UC Berkeley
UC Berkeley Previously Published Works

Title

The gendered experience of smoking stigma: implications for tobacco control

Permalink

Journal

Critical Public Health, 27(4)

Author

Antin, Tamar

Publication Date

2016-10-26

Peer reviewed

The Gendered Experience of Smoking Stigma: Implications for Tobacco Control
Journal: Critical Public Health

Tamar M.J. Antin[1,2]

Rachelle Annechino[1]

Geoffrey Hunt[2]

Sharon Lipperman-Kreda[3]

Malisa Young[1]

[1]   Center for Critical Public Health

Prevention Research Center

180 Grand, Suite 1200

Oakland, CA 94612

[2]   Center for Critical Public Health

Institute for Scientific Analysis, Suite 211

1150 Ballena Blvd

Alameda, CA 94501

[3]   Prevention Research Center

180 Grand, Suite 1200

Oakland, CA 94612

Corresponding Author: Dr. Tamar M.J. Antin
                      Center for Critical Public Health
                      Prevention Research Center
                      180 Grand, Suite 1200
                      Oakland, CA 94612
                      tamar@criticalpublichealth.org
                      tantin@prev.org
                      510-883-5749

ABSTRACT

Tobacco denormalization is a widely accepted tobacco control strategy, shaping policies and programs throughout the United States as well as globally. In spite of widespread beliefs about the effectiveness of tobacco denormalization approaches, concerns about their emphasis on stigmatization have emerged. Social science research on smoking stigma raises questions about the potential iatrogenic consequences of tobacco denormalization approaches. Few studies have considered how smoking stigma may be internalized differently by different people, particularly those who experience stigmatization because of other socially-ascribed makers of inequity (e.g. race, ethnicity, gender, sexuality). The intersection of multiple stigmas may work to intensify the "social isolation and marginalization" that some people already experience (Greaves & Hemsing 2009; pg S127). This paper presents results from a pattern-level analysis of focus group and interview data from a study investigating smoking-related stigma and perceptions of tobacco denormalization approaches among 15 low income Black women who smoke in the San Francisco Bay Area. Our analysis revealed a cycle where Black women's experiences with structural oppression resulted in stress and the use of cigarettes to cope with that stress. Though the connection between smoking and stress is well documented in previous research, our analysis further revealed the additional contribution of the stigmatization of smoking and how it intensifies inequity for Black women who smoke. Implications of these findings for tobacco control and prevention are discussed.

Keywords: qualitative, health inequity, tobacco control, stigma

INTRODUCTION

The prevalence of smoking among women increased dramatically early in the 20th century, due in part to its emergence as a symbol of women's emancipation and tobacco companies' exploitation of this symbol (Amos & Haglund, 2000; Ernster, Kaufman, Nichter, Samet, & Yoon, 2000). However, gender did not develop as a focus in tobacco research until the 1980s (Batten, 1993; Greaves & Jategaonkar, 2006), fueled in part in the United States by the 1980 Surgeon General's report warning of an "epidemic of smoking-related disease among women" (U.S. Department of Health and Human Services, 1980, 2001). In the latter part of the 20th century, research on gender and tobacco proliferated. However, many of these studies were epidemiological investigations that "conflated 'women's smoking' with 'pregnancy and smoking,'" and therefore did little to elevate the position of women's health (Greaves, 2015, p. 1451). Some notable exceptions emerged at this time from feminist researchers who highlighted the unique role cigarettes play in women's lives and the gendered meanings ascribed to smoking (Graham, 1987, 1993; Jacobson, 1982). For example, Graham's seminal qualitative work on disadvantaged mothers in the U.K. drew attention to the context of women's everyday lives, particularly their role as "carers" and specifically "caring-in-poverty," and its influence on smoking (Graham, 1987, p. 51). She argued that smoking plays a contradictory role in women's lives in that it promotes a sense of well-being for women (e.g.

coping with the stress of care giving) yet also imposes significant health risks for women and their families.

Since these early studies, qualitative research on women's smoking has grown, contextualizing women's smoking and situating it within a broader discourse. A large majority of these studies have focused on maternal smoking, both pre- and post-partum [e.g. see (Flemming, Graham, Heirs, Fox, & Sowden, 2013; Graham, Flemming, Fox, Heirs, & Sowden, 2014) for a review], though exceptions exist that include studies of women living in circumstances of disadvantage (Stewart et al., 1996, 2011), smoking among college women (Nichter, Nichter, & Carkoglu, 2007; Nichter et al., 2006; Stromberg, Nichter, & Nichter, 2007), and meanings of smoking for adolescent girls (Bottorff et al., 2014; Haines, Poland, & Johnson, 2009; Young & Banwell, 1993). In spite of evidence documenting unique contexts, practices, and pathways of tobacco use for women [see (Greaves, 2015)], tobacco control and prevention agendas still remain largely gender neutral (Amos, Greaves, Nichter, & Bloch, 2012; Greaves & Hemsing, 2009).

Tobacco denormalization, for example, has become a widely accepted tobacco control strategy, shaping policies and programs throughout the United States as well as globally (World Health Organization, 2008). Tobacco denormalization describes all programs and actions, including policies and interventions such as media campaigns and public smoking bans, undertaken to reinforce the idea that tobacco use is not a mainstream

or normal activity in society (Lavack, 1999). The California tobacco control program is known for its denormalization approach and is credited for both reducing the prevalence of smoking and the social acceptability of smoking (Al-Delaimy WK, White MM, Mills AL, Pierce JP, Emory K, Boman M, Smith J, Edland S, 2010). In spite of its success, smoking remains high among the most disadvantaged groups in California, including low income racial and ethnic minority women. More specifically, smoking prevalence for Black women is the highest in the state (~15.2%-19.5%) and the rate of smoking among low-income Black women is likely much higher given that the prevalence of smoking for low-income Blacks in California is 29% (California Department of Public Health, 2015). Such pronounced disparities in smoking raise critical questions about the extent to which these strategies are inclusive and equitable (Greaves & Hemsing, 2009).

