WHAT HAVE LOW INCOME SMOKERS LEARNED FROM A LIFETIME OF 
EXPOSURE TO PUBLIC HEALTH PEDAGOGY? A NARRATIVE INQURY

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by 

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ABSTRACT

Though the prevalence of smoking continues to decline overall each year, in segments of the population, such as those with low income or low education levels, the prevalence of smoking is almost double that of the general population. The slower rates of decline in these groups are possibly due to the unexpected ways that public health messages are received, understood, and assimilated into the lives of individuals in these groups.

This qualitative study used narrative inquiry methods to understand what 15 low income smokers with less than a bachelor’s degree have learned from a lifetime of exposure to public health pedagogical messages and how this learning may have contributed to their smoking behavior. This study was informed by critical theory which assumes that power and influence within society are unequally distributed, and experiential learning and public pedagogy which consider what people learn from public sites. Data were analyzed by using the constant comparative method to code the data into themes and by re-storying the participant narratives.

The findings from this study suggest, for the most part, participants were accepting of many public health pedagogies including things such as indoor smoking bans and paying more in cigarette taxes, and they were willing to comply with most messages. However, some of the messages that participants’ received from public health pedagogies and public health professionals were received in unintended ways. Most importantly, they had negative or mis-educative experiences that caused them to either doubt, resist, or rebel. Finally, some experiences prompted participants to distrust public health professionals who they perceived as having power in society and who they felt were treating them unfairly, judging them, or providing them with suboptimal care. Many mis-educative experiences revolved around failing
to successfully quit smoking and the participants did not identify any public health pedagogies that challenged these mis-educative experiences.

This study makes a contribution to the growing body of public pedagogy literature by suggesting that learning does occur through public sites and that personal experiences can either lead to confirmation or resistance to messages individuals receive. The findings also suggest that public health professionals should work to restore the trust of smokers while also exploring new public pedagogical messages designed to challenge the mis-educative quitting experiences that smokers have accumulated throughout their lives.
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CHAPTER 1

My Dad told me that he learned to smoke cigarettes by first trying to smoke corn cobs with his brothers when they were out in the fields of their family farm in rural North Dakota. He moved on to smoking cigarettes in 1959 when he was 13 years old. At that time, the physical harms of cigarette smoking were only known through anecdotes and “old wives’ tales” since scientific information was only just beginning to surface in academic circles. Sufficient scientific evidence to support a causal relationship between tobacco smoke, lung cancer, and other diseases of the lung would not be publicly announced for another 5 years. By the time Surgeon General Luther Terry issued the historic 1964 report on tobacco use and lung disease, 42% of the U.S. adult population smoked cigarettes (U. S. Department of Health Education and Welfare, 1964).

Although the 1964 Surgeon General’s announcement is credited with directly contributing to 33 million smokers quitting (Brandt, 1990; Schudson & Baykurt, 2016; U. S. Department of Health and Human Services, 2014), when I was born in 1972 my Dad was not among the quitters. In fact, when I was 5 or 6 years old, I vividly remember my Dad smoking at the dinner table. Of course, I remember this not because smoking in the home was particularly unusual at that time; it wasn’t. Rather, I was struck by how he would put his cigarettes out in the ketchup on his plate after he was done eating. My Mom would tell me how she hated those cigarette butts although it seemed to me that she hated the ketchup even more.

At some point in the early 1980s, I don’t remember Dad smoking in the house anymore. Not surprisingly, the absence of these memories coincides with the scientific evidence that began to accumulate about the harms of second-hand smoke during that decade (then officially called “Involuntary Smoking”) which culminated in three influential reports confirming that second-
hand smoke was linked to lung cancer in healthy non-smokers and respiratory symptoms in children (National Research Council, 1986; Saracci, 1986; U. S. Department of Health and Human Services, 1986)

The 1980s was also when the Non-Smokers Rights grassroots movement gained momentum and this, along with evidence linking second-hand smoke to cancer, eventually led the Environmental Protection Agency to declare second-hand smoke as a known human carcinogen in 1992 (Environmental Protection Agency, 1992). These important landmarks in the evolution of our societal understanding of second-hand smoke set the stage for the beginning of nearly ubiquitous restrictions on cigarette smoking in restaurants, work places, public buildings, and other sites.

These restrictions didn’t occur overnight and laws were not enacted uniformly across the nation. Rather, individual cities, municipalities, states, and families like mine slowly began to develop rules, policies and regulations in their own way with the primary intention of protecting non-smokers from cancer causing second-hand smoke and with the secondary intention of changing societal norms about the acceptability of smoking.

But what about the smokers? Why did they continue to smoke? Surely, like much of the non-smoking public, cigarette smokers were equally aware of the publicity surrounding each new piece of scientific evidence that surfaced about the harms of smoking. In fact, the societal historical knowledge about the harms of smoking among both smokers and non-smokers is similar (Liedner, Shaw, & Yen, 2014). But, smokers personally experienced restrictions in what they could do as each regulation dictated to them where they could or could not smoke. They were equally present as society formed new norms about their behavior and developed an awareness that smoking was not just hurting the individual, but also those surrounding them.
One reason people continued to smoke is because of the addictive properties of nicotine. As I think back to my teenage years, I never considered the possibility that Dad was addicted to cigarettes. Of course I had little reason to know this because the idea that nicotine was the addictive chemical in cigarettes driving smokers to continue smoking was a closely held tobacco industry secret for more than 30 years (Glanz, Slade, Bero, Panauer, & Barnes, 1996). Smoking at that time was considered merely a bad habit and a matter of personal choice. That nicotine was addictive was not formally recognized until the 1988 Surgeon General’s report, when C. Everett Koop compared the addictive properties of nicotine to drugs like cocaine and heroin (U. S. Department of Health and Human Services, 1988).

But even then, and now, the addictiveness of cigarettes was not firmly established in the social understanding of smoking in large part due to efforts of the tobacco industry. For decades, the industry has purposefully used their political influence and money to engage in a sophisticated public relations battle designed to deny the addictiveness of nicotine with the goal of sowing seeds of doubt and confusion among smokers and the general public (Brandt, 2007; Kessler, 2001).

In my early teens, Dad, Mom, and I would make deals about what we would do for Dad if he quit smoking. My family and I never doubted Dad’s sincerity in wanting to quit smoking, but for some reason, we were also never really surprised when he didn’t uphold his end of the bargain. Back then, I wouldn’t have used the word “addiction” to describe this cycle of attempting to quit and failing, but I knew that there was something about cigarettes that made it difficult for my Dad to stop using them.

**Background of the Problem**
Since 1964, more than 20 million preventable deaths have occurred as the result of cigarette smoking and to this day it continues to be the leading cause of premature death and disability in the U.S. (U. S. Department of Health and Human Services, 2014). Cigarette smoking negatively impacts virtually every system of the body and directly contributes to heart disease, lung cancer, and chronic obstructive pulmonary disease making tobacco use initiation and cessation a major public health priority.

My family’s experiences with my father’s smoking did not develop in a vacuum with no external influence. On the contrary, the fields of public health in general, and tobacco control more specifically, have worked over many decades to implement a number of public health initiatives that are credited with helping to decrease the prevalence of smoking from its high of 42% in 1964, to the current rate of 15% (Jamal et al., 2015). Many of these efforts make up the social background and context in which my family was operating as we navigated our days with my Dad and his smoking.

These public health initiatives include not just the publicity generated by Surgeon General Reports and policies that restrict smoking in public places; they also include broad initiatives such as media campaigns, tobacco excise taxes, restrictions on youth purchasing of tobacco, law suits against tobacco companies, tobacco regulations implemented by the U.S. Food and Drug Administration, and marketing and advertising restrictions on the industry (U. S. Department of Health and Human Services, 2014). After their initial implementation, however, these initiatives all become part of the fabric of our daily lives and shared cultural norms.

Despite public health advocates’ successes in decreasing the prevalence of tobacco use, declines in national smoking prevalence have slowed and it has become increasingly apparent that not all segments of the population are experiencing the same decreases in the number of
people who smoke. In 2015, the overall national prevalence of smoking in the U.S. was 15%, but as education level goes down, smoking prevalence goes up so that among those with a GED, 34% smoke while among those with a graduate degree, only 4% smoke (Jamal et al., 2015). And differences in education levels are not the only place where important differences exist. For instance, those living below the federal poverty line (26% smokers) are nearly twice as likely to smoke as those who live at or above this level (14% smokers), and those living with serious psychological distress are almost three times more likely to smoke (41% smokers) as those who do not (14% smokers) (Jamal et al., 2015). And, the rate of change in these groups is also different. From 2005 to 2015, there was decrease in the overall population prevalence of smoking that equates to about 28%, but for those living below the poverty line, it was 12.7% (versus 32.8% for those living above poverty), and only a 3% decrease for those living with psychological distress (versus 31% for those without) (Jamal et al., 2015).

What is also becoming apparent is that some of these groups often don’t respond to traditional public health initiatives as expected. Health communication theories such as the knowledge-gap hypothesis and the communication inequities hypothesis (McCombs, 2004; Tichenor, Donohue, & Olien, 1970) suggest that societal inequities influence media interpretation. They propose that people from higher socioeconomic groups (e.g., higher income or education) either have more access to information or will more readily take advantage and implement health-related recommendations than those in lower socioeconomic groups. This ability to access and act on educational information thereby widens the knowledge and health disparities gap between higher and lower socioeconomic groups. Unfortunately, evaluating exposure to public health messages, connecting exposure to a message with behavior, and
understanding how meaning is made after exposure is not a simple task. Regardless, there are common methods that have been employed by the field of public health as I will discuss below.

**Traditional Public Health Intervention Evaluation**

When evaluating the impact of public health education interventions, advocates often begin with health behavior change theories (e.g., Health Belief Model (Maiman & Becker, 1974), the Theory of Planned Behavior, or the Theory of Reasoned Action (TRA) (Madden, Ellen, & Ajzen, 1992). These theories are focused on encouraging the individual to change in some way by offering a health-related argument that demonstrates either the individual risks of continuing a particular health behavior (e.g., smoking) or the benefits of changing this behavior (e.g. smoking cessation). In practice, this means that outcomes for public health interventions are quantified using behavioral measures before and after campaign implementation such as: 1) how many people received the intervention or heard the health message, 2) how many people were able to recall some of the content, 3) whether the intervention or campaign changed someone’s intention to do something (e.g., quit tobacco), or 4) whether the intervention changed someone’s “belief” about the topic addressed in the intervention as measured quantitatively using a Likert scale (National Cancer Institute, 2008).

It is understandable that campaigns are evaluated in this way. National public health efforts require significant commitments of both human and monetary resources. Because of this, campaign funders want immediate feedback as to intervention effectiveness so that they can justify their expenditures. However, while behavior change is the ultimate goal of many health education campaigns, evaluation that focuses only on behavior leaves the interventionist with little information on why their initiative may have succeeded or failed. For instance, that 33 million people quit smoking shortly after the 1964 Surgeon General’s announcement about
smoking and lung disease is an observation of historical record (Schudson & Baykurt, 2016). However, subsequent Surgeon’s General reports such as the negative health consequences of smoking for women (Office on Smoking and Health, 2001; U. S. Department of Health and Human Services, 1980), or smoking and nicotine addiction (U. S. Department of Health and Human Services, 1988) made little documented impact on the prevalence of smoking. Using a behavior change theory to explain this lack of progress, researchers might suggest that the messages generated did not resonate with the individuals who received them. Another common frustration is that there were other messages, influences, or “noise” that “confounded” the researcher’s ability to detect whether their message made any impact (National Cancer Institute, 2008). Regardless of the reason, when behaviors do not change in response to a public health intervention, researchers relying on behavior change theories are left with little other actionable information. Missing from these theories, and the public health education literature, are ways to answer questions related to what smokers understand about smoking and their health, how they made meaning of health information they have received throughout their life, and how they have translated it into action or inaction in their daily lives.

**Experiential Learning Theory and Public Pedagogy**

Theories from other disciplines, such as adult education, can further contribute to behavior theories by offering an additional focus on what an individual learned from a particular health-related message, how they made meaning of it, and how their personal health-related values may contribute to their understanding. For instance, experiential learning theory proposes that adults have life experiences that contribute to their cumulative learning and that they “carry around with them past and present images of themselves,” (Caffarella & Barnett, 1994, p. 34) which are then applied to new learning situations. This cumulative learning may include things
that were learned from individual experiences (e.g., my Dad smoking at the dinner table) in addition to societal influences (e.g., evidence on second-hand smoke that may have caused my Dad to move his smoking outside).

A more specific learning theory that falls under the umbrella of experiential learning is public pedagogy (Sandlin, O’Malley, & Burdick, 2011). Public pedagogy, the idea that adults learn through public sites, has emerged as an adult education theory from the fields of curriculum theory, cultural studies, and arts-based approaches to learning. It considers what adults learn through, and how they make meaning of their exposure to traditional media (TV, newspapers, magazines, radio), non-traditional media (YouTube, blogs, zines), public spaces where art or theatrical performances are exhibited, public policies and regulations, popular culture, grassroots social movements, and formal institutions such as zoos, museums and public parks (Sandlin, O’Malley, & Burdick, 2011).

Using the perspectives of experiential learning and public pedagogy, the development and evaluation of a health education intervention would take into consideration not just the behaviors and beliefs of an individual immediately before or after exposure to the intervention. Rather, it would attempt to understand the cumulative personal life experiences that contribute to an individual’s understanding of that intervention and how they made meaning of the information they received. Importantly, it would also consider interactions and intersections of social and societal influences that may contribute to the meaning that an individual makes and issues related to power and positionality in society (Brookfield, 2005).

Heyman, Alaszewski, and Brown (2012) have suggested that health is valued and viewed in different ways by different people because of varying lived experiences, group social norms, reasons for smoking, and values related to health. Since an individual’s understanding of an
experience often influences their behavior, it is possible that one of the reasons that people of different socioeconomic groups may react to public health interventions in varying ways is because they have a different understandings of what those interventions mean for them individually and as a member of society.

Applying these ideas to tobacco use, the purpose of this study is to better understand the various public pedagogy influences that contribute to smokers’ understanding of the health risks of tobacco use, how they interpret the messages that they receive through these venues and how they assimilate them into their daily lives. Further, an important focus of this work will be on how these interpretations and assimilations may influence their tobacco use.

**Theoretical Framework**

How smokers understand and interpret health-related messages must first be placed in the larger context of public health and the society in which these individuals operate. The field of public health is expansive and includes efforts from federal, state and local government agencies (e.g., Centers for Disease Control and Prevention, National Institutes of Health, the Food and Drug Administration, or state departments of health), healthcare delivery systems, communities, academia, businesses, and the media (Institute of Medicine, 1994). Each of these entities addresses different public health issues and approaches them in different ways through different avenues. In addition, because societies are highly unequal structures, many health-related studies have found that poverty, and racial and gender inequalities contribute to major health disparities (Marmot, 2005; Pampel, Krueger, & Denney, 2010). Below, I will discuss experiential learning theory, public pedagogy and critical theory which are the three main theoretical frameworks that I will use in this project to provide structure to the methodology and to act as the lens through which I will analyze the data.
Experiential Learning and Public Pedagogy

Experiential learning is the most basic form of learning and John Dewey (1938) initially suggested that our present learning is a function of our past experiences and understanding. When thinking about experiential learning in terms of health and smoking, Peter P. Jarvis (2006) also suggested that there are many ways that experience can teach, and particularly relevant to smoking is that we also learn not just through our mind, but through our body as the “whole person”. This type of learning is not just cognitive knowledge, but it also contributes to our self-esteem and how we think of ourselves in the world (i.e., self-identity).

However, when thinking about public health, those experiences that occur in the public sphere are particularly important and scholars have long used the term public pedagogy to narrow down the broad field of experiential learning (Sandlin et al., 2011). In particular, there are four main conceptualizations of public pedagogy, or learning in the public sphere, that are most relevant to tobacco-related health messages including how people learn from dominant societal discourse, informal institutions and public spaces, popular culture and mass media, and public intellectuals (Sandlin et al., 2011). Below I will briefly describe each of these and I will provide a more comprehensive review in Chapter 2.

**Dominant Societal Discourse.** Sites of learning related to dominant societal discourse that are particularly relevant to public health are governmental policies, regulations, Congressional testimony, and litigation. In the case of policies or regulations, it is not the written document that is important, but rather how it is implemented and enforced within society. Therefore, the type of learning that occurs in this form of public pedagogy is more about “ideological forces that act upon individuals” (Savage, 2014, p. 85) than about concrete spaces where learning occurs and how these policies are enacted are completely dependent on the context in which someone lives.
Because of this, public policies can both create cultural identities and marginalize groups of citizens based on an individual’s exposure to them and how they are enacted in a local community.

An example of how policies can create cultural identities would be the implementation of smoking restrictions in restaurants and airplanes that began in the 1980s. These regulations were implemented at the societal level and were imposed on anyone who entered these spaces. Due to the unilateral execution of these regulations, they had the potential to create a broad societal discourse about smoking that could be considered educational. Requiring smokers to go outside to smoke is intended to keep non-smokers safe from the harms of second-hand smoke. But, there is also a secondary component which is to make smoking an unusual occurrence in public spaces (i.e., de-normalizing) which creates educative discourse about socially acceptable and unacceptable behavior.

**Informal Institutions and Public Spheres.** Another site where learning can occur is through public institutions and public spheres, an idea that is heavily influenced by Elizabeth Ellsworth (2004) in her book, *Places of Learning: Media, Architecture, Pedagogy*. This site of informal learning includes institutions such as museums, zoos, parks and cemeteries in addition to public art (graffiti and architecture) and historical sites that contain public memory or insight into historical events. Some institutional sites can be seen as having an identifiable, purposeful educational aim. However, even though many of these sites may not have an easily identifiable intention for what learning may occur, this does not mean that opportunities for learning do not exist (Sandlin et al., 2011).

For instance, clean indoor air laws that were enacted in Pennsylvania in 2008 require that no smoking signs be placed in all areas where smoking is restricted which teaches individuals
about socially acceptable norms for smoking. In addition, an art exhibit in a museum may include artwork or historical advertisements that have depictions of smokers. Depending on how the individual attends to and interprets these depictions, they have the potential to offer some kind of informal lesson to its viewer. Similarly, these spaces can quite unintentionally teach norms about smoking based on the presence or absence of tobacco-related sales and advertising (Hamilton, Biener, & Brennan, 2008).

**Popular Culture and Mass Media.** Popular culture includes traditional media, (movies TV, newspapers, magazines, radio) and non-traditional media (YouTube, blogs, zines, social media). The field of tobacco control has a long history of implementing large-scale anti-smoking advertisements that have reached millions of people through national media channels (National Cancer Institute, 2008). Many of these advertisements have been found to contribute to both knowledge of the harms of tobacco use and to influencing smokers to quit (Davis, Duke, et al., 2017; Richardson, Green, Xiao, Sokol, & Vallone, 2010; U. S. Department of Health and Human Services, 2014).

In addition, tobacco control researchers assert that movies have the potential to teach and influence behavior and have consistently documented associations between youth media exposure to people smoking in movies and the uptake of smoking (Charlesworth & Glantz, 2005). Those in the field theorize that this occurs because people who smoke in both movies and magazines influence their viewers by being portrayed as sexy or rebellious without experiencing any of the negative health consequences of smoking (Grube, Weir, Getzlf, & Rokeach, 1984; National Cancer Institute, 2008).

**Public Intellectualism.** Learning that occurs through public intellectualism includes things such as announcements from community leaders, interviews with health experts, or any
other reports about the life and events of public intellectuals (e.g. the president, community leaders, or scholars). This would also include public demonstrations such as grassroots protests or public town meetings. These types of activities often take place outside of formal institutions and are theorized to heighten the public’s awareness of a particular issue with the hope of stimulating dialogue, action, or social change. An example of public intellectualism from the field of tobacco control is the 1964 announcement by Surgeon General Luther Terry that cigarette smoking causes disease. In this case, the Surgeon General’s announcement contributed not just to individual and societal learning about the harms of smoking, but it is also credited as changing behavior and producing a marked decrease in smoking prevalence (Schudson & Baykurt, 2016; U. S. Department of Health and Human Services, 2014).

While each of the public pedagogy categories discussed above offers a useful structure for conceptualizing the various avenues through which the field of public health disseminates messages, it remains incomplete as a way to explain the inequitable burden of poor health on smokers. For this, critical theory offers an additional perspective.

**Critical Theory**

One of the main utilities of critical theory for this project is its ability to offer a theory for why the burden of poor health in general and the cigarette smoking specifically is so inequitably distributed among the poor, minorities and those with less education. Brookfield (2005) summarizes critical theory as being focused on three main assumptions about how the world is organized. First, it assumes that “Western democracies are actually highly unequal societies in which economic inequity, racism, and class discrimination are empirical realities” (p. viii). Second, this state of affairs is taught and learned in ways that make it seem natural, inevitable or just the way things are through the “dissemination of dominant ideology” (p. viii). Finally,
critically theory “attempts to understand this state of affairs as a necessary prelude to changing it” (p. viii). Returning to the field of tobacco control, public health experts often lament about how the burden of disease from tobacco use is higher among disparate populations, however, they rarely question how their own actions may be contributing to these inequities.

When considering economic inequity for example, although public health advocates propose to improve the health of entire populations, many health interventions actually only target individuals. For example, as a way to help decrease the prevalence of smoking, the tobacco treatment guidelines suggest that smokers receive treatment and medications from a tobacco treatment specialist (Fiore et al., 2008). Dominant ideology in public health leads practitioners to disseminate information about the usefulness of this type of intervention while trivializing and dismissing the barriers an individual may face to receive such care (e.g., paying for transportation, medications, and medical insurance).

In effect, while certainly useful for some people, these types of health interventions ignore the “fundamental composition, organization, and operation of society” that form “the underpinnings of the determinants of health” (Frieden, 2010, p. 590). Thus, critical theory offers a vital perspective through which to view public health that brings to the forefront societal and structural inequities that may contribute to how smokers receive, understand, and assimilate public health messages in their daily lives.

**Research Problem, Purpose, and Questions**

Despite successes in decreasing the prevalence of tobacco use, declines in national smoking prevalence have slowed considerably in recent years (U. S. Department of Health and Human Services, 2014). In addition, while the overall prevalence of smoking is at 15%, it has become increasingly apparent that not all segments of the population are experiencing the same decreases
in the number of people who smoke. This includes those with low levels of education, those living below the federal poverty line, those with mental health disorders, American Indians/Alaskan Natives, and those who identify as lesbian, gay or bisexual (Jamal et al., 2015). These differences in declines of smoking are possibly due to cultural differences in the importance of health or differences in how information about the harms of smoking is received and understood by these individuals.

Rather than evaluating what was learned by an individual from a particular public health intervention, the field of public health often determines the success of an intervention by counting how many people were exposed to or recall the message and then by measuring how many people actually changed their behavior (National Cancer Institute, 2008). This evaluation method ignores the cumulative life experiences of the individual receiving the message and provides no information about what was learned or how the message could be made more effective.

Thus, with the ultimate aim of improving tobacco-related public health messages, the goal of this project is to understand the smoker’s perspective by evaluating how a variety of public health educational messages and social and societal influences intersect and interact cumulatively throughout a smoker’s life. In addition, a key objective is to gain insight into how these messages help to form the smoker’s understanding of their tobacco-related health risk, and how this may contribute to their smoking behavior. The specific goals are as follows:

1. To identify through what public venues smokers learn about their tobacco-related health risks (e.g., popular culture, regulations, public policy, public intellectuals, and societal discourse from an experiential perspective);

2. To gain perspective on the cumulative learning that occurs through these venues and how
smokers understand and assimilate the information into their daily lives.

3. To evaluate how societal positionality (i.e., perceived social class) may influence how an individual understands messages; and

4. To identify any connections between how the information is received and interpreted and how it may influence smoking behavior.

Questions that guided this research effort included:

1. What tobacco-related public pedagogies have adult smokers been exposed to either in the past or in the present?

2. How do smokers understand and interpret the smoking related information that they identified?

3. How does positionality, personal experiences, interpersonal interactions, and social context influence how smokers construct and make meaning of their personal health risk and the risks of others related to their smoking?

4. How is this information assimilated into the smoker’s daily life, and how might it contribute to smoking behavior?

Because these questions deal with individual thoughts, opinions, values, and beliefs, I used the qualitative method of narrative inquiry. In the next section, I provide a brief overview of why I chose a qualitative research paradigm in general and narrative inquiry in particular. In addition, I briefly outline how study participants were selected, how data was collected and analyzed, and how I ensured trustworthiness of the data.

**Methodology Overview**

The field of public health and the empirical literature that evaluates public health interventions are both primarily dominated by logic-based, scientific, and paradigmatic ways of
understanding the world (Hinyard & Kreuter, 2007). However, qualitative (QUAL) studies “may be especially useful when addressing issues involving morality, religion, personal values, meaning in a person’s life, and complex social relationships” (Hinyard & Kreuter, 2007, p. 778). Health and smoking are both related to personal values which are complex, multidimensional, and heavily influenced by context. Thus, because QUAL methods allow researchers to document how and why people have come to hold a particular belief or value, this paradigm was chosen for this study.

QUAL methods are founded on constructivist perspectives where phenomena are subjectively constructed and understood by individuals or societies and it allows for the possibility of multiple realities (Gunzenhauser & Gerstl-Pepin, 2006). The constructivist perspective accepts that each individual may construct a different understanding of the same experience and researchers working in this paradigm must attend to the voice of the individual first and foremost.

For this project, the ability to listen to the voice of the smoker is especially important since I want to understand the multiple interpretations that people offer as reasons to support their smoking behavior (Lincoln & Guba, 1985). Within the QUAL paradigm is a method of inquiry called narrative (Riessman, 2008; Rossiter, 1999) which is focused on an individual’s stories and how they assemble events and use language to make meaning of their experiences (Riessman, 2008). Narrative inquiry also requires that individuals share the contextual elements of their experiences so that additional meaning can be made of the stories that they share. This can includes not just cognitive, affective, motivational, biological, and environmental influences (Rossiter, 1999), but also economic, political, and societal influences that may contribute to how individuals understand their life experiences (Eakin, 1999).
Narrative inquiry is in direct contrast, to the logic-based, paradigmatic mode of thinking that predominates in the field of public health because it does not depend on logic. When individuals use the narrative mode of thinking, they can easily alternate between two opposing and contradictory concepts even within the same instance because this way of thinking is how people construct meaning of experiences. Thus, narrative inquiry is a useful methodology to employ when exploring smoking-related experiences because provides a way to explain or give plausibility to an experience (Bruner, 1986) and it can document how people have come to hold a particular belief or value.

A heterogeneous sample of low income smokers who had less than a college degree were recruited for this study. I used narrative inquiry in the form of personal storytelling as a way to document how low income smokers have constructed knowledge about smoking and their health and how they have understood historical events related to smoking that have occurred in their lifetime (Rossiter, 1999). This was done by collecting stories from study participants and arranging them in a sequential, temporal manner. A thematic analysis was performed using all the participants’ transcribed interview data to identify themes that emerged across the interviews. A detailed discussion of the study methodology including participant eligibility criteria, and data collection and analysis methods can be found in Chapter 3.

**Significance**

Despite decades of effort from the public health community to reduce the prevalence of cigarette smoking and the harms it inflicts on its users, it remains the number one cause of premature death and disability among Americans (U. S. Department of Health and Human Services, 2014). The goal of decreasing the number of youth who start to smoke and helping current smokers to quit, particularly among low income populations continues to be a major
public health priority (Bonnie, Stratton, & Wallace, 2007). As discussed previously, the main focus of evaluation for many health education campaigns is to statistically measure how many people were exposed to a particular message and then identify how many people did or did not engage in a particular behavior (National Cancer Institute, 2008). A weakness of this method is that it provides little information as to why an intervention may have succeeded or failed and it provides no feedback as to what smokers understood about the message, how they made meaning of it and how they translated it into action in their daily lives.

This study will employ adult education learning theories, including public pedagogy, as a way to provide deeper insight into how smokers understood public health pedagogical messages. A major benefit of using public pedagogy for this study was that it allowed me to conceptualize the field of public health as an educator, its pedagogical messages as a curriculum, and smokers as the students (Savage, 2010). In doing this, I was able to consider not just what smokers understood from the public health pedagogies to which they are exposed, but I was also able cross reference this understanding with the intention of the pedagogue.

If tobacco-related health messages are not being received as intended, efforts from those in the field are wasted at best and counter-productive at worst. Thus, an additional contribution this study makes is to the fields of tobacco control and tobacco regulatory science as it provides a window into the lives, experiences, and perceptions of the smokers which can in turn help to inform future health education messages. Additionally, if these fields are better able to understand the smokers’ perspectives, this two-way dialogue helps smokers, as they can potentially benefit from the efforts of the field to communicate with them more effectively.

Personally, I often find that knowing an individual’s past history, experiences, and stories about how they came to be the person they are is helpful as I try to understand their perspective
and engage in dialogue. For me, this study offers an especially important view into the lives of smokers, how they came to understand the risks of smoking (or not), and how they assimilated their past experiences into their current lives. With this knowledge, I provide a voice for them as I navigate my daily life working in the field of public health.

Assumptions

As with any study, the current investigation comes with a number of important assumptions that must be acknowledged. Below I highlight several that I think are important.

1. One of the central assumptions of this study is that people do not live in a vacuum where a single public health message can be isolated from all other previous messages, social contexts, or perceptions. Rather, I assume that just like when two separate chemicals are mixed together in a laboratory to form a new compound, public health messages are intricately related so that new information mixes with the old to react and form new knowledge.

2. A second assumption is that people’s health would improve if they quit smoking. Further, that an improvement in their health would yield a positive change in their overall quality of life.

3. Another major assumption I make throughout this work is that nicotine is an addictive substance. Although the majority of smokers started smoking in their youth, they continue to smoke into adulthood because they are addicted to nicotine. This addiction is what perpetuates smoking and makes it difficult for individuals to quit.

4. Another important assumption of this work is that the field of public health has a responsibility to develop public health messages and interventions that are relevant, appropriate, and that effectively communicate their messages to the publics that they
serve. I will assume that it’s not enough to accurately inform the public about the harms of tobacco, but that it is also important to strive to identify ways to effectively communicate with a variety of people from many different walks of life.

5. Along a similar vein, I also assume that the field of public health has the best interests of smokers in mind as they work to educate the public. Even though I assume this to be the case, that doesn’t mean they are particularly effective and it’s possible that well intentioned efforts do not have the desired effect.

6. The tobacco industry has a long history of appearing to support the autonomy of their customers and protecting their “right to choose” to use their products. An important assumption I make about this concept is that choice is not a reasonable option when someone is addicted to nicotine. My stance throughout this work is that once an individual is addicted to nicotine, it becomes a biological compulsion that negates that individual’s choice about whether to use it or not.

7. A final assumption that I make throughout this work is that the tobacco industry has very little interest in the health and well-being of their customers. Historians and tobacco control advocates have thoroughly documented the deceptive practices of tobacco industry representatives throughout the past 50 years (Brandt, 2007; Glanz et al., 1996; U. S. Department of Health and Human Services, 2014). Actions of the tobacco industry, regardless of how positively they may be presented to the public, are undertaken to influence sales, encourage youth to take up tobacco use, and avoid any regulatory efforts that may hinder their activities.

**Definition of Terms**
• **Public Health:** Throughout this work, I refer to the field of public health which includes contributions from federal, state and local government agencies (e.g., Centers for Disease Control and Prevention, National Institutes of Health, or the Food and Drug Administration, state departments of health), healthcare delivery systems, communities, academia, businesses, and the media (Institute of Medicine, 1994).

• **Tobacco Control:** Tobacco control is a sub-field within the larger field of public health that is specifically concerned with reducing the harms and use of tobacco. Public health experts in this field are involved with treatment and prevention, monitoring of tobacco use and policies, and advocating for policies that will help decrease the prevalence of tobacco use.

• **Tobacco Regulatory Science (TRS):** Tobacco regulatory science is encompassed within the field of tobacco control, but has a very narrow focus on developing research evidence that will aid the Food and Drug Administration in making regulatory decisions about tobacco products that are under its purview.

• **Addiction:** When discussing cigarette smoking, I often use the term “addiction” which I define as a biological dependence on nicotine that has well defined physiological characteristics when it is withheld. These include anxiety, nervousness, restlessness, difficulty concentrating, increased appetite, depressed mood, irritability, anger, frustration, and insomnia. Smoking a cigarette relieves these symptoms.

• **Nicotine:** Nicotine is a naturally occurring chemical found in the leaves of the tobacco plant. It is the addictive component of cigarettes and other tobacco products.

• **Prevalence:** Prevalence is a statistical concept that refers to the proportion, or percent, of a population that has a given condition at a particular time point. For instance,
throughout this paper I note that the prevalence of cigarette smoking is 15% which is the proportion of the total U.S. population that currently smokes.

- **Intervention:** An intervention in the field of public health is a specific act that is intended to educate or change behavior in individuals or groups of people. For instance, a television ad discouraging tobacco use among youth would be considered an intervention.

- **Cigarettes and smoking versus tobacco and tobacco use:** Throughout this work, I will refer to tobacco use and cigarette smoking as two distinct entities. Tobacco use encompasses all tobacco products currently available on the market including pipes, cigars, snus, snuff, dip, chew, hookah, electronic cigarettes, and dissolvable tobacco products (e.g., sticks, strips, lozenges). Cigarettes smoking, or smoking, refer specifically to cigarettes and no other smoked products.

**Chapter 1 Summary**

In this chapter, I have provided an overview of the how the field of public health uses pedagogy to teach not just smokers, but all members of society. I began the chapter with the story of the ways in which I believe the public health pedagogy of the harms of tobacco impacted my immediate family as I grew up. Though my father eventually moved his smoking to the outside of our home he did not quit. This suggests the possibility that his understanding of the public health messages he has received over time are likely different than how those messages were intended; and he is not likely alone in this.

In the course of this chapter, I have argued that I, and others in the field of public health, would benefit from conducting research studies that use experiential learning theories such as public pedagogy as a framework for evaluating the learning that has occurred for low income
smokers over a lifetime of exposure to public health messages. In the next section, I will review the literature and discuss what scholars have done previously to evaluate how and what smokers have learned from the field of public health through the pedagogical elements of popular culture and mass media, informal institutions and public spaces, dominant societal discourse, and public intellectuals.
CHAPTER 2

Review of the Literature

The overarching goal of this study is to understand what low income smokers have learned from a lifetime of exposure to various public health pedagogies and how this learning may influence behavior. Heyman et al. (2012) have suggested that health is viewed by individuals in different ways because of varying lived experiences, social norms, and values related to health. A major focus of this project is to explore the cumulative life experience of low income smokers using the assumption that they may be receiving, understanding and assimilating public health educational messages in a different way than they are intended. If this is the case, it is also possible that the efforts of public health advocates may be influencing smoking behavior in unintended ways.

While using the frameworks of critical theory, experiential learning, and public pedagogy, I will use narrative inquiry to assess the cumulative learning that occurred in my study participants’ lives. Narrative inquiry is designed to understand individual experiences while also taking into account social interactions and societal influences. In this chapter, I will begin with a review of the purpose of the study. In addition, because this project is focused on adult learning within the context of public health, I will describe how the field of public health has developed over time, how it traditionally operates, and some of the philosophical views commonly held by those who practice in the field.

Next, I will provide a detailed overview of theoretical frameworks that I will use for this study and discuss how they are relevant to public health. One of the most important frameworks I will use is that of public pedagogy and I will discuss how it will be used in this project in detail. Once the framework of public pedagogy has been established, I will also use the categories
within that framework to provide a review of the history of tobacco control starting with the 1964 Surgeon General’s report (U. S. Department of Health Education and Welfare, 1964). It should be noted that there were some public health efforts to decrease tobacco use prior to this time point, but the most formal efforts made by public health advocates to reduce the prevalence of tobacco use in the U.S. occurred after 1964 (Brandt, 1990, 2007). Finally, I will provide an overview of what empirical studies have been done related to smoking and public pedagogy with a particular focus on studies that have examined what adult smokers learned through these various pedagogical messages.

**Goals and Objectives of the Project**

The goal of this project is understand the perspective of the smoker by evaluating how public health messages, media, social and societal influences intersect and interact cumulatively throughout their lives. In addition, a key objective is to gain insight into how these messages help to form the smoker’s understanding of their tobacco-related health risk and how this may contribute to their tobacco use. The specific goals are as follows:

1. To identify through what public venues smokers learn about their tobacco-related health risks (e.g., popular culture, mass media, public spaces, public intellectuals, and societal discourse).
2. To gain perspective on the cumulative learning that occurs through these venues and how smokers understand and assimilate the information into their daily lives.
3. To evaluate how positionality (e.g., perceived social class) within social groups and society may influence how an individual understands health messages.
4. To identify any connections between how the information is received and interpreted and how it may influence smoking behavior.
Questions that will guide this research effort include:

1. What tobacco-related public pedagogies have smokers been exposed to either in the past or at present?

2. How do smokers understand and interpret the smoking related information that they identified?

3. How does positionality, personal experiences, interpersonal interactions, and social context influence how smokers construct and make meaning of their personal health risk and the risks of others related to their smoking?

4. How is this information assimilated into the smoker’s daily life and how may it contribute to smoking behavior?

In order to answer the above questions, it is important to understand the public health context in which health messages are created and distributed to the public. Therefore, in the next section, I will provide a brief history of public health and how public health pedagogies are typically communicated to the general public.

**Historical Evolution of Public Health**

Understanding what messages smokers may receive about smoking and their health is directly related to the development of the field of public health. Historically, public health was focused on the identification and eradication of immediate risks that were attributed to acute illness or death. For example, in 1854 an early practitioner of public health, John Snow, examined the location of individual cases of cholera in London and identified that they were being caused by contaminated water from a neighborhood water pump (Hempel, 2013). In cases like these, the absence of disease was the goal of public health and it served a utilitarian purpose to help prevent acute disease by improving unsanitary living conditions. Over time however, the
field has expanded to include not just Snow’s practice of identifying immediate health risks, but to a much broader “new public health” (Petersen & Lupton, 1996) which Winslow (1920) describes as “the science and art of preventing disease, prolonging life, and promoting physical health” (p. 30). This new version of public health encompasses virtually every aspect of the human condition including acute illnesses and infectious diseases (e.g., food poisoning, Zika, tuberculosis), prevention of chronic disease (e.g., heart disease, cancer), mental health conditions, maternal and fetal medicine, substance abuse, dental hygiene, environmental toxins, teen pregnancy, and geriatric disorders, to name a few (Institute of Medicine, 1988).

