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Young Women as Smokers and Non-smokers: A Qualitative Social Identity Approach

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Abstract

A social identity perspective was used to explore young women's perceptions of smoking. Thirteen focus groups and 6 intercept interviews with women aged 16-28 years old were carried out in regards to the social identities that may influence young women's smoking behavior. Three identities emerged: the "cool smoker" applied to the initiation of smoking; "considerate" smokers, who were older addicted smokers; and the actual and anticipated "good mother" identity which applied to young women who quit smoking during pregnancy. These identities add to our understanding of the meaning of smoking within the lives of young women and may allow more focused initiatives with this group to prevent the progression to regular addicted smoking.

Although smoking prevalence in Australia has fallen substantially across the population in the past three decades, the rates for women have declined less than those for men (30% in 1980 to 21% in 2001 compared with 40% in 1980 to 25% in 2001, respectively, White, Hill, Siahpush & Bobevski, 2003).

The prevalence is higher in younger age groups: For young women aged 18-24 years and 25 –29 years, the ages at which smoking prevalence peaks, prevalence were 28% and 27% respectively (White et al, 2003). Moreover, the prevalence of smoking among teenage girls (aged 12-17) is no longer declining (Hill, White & Effendi, 2002), suggesting that future proportions of young female smokers may be higher. These figures represent a significant cost to women's short and longer-term health. In 1998 an estimated 6075 women died in Australia as a result of smoking, approximately 10% of all deaths amongst women in that year. The apparent halt in decline of the proportion of younger women smoking suggests that the impact of smoking-related disease is likely to increase for some time into the future.

Cross-sectional and longitudinal studies have identified socio-demographic, environmental, behavioral and personal factors associated with smoking (Tyas & Pederson, 1998). Differences in correlates of smoking for young women from those for young men have also been found (Oakley, Brannen & Dodd, 1992). This is particularly the case for behavioral and personal factors such as stress (Milligan et al, 1997; Oakley et al, 1992), self-esteem and depression (Pederson, Koval & O'Connor, 1997; US Department of Health and Human Services, 2001), self-concept (Thornton, Douglas & Houghton, 1999), concerns about body weight or shape (Crisp, Sedgewick, Halek, Joughin & Humphreys, 1999; Honjo & Siegal, 2003; French, Perry, Leon & Fulkerson, 1994), dieting behavior (Austin & Gortmaker, 2001) and social factors such as peer influence (van Roosmalen & McDaniel, 1992).

Some studies suggest that young people actively choose to smoke because it confers specific social advantages (Leventhal, Keeshan, Baker & Wetter, 1991). For instance, teenage girls who smoke may place a higher value on being part of a particular social group (Snow & Bruce, 2003). Smoking may also act as a signifier of higher, rather than lower, social status and self-esteem for girls (Michell & Amos, 1997).

Given the possibility that young women may derive such perceived benefits from choosing to smoke, there is a need to better understand why young women begin to smoke and why they continue. An understanding of how smoking is perceived by this group and what role these perceptions play in young women's smoking behavior may assist in the design of interventions to prevent smoking and to help young female smokers to quit.

Qualitative methods offer researchers a way to develop a subtle understanding of motivations and behavior. Qualitative approaches investigating adolescents' and teenagers' experiences and explanations of smoking have shed light on the meaning of addiction (e.g., Moffat & Johnson, 2001) and tobacco dependence (e.g., Johnson et al., 2003), the role of smoking in pregnant adolescents' lives (e.g., Lawson, 1994) and how teenagers manage the process of refusing to smoke (e.g., Dunn & Johnson, 2001; Plumridge, Fitzgerald & Abel, 2002).

Social identity concepts offer a way to understand the influence of peers and social contexts on the smoking behavior of young people (Kobus, 2003) since they allow a more complex consideration of social forces than is offered by the concept of 'peer pressure' (Nichter, Nichter, Vuckovic, Quintero & Ritenbaugh, 1997). This is important because, although peers are a significant factor in smoking amongst adolescents (Biglan, Duncan , Ary, & Smolkowski, 1995), adolescents themselves perceive this as influence from their affiliations with particular peer groups rather than peer pressure as such (Plano Clark et al., 2002).

