Tobacco denormalization as a public health strategy: Implications for sexual and gender minorities

Tobacco denormalization, as a public health strategy, describes “all the programs and actions”, including policies and interventions such as media campaigns and smoking bans, “undertaken to reinforce the fact that tobacco use is not a mainstream or normal activity in our society.”[1] This strategy has roots in social learning theory,[2] and emphasizes the role of social constructs in shaping an individual's smoking beliefs and behaviors. Studies suggest that tobacco denormalization is a successful population-level approach for reducing the prevalence of smoking.[3–8] For example, Alamar and Glantz[9] found that increasing the social unacceptability of smoking is an effective policy tool to reduce cigarette smoking, with results revealing that for every 10% increase in the social unacceptability of tobacco index, there would be an associated 3.7% drop in cigarette consumption.

A tobacco denormalization approach is unique in that it **endorses** tobacco-related stigma rather than works to mitigate stigma like, for example, prevention and treatment efforts focused on HIV/AIDS or drug use.[10–14] Tobacco-related stigma refers to the negative social meanings and stereotypes associated with tobacco use, usually smoking, identifying smoking as shameful. Smokers can come to be seen as “weak-willed”, “outcasts” and “lepers”, and abusers of public services.[15–17] Researchers have found increasingly strong anti-smoking attitudes in the United States, largely due to the denormalization of tobacco use.[6,7,14,18] Though tobacco denormalization is widely lauded as a successful population-level approach for reducing the prevalence of smoking,[4,6,9] debate surrounding the ethics of using stigma in tobacco control has emerged in the literature.[14,19–21] Some have argued that stigmatization is never ethical as it is always a

“cruel form of social control”.[20] Others suggest, however, that the benefits associated with stigmatizing tobacco outweigh the potential for short-term consequences.[14,19] Additionally, concerns about the potential of tobacco denormalization efforts to exacerbate rather ameliorate health inequities have been raised.[14] Groups who experience health inequities and exhibit the highest prevalence of health compromising behaviors, like smoking, also tend to be groups that are historically disadvantaged and characterized by other social identity stigmas like low socio-economic, ethnic minority, or sexual and/or gender minority status.[22,23] Because of this social gradient of smoking, the burden of tobacco related stigma arguably falls on the most marginalized populations whose risks of smoking are, in some cases, double that of the general population.[14,19]

For instance, the prevalence of tobacco use for sexual and gender minorities remains alarmingly high. [24–32] Sexual and gender minority is a broad term that acknowledges the fluidity of identities and includes people who identify as lesbian, gay, bisexual, transgender, intersex, and/or queer.[33] Trend data on the prevalence of smoking among sexual and gender minorities is limited due to a failure to measure these identity categories appropriately or at all in surveys as well as participants’ refusal to disclose this information.[34,35] A systematic review of 42 studies on tobacco use among these groups in the US found a significantly higher risk of smoking among sexual and gender minorities compared to the general population (OR = 1.5 to 2.5).[26] In addition to the same risk factors for smoking that confront other groups, sexual and gender minorities also face additional factors that exacerbate their risk, including social environments that are accepting of smoking,[27,36,37] aggressive targeting by the tobacco

industry,[38–42] and perhaps most notably stigma-related processes including minority stress, psychological distress, and social isolation.[24,26,29–31,39,43–49]

The alarmingly high risk of smoking among sexual and gender minorities together with research that has documented a relationship between stigma-related processes and smoking prevalence for these groups raises questions about whether tobacco-related stigma intensifies the disadvantages associated with the stigmas of other social identities.[47,50] Stigma research in public health has been criticized for too narrowly focusing on a singular stigmatizing attribute, and neglecting to recognize that stigmatized people often experience multiple forms of stigma.[51,52] Sexual and gender minority smokers may be vulnerable to tobacco-related stigma. And, importantly, their experiences with, and the extent to which they internalize that stigma, is complicated by their other social identities that may be additionally stigmatized, including their socioeconomic status, race/ethnicity, as well as their distinct sexual and/or gender minority identity.[53]