**The Structure of Public Health**

As public health has expanded to address more than just acute illness, the entities that make up the public health system have also expanded so that the current public health system includes federal, state and local government agencies (e.g., Centers for Disease Control and Prevention, National Institutes of Health, or the Food and Drug Administration (FDA), state departments of health), healthcare delivery systems, communities, academia, businesses, and the media (CDC Foundation, 2017; Institute of Medicine, 1994).

Government in particular plays a large role in public health because government can use its influence, money, and policies to benefit society in ways that individuals cannot on their own (Institute of Medicine, 1994). Public health activities provided through the government include health surveillance systems (e.g., health statistics), policy (e.g., water sanitation and clean indoor air laws), public health education campaigns, funding of preventative actions (e.g., fluoridation of water) and direct delivery of health care (Centers for Disease Control and Prevention, 2014; Institute of Medicine, 1994).
In addition to direct actions that government takes to insure public health, they also directly or indirectly influence numerous activities that are carried out by other parties. For instance, in academia, governmental priorities are directly implemented through monetary grants, public health and medical education, and academic research. Government influences are more indirectly implemented when communities enact policies at the local level, when the media disseminates information and reports on health-related topics, when healthcare delivery systems provide medical care for acute and chronic conditions, and when corporations provide medical insurance to their employees (CDC Foundation, 2017; Centers for Disease Control and Prevention, 2014; Institute of Medicine, 1988, 1994).

All of these systems work independently, but because their work makes up the larger context in which we live, they are also working interdependently to create the field of public health. In addition, each entity can work to create public health messaging that is dispersed through various communication avenues to influence the health behaviors of individuals in society. In the next section, I will discuss some common ways that the field promotes health starting with regulatory activities specific to the Food and Drug Administration and then moving to media campaigns and public health communication.

**Tobacco Regulatory Science as Public Health**

One specific system that operates to promote health within the field of public health is the FDA whose purpose is to protect “public health by assuring the safety, efficacy and security of human and veterinary drugs, biological products, medical devices, our nation’s food supply, cosmetics, and products that emit radiation” (Food and Drug Administration, 2017). Historically, the FDA was not involved in the regulation of tobacco products. However, in 1995, FDA Commissioner David Kessler made the assertion that tobacco companies were not merely
producing a leisure product, but rather that they were distributing and selling sophisticated nicotine delivery devices (Kessler, 2001). He further asserted that tobacco companies were aware of the addictive properties of nicotine and were purposefully manipulating their product to maximize the drug’s effect. On the grounds that these companies intended to cause and maintain addiction in their customers, he believed cigarettes should be considered drug delivery systems and that they should fall under the jurisdiction of the FDA’s regulatory authority.

After making this assertion publicly, the agency was sued by the tobacco industry; a case that was ultimately seen before the U. S. Supreme Court ("FDA v. Brown & Williamson Tobacco Corporation," 2000). At the end of the vicious court battle, the Supreme Court Justices agreed that the industry was in fact intentionally manipulating nicotine as a drug. However, they denied the FDA’s request to regulate tobacco on the technical grounds that tobacco regulatory authority must be granted to the FDA by an act of Congress.

Progress on tobacco regulation stalled until 2009 when President Obama signed the Family Tobacco Prevention Act which gave the FDA the authority to regulate tobacco products with the goal of reducing their harm at a population level ("Family Smoking Prevention and Tobacco Control Act," 2009). The law granted the agency broad authority over product manufacturing, marketing, distribution, sale and product imports. In addition, it also created the Center for Tobacco Products (CTP), a division within the agency whose purpose is to implement the law by using robust empirical science to justify its regulatory policies (Ashley & Backinger, 2012; Ashley, Backinger, van Bemmel, & Neveleff, 2014; Deyton, Sharfstein, & Hamburg, 2010).

Shortly after being established, the CTP collaborated with the National Institutes of Health to issue grants that would foster tobacco regulatory science; the evidence needed to make regulatory decisions. In particular, the FDA was interested in understanding tobacco from many
angles including ingredients, addictive properties, marketing and labeling, and childhood tobacco use (Ashley et al., 2014). In addition, the CTP was also tasked with educating the public about tobacco and its harms in order to impact public perception and product use (tobacco use initiation, continuation, or cessation). Through the avenue of public health education, “The goal of the CTP’s public communication activities is to reduce the public health burden of tobacco by encouraging tobacco use cessation and preventing initiation, especially among children, adolescents, and young adults” (Ashley et al., 2014, p. 1048). In order to meet this goal, the CTP evaluates and encourages scientific studies that can help the agency understand the public’s perceptions of tobacco products and studies that can help the agency evaluate the effectiveness of educational messages, public health communication and media campaigns.

**Traditional Public Health Communication Theories and Philosophies**

Though the CTP’s involvement in the evaluation of tobacco-related communication campaigns is a relatively new area of scientific research, the field of public health has a long history of implementing and evaluating health education campaigns in the public sphere (National Cancer Institute, 2008). This extensive history lays the theoretical and philosophical groundwork of how the field communicates with the public they serve. Though not all public health communications have theoretical underpinnings, those that do are typically based on behavioral theories that have individual, social and societal perspectives (Brennan et al., 2012). In the next section, I will briefly review the vast body of health communication theoretical literature including the philosophical orientation of the field. This review will help to provide a background and rationale for why adult education theories may be a useful addition to future public health educational initiatives.
**Health communication theories.** Though there are many behavioral health communication theories with individual, social and societal orientations, by far, the most commonly used theories are those that are directed at the individual level. At this level, the theories are focused on how to persuade the individual to change in some way by offering an argument that demonstrates either the individual risks of continuing a particular health behavior (e.g., smoking) or benefits of changing this behavior (e.g. smoking cessation). Some of them include the Health Belief Model (Maiman & Becker, 1974), Theory of Planned Behavior (TPB) or Theory of Reasoned Action (TRA) (Ajzen, 1985, 1991; Madden et al., 1992), or an Integrative Model of Behavior (combines TRA and TPB) (Fishbein & Yzer, 2003). All of these theories are similar in that they have a philosophical orientation that assumes the individual is a rational being with control over their choices. Because of this, the assumption is that once the individual is exposed to a message, they will rationally reflect on it and make an informed choice to either follow the advice in the messages, or not. These commonly used theories remain silent on the social and societal influences on behavior and encourage dichotomous thinking about behavior which assumes people’s reasoned choices are either right (quitting smoking) or the wrong (continued smoking).

In contrast to predominantly utilized individualistic theories in the health communication literature, there a handful of social theories that recognize that individuals do not make decisions in a vacuum, and that the information they receive from media is influenced by interactions with others in their social circles. One of these theories is the Diffusion of Innovations theory, which suggests that new ideas are communicated through social channels by influential individuals within that society (Everett, Schnuth, & Tribble, 1998). In a similar way, the step-flow (National Cancer Institute, 2008) or interpersonal communication hypothesis (Valente & Saba, 2001)
offers a contextual view of how health education campaigns influence individuals by asserting that information is received by influential opinion leaders within a society and then transmitted to others in that community.

Societal level health communication theories differ from individual and social level theories in that they do not see a direct transfer of information from the sender to the receiver. Rather, they view media in terms of an ecological system with feedback loops where audiences receive multiple types and forms of messaging and process it in complex ways. At the societal level, two important theories important for tobacco control are the knowledge-gap hypothesis and the communication inequities hypotheses (National Cancer Institute, 2008; Tichenor et al., 1970). These theories recognize that societal inequities influence media interpretation and propose that people from higher socioeconomic groups either have more access to information or will more readily take advantage and implement health-related information. This ability to access and act on educational information thereby widens the knowledge and health disparities gap between people in higher and lower socioeconomic groups. Another important idea is media agenda setting which suggests that news media selectively cover specific topics thereby amplifying (or ignoring) them and changing the societal perception of a particular behavior or risk (Gerbner, 1981).

**Dominant philosophies within public health.** Although many of the social and societal behavior theories recognize that behavior is not entirely individualistic and dependent on rational thought, the field of public health is dominated by messages and interventions grounded in individualized ways of thinking (Brennan et al., 2012; Durkin, Brennan, & Wakefield, 2012). Perhaps because of this, it is common for those in the field of public health to express dismay at how the lay public interprets and acts on their messages. For instance, although there is
widespread awareness of the negative health consequences of smoking, 15% of those in the U.S. continue to smoke (Jamal et al., 2015). This reality is an incongruity for some health experts who claim that those who continue to smoke are behaving in an irrational way or are denying obvious scientific fact (Diethelm & McKee, 2009; McKee & Diethelm, 2010). Within the field of tobacco control, researchers have explained this dilemma by using the hypothesis that individuals who continue to smoke are hardened smokers who are willfully unresponsive to current public health messages (Bonnie et al., 2007; Costa et al., 2010; Hughes, 2011; Warner & Burns, 2003). The discourse that attempts to understand this continued smoking behavior centers around understanding why public health messages that have worked on certain groups of smokers do not work on others and then progresses to suggesting prudent approaches to protect smokers in spite of their continued denial of rational public health messages (Diethelm & McKee, 2009; Docherty & McNeill, 2012).

What is much less common is for those in the field to engage in dialogue with the lay public in an effort to understand how they learn, what they know, and why they believe what they do. This may be because of a philosophical belief among those in the field that the role of the health educator is as an expert who defines important content rather than allowing the individual to identify what is important to them. This is a position that makes the field philosophically aligned with the liberal philosophy of education which focuses on “organized knowledge, and the development of the intellectual powers of the mind” (Elias & Merriam, 2005, p. 17), and is teacher centered rather than learner centered. Using this perspective, the role of the educator is to transmit accurate information to the learner whose role, in turn, is to receive the information and act appropriately.
Another strongly influential philosophy within the field is positivism which rests heavily on the idea of rational thought, assumes that one true version of knowledge is “out there” to be known, and believes that the health expert is an unbiased reporter of observed evidence. In addition, the positivist perspective assumes that phenomena exist because they can be rationally, objectively observed, counted, and measured (Elias & Merriam, 2005). A key element of positivism is removing contextual factors because it is believed that they interfere the researcher’s ability to understand a phenomenon. By removing context, it is assumed that a controlled setting is created which then allows the researcher to better identify and reproduce a truthful finding.

Though these are some of the traditional philosophies that are prominent in the field of public health, they do not take into account the views of the individual and instead of trying to understand how individuals engage with society, they purposefully remove context that inevitably surrounds individuals as they proceed through life. In addition, they do not consider how societal positionality such as race, class or gender may influence behavior. Now that I have laid the groundwork for how the field of public health typically operates and its theoretical and philosophical perspectives, in the next section of this chapter, I make the case for why I will use theoretical frameworks with an adult education perspective as I explore how and what smokers have learned from public health pedagogical messages.

**Theoretical Framework**

Theoretical frameworks create the underlying structure for empirical research and I identified three that were relevant to this study including critical theory, experiential learning, and public pedagogy. In the next sections of this chapter, I will describe each of these
frameworks, define how I used them in the conduct of this study, and provide a rationale for why I believe these frameworks were best suited for my study.

**Critical Theory**

When I discussed the traditional philosophical perspectives often held by those within the field of public health above, I suggested that these philosophies often try to remove (e.g., control for) societal positionality and contextual factors using variables such as such as race, class or gender. I also previously discussed that the tobacco-related burden of poor health rests disproportionately on those of low socio-economic status, a health disparity that is well recognized by public health professionals (Marmot, 2005). In fact, finding ways to reduce tobacco use by addressing disparities in tobacco use and its harms is a research priority of the National Cancer Institute over the next decade (Tobacco Control Research Priorities Working Group of the NCI Board of Scientific Advisors, 2016).

For this project, I employed critical theory as the lens through which I interpreted the data and used this framework as a way to think about the root of health disparities. In contrast to the individualistic theories discussed above, critical theory offers a contextual, societal perspective for understanding why the burden of poor health in general, and the cigarette smoking specifically, is so inequitably distributed among the poor and those with less education. Brookfield (2005) summarizes critical theory as being focused on three main assumptions about how the world is organized. First, it assumes that “Western democracies are actually highly unequal societies in which economic inequity, racism, and class discrimination are empirical realities” (p. viii). Second, this state of affairs is taught and learned in ways that makes it seem natural, inevitable or just the way things are through the “dissemination of dominant ideology” (p. viii). Finally, critically theory “attempts to understand this state of affairs as a necessary
prelude to changing it” (p. viii). Using Brookfield’s assumptions as an outline, below I discuss how each of these topics is related to this project and tobacco use.

**Unequal societies.** Although the prevalence of smoking in the U.S. has declined to 15% over the last 50 years, it has become increasingly apparent that not all segments of the population are seeing the same decreases (Jamal et al., 2015). As education level goes down, smoking prevalence goes up so that among those with a high school education, 22% smoke, while among those with graduate degrees, only 4% smoke (Jamal et al., 2015). And, differences in education levels are not the only places where we see important inequalities in the prevalence of smoking. Other groups where smoking rates are higher than the national average include those living below the federal poverty line (26% smokers), those with a disability or limitation (22% smokers), American Indians/Alaskan Natives (29% smokers), and those who identify as lesbian, gay or bisexual (24% smokers) (Jamal et al., 2015).

The pairing of public health experts and tobacco users offers a particularly good scenario through which to demonstrate how critical theory can be applied to the social issue of tobacco use. Frohlich, Poland, Mykhalovskiy, Alexander, and Maule (2010) have suggested that even though smoking rates are going down in the general public, “there remains a growing disconnect between the assumptions that tobacco control practitioners take as self-evident.. and how smokers view their smoking and health” (p. 36). This disconnect between public health experts and smokers is rooted in different lived experiences, social norms, reasons for smoking, and the value of health and knowledge which ultimately influence behavior. Using the statistics above, few academic researchers who have obtained a graduate degree are smokers (only 4%) and it is likely that there are few smokers among their peers. However, tobacco-related interventions and
public health educational messages are often generated in academic environments which is the where the “disconnect” occurs.

Since educated academics have different social norms, values and lived experiences, it is entirely possible that interventions designed in these environments do not resonate with smokers who have very different lived experiences. In addition, these interventions are then often disseminated through various public health channels without input from the groups for which they are intended. In terms of critical theory, public health experts are able to disseminate these interventions or health messages because they have social power and the ability to influence people with money and power (governmental and societal leaders). In contrast, smokers tend to have little social power largely due to the large number of smokers who are of low socio-economic status which creates barriers for them in accessing those with money or power.

Nonetheless, because those in the field of public health have power in society, they are able to decide which health issues will be addressed and which values are going to be taught through public health education.

In this way, our current societal structure allows public health experts to exert power and influence over our society which creates system that uses a top down method of teaching health and health-related values. Critical theorist Jürgen Habermas (1987) would challenge this top down method for two reasons. First, he suggests that the negotiation of what is an important health issue lies with communities and societies themselves rather than with public health experts (Habermas, 1987). For Habermas, values and common understanding within communities should be established through face-to-face contact, actions, dialogue, negotiation, discussion and mutual understanding, a process he calls the “lifeworld”. In addition, rather than institutions deciding on and teaching health values, Habermas would assert that it is the
responsibility of the lifeworld to influence these institutions from the bottom up in order to maintain the balance of power in society. However, since our society is not structured this way, the power rests more firmly with public health experts, a situation which Habermas (1987) criticizes because the delicate relationship between institutions and the lifeworld is out of balance.

Another critical theorist, Hans Horkheimer (1972), argues that though public health experts have the ability to exert power over society, their goal should be to dialogue and seek input from those in society they are attempting to study. Similarly, Eakin, Robertson, Poland, Coburn, and Edwards (1996) argue that if researchers hope to understand the experiences of smokers and other potentially marginalized members of society, they must assume a “reflexive posture”.

**Dominant ideology.** Recognizing that societies are imbalanced and unequal Habermas (1987) criticizes those with social power who tend to marginalize and oppress those without power by supporting and propagating unequal structures within society through the dissemination of “dominant ideology”. Dominant ideology can be any idea or way of life that is accepted uncritically by members of society and can even be supported by those who ultimately suffer as a result of these ways. For instance, many members of society, including smokers, believe that smoking is a behavioral *habit* rather than an addiction that requires professional addictions treatment (Dawkins, 2013; Hughes, 2009). This ideology leads smokers to feel that it is a lack of willpower that makes them unable to quit and leads non-smokers to assume that smokers should simply be able to quit if they would just try harder.

Another way to understand dominant ideology is to think about the structure and methods the field of public health uses to create knowledge. Though it is useful and necessary to study many different phenomena by using the traditional public health methods of rational, objective
observation involving counting and measuring, critical theory proposes that not all things can be satisfactorily understood in this way. For instance, an axiom embedded in the scientific method is that until something is “proven” using these methods, we cannot be sure that it is true. This burden of proof, and dominant scientific ideology, is such a high bar that it can be indefinitely challenged and questioned with the possibility that satisfactory “proof” is never obtained.

Although the scientific method can be employed to pursue new knowledge, critical theorists would also suggest that these methods can be used to manipulate knowledge, teach dominant ideologies, and perpetuate societal inequities. For instance, history has documented the manipulation of scientific knowledge by the tobacco industry who would often use their own research teams to challenge the scientific community’s evidence on the harms caused by tobacco use (Brandt, 2007; Kessler, 2001). Even though the U.S. Surgeon General announced in 1964 that cigarette smoking was linked to lung cancer (U.S. Department of Health Education and Welfare, 1964), the tobacco companies were still raising questions and doubt about this evidence more than 40 years later (Brandt, 2007; Kessler, 2001).

Certainly the scientific community is ethically obligated to investigate, identify and prove how and in what ways tobacco causes harm, but critical theory offers the opportunity to question who is benefiting and who is being harmed during this long, drawn-out discourse. Critical theory calls attention to the fact that while the scientific community engaged in academic debate about whether tobacco caused harm, the tobacco companies strategically targeted their products at youth, minorities, and those less educated. Unfortunately, during the debate about the harms of tobacco, dominant ideology within the scientific field about the importance of scientific evidence allowed the tobacco industry to keep the scientific community engaged in proving the harms of tobacco use while they continued to sell products. This distraction gave the tobacco
industry additional time to addict a new population of minority and less educated individuals creating the structure that we now know contributed significantly to the inequitably distributed burden of poor health in these groups (Marmot, 2005; U. S. Department of Health and Human Services, 2014).

Horkheimer (1972) suggests that since scientists live and participate in society, they cannot separate themselves from our societal history which leads to potential for bias. For instance, Habermas (1987) and others (Giroux, 2010) have argued that our societal dialogue (the lifeworld) has been firmly taken over by capitalistic perspectives (hegemony). Because of this bias, even public health experts cannot see how their actions may be detrimental to society. Again, using the tobacco industry as an example, even though it has been firmly established that cigarettes cause serious disease and premature death, our societal discussion defers to the virtues of the free market and rarely questions why these companies are allowed to continue to legally produce a product that maims and kills its customers (Brandt, 2007). In turn, this inability to recognize and challenge dominant societal beliefs allows for the perpetuation of the inequitable distribution of tobacco-related poor health in our society.

**Understanding the state of affairs.** Interestingly, public health professionals have long known and openly recognized that socio-economic characteristics such as the ones described above contribute to major differences in health-related outcomes (Pampel et al., 2010). Unfortunately, as many others have observed, despite knowing that health disparities involve social issues, public health often supports interventions that target individualized behaviors while ignoring the fundamental structures of society that make it difficult for these individuals to take advantage of health-related interventions (Frieden, 2010; Frohlich, Mykhalovskiy, Poland, Haines-Saah, & Johnson, 2012; Heyman et al., 2012; Krieger, 2008). For instance, the 2008
Clinical Guidelines for the Treatment of Tobacco Use advises health practitioners who treat smokers to offer their patients an FDA-approved medication (Fiore et al., 2008). Although this is a sound, evidence-based recommendation, the guideline does not acknowledge that 30% of smokers live at or below the poverty line and 33.3% of smokers are uninsured (Jamal et al., 2015); two conditions that create barriers for the patient in following these recommendations.

Whether the criticisms of Horkheimer (1972) and Habermas (1987) apply entirely to the field public health is certainly up for debate. However, critical theory offers a useful way think about health disparities while developing public health interventions and messaging. In addition, critical theory in educational research recognizes that the social context in which an individual lives shapes both educational practice (of the expert) and the learning (of the smoker) and researchers working from this perspective must purposefully consider how people’s individual experiences of poor health can be framed “in terms of broader social and economic forces” (Brookfield, 2005, p. 352).

Although critical theory offers an excellent way to frame health disparities, this theory alone does not offer enough of a framework to fully understand people’s experiences. For additional insight, I used another theory from the field of adult education, experiential learning theory, to study further illuminate both critical theory and traditional behavior theories used in the field of public health.

**Experiential Learning**

Experiential learning theory offers an additional focus on what an individual learned from a particular health-related message, how they made meaning of it, and how their personal health-related values may contribute to their understanding. This theory acknowledges first and foremost that adults have life experiences that contribute to their cumulative learning and that
they “carry around with them past and present images of themselves” which are then applied to new learning situations (Caffarella & Barnett, 1994, p. 34). This cumulative learning may include things that were learned from individual experiences (e.g., my Dad smoking at the dinner table) in addition to societal influences (e.g., evidence on second-hand smoke that eventually caused my Dad to move his smoking outside). In addition, experiential learning is occurring continuously throughout the life of the individual along with making meaning of both old and new experiences that occur. Theories of how experience influences learning have evolved over time and they continue to be actively discussed in the field of adult education. Below I provide some background and perspectives on experiential learning that are most applicable to this project.

Some of the most influential thinking on experiential learning comes from John Dewey who suggested that our present learning is a function of past experience and understanding (Dewey, 1938). Further, he argued that learning is a continuous process whereby knowledge from old experiences can be adapted and applied to new ones which, in turn, creates the potential for knowledge to be cumulative and additive (Merriam & Bierema, 2014). Dewey also allowed for the possibility that, while experience can be educative, it can also be “mis-educative,” or that an experience can be so profoundly negative that it inhibits any potential for new knowledge (Dewey, 1938). The concept of mis-education is particularly important when thinking about how individuals may learn about tobacco use since early positive experiences with smoking are likely related to future continued use whereas negative experiences may dissuade an individual from continuing.

Malcolm Knowles (1970) added to this theory by suggesting that adults’ previous experiences are so central to their learning that they can lead to future motivations to learn more.
He is well known for articulating the distinction between child learning (pedagogy), and adult learning (andragogy) (Knowles, 1970). Knowles argues that adult learning is self-directed, that they accumulate experiences which are used as resources for future learning, that their readiness to learn is related to the tasks of their social role. The tasks of their social role may be things that they think will help them be a better parent, spouse, or employee and it is the responsibilities of these roles that motivate adults to pursue learning new things. Therefore, adult learning, as opposed to child learning, is problem centered, and learning must have a practical application that is related to their current situation (Knowles, 1970).

Another influential adult educator is Peter Jarvis (2006), who has added other sites of individual learning to the experiential learning discussion by focusing on learning cognitive reflection and learning that occurs in the body through things such as emotions and senses (P. Jarvis, 2006). This type of “whole person” learning not only contributes to knowledge, but the whole person learns through experiences that contribute to self-esteem and become how individuals think of themselves in the world. In addition, he offers the concept of “rejection and non-consideration,” which is willful rejection of learning when there are topics that an individual does not want to know more about (P. Jarvis, 2006, p. 26). Though an individual does not learn what was intended about that topic specifically, they do acquire experience of how to successfully reject that information, thus creating a type of knowledge.

Also under the umbrella of experiential learning is situated learning theory (SLT) which assumes that learning is the “construction of meaning from experience” (Merriam & Bierema, 2014) and that the context or culture in which someone is placed is highly relevant to their experiences and what they learn. Though often discussed in terms of classroom experiences
such as internships or formal mentoring relationships, it is also possible that these types of relationships develop more informally.

SLT was first suggested by Jean Lave, who believed that knowledge learned in the classroom, such as a mathematical calculation, is not always transferrable to other situations (Lave, 1988). To test this theory, she set up a series of experiments in which she first asked participants to complete mathematical computations using paper and a pencil in a class-based situation. The participants were then placed in a grocery store and were asked to identify best-buy grocery items which ultimately required similar mathematical computations as those done on paper. Interestingly, she found no relationship between participants’ ability to perform paper and pencil mathematical tests and their success in using similar concepts to identify a best-buy in the grocery store (Lave, 1988).

Lave (1988) and others (Brown, Collins, & Duguid, 1989; Fenwick, 2000) have suggested that learning does not occur solely as a cognitive action; but rather, it occurs in action as people engage in their situation, use the tools available to them, and participate in specific activities (Brown et al., 1989; Fenwick, 2000). Because people are engaged in activity, they may not be consciously learning by reflecting on something that happened. Instead they are learning in ways that are “corporeal, realized through action, and therefore often worked out in a domain beyond consciousness” (Fenwick, 2000, p. 254). Apprenticeships, or communities of practice, are considered a common example of SLT. Typically guided or coached by a mentor, learners participate in context-specific activities, engage in dialogue with others within that context, and begin to learn the norms, beliefs, values and practices of people who live in that community. Through participation in this group, they engage in problem solving, interpret situations and
make decisions that are considered necessary for them to be authentic in that culture (Brown et al., 1989).

Though not discussing situated learning directly, Frohlich et al. (2012) have suggested tobacco control policies such as clean indoor air may be galvanizing smokers as a group and creating a smoking subculture because they are ostracized. If this is the case, it is also plausible that cigarette smokers, because of their shared experiences as smokers in an environment hostile to smoking, participate in a community of practice that has a shared identity, common language, participation in problem solving around where they can smoke, and shared interpretations of expert health messages.

Whether there is a smoking community of practice or not, experiential learning theory offers a way to understand how public messages may be interpreted using a contextual, social focus. When thinking about experiential learning in terms of health and smoking, it is clear that experience plays some role in what and how we learn about our health and the harms of smoking simply because of the many ways that experience can teach. However, since the concept of “experience” is so broad, researchers have begun to consider more specific experiences in isolation. In the next section, I discuss public pedagogy which attempts to further theorize how informal, everyday life experiences that may influence our learning.

**Public Pedagogy**

A more specific learning theory that falls under the umbrella of experiential learning is public pedagogy. Public pedagogy is the idea that adults learn through public sites, and which has emerged as an adult education theory from the fields of curriculum theory, cultural studies, and arts-based approaches to learning. It considers what adults learn through, and how they make meaning of their exposure to traditional media (TV, newspapers, magazines, radio), non-
traditional media (YouTube, blogs, zines), public spaces where art or theatrical performances are exhibited, public policies and regulation, popular culture, grassroots social movements, and formal institutions such as zoos, museums and public parks (Sandlin et al., 2011).

Sandlin et al. (2011) conducted a major review of the literature on public pedagogy and found that there are many different ways that scholars have attempted to define and describe the concept. Though Sandlin et al. (2011) identified a variety ways scholars have defined public pedagogy, for the purposes of this project, I will focus on the four main conceptualizations that are most related to public health education and tobacco-related health messages. These include popular culture and mass media, informal institutions and public spaces, dominant societal discourse, and public intellectuals (Sandlin et al., 2011). Since this project is specifically focused on tobacco-related public health pedagogies, below I will describe each of these theoretical categories and provide examples of how they can be related to tobacco public health education. Table 2-1 provides an overview of each of the public pedagogy categories I discuss below, along with examples from the field of tobacco control. In addition, more specific examples from a historical perspective are detailed in Table 2-2 by pedagogical category and displayed chronologically within each category.

**Table 2-1**
Categories of public pedagogy relevant to tobacco control from the perspective of what the field attempts to teach the publics it serves

<table>
<thead>
<tr>
<th>Public Pedagogy Category</th>
<th>Basic description</th>
<th>Examples from tobacco control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dominant Societal Discourse</td>
<td>Public policy, political discourse, widespread cultural values, and economic determinism. Also includes</td>
<td>1. Laws and regulations: health warning labels, advertising restrictions, age of sale laws, clean indoor air laws, and</td>
</tr>
<tr>
<td>Informal institutions and public spaces</td>
<td>Informal learning that occurs through exposure to historical sites, museums, public exhibits, zoos, parks, cemeteries, artwork. In terms of public health this could also include sites where health-related information might be found (e.g., no smoking signs) such as restaurants, airports, hospitals, retailers</td>
<td>1. Implementation of laws that impact public spaces such as age of sale and clean indoor air laws. These may be coupled with signage or other displays that could be considered educative. 2. Artwork, museum displays, historical sites that may display smokers or historical lessons about smoking and cultural acceptability.</td>
</tr>
<tr>
<td>Popular culture and mass media</td>
<td>Learning that occurs through traditional and non-traditional media such as TV, movies, newspapers, magazines, radio, YouTube, blogs, zines, and other social media.</td>
<td>Restrictions on smoking sponsorships, smoking on TV or in movies, health education commercials developed by public health experts.</td>
</tr>
<tr>
<td>Public intellectuals</td>
<td>Experts, academics, non-profit organizations, governmental organizations, formal committees and their reports, and grassroots movements that attempt to teach the public about important societal issues.</td>
<td>Various public health experts (individual, collective, anonymous), U.S. Surgeon General, U.S. Food and Drug Administration, U.S. Department of Health and Human Services, American Heart Association, American Cancer Association, America Lung Association, Group Against Smoking Pollution (GASP), Americans</td>
</tr>
</tbody>
</table>
Dominant societal discourse. Within this category, Sandlin et al. (2011) suggest that learning occurs through public sites such as “public policy, political discourse, widespread cultural values, and economic determinism” (p. 352). However, this definition was developed based on the literature that was identified by the authors at the time of their review. Given the extensive history of involvement in public policy by the field of tobacco control, it is necessary for me to expand Sandlin et al.’s (2011) description to be more reflective of the historical events that have occurred through the actions of those in the field of public health over the past 6 decades. Within the category of dominant societal discourse, I propose that there are many elements of “public policy” that contribute to public pedagogy and how individuals learn about smoking and their health, including institutional or local policies, city, state and federal laws, state and federal regulations, and litigation.

When discussing public policy, it should be noted that it is not the written policy, regulation, or legal ruling that is particularly important in terms of public pedagogy since it is unlikely that the average American citizen is reading these documents. What is important for public pedagogy is how the policy, law, or legal decision is discussed, decided, implemented and enforced within society. For this reason, although I will discuss public policy and litigation in detail here, this category heavily overlaps with the public pedagogy category of Informal Institutions and Public Spaces since the implementation of tobacco-related laws and litigation are often carried out in public spaces (e.g., clean indoor air laws implemented in a restaurant, or cigarette taxes that increase the cost of a pack at the store).

Laws and regulations. One of the most identifiable and historical categories of tobacco-related public pedagogy is that of laws and regulations. Throughout this review, I will often
refer to laws and regulations as if they are the same thing, but they are not. Federal laws are written by a Congressperson, discussed, debated, voted on, and passed in both the U.S. House of Representatives and the U.S. Senate. If they are passed, they are eventually signed into law by the President. States and municipalities also have similar methods for passing local laws. At the federal level, within the law is language that assigns the law to a regulatory agency, which then interprets the language of the law and writes the regulations that provide rules and guidelines for the entities that are required to comply with the law, and those that are tasked with enforcement of the law. Just as the law is subject to interpretation by the agency that writes the rules and regulations, regulations are also subject to some interpretation by the individuals who are conducting the day to day work of enforcing them.

Since the Surgeon General’s announcement that cigarette smoke caused lung cancer in 1964, there have been a number of important laws passed and regulations implemented through the influence of public health practitioners with the goal of decreasing the prevalence of tobacco use. Many state and federal laws are related to where smokers are allowed to smoke. Since these regulations are implemented at the societal level and they are imposed on anyone who enters these spaces, the unilateral execution of regulations has the potential to create a broad societal discourse about smoking that is educational. Over the course of the history of tobacco control, there have been many times when each of these public pedagogical elements has been invoked to help improve population health. An example I draw on frequently is that of clean indoor air laws which require smokers to go outside of a defined boundary to smoke. These laws are intended to keep non-smokers safe from the harms of second-hand smoke, but there is also a secondary component which is to make smoking an unusual occurrence in public spaces which creates educative discourse about socially acceptable and unacceptable behavior (Bayer &
Bachynski, 2013). Table 2-2 includes the major laws that have been implemented since 1964, including cigarette warning labels, federal excise taxes, clean indoor air laws, restrictions on marketing and advertising, and age of sale restrictions.

**Litigation.** Along a similar vein as laws is litigation. When laws are written by members of Congress, they are still subject to interpretation by regulatory agencies and those who enforce the laws. This creates the possibility that an individual, corporation or other entity may disagree with the interpretation of a law and they can contest this interpretation through litigation it in the U.S. court system. Though many court cases are tried with little fanfare, occasionally they may be reported on through local or national media outlets. Within the field of tobacco control, there have been a number of contentious courtroom battles between the tobacco industry and regulators, states, and individuals (Brandt, 2007; Kessler, 2001; National Association of Attorneys General, 2017; U. S. Department of Health and Human Services, 2014). Many of these have influenced the enforcement and interpretation of laws, served to re-iterate an accurate enactment of an existing law, or offer a new interpretation of a law that can be implemented by an act of Congress to change the law. The act of challenging laws in court is a well-established tactic used by the tobacco industry to delay implementation of laws by forcing their opponents to lay bare their case in a public forum with the hope that they will run out of money before they are able to achieve their desired outcome (Brandt, 2007).

In the case of legal battles, the eventual decisions that are handed down by the courts may be the force that causes a written law to be changed, although that is not always the case. Sometimes legal challenges may serve to cause a reinterpretation of an existing regulation or law which is then used as a precedent for future challenges of the same law. Regardless of the outcome, there is a disconnect between the law and its interpretation, and how it actually impacts
an individual in their everyday lives. Average citizens may or may or may not know how or when the legal battle they heard about on the evening news will actually touch them in their daily lives, particularly if the litigation does not impact an informal institution or public space. Therefore, the type of learning that occurs in this form of public pedagogy is more about “ideological forces that act upon individuals” (Savage, 2014, p. 85) than about concrete spaces where learning occurs. How these policies act upon individuals is completely dependent on the context in which someone lives and how they are enacted in their community.

**Congressional testimony.** Though not mentioned in Sandlin et al.’s (2011) review, congressional testimonies are common occurrences in the political sphere. On occasion, these testimonies are meant to inform the law making process by having experts in the field offer their views on a particular topic. However, individuals may also be called to testify before a legislative committee simply to make a point politically. If these events are to be considered pedagogical, they must be publicly available. Most likely, if they do become pedagogical it is in the public pedagogy category of popular culture and mass media since reports of these events may be reported on in popular media. However, for this study, they will remain in the category of their origin.

**Informal institutions and public spaces.** Another site where learning can occur is through public institutions and public spheres, an idea that is heavily influenced by the book *Places of Learning: Media, Architecture, Pedagogy*, by Elizabeth Ellsworth (2004). This site of informal learning includes institutions such as museums, zoos, parks and cemeteries in addition to public art (graffiti and architecture) and historical sites that contain public memory or insight into historical events. In addition, though not mentioned by Ellsworth (2004) or Sandlin et al.
(2011), since tobacco is sold at retailers throughout the U.S., these venues also become sites of learning.

**Figure 2-1**  
**Meeting of the 1964 Surgeon General's Advisory Committee**

Some institutional sites can be seen as having an identifiable, purposeful educational aim. However, even though many of these sites may not have an easily identifiable intention for what learning may occur, this does not mean that opportunities for learning do not exist (Sandlin et al., 2011). When considering tobacco use, a museum may display artwork or historical advertisements that have depictions of smoking in ways that are not commonly seen today. For instance, when Luther Terry convened his advisory committee in 1963 to evaluate the evidence on smoking and health, half of the committee members were smokers (Brandt, 2007). And, though not displayed in a museum, Figure 2-1 is a picture from the 2014 Surgeon General’s report commemorating the 50th anniversary of that report. It shows of the committee members around a conference table with paperwork, coffee cups, and ashtrays in front of them (U. S. Department of Health and Human Services, 2014, p. 774). Depending on how an individual who sees these types of historical pictures attends to and interprets them, these displays have the potential to offer some kind of informal lesson to its viewer.

Similarly, public spaces can quite unintentionally teach norms about smoking based on the presence or absence of tobacco-related sales and advertising (Hamilton et al., 2008) or based on the presence of “no smoking” signs that may be displayed throughout the institution. No
smoking signs are a particularly good example of how the public policy pedagogy may be described in two different categories. Clean indoor air laws fall under public policy, but the implementation of the law occurs in public sites since these are often the physical location where laws and regulations are enforced. For instance, the 2008 Pennsylvania Clean Indoor Air Act ("Clean Indoor Air Act," 2008) requires that no smoking signage be placed in all public spaces where smoking is restricted. In this case, the law per se is not the educational force, but rather the public site where the individual sees the no smoking sign (e.g., airports, hospitals, theaters, etc.) is how the law is enacted in the public sphere.

Popular culture and mass media. The public pedagogy of popular culture includes sites of learning such as traditional media, (movies, TV, newspapers, magazines, radio) and non-traditional media (YouTube, blogs, zines, social media). Within adult education, the idea that learning can occur through popular culture is heavily influenced by Henry Giroux, a scholar in the field of curriculum studies who primarily uses content analysis methodologies to discuss what people learn through outlets such as movies, TV or other media. Giroux suggests that the learning occurring through popular media is in the form of both reproducing accepted social norms for people of a particular race, gender, age and class (Giroux, 1998) and it can be a site of contestation for these same norms (Giroux, 2000, 2006). In addition, public pedagogy has received a significant amount of interest in the field of adult education particularly related to how popular culture such as TV and movies contribute to the construction of an individual’s identity (Wright, 2010), or how TV characters and their stories can challenge long-held personal or moral beliefs (C. Jarvis & Burr, 2011).

For the purposes of this project, however, what and how movies, TV, and other forms of popular culture may teach individuals about smoking is only relevant if it is initiated by the field
of public health in some way. Thus, within this category of public pedagogy, there are two areas where the field of public health has been active including TV/Movies and mass media campaigns (including advertisements and social media content) which I discuss separately below.

**TV and movies.** Tobacco control researchers have a strong interest in removing depictions of smoking and cigarettes from TV and movies. They have consistently documented associations between youth exposure to people smoking in movies with the uptake of smoking (Charlesworth & Glantz, 2005) which has led them to assert that these venues have the potential to teach and influence behavior. Researchers believe that depictions of people who smoke influence viewers potentially because these smokers are portrayed as sexy or rebellious without experiencing any of the negative health consequences of smoking (Grube et al., 1984; National Cancer Institute, 2008).