Social identity theory posits that the social categories or groups that people feel they belong to influence their attitudes and behavior. This occurs through the adoption of particular defining characteristics of the group (prototypes) that become part of the self-concept of an individual who identifies with the group (Hogg, Terry, & White, 1995). People have multiple, concurrent identities that are represented in their minds as separate social identities describing and prescribing the appropriate thinking, behavior and feelings associated with group membership (in-group) and non-members (out-group). Different identities are activated depending on what group is salient in the particular context. When a social identity is activated,

self-perception and behavior become in-group stereotypical and normative (Hogg et al., 1995). Moreover, social identity is comparative, and the nature of the social context determines whether the evaluation is relatively positive or negative; thus, in a given situation it may be self-enhancing to be a member of a particular group while in another situation the same group membership becomes a source of threat to self-esteem (Ellemers, Spears, & Doosje, 2002).

Previous studies adopting a social identity perspective have found separate identities for adolescent girl and boy smokers and non-smokers (Lloyd, Lucas, & Fernbach, 1997; Lucas & Lloyd, 1999; Plumridge et al., 2002). In addition, the attractions of smoking (Michell & Amos, 1997) and the resolution of the " 'problem' of being a non-smoker" (Plumridge et al., 2002, p.173) have been investigated through the social representations (Plano Clark et al., 2002) and social identities that young people form around smoking, smokers and non-smokers. These studies have focused primarily on the initiation of smoking amongst adolescents, typically school children under the age of 16 years. However, very little is known about young adults or the identities associated with the maintenance or cessation of smoking.

We used a social identity perspective to explore personal and social factors that influence the likelihood of smoking among young women between the ages of 16 and 28 years. Focus groups and intercept interviews were used to elicit young women's perceptions of the personal and social dimensions of smoking.

Method

Focus groups and intercept interviews were conducted with young women smokers, ex-smokers and non-smokers aged 16-28 years. Prior to conducting the focus groups and interviews, we recruited and met with six young women aged 19-28 years, who agreed to act as our advisors. We held two meetings, with three advisors in each. From these we developed a list of the smoking issues likely to be important to this age group. This was used to generate a guide for questions and prompts in the research. Because recruiting participants in this age group was difficult and time-consuming, even with the help of the reference group and youth workers, we opted for a mix of methods to gather data. Our primary method involved focus group discussions, and these were supplemented with a small set of intercept interviews.

Participants: Focus Groups

In deciding the number of focus groups and their composition, the principle of homogeneity in facilitating an effective focus group discussion was incorporated. Three categories of young women were identified as having sufficiently different life-stage issues or interests to warrant separate discussion groups. These were women of school age (16-18 years old); women who were slightly older but who had not yet started families (19-24 years old, no dependents); and women with children or who were pregnant (young mothers/pregnant women, 16-28 years old).

The groups were further classified according to smoking status (smokers versus non-smokers/ex-smokers). Smokers were defined as those who reported smoking daily or occasionally and who had smoked more than 100 cigarettes in their lifetime. Ex-smokers were defined as having smoked regularly or occasionally at some time in their lives, having smoked

more than 100 cigarettes in their lifetime, but who had currently quit smoking. Non-smokers were those who had never taken up smoking regularly and who had not smoked 100 cigarettes in their lifetime. Half of the groups were planned for rural areas and half for urban areas to allow differences due to location to emerge.

Recruitment of participants was attempted through various means. Youth workers were contacted about possible participants. Posters, flyers and promotional materials were distributed to young women's organizations and other youth-friendly sites in urban and rural locations, and an advertisement was also placed in a popular music street-magazine.

Participants in four groups of young mothers/pregnant women (two smoking; two non-smoking/ex-smoking groups) were recruited through youth workers. These focus groups were attached to the usual meetings that the young parents were already attending. One of the researchers facilitated the groups with assistance from the youth workers who normally met with them. Three rural focus groups were also recruited through the youth networks and were held by videoconference link: two groups of 16-18 year olds (one smoking; one non-smoking) and one group of 19-24 year old smokers. These were facilitated by one of the researchers.