Social scientists have voiced concerns about tobacco denormalization's emphasis on stigmatizing smoking and have highlighted the extent to which these strategies may be particularly problematic for some groups because they contribute to a "social climate in which smoking and smokers are stigmatized" (Bell, Salmon, Bowers, Bell, & McCullough, 2010; Graham, 2012, p. 84; Voigt, 2010). Importantly, for smokers, who already experience discrimination as a result of other socially-ascribed identity categories (e.g. race, gender, class), the stigma that they experience from smoking may intensify the "social isolation and marginalization" that they already experience (Greaves & Hemsing, 2009, p. S127; Voigt, 2010). Though

research on women and smoking is continuing to expand, too little attention has been paid to the differences among women, yielding little understanding about how women's experiences with smoking are shaped by intersecting social identity categories. Interrogating intersections of these social categories has important implications for understanding differences in smoking behaviors and meanings among women as well as variations in women's responsiveness to gender neutral tobacco control strategies, like tobacco denormalization. More research is needed on the unique meanings and experiences of smoking among low income Black women, especially within the context of tobacco control strategies that intentionally or not stigmatize smoking among women who are subject to multiple other axes of oppression.

Intersectional approaches to research on women's smoking are currently lacking in the literature. Intersectionality is a sociological paradigm that emerged from Black feminist thought (Collins, 1990; hooks, 1984) and is most often attributed to Kimberle Crenshaw (Crenshaw, 1991) who coined the term when highlighting Black women's invisibility and arguing that social identity categories are wrongly conceptualized as independent or additive, rather than interactive. Intersectionality emphasizes how multiple social categories (e.g. race, gender, class) intersect and produce different experiences of oppression (Bowleg, 2012; Collins, 1990; Crenshaw, 1991). Just as Angela Davis highlighted how reproductive health challenges can be linked not just to gender and race, but to specific intersections between

gender and race (Davis, 1981), other forms of health inequity may be better understood by examining interactions between multiple social categories. Low-income Black women who smoke may be vulnerable to the social stigma of smoking; but also and most importantly, the social stigma of smoking may be experienced differently relative to the intersection of other stigmatized social markers, including their perceived gender, race/ethnicity, and socio-economic status. In other words, the stigma of smoking does not exist in isolation from other social identities that influence women's lives and, therefore, must be considered from an intersectional perspective. This article presents the results of a qualitative study investigating the lived experience of smoking stigma and other intersecting social identity stigmas for Black women who smoke. Informed by principles of intersectionality, we interrogate axes of stigma, including the stigma associated with being a smoker, to raise questions about the potential unintended consequences of tobacco denormalization policies for low income Black women who smoke.

METHODS

This analysis is based on the narratives of 15 Black women (14 identified as women, and one who described being "constantly read as female" but not identifying with "any particular gender") between the ages of 18-25 who participated in in-depth qualitative interviews (n=10) and one group interview (n=5) for a study investigating smoking behaviors and perceptions of tobacco-related stigma in the San Francisco Bay Area in

California. We conducted a 1.5 hour group interview prior to individual interviews to identify potentially salient issues to integrate into the individual face-to-face interview guide (Bernard & Ryan, 2010). Participants were recruited on the street, through Facebook advertising, and by referral. Interviews lasted approximately 2.5 hours and were designed to elicit narratives from participants about their background, experiences as a member of a marginalized group, personal tobacco use, beliefs about tobacco and the social unacceptability of tobacco. All interviews were digitally recorded and professionally transcribed. To show our appreciation for their time, participants received a $40 honorarium. All study procedures were approved by the [INSERT INSTITUTIONAL AFFILITATION] Institutional Review Board.

Immediately following interviews, the interviewer completed fieldnotes to record preliminary analytical ideas emergent from interviews as well as to contextualize interviews with descriptive information not captured in audio recordings. Pseudonyms, selected by participants, are used for identifying quotations. A research assistant and the lead author coded transcripts to distill data into manageable analytical segments, using ATLAS.ti a qualitative data management system (Muhr, 2006). The code list was extensive and included codes like self-stigma, public stigma, tobacco use, structural inequity, smoker identity, smoking behaviors, stress, and agency. To ensure an iterative approach to analysis, the research team recorded preliminary analytical ideas about the data by attaching memos to segments

of interview transcripts (Birks, Chapman, & Francis, 2008). Themes emergent from memos informed the development of the codebook. After coding all transcripts, the research team used a pattern-level analytic approach to explore multiple ways in which patterns may exist in the data: (1) declaration from the participant that a pattern exists, (2) omission of an expected pattern, (3) frequency of a particular pattern in the data, (4) congruence of a pattern with prior research and theory, and (5) co-occurrence of ideas suggestive of a pattern (LeCompte & Schensul, 1999). We also considered divergent ideas across interviews and conflicting discourses within interviews to identify themes as well as reduce threats to the valid interpretation of the data (Antin, Constantine, et al., 2015).

Sample

All participants included in this study identified as women, except for one participant who identified as genderqueer, a gender identity that implies a rejection of a mainstream gender binary structure (i.e. woman, man) (Baca Zinn, Hondagneu-Sotelo, & Messner, 2016). Seven participants reported their sexuality as bisexual and one participant identified as a lesbian. Since we did not purposely target recruiting to lesbian, gay, bisexual, transgender, or queer (LGBTQ) young adults, nor were participants recruited from the same social network, such a significant representation of LGBTQ participants raises questions about the connection between sexual and gender minority identities, stigma, and smoking prevalence (Hatzenbuehler,

Jun, Corliss, & Austin, 2014; Johnson et al., 2016). The majority of the participants (n=9) reported an annual household income of less than $25,000 USD and only one reported an annual household income above $65,000. The relatively low incomes of the majority of our participants coupled with the fact that most received government-assisted health care for low-income individuals or were uninsured (n=10) suggests the importance of low-income or poverty status in situating these participants' narratives. All participants reported past 30 day smoking, with more than half reporting smoking every day in the past 30 days. Participants varied in the number of cigarettes smoked on smoking days, but the majority (n=10) reported smoking fewer than six cigarettes on days smoked.