The decline of depictions of smoking on TV has been largely due to voluntary restrictions made by TV networks due to consumer pressures to remove these images, particularly during time slots when children may be watching. The influence of public health on the depictions of smokers and cigarettes in movies has come mostly through public health advocates’ efforts to ban smoking, product placements, and payments to actors to smoke in movies. Cigarette product placements in movies, or payments to actors was a common, and lucrative tobacco industry marketing technique (Lum, Polansky, Jackler, & Glantz, 2008) up until the 1998 Tobacco Master Settlement Agreement banned these overt practices (see Table 2-2).

Nonetheless, since a character who smokes can be considered artistically necessary for a movie storyline, movie producers and actors continue to depict smoking in both youth (G, PG, PG-13 ratings) and adult rated movies (Polansky, Titus, Atayeva, & Glanz, 2017). Recognizing that characters who smoke cannot be eliminated from movies entirely, public health advocates
have made progress by exerting pressure on the Motion Picture Association of America to limit smoking to R-rated movies that are less likely to be viewed by children (Polansky et al., 2017). However, successful as these efforts have been up to this point, eliminating unsolicited depictions of smoking and cigarettes remains largely a voluntary activity on the part of the movie producers and studios.

**Mass media.** Mass media as public health pedagogy has received a significant amount of attention from field of public health and there is a large body of literature supporting the effectiveness of public health education campaigns in reducing tobacco use at the population level (Brennan et al., 2012; Durkin et al., 2012; National Cancer Institute, 2008; U. S. Department of Health and Human Services, 2014; M. A. Wakefield, Loken, & Hornik, 2010). However, the evidence is mixed as to whether these campaigns are effective for all groups within the population, particularly for low socio-economic groups (Niederdeppe, Kuang, Crock, & Skelton, 2008).

Public health education campaigns can be implemented at the local, state, or federal level, and any of the public health entities that make up the structure of public health may have a campaign running at any given time (National Cancer Institute, 2008). Because of this, for the purposes of this project, I have only included articles for the most recent (past 8 years) national mass media campaigns. In addition, though media campaigns often have a target audience in mind (e.g., youth, young adults, adults), I have included all campaigns regardless of the intended target market since adults may be unintentionally exposed to campaigns that are intended for youth. Table 2-2 outlines the relevant campaigns that will be considered in this project.

**Public Intellectualism.** Public intellectualism in public pedagogy proposes that intellectuals, academics, or leaders within society can educate citizens about important societal
issues. Avenues for dissemination of their information may include announcements from community leaders, interviews with health experts, or any other reports about the life and events of public intellectuals (e.g. the president, Congress members, community leaders, or scholars), and publicly disseminated discussions with public intellectuals. Though not detailed in Sandlin et al’s (2011) review, for the purposes of this project, I propose to describe public intellectualism in three categories including individual intellects (e.g., the U.S. Surgeon General), collective intellects (e.g., the Food and Drug Administration), and anonymous intellects. Below I describe each offer examples of how each type of intellect may present themselves in the field of public health.

**Individual intellects.** Though most public intellectuals may be unknown to the general public, there are some notable ones that represent the voice of the field of public health and tobacco control. Arguably, one of the most important public health intellectuals is the U.S. Surgeon General who is often called the nation’s top doctor. The Surgeon General is nominated by the U.S. President and confirmed by the U.S. Congress to hold a 4 year term as the head of the U.S. Public Health Service (U. S. Department of Health and Human Services, 2017a). Tobacco-related reports from the Surgeon General are released every 2 years, and though the average U.S. citizen is unlikely to read these lengthy documents, highlights of the reports may be the subject of national media reports. An example of public intellectualism from the field of tobacco control is the 1964 announcement by Surgeon General Luther Terry that cigarette smoking causes disease. In this case, the Surgeon General’s announcement contributed not just to individual and societal learning about the harms of smoking, but it is also credited as changing behavior influencing a marked decrease in smoking prevalence in the U.S (Brandt, 1990; U. S. Department of Health and Human Services, 2014).
Collective intellects. A collective intellects is an organization or group that is communicating with the public. As a collective intellectual, information is offered to the public sphere through formal channels such as the internet, websites, press releases, community events, public demonstrations, or town meetings, and the message that is disseminated does not have an identifiable individual addressing the public (Giroux, 2004; Gramsci, 1971; Sandlin et al., 2011). Examples of collective intellects may be grassroots organizations, non-profit organizations, committees that convene to issue reports, retailers when they are speaking on a public health topic, and governmental agencies. Events hosted by collective public intellectuals take place outside of formal institutions and are theorized to heighten the public’s awareness of a particular issue with the hope of stimulating dialogue, action, or social change (Sandlin et al., 2011).

Both individual and collective intellects are particularly relevant to public health since much of the information that is disseminated to the public by the field is the product of these intellects. When thinking about public intellects, it is also possible that while organizations occasionally address the public, individuals within these organizations can also address the public. For instance, in 2014, CVS pharmacy announced through a number of media channels, that they would stop selling cigarettes in their retail stores. However, after the company made this announcement, CVS Health’s Chief Medical Officer was also quoted in the media (CVS Health, n.d.). Similarly, non-profit organizations, such as the American Heart Association (AHA), the American Lung Association, and grassroots movements, such as the Group Against Smoking Pollution (GASP) and Americans for Nonsmokers Rights (ANR) participated in the dissemination of policy-based non-smoking information through various public venues (Americans for Nonsmokers' Rights, 2017) while individuals may come to the forefront to speak more directly for that organization.
An additional consideration for this category is that it can overlap with informal institutions and public sites. Grassroots movements, town hall meetings, and public demonstrations take place in some physical site (even if it is on the internet), so like regulations that are implemented in the public sphere, intellects who organize events also use public sites for dissemination of their messages. A good example of this from tobacco control is CVS pharmacy. While the retailer collectively announced they would stop selling tobacco, those who didn’t see that company’s announcement would be aware that tobacco products were replaced with nicotine replacement medications on the store shelves for those who went to buy cigarettes.

**Anonymous intellects.** A final consideration in this category is the possibility that individual people may discuss topics or events that occurred without knowing who or where they learned this information. The idea of an anonymous intellectual is more closely associated with second-hand information sharing than direct contact with an intellect. It is therefore included here because though the intellectual may not be identified as an individual sharing the information, that information may still be attributed to an anonymous “they” that is intended to represent the field of public health.

In the sections above, I reviewed critical theory, experiential learning, and public pedagogy which are the frameworks I will use for this project. Public pedagogy in particular was outlined in great detail since I will rely on these categories to formulate a historical timeline of the events that have made up the societal learning that has occurred in smokers’ lives. In the next section, I will provide an overview of the history of tobacco-related public pedagogy and follow this with a review of the literature that has been published on what smokers have learned from these historical pedagogies.

**History of Tobacco-related Public Pedagogy**
The public health community has been working for more than 50 years to educate the public about the harms of tobacco use with the goal of decreasing its use. Over time, our societal knowledge has expanded to the point where 98% of Americans know that cigarette smoking is harmful to health (Leidner, Shaw, & Yen, 2015). The strategies used by those in the field are varied and while some are direct and overt, such as media campaigns, some are implemented in ways that are typically invisible to the general public, such as litigation. Though these events appear to be simple entries in a historical timeline, each marks a significant shift in our societal thinking about tobacco and health. It is important to remember that it not just the simple occurrence of these events that potentially contributes to public learning, but it is also likely that the societal discourse that occurred through other public sites (e.g., the media, public intellectuals, grassroots movements) contributes to how individuals in our society have come to understand how smoking harms health through tobacco-related policy, regulation, and litigation.

Using the framework of public pedagogy, Table 2-2 outlines the pedagogical and historical events that have occurred, starting in 1964, chronologically within each category of public pedagogy described above.

Table 2-2
Major tobacco control pedagogical events and the public pedagogy category under which they fall as described in this chapter and by Sandlin et al. (2011)

<table>
<thead>
<tr>
<th>Pedagogical Event and Date and Public Pedagogy Sub-Category</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dominant societal discourse</td>
<td></td>
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<tr>
<td>Laws: First warning label was mandated to be put on all cigarette packs in the U.S., 1965 (&quot;The Cigarette Label read: CAUTION: Cigarette smoking may be hazardous to your health</td>
<td></td>
</tr>
<tr>
<td>Laws: Labeling and Advertising Act,&quot; 1965)</td>
<td></td>
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<tr>
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<td></td>
</tr>
<tr>
<td>1. Label read: “Warning: The Surgeon General has determined that cigarette smoking is dangerous to your health.</td>
<td></td>
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<tr>
<td>2. Banned all cigarette advertising on U.S. television and radio.</td>
<td></td>
</tr>
<tr>
<td>3. Required warning labels to be placed on print advertising.</td>
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<tr>
<th>Laws: Warning labels on cigarette packs were updated. Comprehensive Smoking Education Act, 1984</th>
<th>Manufacturers and importers required to place 1 of 4 warning labels on packages and they are to rotate on a quarterly basis. These are still in place today. Labels read:</th>
</tr>
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<tbody>
<tr>
<td>1. SURGEON GENERAL'S WARNING: Smoking Causes Lung Cancer, Heart Disease, Emphysema, and May Complicate Pregnancy.</td>
<td></td>
</tr>
<tr>
<td>2. SURGEON GENERAL'S WARNING: Quitting Smoking Now Greatly Reduces Serious Risks to Your Health.</td>
<td></td>
</tr>
<tr>
<td>3. SURGEON GENERAL'S WARNING: Smoking By Pregnant Women May Result in Fetal Injury, Premature Birth, and Low Birth Weight.</td>
<td></td>
</tr>
<tr>
<td>4. SURGEON GENERAL'S WARNING: Cigarette Smoke Contains Carbon Monoxide.</td>
<td></td>
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<p>| Laws: Age of sale laws is strengthened to encourage enforcement of existing laws. Sales of tobacco restricted to | Cigarette age of sale laws were in place in every state prior to the Synar Amendment, however they were not enforced. This law required states to enforce age of sale laws (no sales controls). |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td><strong>those aged 18+</strong> Synar Amendment, 1992 (&quot;Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act,&quot; 1992)</td>
<td>to individuals less than 18 years old) in order to receive their Substance Abuse Prevention and Treatment Block Grant (SABG). The Food and Drug Administration also updated the age of sale laws to include electronic cigarettes in 2016. (Food and Drug Administration, 2016)</td>
</tr>
<tr>
<td><strong>Congressional Testimony:</strong> FDA commissioner David Kessler and the CEOs of 7 tobacco companies testify before the Subcommittee on Health and the Environment, 1994 (Kessler, 2001)</td>
<td>During this session, Kessler asserts that nicotine is an addictive drug that is being intentionally manipulated by tobacco companies in order to sustain addiction in their customers. CEOs of tobacco companies deny that nicotine is addictive and cast doubt on the existing addictions literature.</td>
</tr>
<tr>
<td><strong>Laws-Regulation:</strong> FDA makes nicotine replacement (patch and gum) available over the counter, 1996 (Cummings &amp; Hyland, 2005; U. S. Food and Drug Administration, 2016)</td>
<td>In February, through a re-interpretation of the existing regulations, nicotine gum was available without a prescription. This was followed by nicotine patches in the summer of that year.</td>
</tr>
<tr>
<td><strong>Laws-Taxation:</strong> Federal and state tobacco excise taxes are implemented and increase over time. (Orzechowski and Walker, 2014)</td>
<td>Federal excise taxes on cigarettes were collected early as 1880 although tobacco has been taxed since colonial days. States also tax cigarettes starting in 1921-22. As of 2014, the federal excise tax on cigarettes is $1.01/pack and state taxes range from $0.17 (Missouri)-$4.35 (New York)/pack.</td>
</tr>
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</table>
| **Litigation:** Tobacco Master Settlement Agreement (MSA), 1998 (National Association of Attorneys General, 2017) | As a result of this case, major tobacco companies were required to enter into agreements with the 46 state Attorneys General that required them to:  
- Pay states for tobacco-related healthcare costs which resulted in a cigarette price increase.  
- Limit advertising, marketing and cigarette promotions including:
1. A ban on using cartoons in advertisement largely due to Joe Camel’s appeal to youth (Fischer, Schwartz, Richards, Goldstein, & Rojas, 1991)
2. A ban on product placements in movies and payments to actors
   - Make internal tobacco company documents available to the public.

Litigation: FDA attempts to assert regulatory authority over cigarettes claiming that they are being used as a drug delivery system. They are challenged by the industry and the case is tried in the U.S. Supreme Court, 2000.
("FDA v. Brown & Williamson Tobacco Corporation" 2000) This was the first case in which the tobacco industry was documented to have manipulated the public. The main focus of the FDA’s case was that the industry was aware of the addictive properties of nicotine and they were intentionally manipulating the dose to perpetuate addiction in their customers. In this way, the cigarette could be considered a biological agent designed to deliver a drug and therefore subject to FDA regulation.

("Clean Indoor Air Act," 2008) Signed into law on June 13, 2008 by Governor Ed Rendell, the law prohibits smoking in public places. It also requires “no smoking” signage to be posted and maintained where smoking is not permitted.

Laws- Taxation: The federal excise tax on cigarettes increased $0.62 for a total of $1.01 per pack in tax, 2009
("Children’s Health Insurance Program Reauthorization Act," 2009) Increasing the price of cigarettes is one of the most effective strategies used by the field of public health to decrease consumption (U. S. Department of Health and Human Services, 2014).

Laws-FDA regulation: The Food and Drug Administration is given the authority to regulate tobacco products as drugs, 2009
("Family Smoking Prevention and Tobacco Control Act," 2009) This law served to give the U.S. FDA the authority to regulate tobacco products including requiring product changes that will make them less harmful and public education campaigns about the harms to tobacco use. It granted the agency broad authority to over tobacco product manufacturing, marketing, distribution, sale and product
imports. It also established the Center for Tobacco Products and issued grants to study tobacco regulatory issues.

<table>
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<tr>
<th>Laws-regulation: The Department of Housing and Urban Development (HUD) announces a new regulatory rule that will require all public housing units to be smoke free, 2016 (U. S. Department of Housing and Urban Development, 2016)</th>
<th>The final rule for smoke-free public housing was published on December 5, 2016 and allows for an 18 month implementation period starting in February of 2017. Smoke-free policies must be in place at public housing sites by July 31, 2018.</th>
</tr>
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<tbody>
<tr>
<td>Laws-regulation: PA state parks ban smoking, 2017 (Pennsylvania Department of Conservation and Natural Resources, 2017)</td>
<td>Parks and beaches are not part of the state law that bans smoking. Thus, these types of restrictions are based on the individual institution’s decision on how to handle smoking.</td>
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</table>

**Public intellectuals**

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<thead>
<tr>
<th>Public Intellect: Surgeon General’s Report on Smoking and Health, 1964 (U. S. Department of Health Education and Welfare, 1964)</th>
<th>This was the first official recognition that smoking caused harm to health</th>
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<tbody>
<tr>
<td>Collective Intellect: Non-smokers rights grassroots movement, 1976 (Americans for Nonsmokers' Rights, 2017)</td>
<td>The movement to prohibit smoking in public places truly began at the community level and quickly gained momentum. Organizations such as Group Against Smoking Pollution (GASP), the American Cancer Society, the American Lung Association, and the American Heart Association all eventually joined the movement to lobby for local and national laws that would restrict smoking in public spaces.</td>
</tr>
<tr>
<td>Collective Intellect: American Cancer Society’s 1st Great American Smoke Out, 1977 (American Cancer Society, 2017)</td>
<td>This annual event is paired with marketing and social support to encourage smokers to quit on the Thursday before Thanksgiving.</td>
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Collective Intellect: The Food and Drug Administration announces plan to reduce nicotine in cigarettes and other tobacco products, 2017 (U. S. Food and Drug Administration, 2017a)

Though nicotine reduction in cigarettes was granted as a possible regulatory option for the FDA, they had not publicly announced that this was a direction that they planned to pursue. This announcement sets the stage for public health education about the addictiveness of nicotine and the feasibility of a nicotine reduction strategy in cigarettes and other products.

### Popular culture and mass media

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<tr>
<th>Mass Media Campaign: American Legacy Foundation is founded (1999) and the first truth initiative ads air nationwide (2000) (truth initiative, 2017a)</th>
<th>This campaign began as part of a Florida state anti-tobacco campaign designed to provide an anti-tobacco corporation perspective with the goal of preventing tobacco use initiation and de-normalize smoking in youth. The current campaign features Amanda Seales and accuses tobacco companies “profiling” by targeting Black, low income smokers and youth (truth initiative, 2017b).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mass Media Campaign: Tips from Former Smokers Campaign, Centers for Disease Control and Prevention, 2012 (Centers for Disease Control and Prevention, 2017)</td>
<td>This campaign is directed at current adult smokers and offers the viewer a “tip” from a former smoker about how to manage a health consequence they encountered due to their smoking. The most successful ad was from Terri, a former smoker who provides tips on how to live with a</td>
</tr>
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tracheostomy. Successive campaigns profiled Terrie as she went through chemotherapy for lung cancer and eventually died from her illness.

Mass Media Campaign: The Real Cost, Fresh Empire, and This Real Life campaigns, FDA, 2014 (U. S. Food and Drug Administration, 2017c)

Though these campaigns are directed at youth and young adults, they are currently running in the public sphere and are included here because of the potential to be viewed and discussed by adults. The only existing campaign with published follow up data is The Real Cost.

Informal institutions and public spaces

Target becomes the first major retailer to stop selling tobacco products, 1996 (Feder, 1996; truth initiative, 2016b)

Though Target stops selling cigarettes citing the costs imposed by new regulations to restrict sales to minors (see Synar Amendment) are too costly to implement.

CVS pharmacy follows suit in 2014 and announces they will also stop selling cigarettes, 2014 (CVS Health, 2014)

More recently, this decision was also announced by CVS pharmacy. In states where CVS pharmacy has more than 15% market share, cigarette sales dropped 1% after they stopped selling cigarettes (CVS Health, n.d.).

Literature Review Method

In the previous sections of this chapter, I provided context for my project by reviewing the purpose and scope of public health and by defining public pedagogy as I employed it in this project. With this done, I now begin to review the scholarship that has been published on the topic of what smokers have learned from a lifetime of exposure to public health pedagogy.

Importantly, since the present study is specifically related to how adults learn through what is taught by those in the field of public health, this will be the primary focus of my literature review. In this way, I am considering the field of public health to be the educator and the public they served to be the students. I did not review articles with a focus on how other entities, such
as tobacco companies, film producers, marketing/sales professionals, etc., may teach the public about tobacco use.

Studies were identified for this review by searching the following databases: Pubmed Medline, Cumulative Index for Nursing and Allied Health (CINAL), Communication and Mass Media Complete, ERIC, and Google Scholar. The search was limited to scholarly journals, books, reports, dissertations and theses, and government and official publications published in English. Since what smokers learn through public pedagogy is heavily influenced by culture and how active the field of tobacco control has been in any particular country, I also limited my search to high-income countries that have implemented similar tobacco control policies to those in the United States. These were defined by using established World Health Organization criteria (World Health Organization, 2015) and I included studies from the U.S., Canada, Australia, New Zealand, the United Kingdom, and Europe. My focus was primarily on adults, but due to the limited amount of published scholarship on this topic, highly relevant articles that included adolescents or young adults were also considered for review.

A combination of the following terms was used as appropriate to search each of the databases listed above: smoking, learning or knowledge, public health, public pedagogy, popular culture, media, adult, warning labels, and regulations. A hand search of scholarly educational journals was also conducted including Adult Education Quarterly (2000-2017), International Journal of Lifelong Education (2000-2017), and Studies in the Education of Adults (2000-2017), and Health, Risk, and Society (2000-2017). Conference proceedings from the Adult Education Research Conference are published online and this database was searched using the terms public pedagogy, health, and smoking. Finally, the University of California, San Francisco (UCSF)
maintains an electronic, searchable database of tobacco company videos, web archives, and documents. This database was also searched for any documents relevant to this study.

These efforts yielded 8,339 documents. The titles and abstracts for these documents were examined for relevance. Of these, 165 were found to be related to the study and selected for further review. After reading these articles fully, 80 articles were found to be either directly or tangentially related to public pedagogy. Of these 80 articles, only 28 articles directly documented some form of adult learning from any one of the public pedagogy categories previously described.

**Review of the Literature: Public Health Pedagogy**

There are four conceptualizations of public pedagogy that are most relevant to tobacco-related public health messages including how people learn from popular culture, informal institutions and public spaces, dominant societal discourse, and public intellectuals (Sandlin et al., 2011). Below I discuss the literature that I identified in each of these categories specifically as it applies to how or what adults have learned through these public pedagogical messages.

**Dominant Societal Discourse: Laws, Regulations, and Litigation**

For the purposes of this review, I focused on a number of laws that are relevant to tobacco-related public health including cigarette warning labels, clean indoor air laws, cigarette excise taxes, tobacco regulation by the FDA, and marketing and advertising. In addition, this category includes litigation. I discuss the literature related to each of these categories separately.

**Warning labels.** The placement of warning labels on cigarette packs in the U.S. was the first Congressional and public health response to Luther Terry’s 1965 announcement that cigarettes were associated with lung disease. The rationale for warning labels on cigarette packs, or any other consumer product, is a legal concept of *informed consent* which suggests that
warning labels give the consumer the information they need to carefully weigh the risks of using a particular product (U. S. Department of Health and Human Services, 2000).

The field of public health considers the cigarette pack a particularly useful and convenient way to provide health information to smokers (International Tobacco Control Policy Evaluation Project, 2009), and there is an extensive body of literature showing that various types of warning labels are effective at reaching large numbers of smokers (Hammond, 2011; Kaiserman, 1993). However, warning labels in the U.S. are text based and situated on the side of the pack, which is considered the weakest form of labeling in terms of effectively communicating about the harms of tobacco use to the public (International Tobacco Control Policy Evaluation Project, 2009). Other, more effective forms of warning labels that are being used in other countries include graphic, pictorial warnings and large strongly worded text warnings (e.g., smoking kills) situated on the front of packages (Borland et al., 2009; Hammond, 2011; Hammond et al., 2007; International Tobacco Control Policy Evaluation Project, 2009).

Table 2 provides details on the evolution of U.S. cigarette warning label laws in the U.S. The current labels were implemented in 1984 as a result of a staff report to Congress by the Federal Trade Commission (FTC). In the report, the FTC recommended that new warning labels be implemented because the existing labels were ineffective at educating the public about the specific harms of tobacco use (Bonnie et al., 2007; Myers et al., 1981; U. S. Department of Health and Human Services, 2000). Though the full report was not made public, the press reported on some of the FTC’s conclusions, which were that large proportions of the public did not know that smoking caused lung cancer (41%), emphysema (60%), or heart attacks (50%) (Hinds, 1982). The report recommended that the labels be updated to include these diseases, and
Congress responded with new legislation to update the labels with what appears on packages to this day ("Comprehensive Smoking Education Act of 1984," 1984).

Not long thereafter, the 2000 Surgeon General’s report also recommended regulating tobacco product labeling to include chemical constituents, such as nicotine and carbon monoxide (U. S. Department of Health and Human Services, 2000); a recommendation that has not been implemented. However, adding cigarette product constituents or chemical yields (e.g., carbon monoxide, nicotine, or other carcinogens) to tobacco packaging is currently a regulatory possibility as a result of the 2009 Family Smoking Prevention and Tobacco Control Act (FSPTCA) (Hammond, 2012). The FSPTCA also gives the FDA the authority to place graphic warning labels on packs in the U.S., though the FDA has been hampered by legal challenges from the tobacco industry (truth initiative, 2016a).

Though graphic warning labels may be the next step for cigarette packs, the focus of this study is what smokers may have learned from the existing labels. When asked, smokers and non-smokers state that cigarette warning labels are an important source of health information (Commonwealth Department of Health and Aged Care, 2001; International Tobacco Control Policy Evaluation Project, 2009; Kaiserman, 1993; O’Hegarty et al., 2006), although they also comment that they “learn to ignore” them, thus rendering labels ineffective (Branstetter, Lengerich, Dignan, & Muscat, 2015, p. 6). Additional elements of learning related to health warnings have been heavily studied in terms awareness (Borland, 1997; Hammond, 2011; Hammond et al., 2007; Hitchman, Driezen, Logel, Hammond, & Fong, 2014; O’Hegarty et al., 2006), their association with quit intentions (Hammond, 2011; Hammond et al., 2007; Hammond, Fong, McNeill, Borland, & Cummings, 2006; Hitchman et al., 2014), and knowledge of harms caused by smoking (Baillie, Lovato, Johnson, & Kalaw, 2005; Hammond, 2011;
Hammond et al., 2006; Hitchman et al., 2014; Mutti, Hammond, Reid, & Thrasher, 2013; Popova et al., 2017).

The most important concept for this project is related to what smokers have learned from warning labels, and in the studies above, knowledge was measured almost exclusively using quantitative methods. For example, using survey data from the International Tobacco Control (ITC) Four Country Survey, Hammond et al. (2006) asked smokers to state whether smoking caused heart disease, stroke, impotence, and lung cancer. Participants were also asked whether cigarette smoke contained carbon monoxide, cyanide, and arsenic and possible responses to all these questions were “yes”, “no”, or “don’t know”. Eighty-six to 95% of participants were aware of items that were the subject of current health warnings (lung cancer, heart disease, carbon monoxide), (Hammond et al., 2006) but there was much lower awareness (37%-73%) of items that were not on U.S. warning labels (e.g., stroke, impotence, arsenic, cyanide). However, the subject of this study is not exclusively about this type of technical knowledge. Though important, technical knowledge does not provide any information about what the individual actually knows about these diseases or chemicals, and it does not offer any information about the meaning they may attribute to it personally.

Also identified were two qualitative studies that offered some insight into how teens and young adults understood and made meaning of information related to warning labels (Baillie et al., 2005; Popova et al., 2017). Baillie et al. (2005) interviewed Canadian teen smokers and found that even though they were aware of health warnings, they used their own personal experiences to interpret the information. For instance one participant stated,“I wasn’t pregnant and I was young and healthy, so I thought like, it’s not going to bother me” (Baillie et al., 2005, p. 103). In contrast, a participant in the Popova et al. (2017) study indicated that after seeing a
warning label about lung cancer, his personal experience with his grandmother’s death from lung cancer provided him with a reason not to smoke marijuana.

Though warning labels are one of the most direct communications tools that the field of public health uses to discuss the harms of smoking, with the exception of the studies above, there is very little scholarship on the meaning that smokers make and how they understand the existing messages.

**Clean indoor air laws.** The public pedagogy of clean indoor air laws overlaps heavily with the categories of informal institutions and public spaces and public intellectuals because of the historical evolution of the laws. The origin of these laws began with a grassroots movement to remove cancer-causing, second-hand smoke from public spaces (Americans for Nonsmokers' Rights, 2017). Initially, local ordinances were passed that restricted smoking in isolated locations throughout the country and eventually these ordinances expanded to state laws (Brandt, 2007). In 2008, Pennsylvania passed the Clean Indoor Air act that restricted smoking in a number of public spaces including restaurants, bars, mass transportation, healthcare and childcare facilities, theaters, sports facilities, and work places ("Clean Indoor Air Act," 2008).

Though clean indoor air laws are fairly comprehensive and have positively impacted many Americans (U. S. Department of Health and Human Services, 2014), it has also been found that these laws may unintentionally cause some low income groups to become more exposed to second-hand smoke. In a review of the literature of second-hand smoke policies’ implications for disadvantaged women, Greaves and Hemsing (2009) found that women of low socioeconomic status (SES) were more likely to be exposed to second-hand smoke and to experience stigmatization as a result of these policies. This unintended consequence has materialized because low SES women, particularly minority women, are more likely to work in
environments where clean indoor air laws do not apply (e.g., in hospitality or private homes), and they are less likely to have agency over others who smoke in their homes, such as their partners (Greaves & Hemsing, 2009).

The presence of these inequalities makes it even more relevant to examine what has been learned by smokers as a result of the recent implementation of these laws. The majority of literature identified for this review investigated smokers’ awareness of (or support for) clean indoor air laws (Albers, Siegel, Cheng, Biener, & Rigotti, 2004; Crawford, Balch, Mermelstein, & Tobacco Control Network Writing, 2002; Jones & Williams, 2012; Stillman, Soong, Zheng, & Navas-Acien, 2015), the presence of smoking related stigma due to restrictions on smoking in public places (Frohlich et al., 2010; Stuber, Galea, & Link, 2008), or fears about the harms of second-hand smoke (Stuber et al., 2008). In addition, one study investigated smokers’ thoughts about further restrictions in social venues such as bars and pubs where smoking is currently allowed (M. Wakefield, Cameron, & Murphy, 2009).

Only three studies directly addressed what was learned from clean indoor air laws (Albers et al., 2004; Frohlich et al., 2010; Stuber et al., 2008). Two qualitative studies compared low and high SES smokers and found that smoking bans were related to perceptions of social stigma for smokers, although the results were mixed (Frohlich et al., 2010; Stuber et al., 2008). Stuber et al. (2008) found that smokers with less education perceived social stigma less strongly, possibly because they worked in places with fewer restrictions on smoking (Stuber et al., 2008). In contrast, Frohlich et al. (2010) found that low SES smokers felt more stigmatized about being smoker than those of higher SES partially because lower SES smokers felt that their smoking was largely out of their control and just a “fact of life” (p. 41). They also felt that tobacco control policies were infringing on their quality of life and attempting to control them in negative
ways. These feelings were not as prevalent among higher SES smokers, partially because they were unresolved in their smoking identity and felt that smoking did not fit with their otherwise healthy behaviors such as exercising and eating well.

One quantitative study found that youth in towns with strong smoking bans had less favorable opinions of smoking than youth in towns with weakly implemented bans (Albers et al., 2004). This evidence supports the idea that smoking bans do, in fact, teach and are an important tool for creating a non-smoking social norm. However, clean indoor air laws that create a new social norm about the unacceptability of smoking may be contributing to the stigmatization discussed above, an unintended consequence of these bans.

**Excise taxes.** Excise taxes have been associated with tobacco since long before the American Revolution (Tax History Museum, n.d.), and currently, taxes are levied on cigarettes at the federal, state, and occasionally, the municipal level (U. S. Department of Health and Human Services, 2014). The act of increasing federal or state excise taxes ultimately increases cigarette costs and is often credited with sharp declines in cigarette consumption. Because of this, the influence of tax increases on consumption has been heavily studied, and taxes are considered the most effective tobacco control interventions that are implemented by governments and the field of public health (Chaloupka, Straif, Leon, & Working Group, 2011; U. S. Department of Health and Human Services, 2014).

There is scant published literature related to what smokers may learn from excise taxes as public pedagogy and only two studies were identified through this review (Guillaumier, Bonevski, & Paul, 2015; Hoek & Smith, 2016). Both studies were conducted in New Zealand where investigators interviewed low income, socioeconomically disadvantaged adult smokers to understand how they interpret and manage cigarette excise tax increases. Both studies found that
the imposition of new taxes forced smokers to learn coping mechanisms in order to maintain their addiction which included recycling waste tobacco, sharing cigarettes within their social networks, and sacrificing “other stuff before I’ll sacrifice my smokes” (Guillaumier et al., 2015, p. 603). This “other stuff” included things like going without meals, paying bills late, or having insufficient money for gas or family leisure activities. Hoek and Smith (2016) also reported that smokers felt demeaned and perceived increased taxes as “evidence of an uncaring state that punished its most disadvantaged citizens” (Hoek & Smith, 2016, p. 87). In this case, though the state may intend that these tax increases lead to health benefits, the smokers saw taxation as an imposition that caused resentment toward the state rather than gratitude.

**Age of sale laws.** Although restrictions on youth purchasing have been in place for many decades (U. S. Department of Health and Human Services, 2014), strict enforcement of these laws did not take place on a federal level until the passage of the Synar Amendment in 1992 ("Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act," 1992). There is a large body of research documenting the effectiveness of these programs to limit youth purchasing (U. S. Department of Health and Human Services, 2014). In addition, although there were articles identified in this review documenting youths’ perceptions of age of sale laws (Crawford et al., 2002; Hamilton et al., 2008), no articles were identified that documented what adults may learn or understand about age of sale laws.

**Litigation.** Litigation is a commonly used tobacco industry tactic due to the virtually unlimited monetary resources they have at their disposal (Brandt, 2007). A full review of the history of litigation is beyond the scope of this project, however, a historical account of the most important and influential court cases can be found in Appendix 14.3 of the 2014 Surgeon General’s report (U. S. Department of Health and Human Services, 2014). Table 2 also includes
a summary the two cases that have influenced regulations including the 1998 Tobacco Master Settlement Agreement (National Association of Attorneys General, 2017) and the FDA’s Supreme Court battle to bring cigarettes under its jurisdiction which they lost in 2000 (Kessler, 2001). Though these court cases make significant impacts on our daily lives through reinterpretation of laws or requirements of settlement agreements, I did not identify any articles in this review related to what smokers may have learned from these public pedagogies. **Congressional Testimony.** A major milestone in the history of tobacco control was FDA Commissioner David Kessler’s announcement that the FDA would begin taking steps to regulate cigarettes as drug delivery systems due to the addictiveness of nicotine (Kessler, 2001). This announcement in 1994 lead to an immediate call for Congressional hearings on the topic led by the chair of the Subcommittee on Health and the Environment, Henry Waxman (Committee on Energy and Commerce, 1994; Hilts, 1994). One of the most memorable events to take place during the course of these hearings was the sworn testimony of 7 tobacco company CEOs (Figure 2) that they did not believe nicotine to be addictive (Frontline, 1994). There was no literature identified during this review that documented adult learning from Congressional testimony.

**Figure 2-2**
CEOs from 7 tobacco companies testify before the Subcommittee on Health and the Environment. They swear under oath that they do not believe nicotine to be addictive.
**FDA regulation.** In 2009, President Obama signed the FSPTCA which gave the FDA the authority to regulation tobacco products ("Family Smoking Prevention and Tobacco Control Act," 2009). In 2014, the FDA asserted jurisdiction over a broader range of tobacco products including cigars, hookah tobacco, electronic cigarettes, and novel non-combustible nicotine products through a deeming rule (Department of Health and Human Services, 2014) that was finalized in 2016.

One of the priorities of the FDA is to understand how people perceive the FDA as a regulator, and whether they consider the FDA to be a credible source of tobacco-related information (Ashley & Backinger, 2012). Because of this, several nationally representative quantitative survey studies have attempted to understand public perceptions of tobacco regulation among U.S. adults (Boynton et al., 2016; Fix et al., 2011; Kaufman, Finney Rutten, Parascandola, Blake, & Augustson, 2015; Wackowski & Delnevo, 2015; Yingst, Veldheer, & Foulds, 2017). Although the vast majority of U.S. adults (94.6%) are aware of the FDA in general, (Boynton et al., 2016), Fix et al. (2011) found that less 30% of U.S. smokers in 2009-2010 had heard of the FSPTCA. In addition, in 2013, Kaufman et al. (2015) found that less than half (41.1%) of U.S. adults knew that the FDA regulated tobacco products though this estimate increased slightly to 47.5% in 2015 using updated data from the same survey (Yingst et al., 2017). Finally, Wackowski and Delnevo (2015) measured attitudes about e-cig policies and FDA regulation using data from 2012 and reported that more than half of current smokers (62.5%) thought that the FDA regulated e-cigs which it did not at the time of the survey.

These data suggest that awareness of regulations related to cigarettes is currently limited, and many Americans are not fully aware of how the FDA may influence tobacco products through regulatory measures. Also important to note is that aside from awareness, no studies
were identified through this review that provided insight into what individuals understood about the FSPTCA or FDA regulation, including how it may influence their smoking behavior.

**Informal Institutions and Public Spaces**

Although tobacco-related laws and regulations are ultimately implemented in public spaces, there were no articles identified in this review that specifically evaluated learning that occurred through these sites. Two articles (Albers et al., 2004; Jones & Williams, 2012) reviewed in the regulatory section on clean indoor air were located in public spaces (a hospital and restaurants) but the authors did not specifically address how the location itself may have contributed to learning or taught something unique about tobacco. The lack of empirical evidence supporting learning from public spaces is particularly striking for tobacco control since no smoking signs are ubiquitous in the aftermath of clean indoor air laws.

**Mass Media Campaigns and Popular Culture**

As discussed above, the field of public health has a long history of implementing mass media campaigns to teach the public about the harms of tobacco. Evaluation of these campaigns typically focuses on how campaign exposure influences intention to quit or actual quit attempts although they do occasionally include assessments of beliefs about tobacco use (Bala, Strzeszynski, Topor-Madry, & Cahill, 2013; Brennan, Durkin, Cotter, Harper, & Wakefield, 2011; National Cancer Institute, 2008). Similarly, citing evidence that social norms about smoking are taught through exposure to popular culture such as movies, the field has also been working to influence social norms about smoking by applying pressure to broadcasters and movie producers to limit smoking in these venues (Charlesworth & Glantz, 2005; Lum et al., 2008). Though there is an extensive body of literature to support advocacy for all of these
activities, there is little literature demonstrating what adults learn through the public pedagogies of mass media and popular culture. Below I review the literature I identified in this category.

**Mass media.** The first national anti-tobacco mass media campaign began in 1967, as a result of a challenge to the Fairness Doctrine which required anti-tobacco public service announcements (PSAs) to be broadcast on stations where tobacco advertisements appeared (U. S. Department of Health and Human Services, 2014). These early ads were found to contribute to a sharp reduction in tobacco use until broadcast tobacco advertising was banned; thus negating the requirement for anti-tobacco PSAs (Cummings, 2002). The next large scale, national mass media campaign was the truth initiative campaign which began in the late 1990s and has continued into the present. Given this extensive history of sustained mass media campaigns, this review will only cover literature related to campaigns that ran as of 2012 including the truth initiative campaign (Sly, Hopkins, Trapido, & Ray, 2001), the FDA’s The Real Cost, Fresh Empire and This Real Life (U. S. Food and Drug Administration, 2017c) campaigns (launched in 2014), and the CDC’s Tips from Former Smokers (Centers for Disease Control and Prevention, 2017) campaign (launched in 2012).