A further two groups of 19-24 year old urban women (one smoking and one non-smoking/ex-smoking) were recruited using a snowball technique. Personal contacts fitting the criteria and agreeing to participate were asked to approach others. Once sufficient numbers of women agreed, we arranged a focus group at a time and venue to suit the participants. Finally, five rural focus groups were held at a youth event organized by regional youth councils and involving several hundred young women from locations all over the state. Four of these groups were 16-18 year old women (three mixed smokers and non-smokers; one non-smokers) and the fifth group was with 19-24 year old non-smokers. In all a total of fourteen groups were held: six non-smokers; five smokers; three mixed.

Groups ranged in size from two to seven participants. As indicated above, some of these groups comprised both smokers and non-smokers as a result of recruitment of friendship groups and other circumstances. This did not appear to compromise the discussions, as participants were well-known to one another.

Group discussions lasted between 50 and 90 minutes and were recorded. The method of recording varied depending on circumstances. A professional reporter attended five of the sessions, including the three held by videoconference, and typed a transcript of the discussion as it occurred. The other groups were recorded on audiotape and later transcribed by professional typists.

Participants were offered a department store gift voucher to the value of $20 in recognition of their time. They also received a certificate of acknowledgement.

Procedure: Focus Groups

Focus groups began with an explanation of the purpose of the research, the process of the discussion and issues of confidentiality. Participants were asked to consent in writing to the

recording of the discussion and given an opportunity to withdraw at any time. Ethical approval for this process was given by the University of Queensland's Behavioral and Social Science Ethical Review committee.

Discussions were semi-structured and began by asking: "What sorts of things come to mind when you think of smoking?" Follow-up questions followed the themes and interests that emerged in each group. In groups where some of the research interests did not arise spontaneously, questions directed participants' attention to those issues. Some questions were only relevant to smokers or non-smokers. Examples of questions were: (for smokers) "What do you like about smoking?"; (for everyone) "What are the positives of smoking?", "What are the negatives of smoking?"; (for smokers) "What sorts of things go with smoking?", "Can you tell me what happens around smoking when you go out socially?", "When you think back to when you first started smoking, who had the biggest influence on you then?"; (for non-smokers) "What happens about smoking when you go out socially?", "When you think back to when the people around you started smoking, who would you say had the biggest influence on you then?"; (for everyone) "Why do you think young women start smoking?", "What do you think makes it hard for young women to give up smoking?", "What do you think would help women to give up if they wanted to?"

In the mixed group discussions with young women at the youth event, the facilitator directed questions to smokers and non-smokers separately. This enabled the recorded information to be separated according to smoking status of the speaker.

Participants and Procedure: Intercept Interviews

The remaining urban 16-18 year old participants were recruited using intercept interviews conducted outside shopping venues in two lower socio-economic areas of Brisbane. Two trained interviewers were instructed to approach small groups of young women who appeared to be in the right age group and administer a short open-ended questionnaire. Written permission to record the interviews was obtained and participants were free to withdraw from the interview at any time.

The interview included demographic details, smoking status (for each participant) and five open questions: "What sorts of things come to mind when you think about smoking?"; "When do you think young women smokers are most likely to smoke (what situations or times)?"; "Why do you think young women start smoking at first?"; "Why do you think they keep smoking?"; "What do you think makes it hard for young women to quit smoking?" Six pairs of young women agreed to answer the questions (three smoking groups; two mixed; one non-smoking). Intercept interviews lasted about 10 minutes and were audio taped. Themes were extracted from these tapes in the same manner as for the focus groups (see next section).

Analysis

Transcripts of the focus group discussions were used for the analysis. Analysis of the material began after the first focus group with initial identification of key words and phrases. QSR NVivo © (QSR International, 2002) was used to assist in storing and displaying the material and allowed the grouping of key words and phrases into themes.

Findings

A number of themes emerged. In response to the questions and the ensuing discussion, young women spoke about the connotations of smoking, smoking initiation, triggers to smoke, social aspects of smoking, costs and benefits of smoking and experiences of quitting.

