image means to you.
Interview transcript:

Before the stage three interview you will be sent a copy of a transcript, which is a written version of the stage one interview. This document only records the part of the conversation where the questions about smoking were asked, and leaves out the opening introductions, descriptions of the project and closing goodbyes. What is written in this document is a slightly modified version of our conversation where some of the ‘ums’, ‘ahs’ and pauses have been left out.

This transcript is provided as a way for you to reflect on your experiences with smoking. During the stage three interview you will be asked about whether you would like to make any changes, add new details, thoughts, or stories. Please let me know if you would prefer to receive a hardcopy in the post, an electronic version of the transcript via email, or to listen to an audio recording of the interview.

After two weeks I will check in and see how you are getting on, and see if you are having any issues, as well as scheduling a time for our stage three follow-up interview.

If you have any questions you can contact me via email (z.triandafilidis@uws.edu.au), or phone +61 2 4620 3669, or we can arrange a time to meet in person.

Thank you again for taking the time to share your experiences with us.

Regards,

Zoi Triandafilidis
PhD candidate
Ph: +61 2 4620 3669 | Email: z.triandafilidis@uws.edu.au
Appendix I: Stage Three Interview Schedule

Thoughts on first interview
Reading the transcript from the first interview we did – how did that make you feel?
Prompts: did you agree/disagree with what was written? is there anything you want to add?
I have some specific questions that came up for me when I was looking over the transcript…

Photography activity
Tell me about what it was like taking photographs of your experiences with smoking.
Prompts: How did you decide what you were going to photograph? How did you go about taking the photographs?
Which picture do you want to look at first…
Prompts: what’s in this picture? when you look at the photo, how do you feel? What caption/title would you give to that picture?
Tell me about how this activity relates to other experiences you’ve had taking photographs.
Prompts: which are your favourite photographs? which are not? what photos are missing/what were you unable to photograph?

Feedback on the research
Talk to me about how you have found the experience of being involved in this research project?
Prompts: what parts did you like/dislike? which bits did you find difficult/easy? what would you change?
Tell me about your thoughts on smoking and quitting, after having been involved in this project?
Prompts: have your thoughts on smoking changed in any way?
What would you like to see done with the results of this research?

Closing question
Is there anything else about your experiences smoking cigarettes that you would like to talk about or you think we haven’t covered?
Appendix J: Ethics Approval Letter

Locked Bag 1797
Penrith NSW 2751 Australia
Office of Research Services
ORS Reference: H10426 13/017631

HUMAN RESEARCH ETHICS COMMITTEE

13 November 2013
Doctor Emilee Gilbert
Centre for Health Research

Dear Emilee,

I wish to formally advise you that the Human Research Ethics Committee has approved your research proposal H10426 "Young women's experiences of cigarette smoking: a qualitative examination of the intersection of gender, class, cultural and sexual identity", until 30 June 2017 with the provision of a progress report annually and a final report on completion.

Conditions of Approval
1. A progress report will be due annually on the anniversary of your approval date.

2. A final report will be due at the expiration of your approval period as detailed in the approval letter.

3. Any amendments to the project must be approved by the Human Research Ethics Committee prior to the project continuing. Amendments must be requested using the HREC Amendment Request Form: http://www.uws.edu.au/__data/assets/pdf_file/0018/491130/HREC_Amendment_Request_Form.pdf

4. Any serious or unexpected adverse events on participants must be reported to the Human Ethics Committee as a matter of priority.

5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the Committee as a matter of priority.

6. Consent forms are to be retained within the archives of the School or Research Institute and made available to the Committee upon request

Please quote the registration number and title as indicated above in the subject line on all future correspondence related to this project. All correspondence should be sent to the email address humanethics@uws.edu.au.

This protocol covers the following researchers:
Emilee Gilbert, Christine Metusela, Janette Perz, Jane Ussher

Yours sincerely
A/Professors Debbie Horsfall and Federico Girosi
Deputy Chairs,
Human Researcher Ethics Committee
Appendix K: Ethics Amendment Letter

Locked Bag 1797
Penrith NSW 2751 Australia
Office of Research Services
ORS Reference: H10426 13/017631

HUMAN RESEARCH ETHICS COMMITTEE

25 March 2014
Doctor Emilee Gilbert
Centre for Health Research

Dear Emilee,

RE: Amendment Request to H10426
I acknowledge receipt of an email concerning a request to amend your approved research protocol H10426 “Young women’s experiences of cigarette smoking: a qualitative examination of the intersection of gender, class, cultural and sexual identity”.

The Office of Research Services has reviewed your amendment request and I am pleased to advise that it has been approved as follows:

Amendment: Recruitment through university students as well as through SONA. Students recruited through SONA will be reimbursed. Approved

Amendment Approved for addition to Team:
Zoi Triandafilidis - PhD Candidate
Jasmine Sproule - Honours Candidate

Please do not hesitate to contact me at humanethics@uws.edu.au if you require any further information.

Regards
Professor Elizabeth Deane
Presiding Member,
Human Researcher Ethics Committee
Doing and undoing femininities: An intersectional analysis of young women’s smoking

Zoi Triandafilidis, Jane M Ussher, Janette Perz and Kate Huppatz
Western Sydney University, Australia

Abstract
Previous research has found that young women’s smoking relates to their performance of feminine gender identities. Using an intersectional approach, we explore in this study how young women’s smoking is implicated in the doing and undoing of femininities, as well as other intersecting identities. Discourse analysis was used to examine interviews and a photography activity conducted with young women, both current and ex-smokers. This analysis revealed four culturally dominant repertoires: “cigarettes and smoking styles as gendered”, “smoking as controlling weight”, “smoking as a sexual tool”, and “smoking as compromising appearance”. Young women’s experiences and negotiations of discourse surrounding smoking and femininity were shaped by intersecting social class and sexual identities. These findings can be used to inform the development of smoking cessation interventions which recognise the diversity in how young women perform femininity.

Keywords
smoking, intersectional approach, discourse analysis, interpretative repertoires, gender, photography, visual methods, women’s health

Widespread social disapproval meant that historically women in Western cultures were much less likely than men to smoke cigarettes (Waldron, 1991). Currently, in much of the Western world, this gender gap is not as large, and in some countries women are smoking just as much, if not more than men (Ng, Freeman, Fleming, & et al., 2014). In Australia, the percentage of women who smoke daily is 11.2%.

Corresponding author:
Zoi Triandafilidis, Centre for Health Research, Western Sydney University, Locked Bag 1797, Penrith South, New South Wales 2751, Australia.
Email: z.triandafilidis@westernsydney.edu.au
Although this is lower than the overall percentage of men, in certain parts of Australia, women are smoking at similar or higher rates than men (AIHW, 2014). Australian women are most likely to smoke daily between the ages of 25 and 29. In recent years, there have been increases in the mean number of cigarettes smoked per week by women between the ages of 18 and 29 (AIHW, 2014). Trends such as these have led to calls for research which adopts a gendered perspective in understanding smoking (Sieminska & Jassem, 2014). A gendered perspective helps to provide insight into the specific reasons why young women smoke, and the difficulties they have with quitting, information which can then be used to inform the development of targeted health education material.

Gendered research carried out in a Western context has shown that women are more likely than men to be negatively affected by smoking-related stigma (Evans-Polce, Castaldelli-Maia, Schomerus, & Evans-Lacko, 2015), more likely to report being dependent on cigarettes, and to have lower expectations and less positive experiences with cessation (Sieminska & Jassem, 2014; US Office on Smoking and Health, 2001). In addition to the general health risks associated with smoking, young women face additional risks related to pregnancy outcomes and contraindications with oral contraceptives (Ernster, Kaufman, Nichter, Samet, & Yoon, 2000).

Research on women’s smoking often draws on the concepts of gender and gender identity. Gender has been conceptualised in feminist scholarship as a constructed identity, which is neither stable nor coherent (Bradley, 2013). A number of theorists have examined the way in which gender is enacted on an individual level. For example, West and Zimmerman (1987) use the notion of “doing gender” to imagine gender as a routine, everyday practice. Similarly, Butler (1993, 2006) describes gender as an ongoing performance, made up of stylised acts. Within feminist theory, gender identity has been reconceptualised as “durable but not immutable” (McNay, 2000, p. 2), allowing space for agency and the resistance of gender norms. Butler (2004) uses the phrase “undoing gender” to describe the process by which normative conceptions of sex and gender are routinely undone.

A number of studies have focused specifically on the relationship between women’s smoking and gender identity. Young women have given accounts of constructing feminine gender identities through purchasing long, slim cigarettes and lightly coloured cigarette packets, and through the holding and ashing of cigarettes in a showy style (Gilbert, 2007b). A small proportion of young women report using smoking as a conscious dieting strategy (Nichter et al., 2004), allowing them to maintain the feminine ideal of a slim body (Bordo, 2003). As well as constructing femininity, young women have also spoken about how smoking can compromise their femininity, citing the smell of smoke on their clothing and bodies as one such example (Amos & Bostock, 2007). Scheffels (2009, p. 482) uses the phrase “split vision” to describe this type of tension, where smoking is seen to serve both positive and negative functions.

Young women’s constructions of their smoking as both feminine and unfeminine correspond with broader Western cultural constructions of smoking and femininity, which continue to shift across time and space (Butler, 2006). In the early
20th century, women’s smoking was often seen as a symbol of prostitution (Greaves, 1996), but as women took up smoking in larger numbers, it also came to be seen as a source of liberation and emancipation (Greaves, 1996; Tinkler, 2006). Cultural shifts in women’s smoking transformed it from a “mannish” practice, associated with lesbianism, into a way for heterosexual women to attract men, a shift reflected in portrayals of women’s smoking as glamorous and feminine in tobacco marketing material (Greaves, 1996, p. 22). However, these representations have been challenged over the past 50 years by anti-tobacco messaging, which has worked to reposition women’s smoking as unfeminine and unattractive (Bottorff et al., 2014; Haines-Saah, 2011).

Cultural constructions of women’s smoking are also shaped by intersecting identities, such as social class and sexuality. Throughout history, the consumption of cigarettes has often been marked by distinct socio-economic differentials. In Australia, smoking has become “a badge of unemployment, low socioeconomic status and low educational achievement” (Chapman & Freeman, 2008, p. 27). Among women, lower education and household income levels are associated with higher rates of smoking, a trend which is most visible during pregnancy (Huang & Ren, 2011). Sexuality is another important intersection in understanding women’s smoking. In parts of Australia, lesbian and bisexual women are approximately twice as likely to smoke as the general population (ACON, 2015). Researchers exploring the relationship between smoking and sexuality found that smoking and sexual orientation identities intersect and shape how lesbian and bisexual women develop their self-concept (Comfort, 2012). These studies point to the need to study women’s smoking and identity from an intersectional lens.

Despite calls from researchers for a greater consideration for identities which intersect with gender (Bottorff et al., 2014), there is no previous research that has looked at the intersection of social class, sexuality, and gender in young women’s constructions of smoking within a Western context. The present study addresses this gap in the research literature by adopting an intersectional approach, in order to answer the research question: how does gender intersect with social class and sexuality to shape young women’s constructions and experiences of smoking? A further aim of this paper is to extend existing research on the contradictory constructions of women’s smoking (Greaves, 1996; Haines-Saah, 2011), by exploring how young women negotiate a split vision in relation to their smoking and its ability to both do and undo femininities. We look to advance current quantitative and epidemiological research which positions women’s identities as singular or fixed, by adopting a qualitative methodology, which allows for a more complex understanding of identity as fluid and multiple.

**Method**

**Participants**

Twenty-seven young women, smokers and ex-smokers, between the ages of 18 and 31 (mean age = 24) took part in the study. The target age range (18–30 years) was
selected as it encompasses a time period when women are most likely to be daily smokers (AIHW, 2014). Eighteen of the women were current smokers, with most of these women smoking less than 15 cigarettes a day (56%). The nine ex-smokers who participated in the study had quit smoking sometime between two weeks and two years earlier. Most of the women who participated in the study identified as Anglo Australian (63%), with the remaining women identifying with Aboriginal Australian, Asian, American, European, Middle Eastern, and Pacific Island cultural backgrounds. When presented with the following categories, the majority of the participants identified as being from working-class (44%) and middle-class (48%) backgrounds, while (7%) identified as being upper-middle class. Most of the women described themselves as heterosexual (67%) or bisexual (26%) and a smaller number identified as lesbian (7%). At the time of the study, over a quarter of the women had children (26%), and one woman was pregnant.

Procedure

Participants were recruited through the distribution of flyers at train stations, undergraduate university tutorials, tertiary education campus noticeboards, as well as online advertising on social media. Participants were purposively selected in order to include young women from a variety of social class and sexual identity backgrounds. This approach is used in intersectional research to ensure that women with identities which carry less social power and status, such as working class, or lesbian, are made visible (Warner, 2008). Participants took part in a three-staged study: (1) in-depth, semi-structured interviews; (2) a photography activity; and (3) follow-up, in-depth, semi-structured interviews. The stage one interview explored participants’ experiences with smoking, quitting, and their perceptions of smoking in the media. Participants were asked questions such as: “What were your reasons for starting to smoke?”, which were followed up with prompts, such as, “Do you feel your reasons for smoking are any different now?” In the second stage, participants took photographs of their experiences with smoking for an average period of three weeks. Participant-produced photography offers first-hand insight into how young women construct and visualise their smoking (Haines-Saah, 2011). Participants submitted a total of 157 images, which were mostly photographs, but also included images they had downloaded from the internet or created themselves. During the follow-up interview, participants were asked about their first interview, their photographs, and their experiences of being involved in the study. The follow-up interview also gave the interviewer an opportunity to clarify any issues raised in the first interview. An example of the types of questions participants were asked during their follow-up interview is: “Tell me about what it was like taking photographs of your experiences with smoking”. In order to answer the question of how gender, social class, and sexuality intersect, we asked participants questions about their experiences of smoking in the context of everyday life in order to avoid presenting identities such as “woman” or “lesbian” as discrete entities (Bowleg, 2008; Christensen & Jensen, 2012). The interviews for stages one and three lasted 45 minutes on average. The majority of interviews were conducted by the first author, a young woman, who had
only smoked a handful of cigarettes in her life and would be classified as a non-smoker.

The process of combining multiple research methods, such as interviews and a photography activity, is referred to as "methodological triangulation", and it is said to enhance the quality of qualitative research by providing "a more complete picture" and allowing for "higher level interpretations of the data" (Farmer, Robinson, Elliott, & Eyles, 2006, p. 390). We also used a technique called investigator triangulation, where the perspectives of the four authors were brought into the coding and analysis process. The four authors range in age, have different sexualities, social class backgrounds, and theoretical and disciplinary experiences. As with the first author, the other authors were all non-smokers, although one of the authors could be classified as an ex-smoker as she had spent some time socially smoking in the past. Reflectively interrogating these subjectivities was another way the integrity of the study was increased. For example, reflexive journaling allowed the first author to become self-aware of her motivations, assumptions, and biases as a non-smoker who is doing smoking research (Finlay, 2002).

Twenty-seven women participated in the first stage of the study, and 18 of those women went on to participate in the second and third stages. Due to geographical constraints, 35 out of 45 interviews were conducted over the phone, with the remaining 10 interviews done face to face at university campuses across metropolitan Sydney. Participants gave informed consent to participate in the study and gave permission for non-identifying photographs to be included in publications and presentations. Ethics approval was granted by Western Sydney University Human Research Ethics Committee.

Theoretical framework and analysis

In our analysis, we drew on a number of theories which sit within a social constructionist paradigm. This epistemological positioning grounded our understandings of smoking and identity as socially constituted in time and space (Burr, 2015). Our analysis is based on a social constructionist understanding of gender as being done or undone through routine, everyday practices, and stylised acts (Butler, 1993, 2004, 2006; West & Zimmerman, 1987). This understanding of gender is combined with an intersectional approach, a perspective which looks at how multiple categories of identity intersect and interact (Christensen & Jensen, 2012). We adopt what intersectionality researchers refer to as a both/and approach, where we acknowledge both an overall, or "master" category, and the points of intersection where this category meets other identities (McCall, 2005; Warner, 2008, p. 458). In our analysis, we look at how our master category, gender, shapes experiences of smoking, as well as how these experiences are further shaped by intersections with social class or sexuality.

We adopted a method of discourse analysis developed by Potter and Wetherell (1987) which allowed us to consider how young women's understandings of smoking and identity "are constituted in and through discourse" (Wood & Kroger, 2000, p. 2). In preparation for analysis, the interviews were professionally transcribed and
then integrity checked by the first author, at which point participants’ names were replaced with pseudonyms. The process of integrity checking allowed the first author to listen and reread the interview and photography data. Having become familiar with the interview and photography data, a coding frame was developed through consultation within the researcher team. The data were coded by the first author and checked by the second author. The coding summaries were reviewed by the research team, beginning an iterative process of reading and interpreting segments of data, and identifying discursive patterns (Wood & Kroger, 2000). We drew on positioning theory (Davies & Harré, 1990) to help us examine the ways in which participants took up, or were assigned, subject positions in relation to their smoking, and the ways in which these subject positions allowed women to both do and undo feminine identities. We also used the concept of “discursive footwork” to help us make sense of how young women positioned themselves in relation to discourses of feminine smoking. The term “discursive footwork” refers to the way people negotiate challenges to their identity by aligning themselves with a defensible position (Goffman, 1981). Through this process we came to identify four sets of terms, metaphors, and figures of speech that participants used to construct their accounts, what Wetherell and Potter (1988) call “interpretative repertoires”.

This paper explores the four interpretative repertoires participants used to construct their experiences of smoking and the performance of femininities: “cigarettes and smoking styles as gendered”, “smoking as controlling weight”, “smoking as a sexual tool”, and “smoking as compromising appearance”. We examined the ways participants drew on these discursive repertoires to position themselves in relation to discourses of smoking and femininity, looking at how these relate to broader cultural discourses associated with smoking in public health and popular media. Participants’ age and smoking status has been added in parenthesis in order to help contextualise their quotes.

**Findings**

*Cigarettes and smoking styles as gendered*

Young women in the study spoke about cigarettes and different styles of smoking as being gendered, and how the practice of smoking is used to perform feminine identities. Participants differentiated between “a feminine way” and a “guy’s way” of smoking. A masculine style of smoking was described as “aggressive”, “rude”, and “powerful”. Men were said to be more perfunctory in their smoking, taking less time to smoke, often holding the cigarette between their thumb and forefinger, and concealing it in their palm. A feminine style of smoking was said to be “dainty”, “elegant”, and “posh”. Women were said to take their time smoking, holding their cigarettes between their middle and fore fingers, away from their body in a showy, open fashion. For example, Danielle (30, smoker) spoke about the way she smokes in these terms,

> The way that I smoke is very social. Fingers out, and my wrists are showing and I’m chatting with my hands. Sometimes guys smoke like, it’s almost enclosed in their
palm...their body language suggests that they’re sneaking a cigarette. It’s not like that; it’s very open and chatty and— I don’t want to say feminine, but that’s the word that’s coming to mind.

In her account, Danielle positions her smoking as a performance, where she gestures with her body (fingers, wrists, palms) in order to communicate a feminine gender identity (Butler, 2006). Danielle also talks about how this feminine way of smoking is “very social”, drawing our attention to one of the reasons why young women take up, and continue with, smoking (Gilbert, 2007a; Haines, Poland, & Johnson, 2009). A number of participants took photographs capturing this feminine way of smoking (Figure 1), where cigarettes were often featured alongside other markers of femininity, such as nail polish, or sitting with crossed legs (Figures 2 and 3).

These gendered styles of smoking intersected with the performance of class and sexual identities. In participants’ accounts, a woman adopting a masculine style of smoking was associated with a “butch” lesbian identity. For example, Kalika (19, smoker) said, “I’m around a lot more butch women and they hold their cigarettes a very masculine way, like between two fingers like that [gestures with her thumb and forefinger]”. Within a heterosexual matrix, binary understandings of sex, gender, and sexuality mean that women displaying masculine behaviours may be identified as lesbian (Butler, 2006). Performing smoking may therefore serve as a means of outwardly positioning a woman’s sexual identity. For example, Danielle (30, smoker) spoke about smoking as a way for her and her partner to take up butch/femme identities in their lesbian relationship. While Danielle talked about

![Figure 1](image_url). A feminine style of smoking, where the cigarette is held in an open palm, away from the body.
Figure 2. A photograph of a woman holding a cigarette shows another marker of femininity, nail polish.

Figure 3. A photograph of a woman holding a cigarette shows another marker of femininity, crossed legs.
smoking in an “open”, “feminine way”, she said her partner smoked “the guys’ way”, doing more of a “hiding thing”. She said,

I think for me I would, hope sitting myself as the femme fatale with red lipstick and it’s all very sexy and sultry. But, for my partner, who’s quite masculine I think, she would be in that more Fight Club role where it's cool and it goes with the image.

By smoking in a “feminine way”, Danielle positions herself as a “femme fatale”, while her partner uses a masculine style of smoking seen in the film Fight Club to perform a butch identity. In this account, smoking can be seen as a subversive act, as it allows these women to take up butch-femme roles, undoing gender by disrupting dominant constructions of femininity as heterosexual (Butler, 2006). Women’s masculine smoking styles were open to being interpreted in other ways, however. Some participants described women’s adoption of a masculine style of smoking as representative of a lower class position. As Stephanie (29, ex-smoker) said,

That way of holding a cigarette [between the thumb and forefinger] looks really, really seamy and cheap. It doesn’t make you look classy.

Yeah. And, why do you think that is that way for a woman?

I suppose I see it as being a more refined, a more classy type. I think it’s something that some of us need to aspire to and it just looks really horrible, especially for a woman.