**truth initiative campaign.** The truth initiative campaign ads initially aired in Florida starting in 1998 and they were eventually launched nationally by the American Legacy Foundation (Sly et al., 2001; U. S. Department of Health and Human Services, 2014). The intent of this ongoing campaign is to create anti-tobacco sentiments among youth and young adults with the intention of preventing youth tobacco initiation and use. The campaign uses edgy, anti-tobacco company messages developed in part as a result of internal tobacco industry documents released during the Tobacco Master Settlement that showed how tobacco executives purposefully targeted youth and minorities. Evaluations of the truth initiative campaign have
consistently found that awareness of the campaign is associated with campaign-related anti-
tobacco beliefs in youth and young adults (Farrelly et al., 2002; Richardson et al., 2010; Sly et

For this review, I identified two articles that provided insight into young adults’ exposure
to truth initiative (Popova et al., 2017; Richardson et al., 2010) and one related to adult’s
exposure to truth initiative (Dietz, Delva, Woolley, & Russello, 2008). Richardson et al. (2010)
and Dietz et al. (2008) were both quantitative survey-based studies designed to directly evaluate
campaign effectiveness outcomes, whereas Popova et al. (2017) used semi-structured qualitative
interviews to understand perceived harms and benefits of tobacco product and marijuana use.

Richardson et al. (2010) conducted an assessment of attitudes and beliefs about tobacco
companies among 19,701 young adults aged 18-24 years. They surveyed the participants before
and after the campaign launch and found that campaign awareness was associated with increases
in campaign related beliefs such as “cigarette companies lie” (12.1% increase) and “cigarette
companies try to get young people to start smoking” (10.9% increase). Similarly, Dietz et al.
(2008) surveyed 781 adults aged 30-50 years old to understand campaign awareness and found
that 68% were aware of the anti-tobacco campaign themes.

However, as is common for these types of investigations, the authors did not explore
topics of interest for this review including in what ways campaign exposure may have
contributed to knowledge, what previous public pedagogical messages the participants may have
been exposed to, how the ads were understood by the individuals who saw them, how contextual
issues such as social position may have influenced their understanding of the ads, or how they
assimilated the information into their daily lives in terms of smoking behavior. For instance,
Richardson et al. (2010) reported on pre-campaign knowledge of campaign topics and found that
a large majority of the participants already believed that cigarette companies lie to them (60.9%) and that they try to get young people to start smoking (64.6%). This suggests that a large proportion of the population had learned these beliefs from other sources, which was not explored in the study and was acknowledged as limitation of the study by the authors.

The only study I identified that directly reported on information that was learned from anti-tobacco campaigns was Popova et al. (2017). In the context of discussing how it was “less common” for participants to “cite health authorities” when discussing knowledge of harms for tobacco or marijuana, the authors noted that “several subjects referenced media campaigns explicitly when discussing tobacco-related harms (e.g., truth initiative campaign, Tips for Former Smokers and local anti-tobacco educational campaigns” (Popova et al., 2017, p. 5).

**FDA’s The Real Cost campaign.** Launched in 2014, The Real Cost campaign is targeted at youth and young adults, aged 12-17, and was developed using the theory of reasoned action (Fishbein, 2008) and social cognitive theory (Bandura, 1998; Duke, Alexander, et al., 2015). Campaign themes revolve around non-traditional health outcomes thought to be of interest to youth (e.g., skin, teeth) and loss of control due to addiction (Duke, Alexander, et al., 2015). Although this campaign was developed with youth and young adults in mind (Duke, Alexander, et al., 2015; U. S. Food and Drug Administration, 2017c), it is included here since adults may also have been exposed to the campaign ads. Due to the short time frame between the campaign’s launch and this review, only two articles were identified. Both of these assessed youth exposure and its association with initiation prevention (Duke, Alexander, et al., 2015; Farrelly et al., 2017). In addition, Duke, Alexander, et al. (2015) also evaluated perceived effectiveness of the ads that were seen by participants. Neither of these studies included any evaluation of what was learned from the ads, nor how the information that was received was
assimilated into the individual’s daily life. I did not identify any articles that evaluated other FDA campaigns that were launched after 2014 (U. S. Food and Drug Administration, 2017c).

**CDC’s Tips from Former Smoker’s campaign.** Launched in 2012, this campaign’s focus is on encouraging existing adult smokers to make a quit attempt using graphic images and narrative testimonials of smokers’ who have encountered health problems due to their smoking (Centers for Disease Control and Prevention, 2017). Campaign developers drew on the Theory of Reasoned Action as a way to encourage behavior change among existing smokers (Ajzen, 1985; Duke, Davis, et al., 2015). Each broadcast advertisement ends with a thought provoking “tip” on how to manage these problems (e.g., how to shave around your tracheotomy stoma).

A number of investigations have found that smokers’ exposure to the Tips from Former Smoker’s (Tips) campaign is associated with intentions to quit or actual quit attempts (Davis, Duke, et al., 2017; Davis, Patel, et al., 2017; Duke, Davis, et al., 2015; Neff et al., 2016). Although quit attempts is obviously an important outcome for national campaigns, whether a smoker intends to quit as a result of campaign exposure provides information on just one aspect of the campaign’s influence.

In addition to Popova et al. (2017) reviewed in the truth initiative campaign section, I identified only one additional study that evaluated how the Tips campaign impacted knowledge (Duke, Davis, et al., 2015). In this study, 5,241 smokers aged 18+ were surveyed pre- and post-campaign to evaluate changes in their knowledge about diseases presented in the campaign ads including heart disease, stroke, tracheotomy, Buerger’s disease or amputations of the limbs, and asthma. Participants were asked, “Do you believe cigarette smoking is related to…” followed by one of the diseases above (response: yes/no). The authors found that there were significant increases from pre- to post campaign in the percentage of smokers who responded “yes” to each
disease (all Chi-squared p-values <0.05). In addition, there was a significant dose response relationship between number of campaign ads seen and beliefs about smoking and Buerger’s disease or amputations (OR=1.22, p=<0.001) (Duke, Davis, et al., 2015).

Also assessed in the study was the degree to which campaign exposure influenced health-related worry using a 5 item scale with 4-point Likert responses to the questions: “1.) How worried are you that smoking will damage your health in the future? 2.) I get upset when I think about my smoking, 3.) I am disappointed in myself because I smoke, 4.) I get upset when I hear or read about illnesses caused by smoking, 5.) Warnings about the health risks of smoking upset me. Like disease awareness, health-related worry increased significantly (p=<0.05) and the number of exposures to the campaign was significantly associated with increased health-related worry (p=<0.001).

As I observed above with the truth initiative campaign, though knowledge and health-related worry were assessed in this study, how the individuals understood the messages they received, and how they may have assimilated this information into their daily lives was only assessed by using the questions about intentions to quit. So, although it is encouraging that mass media campaign exposure can lead to increased intentions to quit in some smokers, there is no data that can provide insight into why quit intentions did not change for others. This significant gap in the literature provides an opportunity for further inquiry into how campaign messages were received and understood by smokers.

**Public Intellectualism**

There is limited scholarship on the topic of public intellectualism in terms of what people have learned from public intellectuals however, the field of public health often recognizes through historical accounts that the societal attitudes about the harms of smoking began to
change after the Surgeon General announced that cigarettes contribute to lung disease in 1964 (Brandt, 1990, 2007; Schudson & Baykurt, 2016). Though the 1964 Surgeon General’s report is often credited as having an immediate impact on smoking reduction (U. S. Department of Health and Human Services, 2014), there were no studies identified through this review that documented what people may have learned or how the announcement may have impacted them. The exception is a personal blog entry by Anthony Komaroff (2014) about his mother being so influenced by the announcement by America’s “top doctor” that she eventually quit smoking herself.

There were four articles I identified through this review that are relevant to public intellectuals though one was not tobacco-related (Boynton et al., 2016; Dunn, 2004; Hammer & Inglin, 2014; Robert, 2016). In the non-tobacco article, (Robert, 2016) participants were attendees of an Australian grassroots temporary sobriety charity event (FabFest 2014). At the event participants were encouraged to go 24 hours without drinking and “see the sober ‘after’ as the preferable alternative to the alcohol-infused ‘before’” (Robert, 2016, p. 418). After interviewing event participants, the authors found that learning had occurred through the embodied experience of sobriety, the participants’ reflection on the campaign messages, and positive experiences with peers in attendance (e.g., they had sober fun together). Though not tobacco-related, this data offers insight into the Great American Smokeout (American Cancer Society, 2017) which is also an embodied abstinence event put on by the American Cancer Society (collective intellectual).

Two studies referenced anonymous intellects (Dunn, 2004; Hammer & Inglin, 2014) where participants spoke generally about health professionals’ advice (e.g., doctor or midwife), or “official advice” on smoking and drinking alcohol during pregnancy. In both of these articles,
participants drew on personal experience to justify smoking or drinking during pregnancy and found that their experiences conflicted with that of the public intellects. Because of this, participants in both studies questioned the advice of public intellects on the grounds that the experts were not fully taking into consideration of individual differences in women.

The final article identified (Boynton et al., 2016) used quantitative methods to gain an awareness of the percentage of adults who were aware that the FDA regulated tobacco products and further asked whether they believed the agency could effectively do so. 94.6% of the sample had heard of the FDA, although these numbers were significantly lower for those living in poverty (87.5%) and those with lower levels of education (89.7%). Though 65.2% of the study participants felt that the FDA can effectively regulate tobacco, no further information was collected in order to understand what participants had learned from the agency or why they believed they were qualified (or not) to regulate tobacco.

Although there is some literature on what individuals have learned from tobacco-related public intellectuals, it is limited almost exclusively to awareness and discussions of anonymous intellects where participants happened to make mention of a public health recommendation.

**Research Gaps**

In the sections above, I have reviewed the existing literature related to how smokers learn from a variety to public health pedagogies. While it is interesting to consider that people learn about tobacco and their health through public pedagogy, the idea that it actually happens is only a theory without empirical evidence to demonstrate HOW and WHAT learning has occurred. This is an important point in terms of public health pedagogy. If we hope, as public health educators, to help individuals understand how certain health behaviors may be detrimental to
them, we must better understand how individuals learn from health-related messages, how they interpret these messages, and how they assimilate them into their daily lives.

In 2011, Sandlin et al. (2011) argued that what was missing from public pedagogy scholarship were “studies of how these educational sites and practices actually work to teach the public and how the intended educational meanings of public pedagogies are internalized, reconfigured and mobilized by public citizens” (Sandlin et al., 2011, p. 359). My review of the literature suggests that these types of studies are still necessary. In particular, studies that aim to understand how public health pedagogies are understood, internalized, and assimilated into daily life are needed in order to help move the field forward.

**Implications for Field of Adult Education**

After completing a review of the literature, it is clear that there is very little previously published scholarship attempting to understand what smokers have learned cumulatively from decades of efforts to reduce tobacco use. Though there is an extensive body health communication research identifying effective communication methods about the harms of tobacco, messages from the field of public health are also *educative*. However, I identified very little literature in the field of adult education about public health. This offers me an opportunity to make an important contribution to the field of adult education in two ways.

First, this study combines perspectives from the fields of public health and adult education which is clearly not a combination that has been explored previously to any great extent. This review identified only one article that combined public pedagogy and health (Robert, 2016) which means that by focusing on public health pedagogies, my study will both advance the public pedagogy body literature and expand it into an area that has not been extensively discussed. Second, missing from the adult education scholarship are studies that
help to describe how public pedagogies are understood, what meaning is made by individuals and how the information is assimilated into their daily lives. My study will offer some insight into these areas since participants will be encouraged to discuss these topics during the interviews.

**Implications for Public Health and Tobacco Regulatory Science**

In addition to offering new insights to the field of adult education, my study will also make important contributions to field of public health in general and tobacco regulatory science more specifically. In terms of public health, it is apparent from this review that individuals do learn from public health educational messages, and while doing that, they also interpret and use that information based on their own experiences. This suggests ignoring experiences of smokers is a critical omission. By using qualitative research methods my study will offer smokers the opportunity to dialogue one researcher in the field of public health and to offer their perspective on what they have learned from the field. In this way, my study will offer public health experts a window into the lived experiences of smokers—experiences that may be very different from their own. However, understanding these experiences are critical for public health educators to if they seek to improve the salience and effectiveness of the interventions that they develop.

The FDA announced a comprehensive regulatory plan that will attempt to reduce the harms of tobacco by reducing the addictiveness of tobacco products and at the heart of this strategy is reducing the nicotine content of cigarettes (U. S. Food and Drug Administration, 2017a). While the FDA has funded a number of studies to understand the impact of reduced nicotine content cigarettes on many different types of smokers (Allen et al., 2017; Donny et al., 2015; Krebs et al., 2017; Pacek et al., 2016; Tidey et al., 2017), the success of a reduced nicotine cigarette policy will rely heavily on the support of the public. This means that the FDA will
need to engage additional public health education about not only the harms of tobacco use, but also the addictiveness of nicotine and the rationale for their policies. My study will be able to offer insight into how regulatory action on nicotine by the FDA may be received and understood by a sample of cigarette smokers. Thus this study will inform the FDA and the Center for Tobacco Products as they begin to formulate educational messages about their new regulatory plans.

**Chapter 2 Summary**

In the sections above I have reviewed the literature on a number of public health pedagogies in terms of what was learned by smokers from these avenues. Overall, there is little published literature that purposefully seeks to understand what smokers have learned from public health educational activities. The majority of the literature that did offer insight was limited to an individual’s awareness of a particular idea (e.g., the content of health warning labels). Because of this, I identified a number of gaps in both the adult education scholarship and that of public health. My study fills these gaps by offering a cumulative perspective of what smokers learned from a lifetime of exposure to public health pedagogies outlined in this chapter. In addition, it advances public pedagogy scholarship and public health education by combining both of these perspectives, an approach that has not been employed previously. In the next chapter, I provide an in depth overview of the specific methodologies I employed to execute this study.
CHAPTER 3

Methodology

The public health community in general and tobacco control more specifically have been working for decades to reduce the prevalence of cigarette smoking however, smoking is still the number one cause of premature death and disability among Americans (U.S. Department of Health and Human Services, 2014). This makes reducing the number of people who start smoking, and helping those who already smoke to quit, a significant public health goal. One important strategy to address these priorities is to identify ways to make public health campaigns, interventions and education more impactful among smokers.

Since the prevalence of smoking is higher than the national average among those with low levels of education and those living below the federal poverty level, these groups are especially important groups for the field to understand as public health new health promotion interventions are developed. The main focus of evaluation for many health education campaigns is a measurement of how many people were exposed to a particular message and by identifying how many people did or did not engage in a particular behavior. A weakness of this method is that it provides little information as to why an intervention may have succeeded or failed and it provides no feedback as to what smokers understood about the message, how they made meaning of it, and how they translated it into action in their daily lives. Also lacking in this method is an assessment of the cumulative learning that has occurred throughout the lives of smokers that uniquely contributes to their understanding of new information.

Thus, with the ultimate aim of improving tobacco-related public health messages, the goal of this project is to understand the smoker’s perspective by evaluating how public health messages, media, and social and societal influences intersect and interact cumulatively
throughout a smoker’s life. In addition, a key objective is to gain insight into how these messages help to form the smoker’s understanding of their tobacco-related health risk and how this may contribute to continued tobacco use. The specific goals are as follows:

1. To identify through what public venues smokers learn about their tobacco-related health risks (e.g., popular culture, regulations, public policy, public intellectuals, and societal discourse from an experiential perspective).

2. To gain perspective on the cumulative learning that occurs through these venues and how smokers understand and assimilate the information into their daily lives.

3. To evaluate how specific socio-economic characteristics (e.g., race, gender, education level) and positionality (e.g., perceived social class) within social groups and society may influence how an individual understands messages.

4. To identify any connections between how the information is received and interpreted and how it may influence smoking behavior.

This project is designed to address these questions and in the next section, I provide a detailed overview of the research methodology used in this study. I then provide a general overview of qualitative research and provide a rationale for why I chose this paradigm for my study. After describing the various assumptions of qualitative research in general, I provide an overview of narrative inquiry which is the specific study design I chose from within the qualitative paradigm. Finally, once I discuss these basic concepts, I provide specific details on participant selection, data collection, analysis, and how I verified my data to ensure that it most accurately represented the views and intentions of my participants.

Research Paradigm: Qualitative Research
There are two main paradigms of academic inquiry, Quantitative (QUANT) and Qualitative (QUAL), and each is based on very different world views. QUANT research assumes that there is a single, static reality that can be measured numerically and observed objectively by deconstructing the complex phenomena in question into smaller, decontextualized parts. Once this deconstruction is established, the QUANT researcher is focused on isolating the research topic into a single element and removing contextual factors that may influence it so that cause and effect can be determined and predicted using statistical methods. Quantitative researchers often accept that it is possible that the single reality they seek to understand cannot be perfectly understood and they assume that by using statistical methods, the reality they seek can be predictable at least “in terms of probability” (Allison & Pomeroy, 2000, p. 94). Once an empirical finding is established, it is considered an important finding if it can be replicated under controlled conditions and across various groups of people, which leads the idea that the finding is generalizable (Creswell, 2014).

In contrast to the single reality that is sought in QUANT research, QUAL research assumes that there are multiple realities that are constructed by either individuals or society (Gunzenhauser & Gerstl-Pepin, 2006). QUAL methods are founded on constructivist perspectives in which phenomena are subjectively constructed and understood by individuals or societies. These individualized understandings are highly dependent on contextual elements that can ultimately lead to different conclusions based on who is doing the interpretations. In the QUAL research paradigm, investigators seek to understand the multiple interpretations that people apply to the phenomena in question and they identify empirical findings when they identify a convergence of different realities (Lincoln & Guba, 1985).
Assuming that there are multiple realities, and that these realities are constructed by individuals and societies as they interact with each other, researchers who work from this perspective do not start with a hypothesis about what they expect to find and they do not deduce findings using logic (Merriam, 2009). Instead, they identify the phenomena they would like to study and then attempt to understand how others interpret it by documenting the subjective, contextual elements that people are surrounded by and how people make meaning of the object being studied (Lincoln & Guba, 1985). These subjective contexts include social interactions with others, societal or cultural expectations and constructions, and the historical events that contribute to the present understanding of the phenomenon in question (Riessman, 2008). This is an inductive approach, rather than deductive, since the findings emerge from the data with no pre-conceived expectations of what might be found and the researcher uses the gathered data to then explain and understand the phenomenon they set out to describe (Merriam, 2009).

As a QUAL researcher is attempting to understand the object they are studying they will openly acknowledge that they come to the process with their own personal worldviews, experiences, and biases. The identification of bias is such an important element of qualitative research that the researcher’s perspective, philosophy, or even elements of their personal life story are sometimes included in academic manuscripts. In addition, this description of the researcher’s experience and worldviews can be seen as a strength for some studies since the researcher’s personal experiences may allow them to identify subtle pieces of information that may have been missed by someone who was not as familiar with the topic. Finally, QUAL researchers believe this discloser of possible biases allows the reader to interpret the results of their study with full knowledge of how the researcher’s experiences and worldview may have influenced the design or the interpretation of the study.
Since the QUAL paradigm assumes that there are multiple realities and that multiple people can describe the same phenomenon in a variety of ways, QUAL studies are often based on interviews that allow the participants to share their perspective. As I discussed previously, I agree with Heyman et al. (2012) who proposed that health is valued and viewed in different ways by different people because of varying lived experiences and group social norms. Since the prevalence of smoking is higher among those who have attained lower levels of education, the poor, and other societal minorities it suggests that these differing views about the value of health may be contributing factors to continued smoking. Therefore, in order to bring to light these varying perspectives, I propose to conduct a QUAL study because this methodology will allow the smoker’s viewpoint to be the main focus of the data collection process.

Within the paradigm of QUAL research, there are a number of study designs and each is associated with specific methodologies and assumptions. For this study, I will use narrative inquiry which is a qualitative method that aims to document the stories of people’s lives. The method involves interviewing smokers to gain an understanding of how they have come to understand the various smoking related public pedagogies and societal events that have occurred throughout their lives. In the next section of this chapter I will introduce narrative inquiry and describe its accompanying assumptions.

**Narrative Inquiry**

As I discussed in Chapter 2, public health educational campaigns have historically appealed to logic and reason when conveying anti-smoking messages through public pedagogies. They do this by offering a problem (e.g., disease is caused by smoking) and a solution (e.g., quitting will help prevent disease) and certainly this has been an effective method in persuading many smokers to quit. However, as evidenced by demographic descriptions of those who
continue to smoke in the U.S (Jamal et al., 2015), this method may not work as effectively for the poor, those who often have lower levels of education, and minority populations.

The predominantly logic based way of thinking about the problem of continued smoking among public health advocates has led some to conclude that continuing smokers are willfully non-responsive and illogical (Hughes, 2011). However, Bruner (1986) offers an alternative perspective which is that people may be using different modes of thinking. He suggests that there are two modes of thinking employed by most people: the paradigmatic and the narrative. The paradigmatic mode looks for empirical truth and it “deals in general causes, and in their establishment, and makes use of procedures to assure verifiable reference” (Bruner, 1986, p. 13). The field of public health often uses the paradigmatic mode of thinking when they design health education messages because they use scientific evidence, such as the negative health implications of smoking, as a way to persuade smokers that it is in their best interest to quit.

In contrast, to the logic-based paradigmatic mode of thinking is the narrative mode. The narrative mode does not depend on logic which means people who use this mode of thinking can easily alternate between two opposing and contradictory concepts even within the same instance. This is because the narrative mode of thinking is how people construct meaning of experiences that occur during the course of their everyday lives and this mode of thinking is often used as a way to explain or give plausibility to an experience (Bruner, 1986).

Although the field of public health is primarily dominated by scientific, paradigmatic ways of understanding the world, Hinyard and Kreuter (2007) argue that the narrative mode of inquiry “may be especially useful when addressing issues involving morality, religion, personal values, meaning in a person’s life, complex social relationships” (p. 778). Though the authors don’t specifically mention health or smoking, both of these issues are related to personal values
and social connections/interactions which impact health beliefs and attitudes. In addition, health-related values are complex, multidimensional, heavily influenced by context and may not be predictable or logical. Thus, narrative inquiry is a useful methodology to employ when exploring smoking-related experiences because it documents how people have come to hold a particular belief or value. Through personal stories arranged in a sequential, temporal manner, narrative inquiry can reveal how people construct knowledge, understand events and make meaning of their life experiences (Rossiter, 1999). In addition, narrative inquiry allows the researcher to consider multiple influences that may be contributing to the individual’s narrative, including cognitive, affective, motivational, biological and environmental (Rossiter, 1999).

The most basic description of narrative inquiry is that it “is the representation of an event or a series of events” (Abbott, 2008, p. 13). However, within the realm of narrative inquiry is a particular philosophical approach to the method that Merriam (2009) calls the psychological. This approach, outlined by Rossiter (1999), encourages the individual to offer details of the contextual influences that contribute to their thoughts and motivations. In addition, Rossiter (1999) suggests that an individual’s life narrative is related to their personal development and should be considered in terms of four main elements including the contextual, interpretive, retrospective and temporal dimensions. Below I will briefly describe these four elements and discuss how they are related to my project.

**Contextual.** The contextual element of an individual’s narrative is important because an individual’s understanding of their life’s events does not occur in a vacuum. Instead, how individuals value and interpret a particular event is completely dependent on the context in which it occurred and the events that happened before and after. Using the vocabulary of narrative, we must situate the individual within the “plot” of their lives in order to gain an understanding of
how they value and interpret a particular event. Rossiter (1999) gives the example of a woman named Anne who grew up with no expectation that she would do more than work in a factory all her life just as her parents did. Then, contrary to both her and her parents’ expectations, she decides to go to college and eventually graduates. Rossiter (1999) offers this story as an illustration of how context allows for a deeper understanding of the importance of this particular life event particularly when it is juxtaposed against the story of someone who grew up expecting to graduate from college and eventually does. In both cases, the context of how someone becomes a “college graduate” gives different meanings to the event.

Smoking, like college attendance, is often a familial tradition that is passed down from generation to generation. The familial tradition of smoking creates a cultural environment that must be described in order to understand an individual smoker’s behavior. This culture is also important when I am attempting to understand how an individual smoker makes meaning of the public pedagogies they have encountered over the course of their lives. During the course of my interviews with smokers, I will attempt to understand the context in which they experienced particular public pedagogies so that it can be used to better understand the stories smokers share with me.

Interpretive. While context offers a way to offer deeper understanding of events, the interpretive element of narrative inquiry is how meaning is made. The narratives that people construct as they tell the stories of their lives are not a logical arrangement of facts. Instead, they are “an account of events emplotted according to human values, intentions, and purposes” (Rossiter, 1999, p. 80). Again, using the story of the two individuals above, Anne, interprets graduation from college as a way to change the course of her life, while the second individual may have interpreted graduation as a mundane extension of a pre-determined path. Both of these
examples demonstrate how meaning is allocated based on individual interpretation of an event or behaviors which can vary dramatically among individuals and even at different time points for the same individual. In my study, I will specifically ask smokers to discuss the public pedagogies that they have encountered and also to share with me how the information was interpreted by them, how they made meaning of it, and any behavioral actions they engaged in as a result.

**Retrospective.** Narrative inquiry is by its very nature a retrospective, or backward-looking, endeavor. An individual will tell his or her life’s story based on events that have already occurred and they are therefore reflecting what these events mean while they are speaking. Because of this, the meaning that is made at one particular time point can be different than the meaning that may be made of the same event in the future or the meaning it held at the time the event occurred. But these differences are not predictable or logical and narrative inquiry can only base its conclusions on the version of the story that was presented to the researcher during the interview. The study that I am proposing will be retrospective in that smokers will be prompted to tell me about historical events that have occurred. In addition, their narratives will also be retrospective in that the stories that they share will be an interpretation of the events that occurred in the past.

**Temporal.** Narrative inquiry necessitates that it be viewed as an “unfolding of events through time” and it assumes that there is a “dynamic interrelationship between time and meaning” (Rossiter, 1999, p. 82). This interrelationship allows the individual telling their narrative to place meaning on past events that may be reworked and re-interpreted through the backward-looking lens of time. While the element of time gives the individual the ability to make new meaning from old events, the impact on their current knowledge or behavior occurs in
the present. This idea is particularly important when considering smoking behavior. All the participants included in my study will be current smokers which means that their interpretation of retrospective events may be different at the time of their interview than they were when they were initially exposed to that pedagogy. Because of the dynamic nature of time and how people place meaning on events, my study will offer a unique perspective on how smokers have made meaning of historical tobacco-related public pedagogies.

For my study, a particular strength of the psychological narrative approach is that it will allow me to understand how individuals have experienced and made meaning of various public pedagogies they have been exposed to during the course of their lives. While gathering stories from individuals about their life events, I will also be able to investigate what public pedagogies the participants have been exposed to, how they made meaning of these pedagogies, the context in which participants were exposed to them, and how public pedagogies may contribute to the participants’ continued smoking (or not). Even though I will be exploring the personal experiences of smokers, the design of my study and the questions I ask are influenced by my personal background. In the next section, I will provide background about me and why I chose narrative inquiry for this study.

**Background of the Researcher**

Though my parents talk about times before I was born when they struggled financially, growing up my brother and I never wanted for anything and both my parents were present and actively involved in my life. My father attended 4 years of college but never graduated and in spite of that, he worked his way up over 35 years to an executive level position at an international finance company. My mother graduated from college, became a middle school English teacher and eventually attained a master’s degree in library science. Attending college
was always expected of my brother and me and we grew up knowing that our parents would help us with tuition.

To me, growing up in suburbia surrounded by mostly white, middle and upper middle class friends, going to college, getting a job with healthcare benefits, and being able to afford the necessities in life was common and expected. When I graduated from college, it seemed to me that the opportunities that lay before me were endless and only limited to what I wanted to do. Though I was aware that there were people who were less fortunate than me, it was not until many years into adulthood that I realized how people’s different experiences with family, school, and work made have very different expectations from life than I did.

For the most part, my expectations of life have mostly come true. Today, I work as a project manager with the Penn State Tobacco Center of Regulatory Science (TCORS) where I manage the day to day administration and conduct of 2 large randomized controlled double blind clinical trials that are focused on reduced nicotine content cigarettes and electronic cigarettes (Allen et al., 2017; Lopez et al., 2016). One of the main differences between the projects I manage on a daily basis and the study I am proposing here is the philosophical orientation of the work. Randomized clinical trials (RCTs) are considered by many to be the gold standard in quantitative research because the design is thought to be able to isolate whether the intervention being tested is effective or not (Piantadosi, 2005). One of the important methods utilized during RCTs is attempting to remove subjective opinions and contextual factors that may influence the interpretation of the intervention’s effectiveness (Piantadosi, 2005).

Occasionally, when we are seeing an RCT participant, they will spontaneously offer information that they think may be useful to the investigators. The information may include a suggestion for an additional response category for a question that they are answering, or it may
be information that the researchers do not ask about on a questionnaire at all. This additional information is often discussed during team meetings as we think about the data that we are collecting and as we attempt to interpret our data. However, because of the RCT study design, spontaneous insights offered by study participants are not systematically collected which means these insights from participants are not formally considered as study data.

In stark contrast, qualitative methods make the perspective of the individual the priority of the study by purposefully and systematically collecting their subjective experiences (Creswell, 2014). As I reflect on the differences between QUANT and QUAL research, I often think of the story of the blind men and the elephant. In the story, each man touches a different part of an elephant and when they all came together to describe the animal they investigated, they find that they are in complete disagreement with each other. What I take from this story is that one person’s way of knowing about the elephant was not particularly better than the other because each person had a different experience with the elephant that led them to different conclusions. I think this story perfectly describes how knowledge is made through research, especially when there may be many different researchers trying to understand the same phenomenon.

I chose to use the QUAL paradigm, and particularly a narrative study design, because I think the voice of the smoker is often lost during the course of many academic research studies on smoking. It seems to me that sometimes in my work is so focused on documenting “outcomes” from studies that are meant to help decrease the harms from smoking that I lose sight of the ways that my work may be inadvertently misunderstood by the smokers I am attempting to help. Therefore, this narrative study will allow me the opportunity to document not just the context that contributes to how smokers make meaning of their smoking, but it will allow for the “story” of the participant’s life to be the focus of my work.
Detailed Study Methods

Above, I described my personal experience as a tobacco control researcher and I discussed the theoretical basis for my work. Next, I provide the details of how I executed this project including the participant selection, inclusion/exclusion criteria, the recruitment process, participant screening, and data collection and analysis.

Participant Selection and Recruitment

The goal of this study was to understand what low income smokers have learned from a lifetime of exposure to public health pedagogies. In order to collect meaningful stories about the participants’ experiences, I used a purposeful sampling technique (Merriam, 2009). My intention was to recruit smokers who had exposure to a variety of public pedagogical messages which means that I only included individuals who had long term exposure to public health. Specific criteria that I used to identify participants for this study included smokers who were at least 25 years of age. Smokers often start smoking in middle school or high school, or between the ages of 12 and 18 (U. S. Department of Health and Human Services, 2014). So, by limiting my population to adults who were at least 25 years old, all the participants in my study had at least 10 years of exposure to tobacco-related public health pedagogy while they were smoking, a method that has been employed previously when investigating tobacco control regulations (Frohlich et al., 2010).

In a similar study to the one I am proposing, groups of younger smokers and older smokers offered different perspectives on how public health pedagogies have impacted them throughout their lives (Branstetter et al., 2015). Because of the potential differences in experiences for younger and older smokers, I purposefully attempted to enroll younger (age 25-35) and older (age 36+) smokers. These age groups were chosen because smokers who are
between the ages of 25 and 35 (born after 1983, and not an adult smoker until after the 1998 Tobacco Master Settlement Agreement) have been exposed to less dramatic changes in smoking social norms and the landscape of tobacco control since they started smoking than those born before this time point.

Finally, I focused on enrolling adult smokers who were members of demographic groups where the prevalence of smoking is the highest. To do this, I purposefully included participants with low incomes and excluded those who had attained a bachelor’s degree (Jamal et al., 2015). Therefore, the following inclusion criteria were used:

1. **Current, occasional or daily smokers** of 1 or more cigarette

2. **Aged at least 25 years old**

3. **Have at least 10 years of established smoking history** (regardless of the number of quit attempts or their duration).

4. **Identify as low income** based on **either** of the following:
   a. The participant’s 2017 household income is 185% or less of the federal poverty level (See Table 3-1) (U. S. Department of Health and Human Services, 2017b).
   b. The participant, or a member of their household, received low income assistance in the past 5 years from any of the following sources:
      i. Federally subsidized housing assistance programs
      ii. Supplemental Nutrition Assistance Program (SNAP)
      iii. Women Infants and Children (WIC)
      iv. Head Start
      v. Children’s Health Insurance Program (CHIP)
      vi. Medicaid
vii. Low Income Energy Assistance (LIHEAP)

viii. Free or reduced school breakfast/lunch program

ix. Food bank/pantry

x. Free medical or dental clinics

xi. Charity organizations (e.g., homeless shelter, rescue mission, St. Vincent DePaul Society)

xii. Any other program designed to aid low income individuals and families.

### Table 3-1

2017 Poverty Guidelines for the 48 contiguous states and the district of Columbia, Persons in family/household poverty guideline

<table>
<thead>
<tr>
<th># of persons in household</th>
<th>100% of poverty</th>
<th>185% of poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$12,060</td>
<td>$22,311</td>
</tr>
<tr>
<td>2</td>
<td>$16,240</td>
<td>$30,044</td>
</tr>
<tr>
<td>3</td>
<td>$20,420</td>
<td>$37,777</td>
</tr>
<tr>
<td>4</td>
<td>$24,600</td>
<td>$45,510</td>
</tr>
<tr>
<td>5</td>
<td>$28,780</td>
<td>$53,243</td>
</tr>
<tr>
<td>6</td>
<td>$32,960</td>
<td>$60,976</td>
</tr>
<tr>
<td>7</td>
<td>$37,140</td>
<td>$68,709</td>
</tr>
<tr>
<td>8</td>
<td>$41,320</td>
<td>$76,442</td>
</tr>
</tbody>
</table>

For families/households with more than 8 persons, add $4,180 for each additional


**Exclusion Criteria**

Smokers with less than a bachelor’s degree have much lower rates of smoking than individuals who have not attained this level of education (Jamal et al., 2015). Since my goal was
to understand smokers of low socio-economic status, I excluded anyone who had attained a bachelor’s degree or higher. Additional exclusion criteria were as follows:

1. **Unable to read, write and speak in English**
2. **Have vision problems** that would make it impossible for the participant to watch a short, 10 minute video
3. **Unable to understand the study procedures** and provide consent
4. **Unwilling to complete the study requirements** including a second meeting (over the phone or in person) to member check the re-storied narrative

**Recruitment**

Two major methods for recruitment were utilized for this study including snowball recruitment and contacting participants from the Penn State (PS) Tobacco Center for Regulatory Science (TCORS) database of smokers. The PS TCORS database currently contains demographic details on more than 3,500 potential subjects who have indicated an interest in participating in research. Potential participants were selected from this database, and contacted via email and phone. Using a snowball recruitment method, participants were also encouraged to suggest other individuals who would be willing to participate in the study and they were provided with information on how to contact me. A $20 Sheetz gift card was provided to participants as incentive for participating in the study. All of the participants were offered the opportunity to meet me at a mutually agreed upon public location that was appropriate for conducting private meetings (e.g., a coffee shop, public library, local community center). However, an additional $20 gift card was provided to the participants if they were willing to travel to the Penn State Hershey Medical Center campus to meet me for the interview. Incentive payments were provided using internal Penn State Department of Public Health Sciences funds.
Once participants agreed to participate in the study, an interview date and time was arranged. All of the participants who completed the study were willing to travel to the Penn State Hershey Medical Center campus and received $40 in gift cards.

**Participant Screening**

Screening questions based on the above inclusion/exclusion criteria were developed (See Appendix C) and participants were screened for the study by me over the phone. In total, 71 participants were contacted to be screened from the Penn State TCORS database. Of these, 26 were reached and screened. Upon having the study explained to them, 4 participants elected not to participate, 1 did not meet the age criteria of 25 years old, and 1 did not meet any of the income criteria. An additional 5 participants were screened and were eligible for the study but did not attend the first meeting. This left a total sample of 15 participants who were consented to the study and completed the initial interview.

**Data Collection**

The majority of the data collected for this study was in the form of recorded interviews that were transcribed by me. In addition, prior to starting the interview, a basic demographic questionnaire including smoking behavior and health status questions was completed by the participant using REDCap (Harris et al., 2009) (See Appendix D). After completing the questionnaire, participants watched a brief video about the history of tobacco-related public health (available online here: [https://www.youtube.com/watch?v=HV5aVmyvhhg&t=18s](https://www.youtube.com/watch?v=HV5aVmyvhhg&t=18s)). Participants were also provided with a written timeline of the events presented in the video (see Appendix B). The rationale for this process is described in the narrative inquiry methods below. During the interview, I used a semi-structured interview guide (see Appendix A) which was
designed to encourage participants to tell stories about their exposure to, and understanding of, public pedagogies as outlined in Chapter 2.

After the interviews were completed, I transcribed the interviews and re-storied them using a process I will describe in more detail below. The re-storied narratives were sent to the participant via email or in the U.S. mail and the participants were asked to read the narrative and provide feedback and comments. After they had the opportunity to review the narratives, I contacted the participants again to solicit their feedback and they were invited to add, remove, or correct details from the story. Of the 15 participant narratives collected for this study, all but one participant (Frances) completed the process of providing feedback on their re-storied narrative.

Data analysis began as I was interviewing participants and the final number of participants enrolled and interviewed was determined using the qualitative concept of saturation. In practical terms, saturation means that data is collected and analyzed up to the point where it becomes clear, in the opinion of the researcher, that interviewing additional participants will not provide any additional insight (Merriam, 2009). In practice, saturation for this study was met prior to interviewing the 15th participant but since this participant was scheduled for an interview and completed it, their data was included in the study.

**Narrative Inquiry Method**

Because of the expansive topic and retrospective nature of public health pedagogy, it was necessary for me to help my participants focus their stories on pedagogies that were most relevant to my topic. Riessman (1993) provides a method for narrative inquiry using 5 “layers” through which the interpretation of any one experience can be recorded by a researcher. These include attending, telling, transcribing, analyzing and reading. These layers were used as a guideline for each part of the study conduct.
The first layer, attending, is what the participants do when they consciously reflect on an event in their life. Although participants were interviewed using semi-structured interview questions, it is possible that they would not have thought about public health pedagogies or messages prior to our meeting. Therefore, to help facilitate the process of attending, I created a short historical video of the events that occurred in the field of tobacco control since 1964. The video was placed on the internet so that it could be viewed from any internet browser (available here: https://www.youtube.com/watch?v=HV5aVmyvhhg).

