Cultural context, older age and smoking in Scotland: qualitative interviews with older smokers with arterial disease

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SUMMARY

This paper explores how smoking among older smokers with a smoking-related illness is influenced by the wider cultural context of smoking. The paper draws upon a Scottish qualitative interview study to explore life course changes in smoking-related beliefs and behaviours, in current smokers between the ages of 65 and 84 years with arterial disease. The respondents’ understanding of smoking, as a socially acceptable behaviour of their youth, had undergone dramatic change over the course of their lives. While some respondents continued to associate their current smoking with their, albeit reduced, participation in social activities, others now smoked at home alone and associated smoking with increasing levels of isolation in their lives. Through an examination of how social attitudes may contribute to smoking as a solitary activity, the paper highlights the implications of cultural context for the adaptive strategies that older people use to cope with the circumstances and conditions of later life. The paper concludes that the wider cultural context of smoking is influential in shaping smoking as either an isolated ‘home’ activity, or as a ‘social’ activity for those whose opportunities to smoke in the private sphere are limited by disapproval of significant others. Within the social context, however, these ‘social’ smokers experience further constraints which shape and reduce their smoking behaviour. The data suggest that in order to be successful with this group of smokers, further research is needed to identify aspects of the lives of older people that sustain smoking in later life. These data will be necessary to develop appropriate health promotion measures to successfully target aspects of lives that support smoking in later life.

Key words: older people; qualitative; smoking; social context

INTRODUCTION

Heightened social awareness about the risks to personal health from smoking and of environmental tobacco smoke have led to a major shift in public attitudes towards smoking and have impacted upon smoking cessation. Some older smokers, however, continue to smoke despite having smoking-related disease. The Scottish study on which this paper draws has provided a unique opportunity to explore how older smokers with a smoking-related illness have experienced first-hand the changing tide of public opinion about smoking.

Background

For older smokers, the social context of smoking today is quite different from when they started to smoke. In the first half of the last century, the health risks were unknown (Lock \textit{et al}., 1998) and the unrelenting pressure of social disapproval as we now know it had yet to emerge (Law and Hackshaw, 1996; Mannio \textit{et al}., 1996; Sutton, 1997). The taboos about tobacco use among women (Chollat-Traquet, 1992; Graham, 1993) at the start of the 20th century had given way, as
early as 1935, to the acceptance of cigarettes as a leisure product for both sexes (Harrison, 1976; Wald et al., 1988; Graham, 1993). Data from the Mass-Observation study of 1937, combined with studies carried out in the second world war highlighted the crucial role of the social environment in cigarette smoking during the first half of the 20th century (Hilton, 2000).

It was not until 1950 that UK research findings, identifying smoking as an important factor in the development of lung cancer (Doll and Hill, 1950), were recognized by the medical community, and a further 12 years elapsed before the first of a series of reports on smoking and health was published by the Royal College of Physicians (Royal College of Physicians, 1962). Although prior to the 1950s studies existed that suggested a causal relationship between smoking and lung cancer (Pearl, 1938; Lock et al., 1998), their findings had either been ignored or dismissed in favour of more popular explanations of the day (Doll, 1998). Increased public awareness of the relationship between cigarette smoke and ill health have gradually turned the tide of public opinion against smoking. The health hazards associated with smoking have served to create a climate where smoking in some public places is no longer tolerated (Wald et al., 1991; Ehrlich, 1992; Law and Hackshaw, 1996; Willemsen et al., 1996) and, at the extreme, evoke severe social disapproval (Law and Hackshaw, 1996; Parry and Platt, 2000).

In the past, smoking was associated with increased frequency of social relationships, probably because smokers interacted with other smokers, and increased contact with smokers increased the likelihood of smoking (Ford et al., 2000). While to a lesser extent this may still apply today, in many contexts cigarette smoking is no longer the norm and social support in relation to smoking is now channelled more into smoking cessation (Royce et al., 1977; Murray et al., 1995; Rice et al., 1996; West et al., 1998). While increased public knowledge about the health risks has impacted upon smoking cessation among older smokers (Marsh and McKay, 1994; Clark et al., 1997; Jarvis, 1997; Kviz et al., 1997) and especially those with smoking-related illness (McKenna and Higgins, 1997; Orleans, 1997), some older smokers with smoking-related disease continue to smoke. The reasons for persistent smoking are complex and it is beyond the scope of this paper to understand why some older smokers continue to smoke while others quit.

