Contextualizing smoking: masculinity, femininity and class differences in smoking in men and women from three generations in the west of Scotland

Kate Hunt\textsuperscript{1,2}, Mary-Kate Hannah\textsuperscript{1} and Patrick West\textsuperscript{1}

Abstract

The epidemiology of smoking, and contemporary and historical accounts of tobacco consumption, together suggest that the patterning of smoking by class, gender and gender role identities may differ markedly for people born at different stages in the establishment and demise of smoking in the 20th century. Here, we report an analysis that examines this assertion using empirical data collected from men and women living in the west of Scotland, an area with high rates of smoking, who were born in the 1930s, 1950s and 1970s. Class trends in smoking were less apparent for men than for women in the older two cohorts and there was little evidence of class patterning in either sex in the youngest participants. There was little relationship between the measures of gender role orientation and current smoking amongst men. Amongst women, the strongest association was between smoking and a well-validated measure of ‘femininity’ in the 1950s cohort; each unit increase in ‘femininity’ score increased the odds of being a smoker by 46%. In this same cohort of women, there was also a weaker relationship between smoking and higher masculinity scores. These results are discussed in the context of continuing use of gendered imagery to exploit new markets in the developing world.

Introduction

Tobacco use has been patterned by gender (Elkind, 1985; Ernster, 1985; Graham, 1976, 1987), and other important indicators of social status such as class, for many decades throughout Europe as well as in Britain (Graham, 1996). During the 20th century, different symbolic meanings were attached to the cigarette, particularly in relation to constructions of femininity [see Elliot (Elliot, 2001) for a detailed historical review of smoking amongst women in Britain, and Jacobson (Jacobson, 1981, 1988)]. Here we explore the relationship of indicators of masculinity, femininity and class with smoking in men and women born in the early 1930s, 1950s and 1970s.

Cigarette consumption in relation to sex and class

Greaves’ model that ‘typically, smoking diffuses through populations, establishing itself first among elite men, and working down class and status hierarchies and through the population’ [(Greaves, 1996), p. 32] is largely appropriate for Britain. Tobacco consumption in men was well established before the beginning of the century and increased up to the end of the Second World War. From the 1960s to the 1980s it fell substantially (Doll et al., 1997).

Until the mid-1920s tobacco use was largely a male habit (Elliot, 2001), and it was not until this time that the first cigarette advertisements explicitly directed at women appeared in North
America, the UK and other industrialized countries (Greaves, 1996). Only then did women in Britain begin to smoke on a large scale, almost exclusively in the form of manufactured cigarettes. Female consumption increased (rapidly so in the Second World War) until the 1970s when it began to fall, some 10 years later than for men (Doll et al., 1997). Repeated national social surveys from the early 1970s onwards allow a detailed examination of trends in tobacco consumption in Britain in the latter part of the century (Dunnell, 1997). These demonstrate a dramatic reduction in the prevalence of smoking and the diminution of gender differences: in 1972, 52% of men and 41% of women smoked, but by 1998/99, only 28% of men and 26% of women were smokers (Office of National Statistics, 2000).

Thus, cigarette consumption in women has always been lower than in men (although differences are now small or negligible in some groups). However, female consumption as a proportion of male consumption has been rising. Whilst women’s consumption (in terms of tar-weighted cigarettes per person per day) was only 9% of that in men in the 1930s, it had risen to around 70% by 1987 (Doll et al., 1997). This trend is seen even more strongly in teenagers in whom the traditional male excess in smoking was reversed in the mid-1980s to reveal a female excess which has continued, or even increased, up to the present time in both Scotland (Boreham and Shaw, 2001b) and England (Boreham and Shaw, 2001a).

