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**CONSUMPTION PRACTICES, CONFLICT RESOLUTION AND
BEHAVIOUR CHANGE IN THE UK SMOKERS' MARKET**

DONNA MARIE WALLACE-WILLIAMS

A thesis submitted to the University of Huddersfield in partial fulfilment of the
requirements for the degree of Doctor of Philosophy

The University of Huddersfield

October 2017

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Abstract

In the UK tobacco denormalisation strategies (i.e. indoor smoking ban and display ban), have been acknowledged as important strategies to encourage behaviour change in smokers, through quitting or at least minimising it. This study examines the impact of these strategies on smokers and their behaviours in retail establishments and shared consumption spaces. It extends the work of Festinger (1957) on dissonance manifestation and behaviour, and of Michie and West's (2011) concept of behaviour change interventions, through the examination of smokers as consumers.

The strategy of 'denormalising' tobacco use has become one of the cornerstones of the global tobacco control movement. In the UK, tobacco denormalisation was born out of a need to protect non-smokers from the dangers of second-hand smoke and curb increasing numbers of deaths in smokers. These policies are overseen by the WHO Framework Convention on Tobacco Control (WHO FCTC), to which the UK became a signatory in 2002. Although the UK has strict tobacco denormalisation strategies and leads the way in tobacco control in Europe, there remains a dearth of UK-centric qualitative studies from a consumer standpoint exploring smoking behaviours and the impact of tobacco denormalisation.

An interpretivist theoretical perspective and the phenomenology research design is adopted for this study, drawing on qualitative data using interviews with 25 individuals (current smokers, ex-smokers, and non-smokers, retailers and industry personnel), living and working in and around the town of Huddersfield and the region of West Yorkshire, as well as three separate participant observations held in a stop-smoking clinic in the town of Huddersfield. Data was analysed using the strategy recommended by Miles & Huberman (1984), aided using NVIVO 11 data analysis software to identify emergent themes recommended by Bazeley & Jackson (2013).

Results of this study's analysis of data suggest that tobacco control strategies have overseen behaviour change in smoking participants during purchase and consumption, and whilst in shared consumption spaces but not in the way intended. Smoking participants continue to adopt, purchase and consume tobacco products in the face of mounting social and cultural opposition. However, behaviour change is manifested in ways they circumvent "*barriers to purchase, consumption and use*". For example, making friends with other smokers whilst standing outside to smoke, adopting new or alternative products such as e-cigarettes, engaging in brand switching and bulk buying, becoming brand knowledgeable and more informed about location of products stored in gantries, but also engaging in compensatory health behaviours to justify smoking continuation. The behaviour of smoking participants suggests observation and rejection of tobacco control strategies occur in parallel (i.e. take place at the same time). Findings therefore raise questions about the ethical and practical extent to which tobacco denormalisation strategies influence and encourage smokers to change behaviours.

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To God be the glory, great things He hath done

List of Abbreviations

ART	Anti-retroviral Therapies
ASA	Advertising Standards Authority
BAT	British American Tobacco
BCW	Behaviour Change Wheel
CD	Cognitive Dissonance
CHBs	Compensatory Health Behaviours
CHD	Coronary Heart Disease
CNS	Central Nervous System
COPD	Chronic Obstructive Pulmonary Disease
ENDS	Electronic Nicotine Delivery Systems
ETS	Environmental Tobacco Smoke
EU	European Union
F1	Formula One
HAART	Highly Active Anti-Retroviral Therapies
HD	Heart Disease
HIV	Human Immunodeficiency Virus
IMS	Integrated Marketing Communications
IT	Imperial Tobacco
JTI	Japan Tobacco Industries
LCCs	Little Cigars and Cigarillos
NHS	National Health Service
NRT	Nicotine Replacement Therapy
POS	Point of Sale
SES	Socio-economic Status

SHS	Second-hand Smoke
SLT	Smokeless Tobacco
SSS	Stop Smoking Services
TAPA	Tobacco Advertising and Promotion Act
TB	Tuberculosis
TCS	Tobacco Control Scale
TMA	Tobacco Manufacturers Association
UK	United Kingdom
USA	United States of America
WHO	World Health Organisation
WHO FCTC	WHO Framework Convention on Tobacco Control

Academic Biography

Parts of this thesis have been published in conferences and presented at developmental activities, including:

1. Wallace-Williams, D. M. and Wright, L. T. (2015). Marketing Tobacco Products to Female Consumer Segments in the UK – A Cultural Perspective, (Developmental Paper). Consumer Research SIG PhD Colloquium. Chester, UK, 27th April 2015.
2. Wallace-Williams, D. M. and Wright, L. T. (2015). Marketing Tobacco Products to Female Consumer Segments in the UK – A Cultural Perspective, (Full Paper). British Academy of Management (BAM) Annual Conference. Portsmouth, 8th – 11th September 2015.
3. Wallace-Williams, D. M. and Wright, L. T. (2017). Behaviour Change in Shared Consumption Spaces in the Context of the Indoor Smoking Ban. The Northern Advanced Research Training Initiative (NARTI) Conference. University of Liverpool, 11th – 12th September 2017.
4. Wallace-Williams, D. M. and Wright, L. T. (2017). “No Smoking Here, No Smoking There, No Smoking Anywhere”. Falling Walls Competition, European Researchers’ Night, University of Huddersfield, 29th September 2017.

I have also contributed to the academic development of fellow PhD peers and cohorts (and myself) through involvement in the following events:

1. Planning Committee Member, University of Huddersfield’s PGR Inaugural Conference. University of Huddersfield, 13th November 2015.
2. Successfully securing £4,690 Researcher Development Fund (RDF) to host 2 academic conferences for PhD research students:
 - (i) Academic Writing Workshop held in January 2016
 - (ii) GAMBI PGR Research Symposium held in December 2016.

Introduction

This thesis aims to explain to what extent existing UK tobacco demoralisation strategies encourages behaviour change in *smokers during purchase and consumption, and in shared consumption spaces*. Current anti-smoking climate within the UK makes this a topical issue, but limited UK-centric research in this area creates potential for studies developing this emerging area of consumer research. This is particularly significant as the commercial impact of tobacco control strategies justifies this study's position from a consumer perspective in trying to understand purchase and consumption behaviours. Furthermore, the social impact of smoking *warrants* exploring smokers' reaction to established tobacco control strategies to assist understanding smoking status and attitudes toward smoking regulations. These are the motivating factors which encourage researching this topic.

According to Curry, Vallone, Cartwright, and Healton (2011), tobacco is an equal-opportunity killer in that anyone who smokes will ultimately die from the habit. Numerous studies *also highlight the deadly effect of tobacco smoking*, (e.g. *Avci et al., 2015; Cummings, Morley, & Hyland, 2002; Hymowitz, 2012; Khan, Stewart, Davis, Harvey, & Leistikow, 2015; Lifson & Lando, 2012*). There is no denying that tobacco smoking is dangerous and that this position necessitates the institution of public measures to reduce its consumption. However, smokers feel unjustly discriminated against by these measures, claiming they make them social pariahs and smoking an unacceptable social activity (Dennis, 2013). This position sees smokers' resisting and defying tobacco control strategies, strengthening their resolve to continue smoking or take up the habit. According to Baha and Faou's (2010) study examining social denormalisation and smokers' motives for quitting, unless effective tobacco

control strategies are instituted to encourage behaviour change the high incidences of death and disease in smokers will continue but more importantly, smokers will continue to resist efforts at getting them to change their behaviours.

Throughout this thesis the terms 'tobacco denormalisation' and 'tobacco control' have been used interchangeably. In the current context they should be taken to mean one and the same. Both terms signify strategies and campaigns aimed at changing smokers' attitudes and behaviour towards tobacco and cigarette consumption. Additionally, the term 'shared consumption space' refers to pubs, clubs, bars and restaurants (Line, Hanks, Miao, & Daniell, 2016). Finally, there is awareness of other substances (e.g. marijuana or cannabis, tobacco pipe, shisha pipe) used by individuals recreationally or otherwise. These were not investigated in this study and have not formed part of discussions.

Chapter 1. Introduction

1.1 Background to the Current Situation

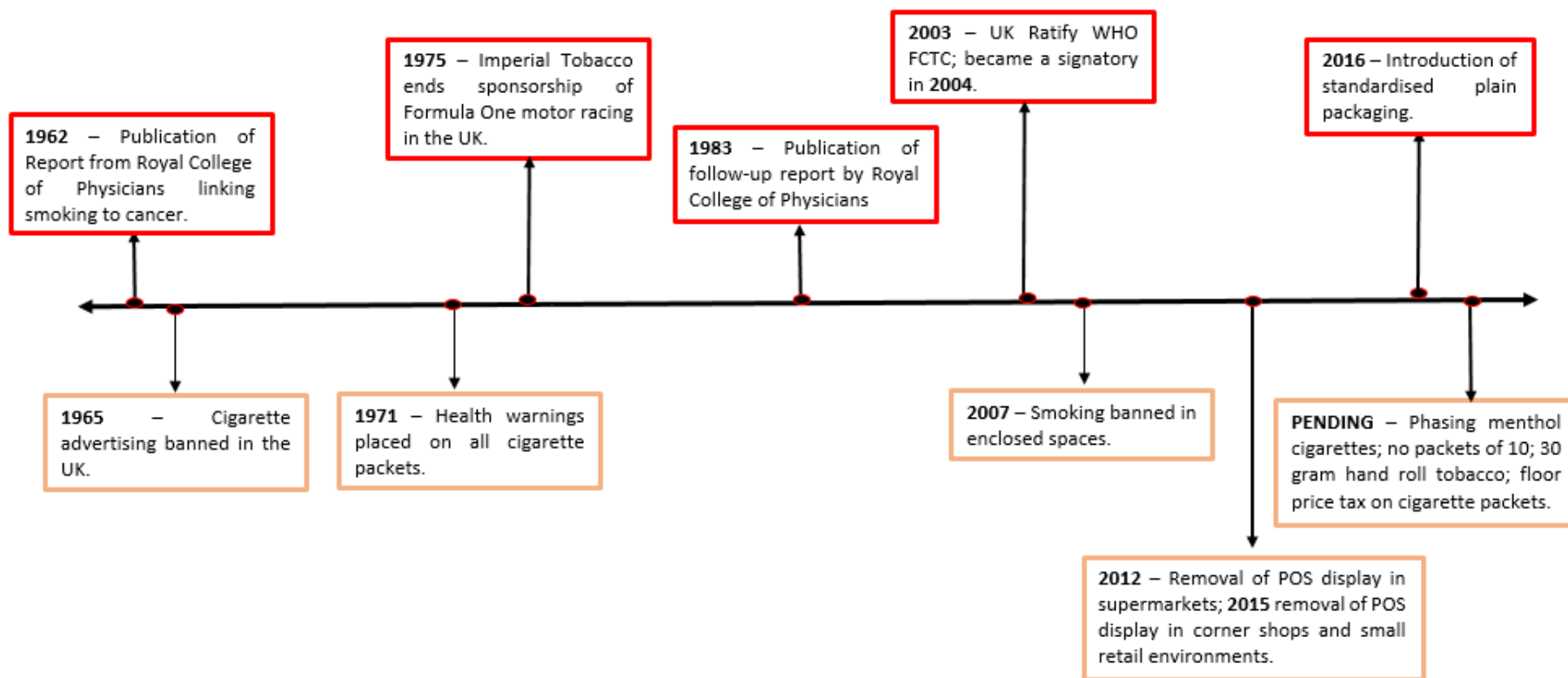
Prior to and leading up to 2007, anti-smoking campaigners and health officials within the UK expressed dissatisfaction with existing tobacco denormalisation strategies. Anchoring their arguments, smoking was being glamorised through on-pack designs and television advertisements and children needed to be protected from taking up the habit of smoking. They demanded more stringent tobacco control measures.

Opposition to smoking and smokers also came from the public. Mindfulness about the dangers of passive or second-hand smoke, as well as being health-conscious, saw complaints levelled at smokers for burdening the NHS with self-inflicted medical issues. Non-smokers accused smokers of having poor personal hygiene, for example yellowing and rotting teeth and being smelly. There was also the feeling that smokers generally pollute the environment with waste from cigarette butts contaminating the air, water and land, as well as polluting enclosed spaces through the emission of tobacco combustion by-products (Repace, Ott, & Klepeis, 1998).

Equally, strong opposition to tobacco denormalisation strategies came from the Tobacco Industry, related agencies, retailers and pub landlords, citing loss of income, trade and jobs to those dependent on tobacco sales. An article written by Hennessy (2008) published online in the Telegraph Newspaper, positioned that pubs hit by the effects of the indoor smoking ban were closing at the rate of twenty-seven per week, seven times faster than in 2006 and fifteen times faster than in 2005.

Despite attempts at tobacco control and increased awareness of the health consequences of smoking (via anti-smoking and shock advertising), some individuals within the UK continue to smoke. These individuals defy and resist established aids to quitting, making non-smokers “unwillingly participants” in the act of smoking through second-hand smoke. According to data released by the Office for National Statistics, 17.2% of the entire adult population in the UK still smoke - 19.3% of the entire male population and 15.3% of the female population (Office for National Statistics, 2014). Adolescents also adopt the habit of smoking encouraged by the mirroring of smoking actions of their parents, siblings and friendship groups. Background to the current situation is summarised in the timeline illustrated at Figure 1.1.

Figure 1-1: Timeline of Background to the Current Situation in the UK



Source: *Researcher's concept of the timeline of events of her study.*

1.1.1 Tobacco Denormalisation in the UK

Observance of the WHO Framework, coupled with continued pressure from anti-smoking lobbyists influenced the implementation of tobacco denormalisation strategies within the UK. The main strategies currently in place are indoor smoking bans, display bans and standardised plain packaging. Other denormalisation strategies are pending, for example the gradual phasing out of menthol cigarettes (McMullin, 2016), the unavailability of cigarettes in packets of 10 and availability of hand-rolled tobacco in 30 gram packets only (Perry, 2014a) and “floor price” tax on cigarette packets (Lipson, 2017).

The UK has strong tobacco control policies compared to other European countries, enabling it to achieve a score of 74 out of 100, the highest on the Tobacco Control Scale (TCS) among 34 European countries (see Appendix 1.1). Six types of tobacco control policies are used to assess tobacco control scale, (i) price (ii) public place bans (iii) public information campaign spending (iv) advertising bans (v) health warnings and (vi) treatment (K. Allen et al., 2016; Gilmore, Britton, Arnott, Ashcroft, & Jarvis, 2009; Joossens & Raw, 2014; Kelsey, 2015). All six policies have all been implemented in the UK.

Tobacco control programmes within the UK have grown in strength (Siddique, 2016), ensuring effectiveness and enabling new policy introductions such as plain packaging. However, Gilmore et al.’s (2009) study on harm reduction in UK tobacco control policies, suggests more radical control policies must be considered, and media campaigns should continue to de-legitimise the Tobacco Industry. Discussions on

existing, pending and contemplated tobacco control policies are presented in the paragraphs following.

1.1.1.1 Indoor Smoking Ban

Indoor smoking bans took effect in the UK since 2007 (Roxby, 2012). According to Anger, Kvasnicka, and Siedler (2011), the main priority of this ban is to safeguard non-smokers from exposure to second-hand smoke. The indoor ban extends to enclosed public places such as pubs, bars, restaurants, offices and factories (Darzi, Keown, & Chapman, 2015), private members' clubs (Dyer, 2006), as well as in cars where anyone under the age of 18 is travelling (GOV.UK, 2015). Following on the display ban's implementation, anti-smoking activists have lobbied for further bans such as exclusion zones in areas around beer gardens and alfresco eating areas of restaurants (Gallagher, 2015), as well as outside school gates and parks (Spencer, 2015).

1.1.1.2 Display Ban

The need to reduce smoking cues which encourage purchase and consumption signalled the implementation of tobacco display ban. This became effective in supermarkets since 6th April 2012 and in corner shops and small stores since 6th April 2015. Limits were placed on all point-of-sale display of tobacco products, strengthening existing policies prohibiting tobacco advertising (Kuipers et al., 2017). Promotion of cigarette sales are limited to price tags on shelves, price lists and signage announcing "*cigarettes sold here*" (Doughty, 2015). Effectively, all supermarket chains, corner shops and small stores removed cigarette and tobacco products from point of sale display keeping them out of sight by storing them in gantry display cabinets. An example of a gantry display cabinet is provided at Appendix 1.2.

Although the display ban affects cigarettes and rolling tobacco, changes have not yet extended to sale and purchase of e-cigarettes. A study examining e-cigarettes and product regulations (Zhu et al., 2014), emphasise that e-cigarettes are largely unregulated which presents challenges for regulating the product. This situation is not helped by the proliferation of retailers or availability over the internet, which makes it difficult to enforce any regulatory laws.

1.1.1.3 Standardised Plain Packaging

May 2016 signalled an end to the way tobacco products are packaged in the UK, although this regulation did not come into effect until May 2017. Under new regulations bright coloured cigarette packets have been replaced by uniformed olive-green colours. 65% of each packet bears graphic images on the front and back highlighting the dangers of smoking, with health warnings appearing on the top of all packets (see Appendix 1.3). All retailers were given a one year transitional period to allow depletion of existing stocks before total implementation (ASH, 2016e; Siddique, 2016).

1.1.1.4 Stop-Smoking Interventions

UK stop-smoking intervention strategies combine visual anti-smoking messages using shock tactics and fear appeal, social marketing campaigns such as *Stoptober* and smoking cessation clinics combining pharmacotherapy and behavioural support (Al-Chalabi et al., 2008). Complementary to existing tobacco denormalisation strategies, these interventions impact at a population level by supporting and reinforcing individual behaviour change (Zhu, Lee, Zhuang, Gamst, & Wolfson, 2012). Al-Chalabi et al.'s (2008) study found that the effectiveness of these strategies is not always guaranteed because smokers who use them often relapse. This behaviour was

evident during participant observation sessions conducted at the stop-smoking clinic. Some smokers would frequently excuse themselves from sessions to have a smoke, suggesting that although in a place where they are accessing help to quit, the need to smoke is greater thus causing smoking dependency. Further discussions on aids to quitting are held in Chapter 2.

1.1.1.5 The New Product of E-cigarettes Marketed to UK Consumers

Electronic Nicotine Delivery Systems (ENDS, e-cigarettes) (see Figure 1.2), are

Figure 1-2: Images of an E-Cigarette



Source: Google Images

battery powered devices which emit nicotine and not smoke, simulating tobacco cigarettes by the heating of nicotine and other chemicals (Weaver et al., 2016). A. Richardson, Pearson, Xiao, Stalgaitis, and Vallone's (2014) examination of reasons current and former smokers uses non-combustible products, found e-cigarettes popular with individuals wishing to circumvent indoor smoking ban and rising cigarette prices. They are also used as a potential smoking cessation tool (Willis, Haught, & Morris, 2017), although the risks are still unknown. Fears of e-cigarettes re-

normalising smoking has led to controls being placed on their use. For example, refill containers have become smaller with the maximum strength being 20 mg, tanks and cartridge sizes have been reduced to 2ml, packages are now child-proof and manufacturers must disclose e-cigarettes' contents (Fenton, 2016).

First introduced in China between 2003 and 2005, e-cigarettes' proliferation and popularity extend to approximately 50 countries worldwide including the UK. In 2012 there were approximately 600,000 adult users of e-cigarettes in the UK (Hiscock et al., 2014), by 2014 this figure increased to 2.6 million (Fenton, 2016). Sales of the product totalled £44 million in 2012 and rose significantly to £193 million by 2013 (Hughes, 2014). Tobacco companies such as British American Tobacco (BAT) have entered into the e-cigarette market, using it to navigate the changing landscape around tobacco smoking and branding them as "*next generation products*" (British American Tobacco). Imperial Tobacco (IT) manufactures its own brand of e-cigarettes called 'Blu' through its subsidiary Fontem Ventures (Akam, 2015). The success of e-cigarettes have seen an increase in the popularity and use of other smokeless non-combustible products, such as dissolvables and snus, little cigars and cigarillos (LCCs) and water pipes or hookahs. Table 1.1 provides a brief description of each.

Table 1-1: Description of Smokeless, Non-Combustible Products

PRODUCT	FEATURES
Dissolvables	Finely milled tobacco containing a mix of tobacco, binders, fillers, and flavours, available in orbs, strips, and sticks. Dissolve in the mouth between 10 – 30 minutes, do not encourage spitting, and contain fewer toxins than regular cigarettes.
Snus	Finely ground moist tobacco packaged in small porous pouches, which is placed between the cheek and gum, and the juices are swallowed.
Little Cigars & Cigarillos (LCCs)	A longer slimmer version of cigars, wrapped in tobacco leaf, and is usually fruit, candy, or alcohol flavoured.
Water Pipes or Hookahs	Water filtration process used to consume tobacco ignited by charcoal, having a ceramic bowl which holds the hookah mixture for burning. It contains a mixture of glycerine, honey/molasses and flavourings.

Source: Sarah E. Adkison et al. (2013); Hiscock et al. (2014); Weaver et al. (2016); Willis et al. (2017)

1.1.2 Tobacco Denormalisation – A Global Overview

Tobacco denormalisation defined by Wigginton, Morphett, and Gartner (2016) in their study examining Australian smokers’ access to health care and support, are measures, actions and programs undertaken to reinforce the fact that tobacco use is no longer a normal or accepted activity in society. Some of the earliest known occurrences of tobacco denormalisation occurred in the 1600s. In 1604, King James I of England imposed a 4,000% increase on tobacco declaring it to be “*harmful to the brain, dangerous to the lungs, and emitting horrible, loathsome, stygian smoke*” (ASH, 2017b; K. Smith, 2010). Twenty years later Pope Urban VIII threatened excommunication to anyone found smoking in church, believing tobacco use prompted the act of sneezing which he felt resembled sexual ecstasy (Cutler, 2007). Between 1634 and 1674, Czar Michael of Russia linked smoking to criminal activities declaring that anyone caught smoking would be put to death (Cutler, 2007; K. Smith, 2010). In

1647, smokers in the state of Connecticut were limited to smoking only one cigarette per day, and could not do so in the company of other persons (Cutler, 2007; K. Smith, 2010).

Studies about tobacco denormalisation position it as a widespread restriction enforced in most countries worldwide (for example, Antin, Lipperman-Kreda, & Hunt, 2105; K. Bell, McCullough, Salmon, & Bell, 2010; Dennis, 2013; Hu, Lee, & Mao, 2013; Radwan, Loffredo, Aziz, Abdel-Aziz, & Labib, 2012; Sæbø, 2016). To further explain this, an overview of tobacco denormalisation strategies existing in some countries for example, Australia, Canada, China, Norway and USA are provided at Appendix 1.4. Most of these strategies exist in the UK although differences have also been identified. Discussing these strategies is not intended to offer a comparative study between these countries and the UK, but rather to help articulate the diversity and contextualise how widespread tobacco denormalisation strategies are.

1.1.3 The WHO Framework Convention on Tobacco Control (WHO FCTC)

The global popularity of tobacco, coupled with the consequential illnesses and deaths, prompted the establishment of an instrument of tobacco control in recognition of the rights of individuals to have the highest standard of health. The WHO Framework Convention on Tobacco Control (WHO FCTC) was developed in 2003, with over 170 countries as signatories. Thirteen countries have not yet signed the Framework, whilst an additional 23 have signed but not yet ratified it (Moodie & Hastings, 2011). The UK became a signatory in 2004 (ASH, 2004).

The WHO Framework Convention on Tobacco Control represents a paradigm shift in regulatory strategies aimed to address the use of addictive substances, according to

Hidayat and Thabrany's (2011) study on addiction and demand for tobacco in Indonesia. Signatory countries have timetabled milestones to help monitor the implementation of effective tobacco control strategies and reduce demand for and restrict supply of tobacco products (Hu et al., 2013). At the Framework's core are key tobacco control policies based on supply and demand reduction approaches.

Demand reduction provisions has two main approaches: (i) price and tax measures (Article 6 of the Framework), requiring signatories to introduce fiscal policies which steadily increase the price tobacco products are sold at and includes possible prohibitions or restrictions on tax or duty-free sales, and (ii) non-price measures (Article 8 of the Framework), requires the implementation of policies which ensure protection from exposure to tobacco smoke (Hidayat & Thabrany, 2011). An overview of elements and objectives of this WHO Framework are outlined in Table 1.2.

Table 1-2: Key Elements and Objectives of the WHO Framework Convention on Tobacco Control Initiative

KEY ELEMENTS AND OBJECTIVES	
1.	To eliminate all forms of illicit trade in tobacco products, i.e. any practice or conduct related to producing, shipping, receiving and being in possession of, distributing, selling or buying tobacco products that is prohibited by law.
2.	Make the supply chain of tobacco products secure through control of the supply chain including licensing, record keeping requirements, and regulation of internet-sales, duty-free sales, and international transit.
3.	Address illicit trade by establishing offences, address liability and seizure payments, and disposal of confiscated products.
4.	Boost international cooperation with measures on information sharing, technical and law enforcement cooperation, mutual legal and administrative assistance, and extradition.
5.	Ensure transparent co-operation between tobacco industry's interests and public health interests, in relation to tracking and tracing.
6.	Promote close cooperation between all parties and international organizations, (including customs and international crime) to ensure successful achievement of the objective of the Protocol.

Source: World Health Organisation (2015a)

Prior to the establishment of this framework, questions were raised by officials within the World Health Organisation as to its capability to successfully implement a policy of such significance (Roemer, Taylor, & Lariviere, 2005). Now hailed as a landmark policy in international cooperation, the legal framework of the Convention is a model for effective universal response to the negative effects of globalisation on health. However, Nikogosian (2010) although supportive of the WHO's initiative, cautions that its success or failure is dependent on the political will and leadership of adopting countries, as well as the stringency of enforcement laws.

1.2 Tobacco's Introduction and Proliferation into the UK

It is said that tobacco was introduced in England around 1586 by Sir Walter Raleigh who brought it from Virginia, USA. Another account suggests Sir John Hawkins and his sailors brought tobacco to England around 1565, after being introduced to it by Portuguese and Spanish sailors (Johnson). There is also the belief that in 1586 when colonists returned from Virginia to England they brought smoking pipes with them which aided the spread of smoking throughout the country (ASH, 2017b). The great 1665 great plague of London helped to further cement tobacco's place in English society. Hymowitz's (2012) examination of the paediatric roots of cigarette smoking and lung cancer, found that tobacco use became popular *during the period of the great plague*, because chewing of tobacco was considered the only effective way to prevent individuals contracting that infectious disease.

Tobacco trade and import in the UK started around 1590 with the manufacture of pipes made of white ball-clay, a cheap and convenient makeshift alternative to smoking devices. By the 17th century trade and import of tobacco to England heightened with

the initial importation of 25,000 pounds of tobacco from Virginia. Once tobacco's financial viability became clear, this amount increased to around 38,000 million pounds signalling the beginning of large scale tobacco production in the UK (Goodman, Lovejoy, & Sherratt, 1995). Extensive trading of tobacco identified the need for places where it could be sold directly to individuals. The first store in the UK was opened sometime around 1847 by Philip Morris in London's Bond Street selling hand-rolled Turkish cigarettes (ASH, 2017b). By 1860, another shop was opened in Leicester Square by Greek captain John Theodoridi, and in 1865 Theodoriki Avramanchi opened his shop located in Regent Street (Wilson, 2002); others soon followed.

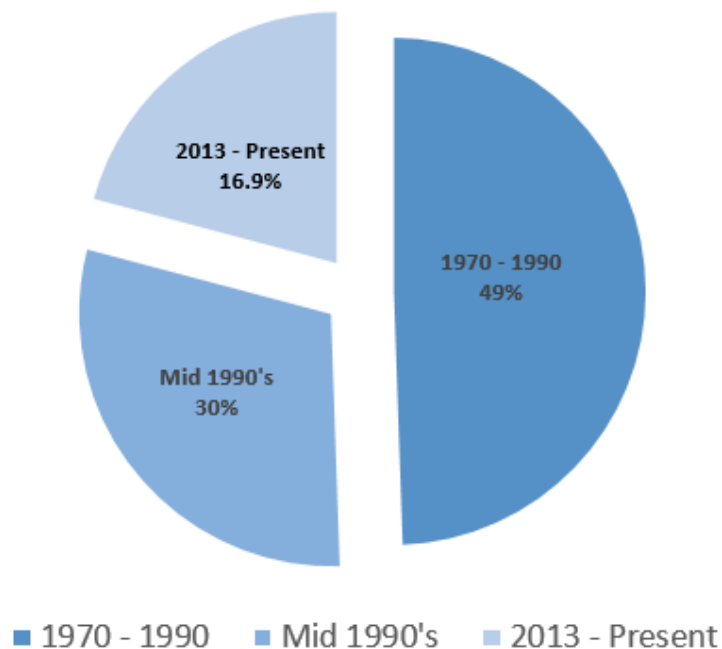
The introduction of matches around 1852 was pivotal to the continued rise in tobacco smoking, as it made it more convenient to do so (ASH, 2017a). The Crimean War which happened between 1853 – 1856, has also been linked with tobacco's proliferation in the UK (Harvey, 2014). During this period, British soldiers learnt the habit of smoking from Turkish and German counterparts who smoked cigarettes called "*papirossi*". Soldiers brought them back to England after the war further enhancing smoking's popularity. Crimean War veteran Robert Gloag also contributed to tobacco's popularity, opening the first cigarette factory in England sometime around 1856 (Daniels, 2015; Harvey, 2014; Wilson, 2002). Tobacco smoking's rising popularity saw the brand *Benson & Hedges* receiving a royal warrant from Prince Edward of Wales in 1876 (ASH, 2017b), and in 1901 smoking conglomerate Imperial Tobacco (*now imperial brands*) was formed (ASH, 2017a).

1.3 Prevalence of Tobacco Smoking in the UK

A study examining the impact of public smoking bans on active smoking (A. M. Jones et al., 2015), found that smoking remains a widespread experience in the UK, with 21% males and 20% females smoking on average 13 cigarettes per day. Evidence attesting to the popularity of smoking shows cigarette sales in the UK for 2016 at £12.1 billion, with brands such as Sterling, Mayfair and Lambert & Butler occupying the top three positions (ASH, 2017c). These statistics are represented in the table set out at Appendix 1.5.

However, there has been a noticeable decline in smoking rates since implementation of tobacco control strategies in 2012. Now only 7.2 million or 16.9% adults in the UK are smokers (Campbell, 2016), compared to the over nine million in 2012 (ASH, 2017a). Studies by Public Health England also identify a drop in smoking prevalence from the mid 1990's when 30% of the population smoked (Campbell, 2016), a further drop from the 1970's when 49% of the population smoked (Triggle, 2015a). This decline is represented in the pie chart at Figure 1.3.

Figure 1-3: Smoking Prevalence Pre and Post-Implementation of Tobacco Denormalisation Strategies

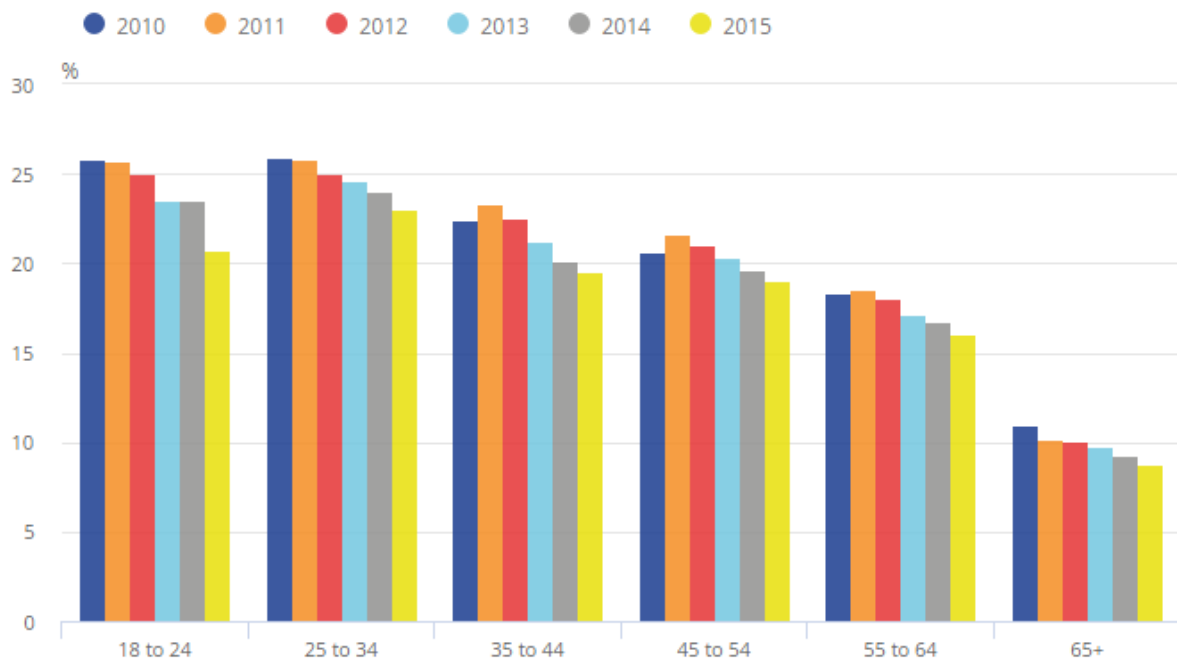


Source: *Triggle (2015a); Campbell (2016)*

Data released from the Office of National Statistics offers further evidence of the declining rates in UK smoking. It provides evidence that between 2010 to 2015 smoking prevalence across all spheres of the UK population has dipped (Office for National Statistics, 2017). This is illustrated in the graph at Figure 1.4.

Figure 1-4: Illustration of Reduction in the Proportion of Current Smokers

Proportion (%) of current smokers



Source: Office for National Statistics (2017)

1.4 Smokers – Definition, Typologies and Representations of Different Users

Several terms have been found in the literature to describe smokers, each with a different definition or meaning. Definitions, *(discussed in paragraphs immediately following)*, across various literatures are inconsistent, conflicting and sometimes contrasting. The difficulty in defining the term “*smoker*” may actually stem from the fact that smokers have been found to be homogeneous and heterogeneous in their consumption practices (Patton, Barnes, & Murray, 1997). *For example, homogeneity exists where smokers consume the same brand(s) of tobacco products. Heterogeneity exists where smokers want and consume different flavour cigarettes for different reasons, i.e. menthol flavoured cigarettes because they were perceived as less hazardous and irritating than other cigarettes.* This situation is further compounded because individuals have different motives and reasons for smoking,

which may be influenced by normative factors, situational factors or individual differences. Accordingly, the goal of this study is not to establish an ideal definition of what a smoker is. Providing a definition could be an almost impossible task, particularly where so many varied definitions are present in existing literatures. Instead, the aim is to offer a clearer picture of the thinking that smokers are indeed a “*fusion*” or group of persons characterised by their levels of consumption and or individual smoking statuses. By taking into consideration the four levels of consumption put forward by Kabat and Wynder (1987), as well as Killen, Fortmann, Telch, and Newman (1988), (*i.e. light smoker, medium smoker, heavy smoker, and ex-smoker*), it is hoped this goal will be achieved.

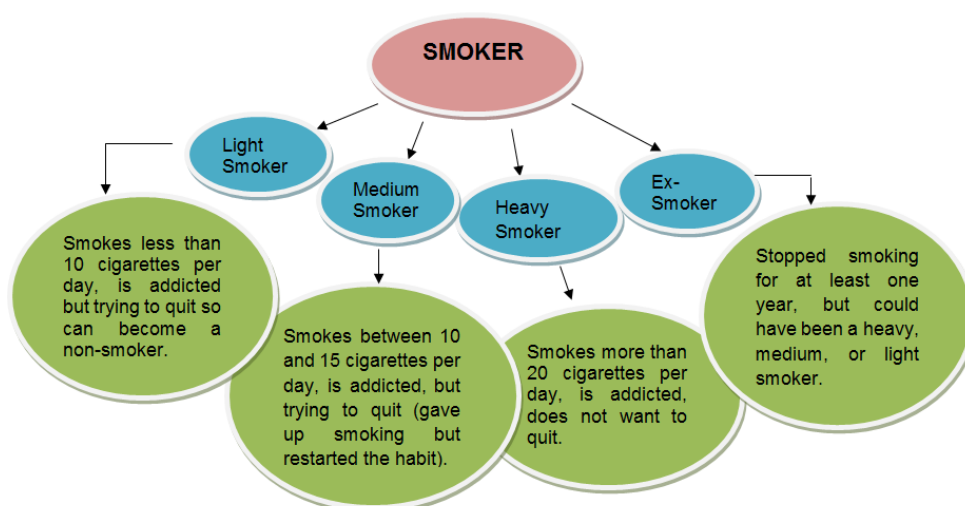
Two typologies of smokers have been identified by Schramm, Carré, Scheffler, and Aubriet (2014) – active and passive. Passive smokers are individuals involuntarily exposed to tobacco smoke, e.g. non-smokers and children. Active smokers are individuals actively engaged in the habit of smoking (Schramm et al., 2014; Slovic, 2001). Casual and compulsive are other typologies into which smokers fit. Casual smokers indulge in smoking at least once weekly and are not addicted to nicotine, compulsive smokers indulge in smoking to relieve tension and are addicted to nicotine (A. K. G. Tan, 2012). Munafo, Roberts, Bauld, and Leonards’ (2011) writing about plain packaging and how it increases visual attention, identified other smoker typologies such as weekly and daily. Weekly smokers smoke one cigarette per week (but not daily); daily smokers smoke at least one cigarette per day.

Words and phrases such as chippers, low rate smokers, non-daily and occasional smokers (Morley, Hall, Hausdorf, & Owen, 2007), have been used to describe

smokers. Further categorisations of smokers were identified in the pilot study, “*Marketing Tobacco Products to Female Consumer Segments within the UK – An Exploratory Study*”, conducted by this researcher in 2015. The study found three categories of female smokers: “**Resisting Roxannes**” – die-hard smokers who are not willing to give up the habit of smoking; “**Uncertain Ursulas**” – social smokers who could have quit the habit with the “right” incentives, but will smoke when in the company of smokers; “**No No Nannettes**” – smokers who have never smoked and are not interested in taking up the habit.

The term consumers are another categorisation used to describe smokers. This is justified by their individual and collective targeting by marketing planners (Nelson et al., 2008), and tobacco companies (Bahreinifar, Sheon, & Ling, 2013). As consumers, smokers can be positioned into four distinct groups according to studies by Kabat and Wynder (1987), and Killen et al. (1988). These are (i) light smoker, (ii) medium smoker, (iii) heavy smoker and (iv) ex-smoker, illustrated and defined in Figure 1.5.

Figure 1-5: Categorisation of Smokers Based on Levels of Consumption



Source: Adapted from Kabat and Wynder (1987); Killen et al. (1988)

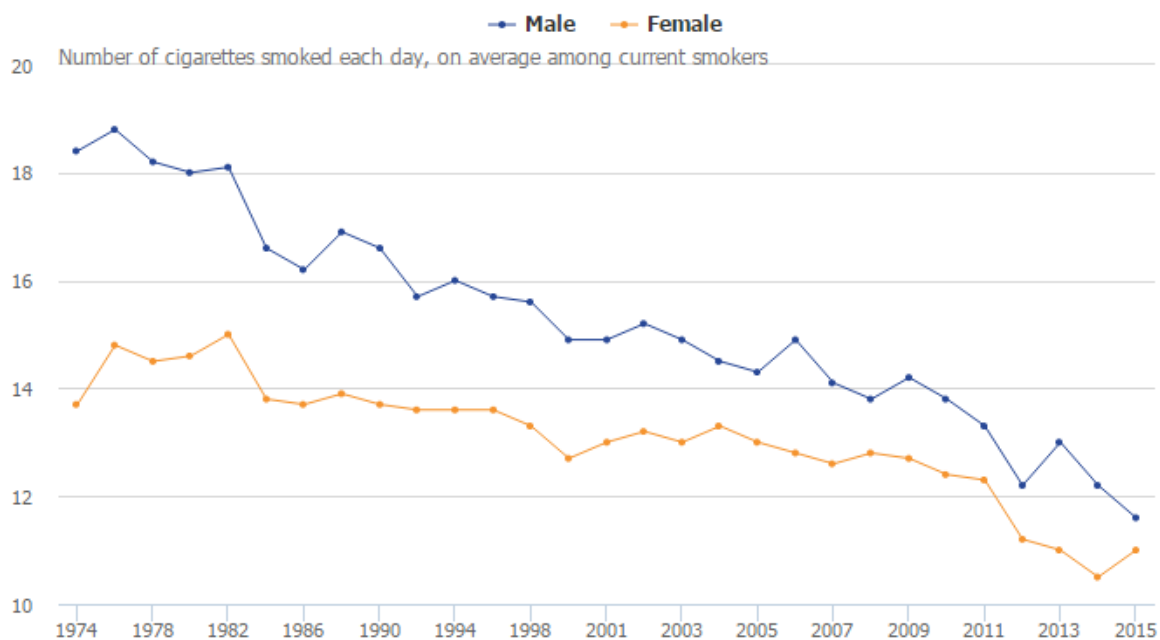
Identifying consumer typologies (see Appendix 1.6), Bressolles, Durrieu, and Senecal's (2014) study on consumer typology identify smokers are heterogeneous in nature. To illustrate, smokers can be **identity seekers** – creating and maintaining personal and social identity through consumption of tobacco products, or **rebels** – adopting smoking as a way of rebelling. Smokers come from different social status, age grouping, ethnic background, religious conviction and have distinct reasons for adopting the habit. There are those who have tried quitting but return to the habit – **medium smokers**, some remain defiant having no intention of quitting – **heavy smokers**, others have cut down on the amount smoked for health or other reasons – **light smokers** and those who have quit – **ex-smokers**. Irrespective of their ethnicity, social background, typology or consumer status, one thing they all have in common is their use of tobacco and tobacco products.

1.4.1 Smoking by Gender

By the period of the Second World War (1939 – 1945), tobacco use was firmly established in British society (R. Elliot, 2006). This adoption started between 1900 and 1920 with increased smoking prevalence amongst males (A. Ayo-Yusuf & T. Agaku, 2015; Graham, 2009). The early 20th century heralded an increase in female smoking influenced by advertisements, the “flapper” craze, style, fashion and femininity (R. Elliot, 2006). Tobacco companies began targeting this new consumer group, particularly females aged 16 – 34, but the trend soon spread across all income segments (Berridge, 2001). By 1996 - 1997 female smoking levelled at around 28% (Tinkler, 2001), with a narrowing of the gap in female consumption of cigarettes compared to males (Beale, 2016).

1.4.2 According to the Office of National Statistics, in 2000 male smokers consumed on average 14.9 cigarettes daily which was 15% higher than females, whilst in 2015 male smokers consumed approximately 11.6 cigarettes daily just 5% higher than females (Office for National Statistics, 2017). The graph at Figure 1.6 highlights the comparison between male and female smoking in the UK, showing the steady gain of female smoking on male smoking.

Figure 1-6: UK Smoking Patterns: Males vs Females



Source: Opinions and Lifestyle Survey; General Lifestyle Survey; General Household Survey - Office for National Statistics

1.4.3 Smoking Amongst the Young and Adolescents

Smoking amongst children aged between 8 – 15 years became widespread by the early 1990's. Studies examining influences on children's adoption of smoking identified parents, older siblings and peer groups to be the main factors (for example, Bricker et al., 2006; Entin, 2009; Maggi et al., 2014; McGee et al., 2015). These

studies point to the link of these influences on increased smoking uptake amongst this group of individuals.

In contrast, there has been a noticeable decrease in smoking amongst adolescents' post-tobacco denormalisation. Between 1982 and 2006 smoking amongst this group was approximately 20% - 25%, but has dropped by 8% (Triggle, 2015a). According to studies by the National Health Service less than one in five 11 – 15 year olds report smoking, a figure down from the 43% which obtained in 2003 (NHS, 2015). A report in the Lancet suggests this change could reflect a lifestyle switch from smoking tobacco to using e-cigarettes (The Lancet, 2017).

Irrespective of the decline in smoking prevalence amongst the young and adolescents, there remains an urgent need to protect them from a lifetime of addiction and tobacco-related disease. Studies by The Royal College of Physicians (1992) found that adolescent smokers are prone to allergies, respiratory and ear infections, enhanced risk of asthma and impaired lung growth. Hymowitz's (2012) study looking at the paediatric roots of cigarette smoking, identified increased risk of smoking-related diseases such as lung cancer and cardio-vascular diseases in adulthood for *adolescents who adopt* smoking at an early age. The study proposes that public health and medical communities within the UK should implement bold strategies aimed at curbing uptake of smoking by children at an early age (Hymowitz, 2012).

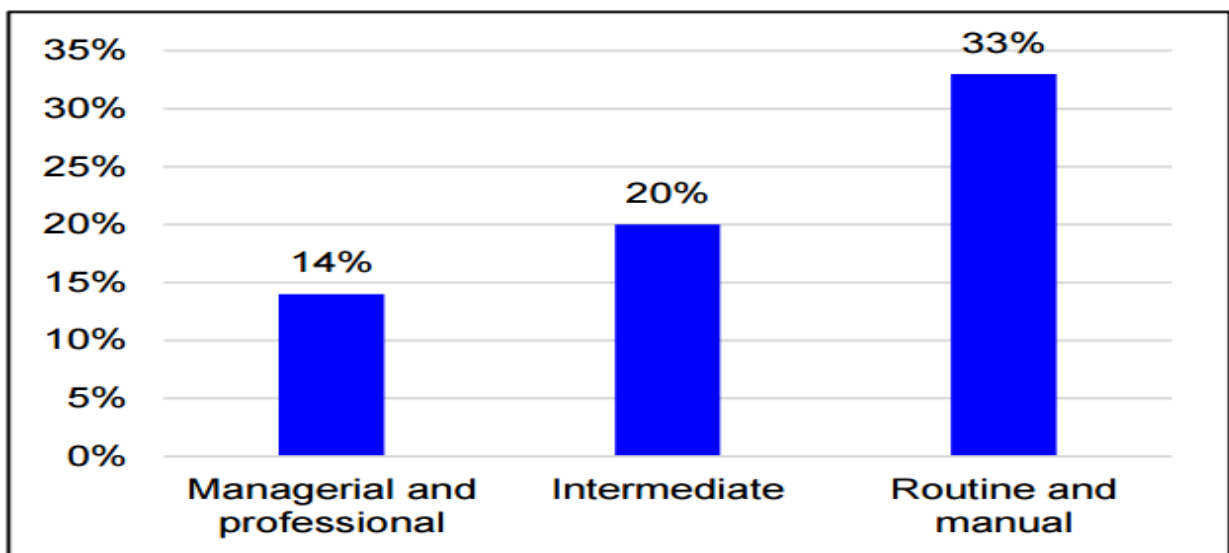
1.4.4 Smoking and Social Status

An important predictor of tobacco use is socio-economic status (SES). In their study examining smoking and social class Barbeau, Leavy-Sperounis, and Balbach (2004) found that individuals with minimum education levels in low-income jobs are more

likely to be smokers than their counterparts in higher income level jobs who are more educated. In later studies by Graham (2012), and Meijer, Gebhardt, Laar, Kawous, and Beijk (2016) examining socio-economic status and smoking, this position was also identified where professional men and women smoke less than men and women in unskilled manual jobs. These studies highlight the substantial difference between smoking behaviour of individuals in lower socio-economic status groups compared to those in higher socio-economic status.

Support for these positions is found in the *demographic profile of participants of this study* (see Tables 3.6 and 3.7). Few hold professional jobs, but the majority are employed in low paid or manual jobs. This disparity is also highlighted in studies by Action on Smoking Health (ASH), illustrated at Figure 1.7, showing that persons in managerial and professional occupations smoke less (14%) than those in routine and

Figure 1-7: Rates of Cigarette Smoking in the UK by Socio-economic Classification



manual jobs (33%).

Source: ASH (2016d)

Building on the arguments *presented* above, research by Public Health England (2015) showed smoking to be mainly concentrated in disadvantaged groups. This study result was brought out during the interviewing where at least one participant who grew up in a care home turned to smoking for solace. Furthermore, smokers (heavy and addicted in particular), often fall into this category because they have little control over how much they smoke (Hiscock, Bauld, Amos, Fidler, & Munafo, 2012), or are less likely to attempt quitting (ASH, 2016b).

The link to tobacco smoking, poverty and low socio-economic status has been identified by Chapple, Ziebland, and McPherson (2004) in their study on stigma, shame and blame. This study identified the vicious circle smokers within this status fall into because they smoke more, suffer more and are more likely to die from tobacco-related illnesses such as lung cancer. It is for this reason the WHO Framework Convention on Tobacco Control (WHO FCTC) was established to ensure everyone has the highest standard of health. Discussions on the WHO FCTC are held in paragraph 1.1.3., whilst discussions on the UK Tobacco Industry are held in Appendix 1.7.

1.5 Research Question, Aim and Objectives of this Study

Prior discussions set the tone for answering this thesis' research question: "Does existing UK tobacco denormalisation strategies encourage behaviour change in smokers during purchase and consumption and in shared consumption spaces?" Drawing on this question the overall objectives of this thesis can be expressed as follows:

1. To understand whether existing tobacco denormalisation strategies encourage behaviour change in smokers.
2. To examine how the display ban in retail environments and the smoking ban in shared consumption spaces affect purchase and consumption intentions and attitudes.
3. To understand the role of marketing stimuli and anti-smoking messaging strategies and interventions on smoking behaviour.

Objective 1 considers Cognitive Dissonance Theory and the Behaviour Change Wheel Concept to help understand how they encourage behaviour change. Reflecting on the wider issues influencing adoption and maintenance of smoking (for example, parental, sibling, and friendship networks; social norms; addiction) Social Learning Theory has also been considered in laying the foundation for understanding issues which impact smokers when trying to achieve behaviour change.

Objective 2 lends itself to an examination of nudging strategy in explaining how anti-smoking regulations attempt to influence smokers' behaviour. *Through positive reinforcement and indirect suggestions, the aim is to achieve non-forced compliance to influence the motives, incentives and decision making in smokers.* For example, in retail environments the objective is to prevent purchase or at least limit it – *hence the display ban.* In shared consumption spaces the main aim is to protect non-smokers from harm caused by second-hand smoke – *hence the indoor smoking ban.*

To explain Objective 3, this study examines self-exempting strategies employed by smokers to diminish the risks of smoking whilst continuing the habit. For example,

engaging in compensatory health behaviours (CHBs) such as exercising or healthy eating, avoiding the risk of social ostracism by conforming to smoking behaviour of membership group(s), and discounting message content which portray smoking in a negative light. It also considers the Theory of Framing to help understand smokers' belief of personal liability for adopting a smoking habit. For example, a smoker who hears a message advocating the dangers of smoking is personally responsible for acting in accordance, (or not), with said message.

In developing these objectives consideration was given to the WHO Framework Convention on Tobacco Control (FCTC), the established international benchmark for worldwide tobacco denormalisation measures. This strategy allows the relationship to be made between measures approved by existing WHO Framework and those established within the UK at the time of conducting this study.

1.6 Structure of the Thesis

This paragraph describes the structure of the thesis, explaining the chronological flow of chapters from start to finish (illustrated in Table 1.3). The thesis is organised sequentially into six chapters allowing the logical flow of information leading to the conclusion and structured in the following way.

Chapter One presents the problem, research questions, aim, objectives and avenues for research or research study. It starts with an overview of the situation which led to the implementation of tobacco denormalisation strategies currently existing in the UK, and also briefly explains the global perspective on tobacco denormalisation. Next, a brief overview of the WHO Framework Convention on Tobacco Control (WHO FCTC)

is given to enhance understanding of why tobacco control is necessary. Afterwards discussions cover tobacco's introduction and proliferation in the UK, followed by discussions on the prevalence of smoking in the UK which includes information on smoking typologies, smoking by gender, adolescents, and social status. The final paragraph of this chapter restates the research question, outlines out the thesis' aims and objectives, and explains the structure of the thesis.

Chapter Two presents the literature review about the problem and explores gaps and limitations of the literature. It begins by outlining the role and purpose of the literature review and demonstrating the theoretical basis for the research. To make a further contribution to the topic under investigation the study's theoretical framework is also proposed in this chapter. Here discussions look at the main theory Cognitive Dissonance along with the Behaviour Change Wheel concept, *demonstrating how both influences behaviour change. To build on this thinking, an initial model of the study's theoretical framework is presented and set out at Figure 2.1. The chapter also presents further discussions on Cognitive Dissonance Theory explaining its origination and growth, assumptions, theoretical and practical application, whilst critiquing the theory and examining alternative theoretical perspectives. Following on from these discussions, an examination of the five inter-related themes of the study is presented. Each theme is discussed in turn demonstrating how they link in with the theoretical framework and smoking behaviour. The chapter concludes with further discussions on Cognitive Dissonance Theory and the Behaviour Change Wheel concept, demonstrating how they combine to shape this study's revised theoretical framework, (illustrated at Figure 2.9).*

The research methodology is written in Chapter Three, where discussions centre on the methodological processes and explaining techniques adopted for this study's qualitative approach. Included here is information on the researcher's assumptions about the world and techniques for enquiry in that world, theoretical perspective, research questions and design, sampling strategy and sample group profile, data analysis process, ethical considerations, and research challenges.

Chapter Four contains analysis and discussions on the findings of this study which employs semi-structured interviewing techniques. It *demonstrates the use of NVIVO 11 data analysis software to organise field notes made during interviewing and participant observation, classify these interviews into themes and sub-themes, and produce graphical illustrations and dendrograms to help explain themes and sub-themes.* Chapter Five *presents discussion* of the results pertaining to the research questions and objectives of the study. It speaks to conclusions and recommendations for smokers, non-smokers, Government agencies, Tobacco Industry personnel, manufacturers and retailers, providing theoretical and practical implications for future consumer *research* around behaviour change in smokers.