Stephanie differentiates between “classy” and unclassy ways of smoking, and in doing so, indicates how smoking might be conceptualised as a classed practice of “distinction” (Bourdieu, 2010, p. 223). Stephanie said that women “especially” should “aspire” to be “classy”. This reference to aspiration suggests a class hierarchy and reinforces the privileged status of a middle-class femininity (Skeggs, 1997). This narrative therefore illustrates one way in which gender and class intersect through doing femininity in the social practice of smoking.

Participants also gave accounts of how femininity was performed and represented through the types of cigarettes participants consumed. The women in the study talked about how cigarettes containing herbal or menthol flavouring were “girls’ cigarettes” (Jing, 24, ex-smoker), and how “cigarette cases”, “skin cigarettes”, and “long cigarettes” were “more feminine” (Danielle, 30, smoker). What is more, as was the case for smoking style, the consumption of certain types of cigarettes was seen to signify a classed femininity. For example, Jessica (22, smoker) talked about how cigarettes in “a white packet with a gold trim” were “sophisticated”. Another woman, Jing (24, ex-smoker), talked about the packaging of the “women’s” cigarettes she used to buy in China, saying, “it looks elegant and looks expensive”. Finally, Tara (24, smoker) gave an account of her sister providing her with “not as strong” cigarettes during high school, as the “harsh” ones were seen to signify a lower social class. These examples show how individuals might be
“driven” to adopt the styles and objects of consumption that are perceived to be the more sophisticated tastes of the affluent (Storr, 2002, p. 32). As with Stephanie’s account of different ways of smoking, the accounts of different types of cigarettes exemplify the way in which class intersects with femininity, and how consumer culture has emerged as a new mode of gender performance (McRobbie, 2007).

Smoking as controlling weight

Within modern Western culture, the creation of a thin body is a significant marker of an idealised (hetero) feminine identity (Bordo, 2003). A number of participants spoke about using smoking to control their weight, and thereby perform femininity. For example, women spoke about smoking providing an “oral fixation” (Jennifer, 26, smoker), saying nicotine was a form of “appetite control” (Lisa), and that they “replaced food with smoking” (Gemma, 25, ex-smoker). One participant, Shannon (23, smoker), said,

I realised that when I binge ate I didn’t smoke during it. So, I was like, “What’s going on there? Maybe if I smoked during that place where I binge eat, then I wouldn’t binge eat, I’d just smoke instead, and that’s fine, right? Because then I’m thin, right? And, that’s where everything’s good.”

Through smoking, Shannon is able to control her binge eating and create a thin body. This leads Shannon to rationalise the implicit health risk of smoking as “fine”, because she is able to socially profit from being thin, saying “that’s where everything’s good”. Shannon’s position is supported by an obesity health discourse where thinness is seen “as a universal good” (Rich & Evans, 2005, p. 346). Conversely, other participants were reluctant to admit to using smoking as a weight control strategy. For example, Megan (26, smoker) said,

I think a lot of people still use ciggies as a replacement to food because there are a lot of super slim people that live around here.

Is that something that you’ve had personal experience with?

I have done in the past. I had an eating disorder for about three years when I was younger. Around the time I started smoking, but I didn’t at that time specifically use smoking as a replacement for food. But I have, definitely, in the past every now and then said “I’m not going to have that meal and I’m going to have a cigarette instead.”

Megan initially distances herself from the use of smoking to control weight by applying this strategy to others. It is only when she is probed that she talks about having done this herself in the “past”, when she was “younger”. Megan’s reluctance could be explained by a desire to present herself as resistant to cultural
discourses associated with thinness and to distance herself from what has been positioned by other young people as an “immature weight-control strategy” (Grogan, Fry, Gough, & Conner, 2009, p. 182).

Putting on weight was a concern in the accounts participants gave of past or future quit attempts. For instance, Shannon (23, smoker) talked about becoming “depressed” when quitting smoking: “I just found whenever I quit I would start eating more, and that would make me really depressed, because then I thought I was getting fat, and then I hated it, so then I’d smoke”. Weight management was also a reason for women to go back to smoking. Jing, an ex-smoker who had quit smoking one year ago, talked about an old photograph (Figure 4) she submitted as part of the study, saying that it showed her looking “really skinny... because of smoking”. She said, “I may think if I want to lose weight, maybe I can go back to smoking”.

However, when asked about whether or not she would go back to smoking, Jing said “I also think being too slim is not beautiful, so maybe now is also good”. Jing talks about how an expanded definition for what is considered “beautiful” for a

Figure 4. “When I see the old photo of me, I think I am so slim because of smoking”.

woman means she does not have to take up smoking again. This account suggests that less restrictive ideas of what constitutes feminine bodies gives young women more space in which to choose not to smoke.

**Smoking as a sexual tool**

A number of participants in the study gave accounts of using their smoking as a tool for performing their sexuality. Within these accounts they spoke about the construction of women’s smoking as sexy: “it’s kind of like sexy for the women to be smoking” (Olivia, 18, smoker). Participants also spoke about the association between women’s smoking and heterosexuality, drawing parallels between smoking, women’s mouths, and heterosexual sex. For example, Shannon (23, smoker) said: “It’s like you have a small penis between your fingers that you’re constantly fellating”. Lisa (26, smoker) remembered smoking when she was younger and this being part of her discovery of her sexual attractiveness. In her account, she talks about accessing cigarettes and alcohol by befriending older men:

The association with smoking is, sort of becoming sexually aware, like realising that these older men would do me favours because they found me sexually attractive, becoming aware that I had a little bit of power... awareness that I wasn’t a child anymore and my friend calls it the ‘power of the pussy’; how women can use the fact that men would like to have sex with them, to manipulate them horribly.

Lisa talks about how her smoking helped her to explore the “little bit of power” her sexual attractiveness offers. In her account, smoking forms part of Lisa’s transition from “child” to sexual woman and is part of her negotiation of contradictory discourses where she is expected to be both “sexually aware” and responsible in using her sexual power (Renold & Ringrose, 2011). Her description of herself as manipulating men “horribly” suggests critical self-positioning, with the acquisition of cigarettes central to her failure to perform responsible feminine sexuality.

A number of women in the study discussed the ways in which the performance of smoking is used to attract potential sexual partners. Megan (26, smoker) talked about how smoking allows people to go into a space that is more conducive to conversation, saying, “a lot of the time that’s how you meet attractive men”. Smoking was also said to be a way for women to attract other women. Brittany (21, smoker) talked about first trying smoking in order to impress a girl she “had a huge crush on”. Kalika (19, smoker) also spoke about this idea of smoking to attract other women:

That’s how you meet lesbians. You go outside for a smoke and then that’s when you can talk to them and yeah it plays a massive part in that... when you see someone smoking I think that it sort of makes them appear as somewhat rebellious and seductive.

This construction of smoking as playing a “massive part” in meeting potential lesbian partners is a potential explanation for why young, single, lesbian women, such as Kalika, might choose to smoke.
In their accounts, the women often drew attention to the contradicting discourse surrounding smoking and sexuality. For example, Megan (26, smoker) took a photograph of a Google image search showing glamorous Hollywood film stars smoking. She spoke about this photograph, saying, “it sounds really gross, but sometimes when you’re all made up, and you’ve got your lippy on and stuff and you have a cigarette, you feel very glamorous and beautiful, like the women in the photos”. In her account, we see Megan qualifies her experience of smoking as “glamorous and beautiful” by saying it “sounds really gross”. Other women challenged the very construction of women’s smoking as a way of being sexual. For example, Julie (31, ex-smoker) describes a photograph (Figure 5) she took, saying:

I just don’t think it looks sexy, it looks trashy, a cigarette hanging out of your mouth, it just looks really trashy, but that’s one of my favourite photos out of all of them because it’s not sexy it’s gross.

In her account, Julie is able to affirm her position as an ex-smoker by challenging the construction of women’s smoking as sexy and reinforcing the stigmatisation of smoking as “gross”. Also, by using the term “trashy”, Julie reinforces the idea that the way in which women smoke is indicative of social class.

Figure 5. “that’s one of my favourite photos out of all of them because it’s not sexy it’s gross".
Some of the women spoke about using their smoking as a tool for negotiating potentially compromised sexualities. For instance, Shannon (23, smoker) says,

I lost my virginity when I was 13... And, it was just a big odd thing about me that everyone knew... And, I guess, smoking for me became another thing that I could call my own, and that was mine. Because, that's the thing, once you, like, "Oh, she's not a virgin anymore," and then all of a sudden you want to have all these other things on you, you know what I mean? Because, you're like... "I can be crazy in all sorts." You know, so I just piled them on.

In the account she offers, Shannon uses smoking as a way to position herself as in control, in the face of the stigma she perceives after losing her virginity at a young age. By actively embracing what she describes as a "crazy" feminine subject position, outwardly signified by her smoking, Shannon is able to position herself as subversive rather than a social or sexual outcast (Lees, 1997). In another example, Lisa (26, smoker) said,

I'd had a massive night and did the walk of shame thing and went to this picnic and my friend's boyfriend was making fun of me, saying that because of, you know, quite dressed up and whatnot, that I looked like I was out of Mad Men, and laughing, saying how I'm such a bogan but for some reason with a cigarette in my hand I'd become really elegant.

Lisa is made "fun of" for being "bogan" or lower class, and her "walk of shame" could potentially have led to a loss of reputation with her being labelled a slag (Bale, 2011). Yet, through her smoking she is repositioned as "elegant", embodying feminine respectability. In both of these examples, smoking is said to help these young women to negotiate the limited boundaries of respectable female sexuality, allowing them to avoid stigma, and to take up a position of sexual agency and empowerment.

**Smoking as compromising appearance**

Many of the women in the study also talked about smoking compromising their physical appearance, and as a result, disrupting their performance of femininity. Participants spoke about how smoking damaged their skin, nails, and teeth, saying, "my teeth are quite yellow... and my complexion is grey" (Tara, 24, smoker), and "if I didn't smoke, I wouldn't be getting all wrinkly" (Lisa, 26, smoker). Lisa took a photograph (Figure 6) of her teeth to show "how damaged they are". The photograph that Lisa took bears resemblance to a smoking cessation image that was featured on cigarette packets in Australia at the time of the study (Figure 7). The similarity between the two images highlights the way in which a discourse of health and smoking cessation campaigns might shape the way women make sense of their smoking (Haine-Saah, 2011) and their bodies.

A compromised appearance, and a spoiled feminine identity, had negative implications for participants' subjectivities. For instance, Tara (24, smoker) said, "I feel
really ugly; it [smoking] makes me feel disgusting”. Another participant, Danielle (30, smoker), said, “I’ve been told that it is not attractive, and I look very unattractive when I smoke, which was hard for me because as a girly girl, that’s kind of very important”. Finally, Courtney (21, ex-smoker) said:

I remember when I used to be getting my eyebrows done and the lady would turn around and say to me, “You smoke.” And, I wouldn’t have even smelled like cigarettes, or had one, and I’d be like, “How can you even tell?” And, she goes, “You can see it in your skin.” And, I hated it. I hated the fact that she could see my skin was through smoking.

In an effort to avoid a compromised appearance, participants spoke about the various ways in which they worked to manage the physical impact of their smoking. For example, Ashlee (21, ex-smoker) said, “I used to have to bleach my fingers to get the nicotine stains off”, while Tara (24, smoker) talked about using whitening toothpastes to remove yellow stains from her teeth. For some women, the impact of smoking on their appearance was a source of motivation for them to quit. For instance, Lisa (26, smoker) said,

I’ve noticed lately that I’m starting to age and it terrifies me and I don’t want to be old, my teeth are getting really very bad, I’m getting all wrinkly, I’m getting the smoker’s wrinkles, you know, the vertical lines on the lips, I’m too vain to be comfortable with that, so I will eventually quit because I don’t know, vanity, I guess, (LAUGHS) will prevail.

Although Lisa talks about “eventually” wanting to quit smoking because of the impact it has on her appearance, she has little discursive space in which to
rationalise this, evidenced by her laughter, and positioning of herself as “vain”. This lack of footing for women to be concerned about their appearance was also evident in other accounts where participants qualified concerns about the impact of smoking on their appearance, saying, “It sounds stupid” (Shayma, 19, smoker), or “I feel really shallow” (Olivia, 18, smoker). This limited space for footwork relates to the lack of entitlement women have to be openly concerned about their appearance, where women’s concerns about appearance are often interpreted as being narcissistic or vain (Fredrickson & Roberts, 1997). Yet, the fact that a woman’s physical appearance has an influence on how she is viewed and treated in society means that this concern for appearance is actually often a strategic way for women to improve their social and economic prospects (Fredrickson & Roberts, 1997).

Participants structured their discourse in order to distance themselves from other women whose appearances are seen to be compromised from smoking. For example, Megan (26, smoker) talked about her mother’s genetics protecting her appearance from the impacts of smoking, saying, “there are genetics that weigh into these things as well. My mum’s been a smoker since she was 18, and she still looks like she’s only 35”. Emily (21, ex-smoker) distanced herself from a smoking cessation campaign that focuses on the impacts of smoking on appearance, by positioning it as being more relevant to other women more concerned about their appearance:

I am still a very natural person; I don’t wear makeup, doing my hair takes about five minutes. But I have friends who spend nearly two hours on their makeup and you
know, if they're being told that smoking is going to do whatever to their appearance, then they're probably going to listen because they value their appearance that much.

Emily is able to distance herself from smoking cessation messaging which portrays a type of idealised femininity she does not aspire to (Haines-Saah, 2011). Participants also positioned the effects of smoking on appearance as only being a concern for “older” women. For instance, Briana (18, smoker) said, “When you smoke cigarettes it ages you, dramatically. It wouldn’t age me now, but as I went on I’m sure it would”. When discussing the effects of smoking on age and appearance, the participants often gave examples, or spoke about people in their 60s, 70s, or 80s, implying that the effects of smoking on appearance can only be seen with lifelong smoking.

Other women shifted between resisting and reinforcing the notion that smoking is unattractive and unfeminine. For example, Tara (24, smoker) said,

Apparently, your skin rejuvenates itself every 35 days... So that's why I try to tell myself, like maybe wrinkles and stuff, won't go, they might fade a bit, but I just feel like, I've been smoking for seven years full-time now. I have to stop now before it does serious damage. It's probably done a lot of damage already. So, the biggest reason obviously is that like an illness and yeah, like what motivates me, but obviously I guess, feeling, like I'm 24, but I feel like I look 30, even though people tell me I look 18.

Tara acknowledges that smoking affects her skin, saying her smoking has “probably done a lot of damage” and that she feels older, but then contradicts this by saying it is not “serious damage”, and that she is told she looks younger. This cycling between confirming and denying that smoking compromises her appearance and femininity is symptomatic of a split vision of smoking.

Discussion

In this study, we examined photographs and interview accounts, in order to understand how young women, both current smokers and ex-smokers, construct smoking in relation to gender, social class, and sexual identities. The ways in which women use smoking to both do and undo femininity can be understood in relation to Bartrky’s (1990) concept of “disciplinary practices”, a feminist adaptation of Foucault’s theory of disciplinary practices and the production of docile bodies. Bartrky (1990, p. 65) describes three disciplinary practices which help construct feminine bodies:

Those that aim to produce a body of a certain size and general configuration; those that bring forth from this body a specific repertoire of gestures, postures, and movements; and those directed toward the display of this body as an ornamented surface.”

The first of these practices, the production of a body of a certain size, relates to the women’s accounts of using smoking to control their weight and maintaining the
thin body shape that is central to traditional notions of idealised femininity (Bordo, 2003; Lissner, 1997). As this study and others (Flussel & Lafreniere, 2006; Grogan et al., 2009; Zucker, Stewart, Pomerleau, & Boyd, 2005) have shown, weight is a concern for women who smoke, making women more reluctant to quit smoking, and more likely to take up smoking again once they have quit. Comparing the consequences of being overweight (such as reduced economic and social opportunities; Fredrickson & Roberts, 1997) with the health risks of smoking, women are able to rationalise their smoking and reject a discourse of health. The idea of women using cigarettes to manage their weight has been reinforced through cigarette advertising and popular media (Tinkler, 2006), and as a result, the association between smoking and weight control is common among women, yet almost absent amongst men (Paul et al., 2010). Previous research has shown that women who have higher levels of body shame are more likely to use smoking as a weight control method (Flussel & Lafreniere, 2006). This suggests that cultivating a more body-positive culture among young women may reduce the number of incentives for them to take up smoking, as well as making it easier for them to quit.

The second of Bartky’s disciplinary practices refers to the construction of femininity through gestures, postures, and movements, as seen in participants’ descriptions of feminine ways of smoking being open and expressive with the body. These types of movements work to undo traditional notions of femininity, where women were expected to constrict their movements, and limit the amount of space they occupy (Bartky, 1990). This undoing of traditional femininity was shown to intersect with performances of butch or femme lesbian identities. This association between smoking and the construction of sexual identities provides explanation for the report that among lesbian women “to be a lesbian is to be a smoker” (Comfort, 2012, p. 212). This finding, combined with the role of smoking in attracting a sexual partner, may also help to explain the higher rates of smoking among lesbian and bisexual women, a propensity that contributes to health disparities between LGBT communities and the general population (ACON, 2015; Fish, 2000).

Bartky’s final disciplinary practice is the production of femininity through the regulation of women’s bodies as ornamented surfaces. In order to produce a feminine body, women must maintain an attractive, youthful appearance, ensuring that the surface of their bodies “betray no sign of wear, experience, age, or deep thought” (Bartky, 1990, p. 69; Skaggs, 1997). Although women are expected to maintain attractive, feminine bodies, this work rarely garners them power, and their behaviour is often positioned as vain or trivial (Bartky, 1990). As has been noted in previous research (Grogan et al., 2009), the women in this study used “othering” as a discursive technique to displace the stigma of smoking and aging onto older women. Grogan et al. (2009, pp. 179–180) note the “interesting tension” between young women taking up smoking as a way to appear more mature, but then having to later manage the negative physical signifiers of aging associated with smoking, such as wrinkles. This is yet another example of the conflicting functions that lead young women to develop a split vision of their smoking.
By conceptualising young women’s smoking in relation to these disciplinary practices, we can consider the subjective and practical implications this might have for identity development and smoking behaviours. If a young woman is able to adopt feminine gestures, postures, and movements when smoking, or is able to use cigarettes as a weight control strategy, her smoking helps her to discipline her body and achieve feminine identities. However, if she is unable to manage the impact of smoking on the surface of her body, she may then be positioned as unféminine and face stigmatisation as a result. These tenuous gender performances were shown to be inseparable from class and sexuality performances. Negotiating the féminine/unféminine, the classy/unclassy, and the heterosexual/ butch elements of their smoking is what leads these young women to feel conflicted about the function their smoking serves and to develop a split vision, and may lead to ambivalence about quitting (Scheffels, 2009).

Some participants rejected traditional notions of femininity and instead of using their smoking to discipline their bodies, they used it to undo gender by performing non-normative femininity. This resistance was exemplified by the women in the study who used their smoking to shift the boundaries of acceptable feminine heterosexuality. However, Badgeon (2014) warns that this type of resistance may be limited and does not always translate into real social change in gender hierarchies. Tinkler (2006, p. 149) also draws our attention to the fact that it is usually only women with a higher class status who have this “leeway” to use their smoking to challenge dominant constructions of femininity.

Smoking cessation campaigns have reproduced the idea that smoking is unféminine through images such as the “ugly older woman smoker” and the “model non-smoker” (Haines-Saah, 2011, pp. 193, 196). These campaigns are often designed in response to studies which show that women are conscious of the impact of smoking on their appearance (Gilbert, 2005). For example, the 2014 Queensland State Government quit smoking campaign shows the aging effects of smoking on Rachael Finch, winner of Miss Universe Australia 2009, and is titled, “If you smoke, your future’s not pretty”. Campaigns such as this perpetuate young women’s anxieties around appearance, reinforce the notion that a woman’s value and worth is tied to her ability to maintain her appearance, create negative stigma for women who smoke, and encourage young women to prioritise appearance over health (Haines-Saah, 2011). As noted in this study, these campaigns present a type of idealised hetero-femininity which for many socially and economically marginalised women is unachievable or undesirable, and can lend them to disengage with smoking cessation messages (Haines-Saah, 2011). Although these campaigns may be deemed a “success” in terms of their potential to make some women quit smoking, they can also have the opposite effect, making women more resistant to quitting, as well as potentially compounding the levels of smoking-related stigma experienced by women (Triandafilidis, Ussher, Perz, & Huppatz, 2016). Based on the findings from this study, we recommend an increase in women-centred smoking cessation programmes that build confidence, work to reduce the stigma young women experience around their smoking, acknowledge the impact of
social and economic structural factors, and tackle young women's ambivalence around their smoking (Greaves, 2015).

Some smoking cessation interventions have recognised the split vision young women have of their smoking. For example, the “Smoke Free, Still Fierce” campaign is designed to empower lesbian, bisexual, and queer (LBQ) women to be “fierce” and to “break-up” with cigarettes (ACON, 2016). The campaign acknowledges the split vision that LBQ women experience, as well as the influence of multiple experiences and identities, saying, “smoking can be a complex, love/hate relationship, enmeshed with identity, mental health and social connections”. The campaign video offers young women alternative ways (aside from smoking) to perform their gender identity, showing women using clothing, hairstyles, and body language to embody both normative and non-normative femininities. The findings from this study highlight the need for approaches such as this, which offer positive gender representations, acknowledge the function of smoking for young women, and recognise the social context in which it takes place.

One of the strengths of this study is the in-depth qualitative approach used to investigate young women’s experiences of smoking and the performance of identities, in both smokers and ex-smokers. By including a photography activity, as well as two semi-structured interviews, participants were able to actively engage with the research process and reflect on accounts of their smoking. The use of an intersectional approach allowed for a consideration of how young women's constructions and experiences of smoking and femininity are shaped by identities beyond gender. We are aware that while gender, social class, and sexuality were made visible, other categories of identity remained invisible. In the future, researchers could explore experiences of smoking and the performance of femininity in relation to other intersecting identities, such as age and ethnicity.