Smoking was seen as meeting a number of needs which varied according to the age group of the women. Younger women referred to the role of smoking in helping adolescents (themselves or peers) to fit in at the crucial time of starting high school (which typically begins at age 13 in Australia, or grade 8). Women over 20 years old still saw a need to fit in, but this was more governed by the normative status of smoking in social venues they attended. Their exposure to these was heightened, as for most people the 19-28 year age bracket represents a time of greater financial freedom and lowered family responsibilities. It is a time when social life and romantic relationships are primary concerns. However, those who had already started their families reported experiences around quitting smoking.

Connotations of Smoking

When thinking of smoking, young women reported both positive and negative connotations. The young women in this study saw the negative side of smoking in similar terms to those identified in other studies. The smell of cigarettes, cigarette smoke and smokers' bad breath after smoking were mentioned frequently as negative aspects of smoking by both smokers and non-smokers. Words like disgusting, revolting, stinky and gross appeared often in these accounts. The cost of cigarettes and the sense that the money spent on them was wasted also appeared in the descriptions given by both smokers and non-smokers. Positive connotations came from smokers or ex-smokers only and referred to the enjoyment and "fun" of smoking and to smoking as a way of relieving stress or enhancing relaxation. One group of women referred to the physical pleasure of blowing the cigarette smoke out as the most enjoyable aspect and one of the most difficult to relinquish in quitting.

Social aspects of smoking also appeared frequently, with smoking seen as a way of meeting other people and of bonding through a common activity. As one young woman put it:

> I used to smoke when there were people around. I used to enjoy it when you are sitting around and your friends are sitting around. When you had a drink, it felt really nice. You all had something in common. It gave you that friendly feeling. You were sitting around. (Young mother, ex-smoker, urban)

This social bonding aspect of smoking was noticed by non-smokers too and seen as a potentially strong influence on them to begin to smoke, as illustrated here:

> I've got a few friends that smoke and I can't smoke with them - I can't be with them when they're smoking because it makes me sick - physically sick. But I know that if I was always with them and it didn't have that effect on me there might be a temptation because they are always together and that's something that keeps them together, is the fact that they all smoke together. (16-18 year old, non-smoker, rural)

Smoking was also seen as an activity that went with particular activities like chatting on the phone, meeting friends for coffee and drinking alcohol, and was an integral part of some routines. This was one reason so many women reported difficulty when trying to quit.

Stress was particularly seen as a trigger or as a justification for smoking. Young women regarded any stressful situation as relieved by a cigarette during or afterwards, so that smoking was seen as a legitimate form of stress management or a coping strategy. For instance:

> Cigarettes are really good for stress. When you have one I find it calms me down. I found that, too, that was the main times when I felt like smoking again [when I was stressed]. When you get stressed you think "Bugger it!" (Young mother, ex-smoker, urban)

This stress management aspect was cited as a significant barrier to quitting by many of the smokers in the study and a strong reason for relapse, as shown here:

> I smoke now. I took it up again. When I was pregnant I gave it up. I didn't want to smoke with [the baby]. Everybody else was smoking around me and I didn't want to breathe it in…[then] After having [the baby] we moved into a new place. My boyfriend stressed me so much. I thought, "Give me a cigarette!" (Young mother, relapsed smoker, urban).

Starting Smoking: The Need to Fit In

Young women spoke about why they thought they had experimented or begun to smoke initially or why they thought others around them had taken up smoking while growing up. Generally they reflected on their school years in doing this, as none of the women who took part in this study had adopted smoking after their teen years.