FINDINGS

Analysis of the patterns of participants' narratives is illustrated by a simple statement made by Jade, a 22 year old smoker who said: "It's very obvious the correlation between systematic oppression and tobacco use." Jade reported a tremendous amount of discrimination and feels strongly connected to a Black identity. This simple but powerful statement encapsulates the theoretical contribution that emerged from the analysis of these participants' narratives: that is, a cycle where structural oppression particular to the experiences of young Black women resulted in stress and the use of smoking to cope with that stress. Whereas the association between stress and cigarette smoking among women has been identified

and described in previous qualitative research (Graham, 1993; Greaves & Hemsing, 2009; Stewart et al., 2011), our study emphasizes the stressors experienced by primarily low income Black women who bear the burden of multiple intersecting oppressions. In addition, our study participants highlighted the ways in which smoking stigma exacerbates the stress Black women experience and perpetuates the continuing cycle of multiple avenues of stigmatization and smoking. In the following sections, we will present data from participants' narratives to illustrate elements of this cycle to theorize about the potential negative consequences associated with efforts that stigmatize smoking.

Structural Oppression

The significance of structural oppression and the relentless discrimination that Black women face every day predominated in narratives. For example, Reese, a 20 year old smoker, talked about navigating constant racial discrimination:

> "In our society, being Black is not good…Based on everything: where you go, where you eat, how you dress. I think that's bullshit too. (Chuckles) I mean, for instance, when I come to places like this [research institute], I always put my game face on, because I don't want anybody to discriminate against me because I'm Black … I always make sure I present myself well, because they automatically think that 'cause you're Black, you're gonna act crazy or flip out or

whatever they say. That's just how I feel. Any place I go to, I'll just... you know, I'll be myself, but I always conduct myself **not** how they perceive us to be." *Reese*

Focus group participants also discussed frequent experiences with racism, many occurring in their workplaces.

"I was canvassing for either Nature Conservancy or Southern Poverty Law Center. And I was talking to this guy. He goes, 'Wow. I'm surprised you know this much.' I'm like, 'What?' He goes, 'Yeah. Surprised that you know this much. You're a pretty educated [*racial slur*].'"

"I was a manager at a store. And there was another manager, an older Caucasian lady. And one day, she said during a shift, "You know, you're not as Black as the other colored girls that I know." And I was very shocked, because I had never even got called a, "colored girl" […]To me, that was actually more racist than "[*racial slur*]."

Speaking to how identities are differentiated, Cherry, an interview participant, emphasized the intersection of social class and race that compounded oppression for some people of color:

"When you don't have money, period, in America, you're a target. And more people of color than white people, because they can slide by

without having money, because there's opportunities for them that aren't for Black people." *Cherry*

Dee introduced the intersection of gender and race, suggesting that Black women are subject to uniquely negative stereotyping compared to White women.

"In this society, you have the Madonna and the whore, right?...The Madonna is the mother. It's the White woman. Then you have the whore. That's like the Black woman, 'cause they constantly demoralize us." *Dee*

In the face of immeasurable discrimination, some participants talked about the pressure to overcome stereotypes associated with being a Black woman in America. Lisa revealed what she perceives to be among the biggest challenges facing Black women:

"You have to prove yourself. I feel like nowadays, as a young African American female – and it also applies to guys too – you have to prove that you're not what the stereotypes are trying to say that you are. You have to prove that you can talk right. You have to prove that you are getting a job. You have to prove that you can take care of children and that you're married...And that's the biggest problem: stereotyping... It's everywhere. It's an unspoken pressure. It gives people power to put you down I think. And the biggest thing is just

proving that you will not be put down because these stereotypes don't mean anything." *Lisa*

While Lisa indicated that Black men also have to prove they are "not what the stereotypes are trying to say," she later went on to describe how such stereotypes could be "completely different for men and women," with women bearing more burdensome stereotypes. Consequently, she did not characterize her experiences as the summation of stereotypes applied uniformly to African Americans, stereotypes applied uniformly to women. Instead, she contrasted her experiences as a Black woman with the experiences of others who did not share the same intersectional identities and therefore did not experience oppression in the same way.

The salience of structural oppression for participants in this study cannot be overlooked. Except for one participant, narratives were saturated with descriptions of oppression, including profiling by the police, surveillance while shopping, discrimination in the workplace, and blatant harassment in public. Notably, participants' narratives were also intersectional, stressing the overlap of race, social class, sexuality and gender identity which resulted in their unique experiences with oppression. Increasingly social and epidemiological research implicates racism as a fundamental cause of morbidity and mortality, operating through various pathways to produce racialized health disparities (García & Sharif, 2015; Williams & Mohammed, 2013). In this study, women's narratives not only illustrate women's

everyday experiences with racism, but they also highlight the unique burdens that low income Black women who smoke face due to the "matrix of domination," as described by Black feminist theory (Collins, 1990).

Stress and Smoking to "Survive"

Women in our study emphasized the role that stress plays in their everyday lives and tended to conceptualize stress as an embodied response to structural oppression. Lisa, described above, discussed the pressures to overcome insidious stereotypes of Black women and directly linked discriminatory treatment to stress in her interview:

> "…To be in a social situation where everywhere you turn, somebody has their eyes on you or there's a group watching you…is very, very stressful." *Lisa*

Though the notion of stress dominated interviews, disentangling discussions of stress from discussions of smoking during analysis was challenging due to their interconnectedness. When discussing how to manage pervasive discrimination and stereotyping, many participants talked about the role of smoking to cope with the stress of expectations and stereotypes imposed on Black women. For example, Nefarious, 21 years old, conveyed the struggles facing Black women and the meaning of the cigarette.