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Note
1. Italics are used to indicate the interviewer’s speech.

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Appendix M: Journal Article 2

An Intersectional Analysis of Women’s Experiences of Smoking-Related Stigma

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Abstract
In this article, we explore how young women encounter and counter discourse of smoking-related stigma. Twenty-seven young Australian women, smokers and ex-smokers, took part in interviews. A sub-sample of 18 participants took photographs to document their smoking experience, and took part in a second interview. Data were analyzed through Foucauldian discourse analysis. Four discourses were identified: “smoking as stigmatized,” “the smoking double standard,” “smoking as lower class,” and “smokers as bad mothers.” The women negotiated stigma in a variety of ways, shifting between agreeing, disagreeing, challenging, and displacing stigma onto “other” smokers. These experiences and negotiations of smoking-related stigma were shaped by intersecting identities, including gender, cultural background, social class, and mothering, which at times, compounded levels of stigmatization. It is concluded that tobacco control measures should consider the negative implications of smoking-related stigma, and the potential for women to experience compounding levels of stigma.

Keywords
gender; interviews; discourse analysis; Australia; qualitative; smoking; social constructionism; stigma; women’s health

From the second half of the 20th century, rates of women’s and men’s smoking in Western countries began to converge, and in some countries, women now smoke just as much, if not more than men (World Health Organization, 2008). In the past decade in Australia, young women have reported a higher rate of daily smoking than their male counterparts (AILHW, 2008, 2011). In addition to the well-established risks of lung cancer and heart disease, there are a number of other health risks linked to cigarette smoking which are unique to women, such as reproductive cancers, iatrogenic consequences, and contraindications with oral contraceptives (Ensrud, Kaufman, Nichter, Samet, & Yoon, 2000). Previous research has explored a range of key psychological and social aspects of gendered smoking (Green, 1996), such as how women use smoking to construct feminine identities (Amos & Bostock, 2007; Gilbert, 2007b) and the role of smoking in social group identities (Amos & Bostock, 2007; Gilbert, 2007b; Mitchell & Amos, 1997). The impact of poverty and social deprivation (Graham, 1987, 1994; Graham, Imskip, Francis, & Harman, 2006), and the role of mothering and caring work (Graham, 1987, 1994) have also been examined. This research has drawn attention to the impact of tobacco denormalization on women’s experiences of smoking-related stigmatization.

Stigmatization refers to the process by which a person’s attributes or behaviors taint their identity or discredit them socially (Cook, 1986). Research looking at the stigmatization faced by smokers has found that smoking-related stigma is enacted through social interaction and self-stigmatization, as well as wider social attitudes and structural policies (Bell, McCullough, Salmon, & Bell, 2010; Brown & Johnson et al., 2015; Farrand & Jeffe, 2006; Kim & Shantahan, 2003; McCaul, Hoet, Edwards, Thomson, & Gifford, 2013; Ritchie, Amos, & Martin, 2010; Stuber, Gales, & Link, 2008). Smokers are almost universally aware of the negative stigma associated with smoking, and although most smokers agree with this stigma, they also disagree, challenge, or only attribute stigma to other smokers (Evans-Polce, Castaldelli-Maua, Schommera, & Evans-Lacko, 2015). For those who do self-stigmatize their own smoking behavior, the consequences are negative feelings of shame, guilt, and embarrassment (Evans-Polce et al., 2015). It is these feelings that many anti-smoking campaigns aim to elicit, in an attempt to reduce smoking.

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behavior (Chapman & Freeman, 2008). However, many individuals continue to smoke regardless of such campaigns, and therefore, have to live with the consequences of smoking-related stigma.

Smoking-related stigma has been examined in relation to multiple identity categories, such as young adults (Scheffels, 2009), social class (Farrimond & Joffe, 2006; Graham, 2012), and mothers (Oaks, 2000; Wigginton & Latham, 2015; Wigginton & Lee, 2013). It is recognized that smoking-related stigma can be experienced differently across social groups. For example, lower socioeconomic smokers tend to internalize smoking stigma, which may mean they are less likely to engage in anti-smoking campaigns and to quit smoking as a result (Farrimond & Joffe, 2006). These studies focus largely on the relationship between smoking-related stigma and a singular identity position, but often discuss the influence of intersecting identities. For instance, Scheffels (2009) focuses on experiences of smoking-related stigma among young women and men, noting that young women can face further stigmatization as a result of their gender and social class identities, with regard to notions of acceptable femininity and “respectability.” The compounding layers of stigmatization faced by these young women suggest the need for further research on women’s experiences of smoking-related stigma which adopts a multidimensional view of identity.

Arguments for the mobilization of stigma in tackling smoking rates are often framed in public health debates by utilitarian ethics of “the most good for the greatest number of people” (Bayer, 2008; Silva, Smith, & Uphar, 2013, p. 411), as social stigma and tobacco commercialization policies are often associated with falling smoking rates (Chapman & Freeman, 2008). However, in Australia, smoking is no longer a widespread behavior. The daily rate of smoking has fallen to 12.8%, having almost halved since 1991 (AIHW, 2014, White, Hill, Staph, & Bovecki, 2003). The highest rates of smoking in Australia are now concentrated among society’s most marginalized groups: single parents, Aboriginal and/or Torres Strait Islander peoples, people with poor mental health, people who are homeless, and people in prison (Australian National Preventive Health Agency, 2013). Australia is internationally recognized for its advanced tobacco control legislation, and was the first country in the world to introduce plain packaging of cigarette packets. This legislative environment has contributed toward growing anti-smoking public sentiment, and the stigmatization of smoking and smokers (Chapman & Freeman, 2008).

Researchers have raised concerns about the impact of smoking-related stigma on individual smokers, as well as on wider social disparities. Although some studies have noted positive individual outcomes resulting from smoking-related stigma, such as smoking cessation, increased intentions to quit, and a decreased risk of taking up smoking again after quitting, smoking-related stigma has also been associated with negative outcomes, such as social isolation and stress, resistance to smoking cessation, and taking up smoking after quitting (Evans-Polce et al., 2015). Thompson, Beato, and Barnett (2007, p. 515) coined the term “smoking islands” to describe a wider social process of “othering” that can result from smoking-related stigma, warning against the ways in which smoking-related stigma can be implemented and reproduced in society. In this article, we look to contribute to the debate about concerns associated with the etiology and efficacy of smoking-related stigma as a tobacco control strategy, by exploring young women’s experiences of smoking-related stigma, and the implications it has for their subjectivity and smoking practices, using an intersectional theoretical framework.

Intersectionality challenges the idea that identity is additive, instead focusing on the interaction of multiple social categories, and how this relates to power and oppression on an individual and structural level (Christensen & Jensen, 2012). Williams and Fredrick (2015) argue that an intersectional approach allows us to develop “a more complete understanding of the experience of stigma” (p. 384). The concept of “intersectional stigma” draws on intersectionality theory to consider the way in which stigma is compounded by axes of identity and inequality (Berger, 2010, p. 24). This concept was originally used to understand how women with HIV can experience multiple layers of stigma resulting from their illness, their status as drug users or sex workers, as well as their gender, social class, ethnic, and sexual orientation positions (Berger, 2010; Logie, James, Tharo, & Losty, 2011). The concept of intersecting stigma, also referred to as stigma layering (Lefcas, Setog, & Leider, 2011), has been used to explore women’s experiences of mental illness (Mizock & Rassirova, 2015), and dominates sex work (Levey & Pinky, 2015). A similar concept, “multiplying stigmatization,” has been used by researchers to discuss the potential for smoking-related stigma to further isolate already socially disadvantaged groups (Farrimond & Joffe, 2006; Graham, 2012; Scheffels, 2009). These studies also noted that compounding smoking-related stigma is often experienced by women. For instance, Farrimond and Joffe (2006) point out the combined stigmatization faced by poor young single mothers who smoke. Although this existing research has shown the potential for women to experience compounding smoking-related stigma, we are yet to fully make sense of how these intersecting identities shape women’s experiences of smoking-related stigma, and the impact this has on subjectivity and smoking practices. In this article, we address the question of how women experience and negotiate smoking-related stigma, adopting a social constructivist,
intersectional theoretical framework. The research questions were as follows:

Research Question 1: How do young women construct and experience smoking-related stigma?

Research Question 2: How do young women negotiate smoking-related stigma?

These questions explore the ways in which young women experience and actively construct, reproduce and negotiate cultural discourses associated with smoking-related stigma.

Method

Design

In this article, we present findings from a study of young women's constructions and experiences of cigarette smoking. Young women, either current smokers or ex-smokers, were involved in in-depth, semi-structured interviews. Participants were then invited to participate in a photography activity and a follow-up interview. This combination of visual and interview methods helped generate insight into the social context in which smoking takes place (Faareb, Olfiffe, Bottrill, & Polkand, 2010). We conducted a Foucauldian discourse analysis, drawing on an intersectional framework and positioning theory to understand how women's smoking is shaped by multiple identities and discourses. Discourse analysis, intersectionality, and positioning theory sit within social constructionism, a theoretical approach which critically questions taken-for-granted understandings of us social world (Burr, 2015).

Participants

To participate in the study, the young women had to have smoked at least 100 cigarettes in their lives. A classification used by the Australian Institute of Health and Welfare (AIHW, 2014) to define smokers. These women were both current smokers (67%) and ex-smokers (33%), although, one of the "ex-smokers" had started smoking again by the time of her second interview. Of the 18 women who were currently smoking, most smoked less than 15 cigarettes a day (56%), with the remaining women either smoking 15 or more cigarettes a day (22%), or not smoking on a daily basis (22%). Participants ranged in age from 18 to 31 years (in Australia, the legal age for purchasing tobacco products is 18), with an average age of 24 years. Participants were purposefully selected from a variety of cultural, social class, sexuality, and mothering backgrounds. Most of the women (63%), identified as Anglo Australian, with the remaining women identifying with Aboriginal and Torres Strait Island Australian, Asian, American, European, Middle Eastern, and Pacific Island cultural backgrounds. When given the following prompts, the participants identified as being from working-class (44%), or middle-class (43%), and upper-middle-class (7%) backgrounds. The highest level of education completed by participants ranged from three years of secondary school (15%), five years of secondary school (33%), tertiary diploma/trade certificate (36%), and university degrees or higher (22%). When asked to describe their sexuality, most of the women selected heterosexual (67%), or bi-sexual (20%), with a smaller number selecting lesbian (7%). Over one quarter of the women had children (26%), and one woman was pregnant at the time of the interviews.

Participants were actively recruited by handing out flyers at train stations and at the start of undergraduate university tutorials. Passive recruitment methods included putting up flyers at tertiary education campuses, and online advertising on Facebook. A brief online survey collected demographic information on the age, culture, social class, sexuality, and childbearing status of potential participants to ensure the selection of a sample which included "multiple categories" of identity (Christensen & Jensen, 2012, p. 110). A total of 197 women completed the survey, and 49 were contacted for the Stage 1 interview, with 27 women accepting the invitation. Eighteen (67%) of those women opted to continue on with the second and third stages of the study. Participants were given a $30 supermarket gift card as reimbursement for their time participating in each of the three stages of research. Ethics approval from the Western Sydney University Human Research Ethics Committee was granted. Participants received an information sheet and signed a form offering informed consent, either physically or electronically.

Procedure

Stage 1. During the first three Stage 1 interviews, a semi-structured interview schedule was piloted, to examine the utility of the questions, the flow of the interview, and any questions that may have been omitted. Following the pilot testing, a broad opening question was added to the beginning of the interview: "Tell me about your experiences with smoking." This exploratory opening question, and a semi-structured style interview were used to encourage participants to play a leading role in constructing the story around their smoking (Graham, 1984). The interview covered participants' experiences with smoking, quitting, and their perceptions of smoking in the media. Participants were asked questions such as, "Can you tell me about when you first began smoking?" and "Have you ever tried to stop smoking?" The interview
focused on smoking in the context of everyday life, in an effort to avoid positioning identities such as "smoker," "woman," or "mother" as distinct entities (Bowleg, 2008). Stage 2. In the second stage of the study, participants took photographs of their experiences with smoking. Participants submitted a total of 157 images: mostly photographs, but also screenshots, and visual designs participants had created themselves. Participants took on average three weeks to complete the activity, using their own personal digital cameras or mobile phones to take the photographs. Prior research has shown that visual methodologies are an effective tool for engaging with young people (Tinkler, 2013). By analyzing young women’s visual accounts alongside their verbal narratives, we were able to explore more of a multidimensional, multisensory understanding of their experiences (Del Buono, 2011).

Stage 3. Once participants had completed Stage 2 of the study, a second semi-structured interview was scheduled at a convenient time for the interviewer and participant. Before the interview participants were sent a copy of their interview transcript from Stage 1, and told that they would be given an opportunity to talk about their accounts. At the start of the interview, participants had the chance to be reflexive, commenting on, and being asked follow-up questions about the narratives they provided during their first interview (Smith, 1994). The participants were then asked about their experiences of taking photographs, before going through and describing each photograph they submitted and their reasons for taking it. The final part of the interview was spent asking participants about their experiences of being involved in the research project and whether there had been any changes to the way they thought about their smoking. Data from this final part of the interview were used to evaluate the effectiveness of the study design for engaging with young women, and is not included in the findings for this article.

Some of the questions participants were asked during the follow-up interview included the following: "Tell me about what it was like taking photographs of your experiences with smoking" and "Talk to me about how you have found the experience of being involved in this research project".

The geographical diversity of the sample meant that most (78%) of the Stage 1 and 2 interviews were conducted over the telephone, with the remaining 10 interviews done face-to-face at university campuses across metropolitan Sydney. As well as allowing for a geographically diverse sample, telephone interviews can aid in the discussion of topics that are sensitive or potentially embarrassing (Novick, 2008). The nature of smoking as a stigmatized activity, particularly in contexts such as smoking during pregnancy, makes it a sensitive topic (Wigginton & Lafrance, 2015). The use of face-to-face interviews allowed for a different type of interaction, where interviewer and participant were able to use facial expressions and body language to communicate. For example, several women used gestures during face-to-face interviews to show the way in which they held cigarettes. However, as reported in previous research (Parten, Ussher, & Perz, 2016), participants generally provided richer accounts in phone interviews. This was most pronounced during follow-up interviews when the physical distance between interviewer and participant meant that photographs were unable to just "speak for themselves," which then led participants to provide fuller descriptions and interpretations of those images. The interviews lasted on average 45 minutes, and were recorded using an audio recorder. The interviews were professionally transcribed, and participants were assigned pseudonyms to maintain anonymity. The data were collected between April 2014 and March 2015.

Analysis A Foucauldian discourse analysis was conducted, focusing on how meaning is constructed through talk, text, and imagery (Tonkiss, 1998). Foucault (1972) was interested in discourse, and how "a certain way of speaking" can convey meaning (p. 193). Interested in the relationship between language and the socio-historical construction of reality, Foucault used the term "discursive formations" to refer to the way in which statements, objects, and concepts are ordered and positioned. This analysis also drew on positioning theory (Davis & Harré, 1990), as a way of understanding the multiple, contradictory subject positions participants took up or were assigned. Positioning theory fits within a social constructionist approach, and helps in making sense of accounts where participants positioned smoking and smoking-related stigma as both positive and negative, or positioned smokers as "other" to their own selves. The analysis followed the steps of Foucauldian discourse analysis outlined by Usher and Perz (2014) and Wúilg (2006). In accordance with this method, the analysis began with the reading and re-reading of the interview transcripts, and the viewing and reviewing of the photographs. This occurred when Triandafyllidou carried out integrity checks of the transcripts, and reviewed the Stage 1 interviews and Stage 2 photographs before conducting the follow-up interviews, as well as further reading of transcripts, viewing of photographs, and discussions among the research team. A subset of interview transcripts were coded by Triandafyllidou and Usher, capturing both semantic and latent content (Braun & Clarke, 2006). Following this
process, a coding frame was then able to be developed. The coding frame was used to structure the coding into thematic areas such as “anti-smoking campaigns and policies.” Using NVivo 10 software, data were organized within this framework through an ongoing process of collapsing and combining codes. For example, the code “smoking and partners” was collapsed, and made a sub-code of “smoking and other people” to separate out data that pertained to women’s experiences of smoking in relation to their partners. Data within each code were summarized, with the aim of identifying discursive constructions. The photographs were analyzed as part of participant’s overall narratives, and offer insight into the material setting in which participants’ experiences with smoking took place (Radley, 2011). In this article, we present four of the discursive constructions that relate to smoking-related stigma: “smoking as stigmatized,” “the smoking double standard,” “smoking as lower class,” and “smokers as bad mothers.” We considered the way in which participants negotiated and positioned themselves in relation to these discourses, the impact of taking up stigmatized subject positions on subjectivity and smoking practice, and how these discourses relate to those available in public health and popular media.

Findings

Smoking as Stigmatized

The “smoking as stigmatized” discourse encompasses the stigma of smoking in relation to moral identity. Many of the women interviewed gave accounts of how their smoking was stigmatized and could compromise their moral status. For example, Sharyn spoke about her relationship with her colleagues at the pharmacy where she works, saying, “They wouldn’t see me as a good person, just because I smoke.” Brittany said, “People would be like, ‘did you know that’s bad for you?’ or ‘seriously, you’re a smoker?’ as if like they thought you were a bad person, and now you’re awful.” For Sharyn and Brittany, their smoking means they are no longer seen as “good” people, and are repositioned as “awful.” This is what Goffman terms “moral stigma,” where stigmatized behavior, such as smoking, leads to “blemishes of individual character” (Goffman, 1986, p. 4). Brittany went on to talk more about the impact of smoking-related stigma on her identity, saying,

I used to be really worried about people judging me because I had a pretty severe social phobia and I got treatment for that about a year ago, but for ages I was still worried about people judging me for smoking. Earlier this year I went to the hospital for depression and after that I just smoked heaps all the time, and I didn’t really care about people, and their response to it. So, it was probably having less anxiety and

also the depression of not caring what other people think and not caring about anything.

Brittany’s account reveals the way in which smoking-related stigma and the judgment of smokers can lead to anxiety and worry, especially when intersected by mental health issues, such as a social anxiety disorder, where a person has a heightened awareness of social judgment and criticism.

One of the ways in which smoking is seen to blight an individual’s moral character is through ideas of dirt and disgust. Participants spoke about being explicitly told, or being made to believe that they, or their smoking, were “disgusting” (Sarah, Megan, Stephanie, Gemma, Lisa, Caro, Tara) or “dirty” (Vivienne). Danielle said, “I’ve had a couple of comments that it stinks.” Some participants agreed with the idea that smoking is dirty and disgusting. For instance, Sarah described the ash tray she photographed (Figure 1), saying, “I hate the smell, yuck. I hate the look of an ash tray as well, they always look so dirty and yuck . . . . But for some reason, it’s just not enough to make me stop.” Even though Sarah applies the stigma of smoking being dirty to her smoking, she claims it does not effect her ability to quit.

Another way in which smoking compromises identity is through notions of addiction and choice. Participants talked about the stigma of being addicted to smoking. Lisa said, “Even if it’s acceptable to smoke, it’s still not acceptable to need a cigarette.” Lisa’s account suggests that it is the lack of control, or the “need” to smoke that is
stigmatized. Participants used a number of techniques to avoid being seen as addicted to smoking. Stephanie talked about monitoring her smoking by thinking to herself, "I really feel like one now, like, how long’s it been? Will it look bad if I have another one when I’ve only just put one out?", while other participants would say to others, "I’m not addicted" (Sarah). However, even when smoking was positioned as a choice, participants still experienced stigma. For instance, Megan said, "There’s just a bit of like free-willing stigma attached to smoking, that people think you’re free to give up at a moment’s notice." Both these notions of addiction and choice had negative implications for women’s subjectivities. Stephanie described the feeling of being addicted to smoking as "embarrassing," and when Caitlyn’s smoking was positioned as a choice, and within her control, but she was still unable to quit, she said, "it makes me feel down on myself."  

Negotiating the stigma of smoking. Participants responded to the "smoking as stigmatized" discourse in a number of ways. Jennifer, a current smoker, positioned this stigma as positive, saying, "it means you’re not to smoke, which is a good thing." By accepting the negative judgment of smoking, Jennifer might be able to avoid accruing further smoking-related stigma (Wigginton & LaFrance, 2015). In contrast, some women disagreed with smoking-related stigma and the negative impact it has on identity, positioning it as a barrier to quitting, saying, "it’s really hard to quit if you’re stressed and worried about people judging you" (Brittany). Several of the women in the study tried to negotiate smoking-related stigma by avoiding being identified as a smoker. For instance, Gemma and Shyama both talked about notwaring cigarettes to "define" them. Sarah used the phrase "closet smokers" to describe people who were able to "pass" as a non-smoker by concealing or managing the visibility of their smoking (Goffman, 1986).

In an effort to maintain a positive aura of subjectivity, some women would hide their smoking from others, or only smokaround particular people or social groups. For instance, Shyama talked about only telling her close friends that she smokes. A number of participants talked about preferring to smoke with other smokers, or preferring to have relationships or friendships with other people who smoke. For instance, Emily said, "I spent more time with the people who didn’t care than the people who did, simply because I didn’t want to listen to it, because it made me feel guilty that I was doing something wrong." In this account, Emily talks about spending more time with people who did not care about her smoking, highlighting how smoking-related stigma can lead women to become isolated from a wider anti-smoking population, as they seek out groups of "dedicated smokers" who continue to smoke, and are resistant to anti-smoking sentiment (Scheffels, 2009, pp. 481, 483).  