Appendix 1.1 lists European countries ranked by total tobacco control scale in 2013. Appendix 1.2 provides an example of a tobacco gantry. Appendix 1.3 provides a graphic representation of standardised tobacco package soon to be instituted in the UK. Appendix 1.4 discusses tobacco control strategies in Australia, Canada, China, Norway and USA Norway. Appendix 1.5 sets out a list of the top ten selling UK cigarette brands. Appendix 1.6 provides examples of customer typologies. Appendix

1.7 discusses the UK Tobacco Industry and strategies they employ to encourage smoking uptake and resist anti-smoking strategies.

Table 1-3: Illustration of Thesis Outline

CHAPTER 1
INTRODUCTION: PROBLEM, ABOUT SMOKERS, RESEARCH QUESTIONS, RESEARCH AIM AND OBJECTIVES, AVENUES FOR RESEARCH OR RESEARCH STUDY
CHAPTER 2
LITERATURE REVIEW
CHAPTER 3
METHODOLOGY: RESEARCH PROCESSES AND TECHNIQUES
CHAPTER 4
ANALYSIS: DISCUSSION OF RESEARCH FINDINGS
CHAPTER 5
DISCUSSION OF RESEARCH FINDINGS: THEORY AND PRACTICE

Source: *Researcher’s Concept of this study’s Thesis Outline.*

1.7 Chapter Conclusion

Arguments continue about tobacco denormalisation strategies. The UK Tobacco Industry personnel, related industries, retailers and small traders have been outspoken about the negative financial impact on sale and consumption which tobacco display ban cause (Bowers, 2010a). Smoking in the UK is now considered a passé pastime with addictive consequences, but many people still smoke evidenced by the 7.2 million smokers in the UK (Campbell, 2016). Still, the progression of tobacco denormalisation strategies negatively impact on smoking enjoyment. Smokers see tobacco

denormalisation as a strategy which reinforces the unacceptability of tobacco smoking within today's UK society. Every space is claimed by non-smokers, everywhere is a no-smoking zone, and for smokers smoking has become "*a paradise lost*".

Nevertheless, smoking creates one of the biggest public health issues in the UK and reducing the cost of smoking necessitates the need for social interventions. Displaying signs in locations informing smokers where they can or cannot smoke is not the intention of tobacco denormalisation strategies (Jakes, 2016). The ultimate intent is to emphasise social constructs which shape smoking beliefs and behaviours in order to successfully reduce the prevalence of smoking, using a population-level approach (Antin, Lipperman-Kreda, & Geoffrey Hunt, 2015). Why? Evidence presented by Malone, Grundy, and Bero (2012) in their study examining the effects of tobacco denormalisation on smoking-related and attitude-related outcomes, suggest that measures which alter the social context of tobacco use can reduce smoking prevalence when endorsed by the wider population.

Chapter 2. Literature Review

2.1 Introduction

The overall purpose of this chapter is to demonstrate that the pivotal point of interest for behaviour change in smokers does not only lie in tobacco control activities. For example, indoor smoking ban, display ban, standardised plain packaging, and stop smoking interventions such as “*Stoptober*”. More in-depth discussions on these tobacco control activities are held in paragraph 2.15.3.1. Other factors such as social norms, dissonance behaviour, behaviour in purchase and consumption environments and communication stimuli, also have an impact. Considering these factors, the goal is to develop a conceptual framework showing how smokers’ can achieve behaviour change. In so doing, relevant behaviour change models will be discussed showing their contribution and how they can be integrated into explaining behaviour change in smokers. There are limitations to what the literature says about these theories, hence they will be applied in the way illustrated in the first and second versions this study’s theoretical framework.

This chapter is divided into three sections. *Section one* explains the role and purpose of a literature review, followed by an outline of approaches to writing and structuring a qualitative literature review, examine the types of literature associated with qualitative research, concluding with a look at how to differentiate between quantitative and qualitative research. *Section two* presents a review of Cognitive Dissonance Theory, and the proposed theoretical framework with relevant discussions. *Section three* presents discussions on key areas of literature linked together by a common theme – adoption, use, purchase and consumption of a socially displeasing product, i.e.

cigarettes and tobacco products. The aim being to show this researcher's current thinking, but also demonstrate the setting from which this study is derived.

2.2 Role and Purpose of the Literature Review

A literature review is an evaluative report of studies found in the literature related to the selected area of research according to Boote and Beile (2005). It describes, summarises, and clarifies the literature thus providing the theoretical basis for the research. Wisker's (2008) position is that the literature review facilitates iterative and ongoing dialogue with theories, theorists and experts which underpins the research. According to M. Saunders, Lewis, and Thornhill (2012), the literature review process is like an upward spiral beginning with the questions and objectives, ending with the final draft of the chapter. The perspective of Hussey and Hussey (1997), is that the literature review provides a statement of the art and major questions and issues in the field under consideration. Braun and Clarke (2013) contribute that the literature review examines, critiques and position results as they relate to relevant literature. Interestingly, the literature review extends throughout the life of the research (Boote & Beile, 2005), although it is one of the first tasks to be undertaken during the research process.

These interpretations helped formulate this researcher's understanding of the role and purpose of the study's literature review, which is to: outline the area of research, put the research into context, demonstrate how the research fits in with previous research(s) and supporting literature, show the originality and relevance of the research problem, justify the research methodology, *and support and identify the research question*. They also confirm the belief of this researcher that understanding

the importance of existing literature is a critical consideration for shaping the research's direction.

2.3 Approaches to Writing a Qualitative Literature Review

Conventional and critical are the two main approaches taken when writing a qualitative literature review. The conventional approach (adopted by this study), gives a comprehensive outline of existing research, identifies key results, discusses the limitations of existing understandings and justifies the existence of gaps and inconsistencies in knowledge. Conversely, the critical approach develops theoretical arguments which frame the analysis, and justifies the use of contextualised questions (Braun & Clarke, 2013). Braun and Clarke (2013) continue that irrespective of the approach taken, a well-planned literature review process should not exclude research purely on the research methodology's style. Instead, it should include studies about the research topic whilst critiquing other studies to identify weaknesses or gaps contained in them.

Literature review in qualitative research can appear at the introduction, in a separate section or at the end (Creswell, 2014), see Table 2.1. Creswell (2014) continues that the literature review should not be done at the beginning of the project and then forgotten. Instead, the process should continue to the writing-up stage, considering current issues which might warrant investigation. Particularly relevant here is the thinking of Dick (2000) that issues will arise at the initial stage, relevance of information gathered will still be unclear, but reading around the investigated topic should be postponed until relevance of the literature is established.

Table 2-1: Placement and Justification of Literature Review Position

PLACEMENT POSITION	JUSTIFICATION OF POSITION	EXAMPLES OF STRATEGY TYPES
The literature is used to frame the problem in the introduction to the study.	There must be some literature available.	Typically, literature is used in all qualitative studies, regardless of type.
The literature is presented in a separate section as a review of the literature.	This approach is often acceptable to an audience most familiar with the traditional post-positivist approach to literature reviews.	This approach is used with those studies employing a strong theory and literature background at the beginning of a study, such as ethnographies and critical theory studies.
The literature is presented in the study at the end ; it becomes a basis for comparing and contrasting findings of the qualitative study.	This approach is most suitable for the inductive process of qualitative research; the literature does not guide and direct the study but becomes an aid once patterns or categories have been identified.	This approach is used in all types of qualitative designs, but it is most popular with grounded theory, where one contrasts and compares a theory with other theories found in the literature.

Source: Adapted from Creswell (2014)

2.4 Literature Associated with Qualitative Research

Literature associated with qualitative research is found in primary and/or secondary sources (see Table 2.2).

Table 2-2: Sources of Primary and Secondary Literature

PRIMARY SOURCES	SECONDARY SOURCES
<ul style="list-style-type: none"> ▪ Autobiographies 	<ul style="list-style-type: none"> ▪ Textbooks
<ul style="list-style-type: none"> ▪ Original documents, e.g. death certificates 	<ul style="list-style-type: none"> ▪ Official statistics (summaries and frequencies)

Source: Adapted from Flick (2015)

Primary sources are immediate, secondary sources are usually condensed and redrafted by others (Flick, 2015). From these sources three types of literature have been identified in the development of qualitative research: (i) **Theoretical Literature** – Literature aimed at gaining background knowledge and insight about the subject. This method assists in raising further questions relating to theory, knowledge, concepts, knowledge and insight about the subject. This method assist in raising further questions relating to theory, knowledge, concepts, and analysis of new research (D. E. Gray, 2014), (ii) **Empirical Studies Literature** – Literature from previous studies which provides tangible evidence to oppose or support an argument, whilst highlighting findings which might be contradictory or ambiguous, to facilitate further research (D. E. Gray, 2014), (iii) **Methodological Literature** - Literature identifying the methodological approaches used to address the subject of interest (D. E. Gray, 2014).

Debate as to whether qualitative research should be based on knowledge of existing empirical or theoretical literature continues. However, Flick (2015) argues this thinking is outdated, recommending qualitative researchers familiarise themselves with the area being researched, basing new insights on knowledge of existing research. Flick's (2015) position suggests thoughtfulness on the part of researchers regardless of the type of literature used. It also brings into focus the study on standards, challenges and guidelines of qualitative research by Malterud (2001), which posits that qualitative methodology does not produce unfocussed dialogue, therefore researchers must be prepared to utilise a wide and diverse set of approaches whilst remaining focussed on the methodology.

2.5 Differentiating Qualitative and Quantitative Research

Research can either be quantitative or qualitative, each position offering different perspectives. Yilmaz's (2013) research comparing quantitative and qualitative research traditions confirms this, pointing out that with the quantitative perspective researchers present as detached from the research process, explaining the phenomena using numerical data which are mathematically analysed based on statistics. Yilmaz (2013) identified that within the qualitative perspective researchers arrive at findings which are not statistical, whilst presenting as intuitive and able to detect possible biases. This position demonstrates the researcher's ability to understand and differentiate what is relevant and what is not (D. E. Gray, 2014).

Researching methodological problems of educational inquiry, Niglas (1999) identified common dichotomies used to differentiate qualitative and quantitative literature. According to Niglas (1999), identification of these dichotomies has been an area of concern, sparking debates amongst researchers and giving rise to the 'paradigm wars'. Some of these dichotomies are explained in Table 2.3.

Table 2-3: Dichotomies Used to Differentiate Qualitative and Quantitative

QUALITATIVE LITERATURE	EXPLANATION OF TERM	QUANTITATIVE LITERATURE	EXPLANATION OF TERM
Anthropology	Study of human society, cultures and development.	Sociology	Study of social problems.
Descriptive	Relating to matters of observation or experience.	Predictive	Ability to predict an outcome or result.
Empiricism	Theorising that all knowledge is based on experience derived from the senses.	Positivism	Recognising only that which can be scientifically verified, can be logically and mathematically proven.
Inductive	Using facts or idea to draw conclusion(s).	Deductive	Deriving conclusions by reasoning.
Subjective	Open to interpretation based on personal feelings, emotions, aesthetics, etc.	Objective	Not influenced by personal feelings or opinions in considering and representing facts.

Source: Adapted from Niglas (1999)

2.6 Theoretical Framework

2.6.1 Introduction

The preceding sections of this chapter presented discussions about the nature of the problem being investigated. This section’s endeavour is to ground the study into the theoretical framework to help understand behaviour change in smokers, particularly in situations where behavioural inconsistencies exist. Cognitive Dissonance Theory as well as variables from the Behaviour Change Wheel concept helps anchor this work in the foundations of behaviour change. This strategy is beneficial to the provision of evidence on behaviour change and the resultant impact, allowing for an eclectic approach to the analysis of the data. Furthermore, it substantiates why most examples used throughout this chapter demonstrate how cognitive dissonance relate to smoking behaviour.

Smoking is one of the major causes of health and economic problems in the UK. According to a study by Vogl, Wenig, Leidl, and Pokhrel (2012) examining smoking and health related quality of life in the English general population, between 2005 and 2006 treatment of illnesses resulting from smoking causes the NHS approximately £5.2 billion, equivalent to 5.5% of the total NHS budget for that year. Vogl et al. (2012) continue that if other indirect costs to society, (e.g. informal care, costs due to passive smoking, and lost productivity), were added this figure would increase several times more. Based on the preceding statement, this study highlights the health, societal, and financial costs of smoking thereby justifying how important it is to achieve behaviour change in smokers.

Interestingly, despite awareness of the adverse effects of smoking, smokers experience conflicting emotions when faced with the choice of smoking or observing anti-smoking strategies. One way to consider this conflict and how it impacts behaviour change is through the lens of Cognitive Dissonance Theory. According to McMaster and Lee (1991), Cognitive Dissonance Theory reasons that mutually inconsistent cognitions produce a state of dissonance. The psychological discomfort it produces acts as a motive for individuals (smokers in this instance), to reduce this dissonant state resulting in behaviour change. Another way to consider behaviour change in smokers is through the lens of the Behaviour Change Wheel concept. According to Michie, Stralen, and West (2011) behaviour change interventions are effective in dealing with public health issues, their goal being to change specified behaviour patterns, for example smoking. Interventions promote uptake and use of effective clinical services whilst actively encouraging healthy lifestyles. These

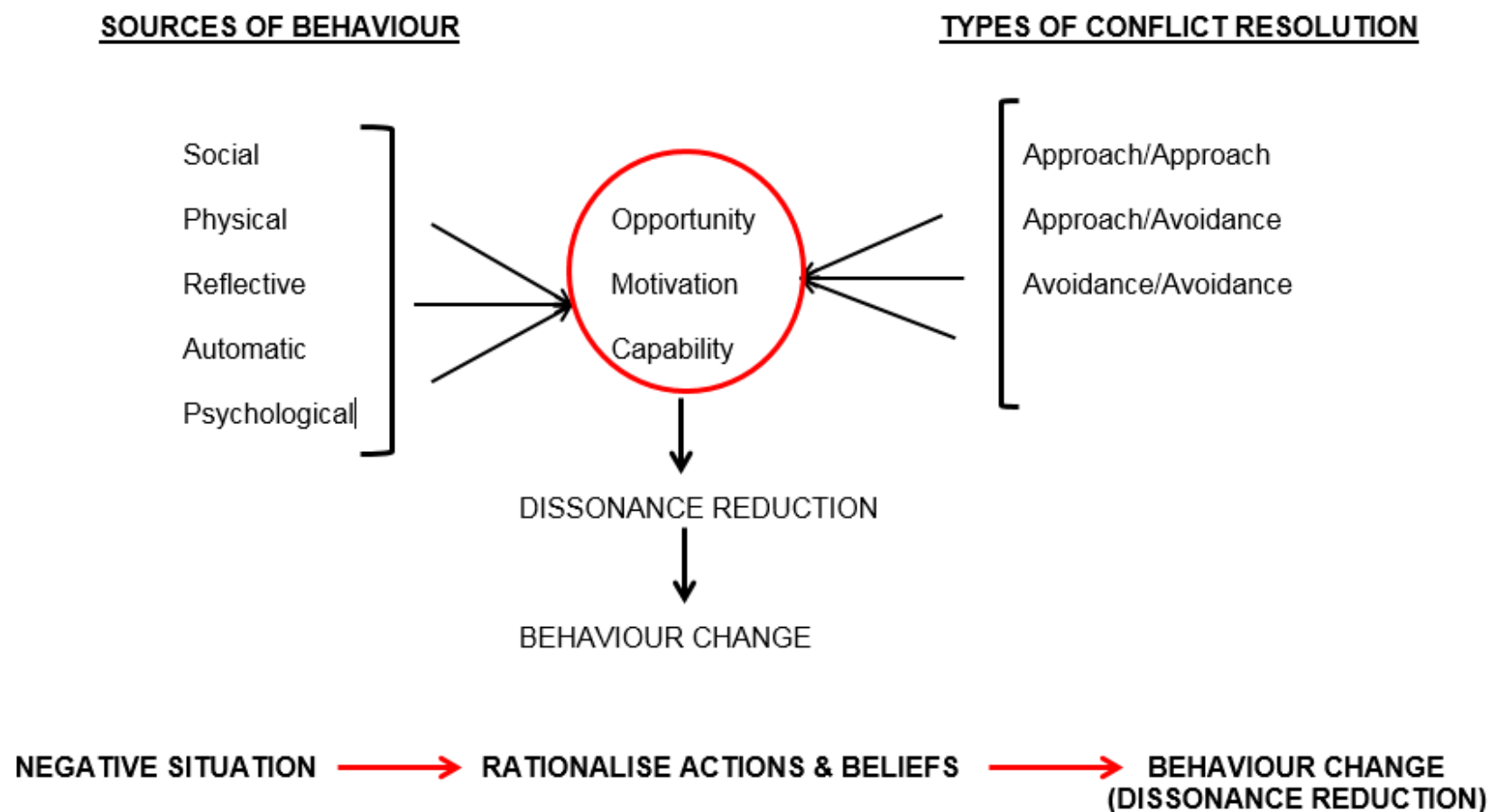
observations justify this study's use of Cognitive Dissonance Theory and the Behaviour Change Wheel concept to examine behaviour change in smokers.

Discussions on both Cognitive Dissonance Theory and the Behaviour Change Wheel concept are held in the paragraphs following. Included in these discussions are information on the formulation of this study's theoretical framework, (incorporating insight on both *assumptions and how they combine*), and illustrations of the initial and later revised versions of the study's theoretical framework.

2.6.2 Formulation of this study's Theoretical Framework

Within both principles, i.e. Cognitive Dissonance Theory and the Behaviour Wheel concept, exist variables which contribute to both the arousal of dissonance and its reduction. For example, in the context of this study the workings of Cognitive Dissonance Theory are likened to a conflict between two desired gratifications: (i) approach-approach, and (ii) approach-avoidance. The approach-approach conflict may lead to some vacillation but rarely to great distress. Approach-avoidance conflicts occur when there is one event or goal that has both positive and negative effects, or characteristics that make the goal attractive and unattractive simultaneously. The other, avoidance-avoidance conflict happens when there are two threats and is usually more disturbing. Discussions on these approaches are set out at section 2.12.2. The Behaviour Change Wheel concept also propose factors which facilitate dissonance reduction, i.e. opportunity, motivation, and capability, further expanded on at section 2.9.7. Combined, both concepts form the basis of the initial approach to this study's theoretical framework illustrated at Figure 2.1, and further expanded later at Figure 2.9.

Figure 2-1: Initial Model of the Theoretical Framework of this Thesis



NB: Arrows represent potential for causal inference (or conclusion drawing).

Source: *Researcher's Own Adaptation of Festinger (1957), and Michie & West's (2011) theoretical concepts for her research study.*

2.6.3 Cognitive Dissonance Theory

Cognitive Dissonance Theory (Festinger, 1957), can be explained as follows:

If a person holds two cognitions that are inconsistent with one another, he will experience the pressure of an aversive motivational state called cognitive dissonance, a pressure which he will seek to remove, among other ways, by altering one of the two "dissonant" cognitions.

Chatzisarantis, Hagger, and Wang (2008)

This statement suggests that a cause of dissonance rests in the characteristics of the elements between which the relation of dissonance holds. Furthermore, because dissonance can be an unpleasant state, individuals try to minimise it by adding consonant cognitions, lessen dissonant cognitions or change cognitions to make them at one with each other. To illustrate, a die-hard smoker who must make a difficult choice, (for example, continue smoking or start doing exercise), experiences cognitions about the negative attributes of the preferred option (i.e. smoking) with having to choose it. However, cognitions about the positive aspects of exercising are dissonant with having rejected it. In this situation dissonance can be reduced by presenting the positive health benefits for smokers, i.e. that physical exercise can increase life expectancy.

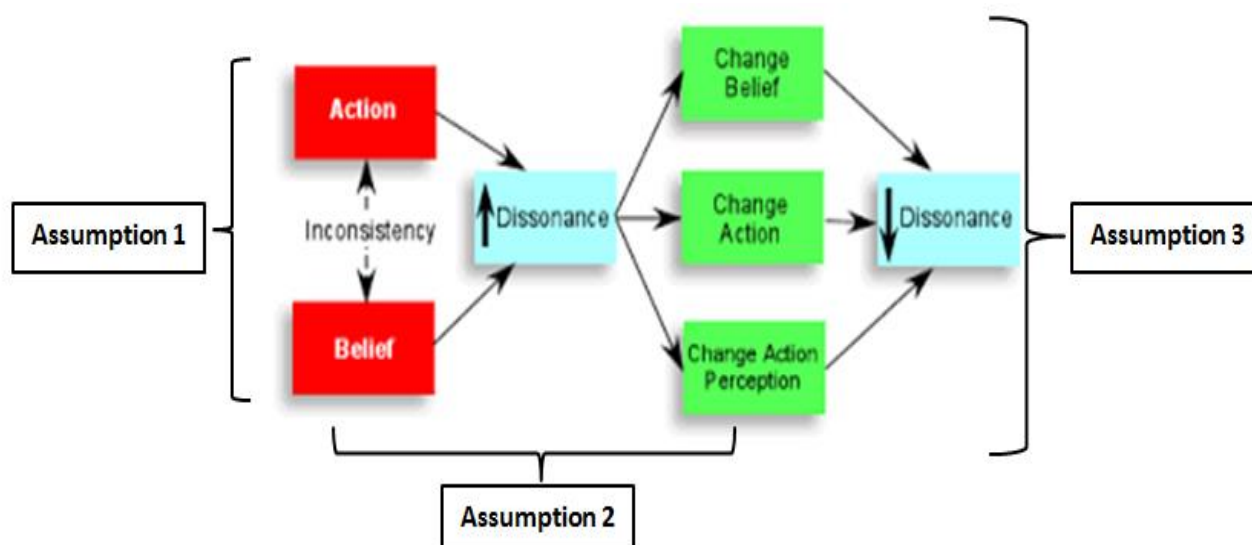
Throughout his book, Festinger (1957) makes reference to and explains the effect of dissonance on health and smoking-related behaviour. Festinger presents his belief that dissonance manifests in smokers by their awareness of the dangers of smoking, although they find ways to justify why they continue with the habit. The main postulation of Cognitive Dissonance Theory is that cognitions which are inconsistent with each other produce a state of psychologically uncomfortable dissonance, acting as a motivator for individuals to reduce the occurrence of dissonance. This is a

position brought out in McMaster & Lee's (1991) study examining the effect of dissonance on smoking behaviours, and how smokers rationalise and distort logic regarding smoking. *This study suggests that by doubting the validity of established and accepted negative facts about smoking, smokers employ subtlety to minimise dissonance.*

Mayer and Cody's (1968) study *applied* Cognitive Dissonance Theory to examine *student's* orientation to school counselling, *identifying that* an individual's belief has certain cognitive elements. These are: knowledge about himself, his environment, his attitudes, his opinions, and his previous behaviour. Each of these elements, according to Mayer and Cody (1968), follows a logical and harmonious process, but for dissonance to manifest each of these elements must deviate from this ordered norm. Cognitive Dissonance Theory has also been used in social psychology works of literature (for example: Hinojosa, Gardner, Walker, Coglisser, & Gullifor, 2017), to explain the motivation behind dissonance in predicting attitude and behaviour change. Described as an "action-opinion theory" (Hall, 1998), cognitive dissonance is characterised by the assumption that *actions can be influenced by attitudes and beliefs. For example, a teenager who smokes although aware that he/she is under the legal age to engage in such an activity, will still be affected by this inconsistency.*

Cognitive Dissonance Theory has *also* been used to predict non-obvious effect situations which seem unrelated (Tedeschi, Schlenker, & Bonoma, 1971). These fall under three fundamental assumptions: (i) the sensitivity of humans to inconsistencies (Chatzisarantis et al., 2008), (ii) inconsistency causes dissonance behaviour (Mayer & Cody, 1968), and (iii) dissonance can be resolved through change (Telcia, Madenb, & Kantur, 2011). These points *are illustrated* at Figure 2.2.

Figure 2.2: Fundamental Assumptions of Cognitive Dissonance Theory



Source: Festinger (1957); Image Adapted from Google Images

Assumption 1 - Humans are sensitive to inconsistencies between actions, attitudes, and intentions. This behaviour was identified in Chatzisarantis et al.'s (2008) study examining Cognitive Dissonance Theory in the Domain of Physical Exercise. The study found that the amount of dissonance aroused in response to a specific cognition, relates to the attribute value of consonant and dissonant cognitions, with the one in question being dependent on the importance of each cognition. Chatzisarantis et al. (2008) continue that since dissonance is unpleasant, individuals try to reduce it by adding consonant cognitions, devaluing dissonant cognitions, and/or changing one or both cognitions to make each of them consonant. To illustrate, smoking may result in negative health consequences, for example breathlessness and the presence of carbon monoxide in smokers' blood and breath (McMaster & Lee, 1991). Nevertheless, those who indulge in the habit do so because they feel it is their personal right.

Assumption 2 - Recognition of inconsistency will cause dissonance and motivate an individual to resolve the dissonance. In their study applying Cognitive Dissonance Theory to School Counselling, Mayer and Cody (1968) submit that in dissonance-creating situations individuals often find different ways to minimise threat(s). This is because in dissonance-creating situations threats can be fostered in several ways, for example expressed verbally from an external source, (i.e. a stop smoking counsellor), even if the individual(s) affected does not express or accept this threat. Mayer and Cody (1968) continue that message(s) received by the individual creates the dissonance because it can either be inconsistent or contradictory to the receiver's previously held beliefs and attitudes. However, by repeating the message the external source has made it easier for the receiver to verbally clarify his/her experience. To illustrate, a smoker hearing the message that lung cancer is caused by smoking might not change his/her smoking behaviour. However, hearing the same message from a Stop Smoking Advisor will encourage the smoker to speak about his/her fear, making them want to seek help to quit fearing for his/her own health.

Assumption 3 - Dissonance can be resolved in one of three basic ways: i.e. change beliefs, change actions, or change perception of action. This statement could be interpreted to mean that dissonance can be resolved by a change in attitudes. According to Telcia et al. (2011), motivation to reduce dissonance increases when there is also an increase in the magnitude of dissonance. The strength of dissonance is therefore affected by the number of dissonant beliefs but also the importance of each belief. Telcia et al. (2011) continue that attitude change occur when individuals try to preserve their positive outlooks, (i.e. predictability, competence, and morality), by limiting behaviours which contradicts their positive outlooks of themselves. To

illustrate, smokers can reduce dissonance by changing their position and say that smoking is not harmful, but instead make them feel calm. In this way dissonance has effected an attitude change. However, attitude change in smokers can sometimes be difficult to achieve particularly as factors such as risk, self-efficacy and addiction also impact on their response. This is a position also identified by Thompson, Barnett, and Pearce's (2009a) study examining smokers response to anti-smoking campaigns.

2.7 Origins of Cognitive Dissonance Theory

Benjamin Franklin's need to borrow a book from a colleague with whom he had a disagreement, stirred up conflicting emotions within the colleague – "*should I lend him the book, after all we are not friends*". (He eventually lent Franklin the book). Dissonance developed when the colleague was torn between his dislike for Franklyn or lending him the book. This incident is one example of dissonance in action, which gave rise to cognitive dissonance being referred to as "*The Benjamin Franklin Approach*" (Rosenzweig, 1972).

In 1954 Leon Festinger and two colleagues infiltrated an all-female UFO cult to measure members' perception of the cult leader after she predicted an apocalyptic event. Cult leader Dorothy Martin aka Marian Keech, convinced members that the world would end but only members of that cult would be saved (H. M. Collins & Cox, 1976; Gazzaniga, 2006; Moser, 2011). Of course, the predicted disaster did not happen, resulting in fringe members negatively changing their attitudes towards Marian Keech, and leaving the cult. However, as predicted by Festinger (and his two colleagues), committed cult members did not change their attitudes. Instead, they held the belief that it was their faith which prevented the fulfilment of the prophecy.

Dissonance behaviour was manifested in members who remained when they eliminated the unpleasant reality of being wrong to achieve consonance (i.e. agreement).

Another experiment conducted by Festinger aimed to prove dissonance in persons undertaking what was believed to be a tedious task. The strategy was to pay one group of participants to tell another group of participants that the task was enjoyable (Festinger & Carlsmith, 1959; Mullainathan & Washington, 2009). Dissonance was manifested when individuals who were encouraged to say something contrary to their personal opinions, changed their opinion(s) to reflect what they were told to say. What is also evident from this experiment is that when individuals are pressured into behaving a certain way, it is less likely that they will comply.

These incidences and experiments demonstrate how dissonance in humans is developed, especially when conflicts occur when trying to achieve internal consistency. It establishes that psychological discomfort occurs in individuals who experience inconsistency. When this happens, individuals are motivated to reduce the occurrence of dissonance by avoiding situations where psychological discomfort is likely to be increased.

2.7.1 Cognitive Dissonance, Moral Conflicts and Decision Making

Examining cognitive dissonance through the lens of psychology, management and marketing, Telcia et al. (2011) found that the theory helps individuals to understand reasons behind moral conflicts, as well as predict the probability of an individual making decisions based on these conflicts. For example, a smoker purchasing cigarettes in the supermarket might only ask for the product he/she desires, without

showing awareness of the cupboard (gantry) the product is stored behind. By so doing, he/she avoids dissonance arousal and purchases the product which allows him/her to carry on smoking. This behaviour supports Matz, Hofstedt, and Wood (2008), who found that individuals react differently to and in situations where dissonance arousal can be manifested.

Tying in to the work of Matz et al. (2008), earlier works of A. J. Elliot and Devine (1994) and Zanna and Cooper (1974), suggest that dissonance can be associated with words such as dissonance arousal, dissonance reduction and tensions due to dissonance, whilst likening dissonance to feelings such as anxiety, tension or states of arousal. These are all feelings which lead to behavioural conflict. Both works replicate those offered previously, (for example, Festinger, 1957, 1964; Festinger & Carlsmith, 1959), whilst illustrating the complexities of dissonance. *For example, one complexity associated with dissonance is regret (Joseph-Williams, Edwards, & Elwyn, 2010), which could be manifested in someone who purchased a 400-horse power motor vehicle after the onset of a fuel shortage.*

Festinger's classic 1957 book, "*A Theory of Cognitive Dissonance*", demonstrates the relationship between dissonance and conflicting behaviour:

The person is in a conflict situation before making the decision. After having made the decision, he is no longer in conflict; he has made his choice; he has, so to speak, resolved the conflict. He is no longer being pushed in two or more directions simultaneously. He is now committed to the chosen course of action. It is only here that dissonance exists, and the pressure to reduce his dissonance is not pushing the person in two directions simultaneously.

Festinger (1957, p. 39)

Berkowitz in his book "*Advances in Experimental Social Psychology*", agrees with Festinger's argument proposing that:

Conflict occurs before a decision is made, dissonance occurs after the decision. During conflict it is assumed that an individual will devote his energies to a careful, dispassionate, and sensible evaluation and judgement of the alternatives. He will gather all of the information, pro and con, about all of the alternatives in order to make a reasonable decision.

Berkowitz (1969, pp. 12 - 13)

Both works support the belief that dissonance only occurs after the decision has been made, because an individual sometimes re-evaluate their attitudes after making decisions. For example, smokers believe that active and passive smoking is less dangerous, but to make relevant cognitions consistent with choice behaviours they ignore or question smoking related information.

Spurred on by Festinger and Berkowitz's earlier works, A. J. Elliot and Devine (1994) examined the motivating properties of dissonance. Their study concluded that dissonance causes aversive feelings (or psychological discomfort), which dissonance-reduction strategies can alleviate. Works by Wichardt, Schunk, and Schmitz (2009) further demonstrate the presence of dissonance, shown in situations where individuals who participate in ultimatum bargaining games try to maximise monetary rewards. More recently, T. Y. Chang, Solomon, and Westerfield (2016) conducted a study further developing Festinger's (1957) theory, identifying that dissonance-based interventions can help investors avoid realising losses by blaming their superior rather than themselves for making investment mistakes.

The concept of dissonance has also been viewed through the lens of counter-attitudinal advocacy (Matz et al., 2008), but is not restricted to this circumstance. Festinger (1957) maintains that dissonance is aroused in individuals through exposure

to messages from others who have different opinions, which can vary dependent on the individual's mood. Matz et al. (2008) advance this reasoning, stating that in these situations dissonance could be reduced by attitude change, avoiding sources of contradicting information, or by sourcing supportive information.

2.8 Criticisms of Cognitive Dissonance Theory

Since its conception Cognitive Dissonance Theory has been tested, re-evaluated and replicated, actions which enable mini-theories to materialise (Aronson, 1992). In a previous discussion studies supporting and replicating Festinger's theory was presented, proving this thesis' support for said theory. However, areas of inadequacy within cognitive dissonance have been identified by a number of academics (for example, Bem, 1967; Brehm, 1956; S. A. McLeod, 2014; Wood, 2000; Zanna & Cooper, 1974), leading to criticisms of the theory. Some of these criticisms are presented here.

2.8.1 Bem (1967)

Bem's (1967) criticism of Cognitive Dissonance Theory is that its deductive reasoning is unrealistic, *i.e. it does not provide a true theoretical explanation. Furthermore, Bem suggests that when measuring dissonance manifestation any reference to hypothetical internal processes should be avoided. Instead, consideration must be given to observed functional relations between current stimuli and responses in terms of the individual's past training history. For example, the implication for smoking is that a smoker can easily learn to describe the term "smoke like a chimney" without explicit discrimination training, although he/she can learn other descriptive responses through socialising with other smokers.* Bem's (1967) belief is endorsed by other studies (for example, Brehm & Cohen, 1962; King & Janis, 1956; Scott 1957 & 1959),

which shows that belief and attitude statements can be manipulated through the inducement of role-play, delivery of persuasive communication, or behaviour implying endorsement of a set of beliefs.

Experimental analysis conducted by Daryl Bem in 1955 and 1956 around the phenomena of "self-persuasion", demonstrates that an individual can base his/her beliefs and attitudes on self-observed behaviours (Bem, 1967). Results from these experiments gave rise to the Theory of Self Perception, an alternative way of explaining or measuring dissonance. *The Theory of Self Perception according to Dico (2017), posits that people are what they do, they interpret their own actions the same way they interpret that of others, and their actions are influenced by their social environment rather than their own free will (Dico, 2017). This position support Bem's (1967) opinion that Self-Perception Theory is counterintuitive, i.e. contrary to intuition or expectation.* Interestingly, Bem's overall position is an adaptation of Scriven's "radical" behaviour approach, a concept associated with noted psychologist B. F. Skinner who developed the Theory of Operant Conditioning (Iversen, 1992).

2.8.2 Tedeschi et al. (1971)

Festinger's (1957) position on dissonance is that it is relevant to behaviour in instances where readjustment of inconsistent cognitions exists. However, Tedeschi et al. (1971) whilst not disagreeing with this view, believe dissonance should be viewed in terms of attitudes that influence the individual to make opposing responses to particular stimulus situations, and not only cognitive tensions which result in coinciding contradictory beliefs and attitudes. This is a credible observation, particularly as *existing literature suggest that attitudes do not always predict behaviour (for example,*

Foxall & Goldsmith, 1994; Wicker, 1969; Wills, Bonsmann, Kolka, & Grunert, 2011). Furthermore, criticism by Tedeschi et al. (1971) highlights that using behaviouristic interpretation of dissonance as a response to conflict, places the theory in the same scope as individual learning theories. Bakx, Sanden, and Vermetten (2002) define individual learning theories as personal theories used to measure, judge, categorise and explain learning and school-related issues about a specific domain. *What are the implications for smoking based on Tedeschi et al's (1971) study? It provides a platform from which to evaluate or determine how smokers behave when faced with the choice of continuing to smoke or to quit, and reason(s) why they make specific choice(s).*

2.8.3 Zanna and Cooper (1974)

Another critical voice comes from Zanna and Cooper (1974) Zanna and Cooper (1974), evident in their study examining induced-compliance to understand the concept of dissonance. They reasoned that subjects chosen to write an essay counter to their beliefs, would not change their attitudes if information about a plausible external source of arousal could be included. In line with the study's prediction, one group of subjects who were given a placebo to make them feel tense, showed minimum attitude change as against another group which took a drug to make them feel relaxed. The result of this seminal work by Zanna and Cooper (1974) makes the case that dissonance is not only behaviour-inducing, but also attitude-arousing, finding support in works by Joel Cooper, Fazio, and Rhodewalt (1978) , and, Martinie, Milland, and Olive (2013). *What are the implications for smoking based on Zanna and Cooper's (1974) study? It could provide a gauge to understanding how smokers respond to external cues directing them to stop smoking, e.g. display ban in supermarkets or no smoking signs.*

2.8.4 Elliot and Devine (1994)

One weakness of Cognitive Dissonance theory identified by A. J. Elliot and Devine (1994) , is it focuses solely on Brehm and Cohen's (1962) derived arousal component of dissonance, rather than on the psychological component identified by Festinger (A. J. Elliot & Devine, 1994). *This is because according to A. J. Elliot and Devine (1994) Cognitive Dissonance Theory commonly uses indirect research techniques such as incidental retention (i.e. recalling a series of events), response competition (i.e. where dissonance affect performance of a task), and misattribution paradigms (attributing an event to something to which it has no connection), to measure attitude change.* Support for the opinion of A. J. Elliot and Devine (1994) comes from Wood (2000), who expresses doubt about Cognitive Dissonance Theory's proficiency in demonstrating capacity to understand all existing literature on attitude change. *Implications for smoking based on Elliot and Devine's (1994) study can be unearthed in the findings of Chatzisarantis et al's (2008) study. This study found that attitude change, (i.e. quit smoking), can be achieved through acknowledgement of conflict (i.e. "although smoking calms me, it is bad for my health"), but only if dissonance inducing aversive states, (i.e. shock tobacco advertisements), are also reduced.*

2.8.5 McLeod (2014)

A more recent criticism of the theory comes from S. A. McLeod (2014). Adding his voice to the opinions of variance, McLeod (2014) challenges the thinking that dissonance can be avoided though attitude change, acquiring new information, or a reduction of the importance of beliefs and attitudes. Based on the reasoning of S. A. McLeod (2014), cognitive dissonance theory does not demonstrate explicitly whether

these modes of dissonance reduction will actually work. Implications for smoking based on McLeod's (2014) study, can be found in an early study by Brehm (1956). Brehm's (1956) study showed that exposure to consonant elements, (for example, personal gratification smoking calms a smoker), does not always facilitate a reduction in dissonance (for example, changing his/her belief that smoking is a personal right regardless of the harm it causes).

2.9 Alternatives to Cognitive Dissonance Theory

2.9.1 Introduction

In 1954 Leon Festinger conducted a study on dissonance related to communication between individuals, addressing reactions by members of a doomsday cult after a failed predicted apocalyptic event (Matz & Wood, 2005). Since then numerous reviews and revisions of the theory have been conducted, giving rise to further and alternative theoretical positions (Telcia et al., 2011), such as: The Theory of Self Perception (Bem, 1967), Social Learning Theory (Bandura, 1977), The Theory of Planned Behaviour (Ajzen, 2002), Social Cognitive Theory (Bandura, 2001), and Prime Theory of Motivation (Michie & West, 2013).

Including discussions about these alternative theories to Cognitive Dissonance Theory is important. First, discussions demonstrate this researcher's reflective and critical thinking. Second, it shows how the viewpoint of different authors have improved the theory through their experience. These discussions are presented below.

2.9.2 The Theory of Self Perception

The Theory of Self-Perception was developed as an alternative interpretation of actions supported by Cognitive Dissonance Theory (Bem, 1967), but also to develop

some of the secondary patterns of data which appeared in dissonance experiments. According to Bem (1967), at the core of this concept is the belief that an individual can respond differentially to his/her own behaviour, and the controlling variables are a product of social interaction. To illustrate, one of the most common responses comprising self-perception are verbal statements, techniques used by a community to educate members on how to make these statements. *As previously stated, the Theory of Self-Perception posits that people's actions define them, they interpret the action of others in the same way they interpret their own, and are influenced by their social environments rather than their own free will (Dico, 2017). Since individuals (smokers in this instance), will do what they want influenced by other smokers, this model highlights the need for stop-smoking strategies to consider the impact of social influence on smokers.*

2.9.3 Social Learning Theory

Bandura's Social Learning Theory is another alternative to understanding and explaining human behaviour, complimenting other sociological theories (Akers, Krohn, Lanz-Kaduce, & Radosevich, 1979). The four component processes governing this type of learning behaviour are: attention, retention, motor reproduction and motivation (Bandura, 1977). Social Learning Theory also shows that people are not born with a ready-made stock of behavioural skills, but instead must learn them. Due to the fact that people learn by interacting with those they deem important to them (Akers et al., 1979), their response pattern can be acquired by direct experience or observation. However, factors such as biological and genetic composition can affect this learning process (Bandura, 1977). *Since individuals (smokers in this instance), learn to smoke*

from parents, older siblings, and friends, this theory suggests a need for stop-smoking strategies to consider the impact of social influence on smokers.

2.9.4 The Theory of Planned Behaviour

The Theory of Planned Behaviour links belief and behaviour in its attempt to identify how human action is guided. Simply put, it postulates that behaviour is shaped by the environment in which an individual exists instead of being intentional or controlled. According to Ajzen (2002) , three considerations guide human behaviour: behavioural beliefs, normative beliefs and control beliefs. Individually, these beliefs create favourable or unfavourable attitude toward the behaviour, social pressure and the ability or inability to behave in a specified way. However, when all three beliefs combine behavioural intentions are developed. *Since the behaviour of individuals (smokers in this instance), is shaped by the environment they are in, The Theory of Planned Behaviour is important to help understand why some smokers only smoke in social situations, e.g. when out at a night club with friends.*

2.9.5 Social Cognitive Theory

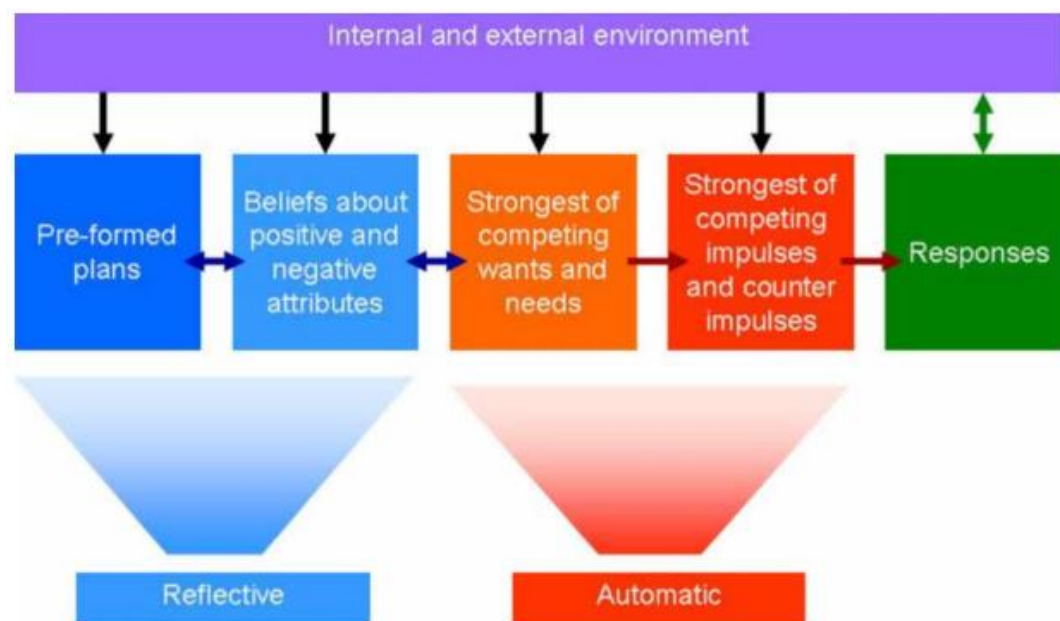
Social Cognitive Theory is used to explain the behaviour of individuals wherein human thought, affect and action are influenced by symbolic communication. The theory is based on the concept that an individual's character is not a hypothetic notion of social reality, but derived from mutual interaction with environmental factors such as social normality and organisational expectations (H.-Y. Lin & Hsu, 2015), and behavioural experiences (Bandura, 2001). *This theory acknowledges the importance of linguistic or gestural communication, and the personal feeling(s) associated with how they are interpreted. Smokers may be motivated, (consciously or unconsciously), to smoke*

when they see “no smoking” signs (Earp, 2012). Social Cognitive Theory is important to smoking as it can help evaluate how this subconscious effect manifests itself in the lives of smokers.

2.9.6 PRIME Theory of Motivation

PRIME (**P**lans, **R**esponses, **I**mpulses/Inhibition, **M**otives, and **E**valuation) Theory of Motivation help in understanding the levels of motivation present in humans, i.e. higher and lower (Michie & West, 2013). This suggests that higher levels of motivation provide greater flexibility of response and act as stimuli to influence behaviour at lower levels. See Figure 2.3.

Figure 2.3: The Structure of Human Motivation



Source: Michie and West (2013)

According to Michie and West (2013), Prime Theory of Motivation model identifies internal and external environments which contribute to human motivation. Features of the internal environment are: (a) plans – self-conscious intentions to perform future

actions, (b) beliefs – propositions believed to be true, (c) wants and needs – a conceptualisation of the future which includes pleasure/satisfaction and relief from mental or physical discomfort, (d) impulses – organised action plans and counter impulses which are inhibited by equal forces, and (e) responses – how an action is initiated, modified, and stopped. Other attributes of the internal environment are the outflowing of changeable emotional states, drive states, images, and cognitive schemata. On the other hand, the external environment involves stimuli impacting on the sense organs. Here reflective processes involve self-conscious information processing, whilst automatic processes negate conscious awareness but forms part of the ongoing experience (Michie & West, 2013).

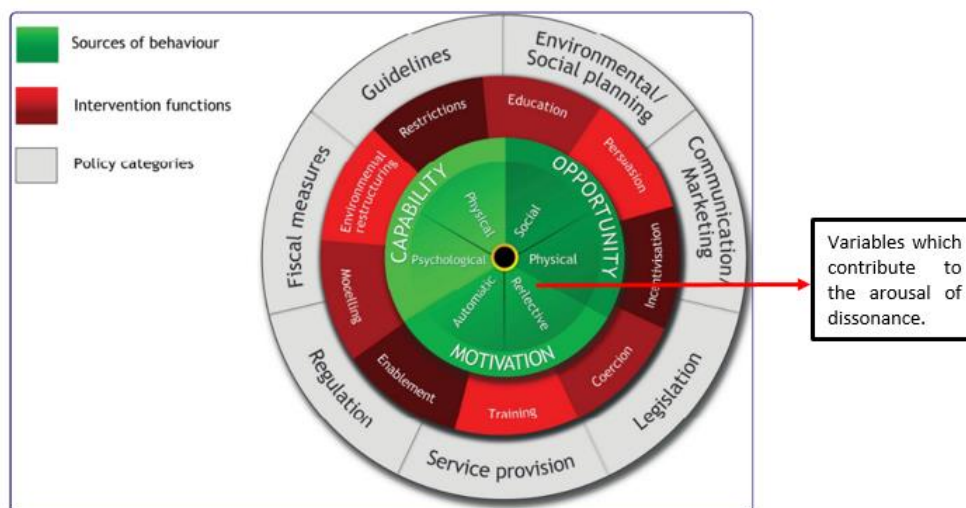
As stated by Michie and West (2013), previous models of health-related behaviour only consider limited ways in which change occurs. With PRIME Theory of Motivation, communication, inferential reasoning and associative learning are crucial. Michie and West (2013) continue that the theory recognises that humans develop strong feelings about themselves which contribute to wants and needs whilst giving stability to behaviour patterns. Furthermore, in many cases behaviour change necessitates changes in behaviour patterns (Michie & West, 2013). For example, identities prompt wants and needs which are key elements in maintaining behaviour change.

2.9.7 The Behaviour Change Wheel Concept

This study's theoretical framework also borrows from the Behaviour Change Wheel, a concept which identify categories of intervention functions and policy levers used to

enact behaviour change (Michie et al., 2011; Michie & West, 2013). As stated by Michie et al. (2011), the concept which is illustrated at Figure 2.4, recognises contribution to the arousal of dissonance and its reduction: (a) opportunity, i.e. social and physical – external factors which prompt or make change possible, (b) motivation, i.e. automatic reflective – brain processes that stimulate and direct behaviour, alongside goals and conscious decision-making, and (c) capability, i.e. psychological and physical – having the necessary knowledge and skill capacity to psychologically and physically engage in the activity concerned. To illustrate, capability can be in the form of physical ability or physical strength. Motivation can be in the form of reflective (e.g. self-conscious planning, analysis, decision making), or automatic processes (e.g. emotional reactions, drives, habits). Opportunity can be what is afforded by the physical environment (e.g. resources, location, physical barriers) (Michie et al., 2011; Michie & West, 2013).

Figure 2.4: The Behaviour Change Wheel Concept



Source: Adapted from Michie et al. (2011)

The Behaviour Change Wheel is a framework developed to assist with the implementation of suitable behaviour change interventions and policies. It borrows from two concepts: (i) the PRIME Theory – a single coherent model which draws

together the broad range of motivational processes, i.e. drives, impulses, analysis and self-conscious decision making, and (ii) the COM-B – a systems approach to understanding behaviour in context (Michie & West, 2013). The Behaviour Change Wheel concept applies choices of intervention functions and develops them into policy categories needed to enact those interventions.

Components within the behaviour change system functions within the intervention layer, and categories within the policy layer all interact with each other (Michie et al., 2011; Michie & West, 2013). To illustrate, the outer grey layer signifies formalities or regulations which can sometimes be confusing and not work. The "middle layer (reddish tones), is that colour to signify *those components'* importance and that they must be paid attention to. The innermost layer (green) and which forms part of this study's framework, are concepts which must be present to enable behaviour change. In a nutshell, the wheel's colour concept could be likened to a traffic signal (*i.e. amber, green, red*). Grey (amber), signifies a general warning to get ready; reddish tones (red) signify stop and pay attention; green provides direction on how to proceed.

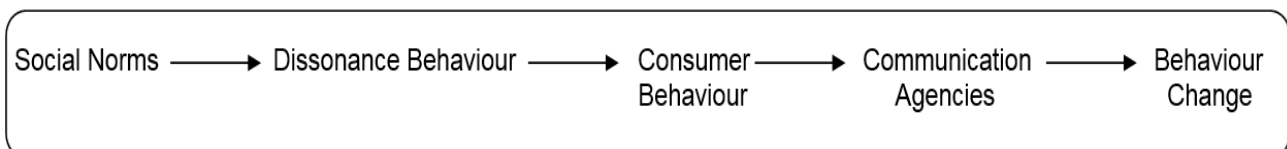
Of significance to this study, the Behaviour Change Wheel classification system demonstrate where principles such as '*nudge*', (*e.g. coercion or persuasion which links into intervention components – opportunity and motivation*), fit within the framework of behaviour change. *It also links into the Theory of Planned Behaviour (TPB), another model used to predict and explain behaviour (Yousafzai, Foxall, & Pallister, 2010). For example, this theory suggests that human behaviour is guided by attitudes, norms, and perception which leads to the formation of behavioural intention (Ajzen, 2002). Therefore, where individuals are given sufficient degree of control over their behaviour*

(i.e. smoking), they are expected to carry out their intentions (i.e. quitting or limiting smoking behaviour), when the OPPORTUNITY arises – a point also considered in the Behaviour Change Wheel concept. Based on the observations of Michie and West (2013), this framework is suitable for analysing behaviour change interventions and policies for change. This also makes it an appropriate concept to help in the development of this study’s theoretical framework.

2.10 Research Question and Inter-Related Themes

The question to be answered by this research is “Does tobacco denormalisation strategies encourage smokers to change their behaviours during purchase and consumption and in shared consumption spaces?” To understand this question and provide background context, five *relevant* inter-related themes, illustrated in Figure 2.5, are now discussed.

Figure 2.5: Inter-Related Themes of this Research



Source: Researcher’s Concept of the Inter-Related Themes of this Study

Social norms examine how normative behaviour, e.g. influence of family, friends, peers and socialising shape smoking adoption. **Dissonance behaviour** examines how discomfort arise in smokers due to the holding of conflicting beliefs. **Consumer behaviour** examines how smokers behave in retail establishments e.g. supermarkets and small retail establishments, and in shared consumption spaces e.g. pubs, clubs and restaurants where tobacco control strategies exist. **Communication agencies** discuss smokers’ response to marketing stimuli from the tobacco industry and anti-

smoking message from anti-smoking advocates. Behaviour change/conflict resolution puts into context positives and negatives which impact behaviour change. Discussions on these five inter-related themes are presented below.

2.11 Theme One: Social Norms

2.11.1 Social Norms Explained

Different interpretations of what social norms are have emerged from studies in the social sciences. According to S. McLeod (2008), social norms are unwritten rules about how to behave within social groupings or cultures. Bobek, Hageman, and Kelliher (2013) believe social norms are established rules and standards governing members of a group or individuals, which direct and/or encourage social behaviour without being lawfully enforced. Caroli and Weber-Baghdiguian's (2016) view social norms as the expected behaviour of group members or individuals within society. These definitions suggest a link between social norms and individual and group behaviour, giving credence to scholars of social influence. For example, Lapinski and Rimal (2006) associate human behaviour with the popularity of certain behaviours.

Social norms can perhaps be explained through early hunter-gatherer societies (Kameda & Takezawa, 2005), where uncertainty existed in resource provision, for example meat. Hunted meat was more likely to be shared communally thus it became the norm to include many individuals in the task of hunting. This norm could have been tacitly understood or implied (through experience), given the primitive nature of those societies. It brings into focus Fehr and Fischbacher's (2004) position that cooperation in human societies is based on social norms, and Loenhoff's (2011)

understanding that “tacit agreements are the unthematized resources of social cooperation.”

Today, social norms can either be tacitly or explicitly understood. A belief tied to Loenhoff’s (2011) conviction that human beings are rational individuals. For example, a child brought up in a home where no one smokes have a tacit understanding of smoking being something bad. Alternately, smokers identify places they can or cannot smoke because signs posted in these locations explicitly state this. This thinking suggests that social norms and behaviour are linked by communication, helping to form perceptions about norms and acting as an influential medium for individuals to behave in accordance with information communicated to them (Lapinski & Rimal, 2006). To sum this up, human behaviour is guided by the popularity of the specific behaviour, therefore individual behavioural decisions are made based on whether others also engage in said behaviour. *The implication for smoking? A smoker will ignore anti-smoking messages because doing so is popular amongst his/her smoking cohorts.*

2.11.2 Other Norms Which Influence Social Behaviour

Other norms also influence social behaviours, i.e. collective, perceived (aka injunctive and descriptive), enacted and prescriptive. These are summarised in Table 2.4 and discussed in the following paragraphs.