> "The single black woman is the hardest-worked person in the world. And that's the truth, because it's either that we have to get ourself

that job and college in the right way without any scandals or schemes, or without people trying to take advantage of us. Then when we become mothers, it's even harder because we got to make sure our youth comes out cool. But before we become moms, we try to get to where we are stable enough to fucking be able to live life, to actually afford those cigarettes. To actually want to quit, like, get to that point where you are so stable financially, emotionally, and family. Like, everything's fine, you know? That's hard. You're going to be like 50, 60 years old, finally able to put the cigarette down and be like, "I can live life and excel." *Nefarious*

Nefarious' quote above is supported by the literature on the Superwoman role—a notion of Black womanhood defined by strength, a duty to assist others and to suppress one's own emotions, independence and imperviousness, and success in spite of a lack of resources (Woods-Giscombé, 2010). Scholars argue that this role is in part a response to negative stereotypes and oppression of Black women, and Nefarious' above quote speaks to the potential meaning of the cigarette as a lifeline under such circumstances.

Smoking has long been associated with "easing tension and mitigating anxiety" (Bell & Dennis, 2013, p. 6; Voigt, 2010). In this study, participants' narratives emphasized cigarettes not just as a way to relieve stress in general but specifically to cope with the stress resulting from oppression.

For example, Jane Doe described the connection between suffering, stress, and smoking when talking about her journey towards identifying more strongly as a member of the Black community. She considers smoking in Black communities to be a result of "slavery days, where the slave masters ripped the men away from the women...and destroyed the family home."

> "In the hoods or the urban areas, I'd see all people around me, Newport, Newport, Newport[1]. I'd have to step back and just evaluate myself and my surroundings and say, "Wow, all these Black people, you see such stress. Why is everybody smoking? Why is everybody angry? Why is it all the time?" Being an African American has made me step up and just look at the world, and how our people are suffering, how Black people are suffering...as a minority group. So just looking at their struggle, I definitely do identify [as Black]...I see the light at the end of the tunnel, but then again, I'm in the dark."
> *Jane Doe*

Many participants described how their own smoking behavior is related to the stress resulting from experiences with multiple stigmas. For example, Jade eloquently explained how stress mediates the "correlation between systematic oppression and tobacco use".

---

1 Newport is an American brand of mentholated cigarettes popular among African Americans due in large part to extensive marketing by the tobacco industry in communities of color (Gardiner, 2004; Rock, Davis, Thorne, Asman, & Caraballo, 2010)

"I think my hope is to stop smoking tobacco because I know that I only smoke tobacco when I'm always stressed... 'Cause ultimately, it's like these systems of racism, of classism, capitalism, heterosexism, all of that comes back and connects to the feeling of me needing a certain substance to deal with it or to navigate through and still be happy." *Jade*

Similarly, Marley, a 22 year old smoker, identified an explicit connection between oppression and smoking when asked whether she had experienced discrimination because of her race. Here she discusses her experiences with being targeted at clothing stores for shoplifting, explaining how shop employees regularly follow her around the store.

"I'll go out there [to a clothing store]...I'm looking at sales. He's like 'Excuse me. Is your purse open? I'm loss prevention."...And, I'm like, 'Do you want me to open my purse right here in front of everybody? Because you could look in my purse. Why would I be stealing? Do you want to see my debit card? I have some cash on me. I'm shopping." He's like 'Oh, no need to make a scene.' But he's making a scene...I just left. I went outside to smoke a cigarette, actually." *Marley*

These narratives illustrate the relationship between discrimination, smoking, and stress for these women. While some participants' experiences were described in terms of a single social identity (for example, race in the examples above from Jane Doe and Marley), others described smoking as a

way to cope with the intersection of multiple axes of oppression. Nefarious, for example, suggested that expectations imposed specifically on Black women to be strong and superhuman ("the hardest-worked person in the world") both perpetuated the use of smoking as a coping mechanism and made it exceptionally difficult or even maladaptive to quit smoking before one is "stable" enough to "live life and excel."

Gendered Stigma of Smoking

Social science research on stigma often focuses on a single stigmatizing attribute (e.g. smoking); however, a stigmatizing process does not exist in isolation (Link & Phelan, 2001). Though in theory the stigma of smoking applies equally to all smokers, in reality other socially meaningful attributes intersect with this stigma (e.g. gender), working to exacerbate or alleviate oppression. In the case of smoking, qualitative studies have suggested that women have to work to mitigate the negative meanings ascribed specifically to women who smoke (Nichter et al., 2007; Nichter et al., 2006). With only one exception, participants in our study felt that compared to men, women were more stigmatized for their tobacco use. Focus group participants discussed how smoking isn't a "cute thing...for women." In Lisa's interview, she described the difference between men's and women's smoking:

> "I think that [in] the media, female smokers are portrayed as this sort of glamorous, devil-may-care, beautiful, ride-a-motorcycle type of thing...There are celebrity-type women smoking cigarettes. Whereas

in real society, it's frowned upon a lot by friends and family, and even strangers on the street will kind of glare at a female if she's smoking. So you have two completely different views… it's completely different for men and women. Men are…portrayed as devil-may-care, stressed type businessman, none of which are necessarily bad images…It's okay for men to smoke in society… or that's the view." *Lisa*

One consequence of the stigma of smoking for women that emerged in narratives is related to participants' loss of feminine status because of their smoking. For example, Eddy, a 23 year old smoker, highlighted how society views women smokers.

"They are usually viewed as loose women, like sluts or whatever, which is not something I condone, but that's what I usually hear. There's even an idiom that I've heard used a couple of times, 'If she smokes, she pokes.'" *Eddy*

In addition to the overly sexualized woman smoker, other participants commented on how smoking marks women as unattractive or out of control.