A number of women took up subject positions as "considerate smokers" to distance themselves from "other" less considerate smokers. Participants described behaviors that helped characterize them as considerate smokers, such as moving away from others when smoking, asking permission to smoke, and not smoking around children. For example, in her account, Hannah said, "When I see parents with little kids, and they’re holding their kid and they have a cigarette in their other hand. Yeah don’t like that either. If I really think about those types of smokers, no, it’s just really inconsiderate."

By distinguishing herself from "those types of smokers," Hannah positions herself as a considerate smoker. Hannah is what Scheffels (2009) terms a "negotiating smoker," where she manages her identity by distancing herself from smokers who are stigmatized. By following the rules of considerate smoking dictated by different social fields, and condemning the actions of other "inconsiderate" smokers, Hannah is able to negotiate the stigma directed toward smokers and avoid taking up stigmatized subject position. Fewer participants, such as Shannon, wanted to be identified as a smoker. Shannon said, "as a young girl I just always desired to smoke, and I wanted to be a smoker," adding that this was "probably very embarrassing." In Shannon’s admission, we see the impact of stigma on subjectivity, whereby one is embarrassed to identify as a smoker.

The Smoking Double Standard  
"The smoking double standard" discourse examines the stigma of smoking in relation to gender identity, as well as the intersection between gender and culture. A number of the participants referred to a smoking double standard in their accounts, where men’s smoking practices were seen as more acceptable, or desirable, and women’s smoking as less acceptable or desirable. In the following extract, Santa discusses this double standard, saying, "I do sometimes hear a lot of guys saying, ‘It’s the most ugly thing, if I ever see a girl smoking,’ and things like that, while they probably smoke as well." Several participants said that the smoking double standard reflected their partner’s desire to control them, rather than a concern for their health or well-being. For example, Shannon talked about having an ex-partner whose friends smoked, but who "hated" her smoking. Shannon described this double standard as "more of a controlling thing," saying, "he wanted me to be a certain idea he had about what a girlfriend was and what a woman was and she wasn’t a smoker, I guess." These accounts highlight how the smoking double standard
operates as a form of power and control, both within individual intimate relationships, as well as shaping broader social norms around what is considered acceptable behavior for women. Participation's accounts revealed that the smoking double standard is shaped by intersecting cultural identities. For example, Sinta spoke about how women's smoking is increasingly stigmatized in Indonesian culture compared with Australian Western culture. She said,

> But I don't think it's as bad as maybe you know, when I do go to Indonesia I would never be caught dead smoking in front of my family, even though all the men smoke. I still wouldn't just, like the culture and out of respect for my family.

Another woman, Jing, spoke about the smoking double standard in the context of her home country China, saying, Chinese men "don't like girls smoking." Finally, Sharyma talked about the smoking double standard that exists between her and her male partner who smoked occasionally, relating this to their "wog" culture. In Australia, the term "wog" was traditionally used as a racist slur toward people from Southern European, Turkish, or Lebanese backgrounds, although in recent times, younger generations have begun to reclaim the word through ethnic humor (Taolida & Pollard, 2009). Sharyma said, "So in our culture, it's pretty much unacceptable for women to smoke." In these examples, Sinta, Jing, and Sharyma are all faced with compounding stigma due to their gender and cultural identities, which then had implications for their subjectivities and practices. For example, Sinta said she "would never be caught dead smoking" around her family. Sharyma talked about hiding her smoking from her parents and others in her community. Sharyma's photographs show her having to clean traces of cigarette ash from her car (Figure 2), having to throw away a cigarette when she thought someone she knew might see her smoking (Figure 3), and pretending to take a shower so that she can smoke when she is at home with her parents (Figure 4). Sharyma's photographs position smoking as something needing to be contained or covered up, reinforcing the discursive positioning of smoking as unacceptable, for herself, and other women in her culture.

Jing spoke about how the stigma associated with "the smoking double standard" was further amplified by other cultural expectations associated with her gender, saying, "I can't stand the looks of my boyfriend because he needs to marry me. Girls of my age who are Chinese, they have to marry within two years." Jing, who had quit smoking for one year at the time of the interviews, said her decision to quit smoking was partly due to cultural pressure for her to get married, and the fact that her boyfriend wanted her to quit smoking. Jing's boyfriend's tolerance for her smoking declined as their relationship became more established, perhaps reflecting the diminishing appeal of partner's risk-taking behaviors in long-term relationship contexts (Sylwester & Pawlowski, 2011). This was one of the few examples in the study in which...
exposure to smoking-related stigma contributed to sustained smoking cessation.

Challenging the smoking double standard. Several of the women who took part in the study talked about wanting to challenge the double standard that exists between women’s and men’s smoking, and wanting to say “f*ck you” to men who tried to regulate their smoking. For example, Lisa talked about an ex-boyfriend who “smoked like a chimney,” but would get “so angry” with her smoking, saying, “I kind of got a bit, like, ‘f*ck you, I can do what I want.’” Another woman, Danielle talked about her reaction to her boss and friend commenting that her smoking was “very unfeminine”:

I think a part of me ... wanted to say, ‘F*ck you, I’ll smoke whenever I want to smoke.’ But, it did actually impact me and it kind of made me want to stop. And, I did for a little while there.

In another example, Shayma spoke about challenging her boyfriend, who was an occasional smoker, by saying to him, “A cigarette doesn’t define me. I’m not going to lose some self-respect just because I’m smoking.” Danielle says the stigma she experienced has an “impact” on her, leading her to quit smoking “for a little while.” Whereas, Shayma becomes more resistant to the idea of quitting, going on to say, “I don’t like to be told what to do.” These examples highlight the complexity of women’s experiences of smoking-related stigma, where although Danielle and Shayma both challenge the stigma directed toward them, it has different outcomes for their subjective and smoking practices.

Smoking as Lower Class

The “smoking as lower class” discourse focuses on the stigma of smoking in relation to class identity, as well as the intersection between gender, class, and cultural identities. Participants’ narratives revealed how smokers are “othered,” with smoking positioned as a sign of poverty, struggle, and a lack of education. For instance, Sarah, a single mother, said, “It’s my outlet and it’s really the only one that I have. I can’t go and buy myself new clothes every day and do all those things, so I smoke.” Courtney, who identified as being working class, talked about her partner who worked in construction, and the smoking culture among construction workers, saying, “It’s definitely got to do with their habits, ways of life and what they do, like, struggle.” Both Sarah and Courtney position smoking as being an “outlet” to help manage “struggle” in their lives. While Sarah and Courtney position themselves or their partners within this discourse, some participants distanced themselves from it by “othering” smokers. For instance, Chelsea said,

I used to think the people that I saw when I was in high school who smoked, they were not very cool. They were very poor, didn’t come from very good backgrounds, they would have teen pregnancies. They didn’t know any better. It was kind of like they were lower people.

Here, Chelsea acknowledges the stigma associated with smoking being “lower” class, but distances herself from it by applying this stigma to an “other,” “they” who “didn’t know any better.” In another example, Jing, an ex-smoker, also distances herself from “other” smokers by saying,

The traditional Chinese thinking is smokers are really not high educated, but I’m a student now and in the future, I hope my profession will be a university lecturer ... if I’m smoking, it’s not at my level.

Here Jing compares her educational capital with that typically associated with smokers, “othering” them. This discursive technique helps affirm Jing’s identity as an ex-smoker, and might mean she is less likely to take up smoking in the future.

However, Jing went on to challenge the construction of smoking as a signifier of lower social class in Australian culture, by commenting on the association between smoking and social class within a Chinese context. She said,
I think people in Australia are more tolerant than people in China because actually when in China, if they are smoking, people will step she is not in a good profession. She is not well educated or her family’s education is not good. But here in Australia… there’s many well-dressed women and they are also managers, they also smoke.

This example illustrates how the construction of smoking as lower class is culturally bound. Jin is able to minimize the stigma that exists in Australia by comparing it with the further judgment she would receive in China. Similarly, Sinta challenged the idea that smoking signifies a lack of intelligence, by saying, “I know so many smart amazing people that occasionally might have a cigarette or always smoke or whatever it is, so I don’t think it is a judgment or it should be a judgment on a person.” Sinta challenges the idea that smokers lack intelligence by individualizing smokers and offering examples of smokers not worthy of this negative judgment. However, by individualizing smokers, Sinta implicitly agrees with this discourse, implying that there might be “other” not such “smart amazing people” deserving of stigmatization.

Some women spoke about their efforts to avoid being positioned as lower class. For example, Tara talked about her sister controlling the brand of cigarettes she smoked during high school, saying,

After a while, she forced me to change to Winfield Sky Blue, which is the lower, not as strong [cigarettes]. She’s like “Winne Blues are dero, you need to change to not as dero cigarettes and not be so harsh and strong.”

As well as being “dero” (an abbreviation of desirable, inferring homeliness, see Gibson, 2013), smoking high-strength cigarettes is generally positioned as masculine (Dewhurst & Spinks, 2003). Therefore, Tara’s sister worked to protect them from the intersecting stigma of being unfeminine, lower class women. Other women repositioned the stigma of smoking being lower class to their advantage, by using smoking as a tool for creating or maintaining social capital. For instance, Lisa spoke about using smoking to maintain relationships with her childhood friends who were not “particularly bright” and whose lives had gone “apart ways,” now occupying different social positions to her own. She said, “we had different friends and different interests and things like that, but we’d still all hang out and smoke cigarettes.” Another participant, Shannon, spoke about how the stigmatization of smoking helped her to mask her middle-upper-class, Anglo-Australian background, helping her to initiate social interactions with people from different social backgrounds. She said,

If I’m smoking, people who would normally write me off because of the way that I look, feel happy to engage with me because I’m there and I’m smoking and working-class people or indigenous people or whatever, you can have a reason in the space where for whatever reason… that shared community of enjoying a cigarette allows you to just be.

In referring to this “moment in the space,” Shannon acknowledges the power of smoking to transcend social barriers is temporal, and spatially limited. A final example of smoking being used as a tool for social mobility lies in Stephanie’s account of taking up smoking when she went from a “really strict” private school to a state school. She said, going from one end of the scale to the other end of the scale. You’re going to do anything to fit in.” Possessing a certain amount of cultural capital, Lisa with her intelligence, Shannon with her middle, upper class Anglo-Australian background, and Stephanie with her private schooling, these women have the power to tactically repurpose the stigma of smoking being lower class to create and maintain social capital (de Certeau, 2011).

Smokers as Bad Mothers

The “smokers as bad mothers” discourse considers the stigma of smoking in relation to mothering identities, as well as the intersection between gender, mothering, and social class identities. In many participant accounts, women with children who smoked were positioned as “bad mothers,” further evidence of the stigmatization of women’s smoking. Participants spoke about the idea that women were responsible for their children’s health, and that women who smoke are irresponsible mothers. For example, Stephanie said, “I don’t think you can light up a cigarette anywhere without people going, ‘But, you have children. You can’t be smoking.’ Or ‘Let’s try setting a good example for your children.’” In another example, Briana takes responsibility for her son’s future smoking habits, saying, “If your parents do it you think it’s okay. So I don’t want him to get into it either. So that’s another reason to quit.” Here, the idea that women are responsible for their children’s health provides Briana with an incentive to quit smoking.

Participants drew on medical discourse in making themselves responsible for the effects of their smoking on their children’s health. An example of this is where Lisa talked about being responsible for her daughter’s asthma, saying, “smoking’s a respiratory thing, asthma is respiratory, it’s sort of logical to assume that I’ve caused or at least had the disposition and I’ve triggered it by insisting on smoking while pregnant and breastfeeding.” In another example, Ashlee refers to medical discourse surrounding “third hand smoke,” a term which describes the residual chemical residue found in the air, or on surfaces such as furniture or clothing, after tobacco smoke exposure.
(Winicoff et al., 2009). This notion of third-hand smoke is invoked by Ashlee when she describes how her doctor made her responsible for her son’s bronchitis, saying, “My daughter gets cough, and my son gets bronchitis, so the doctor said that’s because you’re smoking, even though I’m smoking outside, they could still smell it on my clothes.” Ashlee described this interaction with her doctor as “frustrating,” illustrating the negative implications of internalizing the stigma of being an irresponsible mother who smokes.

Smoking during pregnancy is subject to severe scrutiny in national health campaigns (Oaks, 2000), which was reflected in participants’ accounts of the surveillance and stigma of mothers who smoke when pregnant. For instance, Stephanie said,

“It makes you look like a really shifty mum. With my first I was in hospital... And, they’re not going to want a heavily pregnant woman downstairs so she can have a cigarette. And, I wasn’t going to ask because can you imagine the look on the nurse’s face? But, it’s done, because the lady beside me used to go downstairs for cigarettes all the time, but I wouldn’t because I’d be a little bit more self-conscious of the way people look at me.”

Stephanie focuses on how smoking would make her “look like a really shifty mum,” imagining “the look” the nurse would have given her, and how other people would “look” at her. This language illustrates the monitoring and surveillance that pregnant bodies, such as Stephanie’s, are subject to (Fineeman, Sanders, & Sagersano, 2015; Wetterberg, 2004). Just as Stephanie observed other women, and was aware of being observed herself, likewise, Linda spoke about how she applied the stigma of smokers being bad mothers to other women, as well as having this stigma applied to herself, saying, “I’d probably look down on parents who smoke, a little bit, so I assume other people will look down on me.” These examples demonstrate the way in which women are both “judged and judge” against discourses of “good mothering” (Goodwin & Happey, 2010, p. 1), applying smoking-related stigma to both themselves and others.

Participants also spoke about the construction of smokers as bad mothers in relation to social class. Stephanie refers to the construction of “low class” mothers in the media, saying, “It’s so socially unacceptable to smoke a cigarette with a child... if you want to portray somebody as low class, you want to portray somebody as not caring, that’s the perfect way to do it.” This notion of “caring,” which Stephanie raises, relates to self-sacrifice and being child-focused, which are traits associated with respectable middle-class mothering (Hays, 1996; Siggins, 1997). Therefore, women who have children and continue to smoke, are seen to be bad mothers, as well as occupying a lower social class. In another example, Danielle discusses the intersection between smoking, mothering, and social class, saying,

“It’s extremely frowned upon, and I think you could actually be abused if you were smoking and you were pregnant. At my auntie’s wedding... there was a heavily pregnant woman who was a second cousin of mine, and she was standing there with a glass of wine in her hand and a cigarette in the other, it was horrible. It was really quite unattractive. Very, very unattractive and I don’t want to sound like a snob or anything, but it seems quite low—Bogan. You know, low socio-economic, a bit... just a bit redneck, I think.”

Danielle’s account draws attention to an additional source of stigma, where pregnant women who smoke are seen to be not only of a lower social class, which she describes as “bogan” or “redneck,” but also “unattractive.” This focus on appearance serves as a visual distinction which helps to class mothers, where a lack of care for appearance is seen to signify a lack of care for children (Goodwin & Happey, 2010).

Negotiating a “bad mother” identity. Some women challenged the stigma of smokers being bad mothers by focusing on how their smoking helped them in their roles as caregivers, a rhetorical technique which has been found in prior research on working-class mothers (Graham, 1987, 1994). For example, Sarah talked about how smoking allowed her to take time out from her sole parenting duties.

“Every hour, every whatever, I’ll sneak outside and I’ll sit down and I’ll put the house up so the kids couldn’t come Catherine... Yeah, so obviously I don’t get to have a smoke every hour or whatever, it’s when I can, you know, if you’re sitting quietly watching TV or something, then I can actually sneak out and have one. But yeah, that would be my reasoning for smoking now, like that five minutes, I can sit down, have a smoke, relax and you know, collect my thoughts or sanity or whatever you want to call it.”

Another participant, Ashlee, said, “You go out for a cigarette and I’d shut the house up so the kids couldn’t come out, and then, it was sort of like me time.” In these accounts, these women challenge the discursive positioning of women who smoke as bad mothers by offering examples of how smoking supports them in their caring duties, and how they protect their children from second-hand smoke exposure by going outside. While she challenges this stigma, Sarah also applies it to herself, talking about having to “sneak” outside, implying that she is embarrassed by her behavior, and that it needs to be hidden.

Quitting smoking presents women with an opportunity to repair a spoiled identity as a bad mother (Wigginon & Lafrance, 2015). Ashlee, an ex-smoker, repositions the
stigma of being a bad mother in her account of her photograph (Figure 5), where she said, “Yeah, that’s me and my kids. I can actually run around with the kids now and not struggle for breath.” In her photograph and verbal account, Ashlee positions herself as an active, involved, and caring mother “now,” as she has quit smoking, helping her to reclaim a “good mother” identity. When asked about her reasons for selecting this photo, Ashlee said, “I was just thinking of reasons why I quit, and reasons why it was good for me to quit.” Here we see that the desire to be a good mother might help affirm Ashlee’s decision to quit smoking and decrease her risk of taking it up again.

Discussion

This article has demonstrated that young women experience and negotiate smoking-related stigma in a variety of ways. These findings highlight the complexity of the stigma faced by women who smoke, and the need to recognize the way in which different identities shape their experiences and negotiations of it. The “smoking as stigmatized” discourse explored how the idea of dirt and disgust comprises smoker’s identities. This physical disgust can translate into a moral disgust (Tyler, 2013), which is especially problematic for women, whose bodies are seen to be indicative of morality (Haug, 1987). The positioning of smokers as physically and morally disgusting is part of “othering,” or what Tyler (2013) terms social abjection, which serves to legitimate state control and regulation of cigarettes and those who consume them. The “smoking as stigmatized” discourse also highlighted the implications of smoking-related stigma for people with mental health concerns, who report twice the rate of smoking than the general Australian population (Australian National Preventive Health Agency, 2013). Previous research has shown that women experience intersecting layers of stigmatization as a result of mental health problems (Mizock & Rustinova, 2015), meaning that smokers who also suffer mental illness are subject to compounding levels of stigma relating to their smoking as well as their mental illness. The discussion of addiction and choice showed how women who smoke can experience additional stigmatization as a result of the social stigmatization that comes with being positioned within neurobiological models of addiction (Budman & Reiner, 2009). Finally, participants’ negotiation of a stigmatized smoking identity through the positioning of smokers as considerate and inconsiderate corresponds with previous research on young women’s smoking (Lennon, Gallis, Owen, & McDermott, 2005).

The “smoking double standard” discourse captured the way in which women’s smoking is judged differently to men’s, how this serves to regulate femininity, and is amplified by intersections of culture and age. This discourse highlights the unequal treatment of men’s and women’s smoking, with women experiencing greater levels of discrimination for their smoking than men (Brown-Johnson et al., 2015), where women who smoke are seen as “tainted,” while men are positioned as “macho” (Bush, White, Kait, Rankin, & Rholpe, 2003). The regulation of women through the smoking double standard forms part of a wider patriarchal culture where women’s bodies and behaviors are surveyed and disciplined to fit within boundaries of idealized femininity (Unsher, 1997). A double standard can also be seen in women’s experiences of quitting smoking, where women may face additional pressures during cessation with regard to weight gain and the maintenance of a thinner, “feminine” body (Sánchez-Johnsen, Carpenter, & King, 2011). The “smoking as lower class” discourse considered how smoking is associated with poverty, a lack of education, and struggle. These findings corroborate previous research which has shown that women’s smoking is sustained by material and social disadvantage (Graham, 1994). There was also evidence that cultural background shapes women’s experiences of smoking-related stigma, with class-related stigma intensifying in some cultural contexts. Although differences in experiences of smoking-related stigma among cultural groups has been established in previous research (Stuber et al., 2009), further research might further explore how intersections of social class and culture shape women’s experiences of stigma. These findings also suggest that access to cultural capital allows some women to be
‘cultural omnivores’, where they have the power to socially profit from engagement in a wide range of cultural activities, including smoking (Alan et al., 2005). This analysis contributes to an existing body of literature which highlights the social and cultural benefits young women can derive from their smoking (Gilbert, 2007a, 2007b; Haines, Poland, & Johnson, 2009).

Finally, the ‘smokers as bad mothers’ discourse explored the stigma that surrounds women who have children and smoke. These accounts demonstrated the way in which women are made responsible for the impacts of smoking on children’s health. This responsibilization might be part of the process by which women are more readily reprimanded for parental smoking (Farrimond & Joffe, 2006; Oakes, 2000), adding to the bias they face in the health care system (Burgess, Fu, & Van Ryn, 2009). The responsibilization of mothers is also seen in public health responses to the consumption of alcohol and other drugs by women during pregnancy (Jos, Permutt, & Marshall, 2003). Although women in the study attempted to challenge smoking-related stigma by focusing on how their smoking helped them in their roles as mothers, they continued to self-stigmatize, which suggests that although mothers can adopt techniques to manage or avoid stigma (Burgess et al., 2009), they are unable to escape it entirely. As previous research has shown (Lennon et al., 2005), this analysis showed that the stigma surrounding “smokers as bad mothers” and the desire to be a “good mother” can serve as motivation for women to quit smoking. However, it is important to note that mothers unable to quit smoking experience significant levels of guilt and shame (Nichter et al., 2008), which can create emotional distance between the mother and the child (Tan, 2016). Furthermore, high rates of postpartum relapse among women who have quit smoking (Mermik & Goldstein, 2015), may be reflective of the temporary motivation that stigma offers to mothers. These findings highlight the complexity in how women respond to smoking-related stigma. Although participants accepted smoking-related stigma, by internalizing it or adopting stigmatized subjectivities, they also negotiated it, by challenging it, distancing themselves from it or repositioning it to their advantage. By challenging, distancing, or repositioning stigma, these women actively resisted this process of “being made right” (Tyler, 2013, p. 4-5). Being stigmatized or self-stigmatizing had negative implications for participants’ subjectivities, associated with reports of anxiety, distress, and embarrassment. Stigma also affected smoking practices, leading women to hide their smoking, or to stop smoking, either temporarily or long-term. This study provides further evidence for the demotivating effect of stigma (Farrimond & Joffe, 2006), as smoking-related stigma led some participants to become more resolved in their smoking, and to seek out communities of smokers. Although a number of participants reported that the internalization of smoking-related stigma was a motivation for quitting smoking, only one woman said this stigma led to successful, long-term cessation. Where participants reproduced or aligned themselves with discourses of smoking-related stigma, we witness the power of social stigma as a form of biopower, helping to govern and regulate health behavior (see Foucault, 1988; Rose, 1996; Thompson et al., 2007). Where participants were able to use this stigma as motivation to quit smoking, or to continue smoking, we witness the success of stigmatization as a public health approach, and where participants resisted being made abject, we see how forms of governmentality can be contested. It is important to also consider the biological basis of nicotine addiction, to which women are uniquely susceptible (Benowitz, 2010), and the role this plays in women’s continued smoking when faced with smoking-related stigma.