The overall downward trend in smoking has obscured more complex trends in different age-sex groups (Dunnell, 1997) and the increasing concentration of smoking amongst those from the least advantaged circumstances, whose smoking rates have ‘barely fallen at all’ over several decades (Department of Health, 1998a). Figures for 2000 show a strong social class gradient for both men and women in the proportion who smoke: this ranged for men from 15% of professional men to 39% in unskilled manual occupations and from 13 to 34% for women (Walker et al., 2001). Just 4% of women from professional households report smoking during pregnancy in comparison with 26% of women from unskilled manual households (Office of National Statistics, 2002). In Britain, the Acheson Report on Inequalities in Health identified smoking as ‘an important component of differences in mortality between social classes’ [(Acheson, 1998), p. 83] and the recent White Paper (government policy document) on tobacco consumption states that ‘The objective is…to reduce the difference in smoking rates between manual and non-manual groups’ [(Department of Health, 1998b), 9.4]. These trends over the century demonstrate that smoking in Britain is increasingly emerging as ‘a habit acquired and sustained by those who occupy disadvantaged positions within the social hierarchy’ [(Graham, 1994), p. 102]. However, again a somewhat different pattern is evident at younger ages and class differentials in smoking among young people are not so apparent (Lloyd and Lucas, 1998). This disparity with the adult pattern may be partially explained by higher subsequent quit rates among non-manual compared with manual groups, although it might also suggest a fracturing of the class relationship in late modernity (Giddens, 1991).

Smoking and gendered imagery

It is no accident that tobacco consumption has had such a changeable history in relation to two of the most fundamental markers of social position. In the early part of the 19th century the imagery surrounding tobacco was masculine and anti-tobacco literature assumed the smoker would be male (Elliot, 2001). Military, particularly naval, imagery was especially popular. Smoking among women in the late Victorian period was confined to those ‘on the fringe of respectable society’ including the ‘fashionable New Women who sought to assert their independence’ (Hilton, 1995). Amos and Haglund have drawn attention to the way in which the tobacco industry capitalized on changes in the social and economic status of women and changing social attitudes towards women by ‘promoting smoking as a symbol of emancipation, “a torch of freedom”’ [(Amos and Haglund, 2000), p. 3]. Greaves (Greaves, 1996) argues that ‘the masculinity implied by smoking was a key part of
the cultural symbolism challenged by women smokers during the 1920s in industrial countries’ (p. 20) and comments on the tobacco industry’s efforts to reposition female smoking as ‘respectable…sociable, fashionable, stylish and feminine’ (p. 4). She contends that the development of more sophisticated definitions of sexual equality since the 1930s have allowed ‘six decades of elastic cultural definitions of women’s smoking. Even so, the link between smoking and representations of maleness remains in some tobacco advertising and in popular culture’ (p. 21).

Whilst the cigarette has often been portrayed as a symbol of female emancipation, different images of women and femininity in relation to smoking have prevailed at different points in the 20th century, in response to larger changes in gender role ideology. Elliott has argued that tobacco use in Victorian society amongst women became associated with deviance from constructions of ideal feminine norms, particularly those applying to middle class women of reproductive age, and that smoking was one tool which women could use to tackle dominant notions of ideal feminine behaviour (Elliot, 2001). Immediately after the Second World War women (‘usually young, white and middle class’) were represented in cigarette advertisements ‘as wives and lovers expecting reunions or as brides taking cartons of cigarettes on their honeymoons’ [(Greaves, 1996), p. 24] as large numbers of women were strongly encouraged to relinquish their war-time roles in favour of more traditional roles.

The tobacco industry thus has a long history of trying to promote cigarettes to new markets (as, for example, women in mid-20th century Britain and in many parts of the developing world today). Greaves has argued that the ‘cultural meaning’ of smoking has altered over the course of the 20th century in industrial countries:

…from a symbol of being bought by men (prostitute), to being like men (lesbian/man-nish/androgynous), to being able to attract men (glamourous/heterosexual) [reflecting...] historical differences in the power and control of women over her sexual existence. [(Greaves, 1996), pp. 21–22]

Whilst the tobacco industry has endeavoured to narrow gender gaps in smoking, thus necessitating some challenge to accepted social norms, it has also had to be careful to position its advertising within hegemonic notions of feminine behaviour [see (Elliot, 2001) for more detail].