Table 2-4: Other Norms Which Influence Social Behaviour

NORMS	POINTS OF INTEREST
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Collective	Understandings are modelled and applied to extended groups of persons who interact frequently, using social cues to generalise people and situations, (e.g. public expressions, and the behaviour of role models).
Perceived (aka Injunctive and Descriptive)	Beliefs individuals hold about acceptable behaviour(s) of peers. Both norms act in tandem to encourage compliance with customary actions, although descriptive norms have a greater influence on behaviour.
Enacted	Shapes formal and informal rules governing social rules, laws, and regulations, which dictate right from wrong, suitability or unsuitability.
Crescive	Manifest through exposure to and interaction with persons sharing the same culture.

Source: Reno, Cialdini, and Kallgren (1993); Cialdini et al. (2006); Paluck and Shepherd (2012); Lewis (2013); Pedersen et al. (2013); Eriksson, Strimling, and Coultas (2015); M. R. Solomon (2015)

Collective Norms

Paluck and Shepherd's (2012) work on the salience of social reference, found that when individuals model understandings from an extended group of persons with whom they interact regularly, the process of collective norm manifests. For example, teenagers whose parents smoke might perceive this behaviour to be the norm, thus increasing cigarette consumption amongst that age group. This position could be interpreted to mean that collective norms use social cues (public expressions, salient individuals and behaviours) to generalise people and situations.

Perceived Norms

Holding beliefs about what is the acceptable behaviour(s) of peers shows an understanding of perceived norms (Pedersen et al., 2013). Two types have been identified – descriptive and injunctive (Wahesh, Lewis, Wyrick, & Ackerman, 2015).

Descriptive norms or “the norm of is” (Cialdini et al., 2006), describe the action taken by individuals which implies that individuals should be able to master that specific

action (Thøgersen, 2014). This norm has a positive impact on self-efficacy and produce definitive behavioural outcomes, evidenced by effective and adaptive action. A strong predictor of behavioural outcomes (Reno et al., 1993), descriptive norms increase conforming behaviour in pro-social activities (Panagopoulos, Larimer, & Condon, 2014), for example smoking.

Gelfand and Harrington (2015) question when and in what context descriptive norms predict behaviour, instead identifying other determinants of behavioural outcomes such as: (i) the goal to manage uncertainty and threat, (ii) the goal to manage impressions and (iii) goals derived from power and dependence. Arguably, these determinants recognise epistemic and social coordinative functions despite the lack of a strong normative component. Why? Descriptive norms are not like conventions which provide combined solutions to coordinated problems. Since these norms inform behaviour by example (Cialdini et al., 2006), they are more like fashions, fads and trends which emerge naturally from social exchanges (Muldoon, Lisciandra, & Hartmann, 2014).

Injunctive norms, or “*the norms of ought*” (Cialdini et al., 2006), refer to what is commonly approved or disapproved, motivating individuals by promising social rewards or punishments (Thøgersen, 2014). For example, someone smoking in an area designated for smoking is less likely to experience negative feedback from non-smokers, in strong contrast to a smoker who fails to observe the no-smoking sign wherever posted. Injunctive norms are also strong sources of individual predictive behaviour (Krieger et al., 2016), taking into account the individual’s previous

performance. For example, someone who has quit smoking is more likely to respond to pro-smoking marketing stimuli than someone who has never smoked.

Eriksson et al.'s (2015) research on bi-directional associations between descriptive and injunctive norms, offers a contrasting view about injunctive norms. They argue that as not all behaviours are approved or predictive, an injunctive norm can sometimes mean the imposition of sanctions. For example, in the UK smoking in private cars whilst accompanied by anyone under the age of 18 attracts a £50 fee (Triggle, 2015b). Savani, Morris, and Naidu (2012) agree with Eriksson et al.'s view, evidenced in the following statement:

Injunctive norms do not guide behaviour continuously but only when situationally primed. It should not be seen as uniformly in force at all times and in all situations. That is, norms should motivate behaviour primarily when they are activated (i.e., made salient or otherwise focused on).

Savani et al. (2012)

Savani et al.'s (2012) viewpoint suggests that people often modify their behaviour(s) to match noticeable injunctive norm behaviour. For example, to avoid paying the £50 penalty fee UK smokers will instead smoke an e-cigarette in their vehicle, because the penalty does not apply to e-cigarettes (Triggle, 2015b). To put this into perspective, actions will prompt social rewards or sanctions (Bosson, Parrott, Swan, Kuchynka, & Schramm, 2015), therefore injunctive norms convey information about what most persons morally approve or disapprove of.

Enacted Norms

Enacted norms help govern social lives through formal and informal rules such as laws and regulations which dictate right from wrong, suitability or unsuitability (M. R. Solomon, 2015). For example, smoking in an area designated as a “no-smoking” zone. In group situations, violation of these norms is usually punished by minor criticism such as snide remarks or jokes. In more serious cases, by exclusion or gaining an unfavourable reputation which could undermine position within the group (Styhre, 2011).

Crescive Norms

A more subtle norm, manifests itself through exposure to and interaction with persons sharing the same culture (M. R. Solomon, 2015). Examples of crescive norms are: (i) **custom** – a norm handed down from the past which controls basic behaviours, e.g. a person entertaining guests in his/her home, (ii) **mores** – taboo or forbidden behaviours, e.g. cannibalism or incest, and (iii) **conventions** – the conduct of everyday life, e.g. what would be an appropriate gift to purchase for a bride-to-be (M. R. Solomon, 2015). Both enacted and crescive norms influence cultural as well as social behaviour, although most norms are learnt through interaction with others. Nevertheless, according to M. R. Solomon (2015), norms are sometimes taken for granted because individuals assume they are the right thing to do.

2.11.3 Changing Characteristics of Norms

Norms can shift over time, particularly when individual or group behaviours are affected by the enactment of new laws which require a change in behaviour (Procter-Scherdtel & Collins, 2013). Falk and Skinner’s (2016) study on humanitarian intervention, found that successful norm entrepreneurship must be followed by legal

and behavioural change. For example, international consensus of the WHO Framework Convention on Tobacco Control have strengthened campaigns in the UK which led to the implementation of tobacco denormalisation strategies.

Evidence of the changing characteristics of norms is easily identifiable. For example, being a responsible parent is an accepted and prevalent social behaviour, but current established tobacco control strategies in the UK see parents who smoke as practicing deviant behaviour. Once seen as an acceptable practice, smoking inside UK public buildings is no longer permitted. Smokers may decide to justify their discontinuation of smoking by changing their attitudes toward it. This position reduces dissonance, protecting the individual's self-esteem. Others who do not agree with a new rule, but are obliged to abide by it, can also experience cognitive dissonance. In these kind of situations smokers find themselves in a state of psychological discomfort because their actions and belief become dissimilar.

2.11.4 Normative Theoretical Orientations

Normative theoretical orientations account for consistent patterns of actions. They can be understood through origin orientations describing the causal processes by which norm concepts arise, i.e. (i) **custom** - perception of prevalence of action in group, (ii) **approval norm** - perception of symbolic meaning of action to group and perception of group's reward for action, and (iii) **enforcement norm** - perception of group's threat of punishment. Discussions on these processes are had in the paragraphs following linking relevant examples to smoking behaviour.

Norms are a major factor in group behaviour, distinguishing those inside the group from those who are not. Salmivalli and Voeten (2004) disagree with this statement, citing insufficient knowledge about the attitude of individuals within groups. Their view is that clarity is needed to understand why some people in groups become trendsetters, or whether being too much a part of a group may limit one's ability to "think outside the box"¹. This observation gives rise to questions as to whether group pressure is a powerful influence over certain behaviours. Studies suggest it is reasonable to assume group norms may regulate behaviours through practices such as peer group pressure and conformity (e.g. Fleischer, Lozano, Santillán, Shigematsu, & Thrasher, 2017; Gough et al., 2013; Opp, 2002).

Social relations affect the action of groups where group members uphold the values or norms of said group, becoming conscious of their own behaviour(s). Those individuals within the group who fail to conform can experience negative reaction(s) from group members leading to rejection (Schachter, 1951). For example, products of choice for smokers are cigarettes, roll-ups and e-cigarettes. However, should someone within a group who smoke these products decide to use cocaine or any illegal substance, other members within said group could become antagonistic toward that individual because that individual's attitudes and beliefs vary from the "expected" group behaviour. Studies on group conformity conducted by Levitan and Verhulst (2016), found that non-conformity from others within groups produce cognitive inconsistency, negative states of dissonance and ultimately dissonance distress. Once accepted within a group, members experience positive distinctiveness by

¹ Think in an original or creative way.

conforming to the group norms. The result is conformity or attitude change towards the group, brought on by awareness of social information and normative behaviours.

Matz and Wood (2005) suggest that group norms are manifested in dominant expectations and attitudes, compelling members to obey and preserve the collective norm. Their study identified two salient influencers: (i) normative influence can include motives to achieve favourable self-concept, as well as establishing positive relations with others, and (ii) informational influence pressures originate in the desire for an understanding of reality to effectively negotiate their world. Both suggest that disapproval with the behaviour of individual(s) within a group produces cognitive inconsistency, resulting in a negative state of dissonance.

Some individuals smoke because they are addicted (Baumeister, 2017), or they like the taste (S. J. Anderson, 2011). However, for the majority smoking allows association within peer and friendship groups, allowing the building of trust and feeling as if they belong or making friends. Smoking also facilitates socialising amongst individuals (Mercken, Snijders, Steglich, Vartiainen, & Vries, 2010), where they can identify with reference groups such as best friends, colleagues or family members.

2.11.5 Social Norms and Smoking Behaviour

Social pressures contribute to normative behaviour in smokers, giving consideration to the following factors: (a) the salience of the social norm, (b) the pre-existing propensity of the person being pressured to engage in the behaviour, (c) the degree to which the subject's norm-compliant behaviour is observed by others and (d) the degree to which the subject believes others comply with the norm (Panagopoulos et

al., 2014). This highlights the importance of identifying social cues when trying to understand how norms shape smoking behavioural patterns, as well as instances of behaviour change.

Individuals sometimes reject norms (Paluck & Shepherd, 2012), particularly in situations when they are motivated to define their opposing identities to a context or community, or when they do not fit the community profile. For example, stop-smoking regulations are aimed at getting smokers to quit the habit, but because smokers believe smoking is their own personal choice they continue to smoke and rebel against authority. Wang's (2011) article about how group changes individuals thinking process suggests this discernible shift in behaviour causes misperceptions of the norm, which can be dangerous when it involves risky behaviours such as drug use, alcohol intake or smoking.

2.12 Theme Two: Dissonance Behaviour

Discussions in this section link into those held sections 2.6.3 and 2.9.7 which explains Cognitive Dissonance Theory and the Behaviour Change Wheel concept, respectively. Arguments presented here highlight the link with dissonance behaviour, behaviour change, and the study's revised theoretical framework (see Figure 2.9).

2.12.1 Dissonance Behaviour Explained

Dissonance behaviour can be described as anxiety created when individuals hold two or more opinions which are inconsistent with each other (Wilkins, Beckenuyte, & Butt, 2016), making behaviour inappropriate or dangerous (Tagliacozzo, 1979). This manifestation of an unpleasant state of anxiety prompts individuals to restore internal

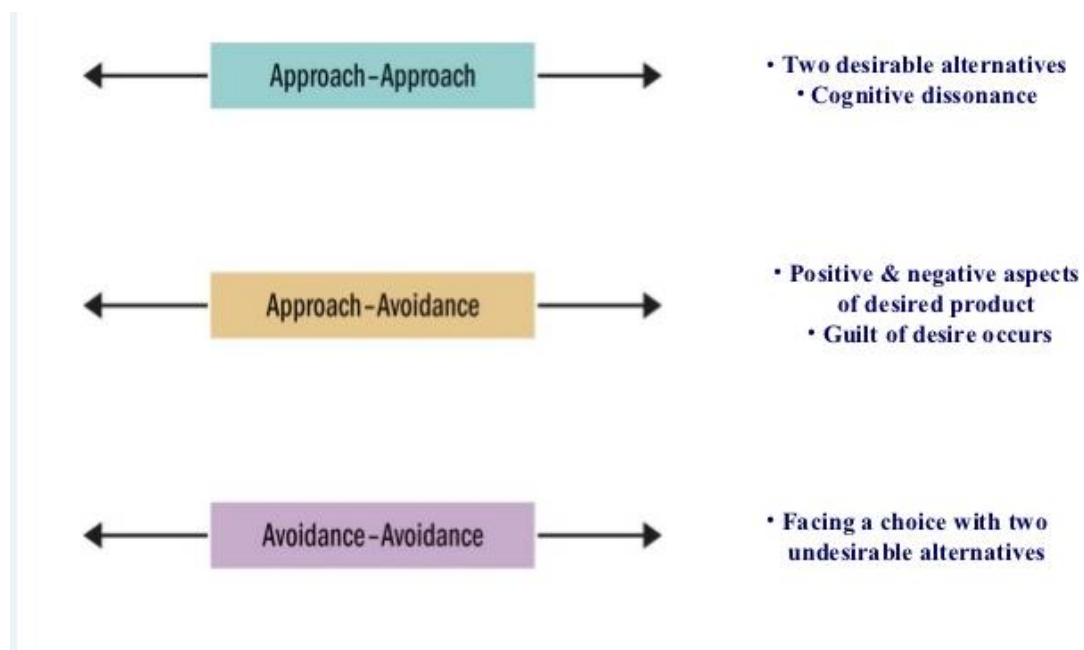
harmony through alignment of beliefs and behaviours (Gbadamosi, 2009; Hinojosa et al., 2017). For example, smokers are aware of graphic images on the cigarette packets but adopt the dissonance-reducing position of completely ignoring these images and still purchase. This behaviour supports their belief that smoking is not harmful.

Dissonance behaviour increases are dependent upon how important the subject is to the individual, how strongly the dissonant thought conflicts, and the individual's ability to explain and rationalise away the conflict. Furthermore, dissonance is stronger when persons hold one belief about themselves yet do something which is contrary to that belief. Simply put, dissonance behaviour is strongly influenced by an individual's self-image, hence feelings such as immortality *or* being foolish can be described as dissonance behaviour (Moss, 2016). *For example, by engaging in smoking behaviour and knowing the detrimental health consequences of smoking, (e.g. lung cancer), smokers display feelings of immortality "I have been smoking for 10 years and nothing has happened to me" and being foolish for denying the obvious health consequences of smoking.* A review of Cognitive Dissonance Theory in management research conducted by Hinojosa et al. (2017), found that trying to produce attitude and behaviour change dissonance can cause motivational conflicts. To resolve these motivational conflicts, smokers try to avoid changing their instead rely on their self-image. For example, adolescent smokers see cigarettes as a way of "appearing grown up", so are more likely to ignore the long-term health consequences of smoking.

2.12.2 Smokers – Motivational Conflicts and Dissonance Behaviour

Individuals experience motivational conflicts when positive and negative motives collide, giving rise to three types of conflicts: (i) approach-approach, (ii) approach-avoidance, and (iii) avoidance-avoidance (M. Solomon et al., 2010; Szmigin & Piacentini, 2015). These conflicts are illustrated in Figure 2.6 and discussed in the paragraphs following to show their relationship to dissonance behaviour.

Figure 2.6: Types of Motivational Conflicts



Source: M. Solomon et al. (2010); Szmigin and Piacentini (2015)

With the *approach-approach conflict* individuals must choose between two desirable alternatives, for example purchasing a packet of cigarettes or purchasing a meal. It is at this point that a state of dissonance occurs when a choice must be made between the good or bad option. Eating a meal satisfies hunger (good), but smoking can cause illnesses (bad). By making a choice between one action over the other, the smoker loses out on the good and gains the bad or vice versa. Dissonance is reduced through rationalisation (M. Solomon et al., 2010), i.e. when the smoker convinces him/herself

that the right choice was made by highlighting the bad qualities of the product not chosen.

The *approach-avoidance conflict* manifests when products being consumed *have negative consequences attached to them, (for example, cigarettes)*. Feelings of guilt arise when the smoker decides to purchase “regular” cigarettes which are considered “not healthy”, instead of the supposedly “healthier” alternative e-cigarette. However, feelings of guilt can be avoided if the smoker chooses the “healthier” alternative. By choosing the e-cigarette instead of the regular cigarette, the smoker can avoid choosing between feelings of guilt or pleasure.

Avoidance-avoidance conflict necessitates that individuals choose between two alternatives which could result in negative consequences. To avoid this conflict, the individual must weigh up the benefits of choosing one option over the other. For example, potential smokers may be concerned about not being able to save money once they take up the habit of smoking. On the other hand, a financially astute individual might have to be persuaded to take up the habit of smoking because they believe it is too expensive or could just avoid this behaviour altogether.

Motivational conflicts are the driving force which leads smokers to experience the psychological effects of smoking, hence the manifestation of dissonance behaviour. *For example, a smoker might purchase a different brand of cigarette, encouraged by promotions from the retailer. However, the smoker’s motivation may be influenced by a friend who might have expressed a negative experience with the product.* Smokers are motivated to reduce dissonance (i.e. change belief, action or perception), by

quitting, cutting down smoking behaviour, ignoring messages which convey the dangers of smoking or adjust non-conforming behaviour (M. Evans, Jamal, & Foxall, 2009). Smokers can also reconsider their actions (e.g. "*smoking is bad for me, but I feel good when I do it*"), to moderate motivational conflicts. Given the difficulties associated with quitting, smokers are more likely to justify their behaviour by adjusting their beliefs, rather than changing their smoking behaviour (Fotuhi et al., 2013). According to J. Cooper (2007), dissonance is one motivating factor which could lead smokers to change attitudes or behaviour and bring about consistency between opinions and actions.

The works of Glanz, Rimer, and Viswanath (2008) Segal (2012) establish that conflict between actions and beliefs gives rise to dissonance which can be resolved through attitude change. Glanz et al.'s (2008) study recognises obvious inconsistencies between actions and beliefs which threaten an individual's current behavioural pattern. These threats result in inconsistencies between actions and beliefs, thereby motivating the individual to resolve the dissonance. Equally, Segal's (2012) five-stage behavioural approach, recognises that inconsistencies occurring throughout any of the behaviour stages can cause dissonance but ultimately motivate the individual to resolve this dissonance.

Smokers experience motivational conflicts caused by dissonance behaviour when positive and negative motives collide. Faced with the choice of conformity (observing the indoor smoking ban) or non-conformity (ignoring display bans), they opt for strategies which reduce dissonance behaviour. For instance, smokers can either deny the ill effects of smoking, accept the ill effects of smoking, or adopt a belief in

personal immunity (McMaster & Lee, 1991). Nevertheless, given the difficulties associated with quitting, smokers usually adjust their beliefs to justify why they smoke rather than change their smoking behaviour (Fotuhi et al., 2013).

2.13 Theme Three: Consumer Behaviour

2.13.1 Overview of Consumer Behaviour

Solomon's (2015) define consumer behaviour as:

The study of individuals, groups, or organisations and the processes used to select, secure, use and disposal of products, services, experiences or ideas to satisfy needs and the impacts these processes have on the consumer and society.

M. R. Solomon (2015, p. 28)

Consumer behaviour also considers the use of services, activities, experiences and ideas, such as going to the doctor, taking a trip, or donating to a charity of choice (Hoyer & MacInnis, 2010). Overall, consumer behaviour focusses on how individuals make decisions on the what, why, when, where, how of consumption, the impact on future purchases, and the disposal of goods/items purchased (Schiffman & Kanuk, 2007).

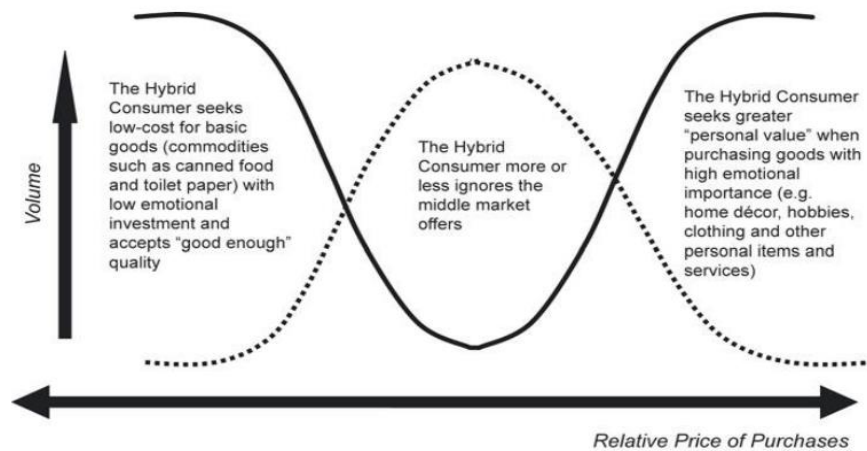
Consumer behaviour is a relatively new field of study which only gained attention and prominence in the 1970's (M. Solomon et al., 2010). *As a subject, consumer behaviour* relates to more than one branch of study, hence its acceptance by scholars from a wide cross-section of disciplines, such as *economics, literature, psychophysiology, and sociology* (Wells & Prensky, 1996). There is also more considerable interest and growth in the study of consumer behaviour, with academics and practitioners contributing to the ever-increasing literature in the subject.

Assael (1998) identifies two main approaches to studying consumer behaviour: (i) a managerial approach, and (ii) a holistic approach. The managerial approach presents consumer behaviour as an applied social science, concentrating on the individual consumer (micro), their thought processes and what influences them (cognitive). Conversely, the holistic approach centres on the nature of the consumption experience rather than the purchasing process, underlining the cultural position of consumption.

In stark contrast to Assael's (1998) position, Ehrnrooth and Gronroos (2013) intimate that studying the behaviour of consumers has been revolutionised with the advent of the 'hybrid consumer'. This consumer does not fit into pre-specified segmentation criteria because of a willingness to combine high and low end purchases, whilst being prepared to pay a high price wherever necessary (Ehrnrooth & Gronroos, 2013). *Based on Ehrnrooth & Gronroos' (2013) study, smokers could be described as 'hybrid consumers'. For example, smokers will pay up to four times more for cigarettes in the UK than in other European countries, even purchasing high-end cigarettes which they would not normally purchase in the UK because the prices are cheaper (Woodhouse, 2016).*

Figure 2.7 illustrates the purchasing pattern of the 'hybrid consumer. The left "tail" suggests trading down to lower priced goods, and the right "tail" suggests trading up to premium products but ignoring mid-priced goods.

Figure 2.7: Purchasing Pattern of the 'Hybrid Consumer'



Source: Ehrnrooth and Gronroos (2013)

2.13.2 Change in Consumers' Behaviour and Attitudes

From a consumer perspective, attitudes and behaviours have changed dramatically over the past decade. Consumers have become more empowered through their ability to exercise choices according to Wright, Newman, and Dennis (2006), developing a "*I want it now*" mentality and demanding speed and convenience (Efros, 2015), whilst at the same time increasing their complaining behaviour (Causon, 2015). These behaviours are enabled by the many and varied retail channel options and strategies available (e.g. online, "click and collect"², and virtual). This is a far cry from only purchasing in stores, which was the most prevalent method available before the introduction of digital technologies (Schiffman & Kanuk, 2007).

Globalisation and technology have also contributed to the change in consumer attitudes (Arnould et al., 2002), with an increase in consumer choices being made on the basis of information obtained from social media sources (Kitchen & Proctor, 2015).

² Ordering online but collecting the product in store.

Irrespective of the noticeable increase in e-commerce, some consumers prefer shopping in '*brick and mortar*' retail establishments, favouring the tactile experience where they can touch and feel products and interact with a store associate (Skrovan, 2017). This is a position brought out in this study, where although some smokers will purchase cigarette and tobacco products from online sources, the majority purchase in retail establishments such as supermarkets and corner shops. Wright et al.'s (2006) study examining how suppliers achieve success by trying hard to empower consumers, found that changes in consumer attitudes impact on their perception of consumption suggesting that consumption is an experience to be enjoyed and not just for obtaining tangible products.

Consumer behaviour manifests in actions such as **acquisition** – to buy, **use** - take or consume an amount and **disposal** – get rid of. These actions are dynamic and can happen over hours, days, weeks, months, or years (Hoyer & MacInnis, 2010). For example, a packet of cigarettes can last a few days, a bottle of dish washing liquid can last a few weeks and a vacuum cleaner is useful for several years. Table 2.5 provides an illustration of consumer behaviour actions, which are discussed in the following paragraph.

Table 2-5: Consumer Behaviour Actions

THE TOTALITY OF DECISIONS	ABOUT THE CONSUMPTION	OF AN OFFERING	BY DECISION UNITS	OVER TIME
Whether What Why How When Where How much/ How Often/ How Long	Acquisition Usage Disposition	Products Services Activities Experience People Ideas	Information Gatherer Influencer Decider Purchaser User	Hours Days Weeks Months User

Source: *Adapted from Hoyer and MacInnis (2010)*

According to Hoyer and MacInnis (2010) **acquisition** can be achieved through buying, although other ways are possible (for example: trading, gifting, finding, stealing, sharing, renting, leasing or bartering), and involves decisions about time and money. **Use** symbolises the buyer’s identity, values, beliefs or feelings about the occasion or reason for which the product has been bought. After use dependant on the experience, the consumer will spread positive or negative feedback about the product. **Disposal** has both sentimental and environmental consequences. Those who have a sentimental value attached to the product might for example, gift it to a close family member or find other ways of “extending its life” (Szmigin & Piacentini, 2015). Consumers who are environmentally conscious will purchase products made from recyclable materials or use recycling facilities provided. However, those who do not care either way might throw the used product on the street instead of in litter bins (Healton, Cummings, O’Connor, & Novotny, 2011). *For example, smokers are accused of not being environmentally conscious, disposing of their cigarette butts on the ground or out of cars (Healton et al., 2011).*

Consumers purchase for individual use (for example: family, friends, household), or organisational use (e.g. offices, government agencies, schools, hospitals). Individual use purchase (aka end-use consumption), is the most popular type of consumer behaviour (Schiffman & Kanuk, 2004), representing every age and background of buyers and users. For instance, a smoker aged 18 purchases cigarettes for his/her own use but can share the contents of a packet of cigarette with other smoker(s), for example siblings, friends or even perfect strangers. Regular use and consumption of essentials, necessities, luxuries, services and ideas establish the relationship between individuals and their consumption habits. Since consumer actions involve decisions about money, consuming habits contribute to the health of the local, glocal³, global or international economies (Schiffman & Kanuk, 2007).

During a purchase consumers are motivated by their situation(s) (Lo, Lin, & Hsu, 2016). According to Assael (1998), in these situations behaviours are moderated by a number of factors. First, **physical surroundings** – how the store is laid out. Second, **social surroundings** – who will be present at the time of purchase or consumption, for example family or friends. Third, **time** – seasonal factors, for example summer or spring for clothing purchases (coats or tank tops). Fourth, **task definition** – buying for oneself, the family or the intended purpose of the purchase, for example a gift. Fifth, **antecedent states** – feelings and mood at the time of shopping, (tiredness, hunger, impulse). These behaviours can either be external (dictated by the environment), or internal (dictated by the consumer's state of mind), although most consumption and purchase situations include all or most of these characteristics. Behaviours can also be moderated where no physical interaction occurs, for example

³ Characterised by local and global factors.

online purchasing, a position identified in studies by R. Davis, Lang, and Diego (2014) about shopping motivation and purchase intentions.

2.13.3 Consumer Decision Making Process

Consumer decision making (*CDM*) considers several unrelated variables which impact on the actual buying of products, as well as personal and social factors unrelated to the actual need to purchase but which motivate shoppers (Srivastava, 2015). Therefore, understanding how consumers represent outcomes and weigh different decision criteria is critical. According to Brassington and Pettitt (2006) and Wen et al. (2014), the consumer decision making process is conducted within the frameworks developed by Howard and Seth (1969), Engel, Kollat and Blackwell (1978), and Engel, Blackwell and Miniard (1990). Since then academics have shaped other interpretations, refined existing models, and developed theoretical foundations around the context of consumer behaviour (for example, Assael 1998; Schiffman and Kanuk, 2004; Solomon et al., 2010; Szmigin and Piacentini 2015). Some of these models are less complex than others, but all try to capture the significance of the experience. Using these models, this researcher has sought to explain the consumer decision making processes that mediate between an individual's values and behaviours regarding smoking.

Assael's 1998 model (see Table 2.6), asserts that consumer decision making is not a single process which can be compared to buying a house or a loaf of bread, instead decisions are made based on two dimensions (Assael, 1998). The first dimension is the extent of the decision making, whether complex (e.g. purchase of a home or car) or limited (e.g. purchase of chocolate or yogurt). The second dimension is the degree

of involvement in the purchase, i.e. habitual, whether the consumer is brand loyal or purchasing common everyday items.

Table 2-6: Assael's Consumer Decision Making

DECISION MAKING (Information search, consideration of brand alternatives)	COMPLEX DECISION MAKING (autos, electronics, photography systems)	LIMITED DECISION MAKING (adult cereals, snack foods)
HABIT (little or no information search, consideration of only one brand)	BRAND LOYALTY (athletic shoes, adult cereals)	INERTIA (canned vegetables, paper towels)

Source: Adapted from Assael (1998)

Following on Assael's model of consumer decision making, Schiffman and Kanuk (2004) highlight three separate but connected stages of the decision making process, (i) the input stage, (ii) the process stage and (iii) the output stage. The input stage allows consumers to recognise their need for a product through marketing efforts (for example, product, place, price, promotion), and external sociological influences (i.e. family, friends, social class and culture). These influences impact on the product being purchased and how it is used. To illustrate, teenagers adopt a smoking habit due to peer pressure, but will adjust their behaviour around persons who do not smoke.

The **process stage** focuses on how consumers make decision based on psychological factors such as learning, motivation, personality, perception, and attitudes. For example, children learn to smoke from parents who are smokers (Doyle, 2014), whilst some smokers display a "don't care" attitude towards health warnings on cigarette packets (Tobin, 2011). The **output stage** consists of two activities – purchase behaviour and post-purchase evaluation. For example, purchase behaviour

for cigarettes may be influenced by the brand smoked by friends or the first cigarette that was smoked. Post-purchase evaluation comes through repeat purchase of the same brand of cigarettes, signifying satisfaction with the one smoked initially.

Solomon et al.'s (2010) consumer decision making process model is an extension of the concept developed by Engel, Kollat and Blackwell (1978). Its succinct and concise configuration, according to Brassington and Pettitt (2006), makes it easy to understand. The assumption of this model incorporates five stages: (i) need recognition, (ii) information search, (iii) evaluation of alternatives, (iv) purchase, and (v) post purchase evaluation (see Appendix 2.1). These five stages are based on the premise that consumers process information logically and make decisions rationally. Caprio and Arteaga's (2016) research on rational decision making recognises that some decisions are made with less than perfect information, providing opportunities for the consumer to acquire additional information to increase the quality of the decision.

Shortcomings have been identified in Solomon's model by Egan (2015). Egan's (2015) belief is that the model is not a straightforward linear model because some stages can be circumvented, others can and have been repeated (see Appendix 3.1). The decision-making process is further complicated because consumers do not always have perfect knowledge of every alternative product. They are only aware of some products and choices are usually made from products in their evoked set.

Szmigin and Piacentini's (2015) model of the consumer decision making process is similar to that of Solomon et al.'s (2010), whilst providing additional insights into both

the problem recognition and evaluation of alternative stages. According to this model, problem recognition manifests itself either in the actual state or the ideal state (Szmigin & Piacentini, 2015). For instance, when a smoker feels the need to smoke (the actual state), they light up a cigarette to satisfy that craving (the ideal state). It is at this point that the consumer recognises a deficiency in the actual state which he/she was not aware of. Awareness can be triggered by an advertisement or word of mouth information (Szmigin & Piacentini, 2015). At the alternative evaluation stage, consumers choose between familiar and unfamiliar brands (Szmigin & Piacentini, 2015) giving due consideration to: (a) evoked set – brands already known, (b) consideration set – brands the consumer might consider purchasing, (c) inept set – brands the consumer might be familiar with but would not consider appropriate for the purpose, and (d) inert set – brands which the consumer does not consider at all. This is an interesting perspective, given consumers' difficulty in justifying when to evaluate information gathered because of the various sources of information.

Examination of the four models of consumer decision making, identified two important considerations: (i) consumption behaviours are not always rational or logical and can be undertaken without planning, (ii) not all consumer decision-making situations receive or require the same amount of information search. Perspectives offered by Assael (1998) and Schiffman and Kanuk (2004), acknowledge the value and limitations of consumer decision making. In fact, Schiffman and Kanuk's (2007) literature review about consumer behaviour demonstrates that the decision making process entails more than selecting one brand from amongst others. Schiffman & Kanuk's (2007) literature pinpoints three additional levels of consumer decision making: (i) extensive problem solving – where significant amount of information is

needed to help with decision making, (ii) limited problem solving – consumers are already familiar with the product, and (iii) routine response behaviour – consumers have experience and set of criteria whereby the product is judged (Schiffman & Kanuk, 2007).

The preceding four models of consumer decision-making demonstrate the varied perspectives of academics within this area of study. Notably, the intention is not to provide sweeping depictions of the complexities of the decision-making process. Rather, it is intended to illustrate how each model links the relevant concepts into a significant whole.

2.13.4 Smokers within the Decision-Making Process

Stages of the decision-making process are no different for smokers from that of any other consumer (Mick & Faure, 1998), having to consider pre-purchase, purchase and post-purchase issues. Given the many and varied types of tobacco products, cigarettes, e-cigarettes and brands to choose from (M. Solomon et al., 2010), the process could however be confusing.

Pre-purchase issues help identify feature(s) smokers desire in the product, for example menthol taste from menthol-flavoured cigarettes. Purchase issues consider the price of preferred brand and how easily available that brand is. Post purchase issues help evaluate product performance, for example did the product “live up to expectations” and whether they would recommend the product to other smokers. Tauber’s (1972) study on why people shop, confirms that individuals consider personal and social factors (related and unrelated), when making decisions about brand, price

and quality of products being consumed (Tauber, 1972). A more recent study by Skaczkowski, Durkin, Kashima, and Wakefield (2017) looking at the influence of premium versus value brand names of smoking experience, found personal and social factors a major consideration when smokers make purchase decisions. The suggestion here is that attitude is an important consideration for smokers during decision making.

Smokers' behaviour during decision making can be put into perspective using components of attitudes. These are: (a) affective (feelings), (b) cognitive (beliefs) (Schaller & Malhotra, 2015), and (c) conative (behavioural tendencies) (Rice, 1997), illustrated in Table 2.7. When examined together, these components suggest attitudes may influence consumers' decision making, but these behaviours can be influenced by reinforcing or altering of attitudes.

Table 2-7: Components of Attitudes

ATTITUDES	COMPONENTS
Affective:	Emotions or feelings that something evokes such as sympathy, hate, or fear. For instance, <i>"I fear exposure to second-hand smoke because it can make me sick"</i> .
Cognitive:	Beliefs, thoughts, and ideas about something. For instance, <i>"Smoking e-cigarettes is a healthier option than smoking regular cigarettes"</i> .
Conative:	To act in a certain way towards something. For instance, <i>"I am too lazy to roll my own cigarette, so I do not smoke roll-ups"</i> .

Source: Adapted from Schaller and Malhotra (2015); Rice (1997)

Smokers also experience problem-solving situations, i.e. routine, limited and extended (Brassington & Pettitt, 2006; P. Butler & Peppard, 1998). Routine problem solving occurs when smokers purchase their preferred brand of cigarette, no decision-making process. Limited problem-solving occurs infrequently but could arise during first time purchases of an e-cigarette kit. There is a higher risk should the wrong decision be

made, particularly as only a minimum amount of information search and evaluation is conducted. Extended problem solving happens infrequently and can occur when there are major health decisions to be made such as undergoing surgery for a smoking-related illness. In this instance smokers are motivated to gather as much information as possible whilst considering the decision-making criteria.

Understanding how smokers' attitudes impact on their decision making is important, especially because attitudes do not always act in tandem with intentions (Foxall, Goldsmith, & Brown, 1998). To illustrate, a smoker might resolve to quit smoking as a New Year's resolution, but fail to carry out this resolution due to personal influences such as peer pressure, habit or addiction. This position sees smokers' acts of consumption sometimes being irrational, complicated and conflicted (Sloan & Wang, 2008) because their behaviours are not only motivated by utility maximisation. O'Rourke and Ringer's (2016) study about the impact of sustainability information on consumer decision making supports this position. Their study found that individuals sometimes make routine and spontaneous decisions, acting within a social context as well as being motivated by social approval and status. This finding can be viewed within the context of existing tobacco control measures where smokers sometimes exhibit such behaviours.

2.13.5 Smokers' Behaviour in Purchase and Consumption Situations

Most smokers within the UK purchase cigarette and tobacco products from retail establishments such as supermarkets, corner shops, small stores and news agents. These establishments are regulated by the Tobacco Advertising and Promotion Act (TAPA), meaning restrictions are in force in these establishments to limit tobacco

promotion. Cigarette vending machines have been outlawed in shared consumption spaces since 2011 (Hartley-Parkinson, 2011; News, 2011), preventing retailing of tobacco products in these venues. However, patrons of these establishments purchase cigarette and tobacco products elsewhere but smoke them whilst on the premises.

Behaviours during purchase, consumption and use in retail establishments and shared consumption spaces are germane to this study. They help formulate an understanding of how smokers behave in these establishments where tobacco control strategies are implemented. Discussions about these behaviours are held in the following paragraphs.

2.13.5.1 Behaviour in Retail Environments

Supermarkets account for a large proportion of tobacco sales than most other retail establishments combined (O B J Carter, Mills, & Donovan, 2009). Smokers doing their daily, weekly or monthly shop in supermarkets will also purchase cigarettes and tobacco products. A popular behaviour is for those purchasing lottery tickets to also purchase their supply of cigarette and tobacco products, because in supermarkets lottery tickets and tobacco products are housed in the same physical space. Forrest and Gulley's (2009) study about participation and level of play in the UK National Lottery, found a strong correlation between engagement with the lotto and expenditure on tobacco products. This finding suggests the strength of association between smokers' willingness to purchase tobacco products and indulge in their personal 'vice' – playing the lottery.

The April 2012 implementation of the display ban signalled an end to tobacco products being openly displayed at point of sale (POS) locations in supermarkets. Since then, products are stored behind cupboards or gantries (refer to Appendix 1.2). This strategy has not deterred smokers from purchasing (Basham & Luik, 2011), but according to existing research, have made smokers more knowledgeable and brand loyal (Cowie, Swift, Partos, & Borland, 2015; Dawes, 2014; Krystallis, 2013).

Smokers report issues which negatively impact them in supermarkets during purchase. First, most supermarket staff manning gantries are non-smokers and therefore unfamiliar with tobacco product brands. Accordingly, smokers must “direct” supermarket staff to the brand they require, pointing to it. Second, smokers find the lack of knowledge of supermarket staff time consuming, preventing them just purchasing and leaving the store. Third, smokers report the gantry obscures view of product prices, which means losing out on offers with the risk of spending more ("Tobacco display ban – The big debate," 2015).

Corner shops, small stores and news agents serve many smokers who are either time-conscious, in-between main shopping at the supermarket, or getting the newspaper (Slawson, 2016). These retail establishments rely on cigarette and tobacco products as a major profit source, although benefitting from sales of other items purchased by smokers (McClean, 2016b). Those retailers are also popular with under-aged teenagers and young children for purchasing tobacco products (BBC News, 2007), where tobacco control strategies are not strictly enforced in these locations ("Shops 'flout cigarette sales law'," 2009; Wheatstone, 2015).

Smokers' behaviour in corner shops, small stores, and news agents differ from in supermarkets. Here, brand loyalty is not a factor and smokers usually purchase the cheapest product, but any increase in price of their regular brand sees smokers switching to a cheaper brand or own brand products (Convenience Store, 2015). Furthermore, to circumvent the issue of missing out on price discounts, most adult smokers bulk buy cigarettes and 'roll your own' tobacco from small retailers, when available (Walker, 2014). Interestingly, in small retail establishments, smokers usually purchase tobacco products and alcohol together, suggesting a positive link between purchase and consumption of both products (L. Richardson, 2013). Again, this behaviour suggests strength of association between smokers' willingness to purchase tobacco products and indulge in their personal 'vice' – drinking.

Regarding cigarettes being stored behind a gantry in small retailers, smokers view this as normal having become accustomed to them in supermarkets. Smokers report that staff use gantries efficiently and are able to communicate prices and locate brands when asked, allowing them to be served quickly (Slawson, 2016). In small retail establishments smokers do not ask for price lists, although on the rare occasion a smoker might ask to browse price lists (Convenience Store, 2015; Forecourt Trader, 2015).

2.13.5.2 Behaviour in Shared Consumption Spaces

Since 2007, UK tobacco control strategies have overseen a ban on smoking in pubs, clubs, bars and restaurants. Basically, any place where individuals meet and socialise. This 'social denormalisation' strategy (Rooke, Amos, Highet, & Hargreaves, 2013), has become a central element of tobacco control seeking to change social

norms around smoking, making smoking an undesirable and abnormal practice. Some have argued about smokers' ethical and legal rights to smoke any time and wherever they choose (for example Oriola, 2009), suggesting laws restricting smoking in shared consumption spaces impinge upon smokers' right to smoke.

Smokers have been careful at managing smoking in shared consumption spaces, (*for example, pubs, clubs, and restaurants*), particularly as many of these spaces are 'tacitly' accepted as non-smoking areas. They view formal and informal controls in these spaces as part of everyday life, have become compliant (Castaldelli-Maia, Ventriglio, & Bhugra, 2016) and accepting their loss of freedom to smoke when in those spaces (Oriola, 2009). What this position suggests is that prohibition has shifted the relationship between smoking and going out, where smokers no longer take for granted the 'going out' experience (Kelly, Weiser, & Parsons, 2009).

Another behaviour exhibited by smokers whilst in shared consumption spaces is to reduce the frequency of their smoking to engage in conversations with their companions. Others whose need to smoke is great, create new smoking practices and social spaces by forming friendship group(s) with other smokers in the similar position of having to stand outside and smoke. According to Rooke et al. (2013), in some situations this allows smoking to continue to be constructed as fun, sociable and relaxing, demonstrating that the link between smoking and 'going out' has not been substantially disrupted. Fear of public disapproval also dictates smokers' behaviour in shared consumption spaces. Some smokers engage in compensatory behaviour to continue consuming nicotine, switching to smokeless tobacco (SLT) products (Adams, Cotti, & Fuhrmann, 2013), the most common being e-cigarettes (Line et al.,

2016). The choice of e-cigarette reflecting the belief they are an “healthier” alternative and more accepted by non-smokers than regular cigarettes.

2.14 Theme Four – Communication Agencies

2.14.1 Introduction

This section provides an overview of marketing communications with specific emphasis on those aimed at smokers. The discussions here examine fear appeal and social marketing strategies. Two main approaches used to bring about attitude and behaviour change amongst smokers. These discussions are held in the paragraphs following.

2.14.2 Marketing Communications – An Overview

Marketing communications, also referred to as Integrated Marketing Communications (IMC), are tools and techniques of mass and direct communication using messages based on the same values (Matović, Knežević, & Brankov, 2015). Egan (2015) defines marketing communications simply as “a two-way exchange”. Fill (2009) believes there is no single definition of marketing communications. An overview of some interpretations of marketing communications are presented out below.

Marketing communications is a management process through which an organisation engages with its various audiences. By conveying messages that are of significant value, audiences are encouraged to offer attitudinal, emotional and behavioural responses.

Fill (2009, p. 16)

Marketing communications is the voice of the product and are a tool to achieve dialogue and can build relationships with consumers.

Lala (2011)

Marketing communications is the coordination of promotional messages delivered through one or more channels such as print, radio, television, direct mail, and personal selling.

Avramescu, Petroman, Constantin, and Varga (2015)

Kitchen and Proctor's (2015) examination of marketing communications in the real world, found that early interpretations of marketing communications were slanted toward advertising and/or public relations. Here marketing communications aimed to influence the purchase of goods and/or services, whilst focussing on one-way communications with short-term perspectives. Other interpretations focused on the dramatic shift in media sources, demonstrating that the route to purchase is shorter, less hierarchical and more complex (Batra & Keller, 2016; Matović et al., 2015).

The “*one communication tool*” approach to reaching intended audiences have been challenged by academics such as Bickert (1997), and Dibb (1998). Their belief is that other communication tools such as market research, market segmentation, micro or niche marketing and word of mouth, also important to enhance and establish relationships whilst influencing attitudes and behaviours. Agreement to the thinking of Bickert and Dibb comes from Kitchen and Proctor (2015) and Egan (2015), who believe that diversity of marketing communication tools allows for a narrowing of defined boundaries. These interpretations gave rise to understandings of marketing communication tools, as well as its uses and benefits.

2.14.3 Marketing Communications Tools

Marketing communications tools are many and varied, encompassing a synergy of promotional instruments to enable mass and direct communication. Some are

traditional (for example: advertising, promotion, sponsorship, direct marketing), others are new and emerging (Matović et al., 2015), for example the Internet. An overview of communications tools and the different authors who proposed them are set out in Table 2.8.

Table 2-8: Marketing Communications Tools

AUTHOR & DATE	MARKETING COMMUNICATIONS TOOLS
Lancaster & Massingham (1993) Lane & Russell (2001)	Advertising, sales promotion, public relations, personal selling
Duncan (2000)	Mass media advertising, sales promotion, public relations, personal selling, merchandising, point-of-purchase (point-of-sale), packaging, speciality advertising (premiums), licensing, direct (response) marketing, e-commerce, internal marketing, events & sponsorship, trade shows (exhibitions) customer service
Sam & Taylor (2002)	Advertising, sales promotion, publicity/public relations, personal selling, direct marketing, sponsorship, exhibitions packaging, point of sale/merchandising, word-of-mouth, e-marketing, corporate identity
Fill (2009)	Advertising, sales promotion, public relations, personal selling, direct marketing
Shimp (2010)	Mass media advertising, on-line advertising, sales promotion, store signage (point-of-sale), packaging, direct mail, opt-in e-mail, publicity, event cause sponsorship, personal selling
Belch & Belch (2011)	Advertising, sales promotion, publicity/public relations, personal selling, direct marketing, interactive and internet marketing

Source: Adapted from Egan (2015)

The abundance of communication tools has brought about revised interpretations of the definition of marketing communications. Indirectly, definitions allude to the evolution and proliferation of media channels, demonstrating their overlapping nature (Egan, 2015), whilst bringing into sharp focus the changing orientation of marketing communications. This is explained in Table 2.9.

Table 2-9: Changing Orientation of Marketing Communications

ORIENTATION	EXPLANATION
Information and Promotion	Communications are used to persuade people into product purchase using mass media communications. Emphasis on rational, product-based information.
Process and Imagery	Communications are used to influence the various stages of the purchase process that customers experience. A range of tools is used. Emphasis on product imagery and emotional messages.
Integration	Communication resources are used in an efficient and effective way to enable customers to have a clear view of the brand proposition. Emphasis on strategy, media neutrality and a balance between rational and emotional communication.
Relational	Communication is used as an integral part of the different relationships that organisations share with customers. Emphasis on mutual value and meaning plus recognition of the different communication needs and processing styles of different stakeholder groups.

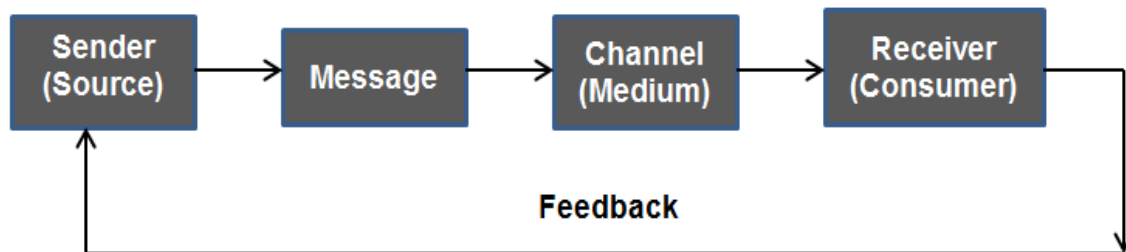
Source: Adapted from Fill (2009)

2.14.4 Marketing Communications Models

According to Chandler and Munday (2011), marketing communications models are based on the idea developed in 1949 by Shannon and Weaver. Shannon and Weaver’s model embraces the concept that communication involves sending and receiving messages or transferring information from sender to receiver. Theorists, for example Berlo, Schramm, and Barnlund further adapted Shannon & Weaver’s (1949) communications model (Egan, 2015). Berlo et al.’s communications model is linear rather than interactive (Stead, 1972), using two-way communication and persuasion (Duncan & Moriarty, 1998) to study and build relationships. Rydel et al.’s (2012) work examining the role of motivational and persuasive message factors in changing implicit attitudes towards smoking sanction this linear strategy. Their belief is that persuasive messages are important to reinforce negative attitudes towards certain behaviours, particularly smoking.

Marketing communications models comprise of five components: sender, message, channel or medium, receiver and feedback. Illustrated in Figure 2.8.

Figure 2.8: Illustration of a Basic Communications Model



Source: Schiffman and Kanuk (2007); Egan (2015)

Here the sender is the initiator of the communication which can be formal (i.e. from commercial sources or not-for-profit organisations such as charities) or informal (i.e. word of mouth communication from friend(s) or reference groups). Messages can be verbal (written or oral) or non-verbal represented by a symbol, picture or illustration. The channel or medium can be impersonal via a mass medium (i.e. a newspaper advertisement), or interpersonal for example a conversation between a telemarketer and a prospective customer. The receiver is the intended target audience(s), which can also include intermediaries (e.g. wholesalers, retailers, distributors) and unintended audiences (e.g. professionals). Feedback demonstrates message effectiveness through the audiences' timely reaction, allowing the sender to reinforce, change, or modify their message(s) making sure it is understood the way it is meant. On the whole, these five components enable the effectiveness of the communication process, complementing the three standard communication models: (i) linear (ii) interactive and (iii) transactional (Schooten, 2014). Therefore, applying these core concepts to communications models allow interactive communication with the intended audiences.

2.14.5 Tobacco Industry Marketing Communications Strategies

The Tobacco Industry marketing communications have evolved over the years. Messages in the 1950's were endorsed by opinion leaders (S. Elliott, 2008), for example medical professionals. Message in the 1960's combined fashion with tobacco advertising, whilst in the 1970's symbols were used to appeal to smokers' ideal self (M. Solomon et al., 2010), for example the *Marlboro Cowboy*. Other marketing communications strategies employed non-verbal communication (S. Smith & Wheeler, 2002), including: sensory marketing, brand design, pack size, price marking and pack modifications (Munafò et al., 2011), for example new opening methods and inventive shapes.

Knowledge about the ill-effects of tobacco smoking necessitated modification of the Tobacco Industry's marketing communications. Strategies changed to create favourable images of smoking whilst ignoring the possible health risks (Slovic, 2001). Chapman's 1986 book "*Great Expectations: Advertising and the Tobacco Industry*" also found the predominant marketing communication strategy in the 1980's ignored health risks, but used favourable images to encourage use and uptake (Simon Chapman, 1986). Boyd et. al.'s (2003) study of tobacco advertising confirm the position of using favourable images to encourage uptake, but ignoring the potential health risks to smokers (Boyd, Boyd, & Greenlee, 2003). Advertising also portrayed smokers as risk-takers, pleasure-seekers, sensual, masculine and sociable (C. Chang, 2007), appealing to self-absorbed smokers trying to reach their ideal self.

Another emphasis of Tobacco Industry advertising was the relationship building, with advertising paying attention to the differing needs of smokers, as well as the reciprocal

value of the relationship. For example, messages targeted at young smokers sponsored teenage tennis stars (Warner, 2002), whilst presenting negative images of non-smokers who did not participate in sports (Peter & Olson, 2010). Established smokers were targeted indirectly through event sponsorship and directly via billboards, commercials and magazines (Madkour, Ledford, Andersen, & Johnson, 2014). The overall intent of Tobacco Industry communications strategy was two-fold. One, to re-normalise smoking by encouraging established smokers to continue using their products and ignore established anti-smoking rules and regulations. Two, get non-smokers to start using their products.

2.14.6 Anti-Smoking Advocates Communication Strategies

Anti-smoking communications strategies incorporate process, imagery, and integration, whilst emphasising rational and emotional messages (Szmigin & Piacentini, 2015). Messages are designed to: (i) dissuade non-smokers from taking up the habit of smoking (Hackleman, 1973), and (ii) scare smokers into quitting by emphasising messages that smoking cause damage to the brain and other organs (Tubb, 2013). More importantly, they present the habit of smoking and smokers in a negative light adding to smokers' increased levels of stigma (Thompson et al., 2009a). Fear appeal messages and social marketing campaigns are the preferred communications tools of anti-smoking advocates. These are discussed in the following paragraphs.

2.14.6.1 Fear Appeal

Fear is an emotional response to the threat of danger, having a significant effect on behaviour, which in turn leads to either the removal or coping with said threat or danger.

Laroche, Toffoli, Zhang, and Pons (2001)

This definition of fear provides an appropriate introduction to this section. Laroche et al.'s (2001) definition points to the impact fear has on behaviour, which can cause attitude change by removing or coping with the issue(s) causing the fear. Smokers' exposure to fear appeal messages "aid" their attempts at quitting because these messages present the dire consequences of continuing to smoke, e.g. lung or throat cancer. These perspectives give justification for the inclusion of fear appeal literature in this study.