Smoking to fit in with peers was cited as an important influence on both experimenting and smoking regularly. As has been found in previous studies (see Plano Clark et al, 2002; Plumridge et al, 2002), young women generally denied that this was peer pressure, seeing it more as a choice made in the expectation that they would feel a sense of fitting in better when they were smoking. Thus:

> Basically, like I say, a lot of my friends were smokers. They were smoking quite a lot. The only way I could fit in was by doing the same thing. (19-24 year old, smoker, rural)

Smoking and Alcohol

Young women identified situations in which smoking seemed more acceptable or where smoking behavior was increased. These were social occasions with smoking friends (as mentioned previously), parties and the pub or club scene. There was a sense that the rules for smoking were somehow different when alcohol was involved, and that cigarettes and alcohol formed a natural partnership. Non-smokers made very similar comments about smoking in these venues to those of smokers. They described socializing with alcohol, particularly in pubs and clubs, as leading to high numbers of people smoking. Smokers reported that when drinking they consumed many more cigarettes than usual. Some non-smoking women, particularly those in the youngest age group (16-18 years), said that socializing with alcohol had led them to experiment

with smoking. Other women described themselves as only smoking in these circumstances; that is, they saw themselves as "social smokers".

This finding suggests that smoking is normative behavior for these young women when it is associated with alcohol and socializing. Thus, in situations where young women are drinking and socializing, this social norm results in considerable pressure on people, even non-smokers and ex-smokers, to smoke cigarettes, as illustrated here:

> I think everyone does [smoke a lot when drinking]. I gave up smoking. When I went out drinking I would have a couple of cigarettes. When I was drinking I still smoked even though I was a non-smoker. (Young mother, relapsed smoker, urban)

Quitting

Young women were asked about their views on what was required for people like themselves to want to quit. Willpower was seen as very important to the process of quitting, and young women thought only people who really wanted to quit could do so. Those who had displayed this willpower by managing to quit either permanently or for several months were admired by other smokers. Some smokers expressed doubt that they could ever do this themselves. Quitting was seen as difficult or even insurmountable, something too permanent in the light of recognition of addiction and previous failed attempts. One young woman expressed this in talking about her current quit attempt:

> You just think it is too hard and you put it in the too hard basket and light up again. Whereas, if you focus on the positive things and think of it in baby steps. To say "quitting" to a smoker is so - to me, I don't know if it is the same for you, but it was so far-fetched. Quitting was like a real deadline. Like, "Okay, tomorrow I'm going to quit and tomorrow there's going to be no cigarettes." And as fast as I quit, as fast as I would start up again. And every time that failed but if you just think of it like a diet, you know, "I'm going to be less reliant on cigarettes." Don't say "quit", but just less reliant and then you kind of cut back as much as you can. (Young mother, trying to quit, urban)

Costs and Benefits of Smoking

All the women in the groups were aware of the health costs involved in smoking. Most seemed to be aware of the dangers posed by smoking during pregnancy, though some of the pregnant smokers either denied or dismissed this, reasoning that giving up was so stressful that it created more harm to the baby than continuing to smoke. Other costs mentioned were the cosmetic effects (wrinkles, yellowing, smelliness etc) and financial impact of smoking.

One distinction between smokers and non-smokers was that, while smokers could cite enjoyable aspects of smoking and benefits to themselves, non-smokers were not convinced of these at all. Thus smokers talked about the physical enjoyment, stress relief, anxiety management and the social benefits of fitting in and having a conversation starter or taking time out for themselves. Non-smokers however, though they could cite many of the same reasons to smoke as smokers did themselves, saw these as trivial, immature or false.

Emerging Social Identities

From these accounts, three social identities that may be helpful in understanding young women's smoking behavior were found. These were the "cool smoker" identity, the "considerate smoker" identity and the "good mother" identity.

Smoking initiation and the "cool smoker". Many of the young women who became regular smokers at some stage reported that smoking initiation was influenced by images of smokers as "cool", especially during the early high school years, supporting findings by other researchers (Nichter et al., 1997). Smoking at that time was seen as the way to join this cool group, who were characterized as rebellious, independent, tough or aggressive and fun loving. At a later stage, this image of smokers was rejected by some, who chose to become non-smokers. One description of this process was as follows:

> When I hit high school and saw people were smoking and it was generally what I thought was cool people doing it, I thought, to be with them, that's what I have got to do. Once you are there it's the other way around. The smart people, the better people [don't smoke]. You think at this stage they [smokers] are being rude to the teachers and smoking. Everyone looks up to them. They are cool. It's not like that [in reality].
> (Young mother, ex-smoker, urban)