Thus, although smoking was largely regarded as a male problem until the late 1970s, there has been increasing interest in smoking amongst women [see, e.g. (Samet and Yoon, 2001) for a recent summary of many of the issues]. Qualitative research has taken increasing account of gender (and its interactions with other axes of social hierarchies) in understanding smoking patterns [e.g. Hilary Graham’s work on smoking with caring responsibilities in disadvantaged circumstances (Graham, 1994), and Lynn Michell’s analysis of hierarchy and gender influences on smoking amongst secondary school pupils (Michell, 1997)].

However, relatively little quantitative empirical research has looked at gender role orientation and smoking (rather than sex differences in smoking) or has compared these relationships in men and women. Exceptions are two work-based studies in Scotland (of 2139 full-time employees in a bank and 1611 full-time university employees) which examined the relationship between gender role orientation [also as measured by the Bem Sex Role Inventory (BSRI)] and smoking (Emslie et al., 2002). These studies found that although there were no differences in smoking prevalence rates amongst men and women working full-time for the same organizations, men and women in the bank (and women in the university) who had high masculinity scores were significantly more likely to be smokers. Femininity scores were not related to smoking in either men or women in either organization. Higher expressions of masculinity have often been equated to greater risk of poorer health behaviours [see, e.g. (Helgeson, 1995)], although it has also been suggested that health behaviours are more favourable in ‘androgynous’
individuals, i.e. those who score high on both instrumental and expressive traits (Shifren and Bauserman, 1996).

Questions posed for the current research

In the light of these changing social meanings of smoking, a crucial omission from quantitative studies of smoking is any notion of historical context. The epidemiology of smoking, and contemporary and historical accounts indicating complex and changing links between tobacco consumption, gender and class together suggest that the patterning of smoking by class, gender and gender role identities may differ markedly for people born at different stages in the establishment and demise of smoking in the 20th century. Here, we report on an analysis that examines this assertion using empirical data collected from men and women living in the west of Scotland, an area with high rates of smoking and related diseases, who were born in the 1930s, 1950s and 1970s. The oldest generation were born at a time when smoking was still predominantly a male habit, and were in early adulthood when a majority of men and increasing numbers of women smoked, before the health risks of smoking were widely publicized. This generation was in late childhood and early adolescence during the Second World War when male smoking was almost ubiquitous and women began to smoke openly in large numbers. The middle generation were born at a time when smoking was at its height, when their fathers and many of their mothers were likely to be smokers, and when smoking in all environments (including the home) was widely tolerated. People in this generation were adolescents and young adults in the late 1960s and early 1970s when many social mores were being actively challenged. This included the strong contesting of assumptions about gender roles and expectations that were central to second wave feminism. As the first national smoking campaigns directed exclusively at female smokers were those focused on the effects of maternal smoking on the unborn fetus, this generation of women were also an early target group for such campaigns. By the time the youngest generation were born in the 1970s, the epidemiological case against smoking was well developed, and legislation restricting the promotion, sale and consumption of tobacco products was gaining momentum. When this cohort had reached their teens in the 1980s, smoking in young people, and especially amongst adolescent girls, had become a cause for concern amongst health policy makers.

Here, we compare the relationship between class and gender role orientation and smoking in men and women in these three cohorts.

Methods

Subjects

Data are presented from the West of Scotland Twenty-07 study, a longitudinal study of the social patterning of health amongst three age cohorts, born in the early 1970s, 1950s and 1930s, aged 15, and around 35 and 55 years when first studied in 1987/88. Respondents were sampled from residents in the Central Clydeside Conurbation, a socially varied, but mainly urban, area centred on Glasgow. Initial sample sizes in 1987/88 were around 1000 per cohort. Respondents have completed lengthy home-based structured interviews on subsequent contacts in 1990/91 and 1995/96, and a fourth round of interviews is ongoing in 2002. Further details on the sample and methods are available elsewhere (Ecob, 1987; Macintyre et al., 1989; Ford et al., 1994; Der, 1998).