Research on stigma suggests that public health policies which purposefully use stigma to change behavior may have unintended consequences for groups who are already stigmatized in society by virtue of some other characteristic, like their sexual and/or gender identity.[14,45,54] For example, stigmatized people may experience a “diminished sense of self-esteem and self-efficacy”[55] that translates into fatalistic attitudes about one’s ability to change.[55–58] Frohlich and colleagues[59,60] suggest that the risk-based framing of tobacco prevention efforts has iatrogenic effects for low-income youth because it stigmatizes them as a group at risk of smoking. The authors argue that framing a marginalized group, such as low-income youth, as ‘at risk’ for smoking results

in more, not less, smoking because the message conveys to youth that smoking is inescapable and inevitable for them, and therefore, their sense of self-efficacy to quit is diminished. Whether and to what extent tobacco-related stigma reduces sexual and gender minority smokers' sense of self-esteem and self-efficacy is unknown, yet may have important implications for understanding the high prevalence of smoking among these groups.

Additionally, stigmatized people might evade stigma by rejecting any association with the stigmatized attribute. For example, people who smoke will not identify themselves as smokers when asked about their smoking status. Leas and colleagues[61] found that 12.3% of all smokers in California could be considered "non-identifying smokers", and ethnic minority smokers were more than 3 times as likely to reject the label of smoker compared to non-Hispanic whites. Similarly, preliminary findings from our own research on smoking among African American young adults suggests that many of those who smoke do not identify themselves as smokers, a phenomenon that may be due in part to an internalized stigma of smoking (TRDRP grant # 22RT-0093). The extent to which sexual and gender minority smokers conceal or disassociate from their smoker identity is not known yet has important implications for prevention and treatment.

Conversely, to avoid stigma, smokers may segregate themselves into communities accepting of smoking. A qualitative study by Thompson and colleagues[62] in New Zealand found that smokers from marginalized groups responded to state denormalization efforts by altering their smoking behavior around others but continued smoking within their communities. This created local norms accepting of smoking. For

sexual and gender minorities, nightlife locations, long considered safe spaces, are also settings traditionally accepting of smoking.[37] This may perhaps facilitate an easy segregation of sexual and gender minority smokers. Also, research with young adults has found that smoking is considered highly normative in sexual and gender minority communities, which may also result in a strong sense of social pressure to smoke.[63]

Finally, research suggests that overlapping stigmas of some social identities and smoking status may intersect to trigger resistance to, rather than compliance with, policies that stigmatize smoking. For example, Factor and colleagues[54,64] propose that stigmatized minority groups engage in everyday acts of resistance to dominant groups by purposely engaging in unhealthy practices like smoking which are stigmatized by the dominant group. This suggests that denormalization policies that stigmatize smoking may have negative consequences for some stigmatized groups because smoking may be used to differentiate oneself from the non-smoking norms of the dominant group. The extent to which this is true for some sexual and gender minority smokers is unclear.

In their theory about the twin aims of justice, Powers and Faden[65] emphasize the importance of implementing public health policies that both (1) improve population-level health as well as (2) reduce health inequities.[50(p1840)] Though the population-level success of tobacco denormalization is widely accepted,[3–8] it remains unclear if tobacco denormalization strategies also alleviate health inequities for sexual and gender minorities. We believe that a focus on stigma should be paramount in research on tobacco, particularly when the stigmatization of tobacco is commonplace and arguably reinforced by public health policies, and when disparities in tobacco use prevalence fall on the most stigmatized. To date, the research community has not adequately

considered how tobacco-related stigma overlaps with other social identity stigmas. Given concerns about the intensification of inequality,[50] this type of inquiry has important implications for understanding the effectiveness as well as limitations of tobacco denormalization strategies for sexual and gender minorities and identifying tobacco prevention, treatment, and policies that work to ameliorate health inequities.

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