The same attributes of "cool" were given by non-smokers, though they meant something different by them. Women in one of the younger groups who saw themselves clearly as non-smoking, were very articulate about these meanings. "Cool" in relation to smoking in their discussion had connotations of being disreputable and of "try hard" behavior. Though they too characterized smokers as "outgoing and rebellious" and "leaders" of others, they also saw them as easily led, easily influenced people, unaware of their own motivations for smoking and in denial about their own possible addiction or vulnerability to health effects. Leading in this context seemed to mean leading weaker others astray rather than positive connotations. One young woman expressed it this way:

> To me, if I see somebody smoking I think "loser!"….. I see them [smokers] as try hards. They are trying to be cool. They are the ones that are trying to look really good. [I want to say] "You are just like--that is just stupid! Why try to be something you are not?"
> (16-18 year old, non-smoker, urban)

Smokers were also seen as having a greater degree of freedom from parental constraint and therefore able to engage in illicit behaviors, such as going to parties, staying out late, drinking and smoking. They were believed to begin all adult behaviors ahead of time, to be "one step ahead of us". In contrast, non-smokers saw themselves as "late developers" or "normal" in development. They were more inclined to care about what their parents thought and therefore less likely to have been to parties without permission or to smoke. Though the non-smokers were somewhat envious of this freedom, they were adamant that they did not want to be like smokers, who were seen as having suspect relationships with other people. Smokers' friendships were described as being more transient and "backstabby" in contrast to the enduring nature of the friendships the non-smokers had experienced in one another.

As well as the opportunities to engage in illicit behavior, smokers were also seen to have

personalities that inclined them towards using those opportunities. They were described as "daredevils" who needed to "always be having fun" and who might be doing other sorts of drugs, engaging in sexual behavior, or drink driving as well:

> …they [cool smokers] started doing everything before us, before the normal people. So now their parents, I guess, would consider [them] just going to a party as the equivalent of us going to the movies…And they are always kind of one step ahead of us…[and] there are always people who sleep with others at an earlier age…not all of them, but a lot of them would probably be more inclined to do physical stuff with other people….I don't like their attitudes…I suppose, going out they just think they are more superior, type of thing. (16-18 year old, non-smoker, urban)

These behaviors were appreciated as risky or life threatening by the non-smokers and as activities they would never do themselves.

The "considerate smoker". The young women in the study noted that smoking has become a much less acceptable habit to display in public places. They had a heightened sensitivity regarding the need for smokers to recognize the impact of their behavior on others and to be considerate rather than "inconsiderate" of non-smokers. Comments with this underlying theme came more often from smokers than non-smokers and, consistent with social identity theory, appeared to serve the function of helping smokers to cope with the negative status that smoking has begun to confer on smokers. Thus smokers distinguished two classes or groups of smokers: the considerate smokers (to which they belonged) and inconsiderate smokers. Considerate smokers recognized the personal choice aspect of smoking and the choice of non-smokers, particularly children, not to smoke. They thought about the impact of their behavior on others and said they did not impose their cigarette smoke on people. In contrast "inconsiderate" smokers were perceived as those smokers who forced their habit on others around them. The following quotes capture these distinctions:

> I got really annoyed at inconsiderate smokers because, I swear I have never done this as a smoker, I never, ever smoked around children and pregnant people and around where people can't, you know, get away and they have to be waiting there. (Young mother, trying to quit, urban)

> Smokers should care about non-smokers. They have made that decision not to slowly kill themselves with nicotine. That is their choice. We need to respect that and leave that with them. If I am in an outside area sitting close to someone, even if they are at a different table…I will get up and move away. I am conscious that it may be annoying other people. (19-24 year old, smoker, rural)

> Speaker 1: Now we go to parties and stuff but usually people just drink. But smokers, they'll go outside and smoke on a veranda.
> Speaker 2: Yeah.
> Speaker 1: Yeah, they're pretty good.
> Speaker 2: Yeah, they're pretty good and they won't smoke inside where the party is and they won't force you - they'll ask you, "Do you want some?" [If] You say, "No" [then]

That's fine.