Data are presented here from the 1995/96 interviews, when 2153 respondents were re-interviewed in their own homes by nurses trained in interview techniques: 676 people in the youngest (1970s) cohort (then 23 years), 754 in the middle (1950s) cohort (then 43 years) and 723 people in the oldest (1930s) cohort (then aged 63 years). A wide range of measures of self-reported health and health behaviour, of physical development and functioning, and of personal and social circumstances, has been collected at each face-to-face contact. In 1995/6, this included the BSRI (Bem, 1981) as a measure of gender role orientation. All
analyses reported here include only those subjects with no missing data on any of the variables included in the final regression models reported (number of men in the youngest, middle and oldest cohorts are respectively 290, 313 and 291; equivalent figures for women are 342, 401 and 261—see Table I). A longitudinal analysis of smoking following the youngest cohort from age 15 to 23 years has already been published (West et al., 1999).

Table I. Basic descriptive characteristics of sample

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Youth (age ~23)</th>
<th>Early mid-life (age ~43)</th>
<th>Late mid-life (age ~63)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
<td>Men</td>
</tr>
<tr>
<td>Total n</td>
<td>290</td>
<td>342</td>
<td>313</td>
</tr>
<tr>
<td>Smoking (% current smokers)</td>
<td>43.4</td>
<td>35.1</td>
<td>34.2</td>
</tr>
<tr>
<td>Hoh social class</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>10.3</td>
<td>8.2</td>
<td>12.1</td>
</tr>
<tr>
<td>II</td>
<td>21.7</td>
<td>23.4</td>
<td>35.5</td>
</tr>
<tr>
<td>IIINM</td>
<td>19.3</td>
<td>29.8</td>
<td>11.8</td>
</tr>
<tr>
<td>IIIM</td>
<td>30.7</td>
<td>23.1</td>
<td>32.3</td>
</tr>
<tr>
<td>IV</td>
<td>12.8</td>
<td>11.7</td>
<td>6.7</td>
</tr>
<tr>
<td>V</td>
<td>5.2</td>
<td>3.8</td>
<td>1.6</td>
</tr>
<tr>
<td>Employment status (% currently employed)</td>
<td>81.7</td>
<td>76.9</td>
<td>88.5</td>
</tr>
<tr>
<td>Marital status (% currently married/cohabiting)</td>
<td>23.4</td>
<td>39.8</td>
<td>87.2</td>
</tr>
<tr>
<td>Mean masculinity score (SD)</td>
<td>4.65 (0.75)</td>
<td>4.39 (0.76)</td>
<td>4.74 (0.81)</td>
</tr>
<tr>
<td>Mean femininity score (SD)</td>
<td>4.95 (0.76)</td>
<td>5.45 (0.73)</td>
<td>5.06 (0.80)</td>
</tr>
</tbody>
</table>

assumption that masculinity and femininity are both conceptually and empirically independent. It relies on an individual’s endorsement of a series of characteristics which have been judged to be culturally characteristic of either males or females. Respondents are asked to indicate the appropriateness of each item as a self-descriptor by assigning a score from 1 (‘never or almost never true’) to 7 (‘always or almost always true’). In this study we used the Short version of the BSRI which has 30 items, of which 10 are ‘filler’ items.

The masculinity score is the mean of the ratings for the 10 items which contribute to the masculinity scale (defend my own beliefs, independent, assertive, strong personality, forceful, have leadership abilities, willing to take risks, dominant, willing to take a stand, aggressive). Similarly, 10 items contribute to the femininity scale (affectionate, sympathetic, sensitive to the needs of others, understanding, compassionate, eager to soothe hurt feelings, warm, tender, love children, gentle). An inspection of missing data showed that for those

Measures

Socio-demographic variables

Head of household (Hoh) occupational social class (I, II, IIINM, IIIM, IV and V), marital status (married or cohabiting versus not currently married or cohabiting) and employment status (not employed versus employed).