Prior to starting the interview, each participant watched this video on a laptop computer and I provided them with a written timeline of this history so that they could refer to it during the interview (See Appendix B). After watching the video, I encouraged participants to review the timeline and reflect on how any of the events were understood by them and how they may have assimilated them into their daily lives. In addition, because the video and timeline could have been an incomplete representation of the participant’s life experience, I also encouraged them to consider events or public health messages that that were not included on the timeline. Any event or message was considered valuable including non-tobacco-related events since participants may have understood non-tobacco messages as meaningful or relevant to their smoking.

The second layer of Riessman’s structure of narratives is the telling (Riessman, 1993). Here, I asked participants to tell me the stories that they reflected on and I focused on eliciting information about the participants’ exposure to, and understanding of, the public pedagogies outlined in Chapter 2 and on the timeline (Appendix B). In particular, I asked them to describe what they thought these pedagogies meant to them, what they learned, and how they may have assimilated them into their daily lives.

**Data Analysis Part 1: Narrative Analysis**
Data analysis for this study was conducted in two ways, a narrative analysis and a thematic analysis, and they were conducted concurrently, each informing the other. However, each analysis has its own methodology and I will begin here with the narrative process. It is important to note that although both have separate methods, the narratives were developed using the themes that emerged from the thematic analysis. I begin with the narrative methods here simply because in practice, this was the first step in the data collection and analysis process.

After attending and telling, the next two layers of Riessman’s (1993) narrative structure are transcription and analysis. Since both of these layers allow for interpretation and misinterpretation, the focus of my attention during this process was on the meaning of the participant’s stories. To do this, I carefully transcribed the interviews and then re-storied the participants’ experiences into a cohesive story attempting to incorporate a beginning, middle and an end though this was not always possible.

**Transcription.** Transcription is considered part of the analytical cycle in narrative inquiry because of the importance of non-verbal elements of speech that can contribute to meaning. For instance, if a participant chooses to emphasize a particular word while they are speaking, that inflection may be a key component to making sure that the text is authentically interpreted. Therefore, the first step in my analysis involved transcribing the recorded interviews to include pauses, utterances, emphases, and inflections.

**Analysis.** Once the transcription was complete, analysis of the narratives included identifying short vignettes that represented the meaning the participant intended while telling the story. Since this study was focused on public health pedagogies, vignettes that were most relevant to my study aims were preferentially selected for inclusion in the final narrative. Thus, I removed elements of the narrative that distracted from the central story such as incomplete
thoughts, unrelated details, and utterances. In this way, the final narrative results chapter only included the short stories that provided the most insight into how the individual made meaning of a particular pedagogy and how they may have assimilated that information into their daily lives.

Once the revised narratives were completed, I sent them to the participant for reading and interpretation; the final stage of Riessman’s (1993) narrative process. The participant was given the opportunity to read the narrative and make comments and edits so that they could confirm, clarify, or change the version of the story that I developed. The goal of this process was to ensure that my interpretation of the participant’s story was a historically accurate account (e.g., fact checking) and to insure that my interpretation of what the participant shared conveyed the meaning and feelings that they actually experienced and intended to share (e.g., member checking). Although narratives can and will be interpreted differently by different readers, my intention was to ensure that the voice of the participant was heard and accurately represented.

In addition to the narrative analysis, an introduction of the participant was written by me using a combination of responses from the quantitative data and data from the interviews. Furthermore, at the end of the narrative, I wrote a summary that outlines the themes from the thematic analysis that are present in the narrative. Once all of the narratives were assembled, I reviewed them for relevance to the study aims, the depth of insight that they provided into what the participants learned, and general readability. Some of the participant narratives were brief and did not offer meaningful insight into the study aims and I therefore chose not to include these in the final narrative results chapter. As a result, only 10 of the 15 total narratives are presented in chapter 5.

**Data Analysis Part 2: Thematic Analysis**
Part 2 of my analysis entailed conducting a thematic analysis where I read through all the transcribed interviews (verbatim transcribed version) and identified overall themes that emerged throughout all of the participants’ combined experiences. To conduct this analysis, I used the constant comparative method as described by Lincoln and Guba (1985) and Glaser and Strauss (1967). The first step in the thematic analysis was to “unitize” the data which involved reading through the transcripts and identifying sections of the interview that should be kept together. These sections were words, phrases, sentences or entire paragraphs of text. Whatever the length of the unit may be, it remained together because of the overall meaning that it provided (Lincoln & Guba, 1985, p. 340).

The next step was to categorize the units which as the act of grouping units with like meanings together. As units are categorized, I “constantly compared” the units to each other to ensure that the units that were grouped together actually offered similar meanings. New categories were identified if, as I compared new units to existing ones that have already been categorized, they did not fit together or have similar meanings. In addition, even if a unit was initially thought to fit within a particular category, they were continuously evaluated to make sure that all the units in a category actually offered similar meanings. Results of the thematic analysis are presented in Chapter 4.

Though not a traditional qualitative method, after I analyzed the data, I decided that in order to fully understand to what public health pedagogies the participants were exposed, it would be useful to count how many times each pedagogy was mentioned using the public health pedagogy framework I discussed in Chapter 2. This was done by reading through each participant’s transcript and tallying how many times they commented on a particular pedagogy. Categories included Dominant Societal Discourse, Public Intellectuals, Popular culture and Mass
Media, and Institutions and Public Spaces. In addition, if the participant discussed going to the doctor or seeking medical treatment, it was counted in the category of public intellects. If the participant mentioned having access to smoking cessation treatment through work, it was counted as a collective intellect. The results of these analyses are presented in Chapter 4.

**Verification**

Verification, or trustworthiness, in QUAL research involves demonstrating to the reader that the data collection process, analysis and ultimate findings are believable and authentic. The objective of QUAL research in general is not to identify one truth, but rather to identify multiple constructed realities and suggest a point at which these realities converge into a common finding using inductive techniques (Glaser & Strauss, 1967). Narrative inquiry takes this point a step further and suggests that “narrative truths are always partial—committed and incomplete” because the process of narrating allows the researcher to document how an individual made meaning of the truths they chose to describe (Riessman, 2008, p. 186).

Using the philosophical perspective of narrative inquiry, my goal with this project was to understand events, their contexts, and how the participant-narrator made meaning of the events they described. The narrative perspective further accepts that the stories I collected may not have been historically accurate. But, accuracy is considered irrelevant in narrative inquiry because the narratives that I documented are just “one articulation told from a point of view that seeks to persuade others to see the events in a similar way” (Riessman, 2008, p. 187). As such, verifiable fact is less important than being able to accurately describe how the participant experienced and made meaning of the event as they told their story. Nonetheless, it is important for me to be able to reassure the reader that the information I conveyed was the most accurate account of how the participant interpreted the events they described and how it may have
contributed to their smoking behavior. In the next sections, I will discuss how I ensured trustworthiness of the data collection and results in terms of confirmability, credibility, and dependability.

**Confirmability**

Confirmability is the degree to which the results can be confirmed or corroborated by others. Even the most well documented data collection and analyses plans will occasionally result in decisions that need to be made by the investigator. To ensure that I was able to accurately describe how the data and analysis took its final form, I kept track of the re-storying and member checking process using an electronic audit log (Riessman, 2008) in REDCap. This log also contained changes that the participants requested to their narratives. In addition, the recorded audio files were saved electronically in a password protected file along with the transcribed interviews so that, should the need arise, they could be cross-checked for accuracy at any time.

**Credibility**

An important element of credibility for this study was the use of triangulation which involved multiple sources of information that, when used together, helped confirm my final conclusions (Merriam, 2009). For this project, triangulation included the participants’ transcribed interviews, member checked versions of the final narratives, a review of historical tobacco control documents that were mentioned by participants, and the themes that emerged from the data during the thematic analysis.

Because I conducted both a narrative analysis and a thematic analysis, I was able to use these varying analytical methods to confirm the authenticity and consistency of the stories that the participants reported. For instance, some of the stories that participants shared had common
themes and similar interpretations. Because of this, occasionally, the narratives could be used to triangulate the themes that emerged in the data across participants, and similarly, themes that emerged from the data across participants could also be used to help interpret the participants’ narratives. In addition, since I asked the participants to discuss historical events, I was able to triangulate their recollection of the event with other historical sources that were available from the fields of public health and tobacco control. Although the participant shared their thoughts, interpretations, and the meaning that they made from these events, triangulating the events they discussed with other historical records helped situate the participant’s story in a temporal fashion.

The credibility in QUAL research is related to the believability or plausibility of the data (Riessman, 2008). I ensured credibility of the final narratives by conducting member checks so that the intentions and meanings that the participant intended were represented in the revised stories. Member checks are particularly important for narrative inquiry because, as participants are telling their stories, it was possible that I contributed to the narrative by asking questions and encouraging the participant to add additional details to their stories (Riessman, 1993). Although this process of narrative co-construction made me an important contributor to the development of the story, my interpretation of what the participants shared could have also been a possible source of misrepresentation (Riessman, 1993). As I have already described, to help alleviate possible misrepresentation, my study design included sending the participants’ re-storied narrative. We then had a second meeting (over the phone or via email) so that participants could correct any inaccuracies or misunderstandings that I may have inserted into their story.

**Dependability and Transferability**
Dependability in QUAL research is the degree to which the data was collected in a reliable manor using transparent methodologies. The description of my methods in this chapter as well as the audit log that I kept throughout the study all contributed to the dependability of the study. Finally, transferability refers to the degree which the results can be transferred to other contexts or settings (Merriam, 2009). Although this study has a small sample size (n=15), I support my findings with detailed descriptions of what the study participants shared during the interviews in Chapters 4 and 5. In addition, by using dense descriptions, and a heterogeneous participant sampling process, I have attempted illustrate the context in which the participants made meaning of the various public pedagogies they experienced. This contextual detail should allow the reader to judge the extent to which the data and findings may be transferable to other settings or individuals (Lincoln & Guba, 1985).

**Chapter 3 Summary**

In this chapter, I have described my rationale for utilizing a qualitative research method in order to explore what adult smokers have learned from a lifetime of exposure to public health pedagogy. The purpose of my study is to understand not just what public health pedagogical messages smokers remember, but rather how they remember it, what meaning they make of it and how they assimilate this information into their daily lives. In practice, this was accomplished by first encouraging smokers to think about what they have learned by showing them a short video and providing them with a written timeline of the history of tobacco control. After watching the video, participants shared stories about what they remembered from their lives and they were encouraged to offer detail and context so that I could better understand how they made meaning of these events and how they may have assimilated them into their lives. Concurrently as the data were being collected, both a narrative analysis and a thematic analysis
were conducted. For the thematic analysis, the full transcripts were analyzed using the constant comparative method to identify themes that emerged from all the smokers’ stories. These results along with a tally of each of the 4 main public health pedagogy categories that were mentioned during the interviews, are reported in Chapter 4. The re-storied narratives were shared with the participants so that they could review them for accuracy and content. Of the 15 total narratives, 10 of the most insightful are presented in Chapter 5.
CHAPTER 4

This study used narrative inquiry to understand what low income smokers have learned from a lifetime of exposure to various public health pedagogical messages. I used two methods of analyzing the data which included a thematic analysis of all the participant transcripts and a thematic narrative analysis (Riessman, 1993, 2008) which is presented in Chapter 5.

In this chapter, I present the results of the thematic analysis where I used the full interview of each participant to identify commonalities across participants. In the first part of this chapter, I will present the study participant characteristics related to their eligibility for the study, their demographic information, their smoking characteristics and behaviors, and their self-reported health status. Next, I will present what public health pedagogies were discussed during the interviews and which ones were most frequently brought up. Finally, I will present the themes that emerged from the data related to what participants learned and how they assimilated public health pedagogies into their daily lives using all the study participant interview transcripts.

Study Participants

In this section, I will provide an overview of the study participants using the study eligibility information, participant self-reported demographics, smoking characteristics and, health status information.

Eligibility, Low Income Status, and Demographics

Participants were considered low income if they had less than a college degree, received any low income assistance in the past 5 years and/or if they lived at or below 185% of the federal poverty level based on the U.S. Health and Human Services criteria (U. S. Department of Health and Human Services, 2017b). The maximum income allowed for participation in the study varied and was based on how many individuals the participant reported living with them in their
household. A full table of the 2017 poverty guidelines is presented in Chapter 3, but as an example, participants who lived alone and reported an income of $22,311 or less to be were considered to be living at 185% of poverty (100% of poverty was $12,060). Similarly, a participant with 5 additional individuals living with them (e.g., Zach with 6 total) could have an income as high as $60,976 ($32,960 or less was 100% of poverty). Using the eligibility criteria discussed in Chapter 3, 15 participants were interviewed for this study, 6 in the 25-35 age group and 9 in the 36+ age group. Table 4-1 demonstrates the participants’ basic demographic information and the criteria which made them eligible for the study.

Overall, the sample had a mean age of 41.6 years (SD: 9.3) and was 53% female, 55.3% white, 33.3% mixed race, and 13.4% African American. In addition, 4 participants (26.7%) identified as Hispanic. More than half of the sample (60%, n=9) had a high school diploma or less and the majority were on disability or unemployed (67%, n=10). Two female participants identified as either lesbian (Rose) or something else (Melody) and they were partners. The most commonly used low income assistance services were Supplemental Nutrition Assistance (SNAP, 67%, n=10) and Medicaid (53%, n=8) and 40% (n=6) of the sample lived at <100% of the federal poverty level (e.g., $12,060 for an individual living alone and up to $32,960 for a family of 6).

**Table 4-1**

Participant demographics and characteristics that made them eligible for the study

<table>
<thead>
<tr>
<th>Participant Pseudonym</th>
<th>Gender</th>
<th>Age (years)</th>
<th>Race</th>
<th>Hispanic (yes/no)</th>
<th>Education Level</th>
<th>Poverty Level</th>
<th>Services Used in the Past 5 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age group: 25-35 years old</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Courtney</td>
<td>Female</td>
<td>29</td>
<td>White</td>
<td>Yes</td>
<td>High school graduate</td>
<td>&lt;100%</td>
<td>Medicaid, Free school breakfast/lunch</td>
</tr>
<tr>
<td>Donna</td>
<td>Female</td>
<td>35</td>
<td>White</td>
<td>No</td>
<td>Some college</td>
<td>&lt;185%</td>
<td>Medicaid, Free school breakfast/lunch</td>
</tr>
<tr>
<td>Johnny</td>
<td>Female</td>
<td>32</td>
<td>Mixed/Asian</td>
<td>No</td>
<td>Some</td>
<td>--</td>
<td>SNAP</td>
</tr>
</tbody>
</table>
Smoking Characteristics, Smoking Behavior, and Health Status

Prior to starting each interview, participants were asked to complete a brief survey. Table 4-2 presents an overall summary of the participants’ smoking characteristics and behaviors, and
general health information from the surveys. Of note, although not asked about systematically in the questionnaires, during the interviews, 6 (40%) participants reported a personal history of drug or alcohol abuse with three of them receiving inpatient treatment, and 3 serving time in a correctional facility due to drug related charges. In addition, 5 (33%) participants reported that they had parents who were drug and/or alcohol abusers and 6 (40%) reported a history of physical and/or sexual abuse, mostly at the hands of parents or step-parents.

Table 4-2
Participant Smoking Characteristics and General Health Information (n=15)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Mean (SD, range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean cigarettes smoked per day (SD, range)</td>
<td>21.3 (12.2, 10-60)</td>
</tr>
<tr>
<td>% who smoke menthol flavored cigarettes</td>
<td>60 (9)</td>
</tr>
<tr>
<td>% who smoke long cigarettes (100 or 120mm)</td>
<td>46.7 (7)</td>
</tr>
<tr>
<td>% who roll their own cigarettes</td>
<td>20 (3)</td>
</tr>
<tr>
<td>% (n) who butt out and relight their cigarettes</td>
<td>60 (9)</td>
</tr>
<tr>
<td>Mean Fagerstrom Test for Nicotine Dependence (FTND) (SD, range)</td>
<td>6.7 (2.1, 3-10)</td>
</tr>
<tr>
<td>Mean Penn State Cigarette Dependence Index (PSCDI) (SD, Range)</td>
<td>14.3 (3.3, 7-19)</td>
</tr>
<tr>
<td>% who ever made a quit attempt</td>
<td>66.7 (10)</td>
</tr>
<tr>
<td>Mean age first tried smoking</td>
<td>15 (3.3, 8-21)</td>
</tr>
<tr>
<td>% who do not allow smoking in their home</td>
<td>60 (9)</td>
</tr>
<tr>
<td>% who, in their lifetime, had 2 weeks where they felt sad, blue or depressed</td>
<td>73.3 (11)</td>
</tr>
<tr>
<td>% who reported ever being diagnosed with depression or an anxiety disorder</td>
<td>80 (12)</td>
</tr>
<tr>
<td>% who felt they had depression or an anxiety disorder in the past year</td>
<td>86.7 (13)</td>
</tr>
<tr>
<td>% who reported their health as good</td>
<td>53.3 (8)</td>
</tr>
</tbody>
</table>

Now that I have described the sample, in the next section I will provide results of the thematic analysis.

**Public Pedagogy Exposures**
Table 4-3 presents the public health pedagogies that were discussed during the participant interviews. Included in this table are pedagogies that participants were able to both identify and to state the purpose for the pedagogy. For instance, if participants mentioned the removal of vending machines (1992, Synar Amendment), they are only included on this table if they were able to state why the pedagogy was implemented.

Table 4-3
Count of Public Health Pedagogies that Participants Were Aware of and Discussed During Interviews

<table>
<thead>
<tr>
<th>Public Health Pedagogy Category</th>
<th>Number discussed</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dominant Societal Discourse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TV and radio advertising ban, 1969</td>
<td>0</td>
<td>No participants remembers seeing any TV or radio advertisements</td>
</tr>
<tr>
<td>New cigarette warning labels, 1984</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Airplane smoking ban 1988, 2000</td>
<td>0</td>
<td>No participants were ever aware that smoking was ever allowed on airplanes</td>
</tr>
<tr>
<td>Synar Amendment, 1992 (increased enforcement of age of sale laws)</td>
<td>16</td>
<td>5/16 were about vending machines being removed from public places</td>
</tr>
<tr>
<td>Congressional testimony, 1994, FDA commissioner David Kessler and the CEOs of 7 tobacco companies testify before the subcommittee on Health and the Environment</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>FDA makes nicotine replacement (patch and gum) available over the counter, 1996</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Federal and state tobacco excise taxes are implemented and increase over time</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Litigation- Tobacco Master Settlement Agreement, 1998 or FDA v. Brown &amp; Williamson, 2000</td>
<td>9</td>
<td>1 (Rita) aware of master settlement agreement and FDA v. Brown &amp; Williamson details specifically. Others mentioned general topics that were the result of this pedagogy. 5, Joe Camel banned, 1 Billboard advertising ban, 2 NASCAR racing advertising ban</td>
</tr>
<tr>
<td>Pennsylvania bans smoking in public places, 2008</td>
<td>15</td>
<td>Though not a law in Pennsylvania, but 4 participants reported that they believe it is illegal to smoke in a car when a minor is present</td>
</tr>
<tr>
<td>Family Smoking and Tobacco Control and Prevention Act, 2009</td>
<td>2</td>
<td>1 (Melody) participant mentioned the banning of flavors that was a result of this law, 1 discussed FDA nicotine</td>
</tr>
<tr>
<td>Housing and Urban Development smoking ban, 2016</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>National Park Smoking Ban, 2017</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

**Public Intellectuals**

| Individual intellectual: | 2 C. Everett Koop, 2 Joycelyn Elders (Frances, Katalea) |
| Collective Intellectual: |  |

- Surgeon General: 4
- Doctors and medical professionals: 8
- American Cancer Society poster: “It Looks just as stupid when you do it” | 2 |
- American Cancer: Great American Smoke Out: 2
- Employer Smoking cessation program: 2
- Scientific committees and the Environmental Protection Agency committee report about 2nd hand smoke containing cancer causing chemicals and causing harm to non-smokers, 1986 & 1992: 15
- Anonymous intellectual: 15

The actual committees and reports were not mentioned, but knowledge of the harms of second-hand smoke was well known.

“They” were mentioned by every participant as implementing a variety of public health pedagogies.

**Informal Institutions and Public Spaces**

| Target becomes first major retailer to stop selling tobacco products, 1996 | 0 |
| CVS follows suit, 2014 | 6 |

3 additional participants were aware of this event, but did not know “why” the company stopped selling tobacco products.

**Popular Culture and Mass Media**

| First truth initiative ads air nationwide, 2000 | 7 |
| Tips from Former Smokers, Centers for Disease Control and Prevention, (2012) | 11 |
| The Real Cost, FDA (2014) | 10 |
| School news or health class videos | 5 |

- 11 “Terrie”, 3 “Shawn”, 1 “Brian”, 1 “Brandon” or “Bill” (mention of a male with a leg amputation)
- 9 “Your Skin”, 2 “Delivery”, 2 “Your Teeth”, 1 “Bully”

Younger participants noted that they saw anti-smoking information in health class or truth initiative videos on school “news programs” like Channel One.
Figure 4-1
Public Health Pedagogy Category Discussed During Interviews

The results of this table are summarized in Figure 4-1 which demonstrates the proportion of public health pedagogy categories discussed during all the participant interviews. The most frequently discussed category was that of Dominant Societal Discourse (e.g., Taxes, Regulations, Laws) and the least frequently discussed was Informal Institutions and Public Spaces (e.g., CVS and hospital campus smoking bans). The category of Public Intellectuals was largely driven by reports about second hand smoke and anonymous intellectuals, both of which were discussed by every participant.

**Results of the Thematic Analysis**

I performed the thematic analysis for this study concurrently as the data was being collected and while the participants’ narratives were being re-storied. The major themes and sub-themes that I identified during the thematic analysis are presented in Table 4-4 and they represent commonalities that emerged across participant interviews. In the following sections, I will present each theme along with data, or quotes, that support each theme taken directly from the transcribed participant interviews.

**Table 4-4**
Themes and sub-themes identified during the thematic analysis of the participants’ interviews

<table>
<thead>
<tr>
<th>Major theme</th>
<th>Sub-theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being aware of public pedagogies and their lessons</td>
<td>1. Accepting that smoking may is bad for health</td>
</tr>
<tr>
<td></td>
<td>2. Whatever: Surrendering without contest</td>
</tr>
<tr>
<td></td>
<td>3. Trying not to cause harm</td>
</tr>
</tbody>
</table>
Disregarding public pedagogies and health messages

1. Doubting the veracity of messages
2. Playing the odds
3. Experiencing marginalization

Learning to avoid the pedagogies and messages

1. Coping by blocking it out
2. Seeking alternatives
3. Rebelling against expectations

Distrusting of intellectuals

1. Feeling controlled
2. Perceiving hypocrisy
3. Suspecting corruption and collusion

### Being Aware of and/or Accepting of Public Pedagogies and Their Lessons

Within this theme, participants acknowledged a variety of smoking-related public pedagogies and are able to provide explanations for why these pedagogies were implemented that were in line with what might be suggested by tobacco control professionals. Many of the learning that they describe in section is experiential in nature (Fenwick, 2000). For instance, many participants noted an awareness of the increase in cigarette taxes over the years. When I asked them why they thought this might be happening, they many responded “so people smoke less” (Damien). Likewise, participants were aware that clean indoor air laws were implemented to protect non-smokers from second-hand smoke. As Katalea said, it’s “common sense. Even before the second-smoke came, I knew that it wasn’t good for my kids”. They also understood that advertising restrictions and age of sale laws were intended to protect kids and welcomed the current restrictive environment because, “I got nieces and nephews and Godchildren and I’m like... Man! This is so much better than it was when I was a kid! (Melody).” In general, participants noted that smoking is “bad” for health and exposure to more recent pedagogies contributed to, but did not intensify, the meaning of this already existing perception. Jarvis (2006) would consider these types of experiences to be “non-learning” such that the knowledge is so well understood that no new learning occurs even in the presence of new information.
In addition to a general awareness and acceptance of public health pedagogies, there are some specific subthemes identified within this category that I detail below.

**Accepting that smoking is harmful to health.** Undoubtedly, the most common theme across virtually every participant’s interview was an awareness of pedagogical messages about the harmfulness of smoking. As Guy said when discussing The FDA’s The Real Cost ads, “They’re going to cost you your life. Every time you smoke. And that’s the thing...we know!” Although not all participants fully accepted every message that they received, all of them were able to, without prompting, accurately articulate several tobacco-related harms. These harms ranged from premature death, to wrinkles, to a variety of cancers to cardiovascular, lung, and gum disease, fetal birth defects, and premature birth in pregnant women. For instance, while referencing anti-tobacco advertising in general, and the CDC’s Tips from Former Smoker’s Terrie ad, Melody says:

Nowadays, they make you more aware of the dangers. It’s not just “it may cause cancer”. It’s not just, you know, it’s “bad for you”. It’s like literally throat cancer, gum cancer, lung cancer... You’re going to be over here in an iron lung with false teeth and one of them things in your throat [hands-free device]. And you’re not even going to be able to play with your grandkids. That’s what it is. And they are so “in-your-face” about it now.

In many cases, participants had first-hand experience with both the physical harms of smoking and the realities of addiction through either their own health problems or those of family or friends. In particular, Courtney explains:

I mean there’s a lot of people I know with lung cancer and other cancers that are caused from smoking... Which doesn’t mean it came from cigarettes, but I’m sure that didn’t help it. My stepbrother, his grandma, she smoked a lot and she bought by the carton and she smoked so many cigarettes with us right in the room. Didn’t give a shit. She died from lung cancer and I remember she was sitting on the couch, she had no hair, she was so skinny...She looked terrible hooked up to the IV. She was still smoking and I was like, “Geez! Is it that intense?”
There were some pedagogies, particularly advertisements, that most participants were aware of which caused fear, sadness, or crying. Occasionally participants comment that they would gain insight from the ads and connect them to experiences and people that they knew. For instance, Frances knew someone who had a tracheotomy and after seeing Terrie’s ad she “put it together” that this person’s condition was due to smoking.

The truth initiative ads from the early 2000s were commonly brought up because they were thought provoking such as, “the ones where people would just drop and they’re just falling down on the sidewalk all over the place (truth initiative, 2003, Tobacco Kills). They hit you and make you think” (Colorado). The CDC’s Tips from Former Smokers ads (2012) were most frequently referenced as causing sadness or fear, particularly Terrie’s ad which “made me cry” (Frances, Rose), and Brian’s ad which was “sad” and “scary” (Donna). The Tips ads seemed to create dissonance for some participants who agreed with the message and struggled to reconcile their continuing smoking behavior with this harmful information. As Zach said:

I’m tired of this advertisement because they start that fear it could happen to me. Fear can change you. I kid you not. When you see that lady with the thing on her throat? When the kids see that commercial, if it don’t affect you, it’s going to affect them. Which it already has affected my kids. They look at me with a sad look, “Daddy please stop smoking because we don’t want to see you look like that.” And I tell them that’s not going to be me, don’t worry about it. But I can’t convince them that it’s not. I can’t even convince myself that it’s not. It might hit me somewhere else, but I try not to have those premeditated thoughts because it do make me scared. And who wants to create fear unnecessary?

Participants also expressed an awareness that their smoking was not socially acceptable. The younger participants in particular felt this strongly since they felt that smoking “was never accepted my whole life” (Johnny). In some cases, this awareness drove them to make changes in their behavior. Colorado whose mother did not smoke, and whose father quit several years back said, “A lot of times, if I’m going to be around my parents, I try not to smoke before I see them”.
In addition, it led them to feel out of place and uncomfortable when traveling to places where they were not allowed to smoke. For instance, Rose shared:

I get self-conscious coming into hospitals and stuff where there’s no other smells except for clean. You know what I mean? And I’m walking through and I’m like, I smell like an ashtray that has perfume smell on it… Because to me I don’t smell that way, and Melody doesn’t smell that way, but then when you go somewhere where there’s no smoking or anything, it’s so strong but we still can’t smell it on ourselves… and it does make me very self-conscious.

She goes on to suggest that she not only feels self-conscious, but she feels judged because she is acutely aware that those around her are also familiar with the health-related harms of smoking:

All the doctors and nurses, then they’re going to smell smoke and know that I smoke and they’re going to judge me because I smoke. I’m like I know it’s unhealthy. I know it. I’m sorry... I’m overweight and I smoke. And I’ve always had issues with doctors when it comes to both of those things. Even though I’m healthy, they don’t like that I’m overweight and then I smoke. And I know they’re thinking, “Oh, kill yourself faster”. You know, that kind of thing like, “Okay, she’s overweight which is dangerous. And she’s a smoker which is dangerous. Yeah, she’s not going to live very long.” That kind of thing.

Thus, participants were aware of the harms of smoking in part due to the presence of public health pedagogies. In some cases, these pedagogies, such as anti-tobacco advertisements, were in line with the participants’ personal experiences either through issues with their own health, or through those of family and friends. In addition, the awareness of harm was so ubiquitous across subjects that new information (e.g., The Real Cost ads information about teeth and skin) offered new details about how smoking harms health, but it did not add much to the overarching understanding that smoking is harmful. Finally, most participants expressed an awareness of the socially unacceptable norms surrounding tobacco use which, for some, caused either self-consciousness or feelings of being judged. This was particularly common among the younger participants since they became established smokers during a time when the social norms of smoking were already shifting.
Being aware and conscious of public pedagogies was a consistent theme throughout the participant interviews, but what also became clear as we talked was a sense of surrendering to the messages, which I will discuss in the next section.

**Whatever: Surrendering without contest.** During the course of the participant interviews, they discussed a number of ways in which they surrendered to the public health pedagogies that they encountered in their daily lives. For instance, with clean indoor air laws, “I just walk outside and smoke” (Tina), or with tax increases, “So you pay the piper. You want to smoke? You pay more taxes.” (Katalea).

However, I choose the word surrender purposefully because it implies a sense of being forced to do something and this should not be confused with willing acceptance. Courtney describes the smoking policy change at the restaurant where she worked that occurred in 2008 when Pennsylvania implemented clean indoor air laws and says:

> It was kind of annoying. I was like, whatever, that’s fine. I can still smoke, you know? But it’s a big place and we had to literally walk through the parking garage all the way over to the place where they let you smoke.

In many cases, when participants were discussing pedagogies such as taxes and smoking bans, they were conflicted because they knew that compliance was good for their health, but they also felt resistance that led them to surrender and comply with a mental, verbal dismissal of “whatever”. When discussing a smoking ban on a hospital campus, Melody shares:

> Hospital grounds? Okay. I’m here. Whatever. I mean, when I brought her [Rose] here last week, I would sit down there [in the lobby], and I’m like, “She’s been up there for a while...I want a cigarette...They’re in the car...No.” No, because even then it’s on hospital grounds, and I have to leave... to drive somewhere. No. I just sat down there and I just waited. Didn’t need a cigarette that bad that I had to go walk to my car and drive somewhere else so I could smoke a cigarette. It wasn’t that critical.

Though the participants were surrendering to public pedagogies, this was not always perceived as a bad thing. Though not smoking in public places may not have been the choice they would
make, several participants (Melody, Courtney, Rose, Colorado, Vince, Johnny) suggested that these types of restrictions “good for me” (Courtney) because they helped them to smoke less by forcing them to be inconvenienced. For instance, while walking at an amusement park, Courtney stated, “If I come across one [a smoking shelter], I’ll go smoke, but I don’t go looking for them because I don’t really care because, like, it’s saving me.” Whether it is saving money, or saving her health, these restrictive pedagogies were seen as helpful. This sentiment was also occasionally the case for taxes and some participants said (Guy, Vince, Tina, Johnny) things such as, “I hope they tax them so much I can’t smoke them” (Vince).

In some cases, surrendering to the knowledge created through public pedagogies led to feelings of hopelessness because participants felt that there was nothing they could do to avoid the consequences of their smoking. In fact, though some discussed the availability of over the counter nicotine replacement medications, they did not believe that they could quit. The participants who had been in treatment for drug or alcohol abuse were particularly aware of the complex cycle of attempting to quit and relapsing due to the addictiveness of cigarettes. Johnny, who has been heroin free for 2.5 years felt that, “quitting that [heroin] was almost easier than quitting cigarettes.” Additionally, Guy, who was in alcohol treatment in his teens offers a more detailed account when he said:

It’s just insane that we keep doing the same thing. We know it’s wrong. I can’t say that I can’t stop smoking because I could, but I need help. I think. Maybe. Maybe not. The problem is, how I’m going to live the rest of my life without it and without come back? Because most of the people that are doing something wrong, they repeat it. AA [Alcoholics Anonymous], NA [Narcotics Anonymous]...whatever...“I’m sober for 24 hours!” “Good for you!” Yeah, but then they go and passed by the bar and drink...And it’s just happen. How to stop smoking? I don’t know. I guess it’s on you personally...The only way you will stop smoking is when you at the bottom. Some people have to hit the bottom with consequence.
Guy, and others, recount a common frustration with addictions treatment which is the high recurrence of relapse which, in this case, is enough to create a barrier to attempting to quit at all.

Further, while participants accepted information about the harms that smoking could do to their health, many expressed confusion at some of the pedagogical messages because they had personally encountered situations that were contrary to what the messages taught. For instance, Frances observes that, “some people get lung cancer...and they’ve never smoked. That’s a mystery to me. And somebody that has smoked all their life probably never get it.” Taking this confusion a step further, four participants (Donna, Rita, Courtney, and Tina) stated that they believe that cancer is “in everyone” and that the development of the disease is purely random or pre-destined. As Tina says, “Cancer’s in everybody and it’s just that it wakes up and it wants to be aggressive on you. You don’t have to smoke and you can get cancer. Or, you can smoke and get cancer.” These participants each recount stories of a loved one battling cancer and not all of them smoked. Since some of the people they encountered did not smoke, these life experiences lead them to believe that no behavior change they can make will guarantee their future good health. As Donna says, “I think everybody has some kind of cancer.” She provides evidence of this from her personal experience as a hospice medical assistant, “I had one patient that had a trach and...she ended up with throat cancer. She never touched a cigarette a day in her life. And people in her family had throat cancer. She just chalked it up that it was hereditary.”

Although participants had a high level of awareness about the harms of smoking, they were conflicted and often surrendered to the messages that public pedagogies conveyed. However, they also felt powerless to change their behavior, particularly since they identified with the addictiveness of cigarettes and were ambivalent about whether behavior change would
be successful, or make any difference in their future health. Regardless of this, participants did describe several strategies that they employed to reduce harm for themselves and for others.

**Trying not to cause harm.** Along with recognizing that smoking is harmful to them, many of the participants were supportive of public pedagogies that were perceived to protect children from either starting to smoke, or restricting their access to cigarettes. They were also accepting of those that they perceived as protecting children or non-smokers from exposure to second-hand smoke. The desire to limit harm to others persisted even in the presence of smoking restrictions or inconveniences that smokers faced on a daily basis and they were willing to make these *sacrifices* for the good of others. For instance, age of sale laws are enforced at many retail outlets by carding anyone who asks to buy cigarettes, and as Colorado says, “Even today I get carded sometimes depending where you go. I mean it’s the law. But it’s still aggravating”. In spite of this aggravation, the general consensus was that pedagogies such as limiting advertising, banning cartoon advertisements (Joe Camel), age of sale laws, and removing vending machines from public spaces are “a good thing” (Damien) to keep cigarettes “away from the kids [because] nobody should be smoking” (Guy).

Four participants incorrectly believed that it is illegal in Pennsylvania to smoke in a car when children are present (Courtney, Guy, Melody, and Rose). Regardless, they were more than willing to abstain from smoking when they were driving so as not to expose children to second-hand smoke. As Guy said:

> I’m pretty sure their health gets bad if I smoke around my kid in my car all the time... So I like what they did. They make it illegal to smoke in the car with kids when they 10 years old and younger.

Others also report going outside to smoke or restricting their smoking to certain areas of the home in order to limit the exposure of smoke to others (Katalea, Damien, Rita, Guy, Vince). Damien
even felt that his cats were a worthy target for harm reduction strategies and reported smoking outside his apartment because, “I don’t want the cats to get cancer”.

In addition, some participants (Colorado, Courtney, Katalea, Frances, Donna) expressed a desire to help prevent others from smoking by personally testifying as to the harmfulness of cigarettes and encouraging them not to smoke either through words or actions. Colorado noted that he even tells people who are non-smokers, “You should be thankful that you didn’t start. And I tell them… Don’t start! Because it’s the worst thing you will ever do in your life to try to quit. I mean, it’s crazy!”

Finally, participants also expressed a desire to reduce the harm that they were doing to themselves by engaging in activities such as smoking “a little less” (Donna, Courtney), switching to a “lighter” cigarette that is either “low tar or low nicotine” (Rita, Colorado), or smoking shorter, 72mm cigarettes (Colorado). In particular, Rose believes that roll-your-own cigarettes are “a lot healthier because it’s unprocessed. It’s just loose tobacco so there aren’t nearly as many chemicals or... preservatives.”

Despite the personal inconveniences that participants reported related to smoking restrictions and public pedagogy messages, they were generally willing to encourage and support these activities if they perceived them to be reducing harm either to themselves or to others. This was especially true in the case of preventing harm to kids. However, as I mentioned at the beginning of this section, surrendering to pedagogical messages is not synonymous with willingly complying. Disregarding public pedagogies and health messages was a common theme that emerged from the data and there were the many ways that participants demonstrated this behavior.

**Disregarding Public Pedagogies and Health Messages**
As I mentioned in the previous section, all the participants were able to articulate the awareness of some harm or negative element of smoking. However, as is common with the narrative mode of thinking, the participants’ awareness of harm easily alternated between opposing and contradictory concepts as they explained their experiences (Bruner, 1986). Given that all the study participants were active smokers at the time of the interview, they expressed a number of beliefs that seemed to help them to reconcile their current smoking behavior with their knowledge of the harms that cigarettes might be doing to their health. I consider these behaviors to be “disregarding” of public pedagogies but that does not mean that participants entirely reject the claims of harm. Much of what the participants had to say in this category is nuanced and conflated with other concepts that are entirely unrelated to smoking such as politics and economics (Eakin et al., 1996).

To be sure, some participants did reject outright many claims of harm that public health pedagogies endorse, and those that did reject them tended to have political or philosophical perspectives that contributed to these views. In addition, some individuals who rejected claims of harm immediately corrected themselves saying they were “in denial” (Johnny) or “making excuses” (Colorado) for their behavior. However, in some cases, the participants felt a true sense of uncertainty, experienced actual injustice, or felt a sense of hopelessness that contributed to disregarding behaviors or beliefs.