Although there were similarities across participants, these women’s experiences of smoking-related stigma were shown to be uniquely shaped by various axes of identity. Participant’s accounts revealed that women experience compounding layers of smoking-related stigma based on intersecting identity positions, such as gender, cultural background, social class, or whether or not they have children. This intersecting stigma was often also applied to women occupying an already “othered” identity position. These findings are in line with previous research which has explored experiences of multiplying smoking-related stigmatization (Farrimond & Joffe, 2006; Graham, 2012; Scherfels, 2009; Thompson et al., 2007). This article has helped to grow this body of knowledge by focusing on women’s negotiation of stigma, drawing attention to the negative impact multiplying smoking-related stigma can have on subjectivity and practice. Although this study has explored a number of axes of intersection, future work is needed to continue to understand intersections of other identities, such as disability, sexual identity, and age. The sample for this study contained women from a range of social class backgrounds; however, one of the study’s limitations was that more than 50% were from middle or upper class backgrounds. Rates of women’s smoking are highest among lower social class groups, therefore, future researchers might also consider studying women’s experiences of smoking-related stigma within a larger sample of women with lower social class backgrounds. These findings have implications for the development and design of anti-smoking responses. In Australia, attention is now turning toward reducing disparities in smoking rates, and managing the impact of smoking-related stigma on already marginalized populations (Australian National Preventive Health Agency, 2013). As other
researchers have noted (Graham, 2012; Graham et al., 2006; Kandel, Grisler, & Schaffran, 2009), tobacco control intervention and funding could be better directed into policies which "engage directly with social inequalities" (Graham, 2012, p. 95), working to improve the material and social well-being of those populations most likely to smoke. This would mean a turn toward tobacco control interventions which address the social context in which smoking takes place, by working to reduce the social and structural inequalities in income, education, and health care which frame the lives of the majority of women who smoke. By targeting certain groups of women, interventions can address specific economic and social barriers to quitting. Anti-smoking rhetoric in the media, as well as that which is used by health care professionals, can avoid reinforcing smoking-related stigma by focusing on the positive aspects of quitting smoking.

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Appendix N: Journal Article 3

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‘It’s one of those “It’ll never happen to me” things’: young women’s constructions of smoking and risk

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In this article, we examine how young women make sense of the risks associated with smoking cigarettes. We recruited young women smokers and ex-smokers living in Australia in 2014 and 2015 to participate in semi-structured interviews and a participant-produced photography activity on young women’s experiences of smoking and smoking-related risk. We analysed the data using discourse analysis to examine how young women positioned themselves in relation to smoking-related risk, and how this was shaped by discourses of health, risk and femininity. We identified four dominant interpretative repertoires: ‘the risks of smoking are self-evident’, ‘it’s not going to happen to me’, ‘smoking as a lesser evil’ and ‘smoking to cope with stress and emotion’. Through our analysis, we found that by drawing on these repertoires, participants were able to position the risks of smoking as both acceptable and unacceptable. Participants also made use of several of these repertoires to position anti-smoking messages as ineffective. We place these findings in the context of broader health and risk discourses surrounding young women’s use of smoking to reinforce and subvert representations of ‘respectable’ femininity. We identify ways in which public health approaches could and should be developed to recognise the complexity and contradiction inherent in young women’s lay accounts of smoking-related risk and situate smoking risks in the context of young women’s everyday lives.

Keywords: smoking; risk; risk perception; discourse analysis; photography; young women

Introduction

The risks of smoking, particularly for young women, are well established. Despite this, young women continue to smoke cigarettes. In this article, we examine the way young women position themselves in relation to smoking-related risk and how this positioning shapes the way young women engage with anti-smoking discourse. Our findings have implications for our understandings of how young women’s ‘risky’ health behaviours relate to notions of ‘respectable’ femininity.

Young women’s experiences of smoking and risk

Despite significant declines in smoking prevalence in major industrialised countries, smoking among specific groups, such as young women, continues to be problematic. For example, in Australia, young women begin smoking at a younger age than young men (AIHW, 2017). The

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major health risks associated with smoking are all-cause mortality, death from cancer and circulatory and respiratory diseases (Iversen, Fielding, & Hamufooi, 2013). Young women smokers experience additional health risks which relate to their use of oral contraceptives, their fertility and pregnancy outcomes (Einstor, Kaufman, Nieter, Suner, & Yoon, 2000). Young women who smoke also have an increased risk of developing breast cancer, although it has been shown that young women have limited knowledge about this risk (Bottorff et al., 2010). Public health campaigns often rely on stereotypical representations of gender and femininity to communicate messages about smoking risks, such as breast cancer (Haines et al., 2010). These studies highlight the need for additional research on young women's perceptions of the risks associated with smoking, in order to improve the policy and programmes targeted at them.

Western societies are characterised by growing uncertainty and an increasing preoccupation with identifying and managing risk, particularly in relation to health and illness (Giddens, 1991). Knowledge of the health effects and addictive nature of cigarettes has contributed to a widespread cultural construction of smoking as a risky behaviour (Lupton, 1995). Understandings of smoking and risk in Western societies are shaped by neoliberal discourses of 'healthism', where health is seen to be a matter of individual responsibility, and behaviours such as smoking are considered to be an internally imposed risk resulting from poor personal lifestyle choices (Petersen & Banton, 1997). Individuals are positioned as agentic, rational and responsible actors, who, when equipped with knowledge about the risks of smoking, will work to avoid these risks by quitting smoking (Lupton, 1995; Miller & Rose, 2008). Smokers who do not quit are at risk of experiencing stigma as a result of their continued smoking (Triandafyllidis, Ussher, Perz, & Huppatz, 2016).

Public health campaigns often draw on a traditional biomedical model of health and risk communication, treating smokers as rational consumers who need to be informed about smoking-related risks identified in medical and scientific research (Gilbert, 2005). These campaigns tend to present an individualised view of health, where smokers are positioned as a risk to themselves and others (Lupton, 1995). However, research has shown that exposure to risk discourses does not always lead to successful smoking cessation and, in some instances, can be counterproductive, leading smokers to develop a sense of helplessness or resentment and may make them more resistant to quitting (Bond, Bough, Sparling, & Hayman, 2012). Smokers often resist the construction of smoking as risky by casting doubt over the validity of smoking risk information (Peretti-Watel, Hafid, & Grémyn, 2007) and by adopting self-exempting beliefs which work to deny their personal vulnerability (Chapman, Wong, & Smith, 1993). For example, smokers rate their personal risk of lung cancer as less than that of the average Australian smoker (McMaster & Lee, 1991).

Researchers have found that age influences the way smokers engage with smoking-related risk discourses. Young adult smokers are more likely than older smokers to underestimate the risk of developing disease as a result of smoking (Lee, 1989). They also contest the validity of the link between smoking and illness (Gough, Fry, Grogan, & Conner, 2009) and minimise the risks of smoking in relation to other risky behaviours, such as alcohol and other drugs (Jameson & Romer, 2001). Young adults are able to present themselves as being invulnerable to the risks of smoking by positioning their smoking as a temporary practice (Gough et al., 2009), and arguing that the impacts of smoking on health are only associated with long-term smoking (Denscombe, 2001). Young adults are more likely than older adults to be non-daily or social smokers, and to hold the belief that non-daily smoking does not carry significant risk, which minimises their perception of risk (Schae, Glantz, & Ling, 2009). Young adults are also likely to
underestimate the addictiveness of tobacco and overestimate their ability to quit (Romer & Jamieson, 2001). Although young adults are often dismissive of the risks when they first begin smoking, once they take up regular smoking, as their awareness of risk increases, as does their intentions to quit (Romer & Jamieson, 2001). This suggests that young adults have a distinctive experience of smoking-related risk, which must be better understood in order to provide smoking cessation support to this age group.

Emphasising the perceived benefits of smoking is another way smokers mediate their perceptions of smoking-related risk (Gough et al., 2009; Helweg-Larsen, Tobias, & Cerban, 2010). In her study of young women smokers, Gilbert (2005) uses the phrase ‘risk profiling’ to describe how young women justify the risks of their smoking in relation to the benefits. A number of researchers have shown that women position their smoking as a way of coping and being resilient. For example, young women talk about using smoking to suppress or reduce negative feelings, to numb emotions or to elicit positive feelings (Haines, 2008). They argue that smoking provides support, comfort, companionship, as well as offering predictability and consistency (Greaves, 1996). The idea that smoking is a way for women to manage emotions, stress and loneliness has been reinforced through both television and film (Tinkler, 2006). Among young women specifically, smoking is said to be a way of constructing identity and negotiating social relationships (Cullen, 2010; Gilbert, 2007a; 2007b; Haines, Poland, & Johnson, 2009; Triandafilidis, Usher, Perz, & Huppertz, 2017), as well as managing anxiety (Copeland, 2003), relieving boredom (Barwell & Young, 1993; Haines, 2008) and coping with stress (McDermott, Dobson, & Owen, 2006).

Commentators have used a range of social and psychological theories, such as cognitive dissonance theory to understand the ways in which individuals negotiate smoking-related risk. McMaster and Lee (1991) have used cognitive dissonance theory to examine the rationalisations and distortions of logic which smokers use to manage the dissonance between their smoking and their belief that smoking is risky. However, these theories often conceptualise the decision to smoke as rational, conscious and independent of social, cultural and material influences. Alternatively, smoking can be conceptualised within a poststructuralist analytical framework, where language and discourse are seen to shape meaning and influence subjectivity (Weedon, 1997). Poststructuralist theories have gained popularity among those researching young women’s smoking (Gilbert, 2007b) and have been used in a study of young women’s perceptions of risk in relation to anti-smoking campaigns (Gilbert, 2005). In this article, we use poststructuralist theory, to better understand how young women position themselves in relation to smoking-related risk, in the context of social and cultural discourse associated with health, risk and femininity.

Methods

In this article, we report on findings from a multimodal qualitative research study, which involved both interview and participant-produced photography data. Previous research has shown that smokers and ex-smokers understand risk differently, with former smokers having higher awareness of smoking-related risk than current smokers (Weinstein, 2001). Therefore, we draw on the perspectives and experiences of both smokers and ex-smokers in this article.

Design

This study involved three qualitative elements. We started with telephone and face-to-face interviews with 27 young women. Following those interviews, 18 of these women chose
to participate in a photography activity, where they were invited to take photographs of their experiences of smoking. Follow this, we re-interviewed all 18 of the women to follow up issues that arose in the first interview and to discuss their photographs.

We used semi-structured interviews to direct the conversation towards women’s experiences of smoking and risk, while enabling participants to redefine this topic and generate new insights into these experiences (Willig, 2008). We also included a participant-produced photography activity in the research design, to provide another mode of communication, and a fuller account of participants’ experiences. The photographs helped us to situate participants’ experiences of smoking-related risk within the contexts of their everyday lives (Roberson, Gifford, McMichael, & Correa-Velez, 2016). The ‘everydayness’ of participants’ photographs also helped to elicit greater depth and detail in the follow-up interviews (Pilcher, Martin, & Williams, 2015). By triangulating interview and photography methods, we were able to explore the ‘convergence, complementarity, and dissonance’ in young women’s accounts of risk in relation to their smoking (Farmer, Robinson, Elliott, & Eyles, 2006, p. 378).

Participants

We recruited 27 young adult women, aged 18–31 (average age, 24) for the first stage of our study. We used flyers to advertise the study and invite young women to talk to us about their experiences of smoking and quitting. These flyers were distributed at train stations, university classes, tertiary education campus noticeboards and through social media advertising. To take part in the study, participants had to meet the Australian Institute of Health and Welfare’s (AIHW, 2014) definition for smokers, which is having smoked at least 100 cigarettes in their lives. We recruited 18 women who currently smoked (67%) including 4 who smoked 15 or more cigarettes a day (22%), 10 who smoked less than 15 cigarettes a day (56%), and 4 who only smoked occasionally (22%).

The remaining nine women (33%) defined themselves as ‘ex-smokers’ who had quit smoking prior to commencement of the research. Participants’ length of cessation ranged between 2 weeks and 2 years.

Seventeen of the women were Anglo Australian (63%), while the remaining women identified as being from Aboriginal Australian, Asian, American, European, Middle Eastern and Pacific Island cultural backgrounds. When asked to describe their social class background, 12 participants identified as being from working-class backgrounds (44%), 13 from middle-class backgrounds (48%) and 2 identified as having an upper-middle class background (7%). Eighteen women described themselves as heterosexual (67%), seven as bisexual (26%), and two women identified as lesbian (7%). One woman was pregnant at the time of the study, and seven of the women had children (26%). All of the women were living in Australia at the time of the interviews. A total of 27 women participated in the first stage, with 18 women opting to continue on to the second and third stages.

Procedure

In the first round of interviews, we invited the women to talk about smoking, quitting and representations of smoking in the media. We started the interview by asking ‘Tell me about your experiences with smoking’. This broad, opening question was intended to put participants at ease and build rapport, as well as allowing them to set the agenda for the interview (D’Cicco-Bloom & Crabtree, 2006). During the interviews, we asked
participants open-ended questions such as, ‘Can you describe what it feels like to smoke cigarettes?’ The use of open-ended questions helped to create a focus on narrative and experience and establish a less formal interview interaction (Willig, 2008).

Following the interviews, we invited participants to take photographs of their experiences of smoking. We asked them to imagine they were taking photographs for an exhibition titled ‘Smoking through the eyes of young women’. We gave participants some prompts to guide them. For example, we suggested that participants might like to photograph ‘a place where you like to smoke’. Participants took on average 3 weeks to complete the photography activity, submitting 157 images in total. Participants had the freedom to take photos of aspects of their experiences which they felt were important to them, while the prompts worked to direct participants towards topics which were relevant to our research questions.

We then followed up the photographs with a further round of interviews. In these interviews, we invited the participants to talk about their first interviews, their photographs and their experiences of being involved in the study. We asked them questions such as ‘What does this photograph mean to you?’ and ‘Tell me about what it was like taking photographs of your experiences with smoking’. In this interview, we asked participants to provide interpretations of their first interviews and their photographs and encouraged them to collaboratively contribute towards the analysis of their data (Jenkins, Woodward, & Winter, 2008).

The initial and follow-up interviews took 45 min on average. Given that some of the participants lived some distance from the institution hosting the research, most of the interviews (35 out of 45) were telephone interviews. Researchers have observed (Trier-Bieniek, 2012) that interviewees often provide rich accounts in telephone interviews, especially when discussing stigmatised behaviours, such as smoking. We gave all participants an information sheet and all participants provided written agreement to take part in the study. The study was granted full ethical approval by Western Sydney University Human Research Ethics Committee. All the interviews were conducted between April 2014 and March 2015. In this article, we use quotes from the interviews but have replaced participants’ names with pseudonyms. We include the age and smoking status of participants to help contextualise quotes.

Analysis

We used poststructuralism, positioning theory and discourse analysis to analyse the interviews and photographs. Poststructuralism is a theoretical approach which challenges structuralist notions of the subject as fixed or contained and conceptualises identity as being multiple and fluid (Weedon, 1997). This theory allowed us to consider young women as capable of maintaining multiple, contradictory subjectivities, such as ‘smoker’ and ‘responsible and risk adverse’. The terms ‘subject’ and ‘subjectivity’ are used in poststructuralist theory to refer to the way individuals are understood by others and the way they understand themselves, through discourse (Weedon, 1997). The term discourse refers to ‘a set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events’ (Burr, 2015, pp. 74–75).

We explored subjectivities and subject positions using positioning theory, examining how language and discourse produce multiple ‘positions’ within social interaction, and considering individuals’ negotiation of these positions (Davies & Harré, 1990; Lock & Strong, 2010). Using positioning theory, we were able to consider how participants
positioned themselves in relation to social and cultural discourses around femininity, health and smoking-related risk.

We used Potter and Wetherell (1987) method of discourse analysis as it focuses on the construction of discourse through linguistic resources, such as ‘interpretative repertoires’ (Wetherell & Potter, 1988). Interpretative repertoires are a ‘culturally shared tool kit of resources’ that include metaphors, tropes or figures of speech that speakers can draw on to construct accounts (Burr, 2015, p. 69). For example, researchers have identified peoples’ use of the phrase ‘everything in moderation’ to make sense of conflicting health advice in relation to diet and heart disease (Lupton & Chapman, 1995).

In preparation for the analysis, we used the services of a professional transcriber to produce text versions of all the interviews, which we checked for accuracy. Triandafilidis and Usher coded a subset of the interview transcripts and identified both semantic and latent themes in the data (Braun & Clarke, 2006). These themes were discussed with Perez and Calgary and a coding frame was developed, which Triandafilidis then used to code the remaining interviews and photographs. This was a dynamic process, with codes continually being collapsed and combined. Participants’ photographs were coded alongside their interviews in order to identify key themes in the images (Rose, 2016). Following coding, the data within each code were read and reviewed and commonalities and differences within coded categories summarised. Using these summaries, we were able to identify patterns in the data through an iterative process of reading, viewing and analysing each segment of data (Wood & Kroger, 2000). We paid particular attention to the detail of language used and to the variation, inconsistencies and differences in how participants’ constructed smoking-related risk and negotiated and resisted subject positions associated with smoking and risk (Wetherell & Potter, 1988). For example, after several readings of the data coded in the category ‘smoking and health’, we identified the phrase ‘it’s not going to happen to me’ as reoccurring in participants’ accounts. Having identified this repertoire, we then examined the implications of this talk.

We used Rose’s (2016) Discourse Analysis I to analyse the photos. We paid close attention to detail, complexity and contradiction, both within the photographs, between the interview accounts and the photographs and between participants’ photographs and broader social discourse on smoking and risk. For instance, we considered how participants’ photographs compared to representations of smoking in tobacco advertising and anti-smoking campaigns. When we looked at participants’ photographs, we did not seem them as representations of any specific truths or reality about young women’s smoking, but rather as representations of participants’ experiences with smoking made visible to the researchers within the context of the study (Pilcher et al., 2015).

Findings

The risks of smoking are self-evident

Participants in the study positioned themselves as knowledgeable about the risks associated with their smoking, describing the risks of smoking as self-evident: ‘we’re not stupid, we do know’ (Jessica, 22, smoker); “it’s a lot of common knowledge … everyone knows it’s bad for you” (Sinta, 19, smoker). Rachel (21, smoker) said:

You’ve got warning signs all over a packet of cigarettes. You’ve got signs everywhere. You’ve got restrictions everywhere. You pay extra tax as a smoker. And you’ve also got the ads that were on TV for a long time. Yeah, obviously we know it’s bad for us. What have I been living under a rock this whole time?
Another young woman, Briana (18, smoker), represented herself as knowledgeable about the risks of smoking in an image she submitted for the photography activity (Figure 1). She created the image by compiling photographs of health warnings on her cigarette packet, with text and emojis, which warn that smoking ‘kills’, is a ‘dirty habit’ and ‘damages your gums and teeth’. In her account of the image, she commented:

I’m sure back when my mum started smoking they didn’t have as much knowledge about it as they do now. They didn’t think it was as bad as it actually is. Now the statistics on it show that smoking is pretty much the number one killer when it comes to dirty habits.

In her photograph and account, Briana took a position as knowledgeable about the health risks of smoking and distanced herself from other, less knowledgeable smokers from previous generations. Drawing on this repertoire, these young women were able to take up positions as rational, knowledgeable, risk-aware and health-conscious, in an attempt to maintain a responsible identity and minimise further judgement for their smoking.

‘It really has no impact on smoking’: knowing the risks and continuing to smoke

Taken up subject positions as knowledgeable and rational in relation to the risks of smoking meant that participants had to draw on particular discursive strategies to manage their inconsistent smoking subjectivities. One strategy participants used to cope with this dissonance was to position themselves as indifferent to information about the risks of their smoking. For example, Kalika (19, smoker) asserted that ‘regardless of all the people that were saying it’s really bad and it’s carcinogenic and whatever, that didn’t really influence

Figure 1. ‘Smoking is pretty much the number one killer when it comes to dirty habits’.
me that much'. In particular, participants positioned themselves as indifferent towards anti-smoking messaging. For instance, Stephanie (27, ex-smoker) said,

We know its negative effects, but, it really has no impact on smoking. I don’t think you’re going to get somebody that’s seen the ads on TV and knows what’s going on to say, ‘When I saw the ad and it really hit home, so I just quit that day’.