Gender role orientation

The BSRI (Bem, 1981) is a widely used measure of gender role orientation. It is premised on the assumption that masculinity and femininity are both conceptually and empirically independent. It relies on an individual’s endorsement of a series of characteristics which have been judged to be culturally characteristic of either males or females. Respondents are asked to indicate the appropriateness of each item as a self-descriptor by assigning a score from 1 (‘never or almost never true’) to 7 (‘always or almost always true’). In this study we used the Short version of the BSRI which has 30 items, of which 10 are ‘filler’ items.

The masculinity score is the mean of the ratings for the 10 items which contribute to the masculinity scale (defend my own beliefs, independent, assertive, strong personality, forceful, have leadership abilities, willing to take risks, dominant, willing to take a stand, aggressive). Similarly, 10 items contribute to the femininity scale (affectionate, sympathetic, sensitive to the needs of others, understanding, compassionate, eager to soothe hurt feelings, warm, tender, love children, gentle). An inspection of missing data showed that for those
cases with any missing data, most subjects either missed all the items or only one or two items. Hence, masculinity and femininity scores were calculated for subjects who answered eight or more of the 10 items. The masculinity and femininity scores were generally normally distributed, although the femininity score for the 1930s cohort showed a slight negative skew. A validation of these items has been undertaken in the west of Scotland (Stroebele, 1992). More detail about its derivation (Bem, 1981) and its implementation in this study (Annandale and Hunt, 1990; Hunt, 2002) is given elsewhere.

**Smoking**

Current smokers (one or more cigarettes per day) are contrasted with never or ex-smokers.

**Analysis**

A series of logistic regression models were constructed using SPSS version 7.5. Unless otherwise stated, the reference category is the first category in the independent variables described above. The models are adjusted for employment status, marital status and all other factors (class, masculinity and femininity scores) in the model. Two-way interactions between the gender role orientation scales (i.e. masculinity and femininity scores) and the other factors, and between social class and employment status were tested for; as only one such interaction was statistically significant we have not included interaction terms in the models presented here. For the masculinity and femininity scores the odds ratio (OR) of being a current smoker is given for each unit increase in score.

**Results**

Table I presents descriptive details of the samples. The prevalence of smoking was around a third in each cohort, varying from 29% of women in their early 60s to 42% in men in their early 20s. As expected, employment status and marital status differed by cohort and gender. Given these major differences in occupancy of these gender-related roles between the cohorts (Hunt, 2002) and the variation of smoking in relation to such factors [see, e.g. (Walker et al., 2001)] all analyses reported are controlled for marital and employment status. As expected, the mean masculinity score was higher, and the femininity score lower, for men than women in all cohorts ($P < 0.001$ in all cases). The mean femininity scores showed a weak trend towards being higher at older ages ($P < 0.001$). No clear trends with age were apparent for the masculinity scores for men, but showed a slight linear decrease for women.

Table II presents ORs for smoking by class and masculinity and femininity scores for women; Table III shows the equivalent results for men. Social class was more strongly related to current smoking amongst the women in the older two cohorts than it was amongst the youngest cohort (Table II). There was no clear relationship between social class and smoking in either men or women in the youngest (1970s) cohort. In the older two cohorts, class trends were less apparent for the men than for women, although the lack of any relationship in the oldest cohort of men may partly be attributable to selective attrition and mortality (since male smokers in less affluent circumstances are the most vulnerable to premature mortality).

There was little relationship between the measures of gender role orientation and current smoking amongst the men (see Table III). The ORs for the masculinity score were very close to 1.00 for men at each age. Similarly, the femininity scores showed no relationship to smoking amongst men with higher femininity scores were somewhat more likely to smoke in the oldest cohort [OR 1.44 (95% confidence interval [CI] 0.98–2.10, $P = 0.062$)] for each unit increase in femininity score], although this fell just below conventional levels of statistical significance.