**Doubting the veracity of the messages.** Within this theme, it is important to distinguish between participant sentiments that are outright rejection of public pedagogies, and those that simply doubt the severity, or implications of their actions related to a particular claim. Outright rejection and complete denial of all public health pedagogies related to smoking was only consistently expressed by one participant (Rita) who states:
The experts...they say you can get emphysema, COPD, it contributes to heart disease, it contributes to stroke...yeah... all the big scary stuff. Cancers, okay? Yeah. I’ve never in my life met somebody who says, “I have lung cancer because I smoked. I have esophageal cancer because I smoked.” My personal experience is that I haven’t met all these people that the boogie man came to visit.

However, while Rita was consistent in her denial, others were equally doubtful of some (but not all) of the messages that they received and this doubt was heavily supported by evidence from personal experiences that were in conflict with public health messages of harm. For instance, three participants noted that their doctors recently told them that they were in good health (Rose, Rita, Zach) and Zach says:

Now, I’m still healthy today after 20 something years of smoking cigarettes from the age of eight and nine. I’m 46 now and I’m still healthy. I just recently had a physical. The only issue I had was cholesterol issues. Okay? I am SOB, short of breath... I think it affects my respiratory breath a little bit because I can’t take a real deep breath but I can still blow out a candle. So no... What these people are saying about cigarettes aren’t affecting me yet. Not saying it won’t. Okay? But I’m just not convinced, or scared right now, that my smoking is causing me serious health problems.

In Zach’s case, and in that of the other participants, their experience of “good” health was a matter of personal opinion, not criteria used for a medical diagnosis. For Zach, the bar for breathing well was set at accomplishing a common activity such as blowing out a candle which is not likely to be the same criteria that medical professionals would use to diagnose lung disease.

Rejection of the messages about quitting was especially common among those who had past experiences with either themselves or someone close to them who had tried to quit unsuccesfully. For instance, Melody stated, “At this point I’m just like, okay, you know what? I tried to quit. I did it! I tried. It didn’t work!” Others made multiple serious quit attempts and found that, in their experience, over-the-counter medications did not help them. As Colorado said:
They don’t work. For me anyway. I mean I have actually I’ve tried the patch I tried the gum...the lozenge. The lozenges actually made me so sick. Like about maybe a minute into it...my gag reflex. Uhhh! I mean, I would have to spit it out. Gum? Same thing. And it tasted terrible. But like the patch never really did anything for me. I would smoke with the patch. In fact one time I had the patch, I was chewing gum, and smoking! And they say, “Oh don’t do that! Don’t do that!” It didn’t do anything to me.

Colorado’s experiences with medications and quitting served to reinforce his belief that quitting is an insurmountable obstacle and there is little he could do about it, in spite of the pedagogical messages that continue to prompt him to do so.

Finally, a few participants believed that smoking could contribute to health problems, but that some of the public pedagogy messages were exaggerated or overstated versions of the truth (Katalea, Malcolm, Rita, Donna). Katalea recalled hearing Surgeon General C. Everett Koop talking about the harms of cigarette smoke and says:

So you know when I first saw him, I just thought it was like...exaggerating. They were making it more than what it really was. I mean, you don’t have to tell us that the cigarette is bad because we see that some people got cancer because of the cigarette. But nowadays, you get cancer by anything! My niece she just passed away from pancreatic cancer at 34. Never smoked in her life. Her husband doesn’t smoke, I don’t think her mother ever smoked, and she died from pancreatic cancer.

Many of the participants had experiences of people close to them, either smokers or non-smokers, who died prematurely from cancer and other diseases which further contributed to their belief that quitting was a useless endeavor simply because premature death was inevitable. In addition, three participants (Donna, Courtney, and Tina) recounted experiences of loved ones in the process of dying from cancer who continued to smoke. The general consensus among these individuals was an ambivalence about quitting that was best stated by Tina’s grandfather who said, “I don’t give a shit! I’m gonna die anyway. I got leukemia cancer and fuck it! Gimme a cigarette!” (Tina).
But this ambivalence caused by personal experiences about quitting smoking played into another theme that I will discuss in the next section. This theme is more broadly aligned with philosophical perspectives that assert that life is a gamble and there are no guarantees for anything, including good health.

**Playing the odds.** The comments that participants made related to this theme strongly suggest that health is viewed and valued differently by different people because of varying lived experiences and reasons for smoking (Heyman et al., 2012). While most participants accepted that public health pedagogies were broadly accurate, many were philosophically oriented toward the idea that life is a gamble, that premature death is inevitable, and that smoking is just one of the many risks in life that can contribute to poor health and eventual death. Participants took an “all things considered” approach to their interpretation of health risk (Allmark & Tod, 2006) and this assumed that because death is inevitable, people should choose things that bring them some level of happiness despite the risks. Finally, there was a belief that individuals are intelligent, autonomous creatures who are capable of understanding risks, making their own choices, and accepting the outcomes whatever they may be.

In the case of Rita, she was fully aware of the events surrounding the 2000 FDA v. Brown & Williamson Supreme Court case and the 1998 Tobacco Master Settlement Agreement. She believed that the tobacco companies were manipulating the chemicals in cigarettes and that they lied about it to the public. However, she perceived the outcomes of the proceedings to be condescending to her personally and to smokers in general:

> When they had the big tobacco issue that tobacco must pay... that really that kinda pissed me off because for me, you know what? I’ve been a smoker for15 years. I chose to smoke. I didn’t smoke because I thought it would be cool. I didn’t smoke because I love the Marlboro Man. Okay? I didn’t smoke because I had a dream where Joe Camel said, “You must smoke!” I felt like they were really dumbing it down to act like people who smoke do it because they’re such “sheep-ple” that they don’t have the will to make their own...
decision...[sarcastically] “I’m only smoking because the cigarette companies said it was safe.” Bullshit! They’re like the slip and fall experts who get $1 million from McDonald’s because there was a French fry under their table. Okay? The big cigarette lawsuit, that really pissed me off.

Rita believes she makes a conscious choice to smoke and because she considers herself to be an intelligent person, she is uncomfortable with any message that suggests she is not fully aware of the consequences of her actions. In addition, she denies that nicotine is addictive in any way that would suggest that she, or her fellow smokers, have lost their autonomy.

Along a similar line of reasoning, some participants expressed an idea centered generally around freedom that allows people to take responsibility of their own actions, “If you want to smoke? Smoke! If I don’t want to do this? I don’t do it! So, I kinda think it’s a choice, you know? Let people do what they want.” (Katalea). Malcolm expands this concept further by suggesting that “everybody has their addiction” and they chose things such as coffee, chocolate, cigarettes, alcohol, drugs, which are “all harmful in their own way” (Malcolm). Therefore, when considering health, he believes risks are inevitable and life is like gambling:

Because that’s what you’re doing. You smoke a cigarette, have a mixed drink, shoot up? You never know which one could be your last. When you have a drink, get behind the wheel, smash your car into a tree? You’re dead. Smoke a cigarette crossing the street playing Pokémon Go? You get run over by a truck by the guy that’s drinking. Somebody sold you a bad batch of heroin? You’re dead. You can’t think every time you do something it’s going to kill you or you’re not living. You might as well be dead. So if you enjoy something in life, enjoy it! The hell with it. It don’t matter how you live your life... you’re going to die no matter what.

Along with Malcolm, other participants (Katalea, Tina, Johnny, Melody) also suggested that smoking is just one of many behaviors that carry risk in life. Johnny in particular believes that “after you overcome a heroin addiction it’s like, I coulda died already, so every day is like an extra day”. It is useful to consider, when thinking about these perspectives, that the context in which the participants lived included pervasive social norms that include drug, alcohol, and other types
of abuse as common and part of daily life. For instance, Courtney, who was living in a drug addiction recovery house, believes that “everyone is dying” from drug and cigarette exposure which leads to a perception that everyone’s life is normally filled with these types of risks.

Finally, some participants felt uncertain that, though cigarette smoking may cause harm to health, there are many other risks and chemicals to which they are being exposed on a daily basis that are also harmful. Although some felt that everything is “bad” for you (Tina, Rose, Malcolm), they listed a number of specific sources of chemical exposure including the highly processed nature of our food supply (Katalea, Rose, Rita, Zach), car exhaust, weed killers, and environmental pollution (Katalea, Malcolm), and cleaning products (Rita, Malcolm).

Playing the odds for many participants was a way to make sense of their daily experiences and provided them with some sense of freedom since they believed they had the autonomy to make choices about their smoking. In addition, because they, and the people around them, were engaged in many high risk behaviors that are harmful to health, their experiences led them to believe that premature death is inevitable and there is little that an individual can do to prevent it. In addition, because many of their personal experiences were in conflict with the messages conveyed by public pedagogies, some of these messages were rejected as exaggerated or inaccurate.

**Experiencing marginalization.** A final theme that emerged in the category of disregarding public pedagogies is an experience of marginalization due to public health pedagogies (Frohlich et al., 2010) that was expressed by many participants. This feeling was tied specifically to a sense of injustice that participants felt because they were complying with public pedagogies, such as such as clean indoor air laws and taxes but, they were still penalized. In
other cases, it was a perception that the penalty for smokers was unfairly distributed or unnecessarily punitive.

The idea that smokers were being “picked on” emerged often during the interviews along with a feeling that there are few places where smoking is acceptable. Katalea felt “they are taking kind of everything from the smoker” and this feeling lead to exasperation. For instance, participants expressed frustration at the reactions of others who scolded them even when they were willingly smoking in designate areas. As Malcolm says, “I’m outside, you know? Who says you have to walk this close?” and Melody exclaims, “If I have to go outside, at least let me stand on the sidewalk!” Similarly, Johnny recounts a story of smoking on a public street:

In 2015, I went to New York City, and walking down the street... you’re allowed to smoke on the street, right? People give you dirty looks. And I think somebody actually said something to me that walked by me. I thought, “Fuck you, I’m allowed to smoke here!”...There’s few places you can smoke now, and I get bad looks and comments even when I’m smoking in the spot I’m supposed to be smoking.

As with Johnny, though they recount the stories of single incidents, many of the participants conveyed a sense that everyone, aside from smokers, would treat them this way and that they were against them.

The feeling that there are few place for smokers to seek refuge seemed to contribute to a more pervasive feeling that smokers are a discrete group that is being unjustly targeted by society. Many individuals expressed dismay at this and they compared the societal reaction to cigarettes to that of alcohol and concluded that cigarettes are unfairly taxed and regulated. Tina questions, “why is smoking even more expensive in taxes than everything else?” and Donna adds “if you’re going to tax cigarettes, you need to be taxing alcohol too. Because there’s people out there that are addicted to alcohol.” The comparison between alcohol and cigarettes came up
frequently (Johnny, Guy, Rita, Zach, Donna), but another societal ill that was perceived to not be getting the attention of cigarettes was the prescription drug problem (Rita).

Interestingly, the discussion, particularly among those who were in recovery for other drugs, often turned to the addictive nature of cigarettes. These participants surmised that smokers are being taken advantage of because they are addicted to cigarettes and can’t stop (Johnny, Guy, Tina). As Johnny says, cigarettes are taxed “because it’s addictive. Because we don’t got no choice. We’ll pay it.” Tina also suggests, “If you’re allowed to buy drugs? Marijuana, cocaine, heroin? I bet you that would be 3 times higher on taxes than regular cigarettes because you got all these addicts that wanted it!” These comments were not just simple observations, but rather they were used as evidence to support the idea among many of the study participants which is that they are being “picked on” or marginalized by society for an addiction over which they have little control.

While participants may have had several experiences that lead them to disregard public pedagogies, they were required to find ways to behaviorally cope the messages they received. In the next section, I discuss a range of behaviors that the participants explained learning as a way to avoid the pedagogies they encounter on a daily basis.

**Learning to Avoid the Pedagogies and Messages**

There are a number of strategies that participants discussed employing as ways to block out or find alternative ways of engaging with a particular public health pedagogy. Jarvis (2006) considers these types of behaviors to be “rejection and non-consideration” such that the individual has the opportunity to learn, but they purposefully rejects it. Sometimes, “rejection” would be better described as outright rebellion as this was occasionally the only way that the participants were able to fully cope with the pedagogies to which they were exposed. Although I
describe some rebellion behaviors here, these appeared to be last resort behaviors for many individuals.

**Surviving by blocking it out: Mass media campaigns.** The most commonly discussed behaviors were those that described how individuals dealt with information they received about their smoking that they believed to be true when they were not ready or willing to make a plan toward actionable change. The simplest way they avoided media ads was by fast-forwarding through them or turning off the TV (Malcolm, Zach). Additional strategies employed included blocking it out (Colorado, Courtney, Vince), pushing it to the back of their mind (Donna, Melody), and thinking they will deal with it later (Johnny, Zach, Rose, Rita). As Guy said, when discussing the 2012 CDC’s Tips from Former Smokers ads:

I can’t stand that commercial because it’s true... Every time one of those commercials come on, and throw it in my face? I can’t even watch it... I get a drink water, or use the bathroom, or go smoke. Nobody like anybody to tell them the truth that you don’t want to hear.

Their awareness that they didn’t want to see the information conveyed to them was common but, several of the participants were not able to articulate exactly what they did to avoid the messages. When questioned, they simply answered that they were “not ready to quit” (Katalea, Malcolm, Johnny, Frances) suggesting that they are acutely aware that the explicit message behind these media campaign messages was to encourage a quit attempt.

Commercials, and other forms of media, could be easily avoided by the strategies mentioned above. However, one of the potential benefits of more societal level public health pedagogies (e.g., taxes and clean indoor air laws) is the difficulty individuals faced when trying to avoid them. For instance, federal and state taxes are uniformly applied to all manufactured cigarette purchases, and clean indoor air laws are ubiquitous in public spaces in the state.
However, participants noted many alternative ways of interacting with these pedagogies that were not likely what the regulators intended to have happen.

**Seeking alternatives.** Within this theme, I discuss behaviors that participants employed to seek alternatives to three specific pedagogies including taxation, clean indoor air laws, and age of sale laws. Many of the examples in this section suggest that the participants were engaged in a community of practice as they learned new ways to avoid specific public health pedagogies (Brown et al., 1989; Fenwick, 2000; Lave, 1988).

**Taxation.** In terms of taxation, many of the participants indicated a fluid concept of purchasing cigarettes that was highly dependent on the amount of money they had on hand. For instance, on the quantitative questionnaire, Damien indicated that he smoked Eagle brand cigarettes. However, during the course of our interview, he said he was rolling his own cigarettes. When I attempted to clarify by asking if he smoked Eagles he said, “I do! When I have the money!” He also stated that he learned to avoid the high cost of cigarettes and taxes while at his local smoke shop where the clerks taught him how to roll his own cigarettes. Likewise, Melody stated that she regularly rolled her own cigarettes when she was at home, but purchased L&M manufactured cigarettes if she was going to be at work.

Guy rolled his own cigarettes on a regular basis, and like the other participants who did this, he was clearly able to discuss the financial benefit of these behaviors. He said, “It’s $8.00 something for a bag [of pipe tobacco], and like $2.00 something for the tubes, and you get, like 200 cigarettes.” This is in comparison to a carton of brand name cigarettes that can “cost up to $70.00” (Rita) for 100 cigarettes. Similarly, Rita indicated that she smoked Pall Malls on the questionnaire, but she also smoked little cigars because, “they look just like a cigarette,” and “I get a carton of these for less than $10.00”.
Although it is often thought that smokers are brand loyal, the participants in this study indicated that brand choice is highly fluid and dependent on cost. For instance, Tina told a story about borrowing a friend’s pipe tobacco and tubes to roll some cigarettes when she didn’t have the money to buy her own. She said that she prefers to purchase manufactured cigarettes because rolling them is “such a pain in the ass”. At the time of our interview, she was smoking Wings brand discount cigarettes which “make her cough” but she responded on the questionnaire that she smoked Pall Malls. Likewise, Courtney stated on the questionnaire that she smoked L&Ms, but during the interview, she said that she was smoking Maverick discount brand which “give me a headache”. She also suggested that “loosies”, or the purchase of a single cigarette (a retail practice which is illegal), are an option when someone doesn’t have any money. “The mom and pop stores in the city... if you have like, a quarter, you can go in there and say, ‘Can I get a loosie?’” So, even though they are not able to smoke their preferred brand, and the discount brands may produce unpleasant side effects, participants were industrious in devising ways to purchase cigarettes.

Participants who did not indicate a willingness to switch to discount brands were highly aware of price and described excitement when receiving coupons in the mail for their preferred brand. They were also willing to price shop for their preferred cigarettes. Melody, who is a pizza delivery driver, provided me with a litany of prices for various brands at various stores she encountered throughout the city as she delivered pizzas. Thus, though the public health pedagogy of taxation is intended to encourage a reduction in the number of cigarettes smoked, in this sample of participants, there was only one participant (Donna) who indicated that she responded to price increases by smoking fewer cigarettes.
Clean indoor air laws. Clean indoor air laws in Pennsylvania were implemented in 2008 and since that time, workplaces and many public sites, such as hospitals, banned smoking on their property. As I discussed in the “Accepting of Public Pedagogies” section, participants were generally willing to comply with the rules and regulations surrounding these laws. However, there were some strategies that they employed to circumvent the laws. Their argument for engaging in this behavior was generally based on the idea that clean indoor air laws, particularly when a smoker is physically outside, are designed to limit smoke exposure for non-smokers.

In this way, participants sought locations where the laws were not enforced, particularly when it was clear that non-smokers would not be exposed to their smoke. For instance, Johnny described his workplace at a manufacturing plant as having designated “smoke houses”. However, when he was working nights at a satellite location, he and his smoking coworkers would “go outside and will smoke outside the door because nobody’s down there and there’s blind spots from the camera”. He further described how his boss, who smoked, was the one who instructed him on where to smoke so that he would not be caught. Additionally, when conducting activities in public places such as shopping malls and restaurants, others stated that they would “step outside” to smoke then return to their activities. As Rita says:

Sometimes it was a little bit of a little defiance, you know? Having our meal and then making a point of telling our waitress, ‘I’m going to take my coffee cup and go outside and have a cigarette. I will be back. Okay? Don’t clear my shit. I’ll be back. I’m not running out on the tab. You can see me right out there smoking my cigarette with my coffee’.

Participants described several instances of this type of behavior which is certainly following the rule of the clean indoor air law, even if the behavior may be slightly outside of the spirit of the law.

A number of participants discussed the importance of having a car parked nearby where they went to smoke if needed. They considered their cars personal property that were not subject
to clean indoor air laws (Malcolm, Melody, Rose, Colorado) and they described their cars as places to smoke even if they were parked on property where bans were in place. For instance, Malcolm says:

At the hospital, I was picking somebody up, and I was sitting there smoking a cigarette. They were like, ‘Oh, there’s no smoking on the property.’ I said, ‘The car’s on your property, I’m inside my property. Get the hell away from the car!’ and I close the window, turn the radio up and kept smoking. To hell with you! I paid for this car. I’ll do what I want with it.

Malcolm in particular was a highly nicotine dependent smoker who smoked 50+ cigarettes per day, woke up every night to smoke, and smoked within 1 minute of waking up. This suggests that clean indoor air laws created challenges for him as he attempted to manage his dependence while accomplishing tasks in his daily life. However, he is not alone, and he and other smokers in the study said that, as a result of the restrictions on their smoking, they “don’t go out anymore” (Colorado, Malcolm, Rose, Melody, Rita, Tina). As Colorado said, before agreeing to go out he will ask “Can I smoke there? Yes? Ok”, such that decisions about going out are made based on the individual’s ability to smoke freely.

Age of sale laws. One of the most consistently disregarded public pedagogies discussed in this study from almost every participant was age of sale laws. All participants were able to clearly state that age of sale laws were designed to keep cigarettes out of the hands of minors because “no kid should smoke” (Damien). However, nearly every participant had a story of how they obtained cigarettes prior to the age of 18 regardless of whether they came of age before or after the Snyar Amendment (1992) when age of sale laws were more stringently enforced. In addition, there was a general belief that kids would “get them anyway” likely because of their own personal experience of getting them. Those who were smoking prior to the Synar Amendment discussed the relative simplicity with which they could purchase cigarettes from
retail outlets prior to 1992. However, after 1992 and prior to being 18, younger participants were able to either “steal” cigarettes from their parents or friends’ parents (Courtney, Rose, Donna), or have either their parents (Rose, Tina) or older friends (Vince, Courtney, Johnny, Melody) purchase cigarettes for them.

While participants displayed a wide range of alternative behaviors to “get around” the public pedagogies of taxation, clean indoor air laws, and age of sale laws, there were few examples of outright rebellion. However there were some instances I discuss in the final subtheme of disregarding public health pedagogies or “rebelling against expectations”.

**Rebelling against expectations.** There were several instances where participants simply could not identify alternative ways to cope with public pedagogies and they simply rebelled against the expectations of these pedagogies. To do this, participants adamantly refused to learn by dismissing these pedagogies as “in-your-face” and “annoying” (Melody). They also described the content of some pedagogies as “forcing” (Zach, Melody, Rita) it on them, or shoving “it down your throat every time you turn around” (Rita). As Zach said:

> But trying to force something down my throat? Like eat it! Jam it! I feel resistance. I don’t feel like I want to smoke more I just don’t like them doing that to me. It makes me feel uncomfortable... Because I just want to smoke cigarettes. Who are you to... make them real inconvenient? So, in other words nothing can stop me from smoking. If you take them vending machines out of there, and you run all these ads... Guess what I’m gonna do? I’m going to cut the TV off, and then I’m gonna go across the river and get the cigarettes! Okay? Because I’m not very interested in hearing you telling me what cigarettes is doing.

Zach’s comment is a general response to anti-tobacco advertising which he “cuts off” and a reaction to restrictions on tobacco sales which he resolves to find other places where he can purchase his cigarettes. Though Zach’s comment appears in isolation here as rebellion against public pedagogies, during our interviews, he, and other participants, frequently vacillated between rebellion, acceptance, and denial of the messages they received.
The participants often reported that cigarettes were a response to the stress of their lives and that they smoked in specific stressful situations. Similarly, several reported (Tina, Guy, Zach, Malcolm) that after seeing public pedagogies such as anti-smoking media ads, “what do I do? Smoke a cigarette! \([\textit{mimics puffing on a cigarette}]\)” (Tina). Likewise, by coincidence, two participants (Colorado, Melody) were pizza delivery drivers for two different companies. Both of these participants discussed the stressful nature of their jobs and, though they were “not supposed to smoke in your car,” they frequently rebelled against this because, “there’s some days where I’m just so aggravated I don’t care and I will light up the minute I get in the car” (Colorado).

Though they didn’t always discuss the addictive nature of smoking, participants often described situations where it was clear that their nicotine addiction was winning out over what they knew to be harmful. For instance, two participants (Courtney, Donna) smoked during their pregnancies despite receiving information from doctors and family members about the harms this might be doing to their babies. Four participants also described situations where people they knew continued to smoke during and after cancer treatment or after COPD diagnoses (Tina, Donna, Courtney, Frances). Finally, Malcolm described a rebellious act that was a response to being confined to the hospital while waiting to receive emergency care:

One time I went to the hospital and I said... “This is taking a while, I need to smoke a cigarette,” and they’re like, “Well, you can’t go outside, and there’s no smoking on the property”. I sat there for another half an hour and at that point I didn’t care. I thought, “Fuck you! I’m going to have a cigarette!” I walked out the door and I thought, anybody tries to stop me, you’re going to find out how mean I can be without a cigarette. I’ve been in there almost 5 hours and I wasn’t even looked at! So, I went outside, smoked a cigarette, and returned.

In Malcolm’s case, he describes nicotine withdrawal (irritability) as the impetus for rebelling. However, the theme of rebellion ties in closely with the next theme I am going to discuss, a
distrust of public intellectuals, and Malcolm’s hospital story will resume as I relay his, and others’, common observations about their lives as smokers in a smoke-free society.

**Distrusting of Intellectuals**

Within this theme, there were three main subthemes that emerged from the data centering on a distrust of intellectuals perceived to have influence, money, and power in society. Participants felt that these intellectuals use societal resources, not to help others, but rather to control others while also demonstrating hypocrisy, corruption or collusion. Often, the intellectual participants cited was “the government”, however, frequently they did not cite a specific entity (Sandlin et al., 2011). Rather participants referred to “they” who were anonymous intellectuals that could not be directly identified, even when I prompted them to do so. These concepts align with those of critical theorist Hans Habermas (1987) who criticized society for letting those with power and money (e.g., public health or corporate entities) dominate societal discourse and oppress those without power such as low income smokers.

It should be noted that the majority of the content identified in this theme was largely derived from seven participants (Rita, Malcolm, Zach, Tina, Katalea, Vince, Colorado), all of whom, with the exception of Vince, were in the 36+ age group. Though these participants represented less than half the sample, sentiments presented by them in this section are the result of very strong opinions and emotions that shaped how these participants viewed the world and their place in it.

**Feeling controlled.** At the most basic level, participants perceived that some of the public pedagogies to which they were frequently exposed were “a form of control” (Katalea) that was being exerted on them simply because there are people with power and influence in society who are able to do so. As Rita described it, these people exert control:
Because they are the people that think we should live the way they want us to live our lives. They’re the ones that want to impose their lifestyle on everybody else because they’re so self-righteous... They’re hand-in-hand with the people who believe that we should worship like they do. They’re hand-in-hand with the people who believe that women’s reproductive rights should be handled according to their personal religious beliefs. And it’s one of those things where somebody, somewhere is sitting back and saying, ‘Okay, well, we pretty much got the cigarette thing handled. What’s next? What are we going to go after next?’ ...It’s basically about keeping everybody in order and identifying those who refuse to be corralled with everybody else.

Rita described a class of people that she believed she is not a part of and who want to corral people into living like they do. She explained that the reason for this is that they have the power and influence to “force” others to comply with their beliefs.

Similarly, Katalea’s version of control focused on government regulation because her father was a political refugee and activist who spoke out against Fidel Castro in the 1970s. She was politically aligned with conservative Republicans who support governmental de-regulation and she does not believe that the government should be involved with people’s health. She stated, “I don’t want the government telling me, ‘You can’t smoke!’ Get the hell outta here, man! You know? It’s a form of control!” For Katalea, she believed that people should have unlimited freedom to make choices, even ones that might be bad for their health, because this is a basic right as a free citizen living in a democratic country. For her, governmental regulation, or control, ultimately leads to communism which she directly equates with the loss of all personal freedoms. Because of this, she takes the position that people must fight for freedom by resisting governmental control including public pedagogies designed to discourage behaviors that may be harmful to health.

**Perceiving hypocrisy.** Participants who demonstrated a distrust of public intellectuals commented that they observed hypocrisy and it took several forms. For Tina, the hypocrisy was
due to differing levels of quality in healthcare. She tells the story of her step-dad’s cancer treatment and eventual death:

I really do think there’s certain cancers that are curable, and if you have the right kind of money for it they can do it... Ever since my dad died... and I said to my mom, “I bet there’s a cure for it” and she says “You’re damn right there is. If you have the money, I bet you one thing. They’ll find it! They’ll get it fast. I believe that. And that’s just not for cancer, it’s for everything really. If you’ve got the right kind of money life is a lot better.

In this case, Tina felt that doctors, anonymous hospital and insurance intellectuals, corporations, and the government are not interested in helping poor people because they don’t have “the right kind of money”. Therefore, she believed that since she lacked monetary resources, her step-father received some healthcare, but that it was sub-optimal. There was a similar sentiment for why warning labels appear on cigarette packs. It was not to warn smokers about the harms of smoking out of a sincere desire to help them, rather it was “just to cover their ass” (Vince, Johnny, Courtney, Tina) because “they” probably “got sued one too many times” (Tina).

Malcolm and Colorado also shared stories about healthcare providers who they perceived to be tasked with helping them, but who actually treated them disrespectfully because they were smokers. In one instance Colorado sought treatment to quit smoking from a doctor and rather than helping him, the doctor doubted his intentions. As a result he stated “I hate doctors, I mean, not personally, but I hate them”. Malcolm’s story that I included in the section about rebelling against public pedagogies (clean indoor air laws) and smoking on hospital property continues also here as he describes the healthcare providers who were treating him:

If someone goes in there [the hospital] smoking and they keep him overnight, if they’re not going to take them out for a cigarette, get them a damn patch or something! You know what I mean? Don’t have to phone down to the pharmacy and go through all that. Have them patches ready! They’re over-the-counter! They have no problem slipping you a Vicodin if you have a headache, but you gotta fill out 10 forms and have it notarized to get a nicotine patch.
When asked why it might have happened that a smoker didn’t receive nicotine patches, he said it’s because “most of them don’t smoke and they just want to be assholes. That’s how I look at it. It’s their own form of torture. That could be their addiction, they like to torture people.” Malcolm perceived hypocrisy in how he believed smokers were treated when confined to the hospital.

Another way that the participants in the study perceived hypocrisy was related to the legality of cigarettes (Rita, Vince, Colorado). As Rita states, “The Surgeon General says that nicotine’s addictive, it’s as bad as heroin and cocaine. Really? Okay, so then why is it still legal to sell this product? If is so flippant dangerous why is it so widely available?” They also question why cigarettes are taxed, in their opinion, disproportionately to other things, such as alcohol, and suggested that it is because, “most of your politicians or doctors or lawyers are drinkers” (Malcolm). Finally, they expressed frustration that they “don’t have a say in how that money is spent” (Rita). Thus, though the government educates the public about the harms of smoking, they continue to allow it to be sold legally, and they frequently increase taxes on the product. Malcolm concluded, “they might act like they’re not happy with it [people smoking], but I don’t see them not cashing that check.” This suggests that not only do the participants feel that the public health pedagogies distributed by governmental intellectuals are hypocritical, but these entities are benefiting from the taxes they receive and, in fact, they are not actually interested in reducing the prevalence of smoking.

Suspecting corruption. Related to the idea of not wanting to help others, is a concept focused on how the participants felt that a sub-set of people are controlling outcomes in society through actions that participants perceived to be corruption or collusion. As Vince suggested, the only reason tobacco companies have not been shut down is because, “they have to be bribing somebody somewhere. Somebody’s getting a portion of their money.” Similarly, Zach,
dramatically described political back scratching that he believes is happening between politicians and tobacco companies:

Just like when people make money they hate to be regulated. They hate to be told what to do... So these are the people that want the government out [of] their life. Joe Cool [referring to Joe Camel and the tobacco companies] is still out there too. Joe Cool put money into your campaign because you’re Joe Cool’s buddy. Joe Cool will tell you, ‘Listen, I want cigarettes deregulated. That’s why I’m going to put thousands to your campaign. You’re going to get elected, and you are going to vote to not regulate cigarettes.’ And that’s what’s about to happen right now... the federal government is gonna lose this battle.

Zach described a relationship between tobacco companies and politicians that is reciprocal, but others also suggested that the government is making money off of cigarette taxes as a business proposition. As Malcolm said:

They act like they’re raising the prices to keep people from smoking, but at the end of the day, do they really want to lose that? ...It’s like a major company losing one of their biggest customers. Do they really want to lose the tobacco industry? I don’t think so.

Though these comments highlight the hypocrisy that participants identified, there is an underlying element of purposeful collusion and corruption and this perception contributes to how participants understand and react to public health pedagogies.

**Chapter 4 Summary**

In this chapter I highlighted the results of the thematic analysis which took into consideration all the participant interviews and identified themes that emerged from the data across participants. The major themes that emerged were an overall acceptance and understanding of a variety of public pedagogies that have occurred over the course of these smokers’ lives. They generally understood the purpose and meaning of these pedagogies including anti-tobacco media campaigns, cigarette taxes, age of sale laws and clean indoor air laws. Though accepting of the messages they received, they also discussed several strategies
they employed to cope with the dissonance they experienced between the messages they received and their behavior. Though there were examples of outright rebellion against specific public pedagogies such as smoking in places where it is restricted, these occurrences were infrequent. Finally participants expressed important ways in which they lacked trust in the intellectuals who developed or sustained public health pedagogies, particularly related to government, those in the healthcare field, and corporate entities.

Though the thematic analysis brings together all the participant interviews, the context in which each participant interpreted various public health pedagogies, why they believed what they did and how this information influenced their behavior was highly individualized. As a secondary analysis, Chapter 5 presents the participant’s re-storied narratives.
CHAPTER 5

Although the thematic analysis is a useful way to identify commonalities among all the study participants, each participant also has individual life experiences that uniquely contribute to their understanding of the public health pedagogies they identified. In addition, the participants are not unidimensional and when the context of the narrative is added to the excerpts in the thematic analysis it becomes clear that, occasionally, an individual will hold conflicting beliefs and express them without acknowledging the conflict. For instance, those who expressed comments that were “doubting” of public pedagogies, could also, in the same series of comments, say something that was accepting of a particular public health pedagogy. Or, someone who was accepting of a public health pedagogy could also express distrust of public health intellectuals. Thus, the narratives offer additional context and nuance to the thematic analysis and provide another way to understand how smokers understand public health pedagogies.

The interviews presented here are written in the words of the participants and they have been re-storied by me. The process of re-storying that I used was to identify a series of comments that were focused on a similar topic (e.g., addiction), and then group them together to form the narrative. I have added very little to the original interview text which means that the speech, grammar, and vocabulary are choices made by the participants as they were speaking to me.

Occasionally, participants would provide insight into multiple public health pedagogies during the interview and caused the narratives to be choppy and disjointed. Therefore, as the narrative editor, I attempted to focus the narrative on just a few specific topics so that the story would flow more cohesively. This means that some stories shared with me during the interviews
were omitted from the participant’s final narrative. After the narratives were written, they were sent back to the participant for their review. All the narratives presented in this chapter were reviewed by the participants and I made any edits that they requested.

Although I interviewed 15 participants for this study, some had more insight and shared more detail about their lives, what smoking meant to them, and their health. In this way, some of the narratives were richer and offered greater insight into the participant’s thoughts, beliefs, and behaviors. For this chapter, I have chosen to present 10 narratives that offer the most insight into the individual’s beliefs and behavior.

It was my initial intention to present only the narratives that most closely matched each of the themes presented in Chapter 4. However, as I discovered during the interviews, and again during the re-storying process, the participants are not unidimensional. Though their stories tended to lean toward one theme or another (e.g., Rita tends to be mostly “distrusting” and Rose is highly “accepting”), the stories, by no means, represent only one theme. Nonetheless, I have attempted to order the narratives in this chapter broadly following the themes presented in Chapter 4 which include “Being aware of public pedagogies”, “Disregarding public pedagogies”, “Learning to avoid the pedagogies and their messages” and “Distrusting of public intellectuals”.

Each narrative begins with an introduction to the participant (e.g., Introduction to Rose, Introduction to Melody, etc.) written by me. These introductions are primarily based on the quantitative questionnaire data completed by the participants prior to their interviews. It includes the participant’s demographics, a short family history, tobacco use information, and a brief summary of information the participant provided on the risks of smoking, their general health, and their mental health. The participant’s narrative follows this introduction and at the end, I also provide a summary of the themes I identified in the narrative.
**Introduction to Rose**

Rose is a 31 year old mixed race (white, Hispanic, Native American) female who has completed some college. She is not employed and currently lives at < 185% of the federal poverty level in an apartment in the town where she grew up. She considers herself to be bisexual and lives with her female partner, Melody, who was also interviewed for this study.

Growing up, Rose lived with her mother in her “uncle’s trailer”. They moved in after her uncle passed away and for most of her time there (~8 years) they did not have running water. Rose would also visit her father who “drank a lot and was into drugs and stuff”. During the course of our interview, Rose revealed that her father sexually abused her and she has been diagnosed with Post Traumatic Stress Disorder (PTSD) due to this past history. She says she “acted out a lot” as a child and her mother “never understood why” she needed therapy and medication. She stopped visiting her father prior to starting high school. Her mother still doesn’t believe that she was abused at the hands of her father. Rose doesn’t try to convince her mother of this anymore because “it’s more trouble than it’s worth” and she feels that her mother “has been through a lot” too.

Rose currently smokes 18 cigarettes per day and smokes within 5 minutes of waking up. Her longest quit attempt was 6 years ago when she quit cold turkey for 15 days. She has never used an FDA approved medication to quit smoking. Overall, she has a very negative opinion of using tobacco, she believes that cigarettes are very harmful to health and thinks about the harms that smoking may be doing to her health very often. Rose reports that her health is good. She reports being diagnosed with anxiety disorders including PTSD and agoraphobia (fear public places, crowds, or being outside her home).
At the end of the interviews, all the participants were given the opportunity to chose their pseudonym. She chose the name Rose Tyler because she is a Dr. Who fan and this is a character that she admires from the show.

Rose’s Story: Tobacco is a Dirty Weed

It’s such a strange thing to absolutely hate something that makes you feel better. It just becomes something that you have to live with… I have to go out for a cigarette, I have to do this, I have to do that, and you just work your life around it. And you don’t even know why. You don’t really notice the changes in yourself unless you’re not smoking. It’s just something you do on autopilot pretty much. I’ve never been able to describe it myself but, there’s a poem about tobacco and it describes it perfectly.

Tobacco is a dirty weed,
I like it.
It satisfies no normal need,
I like it.
It makes you thin, it makes you lean,
It takes the hair right off your bean,
It’s the worst darn stuff I’ve ever seen.
I like it.
- by Graham Lee Hemminger

I started smoking after my mom and dad split up. My mom and I were living in my uncle’s trailer because he died. I think I was like eight years old. For most of the time we were there, we didn’t have running water because my mom couldn’t pay the bill and we didn’t have a lot of food so we would go to my grandma’s a lot to eat.

I don’t remember why I started smoking. I think I just wanted to know what it was like because my mom was a smoker and my dad was a smoker and my grandma used to be a smoker when I was younger. So I took the little cigarette butts out of the ashtrays and went outside and
lit them and pretended to smoke. I think it was just something that my friends and I just did to feel older or to feel like we had more in common with our parents or something.

At first we didn’t inhale at all because we didn’t know how to smoke. We didn’t really pay attention to that you know? So for the first two or three years, we didn’t really inhale. We could just have a cigarette then not have any for months and it wasn’t something we thought about. It changed when I was 11. We started inhaling and it didn’t make us cough anymore. Then the more we did that, the more we smoked and it just kept getting worse and worse to the point where we couldn’t go without ‘em.

