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Research Paper

How will e-cigarettes affect health inequalities? Applying Bourdieu to smoking and cessation

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ABSTRACT

This paper uses the work of Bourdieu to theorise smoking and cessation through a class lens, showing that the struggle for distinction created the social gradient in smoking, with smoking stigma operating as a proxy for class stigma. This led to increased policy focus on the health of bystanders and children and later also to concerns about electronic cigarettes. Bourdieu's concept of habitus is deployed to argue that the e-cigarette helps middle-class smokers resolve smoking as a symptom of cleft habitus associated with social mobility or particular sub-cultures. E-cigarette use is also compatible with family responsibility and sociable hedonism; aspects of working-class habitus which map to the 'practical family quitter' and the 'recreational user' respectively. The effectiveness of class stigma in changing health behaviours is contested, as is the usefulness of youth as a category of analysis and hence the relevance of concerns about young people's e-cigarette use outside a class framework of smoking and cessation. With regard to health inequalities, whilst middle-class smokers have in class disgust a stronger incentive to quit than working-class smokers, there is potential for tobacco control to tap into a working-class ethos of family care and responsibility.

Introduction

The advent of electronic ('e'-) cigarettes has disrupted existing narratives (Stimson, Thom, & Costall, 2014) and there is continuing controversy as to whether they are helpful to tobacco control (McNeill et al., 2015; Nutt et al., 2016). In this article I argue that the impact of e-cigarettes on smoking prevalence and cessation rates in high-income countries can best be theorised through a class lens. Drawing on a range of disciplines including the social sciences, history, politics and public health, I show that Bourdieu's 'struggle for distinction' has driven the social gradient in smoking in high-income countries. I then explore how different aspects of class habitus are more or less compatible with smoking, cessation and e-cigarette use as classed cultural practices and identify different categories of e-cigarette use. Bourdieu suggested that 'the logic of research is inseparably empirical and theoretical' and I ground my theoretical analysis in fieldwork on smoking and the determinants of cessation undertaken in working-class areas of the North of England since 2012, in accordance with his argument that 'one cannot think well except through theoretically constructed empirical cases' (Bourdieu & Wacquant, 1992, p. 159–60),

Bourdieu and health

French sociologist Pierre Bourdieu's work was essentially concerned with class; he argued that a system of class differences corresponds to a system of lifestyle differences, and that it is these class-determined lifestyle differences which underpin structural exclusion processes (Hjellbrekke, Jarness, & Korsnes, 2015, p. 197). This process takes place through 'habitus', an acquired system of dispositions formed in the context of people's social locations (Williams, 1995, p. 585). Bourdieu explored how culture relates to social inequality and how the pursuit of distinction or differential recognition shapes all realms of social practice (Bourdieu, 1984). Although he did not write directly on health, Bourdieu showed how health and lifestyles are caught up in struggles for social recognition (Williams, 1995, p. 599). Whilst some critics have suggested his model is too deterministic, Bourdieu argues that habitus is an open system in which experiences constantly affect and modify dispositions (Bourdieu & Wacquant, 1992, p. 132). One instance of this flexibility is the idea of 'cleft habitus', which Bourdieu uses to describe a mismatch whereby the individual experiences dissonance and does not feel 'at home' in their class habitus, typically because of social mobility (Bourdieu, 2007, p. 100; Friedman, 2016); I will return to this idea in relation to e-cigarette use. Although I have referred to classed practices, Bourdieu resisted the reification of rigid classes and saw class as

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essentially relational. Whilst Bourdieu refers to the dominant and the dominated classes, for the purposes of this paper I will use 'working-class' as a broad term to indicate people engaged in manual and routine jobs, and 'middle-class' as a contrasting term.

Bourdieu's distinction and the social gradient in smoking

Bourdieu points out that cultural practices can change their meaning over time, for instance by becoming associated with lower or higher class (Bourdieu, 1998; Hjellbrekke et al., 2015, p. 190). In this first section, I analyse just such a historical evolution of taste, namely the social gradient in smoking. Although concerns about the effect of tobacco on health have been expressed since the early stages of its diffusion into Western Europe (James, 1954 [1604]), it was the introduction of bright leaf, flue-cured inhalable tobacco in 1839 and the cigarette machine in 1881 (Brandt, 2009, p. 24–27) which led to the public health disaster of the 1950s and 1960s when the consequences of greater ease of smoking and deeper inhalation became apparent in increased rates of lung cancer, previously a rare disease (Doll & Hill, 1950). Since that time smoking has primarily been studied as a public health problem involving the mapping of continued smoking patterns and the design and evaluation of interventions designed to decrease smoking prevalence.

Tobacco use in high-income countries is characterised by a social gradient whereby socio-economic status is inversely correlated with smoking (Barbeau, Krieger, & Soobader, 2004; Blackwell, Lucas, & Clarke, 2014; Hiscock, Bauld, Amos, & Platt, 2012; Reid, Hammond, & Driezen, 2010); Lopez's tobacco epidemic model (Lopez, Collishaw, & Piha, 1994) suggests that cigarette smoking first spread among the most powerful groups, starting with middle-class men then becoming more common across all classes and amongst women. Once smoking became widespread, middle-class men then middle-class women ceased smoking, whilst the least powerful continued to smoke (Dixon & Banwell, 2009, p. 2207). The point of the model is to help predict stages of the tobacco epidemic in countries thought to be in its earlier stages, and try to put measures in place to short-circuit its further development (Cairney, Studlar, & Mamudu, 2011, p. 232).