Relationships between gender role orientation and smoking were not the same in the three cohorts of women (see Table II). The strongest association was between smoking and femininity score in the middle cohort [OR 1.46 (95% CI 1.05–2.04, $P = 0.026$) for each unit increase in femininity score]
Higher femininity scores were associated with a higher likelihood of being a smoker. In this same cohort, there was also a weaker relationship between smoking and higher masculinity scores (although this fell below conventional levels of significance, OR 1.27 (95% CI 0.98–1.65, \( P = 0.76 \)). In the youngest and oldest cohorts of women neither masculinity nor femininity scores were related to current smoking (although the ORs for masculinity score in the youngest cohort were more similar to those seen in the middle cohort of women).

### Table II. Gender role orientation, class and smoking\(^a\) in women by cohort

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Youth (age ~23)</th>
<th>Early mid-life (age ~43)</th>
<th>Late mid-life (age ~63)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR</td>
<td>95% CI (( P ) value)</td>
<td>OR</td>
</tr>
<tr>
<td>Masculinity score</td>
<td>1.21</td>
<td>0.89–1.64 (0.225)</td>
<td>1.27</td>
</tr>
<tr>
<td>Femininity score</td>
<td>0.99</td>
<td>0.73–1.36 (0.973)</td>
<td>1.46</td>
</tr>
<tr>
<td>Hoh social class</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>1.00</td>
<td>(0.279)</td>
<td>1.00</td>
</tr>
<tr>
<td>II</td>
<td>1.58</td>
<td>0.56–4.41</td>
<td>1.37</td>
</tr>
<tr>
<td>IIINM</td>
<td>1.82</td>
<td>0.67–4.93</td>
<td>1.85</td>
</tr>
<tr>
<td>IIIM</td>
<td>1.76</td>
<td>0.61–5.10</td>
<td>4.34</td>
</tr>
<tr>
<td>IV</td>
<td>3.55</td>
<td>1.16–10.82</td>
<td>3.32</td>
</tr>
<tr>
<td>V</td>
<td>1.84</td>
<td>0.41–8.23</td>
<td>3.97</td>
</tr>
</tbody>
</table>

\(^a\)Adjusted for marital status, employment status and all other factors in the model.

### Table III. Gender role orientation, class and smoking\(^a\) in men by cohort

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Youth (age ~23)</th>
<th>Early mid-life (age ~43)</th>
<th>Late mid-life (age ~63)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR</td>
<td>95% CI (( P ) value)</td>
<td>OR</td>
</tr>
<tr>
<td>Masculinity score</td>
<td>1.07</td>
<td>0.76–1.49 (0.706)</td>
<td>1.10</td>
</tr>
<tr>
<td>Femininity score</td>
<td>0.95</td>
<td>0.69–1.30 (0.739)</td>
<td>1.17</td>
</tr>
<tr>
<td>Hoh social class</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>1.00</td>
<td>(0.057)</td>
<td>1.00</td>
</tr>
<tr>
<td>II</td>
<td>0.99</td>
<td>0.39–2.51</td>
<td>0.98</td>
</tr>
<tr>
<td>IIINM</td>
<td>1.62</td>
<td>0.64–4.11</td>
<td>2.51</td>
</tr>
<tr>
<td>IIIM</td>
<td>1.46</td>
<td>0.60–3.52</td>
<td>2.09</td>
</tr>
<tr>
<td>IV</td>
<td>2.61</td>
<td>0.94–7.23</td>
<td>2.98</td>
</tr>
<tr>
<td>V</td>
<td>5.48</td>
<td>1.35–22.27</td>
<td>1.73</td>
</tr>
</tbody>
</table>

\(^a\)Adjusted for marital status, employment status and all other factors in the model.