Fear appeal evolved from communication persuasion models which were formulated by writers such as Hovland, Janis, and Kelley (1953); Leventhal (1970); McGuire (1980); and Rogers (1983) . According to Schmitt and Blass (2008), these works were built on the foundation that threat level and adherence to a recommended response are linearly and positively related. Theorists (for example, Manyiwa & Brennan, 2012), and writers (e.g. Ferguson & Phau, 2013; Redmond, Dong, & Frazier, 2015; Thompson, Barnett, & Pearce, 2009b; Timmers & Wijst, 2007), use fear appeal theory in their studies to demonstrate protection and defensive motivation responses as ways of understanding smokers' acceptance or rejection of health-related marketing communications. This, according to Laroche et al. (2001), can help identify the importance of persuasion in the cognitive mediation processes.

Theoretical models have emerged to help explain fear appeal, for example: Drive Reduction Model, Parallel Process Model, Multidimensional Arousal Model, Mood-Congruent Learning Effect, and Mood-Congruent Learning Effect (K. C. Williams, n.d.). Two additional and more significant models – Protection Motivation Model (PMM) and the Extended Parallel Process Model (EPPM), have also been developed.

Protection Motivation Model asserts that whenever an effective means of coping with a threat is present, individuals manage this threat by adopting the suggested means of coping and changing flawed behaviour. If threat and coping are high, then complete acceptance of the message will be achieved (Manyiwa & Brennan, 2012). The Extended Parallel Process Model helps in the understanding of how individuals adapt to health messages or information deemed threatening (Manyiwa & Brennan, 2012). Both explanations demonstrate distinctions associated with fear appeal marketing communications. For example, the PMM theory identifies the importance of emotion to coping, whilst the EPPM theory establishes a link to behavioural intentions, specifying conditions under which fear appeal messages can be successful or unsuccessful.

2.14.6.2 Smokers Response to Fear Appeal Messages

Fear appeal is a strategy used in anti-smoking marketing communications, with one objective being to scare individuals into stop smoking (Manyiwa & Brennan, 2012). The belief is that if the intended audience is provided with information about the risks of smoking they will eventually change their behaviour. For example, messages using *shock tactics and fear appeal* aimed at smokers include health warnings and graphic pictures on cigarette packs depicting lung cancer caused from smoking. *More in depth discussions on fear appeal strategy are held in Appendix 1.7 at the section titled “Visual Messages Using Shock Tactics and Fear Appeal”. Additionally, an illustration of a visually graphic advertising message is set out at Appendix 2.2.*

Existing literature asserts that fear appeal is reliant upon two factors: (i) perceived threat and (ii) perceived efficacy (Manyiwa & Brennan, 2012; Timmers & Wijst, 2007).

Perceived threat influences how individuals process health information and their motivation to engage in a behaviour. Perceived efficacy determines whether the recommended behaviour will possibly lead to the desired outcome or adoption of the recommended behaviour (Manyiwa & Brennan, 2012). Both interpretations imply that motivation plays a vital role in how smokers' process fear appeal messages, even though they can sometimes be selective in their actions towards these messages.

Schmitt and Blass (2008) found that younger smokers were more accepting to fear appeal messages. A finding also supported by Hamilton, Biener, and Brennan's (2008) study investigating whether local tobacco regulations influence perceived smoking norms. Earlier studies by Schooler, Feighery, and Flora (1996) found that tobacco advertising encouraged smoking in young smokers, evidenced by their ability to name and recognise cigarette ads and match brand names to cigarette slogans. Therefore, the suggestion is that fear appeal messages could have the same recall effect on young smokers. On the other hand, adult smokers respond to fear appeal messages but only when there are significant increases in the amount of fear appeal messages seen. This behaviour is more pronounced during periods of heightened anti-smoking marketing campaigns when they are more likely to quit smoking (A. Hyland, Wakefield, Higbee, Szczypka, & Cummings, 2006). This study also suggests that adult smokers are more likely to participate in social marketing campaigns, e.g. *Stoptober*, than young smokers.

There are noticeable discrepancies in the behaviour of young smokers and adult smokers in how they process and respond to fear appeal messages. For example, images of blackened lungs or rotten teeth on cigarette packets might encourage

younger smokers to quit but could be ignored by older and more established smokers. However, studies suggest that positive reinforcement for good behaviour in adult smokers and irony for younger smokers, could encourage greater attention to fear appeal messages by both groups (Gerard Hastings et al., 2004; Terry-McElrath et al., 2005).

Fear appeal messages are used in public health campaigns to influence behaviour change amongst smokers. The practicality of this strategy is subject to debate (Timmers & Wijst, 2007), as it sometimes produces the opposite result of what was intended (Manyiwa & Brennan, 2012). Laroche et al.'s (2001) viewpoint is that high fear appeal can be counterproductive because it involves emotional and cognitive practices. To illustrate, in situations where smokers are faced with physical and social threats, fear appeal encourages them to protect themselves. Fear appeal also evoke emotions such as surprise, sadness, confusion, or anger possibly leading to anxiety and tension (Timmers & Wijst, 2007). LaTour and Zahra (1988) suggest how these emotions manifest can be understood by studying issues relating to smokers' emotional well-being.

2.14.6.3 Social Marketing – Origin, Definitions, Critique

The original concept of social marketing was developed in 1971 by Kotler and Zaltman (Manyiwa & Brennan, 2012). Social marketing has been described by Khowaja et al. (2010) as the use of marketing principles and procedures to support a social cause, idea, or behaviour. Building on the work of Kotler and Zaltman (1971), Fox and Kotler (1980) defined social marketing as “an application of marketing concepts and techniques to the marketing of various socially beneficial ideas and causes instead of

products and services". Dearing, Maibach, and Buller (2006) position social marketing as a process of developing, distributing and promoting products or services to get a specific behaviour from a targeted audience. MacAskill et al.'s (2007) view is that social marketing utilises commercial marketing principles to change behaviours of an intended audience both for themselves and society in general. These interpretations demonstrate the versatility of social marketing as a communication strategy, particularly in situations where it is directed at specific target audiences, (*for example, smokers*) rather than the general population (*for example, non-smokers*).

Social marketing is not an entirely new concept, but its widespread use by Governments and related health services has seen it rise in prominence (Jackson, 2009). Since then, academics have used social marketing in studies examining behaviour change and health issues; texts and academic literature have also been published around social marketing. Some are listed in Table 2.10.

Table 2-10: Literature and Texts about Social Marketing

WRITER	YEAR	ACADEMIC LITERATURE
BOOKS		
Philip Kotler Eduardo Smoker Lo Nancy Lee	2002	Social Marketing: Improving the Quality of Life
Smoker L Donovan & Nadine Henley	2003	Social Marketing: Principles and Practice
Philip Kotler & Nancy Lee	2008 & 2011	Social Marketing: Influencing Behaviours for Good
Nedra Kline Weinreich	2011	Hands-On Social Marketing: A Step-by-Step Guide to Designing Change for Good
JOURNAL ARTICLES		
Gerrard Hastings & Neil McLean	2006	Social Marketing, Smoking Cessation and Inequalities
Jeanelle De Gruchy & Dara Coppel	2008	“Listening to Reason”: A Social Marketing Stop-Smoking Campaign in Nottingham
Peattie & Peattie	2009	Social Marketing: A Pathway to Consumption Reduction?
Amanda Jackson	2011	Can Social Marketing Bring About Long-Term Behaviour Change?
Paula Diehr et al.	2011	Social Marketing, Stages of Change, and Public Health Smoking Interventions
Marie-Louise Fry	2014	Rethinking Social Marketing: Towards a Sociality of Consumption
Diana Gregory Smith et al.	2015	An Environmental Social Marketing Intervention Among Employees: Assessing Attitude and Behaviour Change
Liang Ma Corinne Mulley Wen Liu	2016	Social Marketing and the Built Environment: What Matters for Travel Behaviour Change?

Source: *Researcher’s Own Concept of Literature and Texts about Social Marketing*

The notion of social marketing is not without its critics. Donovan’s (2011) study describing and dispelling eight “myth understandings” commonly expressed by social marketing practitioners and others, agrees that social marketing encourages behaviour change but also finds the strategies distracting, branding them a “social advertising gimmick”. Spotswood, French, Tapp, and Stead’s (2011) paper examining the scope of social marketing, disagree that social marketing emphasises voluntary

behaviour. They instead believe legislation and legal enforcement against certain deviant behaviour, (e.g. smoking), is what makes behaviour change compulsory.

Findings from Szmigin, Bengry-Howell, Griffin, Hackley, and Mistral (2011) about social marketing and individual responsibility, found that because social marketing appeals to an individual's sense of personal responsibility, issues which it is intended to address are sometimes alienated (for example smoking and the resultant health issues). This view is supported in Fry's (2014) study examining alcohol consumption of an online community, where findings suggest that advocates of social marketing sometimes "*forget*" that behaviour change is dependent upon collective interaction between individuals within a social context.

These prior discussions presented various interpretations of the term social marketing. What they highlight is that social marketing is more concerned with measuring the success rate achieved in influencing behaviour change, rather than its actual contribution to meaningful social change. *To illustrate, some smokers in this study expressed the sentiment that they felt pressured into participating in the "Stoptober" social marketing campaign. Their belief is that engaging strategies, i.e. trying to understand why they smoked, would encourage participation.* Support for this thinking also comes from S. G. Saunders, Barrington, and Sridharan (2014), in their work examining behaviour change beyond the scope of social marketing.

2.15 Theme Five: Behaviour Change

2.15.1 Introduction

Behaviour change refers to a change (preferably for the better), of a person's conduct and activities. It is a principle which rests on and is informed by disciplines such as psychology, economics and sociology. As identified in Michie, Johnston, Francis, Hardeman, and Eccles's (2008) study examining methods for developing behaviour change techniques and linking techniques to theoretical constructs, behaviour change can be explained using theories such as Social Cognitive Theory, The Theory of Planned Behaviour, and Operant Learning Theory. These theories support issues which are impacted by behaviour, namely: intention, self-efficacy, discriminative stimuli, response-reinforcement contingencies, outcome expectancy and perceived behavioural control. Table 2.11 provides a brief explanation of these issues. However, Michie et al. (2008) continue that they are not always used to design behaviour change interventions, only guide understanding behaviours and developing measures.

Table 2-11: Issues Impacted by Behaviour

ISSUES	DESCRIPTION
Intention	Motivation, goals, memory, attention, and decision processes.
Self-Efficacy	Beliefs about capabilities.
Discriminative Stimuli	Environmental stimulus that has been repeatedly associated with punishment for specified behaviour.
Response-Reinforcement Contingencies	Removal of aversive consequence(s).
Outcome Expectancy	Beliefs about consequences of an action.
Behaviour Change Interventions	Strategy or techniques aimed at changing behaviour.

Source: Adapted from Michie et al. (2008)

2.15.2 Effecting Behaviour Change

According to Glanz et al. (2008), for behaviour change to be effective there must be obvious threats to an individual's current behavioural patterns, i.e. perceived susceptibility and severity. Change then will result in a valued outcome at an acceptable cost (perceived benefit), because individuals deem themselves competent enough (self-efficacious) to overcome the perceived barriers to act. Segal (2012) explains this through the five stages of behaviour change. **Stage 1** – pre-contemplation, for example a smoker might say “*I can't manage this life stress without smoking*”. **Stage 2** – contemplation, for example a smoker declares his/her intention to quit sometime in the future, although there might have been an initial attempt which failed. **Stage 3** – preparation, for example a smoker contemplates his/her future move i.e. quitting or continuing the habit. **Stage 4** – action, for example the smoker replaces the habit of smoking with positive actions such as exercise. **Stage 5** – motive/maintain, at this stage the focus is on maintaining the habit, i.e. become a quitter instead of relapsing into the habit of smoking.

Segal's (2012) work highlights challenges which impact the achievement of behaviour change, whilst demonstrating that lapses can and will occur between any or each of the five stages. According to C. McDonald (2015), during this process individuals can realise their behaviours are influenced or altered by forces internal and external to themselves, or by something or someone else. For example, in the pre-contemplation stage a smoker resolves to quit, but by the preparation stage changes his/her mind and continues with the habit because of the influence of a friend, partner, or family member who still smokes. Michie and Johnston (2012) offer an explanation for this behaviour in their study of theories and techniques of behaviour change. In their study,

they suggest that the predictability of behaviour change can be understood by distinguishing between causal action and the human behaviour involved. To illustrate, smokers are aware of the health risks associated with smoking (causal action), but have not been deterred them from doing it (human behaviour). Therefore, identifying what predicts this behaviour can help to change the predictor(s) of such behaviour.

2.15.3 Behaviour Change Interventions

According to Michie and West (2013), behaviour change interventions are coordinated activities aimed at varying specified behaviour patterns and designed to measure the frequency of certain behaviours. For example, how often someone smokes or consults a physician about how to stop smoking. Nicholson and Xiao's (2011) study on consumer behaviour analysis and social marketing practice suggests that design of behaviour change interventions should necessitate: an understanding of the target behaviour, selecting a broad approach, then designing appropriate behaviour change techniques. This process involves a comprehensive analysis of drivers of current behaviour, identifying intervention and policy options, and factoring frameworks in the Behaviour Change Wheel, i.e. COM-B System and PRIME Theory of Motivation (Michie & West, 2013).

Lefebvre's (2011) comparative study examining the evolution of social marketing in developed and developing countries found that behaviour change interventions can also adopt other strategy deemed appropriate to encourage change in behaviours. For example, it can adopt strategies such as using visually graphic messages employing shock tactics or stop smoking services. An overview of each is presented in the following paragraphs.

2.15.3.1 Social Marketing and Behaviour Change

Social marketing promotes well-being and personal health by motivating smokers to participate in activities which benefit themselves and others (Bloom & Novelli, 1981; Peattie & Peattie, 2009). Nicholson and Xiao (2011) expands this thinking, offering two main approaches within social marketing which can achieve behavioural change in smokers. One, increasing/decreasing performance of targeted behaviours and manipulation of associated benefits/costs, accomplished through interventions such as *Stoptober* where smokers are encouraged to give up the habit for an entire month (*October*). Two, manipulation of associated benefits/costs where the objective of an intervention is reversed and behaviour change achieved by active discouragement of an undesirable behaviour. For example, in the UK smoking in cars with young children present is banned and made less attractive by the imposition of a financial penalty. Both approaches portray tobacco smoking as unattractive, whilst encouraging desirable behaviour through abstinence or reduction of smoking.

The ability to accomplish social change makes social marketing more significant than social advertising or social communication (Manyiwa & Brennan, 2012). This position justifies social marketing's inclusion in the UK government's Public Health White Paper (Gerrard Hastings & McLean, 2006), whilst giving rise to the design and implementation of other quit smoking social marketing interventions. Support for this position is found in the findings of this study, confirmed during the interview with a representative from an advertising agency specialising in social marketing campaigns, and also the Regional Tobacco Policy Manager for the West Yorkshire region.

2.15.3.2 Visual Messages, Shock Tactics and Behaviour Change

Smokers are exposed to visually graphic messages in the form of dire warnings and unsightly images on cigarette packaging, for example rotting internal organs and teeth. Through the medium of television, they are also exposed to advertisements showing smokers with clogged arteries (Davey, 2014) and blackened lungs (Brooks, 2014), to convey the dangers associated with smoking. Tubb's (2013) online news article examining anti-smoking ad campaigns, points out that the graphic nature of these messages stimulates and invoke emotional response(s) which in turn encourage smokers to change their attitudes and behaviours about smoking.

2.15.3.3 Stop Smoking Services and Behaviour Change

Although some smokers can quit without help, many smokers need support to do so. This is one reason Stop Smoking Services (SSS) were instituted in the UK to help smokers quit. First time users are tested for their nicotine dependence using a Fagerstrom test (Fagerström & Furberg, 2008) determining the levels of nicotine present in the blood (Ebbert et al., 2006). Based on this diagnosis, treatment can either be in the form of nicotine replacement therapy (NRT) such as gums and patches, or tablets such as Bupropion, Varenicline or Champix (to help replace cravings for nicotine during quit attempts). Treatment given at stop smoking clinics are used in conjunction with behavioural support such as monthly, half-yearly or yearly follow-up telephone calls monitoring smokers quit progress. There is also the option for those who have relapsed to re-enter or re-use the programme. Interview with Stop-Smoking Advisors as part of this study also confirm these programmes.

2.15.4 Behaviour Change and Smokers

For smokers, achieving behaviour change can be difficult (M. Solomon et al., 2010). C. Chang (2007) links this difficulty quitting to being contingent upon who smokers want to be (*the ideal self*) or how they see themselves (*the actual self*). This contributes to issues experienced by smokers when trying to achieve behaviour change, i.e. addiction, loss of positive smoking identity, feeling that their personal freedom to smoke has been removed. It leads them to adopt positions to diminish these issues, i.e. engaging in compensatory health beliefs and moderating attitudes against intentions. Although these issues are not exhaustive, studies about behaviour change and smoking frequently identify these as major points of consideration (for example, Betzner et al., 2012; W. L. Hamilton et al., 2008; Hatsukami, Stead, & Gupta, 2008; Michael L. Capella, Taylor, & Webster, 2008; Schumann et al., 2006). These are discussed in the paragraphs below.

Nicotine is an addictive substance which makes quitting hard (Tamvakas & Amos, 2010), although there is evidence suggesting increased awareness by smokers of the personal harm(s) caused by it (Slovic, 2001; A. K. G. Tan, 2012). Examining predictors of adolescent self-initiated smoking, Sussman, Dent, Severson, Burton, and Flay (1998) found that heavy smokers are less likely to quit because they are more addicted. However, light smokers and those who have had a brief experience of smoking, are more likely to quit because they are more addicted. During quit attempts, some smokers experience withdrawal symptoms associated with addiction (Goodman, 1994). Given the addictive nature of tobacco (Hatsukami et al., 2008), it is unclear whether smokers might be ready or even want to quit making behaviour change a difficult request (Wolburg, 2004).

Positive smoker identity is an individual's positive feelings attached to their identity as a smoker, enabled by an affirmation of their love for being smokers. Addicted individuals are more likely to report positive smoker identity, although studies suggest some categories of smokers (i.e. those aged 18 – 25), might not (Leas, Zablocki, Edland, & Al-Delaimy, 2015; Tombor, Shahab, Brown, & West, 2013). In trying to understand whether positive smoker identity created a barrier to quitting smoking, Tombor et al. (2013) found insufficient research on this subject, preventing further exploration of its impact on smoker behaviour. Therefore, it is unclear whether smokers value this feeling over and above other feelings such as health concerns and enjoyment of smoking.

Smokers believe restrictions on tobacco use take away their personal freedom of self-expression (Barkes, 2013), preventing them co-existing with others but more importantly enjoying a pastime they enjoy (Adler, 2012). A study about myths and attitudes which sustain smoking in China (Ma et al., 2008), found that smokers stoutly defend their right to smoke which they view as a personal lifestyle choice voluntarily adopted. These behaviours displayed by smokers suggest their need and want to smoke is just like any other craving, for example, caffeine, soda, or fast-food. According to Quinn, Mujtaba, and Cavico (2011), smoking is the “drug of choice” for smokers.

Smokers try to circumvent behaviour change by denying the harmful effects of smoking and engaging in compensatory behaviours, for example eating healthy or doing exercise. This behaviour is described as compensatory health beliefs (CHBs) (Glock, Müller, & Krolak-Schwerdt, 2013). By so doing, they can indulge in smoking

whilst remaining emotionally close to long-term health goals. However, this position can cause mental conflict between the desire to engage in the unhealthy behaviour and the long-term goal of staying healthy (Kaklamanou & Armitage, 2012). Compensatory health beliefs contribute to continued smoking behaviour, allowing individuals to smoke without experiencing negative feelings and helping to reduce cognitive dissonance (Glock et al., 2013), a major factor preventing smokers from quitting.

During the quitting process, smokers sometimes moderate their actions against intentions by trying to evaluate reaction to thoughts and actions (Foxall et al., 1998). For example, a smoker might resolve to quit smoking as a New Year 's resolution but fail to carry out this resolution due to personal influences (e.g. peer pressure or habit). Similarly, a non-smoker might attempt to change his/her negative perception about smokers and smoking but decide against doing so because of awareness that involuntary exposure to second-hand smoke can result in illness.

Prior discussions identified issues experienced by smokers when trying to achieve behaviour change and positions they adopt to diminish these issues. Stigmatisation, although not identified as one of these issues, has been found to also impact behaviour change. It is an action significant enough to warrant separate discussions, which are held in the following paragraphs.

2.15.4.1 Stigmatisation and Smoking Behaviour

According to Stuber, Galea, and Link's (2008) study on the emergence of a stigmatised social status, stigmatisation is a mark of social disgrace arising within

social interaction or deviation from social norms, disqualifying those with the mark from being socially accepted. Nagelhout et al.'s (2012) study on stigmatisation of smokers in the Netherlands, suggests stigmatisation evolves when elements of labelling, stereotyping, separating, loss of status and discrimination happens simultaneously. Goffman identified two ways in which stigma can be carried – discredited and discreditable (Page, 1984). Discredited is used to describe stigma already known about or immediately obvious, e.g. smoking. Discreditable is used to describe stigma which might not be known about nor immediately perceived, for example secret smokers (Payne, 2013).

Findings from this study revealed another way in which stigma may be carried – social (see Table 2.12).

Table 2-12: Stigmas and the Ways in Which They May Be Carried

<i>Types of Stigma</i>	<i>Ways in Which Stigmas May Be Carried</i>	
	<i>Discredited</i>	<i>Discreditable</i>
1 PHYSICAL	Paraplegic in a wheelchair	Woman who has undergone a mastectomy
2 CONDUCT	Well-known criminal e.g. Myra Hindley, Ronald Biggs	“Secret” homosexual
3 TRIBAL	Individuals of African heritage	Jew
4 SOCIAL	Smokers	Those who conceal the fact that they smoke (“secret smokers”)

Source: Adapted from Page (1984)

To illustrate, someone born a paraplegic with a visible disability is considered unfortunate. However, because smoking is a learned behaviour of personal choice smokers are deemed culpable for any resultant smoking-related illness. Established anti-smoking policies (for example, indoor smoking ban and display ban), contribute to smokers and smoking behaviour being stigmatised. Negative judgements made of smokers necessitates them finding ways of “fitting in” to manage stereotyping and stigma, but also contributing to what literature about stigma (Aggleton, 1987; Chapple et al., 2004) refer to as “damaged” or “spoiled” identities. Non-smokers view smoking as an activity which warrants smokers being stigmatised and should be discontinued. According to Stuber, Galea, and Link (2008), smokers who experience elevated levels of stigmatisation are more likely to become quitters, although the main tendency is for them to attach themselves to groups or communities where smoking is encouraged. Research conducted by J. Kim (2014) in fulfilment of a doctoral thesis found evidence in support of this behaviour:

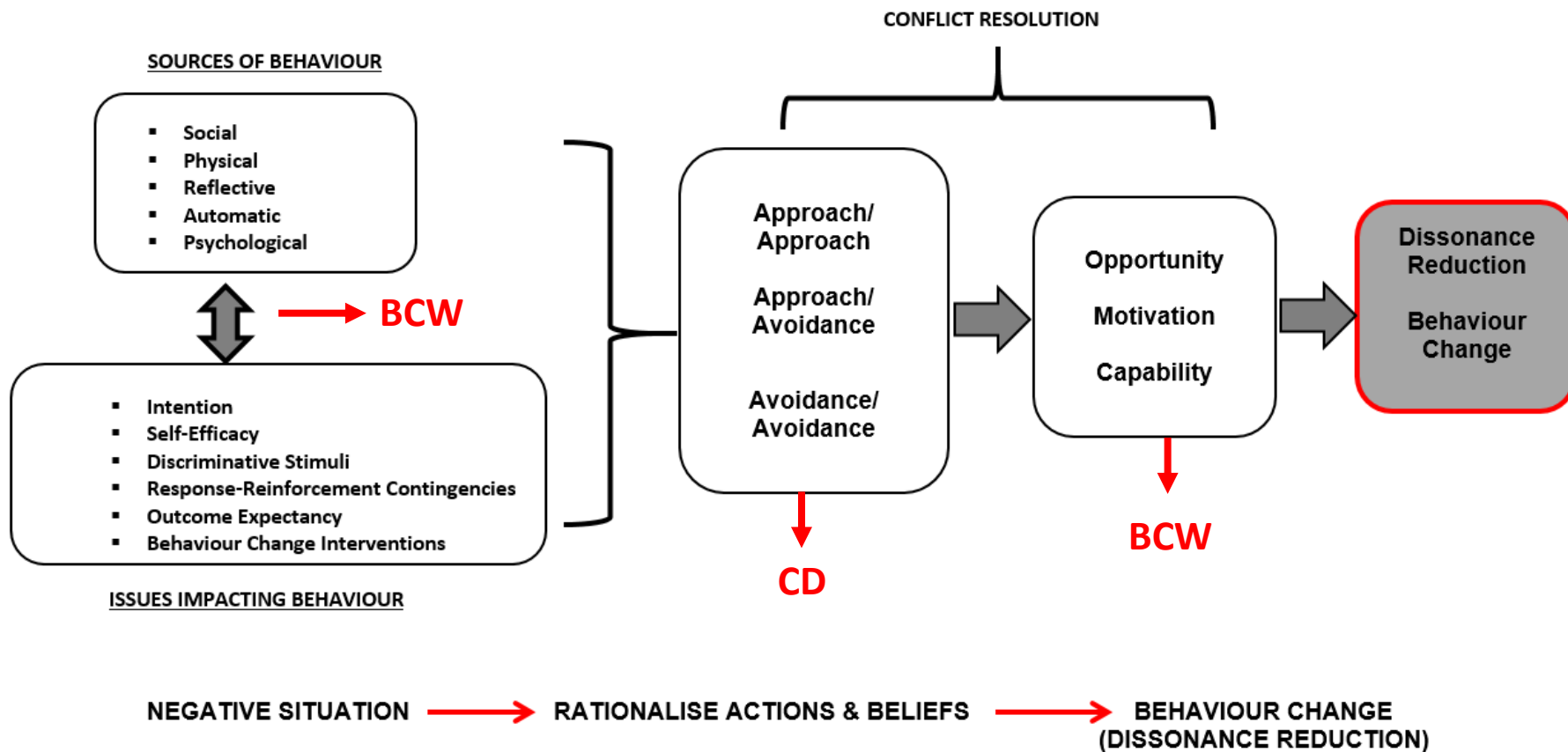
“...Smokers strengthen their ties within the stigmatized group in order to obtain a sense of belonging, acceptance, and social support from other members of the community”.

J. Kim (2014)

2.16 Chapter Conclusion

By providing insights into Cognitive Dissonance Theory and the Behaviour Change Wheel concept, this chapter illustrated the initial framework considered to demonstrate the theoretical implications of this study. After further examination of the literature other constructs which impact behaviour change were identified (i.e. intention, self-efficacy, discriminative stimuli, response-reinforcement contingencies, outcome expectancy, behaviour change interventions). Accordingly, the framework has been revised (see Figure 2.9).

Figure 2.9: Revised Theoretical Framework of this Thesis



NB: Arrows represent potential for causal inference (or conclusion drawing).

Source: *Researcher's Own Adaptation of Festinger, and Michie & West's theoretical concepts for her research study.*

Positions discussed in this chapter amplify Festinger's (1957) argument on cognitive dissonance, making a strong case that dissonance (or its resolution) actually reside within social relations. Ross and Schulman's (1973) study on the salience of initial attitudes, posits that dissonance occurs when behaviours are evaluated and found contrary to expected social norms. This position is also shared by Matz and Wood's (2005) study on dissonance and group behaviour. Their view is that conflict between initial attitudes and behaviour can be resolved by a change in attitudes.

Interestingly, Festinger's seminal work makes it clear that no distinction exists between pre- and post-decision behaviour, because re-evaluation can occur before and after the decision (Festinger, 1964). Support for this position is found in Szmigin and Piacentini's (2015) literature, which identifies that individuals who are more sensitive to positive outcomes avoid re-evaluation altogether by eliminating any negative outcome(s). For example, smokers will try to achieve positive goals and avoid negative results by choosing the "healthier" alternative to cigarettes, i.e. e-cigarettes. This can be linked to the thinking of Medwed's (2014) study examining interrelated cognitive biases, which found that individuals work hard to construct positive images of themselves by trying to reduce damaging evidence which could put them in a bad light thereby creating cognitive dissonance.

Festinger's theory of dissonance remains a powerful one in the research literature, informing studies in psychology, cognitive psychology, communication and other related fields. The theory is also helpful in explaining and suggesting routes to attitude change and persuasion, particularly in situations where decision-making conflicts exist. Although the theory has shortcomings it continues to spark interest and many

ideas from it are still used in present studies by writers such as Fotuhi et al. (2013) Harmon-Jones (2000), and Orcullo and San (2016). Critiques of the theory also enable its revision and refinement. For example, Bern's (1967) reflective interpretation of dissonance phenomena shows that dissonance is actually the consequence of an individual's own inferences about causes of his/her own behaviour. Harmon-Jones (2000) suggests more research needs to be done around the area of cognitions, a step which could unearth a wealth of theoretical insights.

Norms have an influential effect on behaviour, with far-reaching implications which are sometimes difficult to grasp. For example, smoking has become increasingly non-normative (Procter-Scherdtel & Collins, 2013), adding to already existing demand for public smoking bans. Nevertheless, some smokers will ignore "*no smoking*" warnings and smoke in public, disregarding public opinion because they feel their right to smoke is being breached. *These behaviours have also been displayed by smoking participants of this study.* This highlights the importance of applying notions, such as inner harmony, freedom, security and social cues (i.e. body language, gestures, facial expressions), to understand behavioural patterns as instances of change.

Smokers experience motivational conflicts caused by dissonance behaviour when positive and negative motives collide. For example, when faced with the choice of conformity (i.e. observing the indoor smoking ban) or non-conformity (i.e. circumventing display bans), smoking participants may opt for strategies which reduce dissonance behaviour. They could deny the ill effects of smoking, accept the ill effects of smoking, or adopt a belief in personal immunity (McMaster & Lee, 1991). Nevertheless, given the difficulties associated with quitting (Fotuhi et al., 2013),

smoking participants usually adjust their beliefs to justify why they smoke rather than change their smoking behaviour.

Consumption is an ongoing process, not just what happens when goods/services are exchanged for payment. Smokers consume to solve practical problems, whilst considering the cultural, social and personal meanings of cigarettes and tobacco products. Based on the behaviours they exhibit in retail environments and shared consumption spaces, smoking participants try to reduce unfavourable outcomes by structuring activities to minimise motivational conflicts, i.e. engaging in compensatory behaviours such as smoking e-cigarettes, or purchasing cigarettes online.

Smoking participants are exposed to marketing communications messages from two sources: (i) the Tobacco Industry and (ii) anti-smoking advocates (e.g. Government and the NHS), although each have a different intent. Messages from the Tobacco Industry portray smoking as a glamorous activity, the aim being to keep those already smoking in the habit whilst encouraging non-smokers to take up the habit. Messages from anti-smoking advocates take the opposite approach. Their aim is to deter non-smokers from taking up the habit whilst getting established smokers to quit or smoke less, using fear appeal and social marketing messages as their tool.

Negative judgements made of smoking participants necessitate them finding ways of “fitting in” to manage stereotyping and stigma, but also contributing to what literature about stigma refer to as “damaged” or “spoiled” identities (Aggleton, 1987; Chapple et al., 2004). Non-smokers view smoking as an activity which warrants smokers being stigmatised, believing it should be banned. According to Stuber et al. (2008), as a

result of being stigmatised smokers, (including those in this study), attach themselves to groups or communities where smoking is encouraged. Research conducted by J. Kim (2014) in fulfilment of a doctoral thesis found evidence in support of this behaviour:

“...Smokers strengthen their ties within the stigmatized group in order to obtain a sense of belonging, acceptance, and social support from other members of the community”.

J. Kim (2014)

The next chapter of this thesis focuses on the research methodology, discusses the philosophical viewpoint adopted for this study, describes the sampling strategies employed, and explains how the data was collected and analysed.

Chapter 3. Chapter 3: Methodology

3.1 Introduction

In this chapter *different methodological* theories and *authors' perspectives* within the social sciences will be discussed, demonstrating how this study can be located within the field of social science. Methodological challenges relating to epistemological and ontological issues will also be identified, before restating this study's aim and objectives. Thereafter, an explanation of the qualitative research design will be given. Next, the research methods will be described, followed by an explanation of the sampling framework and rationale for the qualitative data collection method used. Afterwards, an account is offered of the analytical process through which findings of this qualitative study are reached. Finally, information about the study's ethical considerations and gaining entry to participants are given.

3.2 Overview of Research Methodology

Research methodology according to Braun and Clarke (2013), is the framework within which research is conducted. It consists of theories and practices to undertake and help with decisions about the research, such as: (i) how to select participants, (ii) what are the appropriate data collection and analysis methods, *and* (iii) who can or should conduct research and what is the role of the researcher(s). Within this framework five methodological components *are commonly* used namely: case study, grounded theory, ethnography, phenomenology and narrative (see Table 3.1). These methodological components outline issues relating to the logic and design of any research complemented by the researcher's theoretical persuasion, i.e. positivist or interpretivist.

Table 3.1: Five Most Commonly Used Methodological Components

METHODOLOGY	POSITIVIST/ POSTPOSITIVIST	INTERPRETIVIST	AIM
Case Study	Yin (2009)	Stake (1995)	To understand what is distinctive of a case defined as 'specific, a complex functioning thing', e.g. a person, an institution, policy, process or system.
Grounded Theory (GT)	Glaser and Strauss (1967)	Strauss and Corbin (1998) Constructivist (Charmaz, 2006)	Generate theory that explains a social process, action or interaction. Theory is constructed or 'grounded' from the data of participants who have experienced the phenomenon under study.
Ethnography	Realist Ethnography (Hammersley and Atkinson, 1995)	Performance (McCall, 2000)	Examine the shared patterns of behaviour, beliefs and language within a cultural group through extended observation by the researcher.
Phenomenology	Transcendental or Psychological Phenomenology (Moustakis, 1994)	Hermeneutical Phenomenology (Van Manen, 1990)	Understand the lived experience of individuals by exploring the meaning of a phenomenon.
Narrative	(Elliott, 2005)	(Elliott, 2005)	Stories or life experiences of individuals. May be biographical or an oral history exploring the personal reflection from one or more individuals.

Source: Adapted from Petty, Thomson, and Stew (2012)

In his book *Introduction to Social Research: Quantitative & Qualitative Approaches*, Punch (2014) suggests that methods of enquiry should be based on assumptions about the nature of the reality being studied, what constitutes knowledge of these assumptions and what are the appropriate methods of building knowledge. The thinking is that each qualitative methodology is unique, have distinctive features and come under the umbrella of a qualitative paradigm. Braun and Clarke (2013) *offer a different perspective with the belief* that the ambiguous nature of qualitative enquiry means there is no single answer to questions or assumptions within the said research.

3.3 Methodological Position of this Study

This researcher's philosophical position is subjectivism, her theoretical perspective is interpretivist, whilst adopting the research design of phenomenology, positions compatible with qualitative research methods used throughout this study. Phenomenological research starts with the interest and passion of the researcher to develop the research question(s). This strategy enables an understanding of the phenomenon (e.g. a situation, event, or lived experience), whilst establishing a relationship to the topic. Finlay's (2012) study examining the phenomenological research process, states that phenomenology allows reflexive thinking, encourages new understandings and going beyond what is already known from prior knowledge and/or experience.

In keeping with the subjective philosophical position, this researcher put herself "*in the place of participants*", embracing what Crotty describes as "the great phenomenological principle" (Crotty, 2003). Although this research's paradigm position contradicts the positivist and/or post-positivist paradigm, it embraces the anti-positivist stance of interpretivism. According to D. E. Gray (2014) , interpretivism

enables historic and cultural interpretations of the social world, i.e. the social meaning of purchase, consumption, and use of tobacco products to smokers – the impact on smokers' life roles.

3.4 Research Paradigms and Social Research

Paradigms are a set of assumptions about the world and the techniques for enquiry into that world (Punch, 2014). MacLean and Williams's (2008) work examining how paradigms shape understanding, pedagogy and pursuit of justice, demonstrate that paradigms allow individuals to understand the world from different viewpoints, focus on specific audiences, identify study problems and methodological directives, whilst suggesting real world solutions. Crotty (2003) suggests that a paradigm enables reality to be studied whilst validating the methodology and methods used. *For example, the aim of this research is to understand the behaviour of smokers in response to established anti-smoking strategies. This researcher's belief is that an interpretivist paradigm allows her to observe the world from the subjective experiences of the study's participants. Furthermore, a phenomenologist approach allows an understanding of the lived experiences of the study's participants. Therefore, both strategies are appropriate to achieve this aim.*

Three fundamental questions addressed by paradigms have been identified by Punch (2014), which should be considered during the conduct of research: (i) what is the form and nature of reality and what can be known about? [**ontological**]; (ii) what is the relationship between the knower and what can be known? [**epistemological**]; (iii) how can researchers go about finding out what can be known? [**methodological**]. Bearing in mind methods are derived from paradigms and paradigms have significant

connotations for methods (Punch, 2014), these questions assist *this researcher* to understand methods and philosophical issues.

Scientific disciplines operate under one or more paradigms (Kirschner, 2014), therefore researchers should be careful to avoid conflicts which could arise as a result.

D. E. Gray (2014) explains:

Normal science is a problem solver and if it persistently fails to solve problems, then the failure of existing rules will lead to a search for new ones. This is what is known as a paradigm crisis, which could turn into a revolution if anomalies continue and new people enter the field, such as researchers who are not committed to the traditional rules of normal science and who are able to conceive of a new set of rules.

D. E. Gray (2014, p. 22)

Gray's (2014) reflection about paradigm crisis highlights the conflicting position which social science researchers face when making methodological choices. This brings into focus the position taken by Brand (2009) in a study examining business ethics and paradigm analysis, that no enquiry should be undertaken without first understanding the paradigm which informs and guides the approach being taken. Cibangu's (2010) article examining the issue of paradigms, methodologies and methods, states that because paradigms sometimes emerge as abstract, they need further explanation to justify the research priorities and choice. Cibangu's view is supported by Crotty (2003):

Paradigms can be inadequate, particularly when findings cannot be explained within the context of said existing paradigm.

Crotty (2003, p. 35)

Paradigms often present challenges around areas of philosophy and terminology (Punch, 2014). For instance, positivism and interpretivism can sometimes represent two different scenarios of research about a similar topic. Thus, researchers who limit

themselves to one scenario might find their research project unclear or impractical (Cibangu, 2010).

3.4.1 Paradigm Assumptions in Social Research

Although researchers sometimes make assumptions about their chosen research, it is important to state what those assumptions are. For example, assumptions in an ethnographic form of inquiry relates to matters of language, communication and interaction. Crotty (2003) proposes that researchers justify these assumptions by explaining their views of the human world and social life within that world. Hussey & Hussey's perspective brought out in their book entitled *Writing about Business Research: A Practical Guide for Undergraduate and Postgraduate Students*, suggest that because the paradigm adopted is determined by the research problem and shaped by the researcher's own assumptions, there is no wrong or right paradigm (Hussey & Hussey, 1997).

Researchers approach their studies with a basic set of assumptions that guide their inquiries known as a paradigm or worldview. Morgan's (2007) study examining methodological issues associated with combining qualitative and quantitative methods, found that linking paradigms to qualitative, quantitative, or mixed methods research entail various considerations about what to study and how to do such a study. For example, some researchers highlight issues of justice and social change, whilst others concentrate on creating or testing theories. These individual preferences not only demonstrate the influence of worldviews on the research topic being studied, but how researchers choose to conduct that work. Table 3.2 illustrates the various paradigm assumptions in social research, shaded areas represent this researcher's perspective. Irrespective of whether the study is quantitative, qualitative, or mixed

method, paradigms address and answer questions about ethical, ontological, epistemological and methodological issues.

Table 3.2: Paradigm Assumptions in Social Research

Assumptions	Theoretical Perspectives	Quantitative	Qualitative
Ontology – What is the nature of reality	Positivism	Reality is objective and singular, apart from the researcher	Reality is subjective and multiple as seen by participants in a study
Epistemology – What is the relationship of the researcher to that being researched <ul style="list-style-type: none"> ▪ Objectivism ▪ Constructivism ▪ Subjectivism 	Interpretivism Symbolic Interactionism Phenomenology	Researcher is independent from that being researched	Researcher interacts with that being researched
Methodology – What is the process of research <ul style="list-style-type: none"> ▪ Experimental Research ▪ Survey Research ▪ Ethnography ▪ Phenomenological Research ▪ Grounded Theory ▪ Heuristic Inquiry ▪ Action Research ▪ Discourse Analysis 	Critical Inquiry Feminism Post Modernism Pragmatism	Deductive process Cause and effect Static design – categories isolated before study Context-free Generalisations leading to prediction, explanation and understanding Accurate and reliable through validity and reliability	Inductive process Mutual simultaneous shaping of factors Emerging design – categories identified during research process Context-bound Patterns, theories developed for understanding Accurate and reliable through verification
Axiological – What is the role of values		Value-free and unbiased	Value-laden and biased
Rhetorical – What is the language of research		Formal Based on set definitions Impersonal voice Use of accepted quantitative words	Informal Evolving decisions Personal voice Use of accepted qualitative words

Source: Adapted from *Hussey and Hussey (1997)*; *Denzin and Lincoln (2011)*; *D. E. Gray (2014)*

Table 3.3 provides an illustration of questions answered by paradigms, followed by discussions on each.

Table 3.3: Questions Answered by Paradigms

No.	QUESTION	CONCERN
1	What is the nature of the phenomena, entities, or social reality to be investigated?	Ontological
2	What might represent knowledge or evidence of the entities or social reality being investigated?	Epistemological concern – links to question 1.
3	What topic or broad substantive area is the research concerned with?	Methodological concern – link to questions 1 and 2.
4	What is the intellectual puzzle, what is to be explained, and what are the research questions?	Link to questions, 1, 2, and 3.
5	What is the purpose of the research and why is it being done?	Axiological concern – link to questions 1,2,3,4.

Source: Adapted from M. Saunders et al. (2012)

The ability to answer these questions provide the basis for researchers to study appropriate forms of knowledge relevant for the different ontological, methodological and epistemological positions (Matthews & Ross, 2010). Epistemological and ontological perspectives can sometimes be contradictory or even inconsistent (D. E. Gray, 2014), irrespective of the fact that they are important prerequisites for undertaking any research project. Discussions on how these positions shape the researcher’s position are held in the following paragraphs.

Ontology

An interpretation of ontology can be expressed in the following statement:

There is a single truth which can be measured and studied, and that nature can never be fully understood because of the hidden variables and the lack of absolutes in nature. Things in the world exist independently of direct human consciousness or interaction, and may only be experienced by those directly affected.

Denzin and Lincoln (2011, p. 102)

Denzin and Lincoln's (2011) viewpoint highlights the importance of understanding human interaction, even though they believe these interactions can happen independently and felt only by individuals experiencing the interaction. In their book *A Short Introduction to Social Research*, Henn, Weinstein, and Foard (2006) offer a different viewpoint. Their belief is that human behaviour does not exist independently of human interaction, is a subtle abstract concept which cannot be perceived but can be understood through cause and effect. For example, if there is increased understanding of the dangers of smoking, it might be difficult to demonstrate to a smoker that anti-smoking regulations could cause this increased understanding. Therefore, the presence of factors which support this reasoning might make it impossible to isolate the specific contribution of the factor of interest. This belief helps shape the ontological position of this study, although there is awareness that other ontological beliefs can be embraced. Discussions contained in this study's Literature Review testifies to this.

Epistemology

The epistemological belief of this study is that knowledge extends beyond the knower and can be produced and verified by understanding human thought processes. Human beings are unable to directly observe reality, so tests of theories must try to

disprove rather than confirm them. Furthermore, because knowledge is open to revision and its discovery goes beyond external appearance, there is no permanent, consistent criteria for establishing whether knowledge can be regarded as true (D. E. Gray, 2014). Braun and Clarke (2013) put this into perspective:

...In a world where all sorts of knowledge exist, how do we know which to trust and which are meaningful?

Braun and Clarke (2013, p. 28)

Understanding human intention and behaviour requires a degree of empathy, which is not evident when explaining behaviour through external causes (Henn et al., 2006). Mindful of Henn et al.'s (2006) observation, this researcher's individual experiences, values and inputs contributes to the research process, particularly as this researcher is not a detached observer.

Axiology

Axiology plays a key role in the ontological and epistemological views of this study. It has influenced the chosen methodology, generation and interpretation of data, research findings and conclusions reached. More importantly, it has brought to the forefront issues about values which are considered during the conduct of research, namely: what should be the definition of the researcher's responsibility, scientific responsibility and societal responsibility. In this situation the researcher's responsibility is to carry out the work fully aware that the way he/she works has consequences, being named as the author of that work acknowledge acceptance of the resultant consequences. Dreveton and Ville's (2014) study examining societal responsibility in management research activities come to the fore here. Their viewpoint is that from a scientific perspective, the researcher should analyse the impact of his/her own activity on the organization, group, or individual being observed.

Using reflexivity is an essential dynamic which can aid in understanding the progress of a research activity. Reflexivity entails three dimensions: (i) operational reflexivity – how the researcher uses his/her skills, (ii) conceptual reflexivity – the work should not be limited to promoting management practices, and (iii) scriptural reflexivity – the researcher contributes directly to the organisation under observation, instead of just describing it (Dreveton & Ville, 2014). To conclude, identifying the societal consequences of research the researcher should incorporate the social expectations of his/her everyday activities, mindful of internal and external stakeholders, for example research participants, the academic community, and the wider society.

3.4.1.1 Positivism and Interpretivism

Two major research design paradigms emerged during the 1700s and 1800s: (i) **positivism** which is linked to quantitative research and (ii) **interpretivism** which is linked to qualitative research (Cibangu, 2010). According to Punch (2014), associating positivism with quantitative methods and interpretivism with qualitative methods might not necessarily be accurate:

It is more accurate to say that positivism is likely to be associated with quantitative methods, and interpretivism and constructivism are likely to be associated with qualitative methods.

Punch (2014, p. 17)

There is not much difference between both paradigms yet they have managed to “divide” quantitative and qualitative researchers (Punch, 2014). Punch (2014) continues that advocates of positivism are opined that knowledge can only be acquired through observation and experiment, without consideration for context and concepts such as feelings, opinions, values, or cultures. On the other hand, advocates of interpretivism share the belief that knowledge can only be acquired through an in-depth and context-specific understanding of lived experience(s) or meaning. These

differences have caused rifts between positivists and interpretivists, leaving no middle ground for either to meet. Both sides believe their perspective is the only way, refusing to acknowledge anything else. However, in these debates consideration must be given to the utterances of Onwuegbuzie and Leech (2005):

...the reliance on just one research paradigm can be very limiting.

Onwuegbuzie and Leech (2005)

Positivism and interpretivism are the two most influential theoretical perspectives, although there are others, for example critical inquiry, postmodernism and feminism (D. E. Gray, 2014). Theoretical perspectives can also be embodied in other methodologies such as ethnography and grounded theory. The thinking is that critical inquiry is linked to action research as well as the transformation of ethnography. So, in a critical inquiry research ethnography now becomes critical ethnography, allowing the researcher to examine power and authority whilst addressing oppressive issues (Crotty, 2003).

As research evolves ontological, epistemological and methodological questions that fall within the favoured paradigm must be considered, according to Flick (2011), these questions should not be answered spontaneously but instead taken on a series of levels: Level 1 – look at how existing data can be used for the researcher's own analysis; level 2 – identify whether the researcher is interested in knowledge, attitudes, or practices; level 3 – consider the necessity to develop a new data collection instrument or use an existing one? Understanding these considerations allow researchers to choose a paradigm which best suit the research project being undertaken. This allows for flexibility should new or significant development(s) arise,

particularly as social science research can sometimes appear abstract (Cibangu, 2010).

3.5 Abstract Concepts

Ideas which can be applied to different situations or phenomena and not just one single event or occurrence, are termed as abstract (White, 2009). Abstract concepts are represented by actions such as kindness and intelligence (Hubler, 2007), translating a foreign language or the conservation of energy (Casasanto & Henetz, 2012). This demonstrates that social research is active because it does not always focus on material objects. Nevertheless, abstract concepts require conscious processing to evaluate (Z. Lin & Murray, 2014) because they are depicted through expressions such as hearing or sight (Chen, 2006), a unique ability fundamental to human thinking and reasoning.

Situations exist where abstract concepts can be inappropriately applied. For example, measuring incidences of lung cancer amongst female smokers is easier than accessing their individual health information. Research of this nature would be too exacting based on the breadth of coverage, lack of consensus definition and the considerable number of indicators which could be used. According to J. Klein (2005), writing about abstractions:

*Awareness of abstraction would reduce the number of “**why**” questions and “**because**” answers. Or it would at least make us realise that when we are dealing with “**whys**” and “**because**”, we are dealing with interpretations, projections, and opinions, and not with bare facts.*

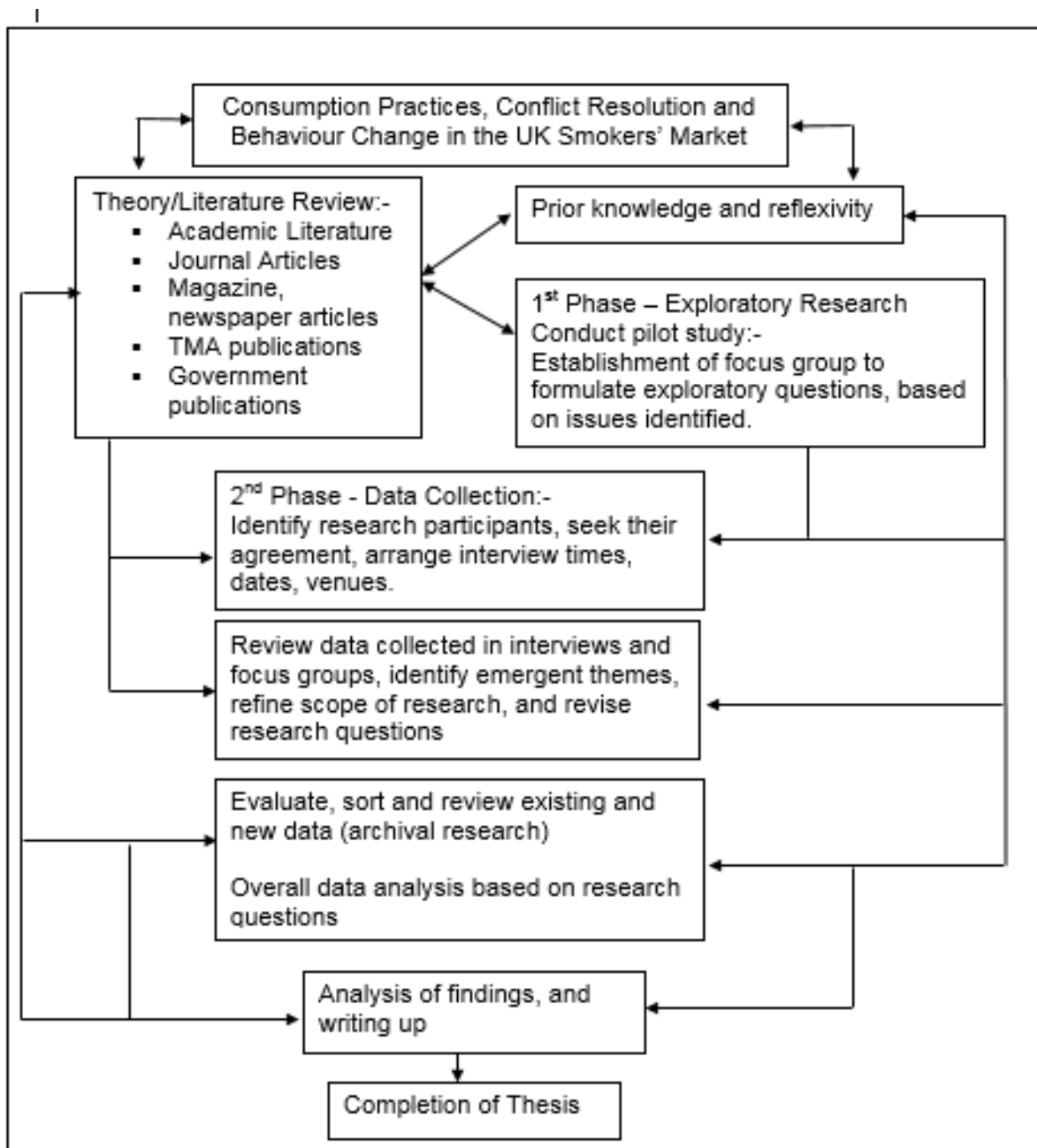
J. Klein (2005)

Klein's (2005) viewpoint highlights problems which exist when using abstract concepts to research human behaviour and interaction. The study of human behaviour can sometimes be controversial, warranting enquirers to be more concerned with specific experiences, individual crisis, or the moment of discovery – in other words “an epiphany” (Denzin & Lincoln, 2011). Therefore, researchers using abstract concepts should make modifications to their research questions if they want to avoid experiencing issues of this nature.

The complex nature of social interactions sometimes makes it difficult to understand abstractions. Clarity is needed when using abstract notions to answer and address research questions, to ensure methods used and data acquired are accurate, reliable and valid. This process allows data to be sourced from natural and semi-natural social settings, artificial settings and social artefacts (Blaikie, 2010). Data can also be sourced from previously published works in the subject area (Mogalakwe, 2009), the researcher's own understanding and experiences or independent sources of data (Curtis & Curtis, 2011); a process which is both iterative and inductive.

This topic's development has been brought into focus by demonstrating the iterative/inductive research process (see Figure 3.1). This process demonstrates how the researcher moved between separate phases such as reviewing literature, data collection and data analysis. The direction of the arrows in Figure 3.1 makes obvious the movement between phases, showing the rational inferential nature of the approach. Behaviour change is analysed conceptually: first, as an abstract idea and second by how smokers (and non-smokers) perceive it. The thinking is that conceptual analysis demonstrate that a distinction between both can be made in several dimensions (Koens, Mann, Custers, & Cate, 2005).