Whilst the Lopez model still has predictive power (Thun, Peto, Boreham, & Lopez, 2012), it does not explain the mechanisms behind the temporal trends it describes. Social scientists, most notably Pampel, have suggested that cigarettes were taken up initially by the middle-class to differentiate themselves from the working-class, then abandoned by them for the same reason (Ferrence, 1989, 1996; Pampel, 2005, 2010). Pampel's analysis of US data concluded that 'smoking declines first among high status persons, who become concerned with health, fitness, and the harm of smoking, and separate themselves from other groups by rejecting smoking and other unhealthy status' (Pampel, 2005, p. 120). Paralleling Pampel's quantitative analysis is Poland's qualitative work with smokers and non-smokers; he found that 'the dominant classes recast as distinctive and worthy of emulation their own rejection of (cigarette) smoking, their smoke-free status' (Poland, 2000, p. 10). These Bourdieuian analyses argue that being smoke-free confers distinction; smoking is rejected by the middle-class not only or primarily because it is objectively unhealthy, but because it has become associated with working-class status.

Despite the explosion of interest in Bourdieu in the social sciences (Outhwaite, 2009), Pampel and Poland's characterisation of the rejection of smoking as an example of class distinction has achieved limited currency. It is generally argued that the decline in smoking resulted from the dissemination of medical findings and the development of tobacco control (Berridge, 2007, 2013; Brandt, 2009) through coalitions of influence which affected public opinion and policy (Cairney et al., 2011; Feldman & Bayer, 2004; Rabin & Sugarman, 2001). The two explanations are not mutually exclusive, since social norms are themselves influenced by policy (Marmor & Lieberman, 2004, p. 275), and as Berridge argues in relation to the post-war decline in smoking in the UK, 'the thresholds for public regulation and intervention were themselves social and political and both reflected and reacted upon culture' (Berridge, 2013, p. 187); she also points out that health education can be effective only if it builds on 'issues already inherent in culture' (Berridge, 2013, p. 152).

Smoking and class stigma

As the middle-class moved away from smoking to distinguish themselves from the working-class, a circular process took place whereby smoking became ever more stigmatised in middle-class circles, leading to ever more middle-class cessation. Stigma involves the rejection of particular people because of attributes which are not acceptable to their wider society; the process results in 'spoiled identity' (Goffman, 1963) and depends on the existence of a power differential which allows labelling, stereotyping, separation, status loss and discrimination to take place (Link & Phelan, 2001, p. 382). In the UK, the stigma attached to poverty (Jones, 2011; Lawler, 2005) meant that as elites abandoned smoking which became a habit only of the poor, class stigma and smoking stigma became mutually reinforcing. Public health campaigns used the 'pedagogy of disgust' (Lupton, 2015) to reinforce a class-based notion of smokers (Frohlich, Mykhalovskiy, Poland, Haines-Saah, & Johnson, 2012, p. 981). In the US, whilst poverty is stigmatised as a failure to achieve the American dream (Lamont, 2009; Sennett & Cobb, 1972), the association between poverty and smoking has been less clear than in the UK because of cross-cutting patterns of smoking by race, gender and acculturation (Barbeau et al., 2004; Kawachi, Daniels, & Robinson, 2005; Navarro, 1990). However, morality plays a key role in American public life and health policy (Morone, 1997, 2004), and although it has taken longer in the US for smoking to be explicitly linked with poverty (Wan, 2017), it has long been constructed as immoral and disgusting (Rozin, 1999; Rozin & Singh, 1999). Similar processes conflating poverty and smoking stigma have taken place in other high-income countries (Peretti-Watel, Legleye, Guignard, & Beck, 2014; Thompson, Barnett, & Pearce, 2009; Triandafilidis, Ussher, Perz, & Huppatz, 2016).

The operation of distinction also explains why tobacco control in high-income countries has accelerated, becoming more active and successful in the past fifteen years (Berridge, 2007; Smith, 2013b); many middle-class policy-makers still smoked in the initial period, whereas only the poor smoked later on: the gradual conflation of class and smoking stigma made stronger action against tobacco possible. Brandt suggests there may be a 'tipping point' for stronger tobacco control based on the changing ratio of smokers to non-smokers (Brandt, 2004, p. 34); Berridge points out that once a substance is connected with a non-mainstream group, further discussion embodies a distancing and fear of 'the other' (Berridge, 2013, p. 78). However, whilst there has been considerable literature on the ethics of using stigma as a public health tool (Bayer & Stuber, 2006; Burris, 2008; Chapman & Freeman, 2008; Stuber, Galea, & Link, 2008; Stuber, Galea, & Link, 2009; Williamson, Thom, Stimson, & Uhl, 2014), few studies have made the point that smoking stigma operates as a place-holder or proxy for class stigma, which it exploits and exacerbates (exceptions are Farrimond & Joffe, 2006, p. 487; Graham, 2012, p. 92–93).

Against this argument, it might be suggested that studies of the experience of social disapproval by smokers have shown no consistent pattern by class status (Ritchie, Amos, & Martin, 2010). Stuber et al. (2008) found less experience of smoking stigma among lower-status compared to higher-status smokers (Stuber et al., 2008), whereas Farrimond and Joffe (2006) found more experience of stigma amongst lower-status smokers – particularly in contexts where non-smoking was the norm – and also that higher-status respondents were more likely to conceal their smoking (Farrimond & Joffe, 2006, p. 486–487). I suggest the explanation lies in the fact that the smoking gradient is spatialized, so that people of contrasting class and smoking status live in culturally and geographically separate social and spatial communities (Barnett,