In the Introduction we argued that quantitative studies of the social patterning of smoking are often devoid of historical context despite the complex and often rapid changes in prevalences and meanings of smoking in different social groups. Our own analysis was intended to highlight how these relationships might change in generations in a relatively confined geographical locale born at three different points in the smoking
epidemic. The smoking prevalence rates reported here are approximately what would be expected for men and women of these ages living in the west of Scotland. In the 1995 Scottish Health Survey, 33% of men and 36% of women aged 16–64 years were current smokers, and rates were higher in the Greater Glasgow region than in other parts of Scotland (Dong and Erens, 1997).

The results in the current study show complex patterns in relation to masculinity and femininity that differ in the three generations studied. Neither the masculinity nor the femininity score showed any significant association with smoking amongst men in any of the generations, perhaps an indication that smoking has remained a less gendered phenomenon amongst men despite the general demise of smoking and its increasing feminization (in terms of prevalence at least). That they should differ amongst women is not surprising, given Greaves’ contention that ‘identity issues are so central and troublesome for women smokers. Women’s self-definitions in relation to smoking with respect to women’s selves are continually pushed to change’ [(Greaves, 1996), p. 105]. It was in the 1950s cohort where the strongest relationships were seen, with a 27% increase in the odds of being a current smoker for each unit increase in the masculinity scale and a 46% increase for each unit increase in the femininity scale. Most of the female smokers in this generation would have taken up smoking as young women during the 1970s, when promotion of images of women smoking (appealing both to idealized constructions of femininity and of independence) were being promulgated in the context of ‘second wave’ feminism. It is perhaps surprising though that relationships between the masculinity and femininity scores were neither strong nor significant in the cohorts born in the early 1970s and the early 1930s. It may be that different patterns might have emerged if ever-smoking, rather than current smoking, had been considered.

Graham has emphasized that it is not only the gender identity of cigarette smoking which has altered radically in the latter half of the 20th century; there has also been a ‘rapid shift’ in its class base (Graham, 1994). It is thus important to be sensitive to complex and changing patterns by class and gender as these are likely to continue to change over time. Whilst some interest has been taken in whether inequalities in health status are equally strong for men and women [see, e.g. (Koskinen and Martelin, 1994; Macintyre and Hunt, 1997)], less attention has been paid to comparing gradients in health behaviour in men and women. This analysis suggests that whilst class trends in smoking are less apparent for men than they are for women in the older two cohorts, there is little evidence of any class patterning in either sex in the youngest participants. This complements the findings of an earlier analysis of smoking uptake between age 15 and 23 which found no differences between young people from different social class backgrounds, a measure derived from parental occupation at age 15 (West et al., 1999).

This last finding is particularly interesting because it suggests the possibility that in this cohort, reflecting the conditions of late modernity (Giddens, 1991), the connection between social class and smoking is less apparent than before. It is also possible that the lack of any relationship between masculinity or femininity and smoking among 23-year-olds could reflect recent, and rapid, changes in gender roles and identities which promote greater homogeneity and androgeny, notably in relation to leisure activities (Wilkinson and Howard, 1997). The rapidity with which such changes can occur is illustrated in a comparison between this Twenty-07 cohort, when aged 15 at the start of the study, and another cohort aged 15 in the same geographical area who were surveyed 12 years later (Sweeting and West, 2003). Over this 12-year period, huge changes in leisure patterns occurred, some of which (an increase in commercialized leisure) involved males and females equally, others which were highly gendered. Most notably, an earlier male excess in ‘street-based’ activity disappeared over this period as males increased their time spent at home (mainly involved in home computing). Furthermore, these changes accounted (at least in part) for an equalization in alcohol and drug use between
genders over the 12-year interval and an increase in smoking among females. These findings demonstrate how quickly social change can impact both on gender identities and health behaviours like smoking.