Another participant, Shayma (19, smoker), took a close-up photograph of a cigarette packet (Figure 2). She described the photograph, saying, ‘I just took that to show that I’m not annoyed by that packaging … it’s just a issue, it’s not even disgusting, it doesn’t annoy me at all’. In both her photograph and account, Shayma took up a position of indifference, showing herself to be unaffected by her exposure to the graphic health warning. Other participants positioned themselves as defensive and defiant. Shannon (23, smoker) described a friend who would tell her how ‘bad’ her smoking was, saying ‘it just made me want to smoke more. I wanted to smoke in her face’. Another woman, Sinta (19, smoker), said,

I’ve heard a lot of times even when I am out in a social setting, you know, ‘that’s not really good for you’, ‘that’s going to give you cancer’, or ‘that’s so disgusting, that stinks’, and sometimes I’ll just pull it out and be like, ‘I’m going to have my cancer stick’ just so I rip it in the bud.

Figure 2. ‘It doesn’t annoy me at all’.
By describing her cigarette as a ‘cancer stick’, Sinta claimed that she was able to ‘put up a shield’ and take up a defensive subject position in response to warnings about the risks of smoking. These accounts captured these young women’s attempts to reconcile their knowledge about the risks of smoking with their continued smoking and to make sense of these apparently contradictory positions by being unaffected or resistant to information about smoking risks.

‘It’s not going to happen to me’

Another way participants minimised the dissonance between their smoking and their knowledge of smoking-related risks was to take up a position as personally immune to risk, using the repertoire that the negative effects of smoking were ‘not going to happen’ to them. As Kalika (19, smoker) observed, ‘you just think that it’s not going to happen to you, you’re not going to get lung cancer, you will be fine’. Another woman, Sarah (28, smoker), said ‘everyone that I know, is like “it’s not going to happen to me”’. Participants gave a number of different explanations for why they thought the risks of smoking were not pertinent to them. Some participants talked about not physically seeing the effects of smoking on health: ‘you just think to yourself, “it’s not going to happen to me” because you don’t actually see it every day’ (Kalika, 19, smoker). Talking about her parents, older sister and other family members who smoke, Briana (18, smoker) noted, ‘they don’t look like they have any health problems or anything, so I just thought, they can do it, I can probably do it as well’. Another woman, Sarah (28, smoker), stated, ‘All of my friends smoked, some of them heavily, through their pregnancies, and their kids are spot on’. These accounts highlight how young women can prioritise material evidence and embodied knowledge over official risk discourses, and how an absence of observable health consequences allows some young women to dismiss claims regarding the risks of smoking. Conversely, participants also drew attention to visible smoking risks. Chelsea (20, smoker) captured visible evidence of the health effects of her smoking in a close-up shot of an ashtray (Figure 3). She described the photograph, saying, ‘kind of like a graveyard of cigarettes. Maybe there’s a metaphor there for the health impact?’ Chelsea’s photograph is reminiscent of anti-smoking advertisements which often use ashtrays to symbolise the health risks of smoking. For instance, one of the graphic health warnings featured on cigarette packets at the time of the study shows an ashtray, with the slogan ‘Quitting will improve your health’ (Figure 4). Chelsea’s photograph and account highlight how young women might draw on anti-smoking imagery to make sense of the health risks and potentially challenge a position of immunity to risk.

Other women avoided being positioned as ‘at-risk’ by locating their smoking within a context of an otherwise healthy lifestyle. Sinta (19, smoker) said that smoking is ‘probably my only bad, or detrimental habit that I have’, and Shannon (23, smoker) told us when she took up smoking she ‘started to do lots of exercise’ and started reading things like, “Can you be a healthy smoker?” and “Can you supplement all the vitamins you lose from smoking by doing all these other things?” By taking up other ‘healthy’ lifestyle practices, Shannon worked to challenge the discourse that smokers are unhealthy and presented herself as seeking healthiness through self-knowledge and self-improvement, repositioning herself as responsible for her health. Participants also distanced themselves from other ‘at-risk’ smokers, such as ‘heavy’ smokers: ‘maybe because I was never a heavy smoker, I never thought that sort of thing would happen to me’ (Gemma, 25, ex-smoker); ‘I have to be smoking a deck [a packet of cigarettes]
a day for something bad to be happening to me, so that’s why I’m not that worried’ (Shayma, 19, smoker). Some participants described the risks of smoking as only applying to older, life-long smokers, positioning themselves as being too young to experience negative health effects: ‘I don’t really care about the health risks because the majority of people who smoke and get cancers are probably a lot older than 21’ (Brittany, 21, smoker).

The ‘it’s not going to happen to me’ repertoire was also used by participants to position anti-smoking messaging as ineffective. For example, Paige (30, ex-smoker) said,

You watch it on TV and because I haven’t been smoking for as long as they have for instance, they’re a mother with four kids and they’re in their late 40s and you think, well, I’m not in my late 40s and I don’t have four kids and I probably didn’t smoke as much as you, so it’s not going to happen to me.

By associating poor health outcomes with heavy, older and life-long smokers who are responsible for the health of their children, Paige minimised her perception of her own personal risks. Paige went on to describe how her perceptions of anti-smoking messaging shifted, depending on her desire to quit or continue smoking: ‘I found that unless I wanted to quit, I wasn’t really paying attention to any of that. A little bit
of, like, that’s not me, it’s never going to affect me syndrome’. Another woman, Sarah (28, smoker), gave a similar account of her responses to anti-smoking messages. She said, ‘even on the cigarette packets when you see the photos, [you think] “it’s not going to happen to me”’. Sarah took a photograph of a packet of cigarettes and lighter (Figure 5). She described the photo saying, ‘I don’t even know what that picture is on the packet. I wouldn’t have even taken notice of it obviously’. The out-of-focus cigarette packet shown in the photo reinforces Sarah’s account of being able to distance herself from the graphic health warnings about the risks of smoking. Olivia (18, ex-smoker) offered a different account, saying that anti-smoking campaigns challenged a ‘it’s not going to happen to me’ repertoire, and her resulting perceptions of immunity. She said,

I think they’re quite effective. Every time I saw one it would remind me that I had to stop because I didn’t want to keep going and just think nothing would happen to me because you could see by all like the images and stuff, that stuff does happen.

This account highlights how challenging the belief that ‘it’s not going to happen to me’ may help young women who are in the process of quitting smoking.
Smoking as a lesser evil

Another way participants minimised the inconsistency between their smoking and their knowledge of its risks was to position it as ‘lesser’ in relation to the multiple risks or ‘evils’ they were exposed to in their lives. For example, Lisa (26, smoker) spoke about the risks she was exposed to growing up in a remote, low socio-economic town which she described as ‘a horrible little place’ with ‘massive problems’, such as welfare dependence, drug and alcohol issues and domestic and family violence. Talking about smoking within this context, she said,

It doesn’t really matter if a child is smoking, because there’s definitely more horrible things that people are doing. If your 14-year-old daughter is smoking cigarettes, then that’s probably not so bad because her 13-year-old friend is about to have a baby, so it’s a lesser of two evils sort of thing.

Smoking was also positioned as a lesser evil than poor mental health. For example, Brittany (21, smoker), articulated her concerns about the risks of smoking in relation to her experiences of depression: ‘I’ve gone through a lot of stuff and I don’t think smoking is that bad compared to a lot of the other stuff I’ve had to go through’. Brittany explained how a ‘smoking as lesser evil’ repertoire was reinforced by other people in her life: ‘because everyone knew that I had depression, they weren’t going to back on me for my smoking, because I had bigger issues that were more important’. By situting the risks of smoking among other, more harmful evils, young women are able to minimise or dismiss the risks of their smoking. Here, young women accept this position of ‘at-risk’ but position this state of risk as not being primarily attributable to smoking.

Alcohol was an ‘evil’ many participants discussed in relation to their smoking. For example, Vanessa (22, smoker) compared the risks of smoking to alcohol saying, ‘I don’t think smoking is as bad as alcohol’. Jessica (22, smoker) described a photograph (Figure 6) she took when she was ‘drinking and hanging out with friends’. She described her interactions with one friend that night, saying,
Every time I lit up a cigarette she'd just go, 'smoking kills, smoking kills,' blah, blah, blah, and in the end, I was just like, 'yeah, you know what else kills, drinking so much'.

The acceptability and ubiquity of alcohol is shown by its overwhelming presence in the photo, and the comparative unacceptability or unpopularity of smoking, which is not visible in the image. In her photo and her account, Jessica draws our attention to the potential difficulty of positioning the risks of smoking as lesser in a social context where the risks of alcohol are more normalised. Another woman, Chelsea (20, smoker), rationalised the risks of her smoking by stating that it was consistent with the risks associated with her alcohol consumption. She said, 'Oh well, I'm drinking [alcohol] and that's a bad thing for my body, I may as well smoke as well'. Chelsea's account of her health is fatalistic, suggesting that negative outcomes resulting from her alcohol consumption are unavoidable, and therefore, the consequences of her smoking are irrelevant.

Participants were often fatalistic when comparing the risks of smoking to other 'evils'. For example, Sarah (28, smoker) used fatalistic talk when discussing her health:

I don't think I'm going to die from [smoking]. I have diabetes now so, if I'm going to die, it's going to be something else, not smoking two or three smokes a day.

Sarah went on to position risk as a normal part of her life, saying, 'People will say "why are you smoking, you can get this and get that" and it's like, yes, but you can also walk outside and get hit by a bus tomorrow as well'. Courtney (21, ex-smoker) also drew on notions of fatalism, positioning her health outcomes as being random or a matter of chance. Courtney said, 'someone who doesn’t smoke, trains all their life, can die of a heart-attack at 30, 40. My mum had her heart-attack at 45, and she’s never smoked a day in her life'. These young women exploited the ecological fallacy inherent in smoking-related risk research, where the statistic (and risk) applies to a group and not to specific individuals. This allowed participants to frame the risks of their smoking as a matter of chance rather than certainty. The fatalistic talk used by these women works to imply that their health is beyond their control.
Participants also spoke about the risks of quitting smoking, at times positioning smoking as a lesser evil in relation to these risks. For example, one participant, Tara (24, smoker), spoke about having a history of being suicidal and spending time in hospital with mental health issues. She spoke about her experiences with the smoking cessation drug Champix, saying that when she used it she had ‘bad dreams’, and got ‘really emotional’, ‘paranoid’, ‘delusional’ and ‘became suicidal’. Tara said that she did not want to use Champix and ‘risk that happening again’. Another participant, Sarah (28, smoker), spoke about continuing to smoke during pregnancy to avoid the risk of another miscarriage:

The specialist said, ‘we want you to give it up, but you have that chance of miscarrying again’. So, my brain is bare, there and everywhere thinking ‘what am I going to do?’ But at the end of the day, I chose to continue having those few cigarettes because I didn’t want to have a miscarriage.

Sarah used the medical authority of her specialist and her risk of miscarriage to rationalise her decision to smoke during pregnancy. This positioning helped to protect Sarah’s subjectivity, as she was able to align herself with dominant medical risk discourse and avoid taking up a stigmatised position as a ‘bad mother’.

**Smoking to cope with stress and emotion**

Participants gave accounts of how smoking helped them to cope with stress and manage negative emotions, a strategy which enabled them to manage the dissonance between their positions as smokers and as ‘risk aware’. One participant explained this by saying: ‘[smoking] is a way to move through that emotion and to pass the time while you’re waiting for those feelings to subside’ (Chelsea, 20, smoker). Some women said smoking gave them the time or space to think things through. For example, Lisa (26, smoker) spoke about the stress of being ‘horribly broke’. She described her smoking at that time saying it was ‘more of a crutch than a choice … it was like, “I can’t deal with this, I’m just going to sit and have a cigarette and breathe deeply for a moment.”’. While smoking allowed some women the time and space to work through problems, others used it as a distraction from their problems. For example, Brittany (21, smoker) spoke about using smoking to help manage her depression:

With my depression, sometimes there will be short episodes where I’ll get really down … with smoking I think it’s a bit of a distraction because it makes you feel relaxed … I kind of went to rely on that because it would be a quick convenient way rather than actually dealing with it. I know it’s not the healthiest way.

Another participant, Shannon (23, smoker), explained,

it’s better for your health to stop doing it. But, you can always come up with arguments, like, ‘well, it’s better for my mind at this moment to keep on smoking’.

In both Brittany and Shannon’s accounts, we can see how the benefits of smoking in terms of coping with negative emotions are seen as exceeding the costs of smoking with regards to other aspects of health, providing an incentive to continue smoking.

Participants positioned their smoking as a form of social support: ‘it’s something to keep you company’ (Shannon, 23, smoker); ‘it’s like a little friend in your pocket’ (Julie,
31, ex-smoker). Brittany (21, smoker) spoke about how time spent alone smoking allowed her the space she needed to reflect on her problems after her mother died:

I spend a lot of time just talking to myself about my problems because there's no one there and because my mum passed away. Sometimes I just talk to her, and just like bitch about my life.

These accounts highlight how objects such as cigarettes have symbolic value, providing young women with both social and familial connections. Several women spoke about how smoking helped when they were bored. Lisa (26, smoker) said,

I'm a stay-at-home mum, so I really get quite intensely bored... I really have nothing to do, so I tend to just sit and read a book and have a cuppa and smoke cigarettes.

Smoking was also said to provide a 'stability or reliability' (Jennifer, 26, smoker). The regularity that smoking offered was particularly important to one woman, Shannon (23, smoker), who talked about how smoking helped her to manage her bipolar disorder: 'every single low is a depression, and every single high is being manic, and [smoking] was just something stable about me'.

Participants spoke about how they used smoking to 'manage stress'. Stephanie (27, ex-smoker) spoke about how smoking was an 'awesome stress relief', saying,

I work almost full-time, I have two little kids and I do it all by myself, and smoking was a buffer... it's a coping mechanism. The more stress I had, the more I smoked.

Stephanie shared a photograph she had taken of a Christmas tree (Figure 7). In many cultures, Christmas is seen to be a time of relaxation and family; however, Stephanie described it as 'very stressful'. Stephanie said, 'last year was the first year I missed out on Christmas morning with my kids in four years. It was like, where's the Malibu and the cigarettes now'. Stephanie's account illustrates how stressful situations might act as a potential trigger for relapse among women who have quit smoking. The contrast between Stephanie's photo and her account highlights how stressful triggers to smoke may, at times, be invisible to others.

Another woman, Briana (18, smoker), also a single mother, offered a similar account:

I smoked during pregnancy, and I know I shouldn't of. I did quit, and then my son's father broke up with me and I was under a lot of stress, and I actually picked up smoking again, and continued it throughout my pregnancy until the end... it just honestly made me feel a lot better when I had a cigarette, especially if I was thinking about all the stuff I was going to have to do by myself now that I was a single mother about to raise a baby on my own.

These accounts illustrate how some of the women in our study positioned smoking as a way to manage the stress and additional caring responsibilities associated with single motherhood. These accounts work to challenge the discourse that smoking mothers are uncaring and selfish, by positioning smoking as helping these women to perform their caring duties.

Along with stress management, some of the women positioned smoking as a way of helping to manage a range of different emotional states. Emily (21, ex-smoker) spoke about using smoking to manage anger: 'I found that if I was getting extremely angry, I'd have a cigarette and I'd calm down'. Others described smoking as having helped them to manage grief. Courtney (21, ex-smoker) talked about smoking as a way of coping when she lost a partner to suicide: 'when he committed suicide I just went into a deep depression, [it was] just alcohol and cigarettes basically, and [I] didn't really talk to
anyone’. For other participants, smoking was a way to cope with low self-esteem. For example, Jennifer (26, smoker) compared smoking to self-harm, saying,

You know it’s bad for you but it’s kind of like self-harming. If you feel bad about yourself you don’t really care that it’s damaging, it feels good and that’s what you want for that point in time.

Another woman, Chelsea (20, smoker), said,

If I’m home alone, I’ll have, this sounds really awful and very sad, but I’ll have some wine and then go for a walk and have some cigarettes because I either hate my life or hate my
body, so it’s just a way to destroy it a little bit, it’s not taking very good control of your body, but you’re making the decisions of what’s going into your body, even if it’s bad.

These accounts illustrate the way in which smoking can be conceptualised as an abstract form of self-harm. As both Jennifer and Chelsea explained, smoking provided them with a way of coping when they felt ‘worthless’ or ‘hated’ themselves or their bodies. By attempting to ‘damage’ and ‘destroy’ their bodies, these women adopted attitudes and behaviours that did not align with a healthfimg discourse and the pursuit of good health, while firmly expressing bodily agency and autonomy. Unlike Jennifer and Chelsea’s acts of self-harm, Shannon (25, smoker) positioned her smoking as more of a ‘reward’ or a ‘comfort’ – an act of self-care:

When I’m seriously depressed, I don’t smoke, it’s almost like smoking’s a reward . . . if I’m smoking that means that it’s ok, if I’m not smoking at all it means something is seriously wrong or I’m feeling really bad because I don’t even want to give myself that small comfort of smoking.

Shannon took a photograph (Figure 8) of herself as she was starting to feel better after a period of depression, saying, ‘the process of being outside and the availability of letting myself have a cigarette is already starting to make me feel better’. For Shannon, smoking acted as external, material evidence of her improved internal mental well-being, physically signifying her ability to manage her depression. Shannon’s positioning of her smoking as an effective way of coping was reinforced in the positive representation of smoking in her photo, where she showed herself to be openly smoking in public.

Discussion

The findings from our study have highlighted how young women took up positions as knowledgeable about the risks of smoking on health. This meant that they must then account for the risks involved with their smoking by drawing on repertoires that discounted this knowledge, positioning themselves as personally immune, minimising this risk in relation to other ‘evils’ and emphasising the benefits of smoking. These findings highlight the complexity in young women’s subjective negotiation of smoking, as they take up multiple and contradictory positions in relation to its associated health risks. These findings are relevant to understanding how young women both exercise agency but are constrained in their ability to engage in risk-taking behaviour as a way of reinforcing and subverting discourses of respectable femininity.

The repertoire ‘the risks of smoking are self-evident’ worked to align young women with dominant health discourse which positions smoking as risky (Lupton, 1995). Using this repertoire, the women in the study positioned themselves as knowledgeable about the risks of their smoking and responsible for their health. However, young women also used this repertoire to disengage from anti-smoking messages, positioning such messages as ineffective, and themselves as defensive, defiant and indifferent. Similar responses to anti-smoking messages have been noted in a study of university students who smoke (Wolburg, 2006). However, as the current study and others have shown (Goczezyńska, Knol-Michalowska, & Petyykowska, 2016), individuals not only acknowledge the risks of smoking but also believe that these risks are not applicable to themselves. As noted in previous research (Wigginton & Laffance, 2014), acknowledging the risks of smoking means that women must then account for the reasons why they continue to smoke and
construct alternative risk-adverse subjectivities, to avoid being positioned as irrational, and to protect themselves from blame from themselves and others.

One way in which participants minimised the perceived risks of smoking was through the use of a ‘it’s not going to happen to me’ repertoire. The sense of invulnerability, or unrealistic optimism identified in participants’ accounts, has also been found in a previous study of young smokers (Denzimben, 2001). These findings show that a young adult’s sense of immunity to risk is affirmed by the lack of immediate harmful consequences from smoking and their limited experiences of ill health. Participants also spoke about the lack of physical evidence for the effects of smoking on their health, a finding which may be explained by a tendency among young women to place greater importance on the
externally visible effects of smoking on health, such as the impact of smoking on the skin (Gilbert, 2005). The notion of the ‘at-risk’ smoker being an older man, who has smoked for many years, has been reinforced in tobacco education literature (Shevaller, 2000). Thompson, Pearce and Barnett (2009) warn that identity struggles can arise as people who smoke are unable to position themselves within binary understandings of ‘healthy’ and ‘unhealthy’. The way in which participants situated their smoking within a context of an otherwise ‘healthy’ lifestyle has also been noted in several studies (Gilbert, 2005; Haines-Saath, Oliffe, White, & Bottorff, 2013). In doing this, young women challenge ‘either/or’ binaries of smoking as healthy/unhealthy.

Another technique used to minimise the perceived risks of smoking was the positioning of smoking as ‘a lesser of two evils’. Young smokers today are situated within a world characterised by uncertainty and doubt (Denscombe, 2001), leading some young women to position their smoking as just one of many evils that they are exposed to within their increasingly risky lives (Denscombe, 2001). Researchers have explored this strategy by which smokers can downplay the risks of their smoking by relating it to other sources of risk (Heikkinen, Patja, & Jallinoja, 2010; Thompson, Barnett, & Pearce, 2009) and we found that the young women in our study related the risks of their smoking to the risks of other social and health issues and their alcohol consumption. Fatalism and determinism were central to young women’s accounts of smoking-related risk. Similar discursive strategies have been reported by Wigginton and Lafrance (2014), in their analysis of luck language in women’s accounts of smoking during pregnancy. These strategies may allow women to make sense of the risks of their smoking and the limited control they have over their health, as well as helping them to save face and avoid blame for their smoking (Keely, Wright, & Conditt, 2009). Further education is needed to challenge the perception that smoking cessation during pregnancy is riskier for the infant than continued smoking, as studies have shown that maternal smoking cessation has been shown to reduce adverse infant outcomes (Batech et al., 2013).

Finally, participants drew on the ‘smoking to cope with stress and emotion’ repertoire in order to convey the benefits of their smoking. In line with the findings of other researchers (Barnwell & Young, 1993; Greaves, 1996; Haines, 2008), the young women in our study gave accounts of using smoking to manage a range of emotions, such as anger and boredom. Women have greater social pressure to regulate emotions, and smoking offers a way to limit, delay or communicate ‘unenviable’ feelings such as aggression, directness and assertiveness (Greaves, 1996). Young single mothers in the study positioned their smoking as a way of managing stress, which suggests that the stresses of sole caring continue to impact on women’s health (Graham, 1987). However, nicotine is a stimulant and researchers have concluded that smoking is more likely to act as a stressor than a stress relief, as Jarvis and Widdle (2006, p. 233) note ‘there is no good evidence in humans that [smoking] ameliorates [stress or adverse moods] other than through withdrawal relief’. This conclusion is strengthened by studies which show that people report significant decreases in stress following smoking cessation (Taylor et al., 2014). At the same time, stressful life events have been shown to have a greater impact on women’s ability to quit, compared to men (McKee, Mackiewski, Fulbe, & Mauze, 2003), further highlighting the need to reduce young women’s exposure to environmental stresses, and to increase the mental health and stress management support available to those who smoke.