"You could be the prettiest girl in the world, but if you're smoking like a cigarette, it makes you look really ugly." *focus group participant*

"I feel like women that smoke cigarettes are looked down upon…like you can't control yourself, you have a problem, da, da, da… If it's a

woman, it's like, "Oh, you don't have control over yourself. You're not really a woman if you smoke cigarettes." *Dee*

The perception that smoking strips women of their femininity has been suggested by qualitative researchers elsewhere (Haines-Saah, 2011; Mimi Nichter et al., 2006; Young & Banwell, 1993). For example, Nichter and colleagues (2006) describe the double standard experienced by young college women who are situated in a university setting where smoking is both generally considered acceptable because one is "not yet in the real world" yet where women who smoke are considered "slutty, trashy, and out of control" (2006, p. 234). Evidence of the gendered stigma of smoking can also be found in public health campaigns designed to discourage smoking among women by perpetuating the view of "smoking as ugly" (Haines-Saah, 2011, p. 208). Haines-Saah (2011) argues that these approaches are a form of symbolic violence against women in that they capitalize on hegemonic notions of respectable femininity that prioritize beauty and render women's bodies subject to control.

Though narratives from our study emphasized the gendered stigma of smoking, the experience of gender and gendered stigma cannot be understood without consideration of women's other marginalized social identities, in particular race (Bowleg, 2012). For example, after describing her experiences with racial discrimination, Reese explained how smoking further confirmed the negative stereotypes that others impose on her.

"[Smoking] makes it worse...because I'm a female, I'm African American, I'm smoking a cigarette, I think it's just kind of like how they perceive us to be...it's just basically giving them what they want to see" *Reese*

Reese's narrative illustrates how one social category alone doesn't sufficiently explain the inequitable treatment that she experiences (Bowleg, 2012). Instead, she emphasizes how her smoking, her gender, and her race intersect to shape her experiences with discrimination. Considering women's axes of oppression may help to shed light on smoking inequities that we see among women.

There are multiple ways in which the stigma of smoking may manifest in women's lives, including social isolation, internalized stigma, including shame or guilt; and/or resistance (Corrigan & Fong, 2014; Link & Phelan, 2001; Pescosolido, Martin, Lang, & Olafsdottir, 2008). Some women in this study expressed shame about their smoking. Marley, who doesn't believe that smoking is "ladylike," described how she attempts to conceal her smoking from others.

"It doesn't mean something good to be a cigarette smoker...It's not something that I would want. Like, a lot of people don't know that I smoke cigarettes...nobody at my old job knows I smoke. They'll never smell the cigarette on me...I never want people to just be, 'Oh yeah,

she's a smoker'. No, that's not want I want people to know about me."

Marley

Accounts of concealing smoking were common in narratives, perhaps suggesting that a number of participants had internalized the ascribed negative characteristics of smoking, resulting in shame, and were attempting to avoid stigmatizing encounters (Evans-Polce, Castaldelli-Maia, Schomerus, & Evans-Lacko, 2015).

Resistance and a refusal to passively accept the stigmatized portrayal of them also emerged from women's narratives. For instance, Kitty talked about enjoying the outsider status ascribed to smokers, relishing that smoking makes you "bad" which makes her feel "fucking cool." Similarly, a focus group participant talked about actively resisting the negative reactions she gets from her smoking:

> "For those people who walk past us and they're putting it on extra thick when they cough out loud, at times, it makes me wanna go back where they are and blow the smoke in their face, and say, like, "That's what you get."

Lisa, who conceals her smoking in certain contexts and perceives a high degree of tobacco-related stigma, dislikes the outsider status imposed on her for smoking. But, as someone who feels like an outsider and experiences social anxiety, her narrative also emphasizes a perceived positive aspect of

stigma when she discusses benefiting from the community that she gains as a smoker (Shih, 2004).

> "When I think of a tobacco smoker, the images are actually sort of positive in my mind, although I know it shouldn't be...I think of somebody who turns to tobacco... And I almost feel like that's the kind of person that I can relate to... it makes me feel like there's a group out there that I can connect with, a group of people who turn to the same thing because they felt the same way relatively." *Lisa*

Though health researchers argue that the stigmatization of smoking is effective in encouraging people to quit smoking (Al-Delaimy WK, White MM, Mills AL, Pierce JP, Emory K, Boman M, Smith J, Edland S, 2010), analyses of women's narratives from this study illustrate how it may also work to perpetuate rather than discourage smoking, particularly for people who experience multiple forms of stigma (Thompson, Pearce, & Barnett, 2007). As Nefarious, who reported regular experiences with racial discrimination and perceives considerable tobacco-related stigma, explained:

> "You know, I might be a stigma, but I'm not a bad person at the end of the day. And, fuck. Like, I'm already stressing out because I have to get my shit together and figure out how I can be this perfect person and figure out how to deal with life. That's why I'm smoking. And y'all just making it so much harder...Like, you would just sit there and wanna start chain smoking, like, "Fuck you, fuck you, fuck you." 'Cause they're just

looking at me. We just sit there, like, "What are you looking at? Why you looking at me crazy? Do you want me to get crazy? ...Can I smoke a cigarette in peace?" *Nefarious*

CONCLUSION

In one sense, cigarette smoking among women has become far less taboo, not more, over time. Since the early 20th century, images of women smoking became more common and the tobacco industry began successfully advertising the cigarette as a marker for the "emancipation of women" and women's rights to freedom of expression (Amos & Haglund, 2000; Tinkler, 2006). Notably, however, the extent to which these positive images applied equally to all women is unclear. Nevertheless a shift occurred in the latter part of the 20th century which gave rise to new smoking taboos due in part to tobacco control efforts designed to denormalize the practice. Smoking cigarettes became a marker of immorality and one that indicates the sign of an irresponsible citizen (Bell, 2011; Bell et al., 2010; Keane, 2014). All women arguably bear the brunt of the stigmatization of smoking due to women's bodies being legitimate sites of control and hegemonic views about acceptable femininity (Haines-Saah, 2011; Hollway, 1984). However, the implications of this stigma may be experienced differently among Black women, because Black women's bodies are systematically discredited in different ways (Crenshaw, 1991; Tuana, 2006). Highlighting the convergence of these oppressions, including poverty, within the context of

the stigmatization of smoking sheds light on the unique meanings of smoking for low-income Black women. Such an investigation helps to understand why inequities in smoking persist, even among women who may all be unduly marked by the gendered stigma of smoking.