However, the data do allow us to explore effects of the changing cultural climate on smoking behaviour in later life, and the implications for smoking cessation among these smokers.

METHODS

The sample
Seventy respondents were recruited from the Edinburgh Artery Study (EAS), which is a longitudinal study funded by the British Heart Foundation (Fowkes, 1994; Fowkes, 1995). The sampling frame for our study comprised those participants of the EAS (n = 110) who were aged between 65 and 84 years (in 1998), who had at least 10 years smoking history and an average cigarette consumption of not less than 10 cigarettes a week, and who had peripheral arterial disease and/or angina. Reasons for non-participation in the study were as follows: nine respondents were non-contactable, 10 refused, 18 were too ill to take part and three had died. Analysis presented in this paper is based upon data from the 22 current smokers in the sample.

The interviews
The study used one-off qualitative interviews with individuals, which incorporated an adapted version of the ‘life grid’ (Parry et al., 1999) to collect smoking data across the respondent’s lives. The interviews were conducted in people’s homes, lasting ~1 h. In the first part of the interview the grid was completed (by the interviewer) as a joint endeavour between researcher and interviewee. The grid was used to record structured data on experiences and events across different life domains (home, work, leisure, family and friends), and patterns and levels of cigarette use across the lifecourse. Information contained on the grid was used as a resource for both researcher and respondent in the second part of the interview, which explored in greater depth the levels and patterns of cigarette consumption, reasons and justifications for smoking, the smoking environment, wider social influences on smoking, changes in smoking behaviour (including quit attempts and returns to smoking after periods of abstinence), experiences of quitting and future smoking/cessation intent.
Analysis

The interviews were transcribed and entered into NUDIST. Patterns and themes emerging from the grids were identified and discussed in the interview, rather than being analysed separately. The interview transcripts were read in conjunction with the grids and a profile of lifetime smoking behaviour was established for each respondent. These profiles enabled changes in smoking behaviour to be contextualized within events and experiences of respondents' lives. The qualitative data were analysed thematically. First, the transcripts were re-examined for respondent references to the circumstances and contexts in which respondents' smoked. Recurrent themes were identified and tested by reference to the individual cases, and conditions and circumstances under which smokers deployed these formulations were compared and contrasted. In this paper, extracts from both transcript and profile data are used to illustrate key points.

The sample

The respondents comprised 14 women and eight men, aged between 65 and 84 years at the time of interview. Five were in their 60s, 14 in their 70s and three were in their 80s. Eleven of the respondents lived with their spouses, one lived with a brother, and the remaining 10 lived alone. Of the 12 respondents who did not live alone, four lived with smokers, six lived with ex-smokers and two lived with never-smokers. Of those who lived alone, one respondent was unmarried, two were divorced and seven were widowed.

The Standard Occupational Classification (HMSO, 1990) was used to guide the allocation of respondents to social class groups. Because the respondents were of retirement age, men were allocated to groups according to their pre-retirement occupation. Because of the older age range of the sample, relatively few of the female respondents (compared with today) had worked full time outside of the home. For this reason, married females were allocated to social groups according to their husband's pre-retirement occupation. However, in the case of the unmarried female respondents in the sample, allocation to a social class was guided by her own pre-retirement occupation. Using this method, no respondents were allocated to social group I, six respondents were allocated to social class II, three were allocated social class III non-manual, seven to social classes III manual, none to social class IV and six were allocated to social class V.

Reported levels of current smoking among the respondents were as follows: four respondents claimed to smoke less than one cigarette a day, four between one and nine cigarettes, nine between 10 and 19 cigarettes, and five claimed to smoke \( \geq 20 \) a day. It should be noted that many of the respondents claimed to have reduced their level of smoking and that the average levels of smoking across the lifecourse for many of these respondents was considerably higher than the current levels reported here. The majority of the smokers had lengthy smoking histories. In 1998, four had smoked for 40–49 years and 18 had smoked for \( \geq 50 \) years.