The women in our study also described how smoking provided them with a sense of control over their bodies, a finding which has been noted in a number of previous studies of women’s smoking (Graham, 1993; Greaves, 1996; Haines, 2008). This sense of control is particularly appealing to young adults, who tend to have limited authority in their own
lives (Denscombe, 2001). By taking up this position, these women challenge public health discourse which constructs smokers as lacking self-control (Lupton, 1995). Yet, young women report that in addition to smoking making them feel in control, they also feel controlled by their smoking (Health Canada, 1996), highlighting the contradictory functions smoking can play in young women’s lives. In contrast to previous research (Weinstein, 2001), our analysis identified little difference in how smokers and ex-smokers drew on these repertoires. This could in part be explained by the ubiquity of these repertoires, not only in relation to smoking-related risks but also in health discourse more broadly (Heikkinen et al., 2010).

**Conclusion**

In this article, we have shown that young women have ways of managing their knowledge of smoking risks and are able to reposition these risks as acceptable. By positioning their smoking as a way to cope, young women resist being positioned as at-risk. This is what Brown (2011) terms a ‘both/and’ position, where the speaker both reinforces and rejects dominant discourse. In taking up a both/and position, participants are able to position the risks of smoking as both acceptable and unacceptable and themselves as both at-risk and safe. In doing this, these young women challenge dominant public health discourses which position smoking as an activity, which carries few benefits and which has significant financial, social and health-related costs (Lupton, 1995).

Young women’s constructions of smoking-related risk relate to wider risk discourses surrounding young women and femininity. Young men are socially perceived to actively engage in risk behaviours as ‘risk-takers’, while young women are more often represented as passive recipients of risk and to be ‘at-risk’ (Mitchell, Crawshaw, Bunton, & Green, 2001). Young women can challenge these representations by participating in risky behaviours such as smoking and other leisure activities (Green & Singleton, 2006). By engaging in risky behaviours, young women are also able to disrupt dominant discourses of feminine respectability and notions of the ‘caring self’ (Green & Singleton, 2006; Skeggs, 1997). However, young women are also constrained by discourses of respectable femininity, evidenced by their efforts to reframe their risky behaviour as acceptable, responsible and caring (Mitchell et al., 2001). Our findings contribute to a broader understanding of young women’s subjectivities as complex and contradictory, capable of individual agency but also constrained by structural conditions.

Many anti-smoking campaigns operate on the premise that knowledge about the risks of smoking will lead to behaviour change (Thompson et al., 2009). The findings from this study highlight the need for broader, more inclusive understandings of health and well-being. Anti-smoking messaging needs to move away from discourse which positions people and practices within binary understandings of risky/safe and healthy/unhealthy and understand that young women see themselves as engaging in a range of practices which both contribute to and help manage risk (Haines-Saah et al., 2013). As with other commentators (Duff, 2003; Heikkinen et al., 2010), we would suggest that public health messages move away from ‘expert’ risk discourses by acknowledging young women’s lay accounts of risk and the presence of everyday risks. The Triggers campaign (Quit Tasmania, 2015) released in Tasmania, Australia, in 2015 is an example of a campaign which helps to situate smoking within a range of different everyday social contexts. The advertisement depicts smoking in relation to alcohol consumption and stress. Campaigns such as this, which situate smoking in the context of everyday life, may help young women to identify and challenge their own understandings of smoking and risk,
something previous campaigns have, at times, failed to do (Weinstein, 2001). Tobacco control interventions need to go beyond just presenting information about the risks of smoking. Young women need greater support in relation to mothering, domestic labour, wage disparities and their mental health.

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Appendix O: Journal Article 4

Young Australian women’s accounts of smoking and quitting: a qualitative study using visual methods

Zoi Trancikfield1, 2, Jane M. Usher1, Jetette Pezz1 and Kate Huppesz2

Abstract

Background: Although the overall rate of smoking in Australia continues to decline, the rate of decline has begun to slow. Rates of smoking among young women in Australia have been a particular concern, which has led to the development of targeted public health campaigns. Poststructuralist theory has successfully been used in research to explore the way in which young women experience smoking. However, there is an absence of poststructuralist analysis of young women’s experiences of quitting. This study aims to address this gap.

Methods: We carried out 27 interviews with young Australian women smokers and ex-smokers. Eighteen of these women then participated in a photography activity and follow-up interviews. A Foucauldian discourse analysis of the data was conducted.

Results: Through our analysis, we identified three discourses: ‘The irresponsibility of smoking: Quitting as responsible’, ‘The difficulties of quitting: Smoking as addictive’, and ‘Making a decision to quit: Smoking as a choice’. In relation to these discourses, participants took up contradictory positions of responsibility and resistance, addiction and agency. Taking up these positions had implications for young women’s subjectivity, and the way they engaged with tobacco control and cessation support.

Conclusions: The analysis highlights the complex and contradictory nature of young women’s experiences with smoking and quitting. The study’s findings are considered in relation to the improvement of tobacco control policies and cessation support programmes targeted at young women.

Keywords: Young women, Smoking, Cessation, Qualitative, Interviews, Photography, Discourse analysis

Background

Growing public awareness of the negative health implications of smoking, and the erosion of “smoking positive cultures” have contributed to declining rates of smoking in Australia for over fifty years (pg. 25) [1]. However, recently the rate of smoking decline has slowed [2]. Considering that smoking remains one of the leading causes of preventable death and disease [3], a decrease in the rate of smoking decline is worrisome. Rates of smoking among young women are an area of particular concern. In Australia, young women are taking up smoking at a younger age than men [4]. Smoking among young women is associated with negative health outcomes, including increased mortality rates, death from cancer, circulatory, respiratory and other diseases [5]. Compared to men, women are at an increased risk for certain smoking-related diseases, due to factors such as oral contraceptive use [6]. However, if women quit smoking before the age of 30 they can avoid more than 97% of the excess mortality risk associated with continued smoking, which indicates that young women should be a target group for intervention [7].

Research on smoking cessation has primarily focused on adult smokers, which has resulted in a lack of awareness of young peoples’ experiences of quitting [8]. Young women are aware that smoking is risky, and are highly motivated to quit, but often report a sense of hopelessness in relation to the difficulty of quitting [9].

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young women are concerned about the social, emotional, and physiological costs of quitting smoking [10]. These costs include the loss of the perceived benefits of smoking, such as social advantages and a method of weight control [11]. It has also been reported that young women are reluctant to engage with smoking cessation programmes, preferring to quit on their own, or with the support of a friend [12]. These studies highlight the need for further research which focuses on constructions and experiences of smoking cessation among young women, in order to better understand barriers to quitting, and to allocate tobacco control resources more appropriately. This is the aim of this paper.

Smokers' experiences of quitting are shaped by prevalent social and cultural discourses surrounding health and wellbeing. In wealthy neoliberal western countries, a prevailing 'healthism' discourse maintains that the pursuit of good health is an individual responsibility [13]. Rational, responsible smokers are expected to maximise their health and avoid risk by complying with tobacco control policies and making attempts to quit smoking [14]. The majority of smokers appear to assume this position of responsible, health-seeking citizens, by saying they are interested in quitting [15] and making attempts to quit or cut down [16]. However, the process of quitting smoking can be difficult. Few quit attempts are successful [17], and most smokers make multiple attempts to quit before achieving long-term cessation [18]. At the same time, many smokers also challenge these health imperatives, expressing resentment and resistance towards quitting smoking [19]. By maintaining a smoking identity, smokers risk being positioned as irrational, and experiencing the negative social stigma applied to those who smoke cigarettes [20].

In the 1980s researchers began to identify nicotine and tobacco products as dependence-producing. Nonsmokers have developed a brain disease model of addiction, where nicotine is shown to activate brain pleasure centres – establishing a neurological basis to addiction [21]. Smoking dependence also relates to the content in which smoking takes place, smoking rituals, and sensory stimuli such as touch, taste and smell [22]. Characteristics of nicotine dependence include smoking soon after waking, smoking more than 10 cigarettes a day, and a history of withdrawal systems with previous quit attempts [22], while withdrawal from nicotine is associated with negative psychological and physiological effects, such as irritability, mood, anger, anxiety, difficulty concentrating, increased appetite, restless, depressed mood, and insomnia [23]. These findings led to the inclusion of tobacco use disorder and tobacco withdrawal in the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association (APA), and the International Classification of Diseases (ICD) of the World Health Organisation (WHO) [24]. These physiological and psychological conceptualisations of smoking and addiction have contributed to the medicalisation and commodification of smoking cessation [25], and the development of a range of psychological interventions, such as counselling, and group interventions [26]. In Australia, health professionals advise pharmacotherapy for smoking cessation, such as nicotine replacement therapy (NRT), varenicline, and bupropion, as well as non-pharmacological supports, including group or individual counselling, cognitive and behavioural coping strategies, written information, and telephone counselling [22].

Most smokers stop smoking without formal help, either by cutting down, or quitting abruptly, also known as quitting 'cold turkey' [27]. However, smokers who are more nicotine-dependent are more likely to use pharmacotherapy and seek behavioural support to assist in quitting [18]. Health professionals in Australia are instructed to use the 5 As approach to ask patients about tobacco use, assess their willingness to quit, advise quitting, offer assistance, and arrange to follow-up with patients [22]. This approach draws on cognitive theories, such as the stages of change (SOC) model, which is based on the assumption that smokers are rational and coherent, who make gradual steps towards quitting [28]. However, these theories assume that the attitudes and beliefs shared by smokers are expressions of stable underlying cognitive structures, an assumption challenged by discourse analysts, who argue that understandings of smoking behaviour are complex and contradictory, shaped by a range of environmental and social factors [29, 30].

Counter to cognitive theories of smoking cessation, discourse analysts have sought to examine the way smokers position themselves in relation to cultural discourses of smoking and addiction. For example, adopting a subject position as an addict can provide a causal explanation for the continuation of a seemingly irrational behaviour such as smoking [13]. This subject position is enabled by tobacco control campaigns which construct smokers as powerless against their addictions, and position young adult smokers in particular, as addicts who lack self-control, discipline and willpower [19]. However, many young adults resist this construction, instead positioning themselves as 'in control' of their smoking, constructing their smoking as a choice rather than an addiction [31]. Young adults are often reluctant to describe themselves as having a 'full-blown' addiction to smoking, and are more likely to identify with 'weaker' forms of dependence, such as being socially or emotionally dependent on cigarettes [30]. Contradictory discourses of smoking and quitting are also evident in the accounts of adult smokers, who
draw on notions of indulgence and control, addiction and abstinence, to account for their continued smoking and inability to quit [32, 33]. Poststructuralist theory can provide an explanatory theoretical framework for these contradictions, conceptualising smoking identities and practices as fluid and non-linear, associated with multiple, complex subject positions [34]. Poststructuralist theory allows us to recognise that young women can move between ‘smoker’ and ‘non-smoker’ identities, and that the transition from ‘smoker’ to ‘ex-smoker’ is a process of becoming rather than being [36].

Whilst poststructuralist theory has been used to inform explorations of contradictory constructions in young women’s accounts of their smoking [35, 36], these studies have not considered how young women’s constructions of smoking relate to their experiences of quitting. The present paper is necessary to improving our understandings in this area. Empirical findings from a qualitative study of young women smokers and ex-smokers are analysed using a poststructuralist approach, in order to address the following research questions: How do young women smokers and ex-smokers construct quitting and continued smoking? How do young women smokers and ex-smokers position themselves in relation to discourses of quitting and continued smoking?

Methods
This study draws on data from a broader qualitative study which aimed to explore young women’s constructions and experiences of cigarette smoking. The study was made up of three stages. In the first stage, twenty-seven young women smokers and ex-smokers participated in exploratory semi-structured interviews. Eighteen of those women opted to participate in the second and third stages: a photography activity and follow-up interviews. The triangulation of different qualitative methods allowed us to understand young women’s experiences of quitting in a way that would not be possible through interview accounts or photographs alone. The study was carried out in metropolitan New South Wales. However, the majority of interviewees (n = 35) were conducted over the phone, allowing us to recruit participants living interstate and regionally. The data were analysed using Foucauldian discourse analysis and positioning theory.

Procedure
Participants were recruited through the distribution of flyers at train stations and university campuses, which asked, “Are you a young woman who currently smokes cigarettes, or an ex-smoker?” The study was also advertised on social media, with the message “3 stage study of women’s experiences of smoking and quitting”. These two different messages were used to recruit women who might identify as a ‘smoker’ or an ‘ex-smoker’, as well as women who might not identify as ‘smokers’ or ‘ex-smokers’, but see themselves as ‘smoking’ or ‘quitting’. During the first stage of the study participants engaged in interviews which explored their experiences with smoking, quitting, and representations of smoking in the media. Eighteen of these women then chose to go on to stage two of the study, a photography activity, where they were invited to take photographs of their experiences with smoking. The process of taking photographs helps participants to reflexively engage with their smoking practices in the context of their everyday lives [37]. The photography activity drew on elements of a photo-elicitation study, a method which actively engages participants in the research process, allowing them to share their ‘voice’ [38]. We also drew on elements of a photo-elicitation study, where the discussion of photographs in the context of an interview allows for the elicitation of rich, in-depth data [39]. This combination of photography methods has proven successful in previous qualitative studies of women’s health [see 40]. Participants took an average 3 weeks to complete the activity and submitted 157 photographs. The 18 women from stage two of the study then went on to the third stage, a follow-up interview. Following their first interview, participants were sent a copy of their interview transcript. During the follow-up interview participants were given an opportunity to reflect on their first interview, and the interviewer was able to ask follow-up questions. During the follow-up interviews, participants also discussed their photographs, and their experiences of the photography activity. The stage one and stage three interviews ranged between 25 and 90 min, and were audio recorded.

Analysis
Poststructuralism refers to a school of thought that emerged in the 1960s and 1970s which challenged traditional understandings of language, meaning and subjectivity [41]. A poststructuralist approach considers subjectivity as multiple, and as constituted and reconstituted through language and discourse [42]. In doing poststructuralist analysis there is an opportunity to be transformative, not only through the deconstruction of current ways of knowing, but also in the development of strategies for change [43]. Foucauldian discourse analysis was used to examine the discourses of smoking and quitting available to young women [44], and positioning theory allowed us to consider the subject positions made available through these discourses [45]. Positioning theory also provided a way of conceptualising young women as capable of taking up, resisting, and repositioning, multiple, often contradictory subject
positions, such as 'smoker' and 'ex-smoker'; 'addict' and 'agent'.

We followed a style of Foucauldian discourse analysis outlined by Usher and Perez (2014) [66]. The first step of the analysis involved reading transcripts and viewing the photographs. This process began when the first author integrity checked the professional transcriptions made from the interview audio recordings. The data were read and viewed again and a coding frame was developed, allowing us to code the interviews and photographs together using NVivo, a qualitative data analysis software program. This software allowed us to do an integrated analysis of the data, and identify the similarities and differences across the interviews and photographs [47]. The coded data were then summarised, and these summaries were read by all four authors, allowing us to identify dominant smoking and quitting discourses. Having identified these discursive constructions, we were then able to examine the function of these constructions, the subject positions available to participants, and implications of these positions for participants' subjectivity and smoking practices.

The triangulation of research methods often requires the privileging or weighting of a particular data set which is better suited to the research questions [48]. Given the close relationship between discourse and verbal language, and the study's aim to explore young women's discursive constructions of quitting and continued smoking—the interview data were given priority during analysis. The photographs were analysed alongside the interview transcripts, and helped to provide further insight into the materiality of participants' experiences [49]. As with their interview accounts, participants' photographs were not considered to be a direct representation of reality, but rather, another account of their experiences of smoking and quitting processed within the context of the study [50].

**Results**

The sample was made up of 27 young women aged between 18 and 31. Participants reported that they started smoking regularly between the ages of 13 and 24 years, and the average age of regular smoking was 16 years. Participants had been smoking for between two and 36 years, for an average length of 7 years. Eighteen of the participants were current smokers. Of those participants who smoked, most smoked less than 15 cigarettes a day (56%), with a smaller number smoking 15 or more cigarettes a day (22%), or not smoking on a daily basis (22%). The remaining nine participants had quit smoking at the time of recruitment. Participants' length of cessation ranged from 2 weeks to 2 years. By including both 'smokers' and 'ex-smokers' in the sample we were able to bring together their experiences, and deconstruct binary understandings of smoking and non-smoking. Most of the sample said they were Anglo Australian (63%), and the remaining women identified as being from Aboriginal Australian, Asian, American, European, Middle Eastern, and Pacific Island cultural backgrounds. When asked about their social class background, most participants described themselves as working class (44%) and middle-class (48%), and a smaller number identified as upper-middle class (7%). Participants mostly characterised themselves as heterosexual (67%), and bisexual (26%), with a smaller number identifying as lesbian (7%). At the time of the study, one participant was pregnant, and seven others had children.

During our analysis, we identified three dominant discourses in participants' accounts of quitting: 'The irresponsibility of smoking: Quitting as responsible'; 'The difficulties of quitting: Smoking as addictive'; and 'Making a decision to quit: Smoking as a choice'. Participants' names have been replaced with pseudonyms, and their smoking status is provided in parenthesis to contextualise quotes.

**The irresponsibility of smoking: Quitting as responsible**

Most participants discursively constructed smoking as irresponsible, and quitting as a way of being responsible. In positioning smoking as irresponsible, participants spoke about the impact of smoking on their health, the financial cost of their smoking, and the impact of smoking on partners, parents, friends, and children. For example, Caitlyn (smoker) said she wanted to quit smoking because, "It makes me sick, and it's expensive." Gemma (ex-smoker) said she quit because she was "Wanting to save money and wanting to be healthy." Jing (ex-smoker) explained why she wanted to remain a non-smoker: "My boyfriend doesn't want me to smoke. If I go back to smoking he will be very angry and won't marry me." Briana (smoker) spoke about her chances of developing a smoking-related illness, saying, "I don't want to have to put my family through that because of a stupid decision I made." In describing her continued smoking as a "stupid decision", Briana implicitly positioned her smoking as a choice, and herself as responsible for the negative health outcomes and impact on her family that result from her continued smoking.

Participants' status as 'smokers' or 'ex-smokers' had implications for their positioning of self and subjectivity. For participants who had not quit, the irresponsibility associated with their continued smoking was described as having negative implications for their subjectivity. For example, Sarah (smoker) spoke about her inability to quit smoking during pregnancy, saying, "I hated myself, and I still hate myself for it today." Conversely, participants who had quit smoking were able to take up a position of responsibility. For example, Ashlee (ex-smoker),
a single mother with three children, said she took a photograph of money (Fig. 1) to represent the savings she had made since quitting smoking. Ashlee positions herself as financially responsible after quitting smoking, saying, "I'm not scraping through to get bread or milk anymore, I've actually got money there. And I actually have a savings account open as well now." Lisa (smoker), reported that a past quit attempt made her feel "self-righteous", saying, "I was somehow a better person because I was not addicted to it...I think I was just proud of myself...like I'm a better person now because I'm not smoking cigarettes." Lisa's account highlights how adopting an 'ex-smoker' identity allows young women to adopt a more positive sense of self, and avoid the negative stigma of an 'addicted smoker' identity.

In negotiating discourses of responsibility, a number of participants took up a position of resistance in relation to quitting smoking. For example, Rachel (smoker) explained, "You get told what to do almost all the time and it's like that one small way of going against what everyone is telling you to do." This position of resistance had implications for the way participants, such as Rachel, responded to tobacco control measures. She said,

"Right before the price goes up or right before a new ad campaigns starts, I’ll see that and I'll be like, ‘You know what? I'm going to keep smoking just to be stubborn.’"

Although Rachel takes up a position of resistance, she also adheres to discourses of responsibility, by then saying, "I definitely intend to quit before I decide to start a family." In a similar vein, participants spoke about intending to quit when they were older. For example, Jessica (smoker) said, "I haven't actually really tried [to quit] because I don't want to...I'd try and quit when I'm 30 and see how I go." By purporting that they "intend to quit" in the future, young women, such as Rachel and Jessica, can position their current smoking as temporary, and distance themselves from a fixed identity as a "smoker.

Other participants distanced themselves from the stigma of a smoking identity, and demonstrated responsibility, by saying they would "cut back" or only smoke "a few cigarettes a day." For example, Sarah (smoker) said, "I do want to quit, but it doesn't bother me if I continue to have a few cigarettes a day." Shyama (smoker), said, "I basically know that I'm just someone that probably won't stop smoking. I'll probably cut back." Occasional smoking allowed young women to demonstrate a sense of agency and control over their smoking. By cutting down their smoking, but not quitting, young women can simultaneously take up positions as responsible and resistant.

**The difficulties of quitting: Smoking as addictive**

Accounting for the difficulty in quitting smoking, participants constructed their smoking as an addiction. For example, Hannah (smoker) said, "Quitting cigarette smoking is like trying to quit heroin. It's similar because it's such a strong drug in a way." By situating smoking within a wider drug discourse, Hannah can take up a position as an addict, and can account for her continued smoking. Another participant, Danielle (smoker), said, "It's an addiction, it's not really a choice. I would love to stop if it was that easy, but it hasn't seemed to be so far." Danielle positions herself as an addict who lacks "choice", which again, helps to account for an inability to quit smoking. This position of addiction was also assumed by Stephanie (ex-smoker), when she was trying to quit smoking:

"I was always one of those people who would say, 'I'm definitely not addicted, I can quit whenever I want, I just don't want to.' And, when you do try and quit you realise you're kind of really addicted to them.