Low income racial and ethnic minority women who smoke experience stigma as smokers, and importantly, those experiences are further shaped by the fact that the stigma of the smoker does not exist in isolation but instead intersects with other stigmatized social identities, e.g. gender, race and ethnicity, sexuality, and/or low income status. Intersectionality scholars have long recognized that social identity categories are "interdependent and mutually constitutive" (Bowleg, 2008, p. 312), and only by considering the intersections can one understand the whole of an individual (Bowleg, 2012; Collins, 1990; Crenshaw, 1991; McCall, 2005). Calls for intersectional approaches to health research exist (Hankivsky & Christoffersen, 2008; Institute of Medicine, 2011), yet few studies have considered how stigmatized health behaviors, in our case smoking, additionally mark out individuals linking them to other stigmatized identity categories. Our study illustrates how the stigma of smoking manifests in the lives of low income Black women, resulting in the intensification of their oppression and social exclusion.

Our study should be considered in light of the limitations operating in all research, and specifically in qualitative research. The women in this study

all reside in the San Francisco Bay Area and were recruited purposely, possibly comprising a unique sample of low income Black women who smoke. Also, theoretical insights discussed here are based on our research team's interpretation of the transcripts of 15 participants. Though a sample of 15 is defensible for in-depth qualitative research with relatively bounded samples (Guest, Bunce, & Johnson, 2006), our interpretation is but one interpretation of these data. Of note, data presented in this paper may be perceived as further victimizing these participants. However, these narratives illustrate the significant voice and perspective of these participants, and we argue for their rightful place in the public health debate on stigma as a tobacco control strategy.

Critical and feminist scholars have called for more equitable tobacco control strategies (Bell & Dennis, 2013; Bell et al., 2010; Graham, 2012; Greaves & Jategaonkar, 2006; Voigt, 2010). For example, Graham (2012), in her analysis of the debate of tobacco denormalization and the stigmatization of smokers, argues that tobacco control policies, reliant on denormalization, serve to reinforce class-based hierarchies and prejudices, because of the social gradient of smoking where smoking prevalence is higher among those with the least social advantage. Rather than discouraging smoking among socially disadvantaged smokers, tobacco control strategies that rely on social denormalization may only serve to intensify oppression for the most oppressed and perpetuate smoking. Due in part to a lack of emphasis on intersectional approaches to women's smoking, studies have not yet

empirically considered to what extent the stigmatization of smoking inequitably affects women of color living in poverty, who compared to other groups of women are far more likely to smoke. Our study suggests that the stigmatization of the smoker may only serve to reinforce low income Black women's oppression and their smoking.

In spite of calls from feminist scholars arguing for women-centered, trauma-informed, and harm reduction approaches to tobacco control (Greaves, 2015), the state of California remains committed to a tobacco denormalization agenda. For example, on June 9, 2016, California implemented new laws to restrict the sale of all nicotine and tobacco products, including electronic cigarettes, to those ages 21 and over (Hernandez, 2016; Leno, 2016). Given that the prevalence of smoking at the population-level in California is among the lowest in the United States and increasingly visible inequities in smoking remain particularly among low-income Black adults (California Department of Public Health, 2015), it is time to conceptualize an equitable tobacco control strategy that includes a focus on the social determinants of smoking (e.g. racism, sexism) and works to lessen the stigmatization of the smoker.

One novel approach to tobacco control and prevention may involve shifting focus away from people who smoke and instead tackling head on the unintended consequences of the stigmatization of smoking for some groups. Facilitating contact between those who experience stigma and those who

endorse stigma has been shown to be an effective tool in reducing the societal-level stigma of mental illness (Corrigan & Fong, 2014). Consequently, a specific approach for tobacco control designed to reduce the prevalence of smoking among low-income Black women may involve media campaigns that highlight the lived experiences of stigma for women of color in an effort to draw attention to the counter-intuitive impact that the stigmatization of smoking may have on some marginalized groups. Though some groups may respond to tobacco denormalization efforts and quit smoking, we must not ignore the potential for iatrogenic consequences of public health policies and be sure that our public health agendas are ethical and prioritize health equity (Antin, Lipperman-Kreda, & Hunt, 2015; Hankivsky et al., 2014).

ACKNOWLEDGEMENTS

REFERENCES

Al-Delaimy WK, White MM, Mills AL, Pierce JP, Emory K, Boman M, Smith J, Edland S. (2010). Final Summary Report of: Two Decades of the California Tobacco Control Program: California Tobacco Survey, 1990-2008. La Jolla, CA: University of California, San Diego.

Amos, A., Greaves, L., Nichter, M., & Bloch, M. (2012). Women and tobacco: a call for including gender in tobacco control research, policy and practice. Tobacco Control, 21(2), 236–243.

Amos, A., & Haglund, M. (2000). From social taboo to "torch of freedom": the marketing of cigarettes to women. Tobacco Control, 9(1), 3–8.

Antin, T.M.J., Hunt, G., Constantine, N. (2014) Conflicting discourses in qualitative research: The search for divergent data within cases. Field Methods, 27(3), 211-222.

Antin, T. M. J., Lipperman-Kreda, S., & Hunt, G. (2015). Tobacco denormalization as a public health strategy: Implications for sexual and gender minorities. American Journal of Public Health.

Baca Zinn, M., Hondagneu-Sotelo, P., & Messner, M. A. (Eds.). (2016). Gender Through the Prism of Difference, 5th Edition (5th edition). New York: Oxford University Press.