RESULTS

The social context of smoking when the respondents were young

The majority of respondents started smoking between 1930 and 1950, when smoking was a socially accepted behaviour. This was a period for men and women when 'smoking was the done thing' [respondent (R)7], 'when everybody smoked' (R3). In those days smoking was a social activity and respondents such as R1 did not recall solitary smoking: 'on my own, no'.

This was an era when the relationship between smoking and health was not public knowledge: 'There was no question of people knowing about lung cancer or anything like that' (R16). But even after the association between smoking and ill health had been made public, smoking continued to be accepted as 'the done thing'. Of her hospital experience in 1965, R13 said 'I went in for my first heart operation (and) you had an ashtray on your locker'.

The current social context of smoking

All the respondents acknowledged how the social context in which they currently smoked was markedly different from the contexts of smoking when they first started. From being a socially accepted and expected activity of their youth, smoking had, over the course of their lifetimes, become socially unacceptable to the extent that, as R17 reported: 'I feel a second class citizen anyway for smoking now', and R15 said 'we're the outcasts now'.
In the accounts of their early experiences of smoking, many of the respondents described experiencing social pressure to smoke. Conversely, respondents claimed that social pressure was now exerted to the opposite effect, in support of cessation. R1, for example, claimed that being ‘a social outcast in some quarters if you smoke’ had motivated him to attempt cessation because ‘you didn’t want to be out on your own’. While these smokers persisted in smoking regardless of social disapproval, many had moderated their smoking behaviour, at least in public. R10, for example, claimed no longer to smoke in public, after reaching ‘the stage where I felt guilty if I lit up a cigarette’.

Certainly, in some cases, social disapproval was effective in reducing the level of public smoking among our respondents. We found the female respondents, like R15, who said ‘you just dare not pull out a cigarette packet’, particularly sensitive to social norms surrounding smoking in public. In private, respondents experienced disapproval of their smoking from family members:

If I’m in somewhere where, I mean, my family they hate to see me smoking so I never smoke in front of them, even my husband, I dinnae smoke in front of him. I go away to the toilet or outside you know to have a smoke. You know I felt so guilty about it because I know that the doctors have done so much to help me and you know, I feel I’ve sort of let them down you know (R13).

**Smoking as a social activity**

Despite acknowledging awareness of changes in public attitudes towards smoking, some respondents related their own current smoking (albeit at a reduced level) to social activity. R8 (74 years old) had lived with her husband, who was an ex-smoker, until he died in 1990. She attributed the reduction in her level of smoking since her husband’s death to a reduction in her level of participation in social activities. In the data extract below, R8 describes an association between socializing with others and her previous level of smoking:

When you’re sitting drinking, the cigarettes are there and it’s just, you smoke more ... maybe it’s because you’re sitting doing nothing and you’re just sitting drinking and of course you know what it is, just habit really isn’t it and it’s just automatic ... you just do smoke more when you go out socializing.

R16, aged 67 years, quit smoking following a heart attack in 1997, but returned to smoking a few months later, following the death of a close family member. In the data extract below, R16 describes how she started smoking again during one of the weekly evenings out socializing with her sister:

Well I didnae have to start, it was just she was smoking and I just, said give me a cigarette one night and we had a fight about it and I eventually got one off her and then I got another one.

R16’s return to smoking was marked by a reduction in her level of smoking. Whereas before the heart attack R16 smoked 10 cigarettes a day, she now smoked only two cigarettes a week, and only when she was out with her sister. Other respondents specifically linked the level of their smoking with the level at which they socialized. R22, whose wife was a non-smoker, had reduced his smoking when they moved to a new city following his retirement:

Well I used to smoke before I came up here, used to smoke a lot because I used to go out more ... (now) I only smoke at funerals and functions (and) stag nights (laughs). If I went in the pub or I went in the (club) or anything like that I’d have a cigarette. but I don’t normally bother (going to pubs). But I must say if I’m socializing or out with anybody I must have a cigarette.

Other respondents also described how disapproval from partners and/or close family meant that smoking was restricted to outside the home environment. R13, married to an ex-smoker, said she smoked neither at home nor in the company of her non-smoking family:

Eh well if I was out having a drink I would enjoy a cigarette you know. But if it’s with my family or my husband I cannae have one ... he’d give me a hard time. He knows if I want to do it I would do it, but you know it’s sort of out of respect for him that I dinnae smoke in front of him.