So I think by the time I was 12, I was already… You know if I could get my hands on them I would smoke a pack a day. I used to buy cigarettes for my mom at the local corner store in town because sometimes she didn’t want to go down the street to get them. It was a family run store and the owners were old friends. At some point, the owner of the store told me that the age to buy cigarettes was going to be 18 and for me to make sure my mom knows that (1992, Synar Amendment). But then even after that she still let me buy them because she automatically thought that they were for my mom.

After I was in eighth grade (2000-2001), the store owners wouldn’t sell them to me anymore because they had seen me around smoking and they knew they weren’t just for my mom. So around I think eighth grade I had to start getting people to get them for me, or I would steal them from my mom or my dad. My dad kept packs of them in the freezer and he would never notice if they were missing because he drank a lot and was into drugs and stuff.

My friends and I would also steal them from this gas station in the next town over. This was before they put everything behind glass and locked it. There was this big cardboard box in the middle of the room that was filled with packs that were discounted cigarettes that nobody
really liked so we could just walk past it. I’m not proud of that but when you’re like 13, you don’t think there’s anything wrong with it. “Hey! Can’t I have this for free? I shouldn’t have to…” You know. So… But, I would say most of mine were just given to me from my older friends and stuff.

My mom never told me she was upset or disappointed that I smoked. She was just like you know I really wish you wouldn’t do that. She felt like she couldn’t tell me not to because she was a smoker it would make her a hypocrite to tell me not to. She just didn’t want to see me doing it. She never actually gave them to me until after I was already smoking every day. Then, one time when I was 13 or 14, my mom was taking me to my dad’s and I asked if I could smoke a cigarette. My dad lived an hour and a half away and she was like, “All right fine! I don’t care”. And then after that she just started buying them for me because it was easier and at least then she knew I wasn’t going to older people and asking them to buy them for me.

One day, we stopped at the store to get cigarettes and then my mom dropped me off at school after. I was tardy so I had to go to the office to get a pass and they smelled smoke on me and searched me and found them. We didn’t have time to stop at home and drop them off and that’s when they told me… “if you’re going to be late already, go home and don’t bring them into school”. You know they didn’t really try to stop me or lecture me, they just said to leave them at home and I won’t get in trouble.

There were a lot of posters and things at school where they would talk about not smoking and not doing drugs. Sometimes there would be ads playing during this news program that they played in school every morning--Channel One. They would talk about how cigarettes cause cancer and you know they kill all the little air sacs in your lungs. But, you know? When you’re smoking and you’re seeing those things, you know that it’s bad, but you don’t really care. You’re
like, “Okay I know it’s bad for me but I’m going to do what I’m going to do because I’m young and I don’t care.” Then you get older and you’re like I really wish I didn’t have to do this anymore but it just feels like you have to. With the smoking ads the most shocking ones were where they showed the people with the actual ailments from smoking. You know if you just show me a picture of a gross lung it’s not going to be relatable because it’s just a body part. I don’t care. Or if you show me statistics, it might not sink in. But if you show me somebody that’s struggling every single day? That’ll affect me a little more than anything else.

One time, I was at my grandma’s house watching TV and I saw that ad with the woman who had the wig and she was getting dressed for the day (2012, Tips from Former Smokers, Terrie). It made me cry. At first I think it was because of her voice, it just scared me. You know? My mom had a friend that she worked with at the state building downtown and he had one of the hands-free device things. I met him a few times and he sounded just like that. I think it was from chewing tobacco and he got cancer in his mouth and then in his throat. So ads like that are probably the most realistic ads you could show when there is someone that’s living with real problems because they were smokers or use tobacco in some way.

I know people, or have known people, that have had issues like that, and I know more what it’s like to live that way. I don’t want to live that way. The thing is, you know the people making those ads are right, but you feel like you can’t do anything about it. Because it feels like it’s a lot harder to quit than it is to just live with being unhealthy. Because you’re so used to it. And it’s a habit you know it’s not just addictive. It’s a habit.

I’ve seen other ads to like the one with the girl peeling her skin off (2014, FDA The Real Cost, Your Skin) and the one with where the skin peels off the hand and there’s liver spots or something under there (unknown campaign). But I think the problem with ads like that is that
people already know. And it’s an addiction, so they don’t care. A heroin addict knows that heroin is bad for them, but they no longer care. So you can show them all the videos and anti-drug stuff you want to, but ultimately if the addiction doesn’t go away, then they’re never going to care. They agree with you, but there like “Okay, but what do I do?” You know? “That’s nice, but how do I stop this?” And I think that’s the problem. People know it’s just… it’s not that they don’t care… They can’t care, I guess would be more appropriate, because they do care, they just can’t stop. I do appreciate the ads for younger people who might not know those things. They are important for those people, but for the people who do know, for the smokers, it’s like, yeah, we know that.

I think it’s a good idea that you can’t smoke in public. Just recently Melody, the woman I live with, she and I went to a birthday party in our local park and when we got there my niece’s mom said that we couldn’t smoke (2016, National Park Service smoking ban) and I was like, “What do you mean?” Because normally that’s just for the indoor buildings and we were outside. So I said, “What’s going on?” And she was like, “There’s this new law, you can’t smoke in parks or anything anymore” and she told us that there was actually workers there and if they saw you with a cigarette they would kick you out. And I was like, “Well, that’s good, because kids play here and you don’t want them to be exposed to it any more than they already are if their parents are smokers”. So I think it’s a good idea.

For Melody and me though, every time we wanted a cigarette (which we only smoked like two or three while we were there because it’s just more hassle than it’s worth), we would go into the car and smoke in the car in the parking lot. The parking lot was detached from the park so, and they didn’t care that we did that. I was surprised, because I never heard that you couldn’t smoke in parks because it was outside. Everyone assumed it was safer because you’re outside
and there’s no walls to close the smoke in. But actually I think it’s a good idea just to ban public smoking in general. Which I guess would mean your car…

See that’s where gets the gray area again because… If they tried to get you to quit smoking in your car I’d be upset, very mad. Because that’s private property in my opinion so I think that would bother me. Or if they tried to do that in the home. I understand if you could possibly get in trouble for smoking in a house with kids, but at the same time, that’s your house, your private space, so it would bother me if they went that far. Maybe in your car if they forced people to keep the windows up, maybe they won’t want to smoke in their car anymore because they won’t be able to breathe! When we went to our car, we kept the windows up just to make sure because we didn’t want the smoke to get out there and bother anybody. We just turned the air on to rotate the air through the car. It helped a little bit but it wasn’t really worth it.

In fact, nothing about smoking is fun and it’s expensive. When the last tax increase happened (Pennsylvania state tax increase was August, 2016), Melody and I stopped getting store bought cigarettes and we started rolling them ourselves all the time. It’ll be about $60 for a carton of store-bought cigarettes and then if we roll our own, 4 cartons is only about $24. So it’s a lot cheaper. When we got store-bought cigarettes, Melody would buy a pack for work because it takes a long time to roll them but when she would be at home, she would leave her store bought ones in the car. Then, when the price went up we were like, okay, yeah, we can’t do that anymore. We do still buy a pack here and there like if were going out of town or something but otherwise we just roll our own because it’s cheaper. And it’s actually a lot healthier because it’s unprocessed. Since it’s just loose tobacco, there aren’t nearly as many chemicals or anything. It’s still bad for you but there aren’t 14,000 chemicals in the home-rolled ones because it’s just loose unprocessed tobacco and they don’t need any of the preservatives or anything like that.
I think about quitting smoking all the time. I only tried to quit one time five or six years ago. I was just, I was tired of it and I quit cold turkey. I didn’t have any medication or anything to help me and it lasted for two weeks. But you know, every time Melody would light a cigarette I would think, “Hey! Can you… Oh! I don’t smoke anymore.” And I just didn’t know what to do with myself. I just sat there like, “Oh, this is boring. I have nothing to do and I don’t know what to do with myself”. You know? But I went 14 days and I did pretty good. But then I think the stove caught fire and I was like you know what? And we had to use a fire extinguisher and there was that white foam everywhere and it was just really a stressful situation. And I haven’t tried to quit since then.

But I hate smoking, you know what? I get self-conscious coming into hospitals and stuff where there’s no other smells except for clean. It’s like, I’m walking through and I feel like I smell like an ashtray that has perfume spilled on it. I’m a smoker so I don’t think I smell that way and Tina doesn’t smell that way but then when you go somewhere where there’s no smoking or anything, it might be strong to others. But we still can’t smell it on ourselves.

But, I know I smell like smoke and it does make me very self-conscious and it makes me not want to go to places like hospitals. That’s mainly because it’s all doctors and nurses and then they’re going to smell smoke and know that I smoke and they’re going to judge me because I smoke. I’m like I know it’s unhealthy. I know it. I’m sorry. It’s also because I’m overweight and I smoke. I’ve always had issues with doctors when it comes to both of those things. Even though I’m healthy? They don’t like that I’m overweight and then I smoke. I know they’re thinking, “Oh, kill yourself faster. She’s overweight which is dangerous, and she’s a smoker which is dangerous. Yeah, she’s not going to live very long.”
Even so, as far as they all know I’m healthy. Every checkup I’ve ever had there’s nothing wrong. Even my blood pressure is perfect. Blood sugar, blood pressure, my lungs are fine. And I don’t understand why I’m healthy because I’m overweight and I smoke, but I’m healthy. I know I’m 31 so eventually I’m not going to be healthy anymore but… Maybe my body is just better at handling it so maybe the sooner I stop the healthier I’ll be later. But, how do I stop? Like I said it just goes in a circle. It does.

**Narrative Summary: Rose**

In Rose’s narrative, her comments are all made with an awareness of the many public health pedagogies she has been exposed to at school and in her everyday life and overall, she is Accepting of the messages. Rose is especially aware that she is addicted to nicotine and does not believe that she is able to quit, two things which I consider to be forms of Surrendering without Contest. Rose was also willing to Try Not to Cause Harm to both others and herself. For others, she and Melody rolled up the car windows when they smoked at their local park, a behavior that was also learned as a way to Avoid the smoking ban. For herself, she believes that smoking roll-your-own cigarettes is “healthier” for her than smoking manufactured cigarettes because the pipe tobacco contains fewer chemicals.

Although Rose was very accepting of public health pedagogies, she does exhibit some Disregarding and Avoiding behaviors. She Learned to Avoid the pedagogy of Taxation by rolling her own cigarettes and she shared two stories that revealed some Distrust of Public Intellectuals. In one instance, she said she would “be upset” if Anonymous Intellectuals (“they”) tried to Control her smoking by banning it in personal spaces such as her home. She also expressed the Hypocrisy she perceives when Individual Intellectuals (e.g. doctors and nurses) judge her when she is at a medical establishment. This distrust of medical professionals
was expressed by Rose, and other participants (Colorado, Malcolm), and ultimately causes them to be hesitant to seek medical care.

The next narrative I will present is that of Melody, Rose’s partner. Melody is accepting of public health pedagogies and surrenders to her inability to quit, but she also engages in more avoidance behaviors and is more distrusting of public health intellects than Rose.

**Introduction to Melody**

Melody is a 34 year old white female who has a high school diploma. She does not identify as heterosexual, lesbian or bisexual but rather she identifies “something else” and she currently lives with her female partner, Rose (above). She works full time as a pizza delivery driver and she lives at <185% of the federal poverty level. Though Melody does not receive any federal assistance, she does report visiting a food pantry in the past 5 years. Growing up, Melody reports having a fairly stable childhood and though her parents split up, she lived with her father and saw her mother regularly. She does report being bullied in school, however.

Melody smokes 30 cigarettes per day and she smokes within 3 minutes of waking up. Her last serious quit attempt was when she was 16 years ago and it lasted for 13 days. She has never used an FDA approved medication to quit smoking although she did try a patch which made her “red and itchy”. Though Melody provided me with information on her preferred brand of cigarettes, L&M, she only smokes these when she is working. When she is at home, she smokes machine rolled cigarettes (roll-your-own).

Melody’s overall opinion of using tobacco is negative, she believes that cigarettes are extremely harmful to health, and she often thinks about the harm that cigarettes might be doing to her health. She reports her general health to be fair and she has been diagnosed with depression or anxiety disorders in the past.
Melody’s Story: A Little Aggressive

My mom’s been a smoker my whole life and growing up, I used to try to get her to quit smoking all the time. My parents divorced when I was six (1988). I remember that because my seventh birthday was in the new trailer where I lived with my dad and sister. It wasn’t long after that that my sister started smoking... she was 13 or 14. I was always adamant when I was younger about not smoking and I didn’t want to be like my sister who always got into trouble.

When I was real little, I used to sit right next to my mom and when I was walking around with her I’d try to hold her hand. Her cigarette was always in her right hand and sometimes I would end up burning my hand, or my arm, because I was walking so close to her that her cigarette would burn me by accident. Once I heard about the second-hand smoke thing (1986-1992), I would get on her case about it and say, “You know mom, that’s not just bad for you anymore, that’s bad for me too”. I actually started sitting further away at the table or going to a different room to avoid it.

At some point, all of a sudden there were lots of commercials on TV for quitting smoking stuff, like nicotine patches (nicotine replacement became available over the counter in 1996). I actually thought it was kind of a good thing because making them available over the counter did give me more options when I was trying to talk my mom into quitting. I’m like, “Hey, you can do this now mom!” But, it was always “It’s hard”, “It’s expensive”, “I’m not ready”. She tried to quit once when she found out she had emphysema, but then when grandma wound up in the hospital she started smoking again. I know she even smoked when she was pregnant with me.

Most of my friends smoked long before I did because I didn’t start smoking until I was 17 (1999). Peer pressure. I think my first cigarette was down the street from the church where we used to go for Wednesday night youth group. They wouldn’t let us smoke on church property, so
the whole crew would go down a block, at the bottom of the hill, and they’d smoke down there. I would go with them because I didn’t want to sit in the parking lot by myself, and eventually I just ended up starting smoking with them. It was never really an issue for me to get cigarettes since I had friends who were 18, 19, in their mid-20s, and they would go buy the cigarettes whenever. They would also tell me where they could get cigarettes without being carded because back then it was a lot easier to get cigarettes.

I read once about a study that was done and how children that come from broken homes, or abusive families, are more likely to become smokers. For me, home wasn’t bad. I had my dad, I had my sister, and I saw my mom regularly even though my parents were divorced. There was no physical abuse, there was no violence… Dad was such a quiet person and he never yelled or screamed. Home was fine, but school was awful. Awful, awful! When I heard about that study, I thought “Well, my home life isn’t that bad… But my school life? Dreadful!” I had no friends, I was picked on, I had books knocked out of my hand, one girl shoved my head into a brick wall in the stairwell…. School was horrible! So, even though nicotine’s an upper, it initially can relax you a little and it has an anti-depressive quality to it. Most teens nowadays absolutely dread school to begin with, and cigarettes are just one more escape from having to deal with what they’re doing.

That’s why I completely understand seeing cigarette advertisements near schools. I deliver pizza now and I drive around usually in a 12 mile radius on a daily basis. I have noticed the stores getting closer to Harrisburg and right down between J.H. high school and the old B.M.D. school, their windows are all plastered with cigarette advertisements and they have the lowest prices. It’s the demographic there. They’re advertising to the people that they think are going to want it more and schools… let me tell you…!
Since we’re talking about school, I remember sitting in class and there were these posters on the walls. There was the one of the Smoke Out campaign (American Cancer Society, Great American Smoke Out) with the hand, and there were posters of pigs and ducks with cigarettes hanging out of their mouths and it said, “It looks just as stupid it when you do it” (American Cancer Society posters). There were also some where a teacher or student group had gone around and they had printed out bright neon papers with black ink and it had a list of all the things that are in cigarettes including like rat poison and all the negative stuff. They posted it all over the walls of the school and it was like, “Hey! This is what you’re doing [smokers]!”, “Hey! This is bad for you”. It was to get people’s attention, but it didn’t make any difference to me at the time because I was already smoking by that point and I was like, “Yeah, I know that this is bad for me. I’m choosing to do it….” It was really in-your-face.

One time, during the Great American Smoke Out, some of my older friends would gather in groups and smoke cigarettes. It was just to be belligerent, obnoxious, to prove that they can. It was also just to be annoying to all the non-smokers so the smokers could make a point like, “We’re going to smoke everything!” I thought it was funny because they were just doing it out of spite and I was like, yeah, yeah, you do whatever you want. See you. Bye. There wasn’t anything I could do about it. I wasn’t going to change their minds. That’s the thing when it comes to smokers, there’s not much that you can do to change their minds when it comes to smoking.

After they started banning the cartoons and stuff like that (Tobacco Master Settlement Agreement, 1998) there was this very aggressive start-up on anti-smoking stuff. Like Joe Camel and the Marlboro man… I remember seeing them everywhere when I was a kid. You know, Joe Camel playing cool with a cigarette. I heard about them getting rid of that on the news and in school and stuff and I was like, “Oh come on! He didn’t do anything to hurt anyone!” Okay
yeah, it’s a cartoon character, but at the same time it’s a cartoon character in a bar playing pool. It’s not something kids did. You know? So I thought it was a little aggressive to take away cartoon characters that were created by the tobacco company. Joe Camel was an adult figure, not something that kids were familiar with so I thought it was weird that they took him away. The Marlboro man especially because he wasn’t because he wasn’t really a cartoon.

Yeah, at that time, they really got aggressive with the anti-smoking commercials and stuff for truth ads. They were basically a more elaborate version of what’s already on your cigarette packs… that cigarettes are harmful to you, and not just you, they’re harmful to other people, harmful to animals, harmful to the environment because cigarette butts don’t biodegrade. It was that kind of stuff to make people more aware than just the general warnings that are on the packs themselves. And it’s not just the cancer? You think lung cancer, but it’s also mouth cancer, gum cancer, throat cancer, you know? And that little label on the cigarette pack doesn’t tell you all that.

I mean I’ve seen the warning labels on cigarettes my whole life, like ever since I can remember. And I read them almost every time I buy a pack of cigarettes. I actually sit and I read the warning labels on it and I’m like, “Huh!” So I read it and then I just smoke a cigarette. To me, it’s always been there so it doesn’t mean much. I know it’s bad for you, that it’s hazardous, that it has been linked to cancer, it can cause problems with pregnancies and fetuses, and emphysema. It doesn’t tell me anything I don’t already know and it just doesn’t really seem to affect my decision. It never did.

And now, the non-smokers who instigate the government to be like, “Hey!” (I mean a lot of former smokers tend to be the most aggressive.) I think they’re taking it a little far. They’ve quit so everyone else needs to quit too, “There’s no reason these smokers can’t do it!” And I
understand that smoking is a public health risk. The government needs to come in and say, this really is bad for people. We need to restrict some things. But at the same time, I’m a smoker so I’m like, “Hey!” That’s impeding on my wants. Not my needs. Not my rights. But I want to do this, and now I can’t.

You know, I worked at a restaurant when they banned smoking indoors and it was very difficult for us at the time because the company that I worked for decided to go non-smoking several months before smoking inside was illegal. It was like this weird, modern, we’re with the times, we know what’s going on kind of move. Downside was, all of our smoking customers went to other places and never came back. By the time the other places went non-smoking the smokers were already regulars at the new places and they were familiar with those places so they didn’t come back to us. They just stayed there. That’s the thing about smokers they find something they like and they stay unless something really makes them angry and then they find something else they like. But, most of our smoking customers…we lost them.

Even when we could still smoke inside restaurants, we had customers who would come in and they would want non-smoking. “As far away from the smoking as you can get us! We don’t like the smoke!” Okay, I understand that. We had these glass-walled barriers between the smoking section and the non-smoking section to keep most of the smoke in and I would literally seat people as far away from the tiny smoking section as you could be. So, I would put these folks right up near the front door just as far away as the smoking section is you can get and they would still complain about the cigarette smoke. I can’t get you any further unless you go outside!!! Like, I can’t! And they would still complain. Then when we got rid of the smoking section, all my friends stopped coming to the restaurant because they couldn’t smoke there. They went elsewhere because everyone else let them smoke and then when they got rid of smoking,
they were just like, “Eeh! I’m already here” and they never came back. Our business completely just dwindled until they shut the restaurant down entirely which sucks because I was there for five years and then they closed the restaurant down and I didn’t have a job! Bad for business, good for health.

There are some places that won’t even let you smoke outside on the sidewalk because of second-hand smoke to passers-by. I’m like, okay, I do understand that second-hand smoke is bad but at least you’re not in an enclosed area. People can walk around the smokers. There are options, you know? You’re getting a little aggressive with this! If I have to go outside at least let me stand on the sidewalk. Nowadays, I think it’s even illegal to smoke in your car if you have children in the car! It’s hard for me to keep track of it all. Of course, we don’t smoke in the car with my nephews or anything like that.

At this point, I’m just like, okay you know what? I tried to quit. I did it. I tried. It didn’t work. I quit once when I got my wisdom teeth taken out because that was just dreadful. And the nicotine patches make me all red and itchy I think I’m allergic to something and I ended up going back to cigarettes. Then, I got dry socket on both sides on the bottom and it was a Friday so I had to wait till Monday to see the dentist. So it was all weekend long, I’m in pain, and I was like, oh well it already hurts I’m just gonna keep smoking. The other time, I joined the Navy (2001) when I got out of high school and they kicked me out of boot camp about two weeks in. But for two weeks I didn’t smoke. And then when I got out of boot camp the first thing I did was take a taxi cab to the local gas station, bought a carton of cigarettes, split it with the one guy I was with and we hopped on the train home from Chicago. But yup, two weeks that’s about as long as it lasted.
But, trying to quit’s not easy and even if you do manage to, you’re always gonna want that cigarette. It’s hard to get rid of those cravings. It’s an addiction! Like one time, I met a man outside of the courthouse in Harrisburg that said he quit smoking 20 years ago and it was the worst decision he’s ever made because he’s miserable now. He’s just straight up miserable. Hates his life. He was an old man, probably around 70 or 80 years old and I just thought it was absolutely hilarious. And I’m like “Yeah, maybe one day all quit but I’m not there yet.” He just kept going and I finished my cigarette and went back inside the courthouse.

Here’s the thing, I’ve heard my whole life…I’ve heard people and commercials and everything telling me smoking is bad for you. Okay! Yes! Smoking is bad for you! I know this! You keep telling me this! I’m doing it anyway! Because these are my lungs, this is my life, and I’m going to do what I’m going to do. I think I should quit, but I’m not ready for that. I know I’m not. At this point I’m addicted and it’s really hard to quit once you’re addicted. So, for me it’s kind of annoying to keep seeing the anti-smoking stuff because I already know and my whole life I’ve been told this. I’m not ready to quit yet so stop telling me because it feels like you’re trying to force me. I’m just like, get out of my face already, you know!? I know I’m a minority when it comes to smoking. It’s just normal. If I wanted, I could quit smoking. I mean I’m not going to force other people to start smoking so that I’m less of a minority. That’s just rude. That’s not healthy. I could quit smoking and then I would be a non-smoker. And then I’d be one of them and I’d be included in something else but like I said, I have choices. I’ve made my choices. So that’s what it is.

**Narrative Summary: Melody**

Melody’s narrative contains many different thematic elements. In general, she is **Accepting** that smoking is bad for health and she does not deny this fact and she is able to list
many harms that smoking causes. In doing this, she recalls pedagogies to which she was exposed during school (e.g., truth initiative, American Cancer Society and other posters) and in her daily life (e.g., warning labels, Clean Indoor Air laws). She also Surrenders to public health pedagogies that she should quit and is willing to try not to cause harm to others by not smoking in her car with children present.

Simultaneously, Melody consistently Avoids some public health pedagogies and Doubts the Veracity of many. In particular, Melody avoids quitting pedagogies by saying that quitting is “hard” and she’s “not ready”. She supports these beliefs with a number of doubts about whether particular pedagogies were really necessary such as banning cartoon advertising (Joe Camel), or suggesting that Clean Indoor Air Laws were “bad for business”.

Finally, Melody offered several examples of where she Rebels Against the Expectations and is Distrusting of Public Intellects. For instance, she exhibits rebellion when she talks about reading pack warning labels and then proceeding to smoke, when she participated in a protest of Great American Smoke Out by smoking with her friends, and by saying that she is not ready to quit in spite of pedagogies that encourage quitting. For Melody, her distrust of public intellects comes in the form feeling that “they” (anonymous intellect or the government) are trying to Control her or “force” her to behave in ways that goes against her “wants” by using “aggressive” public health pedagogies.

In the next narrative, I introduce Courtney who is also very accepting of th

**Introduction to Courtney**

Courtney is a 29 year old mixed race, Hispanic female with a high school diploma. She currently lives in a drug recovery group home and works part time as a waitress. She has never been married and has a 6 year old son who is cared for primarily by her grandmother at this time.
Her son’s father is also in recovery for heroin abuse and he lives about 2 hours away in Pennsylvania. She currently lives at <100% of the federal poverty level, receives Supplemental Nutrition Assistance (SNAP), and her son participates in the USDA’s free school breakfast/lunch program.

Growing up, Courtney lived with her mother and her step-father and her step-father was a crack addict. She had a very close relationship with her maternal aunt and she says she “went off the deep end” with drugs at the age of 17 due to the death of her aunt and uncle who both died of cancer within 5 days of each other. During our interview, Courtney emotionlessly recounted stories about the deaths of many of her friends and family members. These are included in her story below. Most of the people in Courtney’s immediate family and social circle smoke with the exception of her mother (who was treated for thyroid cancer) and grandfather (who died of pancreatic cancer).

Courtney currently smokes 10 cigarettes per day, she smokes within 60 minutes of waking up, and approximately 3 times per week she wakes up at night to have a cigarette. She also reported using an electronic cigarette 2 times in the past 7 days. Her last quit attempt was 1 year ago and it lasted for 2 months. During our interview, Courtney repeatedly discussed how cigarette smoking and drug use are related and that she “smoked so much” when she was using drugs because the drugs “just make you want to smoke more”.

Overall, Courtney has a negative opinion of using tobacco, she believes cigarettes are very harmful to health, and she sometimes thinks about the harm cigarettes might be doing to her health. She believes that, in general her health is good. In the past, she has been diagnosed with a mood or anxiety disorder, and during the interview she mentioned that she is not currently “not
allowed” take her Attention Deficit-Hyperactivity Disorder (ADHD) medication which makes it difficult for her to concentrate.

Courtney’s Story: High Risk

Before my boyfriend and me went to jail, I found out I was pregnant. I had just relapsed on heroin so I’m grateful they put me there because I couldn’t save myself. In February of 2010, somebody that I took to get heroin had an undercover with them, so they set me up and I was arrested for possession with intent to deliver, unauthorized use of a communication device, and possession of paraphernalia. Once I got to jail, they left me detox for five days and then came to my cell and told me that I had to be compliant with the methadone program or I’d be put in the hole. That was my first time in jail and my first kid. I was nowhere ready for a child and I was freaking out because I know what it’s like for people to have their babies on methadone and I really didn’t want to do that to him. But detoxing is high risk and I would’ve miscarried if they had left me continue so I didn’t want to lose him either.

You’re not allowed to smoke in the County prison. I wanted to smoke, but obviously I couldn’t so that was three months without smoking. They would take me out every day to go to the methadone clinic. They didn’t shackle me or anything because they can’t when you’re pregnant but I wasn’t allowed to talk to anyone. The guard told me that if I tried to run he would shoot my kneecaps out, and I was like, “Do you think I’m going anywhere? It’s snowing, I’m in a highlighter green jumpsuit with Dauphin County prison on the back, and my shoes…I have no socks!” He ended up getting me socks because he’s like, “You can’t walk around like that!” I got really close to him and when I see him sometimes, he asks how I’m doing.

The day I got out, I was five months pregnant and I was on house arrest but as soon as I could, went right through the gate to Toys “R” Us and I asked somebody for a cigarette. They
looked at my stomach and looked at me and they were like, “All right, but this is on you”. I was like… “Okay… thanks.” I couldn’t smoke all the time because my mom was going to rip my head off so I tried not to. But I did here and there. After my son was born, he had to be at the hospital for a month longer than usual. It was stressful and as soon as I had him, I detoxed off the methadone and went back on Suboxone maintenance because I hated the methadone. I smoked a lot then because I was bored and I just… I couldn’t get high so I just smoked cigarettes. ALL… THE… TIME.

I grew up a lot around a lot of people that smoked and I started smoking when I was in sixth grade, maybe 13 or 14. My aunt used to smoke like half of a Virginia Slim and then put it out, so I would take the butts and go hide somewhere and smoke them. At first I wouldn’t smoke every day. I liked it but I would smoke just sometimes when I would get really irritated or something, or bored, whatever. If I didn’t find my aunt’s butts, I would get my stepdad’s Marlboro Reds and I’d smoke them right out my bedroom window even though I had no lock on my door and they could just walk in at any time. Or I’d go down in the basement and smoke them because if I went outside someone would see me. It was pretty stupid because I could’ve got caught easily but I guess I just didn’t really care.

I would always get my cigarettes from other people. By the time I was 17, I was smoking every day and I would drink a lot too. I had a friend, Angel, who was two years older than me and she had an older boyfriend who would buy cigarettes and beer for us. Angel turned 18 before I did so my senior year, she could just buy them all the time. It was easy. It makes me sad to talk about Angel because she died of an overdose not long ago. Anyway, I don’t think that kids under 18 should be able to buy cigarettes and that 18 is a good age to set that. But I do know a lot of kids like 16, 17 start smoking and want other people to buy them for them. And I’m
guilty of that myself. My brother is 18 now but when he was younger, his friends would ask me to buy them cans of chew. And I’d be like, “Are you freaking kidding me?” And they’d be like, “If you don’t do it somebody else is going to do it.” And I’d be like, “Don’t give me that shit because I don’t care.” It was annoying. Oh my God! I can only imagine how annoying I was to other people when I was that age.

My stepson is 13, I raised him since he was like three and now he lives with his grandparents because is mom died of an overdose in January. He recently started Snapchattering me videos of him smoking cigars, or Black and Mild’s? I forget what they’re called but they’re really cheap cigarettes that he stole from across the street at the convenience store. He ended up getting caught and they banned him for a week. But I was mad that he was smoking and I was like, “What are you doing?!” He’s not even inhaling in the video, so clearly he’s just doing it for attention. So I was like, “If you’re going to do it why don’t you do it right? It’s not cool to pretend that you’re smoking!” I said, “I can tell you from experience, it’s not fun!” And he was saying things about smoking weed and stuff too and I just went on a whole rant telling him he’s high risk for abuse, for addiction. “Your mom died of an overdose! I live in a recovery house! Your dad was on Suboxone maintenance for how long?! It’s not somewhere you want to be. Your cousin was in jail, you know so many people and yet you…!!!” His grandmother smokes in the house, I guess it’s only in her room but it still smells like shit in there.

I’ve been to rehab and detox at least 10 times altogether. Actually, it’s probably more than that now. In recovery and addiction, the majority of people smoke so it’s kind of hard when I go to a meeting and everybody else’s outside smoking and drinking coffee. That’s the two main things you have when you’re clean. When I was at rehab, I liked it when there were rules that
you can’t smoke because I don’t want to be defiant…. Like, “Screw you! I’m going to do it anyway.” Some people do that, but I don’t. I just follow the rules.

I had a job not long ago where you couldn’t smoke at all unless you are off the clock. That was good for me. Even at the amusement park there are designated smoking areas but they are so random and hidden that it’s hard to smoke. So I’m like, whatever, I’ll just wait till we leave, or if I come across one, I’ll go smoke but I don’t go looking for them. I don’t really care because it’s saving me. This one partial program I was in, it was only six cigarette breaks. They would hand you the pack and you would pull one cigarette out or they’ll pull one for you so I could only smoke six cigarettes a day. But I’ve been at rehabs where there were 13 smoke breaks a day. Then there was this other one where they had one of those vending machines, but the cigarettes in the machine were like a dollar more than what they were in the actual store. So it was either buy them out of the machine or wait till they did the store run. That was really shitty.

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*I do feel like I’m high risk for cancer. The labels on cigarette packs, that’s pretty much to cover the tobacco companies’ ass because, yeah, it can cause cancer. I mean, smoke at your own risk is basically what it’s saying. You know what can happen, COPD, lung disease, heart disease, cancer… you know the cause. Half the people I know that had cancer smoked and there’s a lot of people I know with lung cancer and other cancers that are caused from smoking. That doesn’t mean their cancer came from cigarettes, but I’m sure that didn’t help it. Here is a list of them:

- My aunt and uncle smoked and when I was 17, they both passed away 5 days apart. My aunt had leukemia and my uncle had lung cancer. My aunt was like a mom to me and*
once that happened, I just went off the deep end... drinking, doing coke, and smoking so much.

- My stepbrother’s grandma smoked and she died from cancer. Her whole apartment reeked and it was disgusting. I remember her sitting on the couch with no hair and she was so skinny. She looked terrible, hooked up to the IV.... And she was still smoking. I was like, “Geez, is it that intense?!”

- My son’s grandma, Kelly, she has cancer in three different spots and she was just admitted to the hospital a couple days ago. She has cancer in her rectum, her liver and she has a blood clot in her lung.

- My stepfather was a drug addict and an alcoholic. He smoked a lot of crack, drank a lot, and smoked a lot of cigarettes. He had stents in his heart but then ended up having a stroke in our pool and then in January 2010. They removed the top right side of his skull and he got an infection and it killed him.

- Then two months after that my grandpa died from pancreatic cancer. He didn’t smoke though.

- My mom didn’t smoke but she was diagnosed in 2016 with thyroid cancer. They took her thyroid out and then they told her about a month ago that she is high risk for intestinal cancer.

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I’ve seen those ads with the woman who has the hole in her throat (2012, CDC’s Tips from Former Smokers, Terrie). She kinda reminds me of my aunt who died of leukemia. She didn’t have the hole in her throat, but she was bald. I can remember one time when she was in the hospital, I took her from the sixth floor outside to smoke. I guess because she was suffering
anyways, I felt like I would do this for her. She was hooked up to an IV and she had a pull that
with her to go outside. She was so out of breath by the time we even got down there because the
treatment wasn’t helping, it was killing her, and I felt bad about that because she had cancer and
I didn’t want her smoke. I was just like… this is too much you just can’t do it. Then after that
she just stopped smoking.

Sometimes you know smoking makes my heart rate increase and if I’m smoking a lot it’s
really bad. The shortness of breath is terrible, your heart’s pounding and you’re like sweating
and it’s just terrible. There was this ad I saw a lot when I was younger, it was like a bunch of
people just laying everywhere in the streets and it would be like this many out of this many die
every year and so many men and so many women (2003, truth initiative, “Tobacco Kills”). And
I’d be like, “Holy shit! That’s a lot of freaking people! Smoking is not good for you!” But some
of them would go in one ear and out the other because I knew… oh my God, they’re over
exaggerating that. And they were so repetitive. They were always on every other commercial,
and then I’d be like, “Oh my God this is so annoying!” But, I guess it does scare me. I was
thinking about it on the way here since I feel like it’s inevitable that I’m going to get cancer and
die. That’s very scary to think about because I don’t want to go through that, but when I’m

I do think it’s true what they say about smoking. It’s not that I’m invincible because it’s
the same thing with drugs and the cigarettes. I’m like, “Oh yeah, everybody else is dying but it’s
okay. I don’t think I’ll die because I know what I’m doing.” But ultimately, that can be me and I
could be the one with the hole in my throat. That scares me because I’m 29 now and I don’t
really wanted die when I’m 39. I deal with it though. I just push it to the back of my head and
try not to think about it. But it’s a real thing.
Narrative Summary: Courtney

The majority of Courtney’s narrative is focused on her Awareness of the harms of smoking and she very clearly Accepts that smoking is bad for health. She also Surrenders to public health pedagogies, such as clean indoor air law restrictions when she discusses not smoking in restricted areas, and she Tries Not to Cause Harm by encouraging her stepson not to smoke. In the narrative above, Courtney is able to relate this knowledge of harm back to mass media campaigns that she has seen (truth initiative and Tips from Former Smokers campaign) and personal experiences that she had with people who died prematurely from smoking-related diseases. Courtney is somewhat Rebellious because she smoked during her pregnancy, but she minimizes this rebellion because it was done while she was also trying to remain abstinent from heroin use. Also, although Courtney Avoids public health pedagogies by blocking them out, this is clearly done with full knowledge that the harms to her health from smoking are “a real thing”.

Finally, Courtney is a very good example of Surrendering and feeling hopeless in the context of the overarching public health pedagogy about the importance of quitting. She readily agrees with pedagogical messages that suggest quitting is beneficial to health. In addition, in her life experience, many smokers and non-smokers have died prematurely from smoking, drug abuse, or other unknown causes. The quantity and randomness of the deaths of people close to her has also contributed to some Doubt about the Veracity of public health pedagogies. The perceived randomness of the deaths in particular leaves Courtney feeling ambivalent about quitting smoking and unsure about whether quitting will actually have any long term benefit for her.

Up to this point, the participants in the narratives I have presented primarily share stories about their own personal smoking experiences. They do acknowledge that they are addicted to
cigarettes in some capacity, but they generally do not consider societal influences that may contribute to the perpetuation of smoking and nicotine addiction. Vince is the first participant presented here who demonstrates a Distrust of Public Intellectuals even though he fully accepts messages about the harms of cigarettes created by public intellectuals.

**Introduction to Vince**

Vince is a 29 year old white male who has a GED and has completed some college. He is currently works part time at a dollar store and is enrolled in an online university studying homeland security, emergency management and counterterrorism. At work, he regularly gets scheduled for fewer than 36 hours so he is not eligible for insurance and if he needs to go to the doctor he pays out-of-pocket or goes to an emergency department. He reports living in a rural area with a roommate and his income is <185% of the federal poverty level.

Growing up, Vince describes being rebellious with his parents and at school. He would not complete homework assignments and frequently left school during the day. The story of how he started smoking is detailed below. He attempted to join the Navy after finishing his GED, but was honorably discharged during basic training due to a medical issue. More recently, Vince sadly reported that his mother took her own life in 2015.

Vince smokes around 30 cigarettes per day and smokes within 1 minute of waking up. His longest quit attempt was 7 years ago and it lasted 2 months and he has used nicotine gum in the past. Vince’s overall opinion of using tobacco is very negative, he believes that cigarettes are extremely harmful to health and he states that he thinks about the harm that cigarettes might be doing to his health very often. He feels that his health in general is fair and he reports that he has had 2 weeks or more in his lifetime that he has felt down or depressed. He has never been
diagnosed with depression or anxiety disorders, but in the past year he has felt that he may have one of these.