Batten, L. (1993). Respecting Sameness and Difference: Taking Account of Gender in Research on Smoking. Tobacco Control, 2(3), 185–186.

Bell, K. (2011). Legislating abjection? Secondhand smoke, tobacco control policy and the public's health. Critical Public Health, 21, 49–62.

Bell, K., & Dennis, S. (2013). Towards a critical anthropology of smoking: Exploring the consequences of tobacco control. Contemporary Drug Problems, 40(1), 3–19.

Bell, K., Salmon, A., Bowers, M., Bell, J., & McCullough, L. (2010). Smoking, stigma and tobacco "denormalization": Further reflections on the use of stigma as a public health tool. A commentary on Social Science & Medicine's Stigma, Prejudice, Discrimination and Health Special Issue (67: 3). Social Science & Medicine, 70(6), 795–799.

Bernard, H. R., & Ryan, G. W. (2010). Analyzing Qualitative Data: Systematic Approaches. Los Angeles: SAGE Publications Ltd.

Birks, M., Chapman, Y., & Francis, K. (2008). Memoing in qualitative research Probing data and processes. Journal of Research in Nursing, 13(1), 68–75.

Bottorff, J. L., Haines-Saah, R., Kelly, M. T., Oliffe, J. L., Torchalla, I., Poole, N., … Phillips, J. C. (2014). Gender, smoking and tobacco reduction and cessation: a scoping review. International Journal for Equity in Health, 13(1), 114.

Bowleg, L. (2008). When black + lesbian + woman not equal to] black lesbian woman: The methodological challenges of qualitative and quantitative intersectionality research. Sex Roles, 59(5–6), 312–325.

Bowleg, L. (2012). The problem with the phrase women and minorities: intersectionality-an important theoretical framework for public health. American Journal of Public Health, 102(7), 1267–1273.

California Department of Public Health. (2015). California Tobacco Control

      Program, California Tobacco Facts and Figures 2015. Sacramento, CA.

Collins, P. H. (1990). Black Feminist Thought: Knowledge,Consciousness,

      and the Politics of Empowerment. Boston: UnwinHyman.

Corrigan, P. W., & Fong, M. W. M. (2014). Competing perspectives on

      erasing the stigma of illness: What says the dodo bird? Social Science

      & Medicine, 103, 110–117.

Crenshaw, K. (1991). Mapping the Margins: Intersectionality, Identity

      Politics, and Violence against Women of Color. Stanford Law Review,

      (6), 1241.

Davis, A. Y. (1981). Women, Race, & Class. New York: Vintage.

Ernster, V., Kaufman, N., Nichter, M., Samet, J., & Yoon, S. Y. (2000). Women

      and tobacco: moving from policy to action. Bulletin of the World

      Health Organization, 78(7), 891–901.

Evans-Polce, R. J., Castaldelli-Maia, J. M., Schomerus, G., & Evans-Lacko, S.

      E. (2015). The downside of tobacco control? Smoking and self-stigma:

      A systematic review. Social Science & Medicine (1982), 145, 26–34.

Flemming, K., Graham, H., Heirs, M., Fox, D., & Sowden, A. (2013).

      Smoking in pregnancy: A systematic review of qualitative research of

      women who commence pregnancy as smokers. Journal of Advanced

      Nursing, 69(5), 1023–1036.

García, J. J.-L., & Sharif, M. Z. (2015). Black Lives Matter: A Commentary on
Racism and Public Health. American Journal of Public Health, 105(8),
e27-30.

Gardiner, P. (2004). The African Americanization of menthol cigarette use in
the United States. Nicotine & Tobacco Research, 6(1), 55–65.

Graham, H. (1987). Women's smoking and family health. Social Science &
Medicine, 25(1), 47–56.

Graham, H. (1993). When life's a drag: women, smoking and disadvantage.
H.M. Stationery Office.

Graham, H. (2012). Smoking, Stigma and Social Class. Journal of Social
Policy, 41, 83–99.

http://doi.org/http://dx.doi.org/10.1017/S004727941100033X

Graham, H., Flemming, K., Fox, D., Heirs, M., & Sowden, A. (2014). Cutting
down: Insights from qualitative studies of smoking in pregnancy.
Health & Social Care in the Community, 22(3), 259–267.

Greaves, L. (2015). The Meanings of Smoking to Women and Their
Implications for Cessation. International Journal of Environmental
Research and Public Health, 12(2), 1449–1465.

Greaves, L., & Hemsing, N. (2009). Women and tobacco control policies:
Social-structural and psychosocial contributions to vulnerability to
tobacco use and exposure. Drug and Alcohol Dependence, 104,
Supplement 1, S121–S130.

Greaves, L., & Jategaonkar, N. (2006). Tobacco policies and vulnerable girls and women: toward a framework for gender sensitive policy development. Journal of Epidemiology and Community Health, 60(Suppl 2), ii57-ii65.

Guest, G., Bunce, A., & Johnson, L. (2006). How Many Interviews Are Enough?: An Experiment with Data Saturation and Variability. Field Methods, 18(1), 59–82.

Haines, R. J., Poland, B. D., & Johnson, J. L. (2009). Becoming a "real" smoker: cultural capital in young women's accounts of smoking and other substance use. Sociology of Health & Illness, 31(1), 66–80.

Haines-Saah, R. J. (2011). Pretty Girls Don't Smoke: Gender and Appearance Imperatives in Tobacco Prevention. In K. Bell, A. Salmon, & D. McNaughton (Eds.), Alcohol, Tobacco and Obesity: Morality, Mortality and the New Public Health. New York: Routledge.

Hankivsky, O., & Christoffersen, A. (2008). Intersectionality and the determinants of health: A Canadian perspective. Critical Public Health, 18(3), 271–283.

Hankivsky, O., Grace, D., Hunting, G., Giesbrecht, M., Fridkin, A., Rudrum, S., … Clark, N. (2014). An intersectionality-based policy analysis framework: critical reflections on a methodology for advancing equity. International Journal for Equity in Health, 13.