**Smoking as a solitary pursuit**

For other respondents, smoking was a solitary rather than a social pursuit. These were respondents who described having limited social contact and for the most part lived alone. Moreover, these respondents tended to associate smoking with isolating aspects of their lives, which had arisen as a function of changed personal circumstances. These circumstances appeared to be
those that are often, although not exclusively, associated with older age. R4 had quit smoking at the age of 73 following surgery for peripheral arterial disease, but resumed smoking 2 years later following his wife’s death. Explaining that his wife’s death had left him lonely and bored he said ‘you come into an empty house, what do you do?’. When asked whether he would still be smoking if his wife, a non-smoker, was alive, R4 said ‘I might no have started again’.

R3, aged 82 years, returned to smoking after 19 years’ abstinence when his wife developed dementia. The reason R3 gave for restarting was to relieve the stressful situation of caring single-handedly for his wife until she died 4 years later.

R3: I nursed her for 4 years … a long time and eventually I had to start smoking. After putting her to bed I just oh … oh … relax, you know … it was really a 24 hour job, with her …

Researcher: Did you get any help or anything?

R3: No, no, I didn’t get any help, but (from) a neighbour.

Researcher: Did you have family here to help out then?

R3: No-one, my son was in Canada.

R3 persisted in smoking after his wife, a non-smoker, died because since her death he could not, he claimed, identify a sufficient reason to quit:

Life to me is now over as far as I’m concerned. She (my wife) died about 3 years ago. So, ah, (I’m) pretty lonely … Well, at this stage, I don’t worry about illness at all. I know I’ve only got what, a year or 2 years, 3 years to live so I don’t care what happens. So, no I’m quite strong though, to be honest I could give up smoking tomorrow (but) I don’t want to, there’s nothing to stop me unless I remarry.

Other respondents who smoked alone, like R16 (aged 79 years), reported that the death of a spouse had led to a changes in their daily pattern of smoking and/or increases in levels at which they smoked:

R16: Well I’ve seen me getting up and having a fag, first thing. Not every day but quite often I’ll get up and light a fag while I’m putting on the breakfast. I’m on my own now. And you know when the wife was alive I could get up and not smoke while breakfast was getting ready.

In some cases respondents who smoked alone at home said that increased isolation, caused by the death of partners, close family and other significant others was compounded by deterioration in their health. Often debilitated by smoking-related symptoms, these respondents associated increases in their level of smoking with decreased social participation. R15 (aged 73 years), for example, had lived alone all her life since leaving the parental home. R15, who had no living relatives or close friends and was virtually housebound due to the debilitating symptoms of peripheral arterial disease, said ‘I can’t do things I used to do and I find it’s quite easy to sit and smoke you know’.

DISCUSSION

When the respondents had started to smoke, smoking was, for both sexes, both acceptable and expected, and many described experiencing social pressure to take up smoking. Today, in contrast, they were clearly aware that in many contexts smoking was no longer socially acceptable or expected. Many were wary about their social reception, to the extent that some expressed unease about smoking in public, even in designated smoking areas. Most of the respondents acknowledged pressure from family and significant others to reduce levels of smoking and/or quit. That they had experienced, first hand, the tide of public opinion turning against smoking, arguably made them more sensitive to contemporary social norms surrounding smoking.

Some respondents continued to associate smoking with social interaction while others associated smoking with isolating aspects of their lives. Respondents who maintained social interaction, albeit at a reduced level, resisted social pressure to conform to contemporary societal expectations of smoking by maintaining that their current smoking was primarily a social activity. Some of the respondents who described themselves as ‘social smokers’ were discouraged or prohibited from smoking at home by spouses and/or other significant others, and in effect smoking outside the home provided them with their only opportunity to smoke. The fact that they now had less social opportunities to smoke available to them, due to a combination of social constraints and their life circumstances, arguably had implications for their current level of smoking. They tended to describe themselves as light smokers, many having reduced the level at which they smoked following periods of abstinence and
relapse. The data suggest therefore that although "social" smoking may provide an opportunity to continue smoking for some older smokers, the social context imposes severe constraints on patterns and levels of their smoking.