Stephanie's account suggests that acknowledging a lack of control over smoking, and taking up a position as an addict, may be necessary in taking up an 'ex-smoker' identity. However, this is not necessarily a comfortable or easy position for a smoker to find herself in. Stephanie went on to talk about the 'embarrassment' she felt at being addicted to smoking, highlighting how the
stigma associated with addiction can negatively impact on subjectivity.

Several participants who had quit smoking continued to position themselves in relation to discourse of addiction. For example, Gemma (ex-smoker) said,

I do miss it. If someone offered me a cigarette without any repercussions or me guaranteed not to get addicted, I'd probably take it, but, I know that if I did have another cigarette I'd start smoking again.

Stephanie (ex-smoker) offered a more fatalistic account of her addiction, saying, "If I start smoking again, I will probably continue smoking until the end. So I'm determined not to start smoking again." These accounts highlight how young women construct quitting smoking as an on-going process, and addiction as having no fixed end point. Constructing smoking as an addiction might prevent young women who have quit smoking from resuming smoking practices. Conversely, some participants resisted being positioned as an addict. For example, Rachel (smoker) said, "I don't really have an addictive personality and I wouldn't consider myself addicted to cigarettes." In this account, Rachel constructs addiction as being a quality of a personhood that is different to her own, which allows her to avoid the stigma associated with being positioned as an 'addict'.

Addiction discourse was used in participants' accounts of tobacco control measures, with varying effects. For example, Shayma (smoker) said she took a photograph (Fig. 2) of a sign advising of an increase in government taxation on tobacco because it made her "pissed" and "angry". She explained,

Back then it was really cheap and people would easily get addicted because it's very cheap and you can afford it. But now, people are finding it really hard to afford them, so it's kind of like "I'm going to buy it anyway, but I can't afford it. What can I do? I'm addicted to it, I need it." I feel like it's kind of cheating in a way... Not that I'm anyone suffering from that, but there are a lot of people that are.

Drawing on addiction discourse, Shayma is able to position taxation on tobacco as unethical and as "cheating". Sarah (smoker) spoke about the graphic health warnings on cigarette plain packaging, saying,

It's not going to work; it's not going to stop people from smoking. Seeing a picture doesn't stop your whole body, and your whole brain being tricked into, "I'm not addicted anymore."

Sarah draws on a neurological explanation of addiction which locates the source of addiction within the body, allowing her to position external stimuli like the graphic health warnings on cigarette packaging, as ineffective in treating her smoking addiction. Conversely, Emily (ex-smoker), said,

I didn't like having cigarettes that had big pictures of cancer and all that sort of stuff on them. I thought it was gross and you know, "what if I looked like this", and yeah, my brain decided it just didn't want to smoke anymore.

Emily also draws on a neurological explanation for her smoking but in opposition to Sarah, positions graphic health warnings as effective in helping her "brain" to not want to smoke. Sarah and Emily's contrasting accounts highlight how addiction discourse can have differing effects on the way young women construct the impact of tobacco control measures on their ability to quit.

Addiction as a social and psychological 'habit'

In their accounts of quitting, participants challenged the idea that their addiction was only physiological by emphasising the habitual aspects of their smoking. As Sarah (smoker) explained, "I'm addicted to the habit rather than the craving I think." In their accounts of smoking being a habit, participants positioned their smoking as "mental", "psychological", and subconscious. For example, Courtney (ex-smoker) took a photograph of a cup of tea (Fig. 3), which she described as a "trigger". She said, "If someone says, 'Oh, do you want a coffee or a tea?' I go, 'Yeah.' And, then in my head I'm like, 'I should light a cigarette'."
And, then I'm like, 'No I don't smoke.' In her account, Courtney positions her ability to disrupt her smoking habits as a psychological process located in her 'head'. Like Courtney, many other participants spoke about how their smoking habits were paired with other habits and addictions, such as alcohol and coffee. For example, Shannon (smoker) said 'it's really hard to drink [alcohol] and not smoke', and Tara (smoker) said 'cigarettes are really good with drinks, like coffee. I find that every night before I go to sleep, I look forward to a coffee and a cigarette in the morning.'

Participants gave accounts of how the habitual nature of their addictions rendered nicotine replacement products ineffective. For example, Shannon (smoker) said, 'I'm not a fan of the nicotine patches and things like that...I think a lot of the hard work in it, particularly when you're younger, is mental and social.' Brittany (smoker), spoke about using a nicotine inhaler, saying, 'I wanted a cigarette, even though I had the nicotine, I still get that kind of nice feeling of relaxation but it was the actual cigarette, like lighting it and stuff. I like the act of smoking.'

In place of nicotine replacement products, participants emphasised the need for mental strength and willpower when quitting, saying 'It's just a mental thing. It comes down to how strong your willpower is' (Tara, smoker). Willpower was said to involve 'using the mind' to "move past", "distract" or "forget about" cravings. A lack of willpower was seen by participants as being a barrier to quitting smoking. For example, Hannah (smoker) said, "I feel like I don't have enough willpower to quit." Another woman, Caitlyn (smoker), said, "I just need to get the willpower and give up." In contrast to Hannah's account, Caitlyn constructs willpower as a non-fixed quality, and something you can "get." This construction allows young women smokers, such as Caitlyn, to take up a position of agency in relation quitting smoking.

Participants spoke about the gendered nature of smoking addiction, contrasting their own habitual addictions to men's physiological addictions. For example, Megan (smoker) spoke about how her father was "physically addicted" to smoking, while her and her mother were "situationally addicted", and smoked in response to "environmental factors". Another participant, Sarah (smoker), distinguished between her and her male partner's addictions, saying, "His body is addicted to the ingredients of the smokes, like an actual cigarette, whereas I think me, personally, I'm more addicted to the five minutes of peace and relaxation." This gendered construction of addiction had implications for how participants understood their experiences of quitting. For example, Julie (ex-smoker), spoke about her husband being much more physically addicted to cigarettes, saying, "He has smoked probably 100 thousand more smokes than what I have. I guess it is so much easier for me to let it go." The positioning of habitual addictions as "easier" to overcome may result in women, such as Julie, experiencing greater pressure to quit, or feeling less entitled to support.

Making a decision to quit: Smoking as a choice

In contrast to their accounts of addiction, participants constructed smoking as a choice, and emphasised the importance of making a decision to quit. For example, Megan (smoker) spoke about how being "badly addicted"
to smoking made it hard to quit, but went on to say "ultimately it's someone's choice [whether they smoke]." Another participant, Courtney (ex-smoker), said, "When you have a wish, you have the choice and the freedom to [smoke]...unless they want to [quit], they won't do it." In her account, Courtney draws on the liberal discourse of freedom to reinforce the construction of smoking as a choice, and the importance of deciding to quit. Sarah (smoker) also emphasized the importance of making a decision to quit, saying, "I think people have to want to give it up and if they don't want to give it up...it's not really going to happen."

The construction of smoking as a choice, and quitting as a decision had implications for subjectivity, allowing participants to develop a sense of agency and optimism around quitting. For example, Chelsea (smoker) takes up a position of agency in relation to her smoking, saying, "If I really don't want to [smoke], I'm sure I could stop." This optimism is also evident in the following comment from Rachel (smoker):

As cliché as it sounds I'm sure I could quit if I really wanted to. I want to do it on my terms. I don't want to do it as in I'm giving in to everyone constantly telling me not to smoke.

In stating that quitting needs to be on her "terms," Rachel is positioning herself as needing to be agentic, and in control of the quitting process. Another participant, Shayna (smoker), spoke about quitting, saying, "The idea that I've done it once makes me feel good because I know I can do it again." Shayna's account illustrates how a position of agency and a sense of optimism can reinforce a positive sense of self, where Shayna can "feel good" about her past quit attempts, and motivated to make future quit attempts. Another participant, Lisa (smoker), said,

I can't continue, and I can't afford cigarettes.

They're going up at a phenomenal rate. Like for a month, I do not have enough money...to justify smoking. It's ludicrous. So I will quit and I know that I can, it's just a matter of actually having that little spur to do it.

Lisa takes up a position of agency, saying she "can" and "will" quit, but indicates she requires something further to prompt her. Lisa's account highlights that despite constructing quitting as a choice, and herself as agentic in relation to smoking, she may need further motivation or support to quit. However, in another account given by Lisa, she describes a loss of optimism and agency:

The first time [I quit] I kind of had the optimism that you know, tomorrow I won't be a smoker, tomorrow I won't want a cigarette." Whereas now I know that that doesn't actually really go away for a very, very long time.

This account from Lisa highlights how the sense of optimism that results from the construction of smoking as a choice, may diminish with multiple quit attempts.

By constructing smoking as a choice, participants were able to dismiss tobacco control messages. Again, talking about graphic health warnings on plain cigarette packaging, Sarah (smoker) said, "I don't think any picture will...you have to want to quit, you have to want to do it." A similar response was given by Jessica (smoker), who said, "I don't think the packages will have anything to do with people's decisions...if they're going to smoke, they're going to smoke." Sarah and Jessica's accounts show that the construction of smoking as an individual choice can lead young women to be dismissive of population-level tobacco control interventions.

The construction of smoking as a choice had implications for how participants approached quitting. Participants favoured quitting 'cold turkey,' without any assistance, as it was seen to be demonstrative of strength, agency and control over smoking. For example, Courtney (ex-smoker) gave the following account of quitting cold turkey,

It's a bit empowering to turn around and say "well I didn't use anything I just stopped," it makes you feel good about yourself that you can just quit like that.

The positive impact of this sense of agency is also evident in Jessica's (smoker) account,

When you use a programme or stuff like that, I feel like you haven't got the strength to maintain it, whereas if you go cold turkey, you've done it all and you've got the strength, and yeah, it's going to be a struggle, but you've achieved it, so you feel like, "wow, I did that by myself, I can do it. I don't need help."

Courtney and Jessica's accounts suggest that the sense of agency gained from quitting cold turkey has positive implications for subjectivity, leading them to "feel good" about themselves. However, Courtney and Jessica's assertions, "I didn't use anything" and "I don't need help," reinforce a discourse of individualism, which may negatively impact on young women's willingness to seek support when quitting smoking. This discourse of individualism was also evident in Megan's (smoker)
photograph of Band-Aids at her feet (Fig. 4). She explained this photograph by saying,

I put the Band-Aids on the ground to kind of push the idea that, this is something I need to heal within myself, I'm not going to get better at this unless I stop the smoking and heal the damage I'm doing to my lungs, and the stop further damage that I'm doing... there's a hope that I can get the balls to say that I want that more than the cigarette with my wine and my beer.

In talking about her need to "feel within," herself, Megan positions herself as personally defective, and individually responsible for the damage she is doing to her body. Megan's account of needing to "get the balls" in order to stop smoking relates to gendered discourse which positions men as having greater agency and control over their bodies.

Discussion
Public health initiatives, such as graphic health warnings on cigarette packets, often target individual smokers, reinforcing the notion that smokers are individually knowledgeable and responsible for the risks of their smoking [51]. Participants in our study took up positions of responsibility by reiterating the irresponsibility of smoking, and expressing their desire to quit, a finding consistent with previous research [52, 53]. The cost of smoking and the impact of smoking on health were the two main reasons for wanting to quit or to change their smoking behaviours, supporting previous research [16, 54]. The responsibility participants took for both their own health, and the effect of their ill health on others, could relate to the unique material and discursive pressure put on women to be primarily responsible for health and to care for others [13]. Similar findings have been identified in other research, which show that women are twice as likely as men to report feeling pressure to quit smoking, saying that pressure mainly comes from children and other family members [55]. This study also provides further evidence that tobacco control policies, such as taxes and health warnings, are successful in prompting cessation, and discouraging regular smoking among young people who are experimenting with smoking [56]. However, despite being motivated to quit, some young women require additional support with the process of cessation [57], highlighting the need for comprehensive approaches to tobacco control which incorporate both population-level interventions and additional supports targeted specifically at young women.

Young women in this study also expressed resistance towards quitting, positioning quitting or cutting down smoking as a future event. Young people often perceive few short-term negative health effects as a result of smoking, which can produce a sense of invulnerability, allowing them to delay quitting until they are older [58]. This sense of invulnerability is also affirmed by the construction of smoking as a temporary, youthful phenomenon, which young people can take up and then quit when they choose to [59]. Tobacco control programmes and policies targeted at women often focus on smoking during pregnancy or women's roles as mothers, and "represent women as adversaries of their babies-to-be" (pg. 64) [60], which may explain the accounts of young women in this study who construct quitting as happening in the future when they plan to 'start a family'. By positioning quitting as a future event, young women acknowledge the need to quit smoking, which allows them to maintain a position of responsibility. By cutting down their smoking and adopting an identity as a social smoker, young women are able to move between the subject positions of 'smoker' and 'non-smoker'. Adopting an 'in between' identity [34], young women are able to retain the socially beneficial aspects of their smoking, while avoiding the stigma experienced by belonged smokers. This indifference towards quitting smoking represents a form of passive resistance to the imperative of health [61].

This study found that addiction discourses and a position as an addict have varying implications for young women smokers and ex-smokers. Participants in this study both adopted and resisted positions as an addict – similar to a previous study of Australian smokers [62]. Addiction discourses alleviate some responsibility for smoking behaviours, allowing young women to defend their smoking and account for the difficulties they face in quitting [29]. This finding is consistent with previous research which has found that the concept of addiction may allow women who smoke during pregnancy to
maintain a 'good mother' identity [63]. However, a position as an addict attracts stigma, and has negative implications for young women's subjectivity, as previous research has also identified [64]. Neurobiological explanations of nicotine addiction, which locate the problem of addiction within the individual as opposed to the cigarette, can also lead to feelings of futility, helplessness and disempowerment [33].

Young women in this study differentiated between the physiological, and the psychological or habitual aspects of addiction, a finding consistent with previous research [29, 65]. Positioning themselves as habit-addicted, rather than nicotine-addicted, allows smokers to contextualise their smoking as a social practice that forms part of their everyday lives [63]. Young women positioned their addictions as more psychological, and men as more physiological, which could relate to a broader gendered discourse that constructs women as more emotional, and men as more logical [66]. This discursive positioning correlates with data that show that women are generally more sensitive than men to the non-nicotine factors that relate to smoking, such as smoking cues, and positive sensorimotor effects, leading them to have greater success with non-nicotine medications and behavioural interventions, compared to nicotine replacement therapies [67]. These findings suggest that it is important that smoking cessation programmes targeted at young women present a comprehensive view of addiction, and offer social and psychological interventions, such as counselling, alongside pharmaceutical treatments for nicotine addiction.

Discourses around smoking being a choice are prevalent among health care workers [68], the tobacco industry [69], in tobacco control messages targeting young people [19], and has been reported in previous studies of young smokers [70]. Therefore, it is seen to be important that smokers 'really want to quit' [71]. The emphasis young women place on decision making in relation to quitting smoking may lead them to think they must put serious thought and planning into quitting. This focus may prevent young women from making spontaneous quit attempts, which may be more successful than planned attempts [72]. Smoking cessation research, policy and practice has concentrated on pharmaceutical and behavioural interventions, despite most smokers reporting that unassisted quitting is their preferred method, and unassisted quitting being the method with which they have the most success [73]. The use of pharmaceutical cessation aids sit at odds with ideas of individual choice, willpower and control, which may explain smokers' preference for going 'cold turkey' [74]. Tobacco control programmes and interventions targeted at young women need to acknowledge the value of unplanned, un-medicated cessation, but at the same time, allow space for those women who need further cessation support. As noted in previous research [75], participants in this study drew on notions of willpower to understand the control they have over smoking. Young women who position themselves as lacking willpower may be reluctant to attempt quitting, highlighting the importance of cessation support that gives young women a sense of power over their smoking. One participant constructed a agency in relation to quitting as masculinist, a finding which relates to research where men report greater agency over cessation [76]. These findings provide further evidence for the need to improve young women's sense of agency and power, specifically in relation to their smoking, as well as more broadly. The use of narrative therapy has been suggested as an intervention which may help smokers to make sense of these contradictory positions of addiction and agency [62]. Though a process of externalising smokers' unsuccessful quit attempts, and reconstructing the way they identify with smoking [77], narrative therapy may help young women, such as those who participated in this study, to develop a sense of agency and power in relation to quitting smoking. This therapy could also incorporate dual process theories of smoking cessation, which integrate contradictory notions of spontaneity and preparation in their model of successful cessation [78].

Young women's optimism towards quitting, where they underestimated their chances of becoming addicted to smoking, and overestimated their ability to quit, has been found in previous research on young smokers [79, 80]. Optimism also plays an important role in quitting, as self-efficacy and feeling able to quit are key to successful cessation [81]. However, as findings from this study, and others have shown [80], realising the difficulty in quitting may also be an important part of the quitting process. Cessation supports and health campaigns need to foster optimism among young women smokers, by positioning quitting as an attainable goal [82]. However, they also need to be careful not to present the benefits of cessation as being immediate, or ignore the physical and psychological challenges of quitting [82]. The best approach for communicating this contradictory message of optimism and difficulty, should be the subject of further research. Strengths and limitations

This study is one of the first on young women's experiences of smoking and quitting to take such an innovative theoretical and methodological approach. The use of qualitative interviews, a photography activity, and follow-up interviews allowed the researcher time to build trust with the women and actively involve them into the production and analysis of data, which helped to increase the credibility of our
research [83]. The triangulation of different qualitative methods added variation to the data, which allowed for a more nuanced analysis to take place [84]. The use of discourse analysis and poststructuralist theory allowed us to examine young women’s adoption of dominant discourses of smoking and quitting, as well as their resistance of them [42]. However, the triangulation of interview and photography data also presents several challenges. For instance, decisions relating to the privileging of one data set above another is a challenging aspect of the triangulation process [85]. The prioritisation of the interview data in this analysis lead to a more limited consideration of the photographs. This limitation could be addressed in future research which places more emphasis on visual analyses of young women’s experiences of smoking and quitting.

The nature of qualitative research means that findings are not generalizable to a wider population, but findings can be transferred to other settings [86]. The transferability of findings to young women of different cultural backgrounds may be limited due to the large proportion of Anglo-Australian women in the sample, Paney, Gale, and Sarsen-Fisher’s (2011) research has highlighted the importance of socio-cultural context in understanding experiences of smoking among Aboriginal women in Australia [86]. Future research could look more closely at culture and ethnicity, and how these identities might shape young women’s constructions and experiences of quitting, in order to develop interventions which are specific to culturally-diverse young women. The findings of the study are also limited to the majority heterosexual sample of women. Bisexual and lesbian women have expressed interest in tailored smoking cessation interventions [87], and such interventions have begun to be developed in Australia [88]. Further qualitative research on young bi-sexual and lesbian women’s experiences of smoking and quitting could support the continued development and evaluation of such interventions. Limitations also surround the applicability of these findings to young women who are pregnant. Previous research has shown that pregnant and non-pregnant women have distinct experiences of smoking cessation [89]. Although this study included women’s experiences of smoking and quitting during pregnancy, these women made up less than a third of the original sample, which limits the transferability of our findings to this group.

Conclusions

The findings from this study add new insight into the complexity and contradiction of young women’s quitting experiences. These findings align with the contradictory depictions of smokers inherent in tobacco control and tobacco industry agendas. For instance, while smoking is portrayed in tobacco control campaigns as a dangerous, risky and addictive habit, cigarettes have also been advertised as a source of pleasure and enjoyment, and as a form of self-expression for women [90]. Findings from this study are relevant to the development of individualised interventions, and important to the evaluation of current public health approaches to smoking. These findings support calls for a comprehensive approach to young women’s smoking, where population-level policies, such as taxation, are delivered alongside local interventions targeted specifically at young women [8]. Interventions targeted at young women need to offer flexibility and variety, allowing women to take control and make their own decisions regarding cessation [91, 92].

Tobacco control messages need to challenge existing public health discourse that suggests smokers are solely responsible for their health, or have complete control over their smoking behaviors. However, it is also important that these messages do not also remove young women’s sense of agency, as this study has shown that a lack of agency in quitting can result in experiences of disempowerment and/or an inclination to resist quitting. It is imperative that programmes and policies targeting young women seek to intervene earlier than pregnancy and motherhood, as many women in Australia are now delaying having children until their 30s [93]. The focus of these programmes and policies could be directed towards improving young women’s mental health, given their reports of increasing levels of psychological distress [94], and the bi-directional relationship between smoking and poor mental health among young women [95]. As previous researchers have argued [96], it is our recommendation that in order to impact cessation rates among young women, we must improve the social and economic environment in which they are situated. The similarity in accounts of young women’s ‘smokers’ and ‘ex-smokers’ in this study, affirms the need for tobacco control responses which conceptualise smoking and non-smoking as non-binary, non-linear practices, and quitting smoking as being more of a process of recovery and relapse [32, 34].

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Availability of data and materials

The datasets generated and analysed during the current study are not publicly available due to ethical restrictions but are available from the corresponding author on reasonable request.

Authors’ contributions

JL, JW, JT were involved in the design of the study. The data was collected by JT, JU, JW, JW, JT were involved in the analysis, interpretation, and writing of the manuscript. JU, JW, JT read and approved the final manuscript.

Ethics approval and consent to participate

Ethical approval for the study was granted by Westmead Hospital, University of Sydney, Concord Hospital. Consent was given by participants for participation in the study. For the face-to-face interviews written consent was signed on paper, and for the phone interviews written consent was given via email. Participants’ names were replaced with pseudonyms.

Consent for publication

Participants gave informed consent for the use of the data from the project, which included the use of their interviews and photographs in publications.

Competing interests

The authors declare that they have no competing interests.

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