Speaker 1: I find they respect you. They're a lot more considerate.
(Members, 16-18 year old, non-smokers, rural)

Mothers smoking around their children and pregnant smokers formed a special sub-group of inconsiderate smokers. They were highly visible and were seen as doing the wrong thing towards their children. One participant went as far as to use the term "child abuse" in relation to smoking around children, illustrating the frequently judgmental tone of comments. This view was shared by many of the mothers themselves, as shown by this next quote:

When I was pregnant he [partner] was really angry [at me for smoking] and I was angry at myself too because I was pregnant. I couldn't help it. (Young mother, relapsed smoker, urban)

However, some young women recognized the effect of addiction and tried not to judge pregnant smokers who had (presumably) been unable to give up while pregnant.

Sub-typing of smokers into considerate and inconsiderate smoker groups suggests that smokers as well as non-smokers are aware of the negative social impact of smoking. Smokers appear to deal with this by claiming membership of the better social group, the "considerate smoker" that allows them to continue to smoke as long as they don't affect non-smokers.

The good mother identity. Young pregnant women and young mothers in this study often reported having given up or trying to give up for the pregnancy. This is consistent with other studies that show pregnancy, or the preparation for it, are strong motivators for women smokers to quit (e.g., Curry, McBride, Grothaus, Lando, & Pirie, 2001). In our study, this behavior was universally undertaken for the health of the baby and to be a "good mother". However, women's feelings about this appeared to be mixed: many expressed regret about quitting smoking at the same time as they clearly appreciated the benefits for the baby. This regret centered around loss of the perceived benefits of smoking, especially those related to routine, alleviation of boredom, stress management and the idea that smoking is more fun than not smoking. Presumably because of these losses, some women were ambivalent about whether they would continue to be non-smokers after the birth, while others indicated that they had only quit for the duration of the pregnancy and would return as soon as the baby was born. This is captured in the following quote:

I miss it. I loved it. I enjoyed just sitting there being able to talk to your friends and have a smoke. I loved it. I will most likely go back to it. I'm not quite sure. (Young mother, ex-smoker, urban)

Other studies have found that smoking during pregnancy, especially among socio-economically disadvantaged women, may be adaptive rather than maladaptive and that pregnant smokers are still very concerned for their children and the health of their babies (see for example Lawson, 1994). There is certainly evidence of this in our study. Young pregnant women appeared to be complying with perceived social norms and pressures of what it means to be good mothers. In the present normative climate, "good mothers" are smoke free during pregnancy.

However, their ambivalence and regret signals that they have not undergone a change in identity from smoker to non-smoker.

General Discussion

This paper adds to our understanding of smoking among young women through explicating the social identities that influence their smoking behavior. We know that smoking starts as a social behavior in adolescence and early adulthood, and as such is bound by social context. However, once addicted, smokers progress to smoking alone as well as socially. So-called "social" smoking is particularly bound by the social contexts in which it occurs. Social identity theory helps to flesh out the normative conditions under which young women begin to smoke socially.

Our findings suggest that women in early adulthood smoke for reasons that are different from those that influenced their initial smoking experimentation or adoption during adolescence. While the "cool smoker" identity emerged in conversations about influences on early smoking, where its appearance lends credence to notions of the functionality of beginning to smoke for some young women, there were clear rejections of this identity's attributes at later stages of women's lives.

As elsewhere (Nichter et al., 1997), we found a particular association between young women's perceptions of smoking and drinking alcohol. While non-smokers may have expressed dislike of aspects associated with smoking, in the context of social venues where drinking alcohol is a primary focus, smoking assumed an acceptable and normative status. This was even more marked for smokers. This finding is important for policy-makers and legislators, who have the power to affect the context in which young people are making this association.

The finding that both smokers and non-smokers are able to see the costs of smoking, but smokers are more aware of the benefits, suggests a possible predictor of vulnerability to adoption of smoking in the later years of adolescence or young adulthood: the appreciation of smoking as beneficial rather than (as for committed non-smokers) being unable to make sense of smoking. This finding is in keeping with that of Dunn and Johnson (2001) that non-smoking girls must first decide that smoking serves no use to them before they can reject it.