Figure 3-1: Iterative-Inductive Research Process of this Research

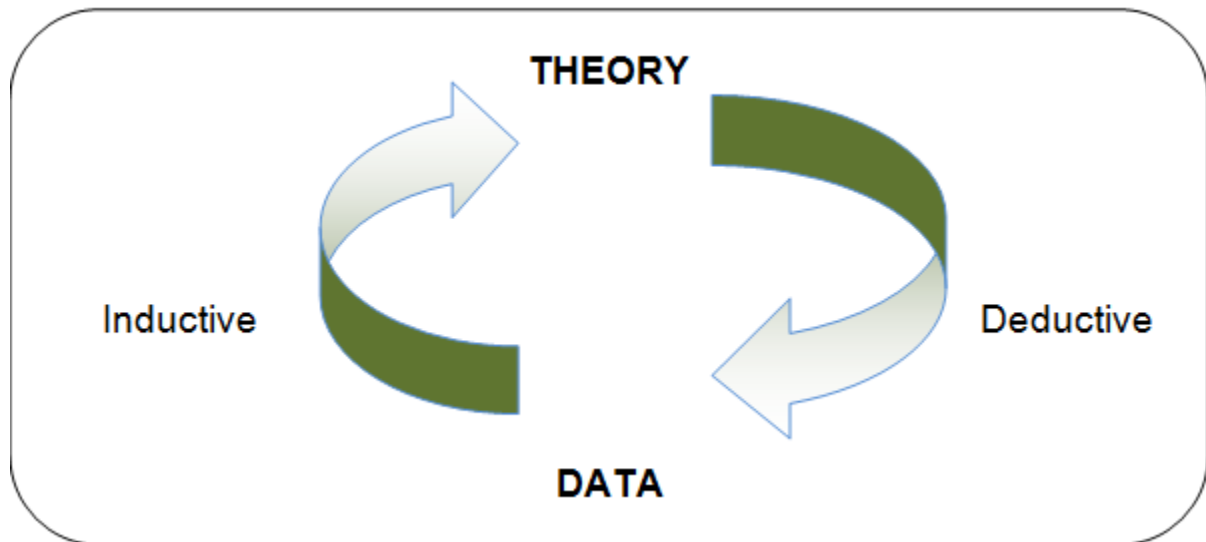


Source: Researcher's Own Concept of this Research's Iterative-Inductive Process

3.5.1 Shaping the Direction of Research

Iterative and inductive approaches shape the direction of research, involving movement backwards and forwards between emergent themes, theory and data (Finlay, 2013) and the researcher's own research base (Thomas, 2006). This is illustrated in Figure 3.2. *The movement backwards and forwards between themes*

Figure 3-2: Competence of Inductive and Deductive Approaches



Source: Adapted from Matthews and Ross (2010)

allow a flexible, coherent and focussed approach to addressing the research questions to be developed within the preferred perspective and/or paradigm. Denzin and Lincoln (2011) support this process, offering the view that researchers should have no fear forging ahead with “*what works*”, because “*what works*” is more than an abstract question, it involves the theory of evidence.

Hyde’s (2000) study highlighting deductive processes in qualitative research, posits that inductive and deductive approaches help draw rational inferences in qualitative studies, facilitating the shape of this kind of research. The ability to draw inferences from statements, observations, data and theory is key, especially because qualitative research seeks to draw inferences rationally in the light of uncertainty. This is a position identified in studies by Ormerod (2010) examining the inference of deductive, inductive and probabilistic thinking.

Inductive research does not validate or bias theory, instead it attempts to establish patterns, consistencies and meanings (D. E. Gray, 2014). On the other hand, deductive approaches test theory by applying it to specific instances (Hyde, 2000), to assure validity and reliability of research findings (Hammond & Wellington, 2013). For this reason Mura (1998) advocates using inductive logic in research because although it cannot be seen, it is reflected at the conclusion of the research. D. E. Gray (2014) concludes that whilst inductive research does not validate or bias theory, it attempts to establish patterns, consistencies and meanings.

3.6 Data Collection and Qualitative Research

3.6.1 Introduction

Qualitative research facilitates an understanding of groups, individuals or an issue, whilst providing a description of events or experiences (Braun & Clarke, 2013). It is also useful in interpreting and understanding words, actions and accounts (Matthews & Ross, 2010, p. 52) as well as how and why something occurs (Bruyaka, Zeitzmann, Chalamon, Wokutch, & Thakur, 2013). Qualitative research design suits data collection methods such as observation, interview, document analysis, focus group, ethnography, and life history (Creswell, 2014; Curtis & Curtis, 2011). When considering data collection methods for qualitative research, other factors about the research design must be considered, such as: (i) the relationship of interviews, individual and focus group to methodological issues, (ii) the unit of analysis, (iii) case study, (iv) sampling framework, (ii) selection of cases, and (v) analytical process relating to the findings. Discussions on these considerations are contained in the paragraphs below.

3.6.2 Interviews

Interviewing is the most common and widely used qualitative method of data collection within the social sciences. It is sometimes used with other forms of data gathering such as observation or document analysis (see Appendix 3.1 – highlighted sections represent those relating to this study). Regarded as a professional conversation aimed at getting participant(s) to talk about individual experiences and viewpoints (Blaikie, 2010), interviewing captures language, ideas and intimations about the topic being discussed. *To illustrate, during the interviewing process of this research, participants would sometimes communicate their feelings through their body language, whether by a hand gesture, shrug of the shoulder, smile, or laughter.*

The statement above demonstrates that flexibility of interviewing is communicated when researcher and researched impact each other through verbal and non-verbal communication. Notwithstanding, Qu and Dumay's (2011) work about qualitative interview provide additional insight through this critical reflection:

There is a danger of simplifying and idealising the interview situation, based on the assumption that interviewees are competent and moral truth tellers "acting in the service of science and producing the data needed to reveal" their experiences (feelings, values) and/or the facts of the organization under study.

Qu and Dumay (2011)

According to Crotty (2003), this position can be counteracted by preventing the individual experience from being prejudiced by using unstructured interviews, and asking open-ended questions to pinpoint emerging themes.

3.6.2.1 Justification for Using Interviewing

The decision to undertake interviewing as a data collection method in qualitative research is influenced by factors such as: (i) emotions, feelings and experiences of

participants, i.e. stigmatisation resulting from a personal habit, (ii) how consumption of a “socially displeasing product” (cigarettes) is viewed by individuals, and (iii) insider experience, privileged insights and understandings (smokers’ lived experiences of being a smoker). Interviewing ties in with the interpretivist paradigm (Collis & Hussey, 2014) and also phenomenology (D. E. Gray, 2014). Interviewing allows for the exploration of feelings or attitudes. For example, a probing question asking “*what happens next?*” (in response to what a participant has said) is useful for establishing the sequence of events or gathering details. These factors contribute to addressing any study’s research questions, producing knowledge which represent the shared experiences of individuals about the topic being researched.

Several types and styles of interviews have been identified (see Appendix 3.2). Interview style(s) adopted depends on the researcher’s philosophical viewpoint and/or appropriateness to the research paradigm. For example, feminist researchers use semi-structured and unstructured interviews to assist with constructing data about the lives of interview participants (Punch, 2014). Positivist researchers use pre-prepared structured or closed questions similar to those used in market research surveys (Hussey & Hussey, 1997). Furthermore, some researches are designed to test hypotheses which are self-evident, using structured interviewing format where questions and analysis are standardised. Others explore meanings and perceptions to gain a better understanding and/or generate hypothesis. The latter technique according to DiCicco-Bloom and Crabtree (2006), requires qualitative interviewing which encourage respondents to impart rich descriptions of the phenomena, whilst leaving the interpretation and analysis to investigators. This is the strategy used during this thesis’s data collection which employed semi-structured interviewing techniques, evidenced in the study’s analysis process discussed at Chapter Four.

As a data collection method, interviewing has attracted criticisms which cast doubt on the technique's ability to transparently elicit data. For instance, quantitative researchers regard data produced by interviews as "unreliable, impressionistic and not objective", believing them to be casual everyday conversations (Qu & Dumay, 2011). Qualitative researchers believe the phenomenological language used in interviewing is too complex, making it difficult to understand descriptive and interpretative orientations. This is according to Bevan's (2014) study examining the suitability of phenomenological interviewing as a method of research.

Criticism of interviewing also comes from Roulston (2010) , adopting an epistemological perspective:

Even setting aside the epistemological question of whether or not there is any ultimate 'reality' to be communicated, the interviewee may have incomplete knowledge and faulty memory. They will always have subjective perceptions that will be related to their own past experiences and current conditions. At best, interviewees will only give what they are prepared to reveal about their subjective perceptions of events and opinions. These perceptions and opinions will change over time, and according to circumstance. They may be at some considerable distance from 'reality' as others might see it.

Roulston (2010)

Advocates of interviewing as a valid research method, deem these criticisms unfounded, citing that the responsibility of any research is to try and understand meanings people attach to events, not to prove nor disprove the accuracy of events (Denzin & Lincoln, 2011). They also believe debates about *interviewing as a data collection method* are unimportant, *because statements can sometimes undermine interviewing as a valid research method which provides practical interpretation(s) grounded in the gathered texts, even if other interpretations can be found.*

3.6.2.2 Interview Approaches and Structure

Knox and Burkard's (2009) work examining the complexity of the qualitative interviewing process used by psychotherapy researchers, identified three interview formats, i.e. open-ended, unstructured, or highly structured with each having unvarying pre-set and uniformed questions. Giving these variations, Knox and Burkard's (2009) study suggests consideration should be given to the questions asked during interviewing because:

"At the root of ... interviewing is an interest in understanding the experience of other people and the meaning they make of that experience".

Knox and Burkard (2009)

An interview topic guide (see Table 3.4), logically designed can make the interview process easier. *Of note, during the interviewing process of this study, this researcher used an interview guide, (similar to that set out in Table 3.4), to help direct the conversation toward topics and issues she wanted to learn about.*

Table 3-4: Example of an Interview Topic Guide

STAGES	PRINCIPLES
Stage 1: Contextual Information	<ul style="list-style-type: none"> ▪ Use opening topics to collect information which will provide important context later. <p>For example, “How often do you visit your local pub or club?”</p>
Stage 2: Opening Topics	<ul style="list-style-type: none"> ▪ Must be straightforward and unthreatening to ease participants gently into the topic and get them talking. <p>For example, “How would you describe the indoor smoking ban?”</p>
Stage 3: Clarify meanings and definitions from the outset	<ul style="list-style-type: none"> ▪ Discuss definitions and meanings of key concepts at the beginning. <p>For example, explaining that “shared consumption spaces” means pubs, clubs, and restaurants.</p> <ul style="list-style-type: none"> ▪ Listen to participant’s definition of and reflection on a concept, instead of later in the discussions when their opinion(s) might be influenced.
Stage 4: Winding down	<ul style="list-style-type: none"> ▪ Ensure sufficient time for main research questions. ▪ End discussions on a positive note to ease feelings of distress, anger or frustration. <p>For example, ask for suggestions or their thoughts about the future.</p> <ul style="list-style-type: none"> ▪ Summarise and check key issues.

Source: Adapted from J. Ritchie, Lewis, Nicholls, and Ormston (2014)

Interviewing is one of the most common qualitative data collection method, allowing the interviewer to talk one-on-one with participants (in-depth interview). Several different approaches to interviewing have been identified, namely: structured, semi-structured and unstructured (M. Saunders et al., 2012), and open-ended or closed (Curtis & Curtis, 2011). All these approaches can be translated into fixed or fluid framings. Fixed framing stipulates researcher adherence to a sequence of procedures and earlier stages of these procedures may not be revisited (Curtis & Curtis, 2011). For example, a research survey where new questions cannot be added to a

questionnaire once it has been completed by the interviewee. Fluid framing necessitates that the relationship between ideas and data vary during research. This makes it possible to modify variables if necessary - variables being the questions asked of research participants (Curtis & Curtis, 2011), bringing into sharp focus the interviewer's role. For example, semi-structured interviewing where the researcher can revisit and modify questions previously asked. The main impact on fluid framing is the interpretation of and answer given to questions asked. This could be because the interviewee provides a different answer to the same question previously asked, or the interviewer asking the same question which is framed differently.

3.6.2.3 Role of the Interviewer

Published literature around the qualitative research interview process, identify the role of an interviewer as controlling unpredictable and unplanned social situations, but also understanding interviewees better (for example: DiCicco-Bloom & Crabtree, 2006; J. Ritchie et al., 2014). Other studies stress the importance of interviewer/interviewee relationship as this helps to (a) strengthen data validity, and (b) determine the extent of disclosure and depth of information contributed about their experience(s) of the area being researched (Knox & Burkard, 2009; Kvale, 1996). Interviewees who do not feel safe with or experience empathy from an interviewer will not be forthcoming with responses. Skilled interviewers manage tensions by listening closely and maintaining silence when necessary. Additionally, being prepared enhances the quality of any interview although unexpected developments may occur.

3.6.3 Unit of Analysis

A unit of analysis is the case which refers to the phenomena (or variables) under study for which data is collected and analysed (Hussey & Hussey, 1997). Unit of analysis focuses mainly on individuals, although it can also concern any level of social life

(Ruane, 2005). In phenomenological research the unit of analysis can be groups, organisations, communities, or individuals (see Appendix 3.3). Defining the unit of analysis in case study research can sometimes be complex, making generalised predictions in social research risky. The purpose of the study is what determines the unit of analysis (Grunbaum, 2007), therefore decisions on the unit of analysis should be made at the design stage of the research because failure to do so can prove problematic.

In studies examining multiple instrumental cases, identifying the link between the unit of analysis and case study is vital. According to Grunbaum (2007) the meaning of a “*unit of analysis*” and the case itself is ambiguous, making the distinction between both concepts unclear. Whilst writers such as Berg (2001) attempt to distinguish both, whilst Miles and Huberman (1994) as cited in Grunbaum (2007) are opined that “*the case is in effect your unit of analysis.*” Supporting this position, Grunbaum (2007) adds that the unit of analysis defines the focus of the case study (or what the case is) whether an individual, group, or organisation.

3.6.4 Research Cases

For this study, cases are smokers conceptualised as “*a fusion or groups of persons*”, (discussed at paragraph 1.4 and illustrated at Figure 1.5). Marcus’s (1998) work examining group dynamics with the social relations model, characterise groups as dynamic but interdependent with their behaviours and opinions mutually influencing each other. This is a trait also found in smokers, which was previously discussed in theme one of this study. It is also a rational perspective considering the following statement:

Adults spend a significant amount of time in groups with their peers, making group the primary socializing influence throughout the different stages of life.

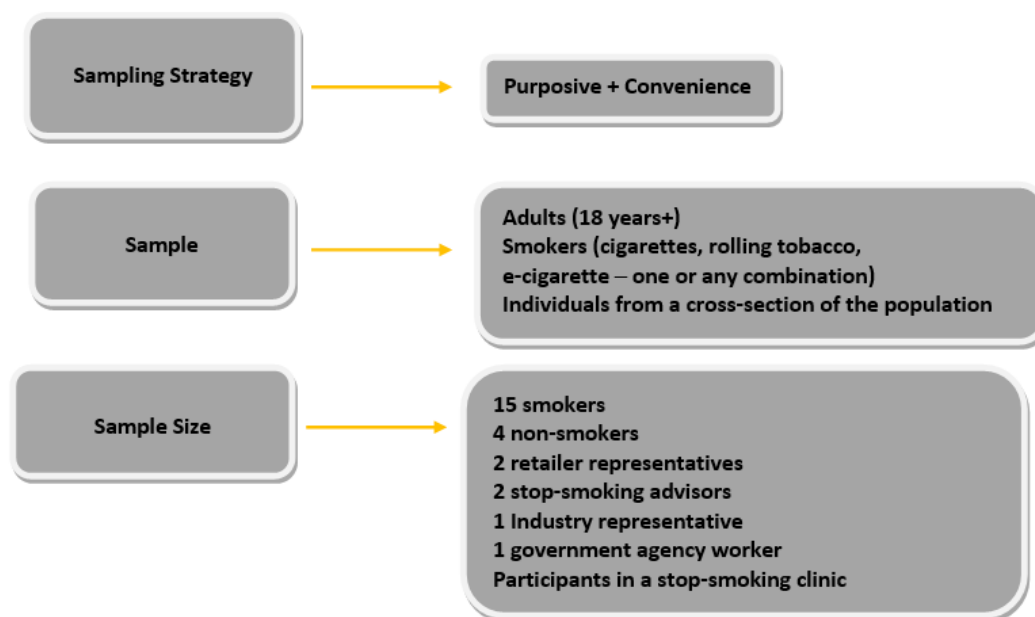
Gerrity and DeLucia-Waack (2006)

Gerrity and DeLucia-Waack's (2006) statement suggest that interdependence is one trait which makes studying groups interesting, particularly as group members can simultaneously assume roles of leaders and followers. Zinkhan and Zinkhan (1997) found the constant inter-changeability of groups makes studying them "*a blessing in disguise*", facilitated by their movement through evolutionary stages, i.e. forming, storming, norming, performing, and adjourning (Bonebright, 2010; Goldman & Schmalz, 2002; Tuckman & Jensen, 1977). These traits also create difficulties when examining groups from a case study perspective, especially because traditional statistical methods are not always effective when analysing group dynamics (Marcus, 1998). Therefore, employing an open-ended theoretical approach identifying problems for which alternative solutions can obtain (Barta, 1998), is one strategic way to facilitate possible change(s) to the unit of analysis of any study.

3.6.5 Sampling Strategy of this Study

The sampling strategy of this study is represented in Figure 3.3.

Figure 3-3: Sampling Strategy of this Study



Source: *Researcher's Own Adaptation of the sampling strategy for her research study.*

Cases in this study are naturally linked by their shared customary practice – smoking, a significant factor when deciding on their selection. Rather than just being a statistical basis for making general assumptions about behaviour change and the site characteristic, care was taken to ensure cases geographically represented the town of Huddersfield, West Yorkshire. This researcher is aware that not all cases work out well (Stake, 1995), so several desirable types were omitted in order to achieve balance. *For example, a focus group interview with four male non-smokers was conducted for this research. As it was not possible to conduct a focus group interview with four female non-smokers, the focus group interview with the males were not included in the data analysis.* Conducting initial assessments of progress helped identify ones kept and those not used. Overall, cases in this study are different, although a common link was found between situation and process. For example, smokers' rejection of the idea that second-hand smoke affect non-smokers. The representation and description of multiple perspectives of diverse cases demonstrate how variations were employed with the sampling strategy.

The sampling strategy considered the paradigm and research epistemologies adopted for this research, in keeping with the recommendation of D. E. Gray (2014). This researcher's phenomenological position necessitated respondents be purposively selected, having shared common experiences and convenient in proximity. Table 3.5 gives examples of sampling techniques used in qualitative research, including those employed in this study.

Table 3-5: Sampling Techniques Used in Qualitative Research

Technique	Description
Convenience Sample	Involves the selection of the cases who meet the criteria, willing to participate, and are most convenient in proximity.
Purposive Sample (aka judgement sample)	Involve the active search for the most productive sample to answer the research question; relies on the researcher's situated knowledge of the field and rapport with members of the targeted audience.
Theoretical Sample	Involves building interpretative theories from the emerging data, conceptual idea, or hypotheses and selecting a new sample to examine and elaborate on this theory. A strategy mainly used in grounded theory research.

Source: Barratt, Ferris, and Lenton (2015); O. C. Robinson (2014); Bagnasco, Ghirotto, and Sasso (2014); Marshall (1996)

Sampling is a complex discipline significant to research and is the foundation on which many studies are built. Consideration must be given to how the sample is drawn, the effect of the sampling method on data, be objective, and maximising accuracy of estimation wherever and whenever possible (Greenfield, 1996).

3.6.5.1 Sample Characteristics of Study Participants

Fifteen smokers were purposely and conveniently selected for individual semi-structured interviews. Interviews were also conducted with four non-smokers, two

representatives from retail establishments, two stop-smoking advisors, one representative from an advertising agency and one representative from a Government Department. Participant observation was also conducted in a stop-smoking clinic held at the Huddersfield Royal Infirmary on three separate occasions. Most interview participants *were directly approached, others referred by someone known to the researcher. Once initial contact was made, all interview participants were contacted formally via e-mail to confirm their participation and giving them details of their participation (i.e. what the study was about, why they were chosen, what would happen to the information collected).*

The average age of smokers in this study is 40 years, the youngest being 18 and the oldest 57; 80% (n=12) are females, 66% (n=10) smoke cigarettes but some in combination with another tobacco or tobacco-less product, 46% (n=7) use e-cigarettes; and 26% (n=4) smoke roll-ups. Over a third (66%, n=10) are White British, 26% (n=4) have Afro-Caribbean heritage and one of Asian descent. Majority are full-time employed, some in education and one unemployed. Smoking participants fall into one or a combination of the following categories: (a) is addicted to the habit of smoking, (b) smokes five or more cigarettes or roll-ups per day, (c) have been a smoker for at least one year, (d) experienced smoking during adolescence or sometime in their adult life, (d) have a history of smoking in their family, (e) is a current user of e-cigarettes. Characteristics of study participants are outlined in Tables 3.6, 3.7 and 3.8. Details about smokers observed in the stop-smoking clinic have not been included because they asked to remain anonymous.

Table 3-6: Sample Characteristics of Smokers

NAME	GENDER	AGE	ETHNIC BACKGROUND	OCCUPATION	PRODUCT SMOKE	USAGE (PER WEEK)
Smoker A	F	41	Mixed Heritage – Afro-Caribbean and White	Unemployed Mother	Cigarettes and e-Cigarettes	30 cigarettes/ 1 bottle e-liquid
Smoker B	F	50	Afro-Caribbean British	Checkout Operator	Cigarettes and e-Cigarettes	20 cigarettes/ 1 bottle e-liquid
Smoker C	F	57	White British	Business Support Manager	Cigarettes and e-Cigarettes	80 cigarettes/ 2 bottles e-liquid
Smoker D	F	52	White British	Stock Control	Cigarettes	42 cigarettes
Smoker E	M	56	Afro-Caribbean	Senior Landscape Gardner	Cigarettes	10 cigarettes
Smoker F	F	33	White British	Catering Assistant	Roll-ups	70 “roll-up” sticks
Smoker G	F	25	Mixed Heritage – Afro-Caribbean and White	Cleaner	Cigarettes	15 cigarettes
Smoker H	F	32	White British	Mature Student	Roll-ups and e-Cigarette	40 “roll-up” sticks/ 20 cigarettes
Smoker I	F	54	White British	Client Financial Affairs Officer	e-Cigarettes	2 bottles e-liquid
Smoker J	F	18	White British	Student	Cigarettes and Roll-ups	70 cigarettes/ 20 “roll-up” sticks
Smoker K	F	42	Asian	Care Worker	Cigarettes	50 cigarettes
Smoker L	M	38	White British	Mature Student	Cigarettes and e-Cigarettes	50 cigarettes/ 1 bottle e-liquid
Smoker M	M	35	White British	Tailor	Roll-ups	40 “roll-up” sticks
Smoker N	F	29	White British	Administrator	e-Cigarettes	2 bottles e-liquid
Smoker O	F	22	White British	Cleaner	Cigarettes and Roll-ups	25 cigarettes/ 40 “roll-up” sticks

Table 3-7: Sample Characteristics of Non-Smokers

NAME	GENDER	AGE	ETHNIC BACKGROUND	OCCUPATION
Non-S. A (no longer smoking)	F	36	Polish	Mature Student
Non-S. B	M	30	Afro-Caribbean British	Retail Management/Accountancy
Non-S. C	F	50	White British	Customer Services Officer
Non-S. D (no longer smoking)	F	43	Afro-Caribbean British	Hotel Worker & Part-Time Volunteer Teacher

Table 3-8: Sample Characteristics of Retailers and Related Industry Personnel

NAME	ORGANISATION	POSITION
R-RIP A	University of Huddersfield Student Union Shop	Assistant Manager
R-RIP B (No longer smoking)	Tesco Supermarket	Customer Service Manager
R-RIP C	Wakefield Council	Regional Tobacco Policy Manager – Yorkshire & Humber
R-RIP D	South West Yorkshire Foundation Trust (SWYFT), Huddersfield	Stop-Smoking Advisor
R-RIP E	South West Yorkshire Foundation Trust (SWYFT), Huddersfield	Stop-Smoking Advisor
R-RIP F (No longer smoking)	Magpie Marketing Agency, Leeds	Co-Founder/Director

Cases in this study are not entirely representative of the smoking population within the town of Huddersfield, West Yorkshire in the UK. Participants were chosen for their ability to provide insights into personal experience(s) and interpretation of the issue under investigation, which supports exploration of a specific behaviour. The intent being to develop the theoretical contribution relevant to this and future studies in related areas of research. There is a lack of gender balance in this study's smoking participants and reflected in the gender composition of smokers - 12 female smokers and 3 male smokers. Although no prior precedence has been found in existing literature to substantiate this behaviour, this researcher found male smokers were more reluctant to speak about their smoking habits than female counterparts. *One reason for this behaviour can be found in a study by Flynn, Hollenstein, and Mackey (2010) examining the suppression of emotions between men and women, where men were found to suppress emotions more than women.* Finally, mention must be made that some participants although not recruited for their smoking status, are themselves former smokers who have quit the habit.

3.6.6 Data Collection

The interviewing process began by this researcher approaching prospective informants (smokers and non-smokers) to ascertain their interest in participating (personally known or referred by someone). Afterwards, informants were sent a follow-up e-mail detailing purpose and format of the research, as well as suggestions on possible time and venue for conducting the interview. Some smokers who were approached agreed to participate at the outset, some who agreed initially declined when informed the conversation would be recorded, (this was not the case with non-smokers). To overcome this "hurdle" the researcher reiterated that information

gathered would be treated in the strictest confidence, and not used for anything other than the production of this thesis. Next, interviews were conducted (they lasted between 30 to 40 minutes) and took place in the natural setting of respondents', i.e. their places of work learning, or homes. This strategy encouraged an equal relationship between this researcher and interviewees (Gagnon, Jacob, & McCabe, 2014) allowing interviewees to feel psychologically comfortable (King & Horrocks, 2010). Information obtained during interviewing were tape recorded for accuracy and thereafter transcribed verbatim.

Some categories of respondents were recruited in a slightly different manner, although all were sent e-mails detailing the nature of the interview, with suggestions for possible meeting dates, times and location. The participant from the Advertising Agency in Leeds was introduced to this researcher by someone from the University of Huddersfield, and he in turn referred the participant from the Government agency in Wakefield. Contact was made directly with personnel from the West Yorkshire stop-smoking clinic in Huddersfield, first via telephone call to ascertain their willingness to participate, then a follow-up e-mail suggesting possible meeting dates, times and location. On the day of the interview, an invitation was extended to this researcher to observe smokers at the stop-smoking clinic. Retailer representative at the University of Huddersfield Student Union Shop, because as a current student at that institution I interact with the manager occasionally. Being a regular shopper in Tesco Supermarket, Huddersfield, and a former employee, the Customer Services Manager was personally known to me and I was therefore able to make direct contact with her. One interesting development was identified during data collection. By the 15th interview with smokers it became apparent that the data was saturated, and no new

ideas would emerge even if more smokers were sampled. This brought into focus question raised by O'Reilly and Parker (2012) about the acceptability of data saturation in qualitative work:

Sample size should be large enough to extract sufficient data, but not too large to make information repetitious.

O'Reilly and Parker (2012)

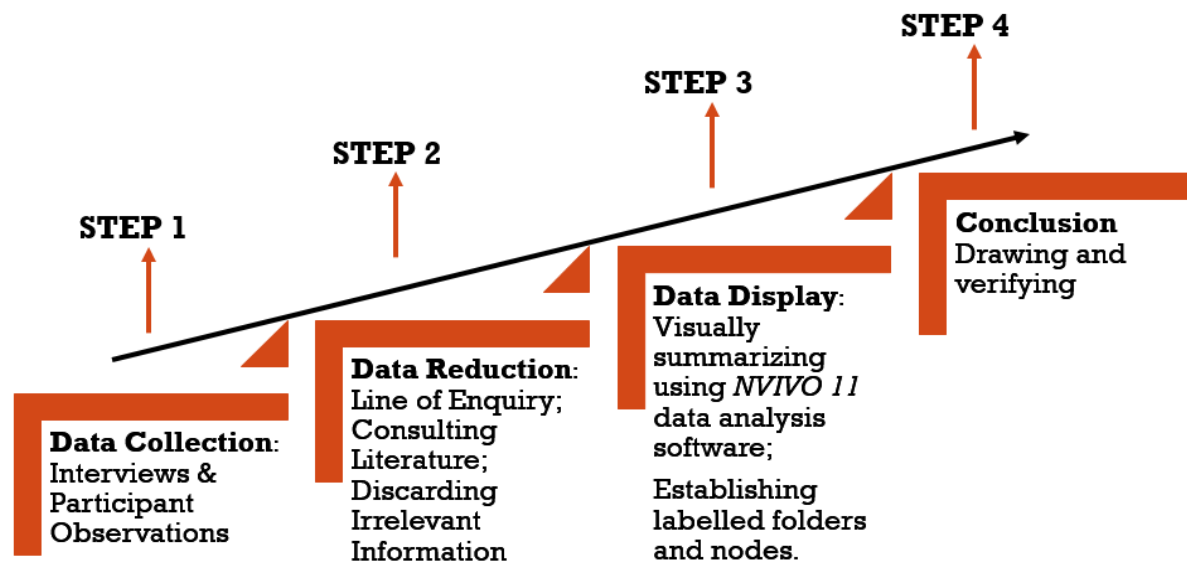
Fusch and Ness's (2015) study identifies that issues of data saturation are frequently encountered in qualitative studies. They offer the perspective that interview questions should be structured to be answered by multiple participants, because failure to reach saturation prevents content validity. From these insights it can be deduced that there is no agreed way of establishing data saturation. However, Wali and Wright (2016) suggest a suitable level of data saturation (or coding acceptance) could be 3%.

3.6.7 Analysis of Data

This study's data analysis process employs a two-step approach: (i) the transcription of data and (ii) the analysis of data. To facilitate transcription of data, fieldwork notes were made during and upon completion of individual interviews and participant observations. Field notes reflected personal feelings, expressions, body language, moods, and facial expressions, and spontaneous laughter (which could possibly be due to unease or embarrassment). The transcription process was further facilitated by developing a line of enquiry as recommended by Matthews and Ross (2010), and Mishler (1990) to record frequency and similarities of opinions expressed by participants. Preliminary codes were developed by reading and re-reading the interview transcripts. Interviews were tape recorded and afterwards transcribed verbatim.

Analysis of data considered a sequential flow of activities: (i) data collection, (ii) data reduction, (iii) data display and (iv) conclusion drawing/verification. Miles and Huberman's (1984) work explaining how to draw valid meaning from qualitative data recommend using this process. These activities are illustrated in Figure 3.4, showing how they fit in with this study.

Figure 3.4: Data Analysis Process of this Study



Source: Adapted from Miles and Huberman (1984)

Sequential analysis of data allowed for a refinement of research were asked and answers given through searching, querying, and displaying the data, a process identified in Bazeley & Jackson's book about *Qualitative Data Analysis with NVIVO* (Bazeley & Jackson, 2013).

During the analysis process the literature was frequently consulted to help corroborate understanding and interpretation of data; those deemed irrelevant were discarded or ignored. This logic links in with this research's inductive approach, enabling a connection between data, research objectives and findings to develop general conclusions from specific observations. It also ties in with the data reduction process

recommended by Collis and Hussey (2014), i.e. selecting, discarding, simplifying, summarising and reorganising.

NVIVO 11 data analysis software assisted in visually summarising themes identified, using a series of labelled nodes with links between them to show their relationship. Concepts were organised into coding hierarchies to create classification of concepts (Bazeley & Jackson, 2013), illustrated at Appendices 3.4, 3.5, 3.6. This strategy allowed the viewing of diagrams which aided the understanding of happenings, conduct of further analysis, and taking action based on insight(s) gained from the data (Miles & Huberman, 1984). By using significant topics found, recurring themes and patterns from the data valid conclusions were drawn. Based on the recommendation of Collis and Hussey (2014), conclusions were verified and tested for validity through: (a) saturation, (b) meaning-in-context, and (c) recurrent patterning. Meanings were extracted from the data to identify regularities, patterns, explanations, possible configurations, causal flows, and propositions (Miles & Huberman, 1984). Discussions about the findings were also held with some participants to gauge their reactions and opinions.

3.6.8 Research Bias

Tainting or compromising research through systemic error or a perspective, causes bias. Bias can be introduced at any stage of the research project (Sekaran & Bougie, 2010), by the interviewer, the interviewee, or the situation. The following passage taken from Quinlan's literature about qualitative research methods put this into perspective:

The researcher has all the power and the researched are, in a sense, colonised by the researcher. Researchers outline and explains the experiences and concerns of those researched, from within their own understanding of those experiences and concerns, instead of allowing those researched to themselves outline and explain their experiences and concerns.

Quinlan (2011)

Research bias in qualitative research using interviewing as a data collection method has been criticised for its perceived “power issues”. Even so, using interviews should not diminish the rigour of the research process (M. Saunders et al., 2012). Some level of bias is expected in any research, because it often involves a trade-off between the interviewer and interviewee(s) (MacKenzie & Podsakoff, 2012). Interview bias can be prevented when an interviewer fosters an air of trust and rapport with interviewees (Sekaran & Bougie, 2010).

Set out below are the steps undertaken by this researcher to avoid interview bias which could prevent critical evaluation of this research’s findings and conclusions.

Provision of Information about Conduct of the Research

Prior to the start of interviewing, interviewees were provided with a transcript explaining the purpose of research, why they were chosen to participate and gave confidentially assurance.

Paying Attention During Interviewing

During interviewing, the researcher listened attentively, asked for clarification when necessary, employed tact in posing and answering questions and recorded conversations to ensure accuracy.

Refraining from Disclosing Personal Status

This researcher deliberately refrained from disclosing her status as a non-smoker prior to and during interviewing. By so doing, interviewees were unable to say what they believed [she] wanted to hear.

Avoidance of Situational Bias

All interviews were conducted in locations chosen and agreed to by interviewees. Being relaxed in the interview environment meant their performances were not compromised, nor were they unwilling to contribute to discussions. This position prevented situational bias (Sekaran & Bougie, 2010), where interviewees might not feel comfortable discussing issues about their workplace at the workplace, for fear of reprisals from employer(s) or fellow employees.

Research is never totally free from bias, but researchers' personal philosophies, experiences, or prejudices can make potential research bias more defined. Minimising bias must therefore be a key consideration when designing and undertaking research. J. Smith and Noble (2014) discusses differing types of bias across research design point to the ethical duty of researchers to explain possible sources of bias, allowing findings to stand up under scrutiny should they shape a policy or be applied to practice.

3.6.9 Establishing the Reliability and Validity in this Study

Research findings are reliable if they have been repeated and the same results obtained; validity comes when the data collected represents a true picture of what is being studied (Hussey & Hussey, 1997). In Saunders et al.'s book *Research Methods*

for *Business Students* they identify triangulation as one way of achieving validity in qualitative research:

The use of different data collection techniques, or using different types of samples within one study in order to ensure that the data are telling you what they think they are telling you.

M. Saunders et al. (2012, p. 179)

Triangulation in this research is evidenced by the variety of participants interviewed, i.e. smokers, non-smokers, industry practitioners and retailers. It also occurs because the study includes users, non-users and industry personnel in researching the same phenomenon of why smokers, despite all the incentive and education available to them, continue to smoke.

Validity was established in three ways: (i) external – relating the sample of smokers to the general population whereby the non-smoker group and industry practitioner groups gave added credibility to the findings, (ii) exit – established by the fit between the perspectives of the different groups and their feelings about the smokers' categories and (iii) face – agreeing that the content discussed with industry practitioners confirm what was discovered.

The reliability of this research has been upheld by making and retaining notes about the research design, giving reasons for choosing this strategy, methods, and how data was obtained. Emergent themes arising from the data, for example '*non-smokers are less judgemental than persons who have quit*' were also discussed informally with friends, (both smokers and non-smokers), and my research supervisor. These strategies form a reference point for other researchers to understand the processes used and enable reanalysing of the collected data.

3.6.10 Ethical Considerations

Guillemin and Gillam's (2004) study explains how researchers deal with ethical problems that arise in the practice of their research, confirms that ethical concerns are present in any research whether it relates to clinical trials, animals, or humans. Consumer research is no different. According to Klein and Smith's (1995) study dealing with ethical issues occurring in consumer research, questionable practices such as coercion, deception and breaches of privacy often occur in consumer research.

During the conduct of this research, care was taken to avoid deviating from the researchers' code of practice, per se.

Avoidance of Deception

Avoidance of deception was achieved by making questions concise and succinct, preventing respondents giving short and incomplete answers to quickly finalise the interview. Names of interviewees were used with their explicit consent, preventing breach of privacy. For those who stipulated otherwise, their request was observed. The ethical integrity of this research is guided by principles upheld by the University of Huddersfield ethical code of conduct, i.e. obtaining ethical approval prior to conducting research. Interviewees were required to sign a consent document (see Appendix 3.7) prior to commencing in the interview, evidencing of their willingness and competence to participate and declaring they were not unduly coerced into participating.

Not Disclosing Researcher's Non-Smoker Status

This researcher's status as a non-smoker is shaped by her religion (Christianity), culture and personal upbringing in her native home of Jamaica. Both her parents are non-smokers and only one of her siblings is a smoker. In Jamaican culture, women who smoke are viewed as rebellious and vulgar (*at least that was the case during my upbringing*). Researching smokers and smoking in the UK unearthed behaviours and attitudes different to her own religious and personal beliefs and upbringing. However, care was taken not to impose my personal opinion, (tacitly or otherwise), nor appear judgemental of behaviours opposite to mine.

Ethical issues in research cannot always be dealt with by an individual researcher without having proper guidelines or framework (E. Bell & Bryman, 2007). Therefore, researchers must be prepared to adjust their behaviour(s) based on the belief of what is right when faced with a particular situation, although ethical issues could adversely impact their research.

3.6.11 Research Challenges

During this PhD "journey" several challenges were identified and experienced by this researcher. Some of these are outlined below.

The stipulated deadline for completion of this thesis by the University of Huddersfield is 3 years, meaning informed decisions and choices must be made to militate against overrunning this deadline. Keeping an updated diary, having regular meetings with my PhD supervisor, setting personal deadlines for completing stages and writing

chapters of this thesis, creating a Gantt chart and following timelines stipulated on said chart, are some of the methods used to keep on track.

Social science research is dependent on participants' willingness to speak openly and honestly about the problem being investigated, as well as gaining access to them. Mikecz's (2012) study focussing on methodological issues arising from interviewing elites and Nakata's (2015) paper discussing research perspectives on the insider–outsider continuum, sum up this particular experience of the researcher during the data collection process. To illustrate, smokers are highly visible in and around the town of Huddersfield, but it was difficult to persuade them to speak about their experiences. Some outright refused, some refused when informed that the conversation would be recorded, and others refused because they felt embarrassed to talk about their smoking habit. Some prospective interviewees were suspicious, even suggesting I was part of the “*stop-smoking brigade*” (their words). They regarded this researcher as an “outsider” and not part of the smokers' “inner circle”, nor having any social connection to them. This behaviour can be explained by examining the insider/outsider contrast.

3.6.11.1 Insider/Outsider Positioning

An insider researcher can be identified with the group being studied, having intimate knowledge of the context of the research. An outsider researcher is not personally connected to the object of study, may be an observer or participant observer in their field of research, but with less social and cultural proximity than an insider researcher. In essence, being an insider researcher might not be the same as being a member of the group being researched (Hellawell, 2006). Researchers can be insiders, outsiders,

or even both but all researchers could be classified as insiders because they are humans studying other humans (Gair, 2012). The quote below from Nakata (2015) Nakata (2015) works on the insider-outsider perspective:

Did my background make me an insider? Was I also outsider in some respects? ... Bearing the distinction between these two sets of perspectives in mind, it appeared to me that I would be conducting research from an emic perspective; that is an 'insider'. After all I was proposing to collect data in an area in which I was very familiar, located near my hometown...Although it seemed plausible that I was an 'insider' in certain aspects, I felt like I was 'outsider' in others as I did not fit either category completely.

Nakata (2015)

Nakata's (2015) viewpoint is significant, bringing into focus the perspective shared by Humphrey (2007). Humphrey's (2007) work examining self-organised groups and her status as an insider-outsider, asserts that a researcher's reflexivity hinges upon the capacity to recognise when he/she is an insider or outsider and being able to commute between both positions. Adding another perspective through his study positioning insider–outsider concept as a heuristic device to develop reflexivity in students doing qualitative research, Hellowell (2006) suggests that researchers can see things more clearly from an insider position than from an outsider position.

3.7 Chapter Conclusion

This chapter justified the methodology and methods chosen for this study, which enable it to “stand up” under criticism and scrutiny. It also proved that conclusions reached are reliable and valid, and are suggestive rather than conclusive (Crotty, 2003). According to Travers (2001):

There is no “hard and fast” rule for writing the methodology chapter of the thesis, but the main aim should be to explain the research objectives and assumptions. The easiest way to do this, however, is by making a contrast between your own position and at least one other research tradition, through reviewing a few studies of relevance to your topic.

Travers (2001, p. 25)

As research evolves, ontological, epistemological and methodological questions that fall within the favoured paradigm must be considered. These investigations, according to Flick (2011) should not be made spontaneously but instead taken on a series of levels: level 1 – look at how existing data can be used for the researcher’s own analysis; level 2 – identify whether the researcher is interested in knowledge, attitudes, or practices; level 3 – consider the necessity to develop a new data collection instrument or use an existing one? Understanding these considerations allow researchers to choose a paradigm which best suits the research project being undertaken. This allows for flexibility should new or significant development(s) arise (Cibangu, 2010), particularly as social science research can sometimes appear abstract.

One focus of methodological writing is the researcher’s experience of the encounter, i.e. how they feel, listen, see and hear. The research encounter is a co-created space with the researcher and the research activity being part of the production of knowledge and research subjects positioned between the researcher and the researched (H. Elliott, Ryan, & Hollway, 2012). As reflexivity manifests during a researcher’s everyday activities, it signifies the need to investigate ethical issues which are important for understanding data that is unspoken or not consciously evident. Care must therefore be taken to employ the appropriate data collection method(s).

Interviews are an essential source of qualitative evidence because knowledgeable interviewees can provide important insights into the area of research, and help identify other relevant sources of evidence. Yin (2014) warns that interviews which focus on actions are subject to interviewer bias, poor recall and inaccurate verbalisation. Therefore, interview data should be corroborated with information from other sources.

The success of any research is dependent upon accessibility to participants and their ability and willingness to disclose information. How successful the researcher is in both endeavours, determines the quality of data collected as well as the trustworthiness of findings presented (Mikecz, 2012). In the context of this study, insider status could have been used to avoid negotiating access establishing the researchers' power in relation to participants, rather than avoiding it (Gair, 2012).

Finally, there could still be concerns about this study's methodology, but writing the chapter has made this researcher ponder more deeply about her own assumptions. Allowing the process to be scrutinised and defending that process as a form of inquiry, demonstrates the sincerity and passion this researcher has for the area being investigated. This should result in a stronger and more developed piece of research.

Chapter 4. Analysis of Research Findings

4.1 Introduction

This chapter presents the thesis' findings and analysis, examining whether tobacco denormalisation strategies influence behaviour change in smokers during purchase and consumption, and in shared consumption spaces. Findings consider the narratives of twenty-five interview participants and information collected from participant observation conducted on three separate occasions in a stop-smoking clinic. These form key themes and related sub-themes presented in Table 4.1.

Table 4-1: Themes and Sub-Themes of this Study

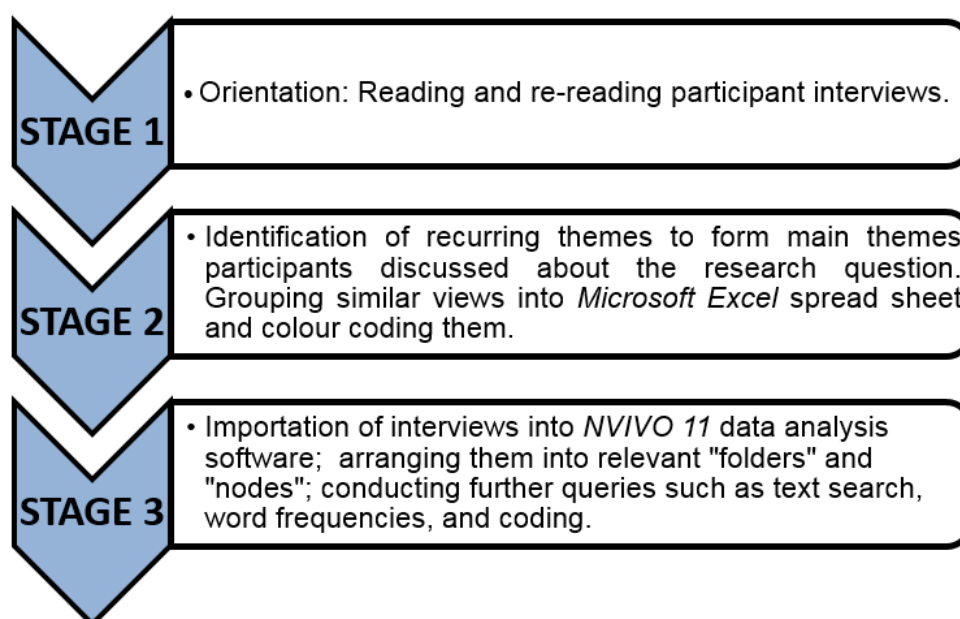
MAIN THEMES		OPINIONS SUPPORTING MAIN THEMES	SUB-THEMES
1.	<p>Social Norms</p> <p><i>Influence of normative behaviour on shaping a smoking habit.</i></p>	<ul style="list-style-type: none"> ▪ Family and friends, peer pressure. ▪ Coping with personal issues, e.g. stress. ▪ Socialising and making friends. 	<p><i>“Me, Why Do I Smoke”</i></p>
2.	<p>Dissonance Behaviour</p> <p><i>How discomfort arise in smokers due to the holding of conflicting beliefs.</i></p>	<ul style="list-style-type: none"> ▪ Issues experienced because of tobacco control strategies, e.g. smoking bans, display bans, loss of smoking space. ▪ Addiction and quitting. 	<p><i>“Can You Smoke Somewhere Else, Please?”</i></p> <p><i>“...But this is My Smoking Space!!!”</i></p> <p><i>“I Just Cannot Stop, It Is Hard to Quit”</i></p> <p><i>“I Can Quit Electronically”</i></p>
3.	<p>Consumer Behaviour</p> <p><i>Examining smokers’ behaviour in situations and social settings where tobacco control strategies exist.</i></p>	<ul style="list-style-type: none"> ▪ Impact of display ban on purchase and consumption. ▪ Brand preference and choice. ▪ Adoption and use of other products, e.g. e-cigarettes. 	<p><i>“I Cannot See What I Want”</i></p> <p><i>“I Could Try that New Product...Maybe Not”</i></p> <p><i>“It’s Too Expensive I Will Buy a Cheaper Brand”</i></p>
4.	<p>Communication Agencies</p> <p><i>Smokers’ response to marketing stimuli from the tobacco industry, and message from anti-smoking advocates.</i></p>	<ul style="list-style-type: none"> ▪ Response to marketing stimuli, e.g. advertising and event sponsorship. ▪ Anti-smoking messages, e.g. shock tactics; stop-smoking interventions, e.g. <i>Stoptober</i>. 	<p><i>“Am I Bothered?”</i></p> <p><i>“Butt Out...I Don’t Need Your Intervention”</i></p>
5.	<p>Behaviour Change</p> <p><i>Positive and negative impacts on this action.</i></p>	<ul style="list-style-type: none"> ▪ Perception of smokers and non-smokers. ▪ Mutual respect. 	<p><i>“The Yoke of Intolerance”</i></p> <p><i>“Victims of Circumstance?”</i></p> <p><i>“Defiant or Compliant?”</i></p>

Source: Adapted from Wali and Wright (2016)

4.2 Development Process of Key Themes and Sub-Themes

The development process of key themes and sub-themes of this study comprises three stages: (1) orientation – reading and transcribing participant interviews, (ii) identification of themes from frequently mentioned views, and (iii) organising themes using *NVIVO 11* data analysis software. This process is illustrated in Figure 4.1 and explained in the paragraphs following.

Figure 4-1: Development Process of Key Themes of this Study



Source: *Researcher's Own Concept of the Study's Data Analysis Process.*

Stage 1: Participant interviews were read and read, a strategy which according to Poth (2012) allows for cross-case analysis to pinpoint contextual similarities and differences in each narrative. **Stage 2:** Recurring themes were identified to form logical and clear pattern, a strategy acknowledged by Sawkill, Sparkes, and Brown (2013). **Stage 3:** Interviews were arranged in the *NVIVO 11* data analysis software to allow further queries to be conducted, a process echoing the recommendation of Bazeley and Jackson (2013). *This allowed for the production of nodes, coding*

hierarchies, and dendrograms to further supplement the themes and sub-themes identified. Examples are set out at Appendices 3.4, 3.5, and 3.6.

Two important theoretical constructs were considered in developing the research's themes and related sub-themes: Cognitive Dissonance Theory, and Michie and West's (2013) Behaviour Change Wheel concept. Cognitive Dissonance Theory provided important theoretical assumptions to help understand the data, explain conflicting human attitudes, beliefs and behaviour and how attitudes are altered to conform socially. Michie and West's (2013) Behavioural Change Wheel concept represents the perspective that behaviour change can be achieved where there is the opportunity, capability and motivation to do so. Behaviour change in smokers is critical to this study, given the current "unfriendly" climate about smoking and tobacco consumption.

4.3 Analysis of Themes and Sub-Themes

4.3.1 Theme One: Influence of Social Norms on Smoking Behaviour

The central issue of this theme is understanding the influence of social norms on smoking behaviour. To aid in this endeavour, information on all fifteen smokers are presented here including information on key aspects of their "smoking journeys". The intent is to establish a link to normative influences which determine their adoption of a smoking habit. Care has been taken to represent everyone as a characterisation of smoker i.e. light, medium and heavy (illustrated in Figure 1.5).

4.3.1.1 “Me, Why Do I Smoke?”

Smoker A

Smoker A is a 41-year-old unemployed mother of two children aged 14 and 12, living with her partner, a former smoker. The youngest of six children, Smoker A grew up in a household where smoking was prevalent – both parents smoked and all her siblings (except one) are smokers. Smoker A’s smoking “journey” began at age 15 whilst at school, not because of peer pressure or exposure to smoking at home but because:

I think when I was at school, whilst I would not say it was peer pressure; I did what everybody else was doing.

Smoker B

Smoker B is 50 years old, of Afro-Caribbean descent but born in the UK, currently working as a Check-Out Operator at a local supermarket. Smoker B started smoking at the age of 25 because “*everybody around me was doing it*”. Her father was a smoker but her mother because of Christian beliefs did not smoke. Smoker B tried quitting “cold turkey”, which she did for three years but when her brother-in-law died she started smoking again to help deal with her loss.

Smoker C

Smoker C, 57, is a White British female who works in her local Council as a Business Support Manager. She first started smoking at the tender age of 6, continued until age 11, then quit and resumed at age 15 because of being “bullied” into in by a family friend. “I started when I was 15 again whilst on holiday and I had gone with my family there and a girl who smoked. I think that was a bit of peer pressure because she was older than me, bigger than me. She was a bit of a bully.” Both Smoker C’s parents smoke but her siblings are non-smokers. Smoker C adopted smoking because of

childhood issues and even as an adult turned to smoking to help deal with getting divorced.

Smoker D

Smoker D is a 52-year-old White female who works in stock control in a supermarket in Huddersfield. She is married, lives with her partner and is a mother. At present, Smoker D is the only smoker in her family although her father and both brothers are former smokers; her partner and children are non-smokers. Smoker D started smoking at the age of 14 whilst in high school. Her friends smoked, and she joined in with them and would use her lunch money to purchase cigarettes. In those days, according to Smoker D, although under-aged she could purchase cigarettes in the corner shop without being challenged by anyone.

Smoker E

Smoker E is a 56-year-old Afro-Caribbean male who emigrated to the United Kingdom from Jamaica at the age of 16. Although Smoker E is a smoker, not many persons in his family smoke:

No, my mother doesn't smoke, my father don't smoke, brother don't smoke, I got one sister who smoke and I got two cousins who smoke.

According to Smoker E his only experience of seeing anyone smoking prior to coming to the UK was his grandfather:

It is only when I came to England I saw people smoking. Only thing I used to see people smoke when I was a child is my grandfather smoking his pipe and that's it.

Smoker E's heritage also plays a key role in his perception of smoking. In the Jamaican culture Christian principles dictate an individual's behaviour, persons who

smoke are viewed in a negative light for not conforming to these principles. Since coming to the UK, Smoker E has made friends with persons who smoke and their behaviours influenced his adopting the habit:

Because when I go out with my friends, they smoke and when I come home I “stink” of cigarette smoke (laughing). My clothes “stink” of cigarette smell, I smell of cigarette, so I just start to smoke.

Smoker F

Smoker F is a 33-year-old White British female, a Catering Assistant by profession educated to University level. Smoker F has been smoking since she was 13 years old influenced by her school friends. She also grew up in a household where both her mother and brother smoked and believes their behaviour normalised the habit in her eyes. Smoker F did quit smoking for a short while, but when she started attending university resumed smoking to help her cope:

I grew up in a household with smokers, and so when I found myself in a group of friends who had all started smoking I just went “yeah, ok” and I started smoking with them...I actually stopped for about 8 years at one point, then I came back to University and I started again.