Respondents who described themselves as "social smokers" were in the minority and this is perhaps unsurprising in that older age is characterized by a generalized decrease in social participation, in both collective and individual terms (Page and Cole, 1992; Dugan and Kivett, 1994; Russell and Schofield, 1999). Decreased participation associated with older age has been described as a function of the cumulative effect of multiple role loss through withdrawal from employment, death of spouses and friends, caring responsibilities, and illness and disability (Russell and Schofield, 1999). The above, combined with low levels of income, have the effect of limiting opportunities for social interaction among older people. As a result, self activity is very important in the organization of their daily lives, and many of their activities (including television, gardening, reading) are done alone (Phillipson, 1998).

In our study the respondents who described smoking as a solitary pursuit tended to associate smoking with isolating aspects of their lives. These respondents tended to smoke at home alone. Living alone, often as a function of widowhood, these respondents said that they lacked social support for either assisting in reducing levels of smoking or quitting. Some, after a period of abstinence, had returned to smoking following the terminal illness and/or death of a significant other. These respondents said that they no longer had anyone at home to stop them from smoking, or to encourage them to cut down or quit, or to provide them with a sufficient reason to do so. Moreover, these respondents felt that in the absence of company and with little to keep them occupied, and being debilitated by disease, there were few if any activities, other than smoking, available to them. This supports the literature which suggests that options or strategies that assist individuals in coping with life circumstances diminish with increasing old age (Smith and Baltes, 1993; Lang and Baltes, 1997). Certainly, when explaining why they smoked, these respondents appeared to draw on what they felt to be a legitimate right to bodily dysfunction and cultural disengagement (Hepworth, 1997; Katz, 1997).

Although those who smoked alone said that continued smoking was linked to increased isolation in their lives, it is possible that these isolating factors were mobilized as an excuse or justification for smoking, and/or as a way of obtaining a sympathetic audience. As Blaxter notes, respondents present a take on the social world that they wish to promote and, when reporting health-related behaviour, may assume a moral obligation to be healthy (Blaxter, 1997). There is evidence, however, that social support was a crucial factor in both maintenance of smoking and cessation among the respondents. The solitary smokers effectively experienced few constraints on their smoking behaviour. This was suggested by the absence of significant others to deter smoking and/or support cessation, combined with low levels of social participation and, arguably, limited exposure to social disapproval.

Smoking may therefore constitute a strategy utilized by some older smokers to cope with the exigencies of later life. This is supported by recent research, which examined the ways in which individuals adapt to conditions of older age (including personal loss and social isolation), given limited (social, psychological or biological) resources (Baltes and Baltes, 1990; Baltes and Carstensen, 1996; Baltes, 1997). An interesting corollary to this is provided by qualitative research on the relationship between smoking and inequality, which has established how smoking is one mechanism by which women cope with living and caring in circumstances of disadvantage (Graham, 1987; Graham, 1993). Similarly, smoking may constitute a way in which some older people cope with or adapt to the conditions of later life.

Our study indicates that the cultural context of smoking contributes to and sustains the social isolation experienced by some older smokers. The socially integrative context of smoking experienced when these respondents were young had given way to a context in which smoking was more socially isolating. Isolation arising out of the respondents' life circumstances was compounded by a cultural context in which smoking is largely an anti-social activity. Smoking for some older smokers may therefore constitute both an isolated and isolating activity. For other older smokers, who do not lead such isolated lives, the social context continues to provide an opportunity to smoke, particularly for those smokers whose opportunities to smoke are limited by the disapproval of significant others. However, within the social context, these smokers experience
further constraints which shape and reduce their smoking behaviour.

The findings of the study have important implications for further research into smoking cessation among older smokers, who, in terms of smoking-related health promotion, are a relatively neglected group (Maguire et al., 2000). The research suggests a need for more in-depth studies into those aspects of smokers’ lives that might sustain smoking, in order to develop measures and combinations of measures to tackle smoking effectively at different stages of the lifecourse. Research is also needed to identify aspects of non-smokers lives that may serve to protect them against smoking in old age.

ACKNOWLEDGEMENTS

The Research Unit in Health, Behaviour and Change is funded by the Chief Scientist Office of the Scottish Executive Health Department (SEHD) and the Health Education Board for Scotland (HEBS). The opinions expressed in this paper are those of the authors, not of SEHD or HEBS. The study on which this paper is based was funded by The ESRC (Ref. R000237632).

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