Implications for Intervention

The emergence of the three social identities associated with young women's smoking has important implications for intervention. Foremost among these is that the social nature of social identities means that interventions can be designed at the social rather than individual level. This could be done through two main approaches.

The first is by altering the social contexts associated with smoking related social identities through restricting smoking behavior in pubs and clubs. Smoking restrictions would effectively break the social association between alcohol and smoking in these venues. This is likely to offer greatest benefit to those women who describe themselves as only, or mostly, smoking in these contexts: the self-identified social smokers. Young female social smokers who have not progressed to regular addicted smoking may not do so if not smoking is supported

through such restrictions.

Our findings provide evidence that interventions based on the issue of passive smoking will be acceptable to many smokers because they fit with the "considerate smoker" identity found here. The existence of the considerate smoker identity highlights smokers' awareness of, and concern about, the harm of passive smoking. They are aware that smoking is a minority behavior in this culture and that non-smokers are affected by it. Sub-typing into considerate and inconsiderate smokers allows smokers to maintain their social status and positive view of themselves through identification with the better group (considerate smokers). This in turn suggests that smokers who identify in this way will be unlikely to resist smoking restrictions that clearly benefit the non-smokers, to whom they wish to be considerate.

The second approach to intervention, which is most relevant to the "cool smoker" and "good mother" identities, is by attempting to influence attributes of the group prototypes. For the cool smoker identity, interventions could reinforce and popularize the stereotypes that are salient to young people, for example being an individual by not smoking, being more mature, and benefits to fitness, some of which were mentioned by the young women in our study.

The good mother identity can be seen as a strong example of the considerate smoker identity, where the woman gives up smoking for the benefit of the baby as part of what it means to be a good mother. It is important to note that this is a social (as well as a personal) identity: participants identified a group or type of mother who did the right thing for her baby by giving up smoking. Other literature suggests that pregnant women give up other health threatening behavior in order to be good mothers, and smoking is just one of these (Floyd, Decoufle, & Hungerford, 1999; Paterson, Neimanis, & Bain, 2003). However, pregnancy is a very strong motivator for quitting and interventions can capitalize on this through reinforcing and supporting quitting as prototypical behavior for good mothers. Extending women's awareness of the benefits of not taking up smoking again to their children may also be possible. Interventions that aim to inform women about the impact of smoking on their breastfed babies or young children, as well as support them to remain smoke free and develop identities as non-smokers, may result in expanding the good mother prototype to the early years of parenting rather than just pregnancy.

It is worth sharing here the difficulties we experienced in recruiting young women to our study so that others may benefit from them. It appears that women in this age group (16-28 years old) are very busy people with few connections to formal groups through which they may be reached. Our greatest success was with the group we anticipated would be the most difficult: the young mothers and pregnant women, whom we had been led to believe would be most reluctant to attend unfamiliar venues. This advice was true. Yet in retrospect, we should not have been surprised to find them easier to reach through health services related to their pregnancies, given that we had already identified pregnancy as a strong motivator for women to engage in health enhancing behaviors (such as attending pre-birth parenting support). Our next most successful, though slower, method was the snowball technique. Here we were assisted greatly by having contacts in the target age group and were prepared to ask friends and acquaintances to participate. Researchers wishing to engage young women in their research could benefit from identifying and utilizing formal organizations, particularly health related

ones. However, researchers must also expect to employ flexible and mixed recruitment methods, particularly if not approaching schools for access to women in the youngest age group.

One important limitation to our study is that the research was conducted within a culture where non-smoking is the norm. The social identities found here and the prototypes associated with them undoubtedly depend on the social environment where there are strong messages about not smoking. Interventions based on social identity theory in other contexts need to take into account the prevailing cultural landscape and social climates in which those identities are embedded. Nevertheless, this study indicates that social identities are potent motives for smoking or not smoking among young women, and must be considered along with individual factors in breaking or maintaining smoking behavior.

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