Smoker G

Smoker G, 25, is of mixed heritage (Afro-Caribbean and White British) and has a daughter aged 8. She is currently employed as a part-time Cleaner in a supermarket whilst attending University full-time. None of Smoker F’s siblings smoke but both her parents do. Smoker G’s mother would often send her to the shops to purchase cigarette on her behalf and Smoker G would take this opportunity to buy cigarettes for herself also. Growing up, Smoker G did not have many friends and turned to smoking as a way of fitting in. Her first encounter with smoking came at the age of 13 but that

was an experience she did not enjoy. At the age of 16 Smoker G again tried smoking to help transition into puberty; by then she had friends who were smokers.

Smoker H

Smoker H is a 32-year-old White British female mother of two currently undertaking a post-graduate degree whilst in full-time employment. Smoker H was introduced to smoking at the age of 15 by friends. At that time, she smoked to fit in and even now finds that smoking enables her to make new friends:

I made friends from smoking because you would go outside and you would stand and chat to other people smoking...Yeah you are all sort of in the same boat; you are all huddled under a canopy of some description (laughing).

Smoker I

Smoker I, 54 years old, works with the local council in the Client Financial Affairs department. Her smoking “career” started at the age of 14 when she was introduced to it by friends. Both of her parents smoked but does not believe this contributed to her being a smoker because she disliked her parents smoking. Smoker I quit smoking on two separate occasions, but weight gain made her resume:

Still, I've stopped on two occasions before. On both occasions where I stopped smoking I gained a lot of weight. Nothing compensates nicotine but you look for something to compensate the habit and so it was food for me.

Smoker J

Smoker J, 18, is of White British/Irish descent who smokes both cigarettes and roll-ups. Having a troubled past (i.e. a dysfunctional family and growing up in care homes) Smoker J started smoking only a year ago (at age 17) as a way of coping with depression brought on by these life issues:

I was 17 years old then. I was having problems with my family and I got moved into care, so yeah that is why I started smoking.

Smoker K

Smoker K, 42, is a British female of Pakistani descent who started smoking at the age of 32, influenced by her sister and a few friends who are smokers. "I started smoking about seven years now when I was about 32 years old. My sister and a few friends were smoking, I tried one of their cigarettes and I thought I could do this too. I found that it took away the stress that I was experiencing at the time." Culture and religion plays a key role in Smoker K's life and as a practicing Muslim is forbidden to smoke. However, issues (i.e. an arranged marriage and subsequent divorce), in her personal life caused her to rely on smoking to relieve stress associated with those issues.

Smoker L

Smoker L is a 38-year-old White British male, father of 3 living with his partner and currently undertaking a University degree. Smoker L's smoking "career" began between the ages of 14 and 15 years old; friends at school were smokers and he would join them and hide and smoke. His mother was also a smoker and sometimes he would conveniently "borrow" a cigarette from her without her knowledge. Smoker L loves to watch sporting programmes on television, his favourites being *F1* motor racing and snooker. It was through this medium that his smoking habit was further developed. Smoker L's and his partner (who is a former smoker), would smoke in each other's company, something Smoker L says they enjoyed doing.

Smoker M

Smoker M, a tailor by profession, is 35 years old. He has been smoking since the age of 13 and did it to fit in with friends at school. There is a history of smoking in Smoker M's family where both his parents smoke; his brother also smokes. Smoker M attributes his smoking behaviour to seeing both parents and older brother smoking and also his friends:

I started smoking probably about 13, both my parents are smokers, but it really happened at school. I think it was the peer group I ended up in, if you know what I mean. I look at it as if I have been a smoker for 35 years because I have always passively smoked through my parents.

Smoker N

Smoker N is a 29-year-old White British female who works as an administrator at her local University. From middle-class upbringings, her mother was a career professional and occasionally smoked cigars, her father was semi-professional and a social smoker; Smoker N's older brother is also a smoker. At the age of 14 she found her brother's stash of cigarettes and tried smoking but did not enjoy the experience. After starting College at age 16 she took up smoking because her friends were doing it. Smoker N's smoking intensified whilst attending university, smoking at least 20 of her favourite brand of cigarettes over a two-day period.

Smoker O

Smoker O is a 22-year-old White British female who currently works as a Cleaner in a supermarket in Huddersfield. Between the ages of 15 – 16 Smoker O smoked her first cigarette, quit for a year and resumed smoking at the age of 18. Losing her mother to cancer whilst still a teenager, Smoker O resorted to smoking to deal with that loss.

Smoker O smokes “regular” cigarettes and roll-ups (“baccy” as she calls them)⁴ and has tried smoking e-cigarettes although a negative experience of the product caused her to abandon that practice. There is a history of smoking in Smoker N’s family – her brother is a former smoker, both her parents smoked, and extended family members also smoke. Smoker N has made friends with smokers and non-smokers.

4.3.1.2 Mind-set of Non-Smoking Participants

This section introduces the other participants in this study, (four non-smokers, two retailers, two stop-smoking advisors, two related industry personnel). These individuals have been included in this study to deepen the understanding of smokers. Their narratives support the inclinations given by smokers in the previous section, thus contributing to the credibility of the research findings. The categorisation of ex-smoker is represented amongst these participants.

Non-S. A

Non-S. A, aged 36, is originally from Poland but now resident in the UK. She is married, has one daughter and is currently in full-time education. Barbara is an ex-smoker and has a history of smoking in her family – her father was a heavy smoker. Growing up on a farm in rural Poland, Non-S. A states that smoking was a regular thing that men did. Females were not permitted to smoke due to the strong influence of the Catholic religion. Nevertheless, when Non-S. A attended university her inability to cope led her to start smoking. She used smoking as a way of making friends, fitting in and relaxing when she was stressed. Witnessing the adverse health effect smoking had on her friends and the personal financial drain on herself, she quit. Non-S. A has

⁴ “Baccy” is a slang term used to describe rolling tobacco or roll-ups.

no issues with those who smoke but believes it is a waste of money and a matter of personal choice:

I personally, I don't really bother. I think it is your choice if you want to smoke. If it makes you feel better. You are lying to yourself if you think smoking will help you. Smoking is a waste of money, (laughing), waste of your health, it's proved by research. If you believe smoking makes you happy, it's your money, your life, I can just encourage or ask you don't smoke, but it's your choice.

Non-S. B

Non-S. B, 30, is of Afro-Caribbean descent born in the UK, educated to University level and is in retail management/accountancy. As non-smoker, Non-S. B has never smoked and no one in his family smokes which he attributes to their Christian values and beliefs. At school, Non-S. B did not associate with persons who smoked so pressure from peers to smoke was not an issue for him. Non-S. B links smoking to alcohol abuse and believes those who engage in the habit are stupid for doing so

If I saw some drunks in the park smoking, I'd probably think it is something that's a part of their habit. Because my perception of them is alcohol abuse or drug abuse, cigarettes is contributing to that perception, so I am thinking that's a part of their ill-gotten habits. I think overall no matter what group it is, my general perception on smoking element is, you are stupid for doing that.

Non-S. C

Non-S. C, aged 50, is a White British female mother of two adult children aged 18 and 20. She works for the local council as Customer Service Advisor. She is a non-smoker. Non-S. C has never smoked and does not have friends who smoke. No one in her family smokes, but as a young girl she remembers seeing her grandfather smoking and the health problems he had as a result. Non-S. C's perspective on smoking and smokers are:

I don't have a problem with somebody that smokes, but I don't want to be around in that environment if they were smoking, especially...I do appreciate like the smoking ban that's come in so people have to go outside and smoke in pubs and restaurants. That's absolutely fantastic because I don't want to be sat somewhere and somebody smoking all the time, and I am inhaling all the fumes and everything. So I think that's absolutely fantastic.

Non-S. D

Non-S. D is a 43-year-old female of Afro-Caribbean descent. Although presently a non-smoker, Non-S. D smoked during her teenage and young adult years. There is a history of smoking in Non-S. D's family, her father used to smoke, and both her paternal grandparents were smokers. Seeing the damage caused to their health, and influenced by her mother, she gave up the habit. Non-S. D does not mind people smoking and still has friends who are smokers:

It doesn't bother me you know if people smoke, it's up to them. Everyone's like to themselves in life, some of it is through generation, family smoke so they smoke, some of them just decide to do it because it is the "in thing". Like the e-cigarette now everybody is with the e-cigarette, it's the "in thing", so it does not really bother me....

4.3.1.3 Industry Insiders' Perspectives on Smokers' Response to Established Tobacco Control and Quit Smoking Interventions

R-RIP A
Assistant Manager
University of Huddersfield's Student Union Shop

The University of Huddersfield is a public university located in the town of Huddersfield, West Yorkshire, United Kingdom. It has an enrolment of approximately 20,000 students from the UK and overseas. The main users of the student-union shop are students, lecturers and academic staff. Persons using the University's facilities (gym or meeting rooms) and those working on building projects within the University also purchase there. The Student Union shop which sells items such as

snacks, hot and cold beverages, memorabilia items, alcohol, cigarettes and tobacco products. This interview was conducted with Claire Sutcliffe, Assistant Manager of the shop and who has been in this position for approximately two and a half years.

Claire offers her perspective on smokers' behaviours when purchasing cigarette products:

Interviewer: *So, customers are not put off by the gantry?*

Claire: *No, I would say unless like I say someone walks in and doesn't realise that we sell cigarettes but no one's..... Actually, the thing that puts people off is not seeing what we have got. They might ask for a cigarette that we don't have and we say we don't have it but this is what we do have. So maybe that puts people off a little bit because they can't see what's there. Especially the international students you might find that they find it difficult to ask due to the language barrier, or they smoke a certain type which might be available in England...*

*R-RIP B
Customer Service Manager
Tesco Supermarket*

This interview was conducted with Tina Winspear, Customer Service Manager at Tesco Supermarket, Huddersfield Branch, who has been in this position for two and a half years. Tina oversees the main customer touch-points, i.e. customer service desk which deals with enquiries, complaints, returns and pick-ups. She is also in charge of the section where cigarettes, tobacco products and e-cigarettes are sold. The UK's leading grocery and general merchandise retailer (S. Butler, 2015), Tesco has over 3,500 stores located in almost every town and city in the UK (Tesco Corporate Website, n.d.). The branch in Huddersfield is located in the town centre adjacent to the main market. When asked about smokers' response to the display ban (installation of the gantry), Tina's gave this response:

Interviewer: *What is the response of customers who purchase cigarettes and tobacco products to the gantry?*

R-RIP B: *They don't seem to care. If they are going to smoke, they are going to smoke whether they can see them or not.*

R-RIP C

*Regional Tobacco Policy Manager
Wakefield Council, West Yorkshire*

This interview was conducted with R-RIP C., Regional Tobacco Policy Manager for the Yorkshire & Humber region. He leads on the policy and strategy behind reducing smoking prevalence, and also reducing tobacco consumption across the Yorkshire and Humber region. R-RIP C (and his team) interact regularly with smokers in West Yorkshire through conducting focus group interviews, administering survey questionnaires and hosting community activities. The information gathering exercises help in planning and strategising social marketing interventions such as *Breathe*, *16 Cancers*, and *Stoptober*. R-RIP C. put forward the general opinion of smokers and non-smokers about smoke-policies implemented across the Yorkshire and Humber region:

In terms of policies I can understand smokers having that dread, but I think that when we do some attitudinal surveys across Yorkshire and the Humber certainly the smoke-free policies are supported, not only by non-smokers but by smokers as well, and they have said they would not like to go back.

R-RIP D & R-RIP E

*Stop Smoking Advisors
South West Yorkshire Foundation Trust (SWYFT)*

South West Yorkshire Foundation Trust (SWYFT) is a stop-smoking service operated by the NHS in the north of England, aimed at getting smokers to quit. The Huddersfield branch of SWYFT operates out of premises at Folly Hall Mills. Weekly clinics are held across Kirklees; one takes place at the Huddersfield Royal Infirmary.

The service is free of charge and can be accessed by anyone, through referral from a GP or other medical professional, from the workplace or even self-referral. Those who access the service are in various stages of quitting, from early to advance. This interview was conducted with R-RIP D and R-RIP E, two Stop-Smoking Advisors attached to the service. Here is what they had to say about attendance at stop-smoking clinics:

Interviewer: *What is the success or failure rate of this programme? Do people go to the end, or do they relapse back into smoking because they cannot be bothered?*

R-RIP E: *I can't give you any figures exactly from the top of my head without running a report, but I think equally both (laughing).*

R-RIP D: *Yeah. If they do follow the programme properly, and they do listen to what we say and they come in to the appointment, it seems to be more of a success rate at that point. If you have come in because you have been told to come in and you are not interested, then your chances are slim.*

Interviewer: *So, in that situation half way through the programme they might just decide that it is not for them?*

R-RIP D: *Yeah.*

R-RIP E: *Like Farai said, depends on the motivation to quit. Like you can't help someone to quit who does not want to. It depends on the person who arrives on your doorstep.*

*R-RIP F
Co-Founder/Director
Magpie Marketing Agency*

Magpie Marketing Agency is located in the city of Leeds, West Yorkshire. Its main area of specialisation is public health and social marketing campaigns. The agency's managers work with private firms and individuals as well as Government agencies (e.g. Public Health England and the NHS), on campaigns such as:

- SONIC (Social Norms in the Community) (<http://social-norms.org.uk/>)

- Breathe 2025 which includes the 16 Cancers campaign (<http://breathe2025.org.uk>)
- Today is the Day (<http://www.todayistheday.co.uk>)

This interview was conducted with R-RIP F, Co-Founder/Director of the Agency and who has worked directly and extensively with smokers in social marketing campaigns. R-RIP F offers this perspective on how smokers' respond to social marketing campaigns and interventions:

Smokers don't like to be told to stop smoking, so it's got to be a much more intelligent approach than that. There has also got to be a lot more empathy when going into projects, campaigns, or interventions. A lot more understanding of differing issues why somebody might want to stop or why somebody might not want to stop. There has got to be more sensitive and approachable towards smokers.

Generally, they think nobody can get them to stop, almost all smokers say that to us "you'll never get us to stop smoking", or "you are wasting your time", or "you are wasting money", "you will never get us to stop"...I think the thing with smokers is quite a few of them feel a bit erm...some of them are like adamant or a bit embarrassed that you are talking to them about it. If you talk about smoking in general rather than smoking individually, you tend to get a lot more out of them.

The section above presented a brief overview of interview participants in this study. With regard to non-smokers and industry personnel, their profiles demonstrate their authority to contribute to this study. Equally, it painted a picture of smokers - who they are and their individual reasons for adopting a smoking habit. For example, Smoker E grew up in a household where other individuals were smokers, so for her adopting a smoking habit was normal. Smoker N started smoking when she tried cigarettes belonging to her older brother. Both Smoker E and Smoker N's reasons are supported by narratives of R-RIP C and R-RIP E:

We are not asking you not to smoke, we are relying on you to help your children and their children to not smoke. So it is for the next generation.

R-RIP C

So if your mom and dad smoke and your siblings smoke, you are far more likely to smoke yourself.

R-RIP E

We are not asking you not to smoke, we are relying on you to help your children and their children to not smoke. So it is for the next generation.

Some adopted the habit as a way of coping with stress, for example Smoker N:

I was not coping very well with the loss of one of my parents. I started smoking because I was under a lot of pressure and stress, and it was a way for me to have a break when I was not meant to have a break at College. I could only go so long without needing a cigarette and being stressed.

Smoker N's reason for smoking demonstrates the positive association she made between smoking and stress relief. However, smoking did not address the initial cause of her stress, instead she became addicted and would do anything for a smoke – even missing lessons.

4.3.2 Theme Two: Dissonance Behaviour

The central theme here is dissonance behaviour, which explores feelings experienced by smokers arising from tobacco control strategies giving rise to them holding conflicting beliefs.

4.3.2.1 “.....But this is My Smoking Space!!!”

Smoking outdoors has become taboo with smokers unable to “light up” as and when they want. Non-smokers appear territorial, even in places allocated for smokers to use they complain about being affected by second-hand smoke. Both parties believe

“it is their space”. In this instance dissonance behaviour in participants is manifested by having to defend smoking in places allocated for them to smoke, or heeding non-smokers ‘protestations’ that they also have a right to the space. Narratives below explain:

I’ve been standing somewhere where I am perfectly allowed to smoke, but somebody will come along and say “Oh, can you not smoke there please, I am stood over here and I can smell it”.

Smoker L

There is no sign outside saying you cannot smoke in a beer garden. So if I am sat on the table having a cigarette and then there is a certain lady sat on a table there and she is looking as if to say “oh”, and looking like this (making hand gesture), because the smoke’s blowing her way – “move love”.

Smoker D

In summer you get “tutted” at because you’re sat in an outside area with your coffee, where you’ve always been put, having a cig and somebody on the next table is a non-smoker. They are huffing and puffing because you are sat there smoking, and I just feel like saying “go inside”.

Smoker H

Non-S. D agrees with the demarcation of smoking space, believing smokers should keep in the space allocated for them to smoke and not mix with non-smokers:

If you smoke there you go to that area and this area is for non-smokers.

Non-S. D

Accounts given by Smoker L, Smoker D and Smoker H sum up their apparent frustration at not being able to smoke outdoors. Non-smokers’ fear of second-hand smoke and the possible dangers being the main contributory factor. Although respondents lament that “nowhere is safe” for them to smoke, they are protective of

the “space” allocated to them for smoking. So, when faced with opposition from non-smokers they ignore protestations and continue smoking.

4.3.2.2 “Can You Smoke Somewhere Else, Please?”

The indoor smoking ban has presented both challenges and opportunities for respondents when in shared consumption spaces. Challenges, in that they are no longer able to smoke indoors; opportunities, in that they can make “new friends” whilst smoking outside with other smokers. Narratives below explain:

I have to make that conscious effort to get my coat on, get my cigarettes. Certainly, like while I am here at work now, I have to make the effort to go downstairs, out of the door and go and have a cigarette...

Smoker L

I don't smoke at work. I just do not, I refuse to go outside to smoke. I am not going outside to smoke, I am not doing it in the cold. Now, you can't smoke cigarettes in your workplace ...how does that work?

Smoker B

I understand that because you start talking to other people who are also standing there and smoking, because they are doing the same thing as you.

Smoker A

Whereas now if you actually go out to the smoking area there is this sort of “community”, you know comradery feel, and you are meeting new people as well. You end up talking, I mean you don't become life-long friends, but for that evening you can make a “new friend”.

Smoker N

Narratives of the other category of interview participants suggest agreement with smokers' viewpoints:

Smokers believe that they are kind of persecuted...but I think that when we do some attitudinal surveys across Yorkshire and the Humber, certainly the smoke-free policies are supported, not only by non-smokers but by smokers as well.

R-RIP C

R-RIP E: *I might get people who will say it is getting harder and harder to smoke in places, and we are more alienated and we are seen as...what's the word?*

R-RIP D: *Anti-social.*

What is evident from Smoker M and Smoker B's narratives is their anger at being "asked" to smoke somewhere else. However, their need to smoke is greater than the anger at being deprived of their right to smoke wherever they like. *This could be because although smokers retain control over their actions they cannot easily stop having frequent desires to smoke (Baumeister, 2017).* On the other hand, Smoker A and Smoker N see it as a way of "making friends", demonstrating that their need to smoke make them engage in actions they would not normally do, i.e. befriending strangers. Non-S. D's viewpoint sums up these positions:

I think it's right. If they want to go outside in the bad weather and smoke, go outside and stand in the rain and smoke (laughter in her voice). You know if they are so desperate they have these cravings, and if they want to smoke...

Non-S. D

4.3.2.3 "I Just Cannot Stop, It Is Hard to Quit"

Some participants confess experiencing conflicting emotions when trying to quit because of their addiction, love of quitting, or dependence on it to help them deal with stress. The following narratives explain.

I tried to give it up, I did give it up for 3 years, but when my brother-in-law passed away I started smoking again. I just enjoy smoking.

Smoker B

I did quit “cold turkey”, but got some patches from my doctor but I did not use them. I could not say whether they are effective or not because I did not actually use them.

Smoker A

I just decided that I had enough and I wanted to quit. I did it with Champix tablets. Yes, and it worked, but then when my brother got ill I don't know why, but I just had cig and then that was it. I have never been in that place where I would like to quit again.

Smoker D

No. I quit “cold turkey”, erm...it was my fault for starting to smoke so it should be my responsibility to stop, and so I did not seek any help.

Smoker N

R-RIP E puts her perspective on these behaviours:

It's difficult to just go up to a smoking shelter and just ask people if they want to quit smoking, it doesn't work like that... I just would not want anyone coming into a smoking shelter and telling me what to do.

R-RIP D

R-RIP D's narrative adds to the understanding of the difficulty in trying to get smokers to change their behaviours through quitting. Smokers attending stop-smoking clinics to access help to quit, sometimes walk out of sessions to have a cigarette. They seem calmer and relaxed when they return although smelling of smoke, their obvious addiction causes them to behave in this way. Narratives also demonstrate the conflict between wanting to quit and actually quitting, suggesting that they are unsure of the action they want to take – dissonance behaviour. To illustrate, Smoker B quit for three years but resumed, Smoker D quit with help from the NHS but resumed, Smoker A and Smoker N quit “cold turkey” refusing professional but resumed after a while. Others, for example Smoker I (a light smoker), realise that the system affords her ways

of changing her behaviour and is willing to access it in her quit attempt, but continues to smoke:

Interviewer: *Should you decide to quit would you consider getting help from the NHS or your doctor?*

Smoker I: *Yeah, I would, I would.*

4.3.2.4 “I Can Quit Electronically”

Narratives of respondents suggest they would prefer using e-cigarettes to help them in their quit attempts. They see e-cigarettes as a way to gradually weaning off nicotine without the hassle or rigour of a tailored quitting programme:

Yes I am. I am using that (pointing to her e-cigarette). Like I said I used to smoke 20 per day, now 20 can last me all week so it does stop me.

Smoker B

I smoke e-cigarette to try and cut out cigarettes. I do like the vaping.

Smoker A

I am quite happy to smoke the e-cigarette for the rest of my life...because you are not receiving the tar and lots of the poisons that you would in a normal cigarette.

Smoker C

I smoke e-cigarette to try and cut out cigarettes. I do like the vaping.....but I do not want to stop smoking only to become addicted to vaping.

Smoker A

This is a position also identified by the Stop Smoking Advisors:

It is becoming a common thing now where a lot of people... they either used it or they are still using it...they probably just want to quit but continue if needs be to use the e-cigarette.

R-RIP D

Even so, narratives of respondents' allude to the potential of becoming addicted to using e-cigarettes, defeating the purpose for which it is intended – this is where the conflict lies. Respondents continue with its use even declaring a preference for it over regular cigarettes.

4.3.3 Theme Three: Consumer Behaviour

The central theme in this section is consumption. Narratives help understand how smokers behave during purchase and consumption. Discussions consider the display ban and ways employed by smokers to circumvent this “barrier to purchase.”

4.3.3.1 “I Cannot See What I Want!!!”

Respondents narratives demonstrate that the display ban interferes with their ability to choose preferred brand(s) or see the price because products are hidden behind a cupboard. Participants recount their experiences:

It has interfered with my purchasing the product because I am unable to see the product I want, an alternative product, and price of the product. Now, I have to ask the assistant for what I want and sometimes they do not know the product – I have had to point to what I want on several occasions.

Smoker A

...It has impacted on me is I cannot see what I am buying anymore. But you know what you want to buy, I know when I go into that shop that I want 50 grams of Golden Virginia Tobacco. Also, you can't see the prices, that is the other thing, if the price has gone up or down you can't see that and suddenly you think “oh, I have only brought so much.”

Smoker E

Even though I cannot actually see the product I want, I still buy because I know what I want so I just ask for it.

Smoker K

Erm...It doesn't really make a difference to me...The only downfall to that is that I cannot see if they have got my cigarettes or not.

Smoker G

These accounts make obvious the problems experienced by respondents during purchase arising from the display ban. Even so, they all agree their inability to see the product does not prevent them buying. Instead, respondents continue to purchase and when necessary “assist” those serving them with product selection. Smoking respondents’ accounts are also supported by both retailers:

Actually, the thing that puts people off is not seeing what we have got...That puts people off a little bit because they can't see what's there. Yes, if they are regulars they will sort of point to the side where the product is.

R-RIP A

Interviewer: *Do you find that sometimes although staff might not know the brand, customers know their brand?*

R-RIP B: *Yes. They go “not that cupboard, it's that one” (laughing).*

5.4.3.2 “Maybe I Could Try that New Product...Or Maybe Not”

Some participants smoke both cigarette and e-cigarettes, others use e-cigarette as an aid to quit or as an alternative to regular cigarettes. Despite e-cigarette’s increasing popularity amongst smokers, issues arise about its makeup and content leaving some to be sceptical about using it. Smokers’ narratives explain:

I have tried them. I did buy one and used it for about four or five days, but it wasn't the same as smoking a cigarette. I didn't enjoy it, it made my chest hurt, and I felt as if my heart was beating faster when I was smoking it. I don't feel like that when I am smoking.

Smoker G

They remind me of a pen, and they also have different flavours. I have tried one and it was all right, but it gave me a sore throat and I was coughing. I do not think I would smoke it again.

Smoker K

I think they are crap. The stuff that you are putting in with those e-cigarettes surely they are just as bad because you don't know what's in them. At least you know with the cigarettes you are putting something bad into your body because it has been tested.

Smoker D

These narratives suggest respondents' willingness to use alternative products, i.e. e-cigarettes to satisfy their nicotine craving. Even so, doubt around content and safety cause some smokers to refrain from using them, a sentiment prevalent throughout most participant's narratives. When asked about this position, both retailers could neither support nor refute participants' actions relating to e-cigarette purchase. E-cigarettes are not sold in the University of Huddersfield's student union shop. Tesco sells the product but not in sufficient enough quantities for a trend to be identified.

We don't sell a great deal of e-cigarettes.

R-RIP B

No, we did trial them actually before e-cigarettes became quite popular, we did trial some, but they did not sell very well so we don't do them anymore.

R-RIP A

4.3.3.2 "If it's Too Expensive I Will Buy a Cheaper Brand"

Respondents believe they are being "punished" for their smoking habit by the constant price and tax increases on cigarettes. Still, they continue to purchase and will either switch to a lower-priced brand(s) or purchase from cheaper sources if they are not financially able to purchase their regular brand of choice.

I have always got my cigarettes through people that have been abroad, so they have always been half the price.

Smoker C

I love to smoke American Spirit, but at the moment I am going on to the cheap stuff, Sterling.

Smoker L

I used to smoke Mayfair, but now I smoke these ones, (Players), because they are cheaper.

Smoker E

...JPS...It's one of the nicest tasting brands and it is one of the cheapest.

Smoker O

Respondents' narratives demonstrate that they are price-conscious. Some participants, for example Smoker C, purchase from persons who travel abroad which makes those cigarettes cheaper. Others, for example Smoker M and Smoker E avoid paying a high price by switching to a cheaper brand. Smoker O, although desiring a nice tasting product, will purchase a cheaper priced product due to her financial position. This is a position supported by retailers:

You've got Benson & Hedges, and Marlboro, which obviously Marlboro's more expensive, that's kind of a higher brand. Your Benson & Hedges is cheaper and we do the dual, the 'click' ones and that has become really, really popular at the moment.

R-RIP A

Interviewer: *All there any particular brand(s) which are very popular?*

Tina: *The cheap ones.*

Interviewer: *Can you expand, please?*

Tina: *Sterling, Richmond, Chesterfield, and Winsor – they are your cheapest ones.*

Interview narratives suggest smoking participants are price conscious about what they spend on cigarette purchases. When faced with prices which could make purchase prohibitive, they either switch to lower priced brands or purchase from cheaper alternative sources.

4.3.4 Theme Four: Communication Agencies

This theme looks at the impact on smokers of advertising and marketing stimuli from the Tobacco Industry, and stop-smoking messages from anti-smoking advocates. Narratives presented evidence how participants react to anti-smoking communication strategies, whether in a positive or negative way.

4.3.4.1 “Am I Bothered?”

A common theme running throughout this study is exposure to advertising, marketing stimuli and stop-smoking messages. Although most participants cannot recall messages on media channels advocating for individuals to smoke, all confirm seeing stop-smoking messages in print and electronic media and on cigarette packets. Their narratives indicate feelings and behaviours evoked by these messages:

The pictures on the back, I think it's rubbish as well. There is this one picture that I don't like, that is the man with the growth under his neck. So, if anybody gives me that packet I ask them to change that.

Smoker D

Interviewer: *Was that your personal effort in trying to quit or were you just acting on the information that was out there from the Government and anti-smoking campaigners asking you to quit?*

Smoker L: *Yeah, I think.....at one point in my life, I saw obviously a big thing on television trying to get people to stop... So I have tried to stop but at the same time I do believe that if you are going to stop smoking you have to do it for yourself and not for anybody else.*

I have seen adverts saying don't smoke. It's good, good. It tells you that smoking rotten out your teeth, it tells you it give you throat cancer, it give you liver cancer, it give you lung cancer, and so on (laughing).

Smoker E

They are right. I do feel bad when I see them, and it makes me think that I am smoking something which is bad for my health...

Smoker K

R-RIP G's narrative supports those given by participants and subtly suggest reasons they are ignored:

I think more psychological techniques are needed to work with smokers, particularly in marketing campaigns. Basically, no campaign can get a smoker to stop; no piece of design can get a smoker to stop.

R-RIP G

The suggestion from participants' narratives is that they pay scant to stop-smoking messages, but also that they are in denial of the health risks of smoking. For example, Smoker D's refusal of packets bearing images she dislikes and choosing another, and Smoker L's statement that he will quit when he will quit for himself and no one else, attests to this. Their behaviours, (Smoker L and Smoker D), indicate these messages cause no change in their behaviours. Interestingly, Smoker K and Smoker E believe messages make them actually think about their smoking habit, because they inform about the harm smoking causes. Notwithstanding, Smoker K and Smoker E continue to smoke with no change in their behaviours.

4.3.4.2 "Butt Out...I Don't Need Your Intervention"

Participants acknowledge awareness of smoking interventions such as "Stoptober". Some confess using this strategy as a way of quitting but failing. Others view it with scepticism believing it is nothing more than a gimmick. Narratives below explain:

I tried it for four days and I failed miserably because I tried to do it on my own and go "cold turkey." That did not work for me.

Smoker A

Yeah. I think "oh, I might do that", but then I go for a cigarette (laughs). I don't know, I am in a routine with my smoking. I don't know actually if whether it is that thought that I will do it in my own time kind of thing.

Smoker M

There is no point in stopping for one month. You see “Stoptober”, it’s a gimmick. I don’t care what day it is or what month it is, if I want a cigarette I am having a cigarette. To me again that’s just like another kind of pressure, it’s putting pressure on people to stop.

Smoker F

I think they are rubbish. To me you have no backing. If you went to the NHS, you went every week and you taught this and that and the other. You have the backing. If you do this “stop” for a month, then you light up a cigarette on the 1st November.

Smoker D

Stop Smoking Advisors R-RIP D and R-RIP E agree with narratives of participants. They report no significant increase in attendance at stop-smoking clinics during the period of “Stoptober”, but believe support from the media and additional funding would help publicise it. Equally, participants’ narratives also suggest their rejection of this intervention. For example, Smoker D’s inability to freely choose to participate is a deterrent, and views “Stoptober” with scepticism whilst questioning the effectiveness of quitting for just one month. Smoker A and Smoker M opinions of the strategy differs from Smoker D and Smoker E. Smoker A is apparently not averse to participating in *Stoptober*, and has actually tried quitting via that medium but failed. Smoker M has considered trying that strategy but is yet to participate. These behaviours suggest most smoking participants will quit when they are willing and ready and not before. Smoker B’s narrative sums up this position:

...and non-smoking day. They can do whatever they want to do, it doesn’t affect you because your mind is not thinking like that and you just want a cigarette. I will stop when I am really, really, ready I will stop.

Smoker B

4.3.5 Theme Five: Behaviour Change

This theme examines the issue of behaviour change looking at positive and negative actions which impact smokers’ experience, eventually leading to behaviour change.

4.3.5.1 “The Yoke of Intolerance”

Participants bemoaned the intolerant treatment meted out to them by non-smokers.

This action made them feel like outcasts especially in instances where they have been

banned from family homes, or accused of being smelly amongst other things.

I don't go to my sisters and brothers because I can't smoke in their houses or around it. They don't like the cigarette smell whatsoever, so I have to go way out to smoke, and when I come inside the house they complain that they can still smell the cigarette on me.

Smoker B

My sister, she don't smoke but she started smoking socially. One time we were outside, and her boyfriend locked us outside the house because he was like you are going to smell and the house is going to stink, and we don't want you in here.

Smoker G

Once I hugged my niece just after I had finished smoking, she smelt the cigarette smoke on my clothing and asked whether I had been smoking. She scolded me for smoking, and has never allowed me to hug her again (laughing).

Smoker K

Very, very negative reactions. The e-cigarettes that I smoke are menthol flavour, and does not give off any smell. Even though it does not smell they still do the old you know, wafting, “stay away from me you're a smoker” kind of thing.

Smoker I

Equally, sentiments expressed by non-smoking participants suggest although not always judgmental of smokers, they do not wish to become unwilling participants in the act of smoking:

It doesn't bother me you know if people smoke, it's up to them. Everyone's like to themselves in life, some of it is through generation, family smoke so they smoke, some of them just decide to do it because it is the “in thing”.

Non-S. D

I don't like anybody that's smoking. I just don't want to inhale their fumes; I really don't like it. I think that's from a health point of view as well.

Non-S. C

Smoking participants' narratives demonstrate how they have changed their behaviours due to the negative treatment they receive because of their smoking habit. Smoker B and Smoker G now smoke outside when visiting homes of other family members, Smoker K is careful not to smoke before interacting with her niece, whilst Smoker I who smokes e-cigarettes refrains from smoking around others whenever possible. Non-S. C and Non-S. D's positions are interesting. Non-S. C has no experience of smoking nor does she have friends who are smokers, so her intolerant behaviour could possibly be excused. Non-S. D is an ex-smoker and has family members and friends who are smokers, so her position adds to the belief that smokers can sometimes be "victims of circumstance".

4.3.5.2 "Victims of Circumstance"

My relationship towards my friends who smoke is a lot better because we have more in common and we have a lot to talk about.

Smoker O

The people who have quit are the worst. They are the worst people to talk to about "oh you are going for a "cig", oh it's disgusting".

Smoker D

My partner she used to smoke 40 a day at one point and she just stopped. If I am in the house on my own I might light up a cigarette in the kitchen, but then she will come home 3, 4, 5 hours later and she will still smell it and I still get told off.

Smoker L

To be honest with you, I find a lot of people who smoke "roll-ups" they are the people who are addicted to smoking.

Smoker E

Smoker O presents as socially competent although preferring to confide and communicate with friends who are smokers. Smoker E presents as self-doubting by distinguishing himself from individuals who smoke “roll-ups”. Smoker L and Smoker D’s experience of reproach and rebuke from former smokers leave them feeling insecure. Therefore, the suggestion is that they see themselves as “victims of circumstance.” However, the narratives of non-smoking participants suggest they do not agree smokers are victims of circumstance. Their belief is that no one forced smokers to smoke, but have made a conscious decision to do so. Non-S. B’s narrative explains:

I think a lot of smokers probably have parents that smoke, (I would assume), or they come from an environment where there is a lot of smoking going on. The thing I never understood about smoking is you never like it at first, do you? You have to push through that barrier for it then to become a habit.

Non-S. B

To smoking participants, smoking is a normal behaviour which enables a “bond” with other smokers, and acts as a coping mechanism to survive intolerance and rejection by non-smokers. It is this intolerance and rejection [even from former smokers] that make respondents change their behaviours by adjusting their social skills. Some blame other smokers for the situation they are in, whilst others distance themselves from other smokers.

4.3.5.3 “Defiant or Compliant?”

Smoking participants confirm that the current anti-smoking climate poses challenges for them. They can no longer “light up” anywhere and are treated with some degree of disdain even from ex-smokers, behaviours which encourage tensions and conflicts

between themselves and non-smokers. However, they have found ways of circumventing these issues. Narratives below explain:

A lot of people will go to the “Off Licence” and buy their booze and come home and sit down and drink and smoke. A lot of them do that.

Smoker E

I do not think it matters to a lot of people. If your mate smokes, they smoke. If you didn't like smoking, you just have non-smoking friends. I think people make it out to be a lot worse than it is.

Smoker H

It used to be normal for people to smoke; now it is normal for people not to smoke. I say the biggest impact on that where they ban smoking indoors, is that I have just stopped going to places like that.

Smoker F

For me I think most smokers do not care, and that goes for me too – I do not care.

Smoker A

There is agreement amongst smokers that tensions and issues occur between themselves and smokers; their narratives support this. Still, narratives of non-smokers suggest a “softening” of attitudes towards smokers and a willingness to identify a way of resolving tensions and issues:

It is a difficult one really. So much negativity against smoking and smokers. Maybe if you have a different approach to me and try appreciating me, understand me that would actually push me to quit smoking faster than you actually being so negative towards me smoking.

Non-S. A

I think because they have had that split now, it's part of normality now, people are used to that. So, people have become so used to that now they are not going to accept it. So, I don't think people will come together now. I don't think there will ever come a law where you could smoke in the same environment.

Non-S. D

Smokers' narratives highlight how they have adjusted their behaviours to deal with established tobacco control strategies, and ultimately resolve any issue(s) with non-smokers. Smoker E purchase cigarettes from the *Off Licence* and smokes them in the comfort of his home. Smoker F no longer goes out to pubs and clubs because she can no longer smoke inside them. Smoker H socialises more with non-smoking friends who do not have issues with her smoking. Smoker A is defiant, her position suggesting a "don't care attitude" towards issues which arise. Smoker L has accepted that issues will arise and deals with these in his own way:

Mutual respect. I do not get aggressive when someone says they do not like the smell of the cigarette. As long as they are polite with me, I am fine.

Smoker L

Smoking participants display defiance in continuing to smoke, but compliance in compromising to change their behaviours. Non-smoking participants believe current anti-smoking climate makes it difficult to accept smoking and smokers, although there is a willingness on their part to resolve tensions. For example, Jones & Brewer's (2011) study examining smokers and non-smokers in the workplace, identify tensions which arise between smokers and non-smokers where smokers' are allowed to take "cigarette breaks" which are seen by non-smokers as unnecessary and non-productive (P. D. Jones & Brewer, 2011). This study found that non-smokers varied their attitudes toward exposure to cigarette smoke from smokers. Some non-smokers appeared unconcerned, able to work with smoke billowing around them. Others tolerated small amounts of smoke, but not so tolerant to exposure to larger quantities.

4.4 Discussion of Findings: Themes and Sub-Themes

In the previous section, participant narratives were presented relating to the five key themes and sub-themes of this study. This section discusses the findings of these five themes and related sub-themes, which were identified using an inductive approach allowing for further amplification and confirmation of the analysis. As recommended by Thomas (2006), adopting an inductive approach in qualitative research helps to: (a) condense and summarise raw textual data; (b) establish links between the research objectives and the summary findings obtained from the raw data; and (c) structure the underlying experiences or processes evident in the raw data. In summary, the inductive approach allows the use of a systematic set of procedures for analysing qualitative data which can produce valid and reliable findings (Thomas, 2006).

4.4.1 Finding One: Social Norms

4.4.1.1 “Me, Why Do I Smoke?”

Findings

I didn't have any friends when I was young and I did not really socialise that much and I was a bit lonely, and I just thought I want to try it, and I did try it.

Smoker G

I look at it as if I have been a smoker for 35 years because I have always passively smoked through my parents.

Smoker M

I was having problems with my family and I got moved into care, so yeah that is why I started smoking.

Smoker J

These narratives open discussions about the normative influences which led respondents to adopt and continue to smoke, citing two most common reasons for this behaviour: (i) adoption of a smoking behaviour is a complex process involving several factors, and (ii) smoking behaviour is a combination of events and circumstances.

These reasons mirror findings in a study by Maggi et al. (2014) examining parental influence on adoption of a smoking behaviour. In the context of this study, smokers for example Smoker B, Smoker J, and Smoker K, started smoking to cope with stress. Smoker E started smoking because of the influence of friends, while Smoker C was “pressured” into smoking by someone she knew. Regardless of their reason(s), to each person smoking represented an escape from the stresses of everyday life, a way of socialising with friends or just fitting in with others.

Most smoking participants started smoking between the ages 13 – 15 years, mirroring the actions of adults and older siblings. For example, Smoker K was introduced to smoking by her elder sister who is also a smoker. Smoker C, who started smoking at the age of six thought smoking was normal because she saw both her parents doing it. Smoker F also grew up in a household where smoking was prevalent – her mother and brother smoked. Both Smoker L and Smoker N recounted “helping themselves” to cigarettes belonging to their mother and brother.

In contrast Smoker E, Smoker B, and Smoker K began smoking during adulthood; Smoker D was aged 27, Smoker B was aged 25, and Smoker K was aged 32. For Smoker B and Smoker K, adopting smoking was a way of relieving stress and feeling relaxed while dealing with personal issues. Interestingly, Smoker E and Smoker K’s late adoption of smoking is due to cultural and religious reasons. Smoker E’s formative years were spent in Jamaica, and strong Christian beliefs and principles meant smoking was not always a socially acceptable habit in that culture. Smoker K, as a practicing Muslim is not allowed to smoke. Her behaviour contradicts her religious

beliefs, so she smokes out of sight for fear of being discovered, even hiding her smoking habit from family members.

The ability to act older or appear rebellious is another factor which influenced participants to take up the habit. Smoker D could purchase cigarettes in the shops without being challenged about her age because she appeared older than she was at the time⁵. Smoker G would buy cigarettes for herself, pretending it was for her mother or some other adult person, to avoid being challenged. These actions show the deviant nature of both Smoker D and Smoker G in their ability to circumvent established purchasing laws, which added to the “attractiveness” of adopting a smoking habit.

Discussion

Majority of smoking participants’ state that modelling actions of parents and/or siblings who smoke is a common reason for them adopting a smoking behaviour. They believe that smoking offers the opportunity to be like their parents or siblings by imitating their smoking actions. These reasons support Bandura’s Social Learning Theory (Bandura, 1977), which posit that learning is a cognitive process allowing individuals to acquire knowledge from each other through observation or direct instruction (Akers et al., 1979; Bandura, 1977; Brauer & Tittle, 2012; J. Phua, 2011). Some smoking participants even experimented with smoking, encouraged by “finding” or “borrowing” cigarettes belonging to parents and/or siblings. These findings are consistent with arguments presented on parent-child relationship (Maggi et al., 2014) and family interaction (Bricker et al., 2006).

⁵ Prior to 1994 the legal age for purchasing cigarettes and tobacco products in the UK was 16 years; the current legal age now stands at 18 years.

What is clear from this analysis process is that the smoking behaviour of parents and siblings are strong motivators for smoking participants to take up the habit, whether during adolescence or in adulthood. Imitating actions of parents and/or siblings is not the only reason some participants adopted a smoking behaviour. Some started smoking to deal with and relieve stress. This reason corroborates findings of Choi, Ota, and Watanuki (2015), and Kassel, Stroud, and Paronis (2003) that cigarette smoking can alleviate negative moods such as stress, anger, anxiety or sadness. Although the positive relationship between smoking and stress relief has not been entirely proven (Parrott, 1998; Vollrath, 1998), this study found that when under stress smoking participants use smoking to limit negative emotions. They report smoking often get them through studies, a painful divorce, even death in the family. Smoking also represents an outlet for personal frustrations, providing the freedom to effectively cope with daily stressors. Findings suggest that smoking respondents' behaviours mirror the transactional nature of the coping process, which is sometimes situation specific but based on personal predisposition. This finding is consistent with that of Lazarus and Folkman's (1987) 10 year programmatic empirical research study examining the fundamental premises of cognitive-relational theory of emotion and coping.

Another finding identified is that smoking offers a route to making friends, having a direct impact on the adoption of smoking behaviour. This is consistent with the viewpoints of academics that smoking and friendship groups can increase smoking prevalence (for example: Huang, Soto, Fujimoto, & Valente, 2013; Kobus, 2003; Schaefer, Adams, & Haas, 2013). Smoking participants also recounted how during adolescence they chose their friends because they were smokers, particularly those

who could provide direct access to cigarettes. These behaviours support findings of Simons-Morton and Farhat (2010), that in situations where older smokers afford opportunity, support, and access, adolescents are more likely to form friendship groups with these persons.

This study found that forming friendship networks with smokers is not only common during adolescence. Smoking participants report that the indoor smoking ban caused them to “make friends” with other smokers whilst standing outside smoking or huddling under a smoking shelter. The common bond of smoking allows smoking respondents to start conversations and meet and talk with others outside their friendship groups. These actions are described by M. Wakefield, Cameron, and Murphy (2009) as a “signifier of universal friendship”. Why? All smokers (including those participating in this study), endured a shared crisis i.e. the inability to smoke indoors and socialising with already established friendship groups. Origins of this behaviour lies in and supports what Homish and Leonard (2005) call assortative mating, where individuals chose relationships with persons who share similar personality traits, characteristics and behaviours. This finding also supports Heikkinen, Patja, and Jallinoja’s (2010) reasoning that smoking is a behaviour which comprises of physiological, psychological and social elements.

4.4.2 Finding Two: Dissonance Behaviour

4.4.2.1 “Can You Smoke Somewhere Else, Please?”

Findings

Interview narratives of smoking participants identify differing views and opinions of the indoor smoking ban, most oppose and reject it although some support it. Opposition

to and rejection of the ban stems from smokers' inability to socialise with members of their social group i.e. have a meal or drink with friends to unwind, catch-up, or just have fun. Having to go outside for a smoke makes it difficult to have uninterrupted conversations. Another point of contention is the non-provision of smoking areas inside shared consumption spaces. This possible "oversight" forces smokers to smoke outside in the cold and wet weather during winter months, giving the impression that although owners of pubs and clubs want their custom conveniently fail to provide for their comfort.

On the other hand, some smoking respondents support the indoor smoking ban. For example Smoker B and Smoker L. Smoker B believes her clothing is not damaged by cigarette burns or smoke and she no longer "smell like ashtrays" after a night out with friends. Smoker L's support is based on his desire to respect non-smokers who do not want to be harmed by second-hand smoke. By going outside to smoke Smoker L believes he is preventing non-smokers from harm, a behaviour contradicting the perception that smokers cause harm to non-smokers by their smoking. A most interesting finding in support of the indoor ban is smoking respondents' ability to make friends or bond with other smokers. Through the common thread of smoking, they are emboldened to initiate conversations with other smokers, becoming part of the "outside smoking community."

Findings presented here add to the thinking that irrespective of whether smokers support or oppose indoor smoking ban, their need to smoke far outweighs any penalty for engaging in the habit. For example, having to smoke outside in the cold, missing out on conversations with friends, or appearing daft for doing so.

Discussion

For participants who smoke, smoking represents a way to socialise with and be part of friendship groups. This finding supports the position of S Chapman and Freeman (2008) in their study examining the markers of denormalisation of smoking and the tobacco industry. Here they found that the practice of smoking is often conducted in both public and social settings. It also adds to the thinking of Paul et al. (2010) that social and environmental factors dictate smoking behaviours especially in a socio-economic context.

Although restrictions on smoking in public indoor areas are now the norm (Borland et al., 2006), the indoor smoking ban prevents smoking in shared consumption spaces. Smokers oppose this ban, believing it contributes to the overall strategy of denormalising smoking and adding to negativity around the behaviour (S Chapman & Freeman, 2008). Smoking participants see themselves as being stigmatised, which according to Farrimond and Joffe (2006) is a mark of social disgrace particularly in situations of social interaction. Here Nagelhout et al.'s (2012) view of stigmatisation is exercised, whereby smokers who are stereotyped and separated from social grouping suffer loss of status as a result.

Support of smoking participants for the indoor smoking ban has been identified in this study. Miller, Wakefield, Kriven, and Hyland (2002) also identified smokers' support for the indoor smoking ban in their evaluative study of smoke-free dining areas in Australia. However, smokers' "support" is an inconsistent behaviour because the indoor smoking ban only deter smoking participants from smoking due to fear of social reprisals or sanctions. Grey's (2010) Theory of Deterrence supports this finding reasoning that through the process of cooperation, an individual can be persuaded to

abstain from doing something they would otherwise do, for example smoking. Interestingly, smoking participants do not view this behaviour in a negative light, but instead see “cooperation” as a willingness to ensure their survival.

4.4.2.2 “.....But This is My Smoking Space!!!”

Findings

Narratives of smoking participants emphasise the fact that their right to smoke has become non-existent. Nowhere is safe for smoking anymore as every public space is claimed as no-smoking zones. It has become almost impossible to smoke outdoors in public view [even in designated places] without the fear or admonition or reprisals from non-smokers. This is the view expressed by almost all smoking participants.

To smoking participants having a “space” to smoke represents a small victory over wide scale efforts to demoralise smoking. For example, narratives of Smoker D and Smoker G shows how defensive they are should non-smokers encroach on their smoking space, particularly if the space is clearly demarcated for smoking. Their behaviours demonstrate the common viewpoint of smoking participants that current anti-smoking restrictions afford non-smokers more rights than smokers.

Discussion

According to K. Bell, McCullough, et al. (2010) tobacco denormalisation strategies exert social pressure to limit the desirability, acceptability and accessibility of smoking. Socialising with other smokers is significant to the development of the social identities of smokers. Limiting accessibility to smoking spaces is one way smoking respondents feel they are prevented from developing their social identities. Why? They are made

to feel as if they have no right to occupy or inhabit these spaces. This action constitutes what Keane (2016) terms as social stigmatisation. It is important to note that stigmatisation negatively impacts the development of identities by vulnerable and marginalised individuals (K. Bell, Salmon, Bowers, Bell, & McCullough, 2010), for example smokers.

4.4.2.3 *“I Just Cannot Stop, I Enjoy Smoking Too Much”*

Findings

Smoking participants' apparent love and enjoyment of smoking is manifested through their unwillingness to quit. Smoker B proclaims her love and enjoyment by stating *“I just enjoy smoking”*. Smoker D's statement *“I have never been in that place where I would like to quit again”*, also demonstrates this. These are viewpoints common throughout the narratives of smokers. During the interview with smokers, it was made apparent that love and enjoyment of smoking resulted in failed quit attempts (whether through help from the NHS, other medical facilities, or “cold turkey”). When this happens, smoking is the “crutch” which provides psychological and emotional support to deal with the “Achilles Heel” (Haaga, 1990), which makes smoking participants vulnerable to smoking lapse.

Discussion

The ability of smoking participants to change their behaviours through quitting, is impeded by their love and enjoyment of smoking. Although not glaringly obvious, this presents a significant challenge to smoking participants' belief that they can succeed in quitting. The notion of self-efficacy put forward by Haaga (1990) and Thompson et al. (2009b) comes to mind. Both studies use the term self-efficacy when discussing

addiction, a determinant factor as to whether individuals start or continue with coping efforts (Haaga, 1990).

Compounding smoking participants' ability to quit is the addictive nature of nicotine. Literature published by writers such as A. K. G. Tan (2012), Slovic (2001), and Tamvakas and Amos (2010), highlight this position. In strong contrast, Thompson et al. (2009b) argue that although addictive, nicotine is not particularly harmful. However, narratives of smoking participants indicate a level of addictiveness which prevents them quitting, although some have tried. Even their attendance at quit-smoking clinics does not definitively indicate quit intentions (Benson, Stronks, Willemsen, Bogaerts, & Nierkens, 2014). Nevertheless, asking any smoker to quit is a most difficult behaviour change request given the addictive nature of tobacco.

4.4.2.4 *"I Can Quit Electronically"*

Findings

One consequence of smoking is addiction which brings its own issue – how to quit. Several smoking respondents indicate they have tried to quit through using e-cigarettes. From a public perspective, e-cigarettes are perceived as safer than regular cigarettes (A. S. L. Tan & Bigman, 2014), its use by smoking respondents could be interpreted as their attempt to nullify negative sentiments around smoking and smokers. When queried during interviewing about this theme, almost all smoking participants (including ex-smokers and non-smokers) made negative comments about e-cigarettes. Smoking participants reported getting ill from using e-cigarettes, questioned the contents, and feared continued usage could cause addiction. Ex-smokers and non-smokers voiced concerns that the e-cigarette market is unregulated.

For smoking participants who genuinely want to quit, using e-cigarettes offers a practical solution to quitting without them being “policed” by specialist smoking cessation services.

Discussions

Smoking participants’ account of quitting using e-cigarettes suggests mixed feelings about using it as a quit aid, and during interviewing accounts given of its use were sometimes contradictory. To illustrate, smoking participants acknowledge possible ill effects from consistent use of the product, yet they still use it. This is a finding akin to Wiltshire, Bancroft, Parry, and Amos’s (2003) moral obligation concept, where individuals justify their behaviours in a way they consider appropriate for the researcher but less damaging for themselves. For smoking participants quitting seems an uphill struggle, an almost unreachable “*carrot on a stick*”; being addicted does not help. Interestingly, smoking participants’ narratives make it clear that they will quit but only when they are ready or if they really want to.

4.4.3 Finding Three: Consumer Behaviour

4.4.3.1 “I Cannot See What I Want!!!”

Findings

The aversion with which smoking respondents view tobacco display bans became evident during interviewing and forms a recurring theme in their narratives. Most if not all agree the display ban hinders their ability to see cigarette product(s) they require during purchase, although it does not stop them from purchasing. Smoking respondents openly disclose ways in which they bypass this “*barrier to purchase*”. To illustrate, consider Smoker C. She purchases cigarettes from persons who travel abroad, meaning she does not have to worry about price or the ability to see her

preferred brand. Others, for example Smoker F, because she is brand loyal knows what she wants, where it is located in the gantry, and just ask for it. These behaviours highlight the importance of the appearance of cigarettes/cigarette packs in brand choice and smoking dependence (A. Ayo-Yusuf & T. Agaku, 2015).

Discussions

Restrictions on cigarette purchase have become tighter with the implementation of display bans in supermarkets and small retail establishments. The contention is that displaying the product contravenes the reason for the ban, i.e. preventing non-smokers from taking up the habit of smoking. This policy can be interpreted through Alemanno's (2012) description of 'nudging', where public policies direct individuals (in this case smokers) to make positive decisions for themselves and society, whilst allowing freedom of choice. Yet Wilkinson (2013) in his study questions the appropriateness of using nudging, suggesting the use of 'nudging' to get smokers to quit can be manipulative because they have not consented to quitting.