Brandt, referring to the late 1920s, succinctly captured the ‘remarkably elastic meanings’ that the cigarette has embodied for both men and women:

The proclivities of the consumer culture reified distinctions of gender, even as the barriers to women smoking came tumbling down… For men, the cigarette evoked images of power, authority, and independence; for women, it represented rebellious independence, glamour, seduction, and sexual allure and acted as a flexible symbol for both feminist and flappers. The cigarette even managed to contain contradictory meanings; while smoking often symbolized rebellion against social mores, at the same time it represented conformity to the mores of the rising culture of consumption. [(Brandt, 1996), p. 64]

The recognition that smoking, like other health behaviours (Courtenay, 2000), is best understood as a gendered phenomenon is now widely espoused. However, it is important to recognize how dynamic this might be. Amos and Haglund commented on the cigarette held by ‘Irish born American femme fatale’ Lola Montez in a photograph taken in a Boston studio in 1851, remarking that ‘neither she nor anyone else could foresee the future symbolic value of the cigarette as a sign of emancipation for women’ [(Amos and Haglund, 2000), p. 3]. They comment on how:

…striking [it is that] tobacco companies have continued to use imagery around emancipation, the cigarette as a ‘torch of freedom’, as they attempt to develop new markets among women around the world. [(Amos and Haglund, 2000), p. 5]

The sale of tobacco products to women is currently ‘the single largest product marketing opportunity in the world’ and there are extensive efforts to recruit new female smokers in Asia [(Kaufman and Nichter, 2001), p. 69]; there is evidence that the tobacco industry is well aware of this (Christofides, 2001). A recent paper on smoking and normative gender roles in Vietnam shows that, to date at least, traditional gender norms inhibit women’s smoking (as they did in Britain in the early part of the 20th century), but warns that:

…health concerns cannot be counted on to discourage female tobacco use if social taboos weaken… Tobacco control advocates must recognise that men and women initiate, maintain and quit smoking within a social context in which gender is a major—but dynamic—fluence. [(Morrow et al., 2002), p. 688]

The press release following the WHO conference on Tobacco and Health in Kobe (WHO, 1999) demanded that the Framework Convention on Tobacco Control (FCTC) should include gender-specific concerns and perspectives and states that ‘gender equality in society must be an integral part of tobacco control strategies’.

Greaves (Greaves, 1996) has commented that ‘tobacco companies react to the diversity of contemporary women far more comprehensively than do health promotion agencies’ (p. 28) and that ‘it is ironic that [they] have perfected the notion of woman-focused advertising and promotion while health promotion in industrial nations has taken several decades to understand the place of gender in smoking’ (p. 92). O’Keefe and Pollay have also noted how the industry moved on from its success with associating certain cigarette brands with masculinity to become ‘particularly adept at understanding, predicting and capitalizing on the feminist movement by seizing the symbols of feminism and equating women’s liberation with smoking’ [(O’Keefe and Pollay, 1996), pp. 67–68]. Until this reverses, it is likely that young women, and those living in countries where smoking prevalences for women are low, will be seduced into smoking by a morass of complex gendered imagery surrounding smoking. As Brandt has remarked:
...understanding the precise cultural meanings of cigarette smoking at any particular historical moment may offer opportunities to understand not just the process of recruitment, but also the process of reducing cigarette consumption. Further, a recognition that cultural mores may be shifted by design offers the possibility of creating contexts that encourage smoking cessation; negative meanings for the cigarette may be ‘engineered’ as well. [(Brandt, 1996), p. 66]

Some smoking education programmes which are directed at youth (e.g. www.fablevision.com/smokescreeners) emphasize the importance of media literacy for young people in order to ‘inoculate’ them against the ways in which glamourized images of smoking (e.g. as presented in films) subtly encourage teenage smoking (Sargent et al., 2001). We would suggest that such programmes explicitly address gendered imagery, and that further programmes are developed to make new generations of potential smokers more aware of the varied and complex ways in which cultural constructions of gender roles and idealized images have been reinforced and modified by the tobacco industry over a number of decades.

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