Hatzenbuehler, M. L., Jun, H.-J., Corliss, H. L., & Austin, S. B. (2014). Structural Stigma and Cigarette Smoking in a Prospective Cohort

Study of Sexual Minority and Heterosexual Youth. Annals of Behavioral Medicine, 47(1), 48–56.

Hernandez, E. California SB 27, Pub. L. No. SB 27 (2016). Retrieved from https://legiscan.com/CA/text/SBX27/id/1255920

Hollway, W. (1984). Gender difference and the production of subjectivity. In J. Henriques, W. Hollway, C. Urwin, C. Venn, & V. Walkerdine (Eds.), Changing the Subject: Psychology, Social Regulation and Subjectivity. London ; New York: Routledge.

hooks, bell. (1984). Feminist Theory: From Margin to Center. South End Press.

Institute of Medicine. (2011). The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding - Institute of Medicine. Washington, D.C.: National Academies Press.

Jacobson, B. (1982). The ladykillers : Why smoking is a feminist issue. New York : Continuum.

Johnson, S. E., Holder-Hayes, E., Tessman, G. K., King, B. A., Alexander, T., & Zhao, X. (2016). Tobacco Product Use Among Sexual Minority Adults. American Journal of Preventive Medicine, 50(4), e91–e100.

Keane, H. (2014). Cigarettes are no longer sublime. Australian Humanities Review, (57).

Lavack, A. M. (1999). De-normalization of tobacco in Canada. Social Marketing Quarterly, 5(3), 82–85.

LeCompte, M. D., & Schensul, J. J. (1999). Analyzing and interpreting ethnographic data (Vol. 5). Walnut Creek: AltaMira Press.

Leno, M. California SB 25, Pub. L. No. 25 (2016). Retrieved from https://legiscan.com/CA/bill/SBX25/2015

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. Annual Review of Sociology, 27, 363–385.

McCall, L. (2005). The complexity of intersectionality. Signs: Journal of Women in Culture and Society, 30(3), 1771–1800.

Muhr, T. (2006). ATLAS.ti (Version 4.2). Berlin: Scientific Software Development.

Nichter, M., Nichter, M., & Carkoglu, A. (2007). Reconsidering stress and smoking: A qualitative study among college students. Tobacco Control, 16(3), 211–214.

Nichter, M., Nichter, M., Lloyd-Richardson, E. E., Flaherty, B., Carkoglu, A., & Taylor, N. (2006). Gendered dimensions of smoking among college students. Journal of Adolescent Research, 21(3), 215–243.

Pescosolido, B. A., Martin, J. K., Lang, A., & Olafsdottir, S. (2008). Rethinking theoretical approaches to stigma: A Framework Integrating Normative Influences on Stigma (FINIS). Social Science & Medicine, 67(3), 431–440.

Rock, V. J., Davis, S. P., Thorne, S. L., Asman, K. J., & Caraballo, R. S. (2010). Menthol Cigarette Use Among Racial and Ethnic Groups in the United States, 2004-2008. Nicotine & Tobacco Research, 12, S117–S124.

Shih, M. (2004). Positive Stigma: Examining Resilience and Empowerment in Overcoming Stigma. The ANNALS of the American Academy of Political and Social Science, 591(1), 175–185.

Stewart, M. J., Brosky, G., Gillis, A., Jackson, S., Johnston, G., Kirkland, S., … Rootman, I. (1996). Disadvantaged Women and Smoking. Canadian Journal of Public Health / Revue Canadienne de Sante'e Publique, 87(4), 257–260.

Stewart, M. J., Greaves, L., Kushner, K. E., Letourneau, N. L., Spitzer, D. L., & Boscoe, M. (2011). Where There Is Smoke, There is Stress: Low-Income Women Identify Support Needs and Preferences for Smoking Reduction. Health Care for Women International, 32(5), 359–383.

Stromberg, P., Nichter, M., & Nichter, M. (2007). Taking Play Seriously: Low-level smoking among college students. Culture, Medicine and Psychiatry, 31(1), 1–24.

Thompson, L., Pearce, J., & Barnett, J. R. (2007). Moralising geographies: stigma, smoking islands and responsible subjects. Area, 39(4), 508–517.

Tinkler, P. (2006). Smoke Signals: Women, Smoking and Visual Culture in Britain. Oxford ; New York: Berg Publishers.

Tuana, N. (2006). The Speculum of Ignorance: The Women's Health Movement and Epistemologies of Ignorance. Hypatia, 21(3), 1–19.

U.S. Department of Health and Human Services. (1980). The health consequences of smoking for women: A report of the Surgeon

General. Washington: U.S. Department of Health and Human Services,

Public Health Service, Office of the Assistant Secretary for Health,

Office on Smoking and Health.

U.S. Department of Health and Human Services. (2001). Women and

Smoking: A Report of the Surgeon General. Washington: U.S.

Department of Health and Human Services, Public Health Service,

Office of the Assistant Secretary for Health, Office on Smoking and

Health,.

Voigt, K. (2010). Smoking and Social Justice. Public Health Ethics, 3(2), 91–

106.

Williams, D. R., & Mohammed, S. A. (2013). Racism and Health I Pathways

and Scientific Evidence. American Behavioral Scientist, 57(8), 1152–

1173.

Woods-Giscombé, C. L. (2010). Superwoman Schema: African American

Women's Views on Stress, Strength, and Health. Qualitative Health

Research, 20(5), 668–683.

World Health Organization. (2008). WHO framework convention on tobacco

control. Elaboration of guidelines for implementation of Article 12 of

the convention: Progress report of the working group. Retrieved from

http://www.who.int/gb/fctc/PDF/cop3/FCTC_COP3_8-en.pdf

Young, D., & Banwell, C. L. (1993). Rites of passage: Smoking and the

construction of social identity. Drug and Alcohol Review, 12(4), 377–

385.