Evidence suggests the impact of the display ban on purchasing behaviours of smokers (Owen B J Carter, Phan, & Mills, 2015; Cohen et al., 2011), but it does not mean "out of sight out of mind". Instead, smoking participants have changed their behaviours by doing two things: (i) buying from alternative sources, and (ii) when in retail environments become brand-loyal and knowledgeable so they can ask for the brand of cigarette(s) they want, sometimes even directing the individual serving them to where it/they are stored in the gantry.

4.4.3.2 *“Maybe I Could Try That New Product...Or Maybe Not”*

Findings

Throughout the interviewing process, dialogue about acceptance, adoption and use of e-cigarettes was common. Some participants (e.g. Smoker O, Smoker N, Smoker L) smoke regular cigarettes and e-cigarettes. Harrell et al. (2015) describe these smokers as “dual users”. Most were introduced to e-cigarettes by family members or friends who already use the product, but significantly they were not influenced by marketing stimuli or advertising. Another recurring theme during discussions was the cost of e-cigarettes relative to regular cigarettes. Smoking participants who use it report they find e-cigarettes cheaper, lasts longer and provides more flavour options.

The main attraction for use by smoking participants is the ability to smoke (or vape⁶), where smoking is not allowed because e-cigarettes are perceived by non-smokers to be less harmful than regular cigarettes. Even so, narratives of smoking participants reflect conflicts they experience regarding use, acceptance and adoption. On the one hand, they use the product even having preferred flavours and brands. On the other hand, because they are sceptical of the contents believing them to be untried and untested, some avoid the product all together.

Discussions

The extent to which smoking participants accept e-cigarettes are debatable and their opinions of the product are inconsistent. In one breath smoking participants embrace e-cigarettes for its supposed “good” qualities, i.e. choice of flavours, convenience, cheap price and an aid to quitting. In another, they cast doubt about the contents

⁶Inhale and exhale the vapour produced by an electronic cigarette or similar device.

fearing constant usage might make them addicted. This is a finding consistent with Bell and Keane's (2012) study about the concept of addiction and tobacco dependence.

Growing criticisms, health concerns and the high price of cigarettes cause behaviour change in smokers by the adoption and use of alternative nicotine delivery products, for example electronic cigarette aka e-cigarette. Their behaviour reflects findings of Litt et al. (2016) that smoking restrictions promotes the use of e-cigarettes by smokers. A further extension of respondents' behaviour change is their belief that in social settings e-cigarettes are more acceptable than regular cigarettes, so they engage in compensatory behaviours and smoke it. This finding conforms to that of Berg (2016), previously discussed in section 2.13.5.2 of the Literature Review.

4.4.3.3 *"If it's Too Expensive I Will Buy a Cheaper Brand"*

Findings

Being able to afford the brand of choice is one way smoking participants exert their freedom to smoke considering existing tobacco denormalisation strategies. Sometimes financial constraints prevent smoking participants from purchasing their preferred brand(s), strengthening the suggestion that smoking participants are brand loyal and price conscious. Take for example Smoker M. His preferred brand is *American Spirit*, but his current financial position prevents the purchase of that brand. He now buys a cheaper brand - *Sterling*. Smoker E also displays a price conscious approach by purchasing cigarettes at the corner shop. In his narrative account, Smoker E says prices at the corner shop are cheaper than in the supermarkets.

The inability to purchase the brand(s) of choice, smoking participants compensate their financial position by settling for cheaper alternatives. What is clear is they are not deterred in their quest to smoke, only limited in their ability to afford the product they want. When this issue is probed, smoking participants defend purchasing a lower priced brand using the excuse that the taste is just as good as the expensive one, or cite other financial commitments such as the need to purchase other grocery items.

Discussion

Brand choice and purchasing ability goes together for smoking participants, although they sometimes choose lower priced brands when their preferred choice is unaffordable. By substituting cheaper products or switching to an alternative brand, smoking respondents demonstrate compensatory behaviour. To illustrate, Smoker L's awareness of the financial strain his smoking habit causes, switched from the more expensive *John Player Special* to smoking the cheaper brand, *Lambert & Butler*. This finding is supported in a study by W. N. Evans and Farrelly (1998) examining compensating behaviours. It is also supported by Nargis, Fong, Chaloupka, and Li's (2014) study investigating how smokers respond to tax and price increases in their choice of discount brand cigarettes versus premium brands.

4.4.4 Finding Four: Communication Agencies

4.4.4.1 "Am I Bothered?"

Findings

Most smoking respondents report never seeing advertising messages advocating the sale of cigarettes or tobacco products, all except one – Smoker L. He vividly remembers watching television programmes sponsored by tobacco companies, seeing his sporting idols (e.g. Alex Higgins) smoking whilst engaging in a competition.

Those messages influenced him to take up smoking. On the contrary however, all participants (including non-smokers) recall seeing anti-smoking messages in print and electronic media, and on cigarette packets. Although aware of these messages, most smoking participants find ways to ignore them. Take for example the narrative of Smoker D:

There is this one picture that I don't like, that is the man with the growth under his neck. So, if anybody gives me that packet I ask them to change that. I tell them I don't want that packet of cigarettes, and ask for another one.

Smoker D

Another perspective offered about this stop-smoking strategy is that stop-smoking messages “encourage” smoking rather than dissuade it. The narrative of Smoker H explains:

I'm sat watching telly on a night, not bothered for a cig at all. You know, I'm sat watching telly and a stop-smoking advert will come on and I will just say “I need a cig now”. (Laughter). I hadn't even thought about it until that was put into my brain.

Smoker H

Although aware of marketing stimuli aimed at getting them to quit, smoking participants find ways to resist and ignore them. Smoker F's narrative explains:

Me and my friends, when I was in my first year at University, used to play “snap” with our cigarette packets. We would hold the packets behind our backs and go “1, 2, 3”, and if any of us had the same picture in front of us we would say “snap” and get a cigarette from the other person.

Smoker F

Discussion

Discussions here are partial towards smoking participants' attitudes and actions regarding anti-smoking messages. This is because only one smoking participant

(Smoker L) recalls seeing advertising messages promoting the use of cigarette and tobacco products. This meant not enough information about messages advocating a smoking habit was obtained during interviewing.

Smoking participants' behaviours can be interpreted as a way of rationalising and supporting their continued habit of smoking, based on mixed feelings about anti-smoking messages. It is worth noting that for some smoking participants, (for example Smoker H), viewing anti-smoking messages provokes a need to smoke which was not present prior to viewing these messages. This action is supported by Wolburg (2006) in her study examining college students' response to anti-smoking messages. Wolburg's study found that some campaigns are ineffective and can actually trigger adverse effects such as increased smoking. This further develops the notion of Framing Theory which state that the way information is portrayed influences an individual's decision making (Kuo, Hsu, & Day, 2009; Tversky & Kahneman, 1981). When this happens, smokers' opinions are easily biased because of the way the information is presented. So, by ignoring anti-smoking messages and continuing to smoke, smokers become personally liable for the resultant ill-effects.

Anti-smoking messages does not have the intended effect on smoking respondents, i.e. to prompt cessation, but they still cause behaviour change. To illustrate, when seen by Smoker H anti-smoking messages encourages a craving to smoke which was not previously present. Based on responses given and actions taken by smoking participants, they view anti-smoking messages as impractical and irrelevant, necessitating the employment of self-exempting strategies to lessen smoking risk. For example, Smoker F and her friends play games using the images on cigarette packets, therefore messages warning of the dangers of smoking "*come through one ear and*

go out the other". This suggests that Smoker F employs the self-exempting belief of being a sceptic (Guillaumier et al., 2016), i.e. her beliefs discount the harms of smoking. This finding challenges that of Netemeyer et al. (2005) which found that advertising messages contribute to decreased cigarette consumption.

4.4.4.2 "Butt Out.....I Don't Need Your Intervention"

Findings

Narratives of smoking respondents suggest they deliberately ignore stop-smoking interventions such as *Stoptober*, failing to see the rationale of quitting for just one month. The narrative of Smoker F is taken into consideration here:

There is no point in stopping for one month. You see "Stoptober", it's a gimmick.

Smoker F

The notion of just quitting for one month seems impractical to some smoking participants, because at the end of the "fasting" period they will resume smoking. Regardless of this position, smoking participants indicate they would participate but only if this strategy was twinned with other intervention services. Smoker D and Smoker A's statements reflect this position:

I think they are rubbish. If you do this "stop" for a month, then you light up a cigarette on the 1st November. I personally do not think it work, you get nothing. I could not just say tomorrow I am not going to light up again because I have nothing there to help me.

Smoker D

For me it did not work because I needed something else with it, perhaps the patch or a substitute which would stop the craving.

Smoker A

Some smoking participants are minded to participate in stop-smoking interventions, although some have used it and failed. However, the majority openly resist

participation believing that only stopping for a period to resume at the end of said period, is useless.

Discussion

Smoking participants' narratives posit that they would engage with stop-smoking interventions, but only where relapse prevention support is provided to supplement the intervention. The spontaneous nature of smokers (Brown et al., 2014), allows smoking participants to respond to interventions dependent on their motives, i.e. drives, emotional state, plans and evaluations, inhibitions and impulses. This finding follows on from Buck's (1985) opinion of the Prime Theory of Motivation, suggesting that behaviour change can originate from external stimuli and cognitive processes. Later studies by Brown et al. (2014) examining how effective and cost-effective the smoking cessation campaign Stoptober was, found that behaviour change (i.e. quitting), can happen in smokers but only with constant monitoring and input to keep them motivated to quit.

4.4.5 Finding Five: Behaviour Change

4.4.5.1 "The Yoke of Intolerance"

Findings

One meaning of intolerance offered is that it is "*an unwillingness to accept views, beliefs, or behaviour that differs from one's own*" (Oxford Dictionary Online). The operative words here are "*behaviour that differs*". In the context of this study, the perceived different behaviours of smoking participants cause them to experience intolerant treatment from non-smokers. For example, Smoker B and Smoker G are prevented from entering homes of family members, accused of smelling of cigarette smoke. Smoker K is prevented from embracing her niece who does not like the smell

of cigarette smoke. Smoker L and Smoker A whose partners are themselves ex-smokers, are constantly chastised by them [partners] whenever they smoke.

Still smoking participants find ways to shake off this “yoke of intolerance”, being non-compliant with smoke-free policies (L. Lazuras, Eiser, & Rodafinos, 2009), but instead continue to indulge in smoking. Studies on smoking behaviours by writers, such as M. Wakefield et al. (2009), S Chapman and Freeman (2008), and Paul et al. (2010), suggest these behaviours stem from smokers’ perception that smoking is important to forming friendship networks and building relationships in social situations.

Discussions

In today’s UK society, the smoking culture has changed from accommodation and acceptance to that of intolerance (Livingood, Allegrante, & Green, 2016). For example, many items previously used to signal the accommodation of smoking such as ash trays, cigarette holders, and lighters, have disappeared from public and private spaces. These actions demonstrate the general intolerance of smokers and smoking. Nevertheless, smoking participants handle intolerance by changing their behaviours, reforming what is referred to as their spoiled identities and try to remain silent (Q. H. Tan, 2013), or appear anonymous (Wigginton & Lafrance, 2016). Smoking participants also establish informal networks with other smokers whilst smoking outside in smoking shelters or designated smoking spaces. In so doing, their sense of identity is developed, a finding linked to Vangeli and West’s (2012) argument surrounding the conceptualisation of smoking identity.

To what extent, therefore, is the notion of intolerance challenged? Perhaps the answer can be found in the broader context of this study. Previous discussions demonstrate

that smoking participants find ways to lessen negative perceptions of their habit to reduce experiences of social stigmatisation and by extension, intolerance. Still, corporate forms of discrimination committed against smokers, i.e. companies denying employment to smokers (Stuber et al., 2008) can also be linked to smoker-related intolerance.

4.4.5.2 “Victims of Circumstance”

Findings

In their narratives, smoking participants suggest they had become “victims of circumstance” arising from current anti-smoking policies. Take for example the narratives of Smoker L and Smoker C:

Certainly, like while I am here at work now, I have to make the effort to go downstairs, out of the door and go and have a cigarette...

Smoker L

I think there could be if things were thought about for both parties, but it is all the Government purely thinking about are the non-smokers saying that if you are a smoker and you go for a meal you cannot have a cigarette. You have to eat the meal, you can drink alcohol, but you can't smoke...so people are getting up and half way through a meal they are having going outside to enjoy their meal because they need a cigarette say.

Smoker C

Smoking participants disgust at this “labelling” sees them challenging this status by taking lightly the personal risks smoking cause to their health. For them, freedom to smoke when and where they want and the ability to socialise are strong motivators to smoke. Smoking participants believe that regardless of the harms smoking cause, it is an individual lifestyle choice shaped by their moral views of smoking. For example, Smoker B and Smoker G both say smoking is a pastime they enjoy, a feeling and experience a non-smoker would not and could not understand.

Discussions

“Men are helpless many a time and they are all victims of circumstance”.

The quote above adapted from Shakespeare’s classic play “*Othello*” (Furness, 2000; Neill, 2006) is frequently associated with the term “*victim of circumstance*”. In the play, Othello is portrayed as a victim because of his ethnicity (i.e. being black and a Moor) and his own weakness (i.e. insecurity, jealousy, easily manipulated). Closer to this study, narratives of smoking participants suggest they see themselves as victims of circumstance resulting from current anti-smoking strategies. The pertinent question therefore is whether this scenario makes smokers victims?

Arguments from writers such as Heikkinen et al. (2010), Ladwig, Baumert, Lowel, Doring, and Wichmann (2005), and Oncken, McKee, Krishnan-Sarin, O’Malley, and Mazure (2005), suggest otherwise. Their views are that smokers’ awareness of the harmful effects of smoking negate any claim to being victims, because their deeds does not always match their words (Benson et al., 2014). When policies such as tobacco denormalisation are implemented to help “control” smoking participants’ actions, they protest claiming to be “victims of circumstances”. Smoking participants can avoid the label “victims of circumstance” by controlling their actions. This can be accomplished through what is known as “the capacity of will” identified in Huoranszki’s (2002) study examining common sense and the theory of human behaviour. *For example, instead of doing what their instincts dictate to them (smoking), smoking participants can rationally control their smoking desires by either avoid purchasing cigarettes altogether, or avoid the company of those who smoke.*

4.4.5.3 “Defiant or Compliant?”

Findings

Respect for the wellbeing of non-smokers sometimes see smoking respondents refrain from smoking. Take for example the narratives of Smoker E and Smoker N:

It is out of respect to me and to them, because I don't want to get into the vehicle and they smell cigarette so I don't. Yeah, I respect those who do not smoke.

Smoker E

I've always been very aware that it is not the nicest of habits, so I will consciously not smoke around certain people that I know don't like it or you know if I am walking down the street and I have got a cigarette I will be very careful about sort of where I am blowing my smoke and not get too close to people.

Smoker N

The notion of respect is a common theme identified throughout the interviewing process, which could possibly be interpreted as compliance on the part of smoking participants. Taken in the context of this study, compliance could mean refraining from smoking around non-smokers. However, there must be awareness that smoking respondents have their own personal identities which influence rebellious and defiant behaviours displayed by them:

I mean all you are going to get from people that you tell that they can't smoke, is they are going to rebel. Smokers are naturally rebellious anyway (laughing).

Smoker M

In Smoker M's narrative, he displays defiant traits and asserting his right to smoke. His narrative also subtly suggests his willingness to respect non-smokers by not smoking around them. Openly flouting some established anti-smoking laws whilst conforming to others, demonstrate conflicts in smoking participants' personal values about smoking.

Discussions

Rebelliousness is a personality trait often linked with smoking behaviour (Kropp, Lavack, & Holden, 1999), causing defiance of established authority, i.e. government anti-smoking laws. For example, smokers sometimes choose to smoke in places where they are not allowed, even when challenged. This behaviour is neither surprising nor isolated, reflecting the ability to oppose anti-smoking policies and defy denormalisation strategies. A study exploring consumers' self-concepts within a risky consumption context (K. Hamilton & Hassan, 2012), characterise defiance as a tactic used by smokers to ignore anti-smoking strategies. This action reflects Defiance Theory (Sherman, 1993), whilst being understood through the lens of Reactance Theory (Brehm, 1988) which speaks to the removal of freedom of choice. Putting this into context, when smokers are threatened with the loss of a freedom, they seek ways to re-establish that freedom by defying behaviour control strategies. The result, smoking becomes more attractive and desirable (K. Hamilton & Hassan, 2012), i.e. increased consumption of cigarette and tobacco products.

From this finding we identify two distinct actions in smokers – defiance, and compliance, behaviours which are supported in existing literature. For example, older smokers who just enjoy smoking tend to be defiant in their smoking behaviours (K. C. Davis, Nonnemaker, Farrelly, & Niederdeppe, 2011). Equally, smokers display their compliant nature by observing spaces allocated as “no-smoking” zones (K. Bell, 2013; K. Bell, McCullough, et al., 2010). Anti-smoking strategies are designed with two behaviour change objectives: (i) to prevent smoking, and (ii) strengthen non-smokers' resolve of not taking up the habit. However, the strategies sometimes work in the opposite way they are intended, in that they trigger boomerang effects such as

defiance or compliance (Wolburg, 2006). This action lends support for Nadler's (2005) flouting and compliance strategy. It also suggests that observance of tobacco control strategies (i.e. compliance) is occurring in parallel (at the same time) as ignoring these strategies (i.e. defiance).

4.5 Chapter Conclusion

This study found that adoption of smoking habit is due mainly to the extent of the influence of others around them (normative beliefs), such as parents, siblings and friendship networks. Smoking participants are also influenced by how they conform to and perform in groups, communities or cultures (social norms). Their adoption and continuation of a smoking habit is shaped by the expectation that they will behave according to typical patterns of behaviour (descriptive norm), as well as prescriptive rules specifying behaviours which they should or should not conform to (injunctive norms). Interestingly, smoking participants disregard those norms and behave in ways contrary to established social norms. Take for example Smoker K, a practising Muslim whose religion opposes female smoking, yet she is a smoker.

This study's findings reveal that in purchase and consumption settings where cigarette and tobacco products are stored in gantries, smoking participants have not been deterred from purchasing. Instead, they have changed their behaviours where they sometimes "assist" those serving them to identify the brand(s) they require. Smoking participants have also changed their behaviours to circumvent the display ban and avoid paying a high price by purchasing cigarettes over the internet, or from persons who bring them back from overseas holiday trips. An interesting development identified in this study is that smoking participants have also changed their behaviours

to that of being open to using alternative products, particularly e-cigarettes. This behaviour change is based on the belief that e-cigarettes are less harmful than regular cigarettes and more socially acceptable. In shared consumption spaces where smoking participants are disallowed from smoking, smoking participants' behaviours have also changed. Now they ban together and form friendship groups in smoking shelters with other smokers who find themselves in the same position. Smoking participants' behaviours have also changed from submission (ready to accept tobacco control laws) to being territorial, i.e. fiercely guarding spaces allocated as smoking zones.

In conclusion, tobacco denormalisation strategies are developed to influence behaviour change, but they contribute to smoking participants feeling that they are "victims of circumstances" therefore becoming defiant or compliant in order to deal with this treatment. Denormalisation strategies encourage tensions and conflicts between smoking respondents and non-smokers by portraying smoking as an unacceptable social behaviour. This study's findings indicate that if future denormalisation strategies are to stimulate behaviour change, then psychological and emotional impact of quitting on all smokers must be considered. Messaging strategies should also give the assurance that quitting is possible (Wolburg, 2004), even for those who have previously tried and failed, for example Smoker A.

Chapter 5 Discussion of Research Findings – Theory and Practice

5.1 Introduction

To begin discussions, the research question asked by this study is restated: “Does tobacco denormalisation strategies encourage smokers to change their behaviours during purchase and consumption, and in shared consumption spaces?”

In reporting these findings, the use of prescriptive statements (for example, ‘*smoking can seriously damage your health*’), have been avoided. These statements can be purely positive, carrying the prescriptive implication ‘*so you must not smoke*’. Nolen and Talbert’s (2011) study on the appropriateness of using prescriptive statements in qualitative studies, agrees they should be avoided so that the outcome of the study can be communicated within the context of the research design and experience.

Research relating to smoking and smoking behaviours are widely studied topics in social science research. Many studies focus primarily on adolescent smokers (for example, L. Richardson, 2013; Sussman et al., 1998; Tilson, McBride, Lipkus, & Catalano, 2004; C. Wang, Hipp, Carter T. Butts, Jose, & Lakon, 2016), and smokers from specific ethnic groups (e.g. Madkour et al., 2014; Scalici & Schulz, 2017; Srivastava, 2015), instead of the general population. *This suggests that adolescent smokers and those from specific ethnic groups could experience barriers to smoking cessation differently than smokers from the general population.* Thus, these studies fail to understand the social impact of smoking on smokers’ everyday lives, and taking into consideration that smokers have homogenous and heterogeneous consumption practices. Only a few studies recognise this, concentrating on consumption leading to social disapproval (for example, S.-H. Kim & Shanahan, 2003; L. Lazuras et al.,

2009; A. K. G. Tan, 2012; M. A. Wakefield, Germain, & Durkin, 2008). It is these criticisms that this research intends to address.

5.2 Summary of Major Findings

Findings of this study confirm that smoking is a learned behaviour influenced by: (i) parents' role in socialising children to the values and norms of society, and (ii) modelling actions of siblings, friends and social group influences. These actions can be explained within the domain of Social Learning Theory (Bandura, 1977), dismissing previous studies which suggest that these learning behaviours do not always encourage smoking behaviour (for example, Blokland, Engels, Harakeh, Hale, & Meeus, 2009; Botvin, Botvin, Baker, Dusenbury, & Goldberg, 1992). The belief is that on their own it is highly unlikely that an individual would adopt a smoking behaviour, but through normative influences and cognitive factors the chance of becoming a smoker increases.

The examination of dissonance behaviour in smokers provides unique insights into smokers' feelings and attitudes towards smoking restrictions. This study's findings reveal that smoking bans restrict smoking participants' freedom to smoke, an act they deem as stigmatisation. This finding is consistent with Hinks and Katsoris's (2012) study examining the effectiveness of smoking bans in changing behaviours. Still, whilst these findings suggest smoking participants experience acts of social and cultural stigmatisation, they do not readily accept this situation and instead develop resisting strategies. One way they resist is to behave contrary to their normal practice, i.e. making friends with other smokers whilst smoking outside. By so doing smoking participants lessen smoking non-acceptance and stigmatisation enabling their survival in the unfriendly environment around smoking.

The love for smoking coupled with addiction, further impacted survival strategies but more importantly smoking participants' willingness, ability and desire to quit. *Previous research demonstrates that in trying to quit smokers often make numerous attempts at quitting followed by relapses (for example, Docherty, McNeill, Gartner, & Szatkowski, 2014; Larabie, 2005; Sharma & Szatkowski, 2014).* This behaviour makes it difficult to understand whether smokers have real intentions of quitting. Central to quitting is smokers' ability to do so when they want which suggests a reason why they resist help from established quitting services. Building on this theme, these findings reveal that one increasingly popular way smoking participants try to quit is using e-cigarettes, strengthening and expanding on previous research (Christensen, Welsh, & Faseru, 2014; Torjesen, 2015b; Zhuang, Cummins, Sun, & Zhu, 2016), identifying increased use of e-cigarettes by UK smokers as an aid to quitting.

This *study* identifies smoking participants' behaviours in purchase and consumption situations as another way they resist tobacco denormalisation strategies by changing their behaviours. In supermarkets where cigarette products are hidden behind gantries, smoking participants circumvent this "*barrier to purchase*" by becoming knowledgeable. Here they familiarise themselves where their preferred brand is located in these gantries allowing them to "assist" shop assistants in locating the product. This is because those serving them are not always knowledgeable, particularly as they may be non-smokers. In corner shops where the atmosphere is more "intimate", findings of this study reveal that smoking participants do not necessarily remain brand loyal but engage in brand switching to get cheaper priced products. Acts of resistance also include purchasing from alternative sources, allowing them to avoid the display ban altogether (for example, friends travelling overseas or over the internet).

Smoking participants' response to anti-smoking messages and stop-smoking interventions were also investigated. This study's findings suggest that smoking participants deliberately ignore these interventions and messages, a position supported by studies of Hoek, Hoek-Sims, and Gendall (2013), and D. Ritchie, Amos, and Martin (2010), which suggest smokers disregard anti-smoking messages believing them to be irrelevant and unimportant. This behaviour provides smokers with a vehicle for self-exempting strategies used to diminish smoking risks (Hoek et al., 2013), further justifying their reason for continuing to smoke. Interestingly, this study also found that smoking participants would be willing to participate in stop-smoking interventions, but only where relapse prevention support is provided to supplement said intervention(s). This finding compliments the work of Agboola, Coleman, Leonardi-Bee, McEwen, and McNeill (2010) examining the prevention of relapse in smokers who want to quit.

This research also develops an understanding of how tobacco denormalisation strategies instigate tensions and conflicts not only between smokers and non-smokers, but also in smokers. Tensions and conflicts arise when non-smokers display intolerant behaviours toward smokers, but also when smokers lack the self-efficacy to quit. Findings show that instead of prompting the intended behaviour change response in smoking participants, this imbalance works in the opposite way triggering what Wolburg (2006) refers to as boomerang effects, i.e. defiance or compliance (previously discussed in Chapter 4).

5.3 Contribution to Knowledge

This research's findings has implications for the UK Government and anti-smoking policy makers, but also the UK Tobacco Industry and related industries. Government

spending on anti-smoking advertising and marketing campaigns between 2006/2007 was £51million, £84million in 2009 (Daily Mail Reporter, 2010), and £48 million in 2013/14 including pharmacotherapies to help people stop smoking (ASH, 2016a). Yet, smokers (including those participating in this study), continue to smoke, highlighting this study's finding that anti-smoking advertising and marketing campaigns has only served to foster firmly established anti-smoking sentiments amongst the public, which negatively impact the experience of smokers. Furthermore, given the approach and speed with which tobacco control measures have been implemented in the UK (see Figure 1.1), this is a significant development.

By extension, established display ban in retail establishments and smoking bans in shared consumption spaces, cause tensions and conflicts for smoking participants during purchase, consumption, and social interaction settings. The UK Tobacco Industry is advocating for recognition by government of the full financial fall-out which tobacco denormalisation strategies cause to producers, retailers, and associated businesses.

Both the UK Government and The Tobacco Industry and government have a vested interest in the success or failure of tobacco denormalisation strategies. Issues highlighted in this study can be interpreted to mean there is need for greater and better understanding of how tobacco control strategies impact smoking behaviours. This research entitled "*Consumption Practices, Conflict Resolution and Behaviour Change in the UK Smokers' Market*", seeks to aid this understanding by assessing the effect of tobacco control strategies on smoking behaviours, since their implementation in 2007 to present.

This research's contribution to academia lies in the positioning that smoking is a facilitator of social interaction and a sense of belonging. Here May's (2010) argument about self, belonging and social change is highlighted. May (2011) suggests that belonging is central to social interaction giving rise to creative ways of interacting with pre-existing social structures (in this case tobacco control strategies). To illustrate, this study found that social policies designed to exclude smokers and achieve behaviour change work in reverse. Having to leave the warmth of a pub, club or restaurant, smokers band into elite groups and join up in "little circles" with other smokers. They get the opportunity to meet diverse types of persons (smokers) who they would not meet under normal circumstances. This behaviour happens regularly throughout eating or drinking and should someone cease smoking, that person would ultimately be excluded from the group. By doing something in common smokers have become motivated to smoke, a position agreeing with Graham's study examining women and smoking in the UK:

...the complex nature of changing behaviours in smoking actually gives smokers a new identity.

Graham (1988)

Following on this contribution, another salient finding of this study is that observance of tobacco control strategies and ignoring them happens simultaneously. This suggests smokers' behaviours are in parallel with each other, i.e. occurring at the same time. To illustrate, smokers will not smoke in entrances of buildings in observance of no smoking signs posted there, but will instead move short distances away and smoke. Although no existing literature using the exact term "parallel behaviour" could be identified, literature on ambivalent behaviour in smokers were found and used as a benchmark in these discussions (for example, Lipkus, Green, Feaganes, & Sedikides, 2001; Radsma & Bottorff, 2009; Vitzthum et al., 2013).

Coinage of the term “parallel behaviour” to define smoking behaviours can be used to broaden understanding of existing literature, whilst opening the potential for additional research using this term.

Most literature on smoking and smoking behaviours concentrate mainly on the American, Australian and some European countries, (evidenced in this study’s reference list). Given the stringent tobacco control measures currently existing in the UK, coupled with the UK’s number one ranking on the Tobacco Control Scale compared to other European countries (see Appendix 1.4), the absence of sufficient UK-centric studies examining smoking behaviour and behaviour change is noticeable. This thesis can serve as reference material for academics studying tobacco control strategies and how they impact behaviour change in smokers. It also addresses Costa and Mossialos’s (2006) call for further studies to address the dearth of UK-centric research in this evolving area of social phenomenon.

This present study recognises wider issues which influence adoption and maintenance of smoking. For example, parental, sibling, friendship networks, social norms, addiction. The study also emphasises smokers’ struggles and their “fight” for recognition of their habit as a normal pastime. This draws issue to the symbolic, experiential and institutional root of behaviour change. This study’s findings suggest persuading smokers to quit requires messaging strategies which are respectful, but supportive of their efforts to quit whilst trying to dispel negative misunderstandings they might hold. Therefore, this study can become a reference point for policy makers establishing communication policies and strategies which provide support in the effort to quit, thereby enabling behaviour change.

This study examined the manipulative ways in which the Tobacco Industry try to keep smokers adopting, using and consuming their products. This issue was not examined in isolation, counter strategies employed by health agencies and anti-smoking advocates were also considered (see Appendix 2). Inclusion of this information is a necessary consideration for Government, policy makers and health officials when designing behaviour change strategies and interventions.

5.4 Research Implications

This study considers three research implications: consumer, social, and policy, discussed in the paragraphs below.

According to Claycomb and Headley (2013), most studies around behaviour change are usually partial to public health arguments. In fact, few studies in the consumer behaviour discipline examine tobacco denormalisation strategies (directly or indirectly), when scrutinising consumption issues related to smoking. Positioning smokers as consumers acknowledge that tobacco denormalisation strategies impact much more than the health of non-smokers, but that it impacts smokers in purchase and consumption settings.

Existing studies about tobacco consumption are predominantly quantitative (for example, Aspinall & Mitton, 2014; Harman, Graham, Francis, Inskip, & Group, 2006; Mermelstein, 1999). This creates challenges in understanding consumer behaviour, particularly as there is uncertainty as to how quantitative studies measure causal relationships (Unger et al., 1999). Therefore, by adopting a qualitative approach, this study allows a “one-to-one” approach to understanding behavioural and attitudinal changes which is not afforded in quantitative research. The need for further studies

examining the impact of consuming products deemed socially displeasing (for example cigarettes), is also emphasised by these findings. The objective is to provide new insights into this area of research, generating discussions which add to existing literature around the topic.

As previously identified, parents, siblings and social networks influence adoption and continuation of a smoking behaviour. Previous research confirms this finding (for example, Bricker et al., 2006; Maggi et al., 2014; Mercken et al., 2010). Focussing on these influences gives support for the idea that smoking is a learned behaviour which makes behaviour change difficult. Behaviour change becomes even more problematic when shifting social norms and public sentiment around smokers and smoking also have a negative impact.

Finally, these findings have important implications for stakeholders in the UK such as Government, NHS, policy makers, the Tobacco Industry and related agencies. Current public health policies and campaigns around smoking behaviours is to change unhealthy lifestyles of smokers, and denormalise this behaviour through education campaigns. This study suggests that future UK legislation around smoking and behaviour change should: (a) acknowledge the normative and social influences around smoking, (b) seek to identify measures that foster social inclusion rather than social exclusion, and (c) tailor policies which will help understand the complexities associated with smoking and behaviour change.

5.5 Research Limitations

While the present study yielded important findings, limitations were identified. First and foremost, gaining access to participants was challenging. E-mail

correspondences sent to potential participants as a follow-up to confirm participation, were not responded to. Some smokers when approached outright refused on the basis that the conversation was being tape recorded; others refused because they were embarrassed to talk about their habit.

One limitation experienced was not being part of smokers “inner circle” because of my non-smoker status. This position highlighted the etic and emic dilemma (Young, 2005), which I faced knowing the influence I held over the research itself. However, it was impossible to be completely etic or emic because that meant disregarding personal viewpoints to the detriment of ignoring new and emergent theories.

Another limitation is the sample size. Convenience and purposive sampling techniques were used to recruit participants in the UK town of Huddersfield. Although relatively small, the diverse nature of the sample participants’ balances this out. Nevertheless, this makes generalisation of the findings difficult because opinions expressed by study participants does not represent the entire smoking population of the UK in terms of ethnic background, age, or sex. A larger number of interview participants would allow for more rigorous manipulation of the data.

Finally, limitations identified are not mutually exclusive, but every effort was made to ensure that these and other mitigating factors were kept to a considerable acceptance level.

5.6 Scope for Future Research

Given the currency of tobacco denormalisation strategies in the UK it is difficult to address issues as they develop. However, the ability to replicate this study sometime

soon would help provide a better understanding of the long-term implications of tobacco control strategies and its effect on behaviour change.

An interesting future consideration would be a UK study comparing acceptance/rejection levels of tobacco control strategies in both female and male smokers. The study could also consider another category of consumers, for example those who consume alcohol particularly as studies suggest a higher rate of drinking amongst males than females (Pratten & Lovatt, 2007; Roberts, Bond, Korcha, & Greenfield, 2013). Such research can provide an alternative perspective as to why individuals ignore/reject public policies aimed at changing behaviours around consumption of socially displeasing products.

There is the opportunity for future research examining the perception of potential risks from using e-cigarettes as against regular cigarettes. Findings of this research suggest that investigating the possible risk of becoming addicted to using e-cigarettes is a topic worth further examining.

Future research could consider the relationship between quitting and behaviour change and the help provided by quit smoking services. Although a theme common during interviewing and briefly mentioned in the research, it was not fully explored. This unearths question as to whether stop-smoking services are necessary to tobacco control measures and policies, and quitting behaviours.

The potential exists to develop future research around compensatory health behaviours in smokers. This would be particularly interesting given that smokers view

e-cigarettes as a healthy alternative to regular cigarettes. A brief overview of compensatory health behaviours was presented but not fully explored, creating the potential for further examination of this topic.

A common behaviour exhibited by smokers is smoking outside the entrance to buildings, as well as clubs, pubs, bars and restaurants. It would be interesting to understand whether this practice continues during the winter months when the weather becomes less favourable, as against the summer months. Future studies could therefore consider this seasonal effect on smoking behaviours.

Smoking has a strong association with fire-related and trauma-related injuries, although this was not explored in this study. This creates the potential to study whether smokers are exposed to increased risks of burns and if so, the financial implications to the National Health Service (NHS).

Finally, research into why smokers lapse once cessation has been achieved is an interesting area for future research. Critical to this research path would be to understand whether follow-up strategies, available through the NHS stop-smoking service, aimed at smoking relapse are effective.

5.7 Chapter Conclusion

This study set out to find the effect of existing UK tobacco denormalisation strategies encourage behaviour change in smokers during purchase and consumption and in shared consumption spaces. Normative influences on smoking adoption, behavioural conflicts, behaviour in consumption environments, attitude towards marketing

messages and anti-smoking stimuli, were used as representative factors to measure population-level smoking behaviour and behaviour change.

Taking these into consideration, this study's findings reveal that tobacco control strategies encourage behaviour change in smokers, but not in the way intended by these strategies. Smokers continue to adopt, purchase and consume tobacco products in the face of mounting social and cultural opposition. However, behaviour change is manifested in their ways of circumventing "*barriers to purchase, consumption and use*". For example, making friends with other smokers whilst standing outside, adopting new or alternative products such as e-cigarettes, engaging in brand switching and bulk buying, and becoming brand knowledgeable and more informed about location of products stored in gantries.

Arguably, smokers "try" to conform to established tobacco control strategies but ultimately become rebellious, flouting anti-smoking laws and reasserting their individual identities by reforming their "spoiled" identities. This study's findings suggest that defying tobacco control strategies are linked to other deep-seeded reasons. For example, normative influences, cognitive factors, and most important the addictiveness of nicotine. During interviewing and participant observation, this position was brought out, a behaviour which occurs irrespective of the smoking status (light, medium, or heavy).

Sources of behaviour and issues impacting behaviour does cause conflict i.e. "*should I smoke here, or go to the designated smoking area*". This study identified that conflict resolution and dissonance reduction lie in: (a) opportunity to change behaviour, for

example, awareness of anti-smoking messages, (b) motivation, for example, quitting for health reasons or family and (c) capability, for example, self-efficacy and having the will to quit. When these positions have been factored, they support this study's finding that tobacco control irrespective of where instituted, when present they can encourage behaviour change. This is illustrated in the study's theoretical framework (refer to Figure 2.9).

Smokers in the UK exist in an environment where tobacco consumption and the nature of the regulatory environment are changing. Over the next 20 years tobacco control policies could become more intense, changes made in the types of tobacco products consumed, and smoke-free areas extended to private and outdoor spaces (Andrew Hyland, Barnoya, & Corral, 2012). The future could even see a continuance of smokers filling the air with their smoke, and non-smokers demanding smoke-free air (Lambert, 2012).

Based on the empirical findings of this study, tobacco denormalisation strategies does not engender the intended change in smoking behaviours. Instead, smokers behave in parallel with these strategies. Therefore, if we (Government, regulators, non-smokers), are going to address these parallel behaviours by neutralising smokers' rebellious actions, then the onus is on us to also change our behaviours. Therefore, the hope is that suggested theoretical implications identified in this thesis can contribute to this process.

Appendices

Appendix 1.1 Consumer Typologies

2013 ranking (2010 ranking)		Country	Price (30)	Public place bans (22)	Public info. campaign spending (15)	Advertising bans (13)	Health warnings (10)	Treatment (10)	Total (100)
1 (1)	–	UK	27	21	3	10	4	9	74
2 (2)	–	Ireland	24	21	1	12	5	7	70
3 (4)	▲	Iceland	20	17	12	12	4	1	66
4 (3)	▼	Norway	20	17	3	12	4	5	61
5 (4)	▼	Turkey	21	19		7	5	5	57
5 (6)	▲	France	20	17	1	9	4	6	57
7 (13)	▲	Spain	15	21	1	9	4	6	56
7 (7)	–	Malta	17	18		10	4	7	56
9 (7)	▼	Finland	15	17	3	12	2	6	55
10 (new)		Ukraine	20	17		12	4		53
11 (9)	▼	Sweden	17	15		10	1	5	48
11 (27)	▲	Hungary	15	13		11	3	6	48
13 (13)	–	Netherlands	16	13	1	9	1	7	47
13 (10)	▼	Belgium	14	13	2	8	4	6	47
15 (12)	▼	Italy	15	15	2	8	1	5	46
15 (13)	▼	Denmark	15	11	2	8	4	6	46
15 (24)	▲	Bulgaria	18	15		10	1	2	46
18 (11)	▼	Switzerland	13	11	7	2	5	7	45
19 (16)	▼	Romania	19	7		8	3	7	44
20 (17)	▼	Slovenia	12	15		9	1	6	43
20 (19)	▼	Estonia	14	12		10	1	6	43
20 (19)	▼	Poland	14	11		9	1	8	43
23 (new)		Serbia	18	11		9	1	3	42
24 (17)	▼	Latvia	14	14		8	3	2	41
24 (19)	▼	Portugal	14	11		8	1	7	41
26 (new)		Croatia	14	12		11	1	2	40
27 (22)	▼	Slovakia	13	10		9	1	6	39
28 (29)	▲	Luxembourg	5	15		9	1	7	37
29 (22)	▼	Lithuania	12	12		8	1	2	35
29 (30)	▲	Greece	15	7		6	1	6	35
31 (27)	▼	Czech Rep.	12	9		8	1	4	34
32 (24)	▼	Cyprus	15	7		10	1	–	33
33 (26)	▼	Germany	14	11		4	1	2	32
34 (30)	▼	Austria	11	8		7	1	4	31

Source: Joossens and Raw (2014)

Appendix 1.2 Tobacco Display Cabinet (Gantry)



Source: *Google Images (n.d.-a)*

Appendix 1.3 Standardised Cigarette Packaging



Source: ASH (2016e); Siddique (2016)

Appendix 1.4 Existing Tobacco Control Strategies in Other Countries

Australia

Australia's tobacco denormalisation began in 1986 with a ban on smoking indoors in restaurants, cafes, pubs, clubs, recreational and gambling venues. By 2007, smoking bans were fully implemented in licensed premises across all Australian jurisdictions, the Northern Territory being the only exception (Jae Cooper, Borland, Yong, & Hyland, 2010). Smoking is also prohibited within and 10m (33ft) of a playground, 4m (13ft) of the entrance to a public building, rail platforms, taxi ranks and bus stops (McDermott, 2017). Beaches, jails, and private motor vehicles with children passengers under the age of 16 are also included in smoking restrictions (Freeman, Chapman, & Storey, 2008). On 1st December 2012, Australia became the first country to introduce mandatory plain packaging for tobacco products (McDermott, 2017). This was accompanied by a ban on displaying tobacco products at point of sale (POS), and the restricting of size of "price boards" to being no larger than 1.5 m x 1.5 m (Owen B J Carter et al., 2015; M. Wakefield, Zacher, Scollo, & Durkin, 2012).

Studies on tobacco control in Australia (e.g. French, Jang, Tait, & Anstey, 2013; Medhora, 2015), identify marked reduction in tobacco consumption since the introduction of plain packaging. Findings of these studies are echoed in a study by Burki (2014) examining tobacco smoking in Australia. Burki's study also found that smoking prevalence has declined by 15% over the period 2010 – 2013 and the proportion of persons over the age of 14 years smoking daily have fallen from 15.1% to 12.8%.

Additional laws have since been instituted to further restrict smoking and its uptake. For example, 75% of all cigarette packets are now covered with health warnings and 90% of the back, cigarette taxes will rise by 12.5% every year and proposals are being considered to ban smoking for persons born after the year 2000. In his article entitled *“How Australia is Stubbing Out Smoking”* published online, McDermott (2017) suggest that the goal of the Australian government is to reduce smoking prevalence by 10%, by 2018.

Canada

Tobacco control policies in Canada include smoking restrictions in playgrounds (McIntosh, Collins, & Parsons, 2015), comprehensive bans on indoor smoking, taxes on tobacco products, graphic warnings on packets and restrictions on point-of-sale display and advertising (Li & Collins, 2017). Restrictions also exist in airports and planes (Holm & Davis, 2004), workplaces, government buildings and businesses regulated by government (D. Collins & Procter, 2011). Control policies also extend to private spaces in cars where children under the age of 16 are passengers (Tymko & Collins, 2015).

Although most of the laws are mirrored in other provinces, variations are noticeable where laws exist in one province but not in another. For example, British Columbia currently has plans underway for strata councils to implement smoke-free apartments bylaws (K. Bell, McCullough, et al., 2010). Ontario has banned smoking in restaurant and bar patios under the Smoke-Free Ontario Act (Armstrong, 2015). Quebec banned smoking within a 9m (30 ft.) radius of doors, windows and air intakes of all buildings open to the public (Olivier, 2016). Some provinces even have bylaws which go further

than Canada's national legislation (McIntosh et al., 2015). For example, Ottawa is considering a ban on smoking inside apartments and on post-secondary school campuses, as well as raising the legal age for buying tobacco products to 21 (McPhedran, 2017).

The estimated smoking population in Canada is 4.9 million (Kennedy, Zummach, Filsinger, & Leatherdale, 2014), however 37,000 of which die each year from smoking (Azagba, 2015). A study looking at smoking and fatherhood conducted by Greaves, Oliffe, Ponik, Kelly, and Bottorff (2010), identify a decline in overall smoking rates in Canada evidencing some level of success in the fight to reduce tobacco use, *as well as protecting* the general population from exposure to second-hand smoke.

China

Despite being one of the first signatories to the WHO Framework Convention on Tobacco Control (Hu et al., 2013), China's response to tobacco control has been slow and unenthusiastic. The first tobacco control strategy was implemented in March 2011 with the banning of smoking in public spaces such as hotels and restaurants. In 2013, the ban was further extended to all geographic areas in China. 13 cities have enforced this ban but only in Beijing are fines imposed for individuals and businesses flouting this law (Luo, Wan, Liang, & Li, 2015).

Studies examining smoking and smoking bans in China (Cheng, 2010; Luo et al., 2015), identify that China is the world's greatest producer of cigarettes but also the greatest consumer, a position which prevents the implementation of stricter tobacco control laws. One in every three cigarettes in the world is consumed in China, teenage

smoking is prevalent, 3 out of 5 smokers begin the habit between the ages 15 – 20, even medical professionals (physicians and medical students) are heavy smokers (Cheng, 2010). Tobacco is also the largest income generator for the Chinese government, its taxes are a major source of revenue. The Chinese tobacco industry employs over 24 million people, half a million factory workers, another 10 million in farming and a further 13 million in the retail trade (Cheng, 2010).

Studies around smoking in China (e.g. Yanga, Rockett, Li, Xua, & Gua, 2012), link the country's over one million deaths from tobacco related illnesses annually, to the financial significance and widespread use of tobacco. The challenge for the Chinese government is two-fold: (i) protecting tobacco revenue which is important to the economy, and (ii) protecting the health of its citizens through tobacco control policies. However, according to Cheng (2010) the significant barrier preventing more stringent enforcement of tobacco control is the unwillingness of Chinese Government and related bodies to infringe on the individual's right to smoke.

Norway

Norway is one of the first countries to implement tobacco control policies with the passing of The Norway Tobacco Act in 1973 regulating sale, retail and merchandising of cigarette and tobacco products (Hiilamo & Glantz, 2013). In 1975, all forms of tobacco advertising were banned with health warnings placed on cigarette packets. This ban was further amended in 1984, requiring contents of cigarettes to be included on packets and an amendment to packet design. In January 2010, tobacco products were removed from point of sale display. Currently, there is a ban on smoking in all public buildings and spaces, in aircrafts, public transportation, workplaces, restaurants

and bars. It is illegal to sell cigarettes and tobacco items to anyone under the age of 18 years (Helsedepartementet, 2002),

Since implementation of tobacco control strategies in Norway, tobacco consumption has declined (World Health Organisation, 2015b), although there is a noticeable increase in the use of snus⁷ (Sæbø, 2016). There have been calls for more stringent tobacco control measures, for example banning sale of tobacco products to anyone born after the year 2000 which would make cigarettes unavailable to these individuals by the time they reach the age of 18. Implementation of this strategy might not be straightforward as dissenting opposition believes it to be unworkable. Nevertheless, the main goal of the Norwegian Government and tobacco control advocates is for the country to be smoke-free by 2023 (Staufenberg, 2016).

USA

Tobacco control in the USA include workplace smoking bans (Levy, Romano, & Mumford, 2004), smoking bans in all federal buildings, no smoking in indoor public spaces and within 15 feet from an entrance or operable window of an enclosed area in which smoking is prohibited (Waring & Siegel, 2007), and complete home smoking bans (Mills, White, Pierce, & Messer, 2011). Control strategies extend to employment where some companies adopting a “no-smoking” attitude screen job applicants to identify their smoking status (Anders, 2012).

There are noticeable variances in tobacco control strategies established in the USA. For example, California and New York enforce smoking bans in parks, swimming

⁷ A moist tobacco product originating in Sweden.

pools, pedestrian plazas, on beaches and boardwalks but Mississippi, Oklahoma and Texas still permit smoking in bars and restaurants (Kelsey, 2015). From as early as 1901, attempts *have been* made to implement tobacco control in the US. The National Anti-Cigarette League succeeded in obtaining legislative control on the sale and smoking of tobacco, *but it* met with little success and was therefore repealed by 1927 (Vaknin, 2007).

An estimated 36.5 million adults in the United States smoke cigarettes, more than 16 million of these have a smoking-related illness, *plus* cigarette smoking accounts for over 480,000 deaths annually – about 1 of every 5 deaths (*Centers for Disease Control and Prevention, 2017*). A recent study examining current cigarette smoking amongst adults in the United States (Jamal et al., 2016), identified a noticeable decline in smoking with 15 out of every 100 adults now smoke, down from 21 out of every 100 which was the norm in 2005. According to the American Cancer Society (2016), this decline could be attributed in part to tobacco control strategies and interventions such as the “*Great American Smokeout*”.

Contrary to this belief, Weaver et al. (2016) study examining the uptake and dual use of tobacco and smokeless tobacco products in the United States, *believe* the challenge exist of balancing public health messaging around smoking and its dangers, whilst enhancing the message that quitting is a life-saving alternative. *However, a serious challenge exists with convincing the African-American smoking population that this is so. B. Allen, Cruz, Leonard, and Unger (2010) study about the smoking habits of African-Americans, identified a noticeable demographic pattern of smoking where 70% of this category of smokers preferred to smoke menthol cigarettes believing them*

to be healthier. However, menthol in cigarettes is linked to possible respiratory depression and longer inhalations, resulting in greater exposure to the nicotine and particulate matter in tobacco smoke. Therefore, it could be difficult to persuade this particular demographic of smokers to quit.

Appendix 1.5 List of Top Ten Selling UK Cigarette Brands

Top 10 selling UK cigarette brands: 2016¹				
Rank	Brand Name	2015 Sales (£m)	Year-on-Year % Change	Manufacturer
Total volume change year-on-year: -3.5%				
1	Sterling	1,511.3	-4.2	JTI
2	Mayfair	1,046.1	-8.6	JTI
3	Lambert & Butler	787.7	-11.3	ITL
4	Marlboro	782.2	-5.0	PMI
5	Richmond	724.3	-10.9	ITL
6	Players	718.9	61.2	ITL
7	JPS	677.2	-19.2	ITL
8	Carlton	540.6	5.9	ITL
9	Silk Cut	503.5	-5.2	JTI
10	Windsor	461.9	-18.0	ITL

Source: *ASH (2017c)*

Appendix 1.6 Customer Typologies

CONSUMER	TYPOLOGIES
Chooser	The rational problem-solving consumer, requiring genuine options, finance options, and information.
Communicator	Uses goods to communicate, this can be functional as in the use of a burglar alarm to convey status or taste.
Explorer	Consumers increasingly have places to explore, for example, from car boot sales to the internet: often we explore with little idea of what, or even if, we wish to buy.
Identity Seeker	Creating and maintaining personal and social identity through consumption.
Hedonist/artist	Consumption as pleasure: consumption can fulfil needs for emotional aesthetic pleasure and fantasy.
Victim	The exploited consumer: the consumer may be uneducated or unaware of choices, or they may have limited choice because of their socio-economic situation.
Rebel	Using products in new ways as a conscious rebellion: this can include consuming differently or less, or boycotting, and can also refer to active rebellion (joyriding, looting, taking over consumption spaces, etc.).
Activist	Presented historically from the co-operation movement, the value-for-money movement, especially fighting against corporate greed and political activist, seeking more ethical consumption.
Citizen	Consumers are also citizens with rights and responsibilities: awareness that consumerism encroaches on areas such as housing, healthcare, and education as well as consumer goods.

Source: *Szmigin and Piacentini (2015)*

Appendix 1.7 The UK Tobacco Industry

Introduction

Chapter 1 of this thesis introduced the situation which led to implementation of existing tobacco denormalisation strategies within the UK. It also explained the WHO Framework Convention on Tobacco Control (WHO FCTC), the global benchmark of tobacco regulations instituted in countries worldwide. *Arguments contained in this section take discussions further* by presenting an overview of the UK Tobacco Industry, including discussions on their cigarette and tobacco promotion strategies. *It also examines* the ban on advertising, promotion, and sponsorship and strategies employed by the UK Tobacco Industry to resist and circumvent *these bans*. This chapter also covers strategies employed by Government, health officials and anti-smoking advocates to counter tactics employed by the Tobacco Industry to encourage use and uptake of tobacco products. The chapter concludes with discussions on health issues caused by tobacco smoking.

An Overview of The UK Tobacco Industry

Tobacco is a global business, from growing the leaves to actual manufacture, each part of the tobacco operation contributes to this multi-billion-dollar industry. Six companies lead the world-wide tobacco business (see Appendix 2.1), each earning annual revenues of over US\$20 billion dollars although forty other small businesses or state-owned monopolies also manufacture cigarettes (A. Martin, 2014; Said, 2013). Two of these companies are based in the UK - Imperial Brands (formerly Imperial Tobacco) and British American Tobacco (ASH, 2017c; Said, 2013). The Tobacco Manufacturers Association (TMA) represents the tobacco industry in the UK, British American Tobacco (BAT), Imperial Tobacco (IT) and Japan Tobacco Industries (JTI)

are members. The UK Tobacco Industry supports and employs tens of thousands of jobs, employing over 5,700 people and a further 66,000 in retail, wholesale and distribution. Indirectly corner shops, newsagents and small stores also rely on tobacco sales as key sources of profit (McClellan, 2016b; Tobacco Manufacturers' Association).

Consumer spending on tobacco products between 2012/13 amounted to £15.1 billion, the majority of which was spent on cigarettes (Tobacco Manufacturers' Association). Taxes from tobacco sales also make a major contribution to the national budget and treasury (Lipson, 2017; B. Martin, 2015; Vaknin, 2007). For example, in 2011/2012 tax revenue from tobacco sales in the UK amounted to £12.3 billion, excise duty was £9.7 billion plus £2.6 billion in VAT (Tobacco Manufacturers' Association).

Constant tobacco regulations have necessitated the UK Tobacco Industry to cope with insecurity and uncertainty about its future. Consumers have also become price-conscious and ever-increasing prices see them shifting toward economy brands. “Roll your own” products have overtaken and is now cannibalising actual sales of cigarette (Bowers, 2010b; Riell, 2011). There has been a spate of job losses within the industry whereby JTI Gallagher and Imperial Tobacco ceased operations in the UK (Kollewe, 2014; H. McDonald, 2014).

Despite current anti-smoking climate, the UK Tobacco Industry remains buoyant. The value of cigarette sales increased in 2014 and the market is 30 times larger than the electronic cigarette market (FMCG, 2015; D. Robinson, 2014). Sales of tobacco accessories (e.g. “roll your own”, and “make your own”) have also increased (G. Anderson, 2017). Annual profits at both UK-based tobacco companies have risen

sizeably in recent years. In 2015 British American Tobacco realised pre-tax profits of £5.6bn and Imperial Brands pre-tax profit was £2.6bn (McClellan, 2016a).

Cigarette and Tobacco Promotion in the UK

With increased regulations around tobacco use, the tobacco industry sought various avenues to promote its products. Strategies such as direct advertising, third-party advertising contracts and co-branding, sponsorship, and corporate philanthropy (amongst others) were used in promotion activities. The blanket ban on all tobacco advertising and promotion in the UK means these strategies are no longer practical or relevant. They are however significant to the study thereby warranting mentioning here. Discussions on these are held in the paragraphs following.

Direct Advertising

Advertising was an essential approach used by the Tobacco Industry in the marketing of cigarette and tobacco products (Boyd et al., 2003; Simon Chapman, 1986). Tobacco Industry marketers strategically tailored advertisements to keep existing consumers using the product whilst encouraging adoption by potential consumers. Advertisements represented lifestyles and image aspirations instead of the actual product to encourage purchase and consumption (Ling & Glantz, 2002). For example, in the 1900's cigarette brands (e.g. *Woodbine*, *Craven A*, and *du Maurier*) were associated with brand imagery (Vaknin, 2007). Messages in the 1950's were endorsed by actors, medical professionals and even Santa Claus (Elliott, 2008). Message in the 1960's combined fashion with tobacco advertising and in the 1970's messages appealed to the ideal self through symbols such as the *Marlboro Cowboy* (M. Solomon et al., 2010). Direct advertising was also used to "exploit" the increasing

numbers of female consumers within the UK, achieved by segmentation and targeting. For example, brands such as *Chesterfield*, *Camel* and *Craven A* aimed their products at females showing them to be emancipated and independent, whilst *Virginia Slim* depicted them as sexually liberated (Vaknin, 2007); *Kool and Newport menthol-flavoured brands were targeted at the African-American population* (Edwards, 2011).

By the 1970s when the health risks of smoking became well-known and smoking was on the decline, marketing and advertising strategies changed. Packaging, a major advertising vehicle and communication tool (Moodie & Hastings, 2011), became less inventive reflecting the pressure for Tobacco Industry marketers to avoid presenting tobacco smoking as glamorous (Vaknin, 2007). Advertising and promotion reacted instead to what consumers wanted by shifting from a product-oriented to marketing-orientated approach (Simon Chapman, 1986). For example, cigarettes were manufactured in “*low tar*” brands to appease consumers concerned about the adverse health effects of smoking (Vaknin, 2007).

Third-Party Advertising Contracts and Co-Branding

Third-party advertising contracts and co-branding were used by the UK Tobacco Industry to build alliances and partnerships. For example, another Formula One (FI) sponsor would place a non-tobacco ad in a print and electronic media, but a car would appear in the said ad with the *Marlboro* logo emblazoned on it (Dewhirst & Hunter, 2002). *An example provided later in this section.* Co-branding strategies were used to enhance the product’s image. For example, the logos of “*TIC TAC*” and *Marlboro* would be placed side by side on racing driver Michael Schumacher’s helmet, implying the use of mint to combat smelly breath after smoking (Dewhirst & Hunter, 2002).

Example of Tobacco Industry Third Party Advertising



Honda - Event Sponsor

Lucky Strike and Benson & Hedges – Tobacco product logos.

Source: Dewhirst and Hunter (2002)

Sponsorship

Seen as a more cost effective way to retain cigarette brand imagery (Blum, 2005; Dewhirst & Hunter, 2002), Tobacco Industry marketers shifted strategy to sponsoring televised sporting events. Formula One (F1) motor racing was the most popular (Grant-Braham & Britton, 2012). Annual spend on sponsorship of F1 was approximately £70 million and a further £8 million on other forms of sport sponsorship (In Brief). Sponsorship deals included salaries of drivers and strategic brand placement on cars, helmets, and clothing (Dewhirst & Hunter, 2002).

Corporate Philanthropy

Another strategy used by the UK Tobacco Industry to promote tobacco was corporate philanthropy, the aim being to counter negative publicity about the industry (Fooks & Gilmore, 2013). For example, British American Tobacco donated £3.8 million which was used to help establish the Centre for International Corporate Social Responsibility at the University of Nottingham (World Health Organisation, 2004). Corporate philanthropy was mainly used as a public relations tool, with contributions often seen as a trade-off to compensate for the harms caused by smoking and corporate practices associated with it (Tesler & Malone, 2008). Charitable contributions were given on the basis (i) that they allowed access to policymakers and (ii) constituency building amongst civil society organisations to develop support for policy positions and generate third party advocacy. However, this practice contravenes Articles 5.3 and 13 of the WHO Framework Convention of Tobacco Control, which restricts tobacco companies from benefiting politically from charitable donations (Fooks & Gilmore, 2013).

Involvement in Scientific Research

The Tobacco Industry was involved in scientific research aimed at understanding how and why tobacco products cause harm and lethal diseases to those who use them. This was achieved by sponsoring research in noted scientific journals because they are credible and frequently used as reference materials (Cookson, 2009). This strategy was seen as a façade to hide ulterior motives such as (i) delay the passing of public health policies (Evans-Reeves, Hatchard, & Gilmore, 2015), (ii) produce scientific knowledge disproving existing knowledge that cigarette smoking cause lethal diseases and (iii) unsettle normative processes of knowledge production in medicine, science and public health (Brandt, 2012). For example, the UK Tobacco Industry

would sponsor scientists to conduct research about environmental tobacco smoke (ETS) which concluded it was not harmful to health (Muggli, Forster, Hurt, & Repace, 2001).

Once it was discovered that the Tobacco Industry biased scientific knowledge by misleading, suppressing, and casting doubt on proven scientific evidence about the harms of tobacco by generally creating manufactured controversy (Gage, 2013; Glantz & Parmley, 1992; Godlee et al., 2013), it produced negative consequences. A blanket ban was imposed in 1999 on academic researchers accepting funding from tobacco industries or taking part in joint research activities (Cookson, 2009). In 2013, academic journals such as *PLoS Medicine*, *PLoS One*, *BMJ*, *BMJ Open*, *Thorax*, *Heart*, *Journal of Health Psychology*, discontinued publication of research funded or partly funded by the Tobacco Industry (Godlee et al., 2013; Knight & Rattan, 2013).

Issues, Denial, Compromise of the UK Tobacco Industry

Scientific evidence linking cigarette smoking to cancer and other deadly diseases was discovered sometime in the 1950s (Courtwright, 2005; Hecht, 2006). Later reports published by the Royal College of Physicians in 1971 and 1992, respectively, identified cigarette smoking as the cause of illnesses such as chronic bronchitis, lung cancer, emphysema, diseases of the heart and blood vessels (The Royal College of Physicians, 1971), and respiratory diseases such as asthma and respiratory tract infection in children (The Royal College of Physicians, 1992). These reports substantiated evidence of tobacco's harm which was identified from the 1950's.

In the attempt to undermine reports from the Royal College of Physicians, UK Tobacco Industry insiders issued a statement denying the health risks of tobacco products, although vowing to cooperate in safeguarding public health (Yach, 2014). Stoutly defending their marketing efforts, UK Tobacco Industry insiders' argued the intent of their marketing efforts was not to increase demand for tobacco products, but help maintain brand loyalty and make smokers switch brands (Bates & Rowell, n.d.). Anti-smoking critics disagreed, suggesting the strategy deliberately ignored the health risks of smoking (Slovic, 2001), whilst increasing the Tobacco Industry's market share (Boyd et al., 2003).

Awareness by Tobacco Industry officials of the product's lucrative value (Courtwright, 2005), coupled with commercial marketing restrictions saw adjustments made to their marketing strategies which circumvented advertising restrictions to facilitate the continued sale of cigarette and tobacco products. For example, brand switching and brand stretching⁸ was encouraged and targeted towards youthful consumer segments (Warner, 2002). Cigarette coupons (Gerard Hastings & MacFadyen, 2000) and branded tobacco merchandise (Doward & Teuscher, 2005), were offered as free gifts and promotion through product packaging and point-of-sale materials. Packaging and branding, central communication and marketing mediums also changed. For example, wording on cigarette packets described strength and flavour, whilst packets were structurally designed which enabled consumers to feel the texture of the packet or hear a "click" upon opening (Sarah E Adkison, Bansal-Travers, Smith, O'Connor, & Hyland, 2014).

⁸ Using an existing brand name for tobacco products which are unrelated.

UK Tobacco Industry Fight Back

One way the UK Tobacco Industry fought back was by exploiting critical aspects of consumer culture (Brandt, 2012). Determined to defend its product in the face of mounting opposition, creativity and duplicity were used to accomplish marketing objectives. For example, the ban on availability of cigarettes in packets of 20 were circumvented by making them available in packets of 19 (Walker, 2014).

Legal challenges were also important in the UK Tobacco Industry fight back. When plain packaging for cigarettes sold in the UK was introduced in May 2016 (Gornall, 2015), British American Tobacco (BAT) threatened legal action on the grounds that [they] *had* lost their intellectual property rights, i.e. packaging and branding. More recently, British American Tobacco has been embroiled in legal challenges in Kenya and Uganda (Boseley, 2017), trying to block those countries' governments from instituting regulations which limit the harm caused by smoking. British American Tobacco's aim is to boost its market in Africa which has a young, fast-growing and progressively successful population.

Another more current and popular strategy used by UK Tobacco Industry marketers is participation in the customer-driven revolution known as e-cigarettes (Savedoff, 2014). *Studies on the effect of and exposure to e-cigarette advertising on US adolescents' tobacco smoking, found that e-cigarette advertising has a direct relationship to experimentation, use and re-normalising of tobacco smoking (e.g. Agaku & Ayo-Yusuf, 2014; Petrescu, Vasiljevic, Pepper, Ribisl, & Marteau, 2017).* Although these studies are about adolescents' resident in the United States of America (USA), they can be applied in the context of this study because participants of this

study acknowledge seeing e-cigarette ads which have had an impact on their adoption and use of the product. E-cigarettes are also found to be a popular quit aid for smoking participants in this study, although the product is not endorsed for that purpose by the National Health Service (NHS) within the United Kingdom (UK).

This practice of e-cigarette advertising warrants separate discussions, which are held in the following paragraphs.

Advertising E-Cigarette

The gradual decrease in cigarette sales as well as the indoor smoking ban, necessitated UK Tobacco Industry marketers to promote e-cigarette to smokers and non-smokers alike. Cigarette advertising has been banned on UK television since 1965 (Leicester & Levell, 2016), overseeing the disappearance of this mode of cigarette and tobacco promotion since the early 1990's (Mahdawi, 2014). However, because e-cigarettes are exempt from this advertising ban, it became worthwhile for the UK Tobacco Industry to capitalise on this advertising loophole (Dewhirst & Hunter, 2002). E-cigarette's manufacturing process also makes it easy to bypass established anti-advertising laws (Savedoff, 2014).

The first cigarette advertising appeared on British television on 10th November 2014, after a 20-year absence. This was by British American Tobacco advertising its e-cigarette brand "Vype", developed in its own research facility located in Southampton, UK (Akam, 2015; O'Dowd, 2014; D. Robinson, 2014). Stringent restrictions were placed on the format of this advertisement. For example, no reference could be made

to smokers but instead the word “vapers”⁹ was used; [online advertisements were not restricted in the use of the word smokers] (Perry, 2014b). The advertisement was aired after the 9:00 p.m. “watershed” time (Bentley, 2014).

In its attempt to re-normalise smoking, Tobacco Industry marketers targeted current smokers presenting e-cigarette as an aid to quitting (Savedoff, 2014). Encouragement of this strategy was buoyed by calls from Public Health England for stop-smoking services to recognise e-cigarette’s possible potential to the quitting process (Torjesen, 2015a). Consideration was also given to statements claiming e-cigarettes need only be “safer than tobacco” (Etter, 2013), but more significantly WHO’s position of not discounting the possibility that the e-cigarette could aid smoking cessation (Goniewicz et al., 2014).

However, anti-smoking *lobbyists* and health officials saw the reintroduction of advertising any form of cigarettes as regressive. Their claim was that e-cigarette advertising could signal the beginning of re-normalising smoking. Complaints lodged to the Advertising Standards Authority (ASA) alleged the *advertisements* glamorised smoking and targeted children, that the “tone” of the *advertisements* contravened the Committee of Advertising Practice and the UK advertising codes around advertising tobacco products (O’Dowd, 2014).

Bowing to pressure from anti-smoking lobbyists and health officials, changes to e-cigarette advertising were introduced. May 2016 saw the implementation of the Tobacco Products Directive (GOV.UK, 2016), which governs advertising for nicotine-

⁹ Another name for persons who use e-cigarettes.

containing e-cigarettes not licensed as medicines. On the one hand, this directive bans advertisements appearing on on-demand television, newspapers, magazines and periodicals (excluding trade press), e-mail, internet and text messages. On the other, it gives permission for ads to appear on outdoor posters, side of busses not travelling outside the UK, cinema, fax, leaflets and hard copies of e-mails. Furthermore, it permits Tobacco Industry advertising agencies to provide information about e-cigarettes on their individual websites without directly advertising these products (CAP, 2016; Rigg, 2016).

As e-cigarette's popularity rose advertising spend also rose. For example, in 2010 the UK Tobacco Industry spent £1.7 million on advertising e-cigarettes but by 2012 advertising expenditure reached £13.1 million (Buchdahl, 2013). Irrespective of e-cigarette's popularity however, public health debates (Fairchild, Bayer, & Colgrove, 2014) around its proliferation and use continue. Pro campaigners' welcomed e-cigarettes as a pathway to quitting, whilst anti-campaigners saw it as a dangerous untested drug.

Counter Strategies Employed by Government, Health Officials and Anti- Smoking Advocates

Cigarette smoking is the leading cause of preventable deaths in the UK (Pirie, Peto, Reeves, Green, & Beral, 2013), accounting for approximately 96,000 deaths annually (ASH, 2016c), evidencing the full effect of prolonged smoking on mortality rates. These statistics prompted intervention from Government, health officials and anti-smoking advocates to counter the aggressive marketing strategies of the UK Tobacco Industry aimed at propagating this deadly pastime. Strategies include restrictions on advertising tobacco products, encouraging quitting behaviour through visually graphic

messages, social marketing interventions and stop-smoking services. Paragraphs below explain these strategies.

Advertising Ban and Tobacco Advertising and Promotion Act (TAPA)

The UK Government's attempt to counter the creativity of the Tobacco Industry's marketing strategies saw a ban on tobacco product advertising on television, instituted between 1971 and 1972. Tobacco companies found in contravention of this directive were required to pay a fine of £5,000.00 for failing to observe the following restrictions: (i) placing health warning on cigarette packets, (ii) highlighting the consequential health issues of smoking and (iii) limiting the size of advertisements displayed in pubs, clubs and shops to the size of an A5 sheet of paper (Vaknin, 2007).

Further restrictions saw the staggered implementation of the Tobacco Advertising and Promotion Act (TAPA) in 2002, *prohibiting marketing, advertising and sponsorship of sporting events by tobacco companies* (Moodie & Hastings, 2011). The Act was further validated through the European Union (EU) Tobacco Advertising Directive established in July 2005, broadening the restriction on tobacco promotion across all European Union member states (Grant-Braham & Britton, 2012). At the time of implementation, TAPA did not regulate the display of tobacco products, although these have since been banned by regulations included in the Health Act 2009 (ASH, 2015). Table 2.1 provides an overview of directives and approach of TAPA.

Directives and Approach of Tobacco Advertising and Promotion Act (TAPA)

AIM: To control advertising and promotion of tobacco products for connected purposes. In the context tobacco products are taken to mean a product consisting wholly or partly of tobacco, intended to be smoked, sniffed, sucked or chewed.	
DATE IMPLEMENTED	DIRECTIVE & APPROACH
February 2003	Print media and billboard advertising banned.
May 2003	Direct marketing on tobacco banned.
July 2003	Tobacco Company sponsorship within the UK banned.
December 2004	Restrictions placed on tobacco advertising, where limits were placed on the amount of advertising allowed to a maximum space equivalent to the size of an A5 (21x15cm) piece of paper at the point of sale.
July 2005	Ban on sponsorship of Formula One motor racing.

Source: ASH (2015)

Encouragement of Quitting Behaviour

Through strategic partnership (Peattie & Peattie, 2009), public bodies encourage quitting. Smoking is presented in a negative light, highlighting the personal responsibility of individuals for consuming socially displeasing products which are detrimental to their health (Thompson et al., 2009b). Quitting behaviour is encouraged using strategies such as visual messaging (e.g. public service messages and fear appeal advertising) and social marketing interventions (e.g. *Stoptober*). These are discussed in the paragraphs following.

Visual Messages Using Shock Tactics and Fear Appeal

Graphic warnings and unsightly images on cigarettes packets such as rotting internal organs, body parts and teeth (Davey, 2014) and advertisements showing clogged

arteries and blackened lungs (Brooks, 2014), are examples of visual messages using shock tactics. Another example is presented in Appendix 2.2. These messages are designed to enlighten smokers and non-smokers about the dangers and diseases associated with smoking. According to Cancer Research UK diseases caused from smoking are ischaemic heart diseases, chronic lower respiratory diseases, malignant neoplasm of the trachea, lung, throat and cervical cancers. A study about smoking behaviour in Malaysia (A. K. G. Tan, 2012), identified these diseases amongst the top ten causes of death in smokers. Further discussions on the health consequences of smoking are presented *later in this section*.

In a study on attitudinal variations and reactions towards shock advertising (Parry, Jones, Stern, & Robinson, 2013), fear emotion was identified as being able to directly elicit attitude and behaviour change in smokers such as quitting or minimising smoking. Another study (Manic, 2015) concerning marketing engagement through visual content, concluded that because human perception is mostly visual fear appeals to smokers' understanding and memory whilst prompting direct response. There is, however, growing psychological research (Brooks, 2014), suggesting these types of anti-smoking ads are ineffective and can actually make quitting harder. Sometimes they are even viewed as scaremongering (Gayle, 2015), which cause denial, breed familiarity *and are ultimately ignored* (M. Williams, 2009).

Social Marketing Campaigns and Interventions

A recent study by Chriss (2015) examining the relationship between nudging and social marketing, defines social marketing campaigns as approaches to planned social change using public health interventions to encourage behaviour change in a reluctant and sometimes uninformed public. This definition sums up the position held by

smoking participant of this study. Some indicated that their reluctance to quit was because they enjoyed smoking, others acknowledged being uninformed about how social marketing interventions could help them quit.

Social marketing campaigns offer a promising approach to preventing smoking addiction (Croker, Lucas, & Wardle, 2012). For example, *Stoptober* aims to influence a reduction in smoking behaviour and improve the health and wellbeing of smokers, using sheer will-power to participate in an activity which benefit themselves and others in society. However, a review of the problems and challenges when using conventional approaches to social marketing (Bloom & Novelli, 1981), suggest social marketing interventions sometimes fail because individual behaviour does not always reflect the best interest of others. More recent evaluation of social marketing strategies (Borges & Chebat, 2015), found those who it is intended to help are usually the most resistant.

Stoptober

Stoptober is a popular UK-based social marketing intervention (Kinder, 2013), born out of a need to observe “*No Smoking Day*” observed in March whilst stimulating smoking cessation in the autumn months when smoking rates usually increase. This intervention derives from the dynamics of social contagion¹⁰, underpinned by the principles of SMART goals (**S**pecific, **M**easurable, **A**chievable, **R**ealistic, **T**ime-sensitive), and PRIME Theory (Brown et al., 2014). The word *Stoptober* is an

¹⁰ The propensity for others to copy the behaviour exhibited by one person in the same environment, or who have been exposed to media coverage describing the behaviour of that individual (Bastiampillai, Allison, & Chan, 2013; Boss & Kleinert, 2015).

amalgamating the words “*stop*” and “*October*”, mirroring engagement by association strategy used in other social marketing strategies.

With the *Stoptober* campaign smokers commit to being smoke-free for 28 days or four weeks (Kinder, 2013), demonstrating how workable this creative approach to quitting can be. This is particularly significant given the various issues (e.g. quit intentions, quit attempts, socio-economic status, addiction and exposure to mass media campaigns), which can impact smoking cessation and relapse. These have been identified in findings of a study by A. L. Smith, Carter, Dunlop, Freeman, and Chapman (2015) examining views and experience of smokers who quit unassisted. Still, there is some degree of success with the *Stoptober* campaign. During the month of October the campaign yields a 50% increase in quitting behaviour and an additional 350,000 attempts at quitting (Brown et al., 2014).

Stop Smoking Services (SSS)

Stop-smoking services were introduced in England sometime around 1999, run by the National Health Service, conducted in health-related settings such as hospitals, clinics or pharmacies. Trained stop-smoking advisors provide behavioural support and pharmacotherapy treatment to help smokers quit on a one-to-one basis, or in groups between the smoker(s) and an advisor (Gilbert et al., 2012; Taylor, Everson-Hock, & Ussher, 2010). Tablets such as nicotine replacement therapy (NRT), Bupropion, Varenicline, and Champix (Robson et al., 2013; Venn et al., 2016), are given to reduce withdrawal symptoms caused during the quitting process to replace the nicotine usually obtained from smoking cigarettes or tobacco products.

Stop smoking services have been found to be somewhat effective, *with about 500,000 smokers in the UK interacting with stop-smoking advisors annually (Taylor et al., 2010)*. However, their effectiveness at reaching and supporting disadvantaged smokers (for example, persons in routine and manual jobs) is questioned by Venn et al. (2016). Venn et al.'s position is particularly significant, given that individuals who fall into lower socio-economic status are the most likely to experience social inequalities (previously discussed in section 1.4.1.3).

Arguments in the preceding paragraphs gave an overview of existing strategies aimed at preventing smoking uptake or the continuation of it. Having laid this foundation, it is important to examine the health consequences of smoking which necessitated implementation of these strategies.

Health Consequences of Smoking

Brandt's (2012) study on conflicts of interest and tobacco industry tactics, observed that public awareness of the adverse health consequences of smoking increased during the 1950s, although the UK Tobacco Industry had been aware of the ill effects of tobacco use since the 1940s. Researchers, for example Cummings et al. (2002) and Heikkinen et al. (2010), linked smoking with respiratory disease and heart disease, whilst the risk of causing cancer of the oral cavity, pharynx, oesophagus, stomach, pancreas, larynx, lung, cervix, urinary bladder and kidney have been identified by Hymowitz (2012), *and* Lifson and Lando (2012). Smoking has also been found to increase the mortality rate of persons living with HIV, according to a study on quality of life of smokers infected with HIV by Crothers et al. (2005).

More in-depth discussions on diseases associated with smoking (e.g. lung cancer, heart disease, HIV associated infections) and risks associated with exposure to it (e.g. exposure to second-hand smoke), are presented in the *following paragraphs*.

Lung Cancer

Lung cancer is the leading cause of cancer mortality worldwide, according to a study on second hand smoke and lung cancer risk (Asomaning et al., 2008). Further studies on smoking habits of patients with lung cancer (Avci et al., 2015), found that between 80% - 90% of all cases of lung cancer are credited to tobacco smoking. The inference from these studies show that active cigarette smoking result in a higher mortality rate for smokers than non-smokers.

Lung cancer develops when inhaled tobacco smoke settles in the lungs, spreading to lymph nodes or other organs in the body such as the brain – a process called metastases (Centres for Disease Control and Prevention, 2014). According to Eldridge (2016), metastatic cause complications such as “tumour load” and infections such as pneumonia and sepsis. These complications and infections are what cause a person to die from lung cancer.

Studying global trends of lung cancer mortality and smoking prevalence, Islami, Torre, and Jemal (2015) observed that the proportion of lung cancer deaths differ across populations. For example, it is greater than 80% in the United States and France, 61% in a pooled analysis of 21 Asian cohorts and 40% in sub-Saharan Africa. The study also identified lung cancer as the third most common cancer in the UK, accounting for approximately 13% of all new cancer cases diagnosed. Statistics

released by Cancer Research UK support this finding, indicating that 46,400 cases of lung cancer were diagnosed in 2014. The highest incidences were identified in individuals between 85 – 89 years, approximately 24,800 males and 21,600 females.

Children and adolescents who adopt smoking between the ages 11 – 13 years also run the risk of getting lung cancer. Hymowitz's (2012) review of cigarette smoking, lung cancer and paediatric roots, identified this as the critical life period in which lung tissue becomes susceptible to the first stage of carcinogenesis, increased the risk of lung cancer and cardiovascular disease in adulthood. Children living in homes with parents who smoke (Wheldon, 2005), are also susceptible to contracting lung cancer through exposure to passive or second-hand smoking. It can be inferred from both studies that children aged 11 – 13 who adopt a smoking habit, have a greater chance of developing lung cancer later in life than their cohorts who do not.

Even more significant is the study by Boseley (2017) on maternal smoking and the risk of cancer in early life, which found that pregnant women exposed to environmental tobacco smoke could possibly contribute to the development of lung cancer in the unborn child via breastfeeding. The suggestion is that some forms of childhood cancer could occur during prenatal development, which is not present in pregnant females who do not smoke. In the context of this study, some *female* participants expressed the sentiment that pregnancy would necessitate them refraining from smoking to protect their unborn child from tobacco consumption harm.

Heart Disease

Smoking remains the most common risk factor for heart disease (HD) and coronary heart disease (CHD), according to research conducted by Khan et al. (2015) on the risk and burden of smoking-related heart disease mortality among people in the United States. This suggest that *individuals* who smoke have a greater risk of heart disease (Lee & Fry, 2011) and are most likely to suffer a heart attack (British Heart Foundation). Exposure to passive smoking can also increase these risks (Glantz & Parmley, 1992; Gottlieb, 1999; Whincup et al., 2004).

Heart disease manifests when fatty material (atheroma), build up around the lining of the arteries causing angina, a heart attack or a stroke. This is because the carbon monoxide in tobacco smoke reduces oxygen in the blood, lessening the amount of oxygen needed by the body. Furthermore, nicotine contained in cigarettes stimulate adrenaline production, speeding up the heart rate, raising the blood pressure and making the heart work faster. Therefore, the risk of blood clotting for smokers is higher, thus increasing the risk of heart attack or stroke (British Heart Foundation).

Heart disease is one of the top three killers of persons who smoke. In 2010, a total of 81,700 UK adult smokers aged 35 and over died from heart disease (ASH, 2011). This figure remained unchanged in 2013, although coronary heart disease represents the highest amounts of deaths – 7,900 (K. Allen et al., 2016).

HIV-Associated Infections

In the UK nearly 110,000 persons are living with HIV – 6% are gay and bisexual men, 40,000 black African men and women. This statistic is according to an article about HIV awareness of persons in the UK published in the *Daily Mail Online* by Hodgekiss

(2015). Earlier studies (e.g. Crothers et al., 2005; Drummond et al., 2010), examining quality of life with persons living with HIV show that smoking amongst HIV infected persons is a widespread activity whereby between 40 – 70% of them indulging in this habit. Inference from these studies show that when there is a prevalence of HIV people get nervous and smoking rates increase.

Smokers infected with HIV are more likely to contract other HIV-associated infections (Lifson & Lando, 2012); for example oral candidiasis in the oropharynx and recurrent bacterial pneumonia (Crothers et al., 2005). They may also have increased susceptibility to chronic obstructive pulmonary disease (COPD). Lifson and Lando's (2012) study examining smoking and HIV prevalence and health risks, identified incidences of tuberculosis (TB) to be over 20% higher in persons with HIV infection, and that in developing countries tuberculosis is responsible for more than a quarter of deaths of HIV infected persons.

Prolonged life expectancy in persons living with HIV infection has been made possible through advancements in highly active anti-retroviral therapies (HAART) (Drummond et al., 2010), although more studies are needed to fully establish the effectiveness of these *treatments* (Crothers et al., 2005; Madeddu et al., 2013). Still, the proportion of deaths due to tobacco-attributable conditions including cardiovascular, pulmonary, and non-AIDS defining cancers has increased significantly (Vijayaraghavan et al., 2014), due mainly in part to HIV-infected smokers' decreased adherence to anti-retroviral therapies (ART).

Second Hand Smoke Exposure to Smokers

Second hand smoke (SHS) also known as environmental tobacco smoke, is the side stream smoke emitted from the burning end of a cigarette, cigar, or pipe (Asbridge, Ralph, & Stewart, 2013; Oriola, 2009). Song et al. (2005) describe it as the smoke exhaled by a smoker and released into the surrounding atmosphere. Comprising a potent mixture of over 4,000 chemical compounds (Eisner et al., 2005), second hand smoke also includes gases, uncondensed vapours, tar and particulates (Song et al., 2005).

Exposure to second hand smoke increases the risk of smoking-related illnesses in both adults and children. Studies (e.g. Borrelli et al., 2016; Hawkins & Berkman, 2011; e.g. Martin-Pujol et al., 2013), found that second hand smoke increases the risk of foetal damage, intrauterine growth restriction, neonatal sudden death syndrome, acute respiratory diseases, chronic and acute otitis, atopy, ear infections and asthma. In adults second hand smoke causes illnesses such as asthma (Eisner et al., 2005), increases the risk of urinary cotinine (Song et al., 2005), *and* affects pregnant females by lowering the birth weight of the unborn child (Asbridge et al., 2013). Other studies (e.g. Asbridge et al., 2013; S. J. Kim, Han, Lee, Chun, & Park, 2015), identify a strong correlation to mental health issues and stress in non-smokers due to exposure to second hand smoke.

Worldwide, more than 600,000 people die from the effects of second-hand smoke (BBC News Health, 2011; S. J. Kim et al., 2015). The exact statistical data about the number of deaths in the UK resulting from second hand smoke could not be obtained. However, according to Cancer Research UK (2016), the figure could be in the

thousands with the most common causes being chronic obstructive pulmonary disease, lung cancer, heart disease and stroke.

Conclusion

Despite a reduction in overall smoking prevalence in the UK (Borrelli et al., 2016), and the positive health benefits due to existing smoke free legislation (Asbridge et al., 2013), tobacco smoking continues to be the cause of life-threatening illnesses and life-taking diseases such as cancer. According to the World Health Organisation there is no effective treatment for some types of smoking-related cancers (e.g. lung), with only 7% - 12% of those diagnosed with any form of cancer surviving five years after diagnosis. Islami et al's (2015) study on global trends of lung cancer mortality and smoking prevalence, suggest that current smoking frequency could see lung cancer being a major cause of deaths worldwide for several decades to come. In 2015 lung cancer (along with trachea and bronchus cancers), were responsible for 1.7 million deaths worldwide, ranking 5th in top 10 causes of death globally (World Health Organisation, 2017).

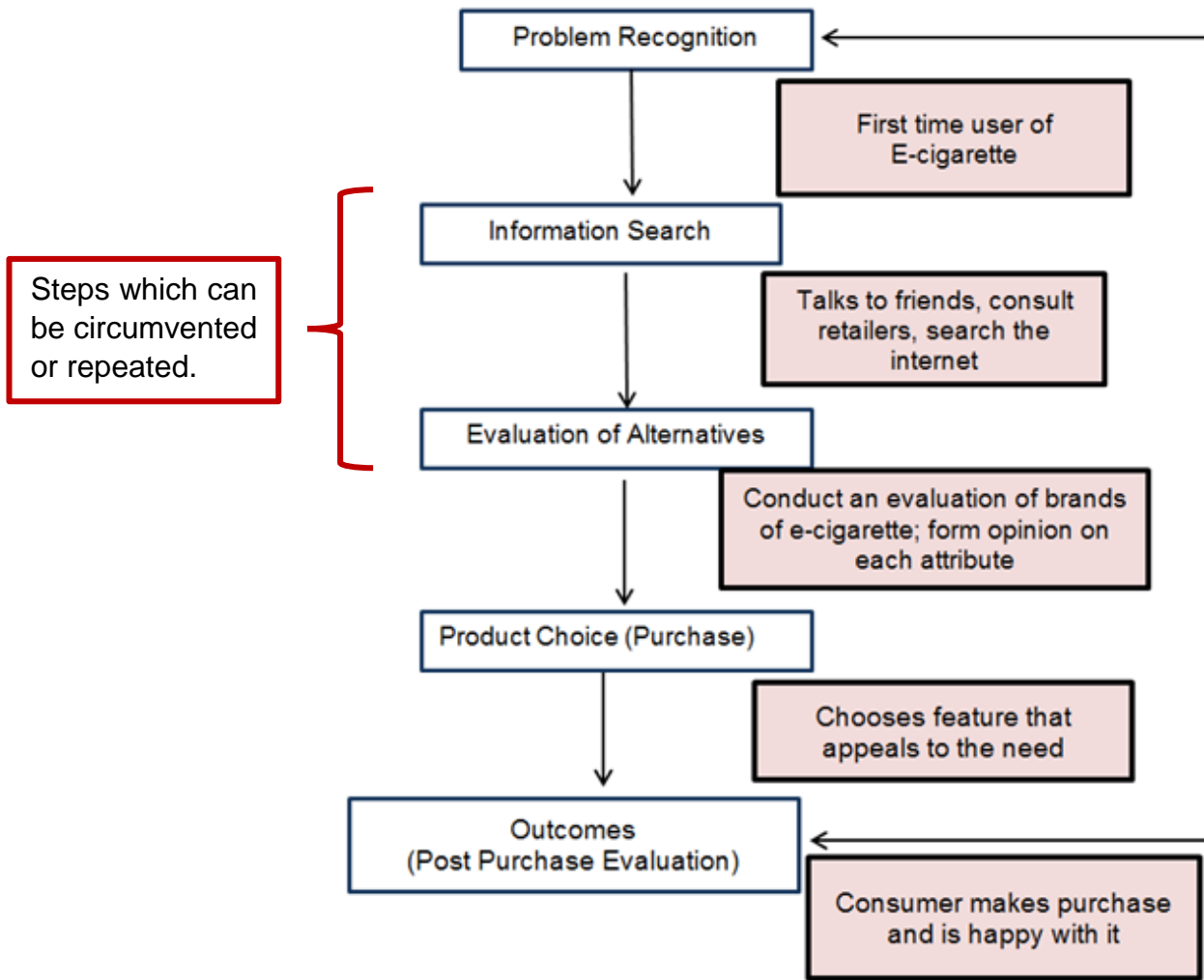
Within the UK strategies have been implemented to counter tactics employed by the Tobacco Industry to encourage smokers to ignore anti-smoking laws and keep using their product, for example social marketing interventions. Although some have been successful, the majority fail because they rely on smokers to voluntarily participate in behaviour change. Current anti-smoking climate and tobacco control measures in the UK, have placed the Tobacco Industry under pressure to limit its advertising and marketing strategy of presenting smoking as a glamorous pastime. The Tobacco Industry has reluctantly accepted tobacco control measures, maintaining that its

product is legal whilst striving for recognition that tobacco products are important consumer merchandise which makes significant contributions to the UK economy, (jobs, trade, retail, advertising, and the treasury). As a result, the Tobacco Industry has fought back, and *their efforts suggest they will not be deterred*. Interestingly, encouragement of the Tobacco Industry strategies come indirectly from smokers who continue with use and uptake, despite knowledge of the harmful effects of smoking.

The detrimental health effects of tobacco consumption are known globally, with many developed countries taking the lead in the fight to eradicate the deadly epidemic of tobacco smoking. Nevertheless, there are still obvious inequalities in adoption and implementation of denormalisation strategies worldwide. The UK is seen as leading the way in Europe (Joossens & Raw, 2014), with strategies such as indoor smoking bans, display bans and most recently plain packaging. These have been enacted despite the UK Tobacco Industry's efforts to thwart them. It could be said that indirectly smokers hinder tobacco control strategies' success by continuing to purchase and consume cigarette and tobacco products. Their behaviour suggests that more needs to be done to curb smoking prevalence *to achieve the intended behaviour change results*.

This section's review of cigarette and tobacco promotion within the UK highlights three things. First, it endorses established beliefs that tobacco advertising can increase consumption. Second, Tobacco Industry marketers will do whatever possible to encourage smoking uptake without thoughts for the health consequences and ignoring ethical practice. Third, tobacco companies will do anything to remain relevant and survive in the current anti-smoking climate (Gerard Hastings & MacFadyen, 2000).

For example, resorting to corporate bribery (Tesler & Malone, 2008), misinforming and manipulating medical research (Cookson, 2009), as well as suing national governments for loss profits (George, 2016). Speaking at the opening of the sixth session of the Conference of the Parties (COP6) to the WHO Framework Convention on Tobacco Control (FCTC) on 13th October 2014 in Moscow, Dr. Margaret Chan, former WHO Director General expressed the sentiment that tactics employed by the Tobacco Industry are “devious”, particularly because they are concentrated and targets every possible channel (World Health Organisation, 2014).



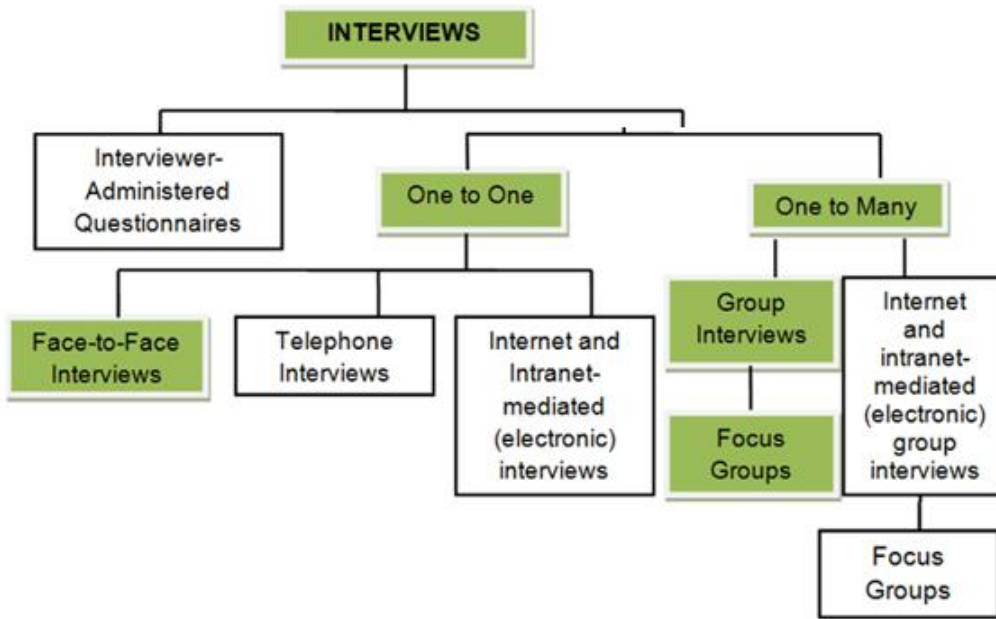
Source: Adapted from M. Solomon et al. (2010)

Appendix 2.2 Visually Graphic Anti-Smoking Message



Source: *Google Images (n.d.-b)*

Appendix 3.1 Forms of Interviews



Source: Adapted from M. Saunders et al. (2012)

Appendix 3.2 Styles of Interviewing

TYPES OF INTERVIEWING	CHARACTERISTICS
Structured Interview	Interviewer administers an interview schedule, thereby enabling all interviewees to be asked the same questions. This enables interviewees to receive the same interview stimulus, to enable the correct aggregation of interviewees' replies.
Standard Interview	Same characteristics as the structured interview, and is an alternative term for structured interview.
Semi-structured Interview	Interviewer presents a series of questions to the interviewee, which is in the general form of an interview schedule but is able to vary the sequence of questions. Interviewer has latitude to ask further questions in response to what are seen as significant replies.
Unstructured Interview	Interviewer has only a list of topics or issues, (interview guide), which are to be covered. The style of questioning is usually informal, and phrasing and sequence of questions will vary dependent on interviewee.
Intensive Interview	Same characteristics as the unstructured interview, as it an alternative term used to describe an unstructured interview,
Qualitative Interview	Embraces interviews that are both semi-structured and unstructured.
In-depth Interview	Can sometimes be referred to as an unstructured interview, but mostly refers to both semi-structured and unstructured interviews.
Focussed Interview	Interview which uses mainly open questions to ask interviewees questions about a specific situation or event that is relevant to them and of interest to the researcher.
Focus Group	Similar to a focussed interview, except interviewees discuss specific issues in groups.
Group Interview	Interviewees discuss a variety of matters that may be only partially related.
Oral History Interview	Unstructured or semi-structured interview in which a respondent is asked to recall events from his or her past, and reflect on them. (Can sometimes be similar to a focussed interview).
Life History Interview	Main aim is to glean information on the entire biography of each respondent; usually in an unstructured interview format.

Source: *Adapted from Bryman (2012)*

Appendix 3.3 Categorisation of Unit of Analysis

UNIT OF ANALYSIS	DESCRIPTION
An Individual	A person is the most common unit of analysis in business research; for example, a manager, a union member or a customer.
An Event	This is a particular incident; for example, a strike, a decision to relocate or a purchase.
An Object	In business research this is likely to be a commodity; for example, a machine, a product or a service.
A Body of Individuals	This includes groups of people and organisations; for example, a work group, a committee or a department.
A Relationship	This is a connection between two or more individuals or bodies; for example, a buyer/seller relationship, a manager/employee relationship, a management/union relationship, a company/supplier relationship or a relationship between a head office and its retail outlets. (An individual or body may be part of more than one relationship).
An Aggregate	This is a collection of undifferentiated individuals or bodies with no internal structure; for example, supporters of a particular football club, parents of children at a certain school, sole traders in a particular part of a city, or companies in a specific industry.

Source: *Hussey and Hussey (1997)*

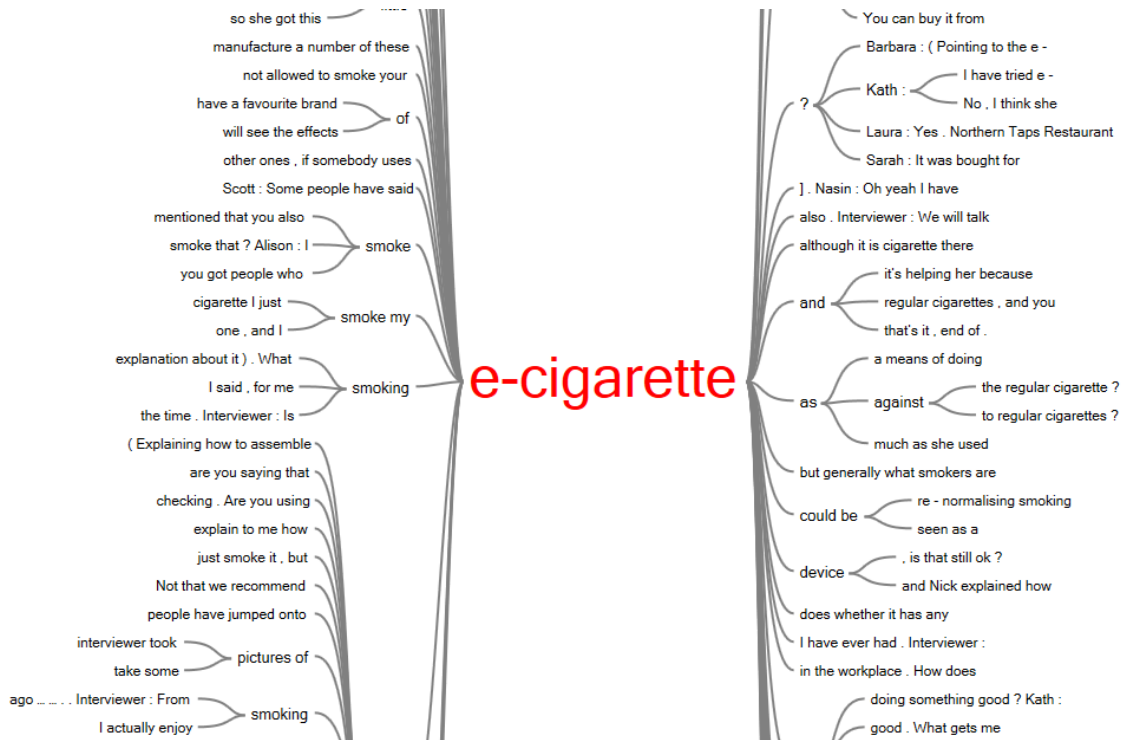
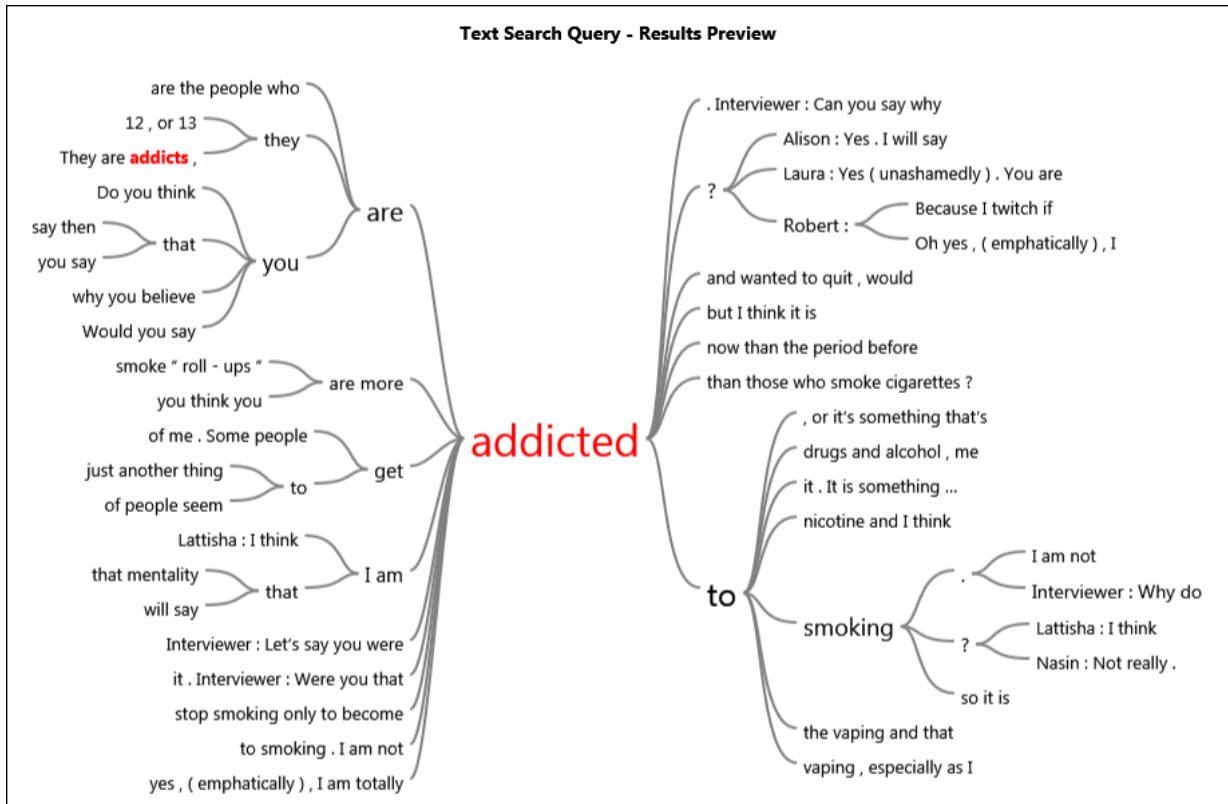
Appendix 3.4 Labelled Nodes Using NVIVO 11 Data Analysis Software

Nodes							
Name	Sources	References	Created On	Created By	Modified On	Modified By	
Addiction		20	35 06/09/2016 18:02	DMWW	09/11/2016 18:32	DMWW	
Care in the NHS		9	15 06/09/2016 17:33	DMWW	09/11/2016 18:29	DMWW	
Harm		19	39 04/09/2016 10:02	DMWW	09/11/2016 17:28	DMWW	
Impact of E-cigarettes		26	93 03/09/2016 23:39	DMWW	10/11/2016 00:14	DMWW	
Impact of Smoking Bans in Pubs, Clubs & Open Spaces		18	43 04/09/2016 18:49	DMWW	09/11/2016 18:26	DMWW	
Non-Smokers' Perception of Smokers		21	35 07/09/2016 17:34	DMWW	09/11/2016 18:30	DMWW	
Reaction to Anti-Smoking Messages in the Mass Media and on Packaging		20	89 06/09/2016 16:50	DMWW	09/11/2016 18:31	DMWW	
Reaction to Displaying Anti-Smoking Bans in Shops & Supermarkets		21	39 04/09/2016 20:01	DMWW	09/11/2016 18:26	DMWW	
Smokers' Perception of Smoking		17	41 06/09/2016 20:06	DMWW	09/11/2016 18:32	DMWW	
Smoking Influence		18	48 06/09/2016 18:45	DMWW	07/09/2016 20:46	DMWW	
Smoking Space		15	23 04/09/2016 14:56	DMWW	09/11/2016 18:20	DMWW	
Social Marketing		8	25 03/09/2016 21:39	DMWW	09/11/2016 18:29	DMWW	
Success or Failure in Combating the Innate Urge to Smoke		21	42 07/09/2016 19:18	DMWW	09/11/2016 18:27	DMWW	
Thematic Mind Map		0	0 22/11/2016 15:05	DMWW	22/11/2016 15:05	DMWW	

Appendix 3.5 Coding Hierarchy Using NVIVO 11 Data Analysis Software

Nodes							
Name	Sources	References	Created On	Created By	Modified On	Modified By	
Addiction		20	35	06/09/2016 18:02	DMWW	09/11/2016 18:32	DMWW
Addictiveness		0	0	10/05/2017 02:32	DMWW	10/05/2017 02:32	DMWW
Unable to ignore anti-smoking strategies		0	0	10/05/2017 02:35	DMWW	10/05/2017 02:35	DMWW
Unable to quit		0	0	10/05/2017 02:34	DMWW	10/05/2017 02:34	DMWW
Cigarette		17	35	08/09/2016 18:27	DMWW	09/11/2016 18:24	DMWW
Cold turkey		0	0	10/05/2017 02:36	DMWW	10/05/2017 02:36	DMWW
E-cigarette		5	6	08/09/2016 19:06	DMWW	09/11/2016 18:21	DMWW
Quitters jealous of smokers		0	0	10/05/2017 02:34	DMWW	10/05/2017 02:34	DMWW
Roll-ups		8	12	08/09/2016 18:53	DMWW	09/11/2016 16:49	DMWW
Self-efficacy		0	0	10/05/2017 02:34	DMWW	10/05/2017 02:34	DMWW
Care in the NHS		9	15	06/09/2016 17:33	DMWW	09/11/2016 18:29	DMWW
E-cigarettes		0	0	10/05/2017 02:31	DMWW	10/05/2017 02:31	DMWW
NHS need smokers		0	0	10/05/2017 02:28	DMWW	10/05/2017 02:28	DMWW
Smoking burden		0	0	10/05/2017 02:28	DMWW	10/05/2017 02:28	DMWW
Undecided		0	0	10/05/2017 02:30	DMWW	10/05/2017 02:30	DMWW
Treatment from NHS		0	0	10/05/2017 02:30	DMWW	10/05/2017 02:30	DMWW
Quit assistance		0	0	10/05/2017 02:31	DMWW	10/05/2017 02:31	DMWW
Treatments		6	13	08/09/2016 17:11	DMWW	09/11/2016 17:24	DMWW
Harm		19	39	04/09/2016 10:02	DMWW	09/11/2016 17:28	DMWW
E-cigarettes		0	0	10/05/2017 01:54	DMWW	10/05/2017 01:54	DMWW
Harm caused by smokers		0	0	10/05/2017 01:54	DMWW	10/05/2017 01:54	DMWW
Harming herself but not others		0	0	10/05/2017 01:54	DMWW	10/05/2017 01:54	DMWW
Harming Others		0	0	10/05/2017 01:53	DMWW	10/05/2017 01:53	DMWW
Self-harm		0	0	10/05/2017 01:54	DMWW	10/05/2017 01:54	DMWW
Quit smoking for 4 years, because of unfavourable medical check up result at his work place		0	0	10/05/2017 01:55	DMWW	10/05/2017 01:55	DMWW
Smokers harm people		0	0	10/05/2017 01:55	DMWW	10/05/2017 01:55	DMWW
Impact of E-cigarettes		26	93	03/09/2016 23:39	DMWW	10/11/2016 00:14	DMWW
Ability to smoke anywhere		0	0	10/05/2017 02:46	DMWW	10/05/2017 02:46	DMWW
Encourage co-existence		0	0	10/05/2017 02:41	DMWW	10/05/2017 02:41	DMWW
Accept e-cigarette smokers		0	0	10/05/2017 02:42	DMWW	10/05/2017 02:42	DMWW
Expense burden		0	0	10/05/2017 02:44	DMWW	10/05/2017 02:44	DMWW

Appendix 3.6 Text Search Query Using NVIVO 11 Data Analysis Software



Appendix 3.7 Consent Form Used in the Interviewing Process



RESEARCH ETHICS – CONSENT FORM

TITLE OF PROJECT: -

Consumption Practices, Conflict Resolution, and Behaviour Change in the UK Smokers' Market

NAME, POSITION AND CONTACT ADDRESS OF RESEARCHER: -

Donna Marie Wallace-Williams

PhD Research Student

c/o University of Huddersfield

Queensgate

Huddersfield HD1 3DH

PLEASE TICK BOX

I confirm that the purpose of the above-referred study has been explained to me, and that I have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw at any time, with or without reason.

I agree to this interview being audio-recorded.

I agree to the use of anonymised quotes in publications by this Researcher.

NB: Anything you say will be held in the strictest confidence. Your name will not be used in the transcript, and should your name be required, a pseudonym will be used instead.

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

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