**Vince’s Story: Cigarettes Make One Feel Trapped**

It was all my fault that I started smoking. I can’t really blame it on anyone else. When I was 16, my mom and dad had gotten divorced, we didn’t really see my dad that much, and I was having trouble in school just because I was a bad student. So, I used smoking as a coping mechanism...an unhealthy coping mechanism for the most part.

How did I start smoking? There were these two adults who lived 4 houses down from us that used to give my friends and me cigarettes all the time. It really is weird that they did that, but there were always large groups of people at their house and most of them were kids. They didn’t have kids in our school or anything, but all my friends would go and hang out at their house. One time while I was there, I smoked an entire pack of Newports in like an hour and a half and it made me throw up.

My parents disapproved that I was going over to this house, but I wasn’t really wanting to listen to them all the time. They wanted to go over there, but I wouldn’t tell them where the people lived exactly. They even tried to ground me but it didn’t work because I just left the house anyways. Of course, I thought these people and their house was awesome at the time, but you know how stupid kids are. Now, I think those people were jerks that they allowed any of that to happen. There was underage drinking, there was underage smoking, and it was just not a good environment for a teenager.

I always expected that I was going to be in the military for the rest of my life and they were going to force me to quit or I would die in the military. So, I thought it wouldn’t matter if I smoked. I actually quit for a month or two because of basic training since I wasn’t allowed to
have any cigarettes. But I was only there for a very brief time and they said I had problems with my back that weren’t correctable to meet Navy standards so they gave me a general discharge under honorable conditions.

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I despise the tobacco industry as much as I dislike the oil industry because they’re making profits on people suffering. They don’t care about the impact on the environment that cigarette butts have and they don’t care about the health of anyone that smokes. They just care about themselves and they’re holding economy above all other interests including the sanctity of life in general. It’s a little disconcerting to me.

I’m not personally interested in money so it bothers me a little bit that I’m giving my money to tobacco companies but it doesn’t really bother me too much. I try not to think about that aspect really because I’m not a business minded person and I disagree with most business minded people. But, I mean, I’m addicted at this point and it’s not really something I can control. It doesn’t matter how much I dislike it, it’s still gonna happen, which is unfortunate. I hope someday they tax cigarettes so much that I can’t afford them anymore.

The other people I know who smoke, they’re not as angry at the tobacco companies as I am. It’s about how I started and that cigarettes are even a product that people can buy. I got addicted to cigarettes so fast! I always figured that I could just put him down and stop, but one day I couldn’t. They should be off the market... something that can addict you and something that’s compared to heroin and cocaine? It’s insane and it’s even legal! I can’t figure out how they can be out there being sold other than they’re holding monetary interest above science... people... life. And I’m not even too sure who these people are. I could blame the CEOs of the tobacco companies for sure, but I don’t know who’s supporting their interests. They have to be
bribing somebody somewhere. Somebody’s getting a portion of their money otherwise they would’ve been shut down.

I have had friends that have been addicted to drugs. A couple, actually, and that’s terrifying. They were stealing from their mom and their friends and ended up in jail. It was awful to watch them go down that road. And, you try to help them and there’s nothing that they’ll do to quit. Cigarettes are like that in a way but I’ve never stolen from anybody for cigarettes. I’ve certainly sucked up my pride and asked random strangers on the street for a cigarette when I didn’t have any. That’s something I wouldn’t typically do and it’s a little embarrassing.

In middle school, we had to watch these videos that came on with the morning announcements. I don’t remember anything specifically but it was like 30 minutes of television in the morning every morning and the truth ads were part of that. Those ads were information about tobacco companies and how they’re making money off the decline of your health and your being addicted. The ads that are out now, they’re scare tactics… some kind of psychological warfare. It’s a good psychological approach, but I don’t think it’s gonna stop the addiction. It might keep kids from smoking, but I saw that stuff when I was in school and I didn’t really care.

Now though, I understand what cigarettes are costing me health-wise… which is EVERYTHING. A couple of times I seen the ad where they’re pulling out their teeth and I seen the one where she’s ripping off her skin. Yeah those are pretty crazy and a little terrifying. Cigarettes are a financial burden, there a burden on my health, and they take away a little bit of the enjoyment from your life. I used to be able to smell a lot better too, like the crisp air in the morning and so on, and so forth. I can’t do that anymore.

It’s hard to be a smoker these days, but I think that’s good news. Second-hand smoke is bad for other people. It’s my fault that I even got addicted in the first place so why should I push
my horrible health choices on other people? It’s not fair. But, I didn’t really notice when they
banned smoking because every place that I used to go was primarily made up of liquor sales and
I could smoke there regardless.

But I’m glad they that they banned it in public places because second-hand smoke is so
harmful and it’s good that they banned it in parks too because of the beauty there. Cigarettes and
littering go hand in hand. I see people flicking cigarette butts out their window, I see people just
stubbing amount stepping on them and walking over them. You don’t want to go through a
national park and see a bunch of cigarette butts that a bird made a nest out of! They aren’t even
going to trashcan. So it’s because the littering but also because of fire safety… climate change,
and how easily things are getting set on fire. Some of it could be the second-hand smoke, but
people are not going to be right next to you if you’re smoking, so if it’s second hand smoke, it’s
a small portion.

If I were to quit, I would need outside help… Maybe Chantix and maybe some kind of
therapy because with the quit attempts I’ve made before, they have lasted less than a day and I
get pretty emotional. Quitting makes me angry and it makes me just unable to think clearly. If I
were to quit, would certainly need something to help hold the cravings because that’s what really
gets me. The only medication I’ve tried is nicotine gum and that really didn’t help much. I was
hoping for Chantix some point in time but I’ve never had the insurance to go up and ask for it. I
don’t know how expensive it is to get on my own and I think that it’s not really up to me to quit
anymore. I don’t want to say it’s beyond my control, but I don’t really have the willpower to just
up and throw them away and never smoke again. Cigarettes certainly make one feel trapped and
I really want to get away.

Narrative Summary: Vince
Vince’s narrative suggests that he is **Aware** and **Accepting** of the harms that cigarette smoking is doing to his health. Like Courtney, Vince **Surrenders** to the public health pedagogy messages of quitting smoking, but he feels that it is “beyond his control” to quit and he feels “trapped”. As such, he also surrenders to pedagogies such as clean indoor air and taxation with the hope that they will help him to quit or reduce his smoking.

However, Vince begins to touch on a theme that will become more prominent in the upcoming narratives which is that of **Distrust of Intellectuals** when he identifies **Hypocritical** messages from **Anonymous Intellectuals**. These hypocritical messages are that cigarettes are allowed to be sold even though they are harmful to health. Vince concludes that these intellectuals must be **Corrupt** and “bribing somebody” to allow cigarettes to continue to be sold.

A variation on the theme of distrust of public intellectuals continues in all the remaining participant narratives. For instance, in the next narrative, Tina begins to describe how hypocrisy and corruption among anonymous intellectuals develops into societal inequities for those who don’t have the “right kind of money”. Her narrative is also the first of several narratives that offer insight into the disregarding theme of playing the odds as she talks about life being a gamble.

**Introduction to Tina**

Tina is a 49 year old white female who completed school through 11th grade. Tina makes some income as a “scrapper” when she collects metal items and brings them to scrapyards for money. She has a truck and receives calls throughout the day with requests to pick up unwanted items. She lives alone and her current household income is < 100% of the federal poverty level. In the past 5 years she has received Supplemental Nutrition Assistance, Medicaid, and has been to food banks.
Tina’s parents divorced when she was 6 at which point she lived with her mother and spent weekends with her father. She started smoking around the age of 14. Her mother, who also smoked, allowed her to smoke in the basement of their home. Her mother re-married and Tina had a loving relationship with her step-father who was also a smoker. However, he quit smoking cold turkey at least 15 years before he died of a kind of cancer that Tina believes was not a “smoking cancer”.

Tina currently smokes 20 cigarettes per day and she smokes within 10 minutes of waking up. Her longest “quit attempt” was 3 years although this was initiated only because she was incarcerated on a drug charge. She has never used an FDA approved smoking cessation medication. Tina has neither a positive nor negative opinion of using tobacco, she believes that cigarettes are very harmful to health and she thinks about the harm that tobacco use might be causing her very often. She reports that her health in general is fair and she has been diagnosed with depression and anxiety disorders in the past.

**Tina’s Story: An Expensive Over-the-Counter Drug**

If you have the right kind of money for it, I think there is a cure for certain cancers and they can do it. You know what I mean? I hate cancer. Ever since I seen my step-dad die and I seen him go in and out of the hospital, I just have another look at it. When that happened, I said to my mom, “I bet there’s a cure for it” and she says, “You’re damn right there is. If you have the money, I bet you they’ll find that cancer and they’ll get it fast.” I believe that and that’s just not for cancer, it’s for everything really. If you’ve got the right kind of money, life is a lot better.

I’m really going to cry because my step-dad shouldn’t of died. It pisses me off, but you know it’s life. I told my mom that she’s gotta get over it, but you can’t really get over it! You can’t be mad about it. It happened. Cancer sucks. I want a pink T-shirt that says, “Hey! Hey you
cancer… [giving the finger]!” Yeah. That’s what I think of you, cancer. I just got a great idea how to make some money. I’ll make a shirt like that. I’ll betcha a lot of people would buy that!

Cancer is cancer and it’s in everybody. It’s just a matter of that wakes up and it wants to be aggressive on you and it doesn’t matter if you’re smoking a cigarette, you’re still going to get it. You don’t have to smoke and you can get cancer. Like my girlfriend right now, she’s dying of cancer, never smoked a cigarette in her life. I don’t know what kind of cancer she has, she just put it up on Facebook that she has 12 months to live. I don’t know what kind of cancer. See? Never smoked.

You can smoke and get cancer too. My grandfather he died of leukemia. That son of a bitch, he smoked up to the day he died… Lucky cigarettes, white, no filters. When he was smoking, I said, “Poppa your dying!” This is him, “I don’t give a shit! I’m gonna die anyway! I got leukemia cancer. Fuck it! Gimme a cigarette!” He’s dying and smoking. But then again, if you want to do what you want to do because you’re dying? Do it! That’s the way I look at it. I believe cigarettes is a gateway to a lot of things, but cancer is just random. It’s just in your body. You know what I mean?

I’m scared of cancer and I hate it but I don’t hate cigarettes. You got understand, I did drugs and if I can’t have my drugs, then cigarettes is my drug and I’m legal. I had a husband and he got me wound up hooked on cocaine. I’ve seen some things and I’ve done some things that I’d never even imagine. I’m not no angel and I ended up in jail because I was addicted. I wanted to get high, so I sold drugs to someone and the person beside them was a cop. I got high with that person so many times, I would’ve never thought… because they got in trouble and I never knew it. But I was only selling them drugs because I wanted to get high. I wanted the money, plus I was taking my share. So yeah, it is an addiction. It’s just something in your brain.
But, I don’t do it anymore though because I can’t. If I do, I won’t have nowhere to live. Oh, well, I’ll have a place to stay… In a room made of cinder blocks and I wouldn’t get no window! But no, it’s not where it’s at no more. I can’t.

Addiction is something in your brain that triggers you to do it. Then you feel like a dick the next day, like an ass. Excuse me to say, but it’s true. To me, a drug is a drug is a drug is a drug, and if I can’t have my cocaine right now, I guess I can have a cigarette. Cigarettes, it’s… a habit… a security… a need…. it’s a drug. There’s alcoholics, there’s potheads, there’s whatever drug addicts, and a cigarette is a drug. But it’s a legal drug and it’s an expensive one over-the-counter. I can’t walk up to someone and say, “Excuse me, can I get some marijuana? Can I get some cocaine?” You know what I mean? So it’s something that I can do that calms my nerves down. I’m not saying I’m dumb, but I swear to God, I lost something in my brain from trying not to do drugs. Like, I couldn’t find my phone before I came here... I found it…. It was in the refrigerator.

The other day I ran out of cigarettes and I was freaking out. So at that point, I didn’t care if it was a good one, I just needed that nicotine. I just needed that taste. So I go down to my friend Marco and Jean’s looking for cigarettes and Jean says, “Well, we roll ours.” Oh, God! You know, rollies, that’s a whole different texture of tobacco because you’ve got good tobacco which is expensive and then you got the pipe tobacco that they use to roll. I don’t usually roll my own because it’s such a pain in the ass. I mean it’s cheaper, but it’s a pain in the ass. When I tried to roll them with Marco and Jean’s stuff it was funny because I didn’t roll them right and there was this big empty space between the filter and the tobacco. Really? I had to smoke it anyway, but it was gross. It was gross, but it was a cigarette. Joy, joy!
Why is smoking even more expensive in taxes than anything else? They get taxed all the time. I think it’s because it’s a drug… And it’s addictive... And they know that they can get it because half the world, half the United States of America smokes cigarettes! Everybody smokes cigarettes! The only ones that don’t smoke cigarettes is because they’re too young or they don’t know no better. Well, they know better not to do it, I should say. I bet you if you’re allowed to buy cocaine or heroin, that tax would be three times higher than regular cigarettes because you got all these addicts that wanted it.

At the store, if I don’t buy my Pall Malls I might buy my generic cigarettes like Maverick or Wings. The generic ones make you cough though, but, they’re less than $6 bucks. Hey, what the hell? Right now I’m smoking Wings and there for a while they were like $5.25 versus $7.50 for another brand. The other day I walked in there and I said, “Why are these cigarettes $5.51 now?” And the lady at the store, she said, “Oh every six months they have a tax increase.” I’m like, “Oh my God! Are you serious?” I mean it’s going to get to the point where I’m gonna up stop. I remember buying cigarettes for like… I think the cheapest I bought cigarettes was maybe $2.00 and I said I’m gonna quit at $5 bucks. Yeah…and here I am still smoking!

But, we’re in Taxylvannia where everything’s taxed, and taxes, they’re all the time! I don’t know where taxes go but it doesn’t go where it should go and it gets spent stupid. We don’t have a budget, the roads ain’t fixed. Meanwhile, and I’m not saying this ignorantly… meanwhile this lady got six kids, lives in the P-Funk (you know? The housing projects?), has a better car than you and I, lives off of welfare, and has $800 in food stamps. And here I am running around in a circle all day trying to make a couple dollars scraping and I get $180 food stamps. And I’m still trying to survive! My fingers are dirty from working, you know? But the tax dollars went to her because she’s got six, seven, eight kids and she’s got a Lexus. Seriously?
We’re screwed. We’re screwed! You know we got screwed when it comes to Hillary or Trump. We didn’t have a very good selection. And I don’t like either one. I’m being honest we got screwed in that deal. And Trump is so ignorant. Did you see that on the news about what he said?

I can’t afford cable but I have seen that ad with the woman with the hole in her throat before (2012, CDC Tips from Former Smokers Campaign, Terrie). They’re putting these ads out because that could happen and that happened to my friend whose dad had the throat cancer, big hole. It was from smoking and he used to have to clean it with a stick, like a gross pipe stick.

When I see things like that, I think about how there’s a chance it could happen. But then again, your life’s a gamble. You’re out in that car today and you might not make it home because someone could hit you. You can hit somebody. You know? You go to bed tonight you might not wake up. Life is just all a cycle. It is. It took me a long time to understand that.

On Facebook, I seen someone put up these two lungs and the one lung was a normal lung, no smoking, no alcohol, no nothing. And then the other lung was pure black! It was like the lung and the heart. You know the good one was just doing its regular thing. The bad one was like, it had no oxygen and it was all this black. It looked like mold on a rock and it was just growing on the lung and in the heart. I don’t know what will make me quit, but maybe if I can actually see my lungs right now the way they look, I’d probably be scared shitless and stop. That thing was ugly! I need something. Seriously! I mean, I know that cigarettes are bad, but if it’s something to do with me? Then they scare the shit out of me to make me stop? To see it with my own two eyes? There. But then, after I seen that thing on Facebook, like an asshole, what do I do? Smoke a cigarette. But that’s another thing too. I’m scared to quit. I know that it’s not good for you. Ha! What is good for you? You know? Nothing!
Narrative Summary: Tina

In Tina’s narrative, she is very **Aware** of the public health pedagogy that cigarette smoking causes cancer and she is **Accepting** of this. However, she also admits that she is addicted to cigarettes just like she was addicted to cocaine and she is willing to **Avoid** public health pedagogies such as **Taxes** by purchasing generic cigarettes or rolling her own cigarettes if need be.

Tina’s narrative also gives a good overview of a commonly discussed **Disregarding** theme of **Playing the Odds** where participants demonstrate an ambivalence about quitting smoking because “life’s a gamble”. Tina supports this belief by using a personal experience of a non-smoking friend who died prematurely from cancer and by discussing other non-smoking ways that people can randomly die, such as a car accident. In addition, because Tina’s friend who died didn’t smoke, the experience causes her to **Doubt the Veracity** of the public health pedagogy of smoking and harm.

Tina’s experience of her step-father’s death also supports her **Distrust of Intellectuals**. In this case, she believes that there was better treatment available for her step-father but that she and her mother didn’t have access to it because they don’t have the “right kind of money” to access it. Finally, these **Anonymous Intellectuals** are also **Hypocritical** in that “they” tax cigarettes more than alcohol and she further conjectures that this is because “they” know that addicts will pay for cigarettes regardless of the cost.

The next narrative I will present is for Zach who, like Tina, disregards public health pedagogies, believes that life is a gamble, engages in many avoidance behaviors, and is distrustful of public intellectuals. In addition, Zach’s story begins a series of explanations about how individuals enjoy smoking and don’t see how they could live their life without it. Zach’s
story is especially demonstrative of the dissonance that public health pedagogies cause as they challenge the individual’s enjoyment of smoking and “force” them to consider how their behavior may be negatively impacting their health.

**Introduction to Zach**

Zach is a 46 year old African American male who has a high school diploma. He is currently unemployed and he lives at <100% of the federal poverty level in federally subsidized housing. He and his 4 family members receive Supplemental Nutrition Assistance (SNAP), and Medicaid, and his children participate in the USDA Free school breakfast/lunch program.

As Zach shares in his story, he lived with his mother while he was growing up and he didn’t know much about his father. However, he does say that his mother and father abused alcohol and drugs together when his father came back from Vietnam. Because of his parents’ drug and alcohol abuse, he was often cared for by his grandmother who he thanks for “getting me out of that environment”.

Zach reports smoking 12 cigarettes per day and he also uses snus, snuff, or dip 3 times per week. His longest quit attempt lasted 2 months and he has never used an FDA approved smoking cessation medication. Zach’s overall opinion of using tobacco is positive. He believes that cigarettes are very harmful to health and he sometimes thinks about the harm that smoking may be doing to his health. In general he believes his health is very good and he reports being diagnosed with either anxiety or depression.

I originally titled Zach’s story “I Feel Resistance”. However, after he reviewed his story and we discussed the details, he suggested that what was written about him demonstrates what he calls “The Conflict Within”. He further explained that when he is thinking about his life, he often has internal conflict as the story describes. As he is debating with himself, he will then
wonder, “Who’s gonna win today?” And so, we decided to change the title of his story. Below, you will see Zach’s story presented in standard font along with the conflict within in italics.

Zach’s Story: The Conflict Within…Who’s Gonna Win Today?

I am going to tell you about the life of me when I was smoking cigarettes. I started at an early age--I was exposed to cigarettes as early as a baby. I believe my mom was smoking when she was pregnant with me, during birth, and at the birth. My mom was an abuser of alcohol and of cigarettes and all throughout my childhood I was exposed to cigarettes.

I don’t know a lot about my father. He was drafted for Vietnam and when he came back he was shot up and wounded pretty bad. The VA, they gave my dad drugs to help him cope, but he was messed up mentally and everything. The drugs didn’t work and he got drunk a lot. Some of my friends said my dad was doing other types of drugs too… to cope with the pain. And right along with him, my mom got addicted to this and this.

So I was in one of those type of lives where it was real hostile. Often my grandma would take me out of that environment and I thank my grandma for getting me out of it-- to get me away from my parents because they was unstable. I like to say that I was raised by my grandmom, but my parents, they were still there.

When I was pretty young, I remember seeing a photo of me of me with a cigar in my mouth and I was playing around with cigarettes. Then one day I got curious about cigarettes and I lit one up at the age of nine. I was around bad people who influenced me and they taught me how to inhale so from there I just like the feeling of the cigarette. That first cigarette, it was a Cool. Cool cigarettes. That fresh menthol. I don’t recall me smoking cigarettes because the way I felt, or to try to change the way I felt. At the time I didn’t think it was addictive ‘cause I didn’t know what addictive was.
My grandmother and my mom had no clue to how I was getting my cigarettes, but they say they smell the smoke on me. They didn’t know how to stop me from smoking because they ain’t always around and I’m goin’ to find a way. They had questions on “How you started smoking cigarettes?”, “Who was involved?”, “Who did this?” I couldn’t answer those questions for them because I wasn’t sure how I got hooked. Of course, there was blame put on my mother for smoking around me and, you know, people blame this person and that person. But one thing I do know is nobody was talking about me stop smoking. They were not talking about “How can we stop him from smoking?” That was no plan.

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Because one thing my parents and my grandmom knew... that they couldn’t regulate me like the government trying to regulate the people today. Because I’m my own person and I’m going to do what I want to do regardless of what you say or what the rules are. Even though the rules are good for me, I just... that don’t apply to my life because I make a choice. Same thing with my parents. It’s ok to disagree with them.

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As I got older, to the age of 12 through 13, my grandmother and my mom told me “You’re stunting your growth because you’re smoking cigarettes” and that offended me. And then they would say you should’ve been tall like your dad. Settin’ them expectations on me made me feel a little depressed because I felt that I didn’t live up to my parents’ standard.

Then, not much later, I met a women who I liked. Her name was Shine. She said, “Zach you’re a nice guy but you’re just too short.” And that really hit home. And I was like “Come on!” And it goes back to that, if I didn’t smoke cigarettes, I’d have been a little taller. I lost that girl because she happen to like taller guys. Everything else was intact, she liked everything else
about me but “You’re just too short, Zach”. And then I got into fights with the bullies because they started to say, “Man, I’ll beat you up because you’re a small guy”. Fighting is what made me famous because I fought them anyway. It was those words… going back to what my mom said and me bein’ the small guy. I took all that in and fought them. I had a problem with that because I didn’t like nobody saying that I was too short because it was offensive. And then I say, “If I didn’t smoke cigarettes I’d be taller.” You know? Today that still bothers me. I could’ve been a little taller if I didn’t start smoking cigarettes.

When I was 16 years old I remember how I thought about stop smoking because people picked on me. I was trying to live up to the expectations of my parents but, I felt depressed. I started failing in school. I couldn’t focus correctly. I wasn’t thinking. I was slow in everything I did. I wasn’t comprehending correctly. Teachers kept repeating themselves and they got frustrated with me. My employers got frustrated with me and they said “Let’s fire this guy, we’re tired of putting up with him. I tell him to do something he’s not paying attention!” I wasn’t focused as I should be. I’m not blaming this on cigarettes but what I’m saying is, that’s what drove me to smoke cigarettes. Because when I smoke cigarettes I didn’t worry about you saying nothing. It’s just me and the cigarette. My mom told me “You’re special to me even though everybody else sees it differently. You’re still special. Now your boss may not think you’re special. Your teacher? No. But I love you.” Not learning was something I was born with. Focusing was not a part of my life. I didn’t develop this, this is who I was. So my mom protected me. She protected me from the world because it was hurtful to me.

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And like my mom, cigarettes was right there with me. Cigarettes didn’t say, “Go!”, “Get out!”, “Fired!” There is nothing that comes between me and that Cool. Cigarettes, you know
they are pleasure. The pleasure, it’s soothing—like a baby with a pacifier. I resort to that. So...

what I know is that when you’re telling me I cannot do something, that’s like discipline. And if I chose to do something and you say “No”? That’s rebellion to me! If I have some cigarettes and you say I cannot smoke here? I’m going to say, “See you later lady!” I’m going to go over here and smoke. So in other words, nothing can stop me from smoking.

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I remember at the age of 12 years old, I wasn’t old enough to purchase cigarettes. Well, I didn’t have enough money to buy cigarettes anyway. So I’m walking and thinking how ‘m I going to get cigarettes? Sometimes, I would steal money from my parents to go buy the cigarettes in the machines and I would hide the pack. That’s when I learned how to become real deceptive about things. How to fool people. How to lie about stuff. Sometimes I would get cigarette butts out the ashtray because I couldn’t afford ‘em. And I would sneak and do this stuff.

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So now when the government take cigarettes away from the machines, I’m going to have to find another way to get cigarettes (1992, the Synar Amendment). And how do you think I feel when I think you’re taking them from me? It made me mad! Because I just want to smoke cigarettes. Who are you to take cigarettes out of places? You make them real inconvenient. So why make it inconvenient?! And then I had to find other means to get cigarettes, like ask adults to go and buy me cigarettes, or just ask an adult for a cigarette, or go pick him out the ashtray. That’s the type of lifestyle was livin’ then.

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Some people say that cigarettes are addictive. And I think I’m in denial because of the fact that I don’t think it’s addictive. I think it’s a choice. I always did. Like with drugs and
alcohol, even if you say it’s addictive, you still choose to do these things. So the question is, it addictive? Is that what the government is telling us? That it’s addictive? And now the government trying to save us from the health diseases or whatever? You know what I mean? Thank you government. Thank you for letting us know that we are killing ourselves. But is it gonna to stop me from smoking? No! It’s not enough. But I do think the government should be educating us. They’re not wasting money in trying to educate us. I believe in education. Letting me know what I’m doing to myself, then I can still make that choice...to continue or to stop.

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But don’t regulate. Just like my parents who said “That’s bad”, but don’t try to stop me. It’s okay to inform me that if you don’t stop smoking, you’re not getting new dates. Inform me because then I can make my decision right there if I want to continue smoking. But trying to force something down my throat? Like, eat it! Jam it! I feel resistance! I don’t feel like I want to smoke more I just don’t like them doing that to me. It makes me feel uncomfortable. Especially when you take it away from me... like the machines. If I can’t smoke in your house then I’ll go to my house to smoke. So restricting me from smoking is not going to stop me so I think they waste their money. I also don’t like how they make these ads to scare us because it puts fear in my heart. So now you’re forcing me against my own conscience to stop smoking. If you don’t stop smoking you’re going to die. Or your throat’s going to be messed up.

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But I believe in education. Keep telling people what a cigarette does and maybe somebody might say, “You know what? I’m tired of this advertisement” because they start that fear that it could happen to me. Fear can change you. The fear… I kid you not when you see that lady with the thing on her throat in the advertisement? And, when the kids see that commercial…
if it don’t affect you, it’s going to affect them. Which it already has affected my kids. They look at me with a sad look. “Daddy, please stop smoking because we don’t want to see you look like that”. And I tell them, “That’s not going to be me, don’t worry about it”. But I can’t convince them that it’s not. I can’t even convince myself that it’s not. It might hit me somewhere else you know? It might hit me somewhere else. But I try not to have those premeditated thoughts.

Because it do make me scared. And who wants to create fear unnecessary? But, it’s gonna come a time when I have to face that fear. And say, you know something? Before I get to that point, let’s stop it right now. Let’s stop the smoking right now. That is, to try and prevent the heart disease and the lung cancer. You try not to get that.

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If you take them vending machines out of there and you run all these ads, guess what I’m gonna do? I’m going to cut the TV off and then I’m gonna go across the river and get the cigarettes. Okay? Because I’m not very interested in hearing you telling me what cigarettes is doing. And when I was a kid, I really did not care about what was going on in Congress or what type of laws were being passed. I didn’t really care because the way I looked at it, they ain’t going to stop me from smoking cigarettes. And you’re not going to stop me from getting them. No matter what type of law you pass or restrictions, I still have access to cigarettes. And, even though I know that at the time it was bad for my health, or whatever it would do to your body, that was not my concern at the time. I thought, “I’m too young for it to happen to me”.

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Am I scared to get young lung cancer? Yes. Am I scared to get heart disease? Yes. And, thinking back to when I was nine years old and they said “You’re too small because of the cigarettes”.... What if I got lung cancer because the cigarettes and I gotta be treated? Would I
stop smoking then? Absolutely! If I develop some kind of lung cancer or heart disease because of a cigarette, I would stop smoking.

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*Fear. I’m not fearing now because I have no reason to fear. I’m not facing the fear and I’m not going to let fear affect me. I’m not gonna let fear control me. Because of the fear the government wants me to have is the fear of cigarettes because it causing the health problems. I don’t want to face that right now and I don’t want to think about it.*

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What can public health do to help me quit smoking? The only thing I can think of is just to keep talking to me. You know what I mean? Just keep talking and I’ll just keep getting educated. The more you guys tell me the more it’s like it’s playing in your head. And then when it starts to play in my head, some of those thoughts throw me into depression, some of those thoughts bring joy, and some of those thoughts educate me. Now I know better. Then it’s the choice do I want to do better? The education make me want to do better.

After sitting here and telling you about the life of me and my smoking, this is how I feel. Let’s say that I have a gun and I put a bullet in it, I spin the chamber, and put it up to my head. That’s how I feel today. <Click!> Because the fact is, every cigarette you smoke you’re causing damage, right? <Click!> You got another cigarette. <Click!> And you’re going to keep lighting those cigarettes, <Click!> <Click!> <Click!> <Click!> <Click!> And tomorrow <Bang!> You know what I mean? Now Zach, it’s finally caught up to you. Didn’t you see this coming, Zach? The FDA warned you… the government warned you… your kids told you… your doctor told you… back when you were 13 you lost a beautiful girl and she told you… your mom and grandmom told you weren’t big enough. All those signs. Now “Bang!”. Now you’re dead.
Right now I’m thinking it can’t happen to me. I’m not going to be that guy. That’s what I’m thinking right now. And it keeps me lighten’ cigarettes up. But I think I’m in denial. Or I don’t want to be that person. I don’t want to be that person. But if I’d tell myself I don’t want to be that person then why do you keep smoking to become that person? Because I think it’s not can happen to me. But it can. But not yet. You know what I’m saying?

Narrative Summary: Zach

Although Zach is Aware of the harms of smoking and is Accepting of the messages that public health pedagogies are conveying, he has Learned to Avoid these messages by turning off the TV and finding other places to smoke when it is restricted. In addition, when he is not able to avoid the messages, he gets angry that Anonymous Intellectuals are trying to Control him with “fear” because they are “shoving” health messages down his throat and “forcing” him to listen to messages he doesn’t want to hear. When he feels especially conflicted, he Rebels Against Expectations to not smoke and “resists” the messages he receives.

Zach provides a detailed account of his ambivalence about quitting and the dissonance that the messages he receives are creating for him. In this way, he is especially clear that he is Playing the Odds, or gambling, with his health as he describes a game of Russian roulette. In the next narrative, Guy further develops this theme of Playing the Odds. Because of Guy’s experience with drug and alcohol rehab, he is more accepting of pedagogies about nicotine addiction and offers more concrete details about how nicotine addiction is comparable to that of a hard drug such as heroin.

Introduction to Guy
Guy is a 45 year old mixed race, Hispanic male who completed an associate’s degree. He currently works full time for a mechanical equipment servicing company. Guy was incarcerated on drug dealing charge in the past 5 years and during this time, members of his family received federally subsidized housing assistance, Supplemental Nutrition Assistance (SNAP), and Medicaid.

Guy grew up in Puerto Rico and started smoking with his friends when he was 11 or 12 years old. His parents caught him smoking when he was 16 and though they disapproved of smoking, they allowed him to smoke outside on the front patio of the house. Both his mother and his step-father were school teachers. As Guy describes in his story below, he was involved with drinking and drug dealing when he was in Puerto Rico. When he was 19 years old, his parents sent him to a Christian drug and alcohol treatment program in Florida. He remained in the United States after spending time in treatment and serving as a counselor in a Teen Challenge drug and alcohol rehabilitation program.

After he left the Teen Challenge program, Guy did not smoke, but started again when his new wife found out she was pregnant. Now, Guy smokes 15 cigarettes per day and smokes within 25 minutes of waking up. He has made quit attempts in his life with the longest one lasting 11 months. He has never used an FDA approved medication to help with his quit attempts. He rolls his own cigarettes because they are cheaper than the manufactured cigarettes his wife smokes. Neither he nor his wife smoke in their home.

Guy has neither a positive nor a negative opinion of using tobacco. He believes that cigarettes are extremely harmful to health and he thinks about the harm that tobacco use may be doing to his health very often. Overall he believes his health is good. He has never been
diagnosed with a mental health condition, he has never felt that he had one, and he has never felt sad or blue for 2 weeks or more.

English is a second language for Guy and though I had no trouble understanding him during our interview, he had a strong Spanish/Puerto Rican accent. Guy’s narrative was the only one to which I made some minor grammatical changes and changes were only made when I felt the grammar would impede a native English speaker’s ability to understand the meaning Guy was trying to convey. Guy did review and approve of the edited version of the narrative presented below.

**Guy’s Story: It Control Your Mind and Your Body**

I can think of something that would make me quit but I ain’t gonna say it. Because I don’t want to talk about it. My biggest fear… that would make me quit. But some people say that, “If somebody I loved got sick, then I would quit”? That’s crap. They can’t fool me like that. You do not going to stop smoking until you get sick. When you know that you sick and you’re going to die? Oh! You’re going to stop! But in the meantime, you don’t.

The reason why we do not stop is because we try to fool yourself that it’s not going to happen to us. We know that it’s coming, but we just hoping. It’s like the person who make a robbery. He prayed to God that this robbery going to work out and that I won’t get busted. They want to sell you drugs? “Please God that I could go get this drug and come back and don’t get busted.” Person who commit a murder? “Oh God I’m gonna kill this dude. Please I don’t want to get busted’’.

There’s a couple of commercials from the same company, “Tip” whatever (2012, CDC’s Tips from Former Smokers Campaign). I think there’s a guy he don’t have a leg or something (Bill or Brandon)? And it’s another guy who had the thing with his throat and had to clean it out
(Shawn). Like, those make you really think about how I don’t want to be like that. I can’t stand that commercial because it’s true.

Every time one of those commercials come on and throw it in my face, I can’t even watch it. I got to get a drink water, or use the bathroom, or go smoke. Nobody like anybody tell them the truth. You don’t want to hear it! You know it’s bad for you, you know that and you still do it! But then you think, maybe this is just crap. I know it’s true, but you want to like lie to yourself. You gotta find excuse to make yourself to feel like you’re right. Even when you know you’re wrong. The thing is that we know it’s bad! So how I deal with it? Just blindfold. Just don’t pay attention. That’s why don’t like that commercial. That commercial is a stronger commercial…. if you do not change your life, something can happen and this is what happened to us.

All of us, we smoke and we think that that could happen to everybody, but not us. Please! <makes puffing sounds> “God please keep me healthy man!” <makes puffing sounds> “I don’t want to die!” <makes puffing sounds> “Please I don’t want to get cancer!” Please. “Hey! You remember this person? Dude they die of cancer!” “What!!?? Oh my God!” <flicks cigarette, starts another one> It’s just insane we just keep doing the same thing. We know it’s wrong.

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When I was a kid in Puerto Rico, I was in the street doing all kinds of stuff. I was drinking, I was smoking, but I was no doing drug itself. I was rolling with the drug dealers and I was actually selling drugs. So since either I was to get killed or the only escape was for my parents to send me to this Christian program. The founder, once in his life he was a heroin addict and he was about to get killed one day and he say God forgive me, help me. And his life
changed. So he became pastor and then there was a program he founded. It was a program not only for drugs, it was meant to be for the drug and alcohol program.

I see what detox is like from this program. It’s like when they say nicotine’s addictive like heroin and cocaine. I do no think it’s like cocaine because cocaine is more a mental addiction. With cocaine, you could pass a week, two weeks, 10 months doing it, and as soon as you don’t touch it again? You fine. You could do Cocaine in one night a couple of hits and you don’t do it again.

But heroin, after you try at the first time, you become addicted. It control your body, it control your mind, it control everything. For you could actually break that addiction, you gotta go through a process of detox. That took like three days, you throw up, you feel all kind of pain and it’s just one of the worst. Even when you break the addiction, and you got all that detox, it take many years to clean your mind because the smell of it, like the thought, like people love the high. Cigarettes are no like cocaine. Cigarettes are just like heroin. It controls your mind and your body.

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I don’t know if it’s true, that when I smoke, the smoke that is around me can make cancer for other people and maybe worse than what I get. Is that right? I do not see why they could get the cancer worse than the one I could get. I’m the one smoking the thing and they just smell it! But I’m pretty sure their health gets bad because if I smoke around my kid in my car all the time, I ruin their life. So I like what they did that they make it illegal to smoke in the car when they say 10 years old and younger in the car. If you get busted you’re going to get a fine so my kid’s life last longer.
My worst fear is to find out I got cancer. What the hell am I gonna do? But, as long as I don’t know? I’m fine. People have sickness for many years and they don’t know. Soon they know? Shit, they die. I have couple of people that I know, they have the HIV for many years. One day they went to the doctor, they find out they got HIV. Before they didn’t know how they get that HIV. Probably in blood or something. People they healthy, people they don’t even take pills or nothing on a daily basis, work and everything, they healthy, and everything fine. They find out they got HIV? Guess what? Six months after? They done.

It’s not because the sickness, it’s because of the depression… to know about it. It’s just how you coping with now you know you going to die. Most of the people they find they get cancer, they don’t last long and it’s because just that. Because the treatment is there. Like right now, I know someone that have cancer and he’s battling that. He did not smoke. He never smoked. All he did was chew. When I was locked up, he was a sergeant on my block for four years. That dude he was the best, now he’s fighting cancer and it hurt me knowing this. He was one of the tools that God used that made me change my life.

I see my wife… she smokes a lot more than I do. She wake up in the middle of the night to smoke. She get up in the morning and she gotta smoke. My wife get a coffee and she smoke like three cigarettes on the back when she’s drinking her coffee and one of my… how you say?… one of my biggest worries is that she get sick on me. And if something happened to her I can’t live without her. Well, I do could live without her, I just try not to.

Recently I quit smoking. I was fine and I was not smoking and I was getting used to it and I was feeling great. But then I was getting more tired and I was kinda depressed. That was a funny thing because before I quit, I don’t have none of those issues. So I stop smoking and I started feeling that. I got depressed, I had this feeling that nobody loved me. I was sitting in my
house watching TV and I look around and I’m like, “Wow! Nobody pays attention to me.” Something that never bothered me before. I never even thought about it. But then I started smoking again.

I can’t say that I can’t stop smoking because I could. But I need help I think. Maybe. Maybe not. I really would like to stop smoking, but for what? If I know I’m going to go back to smoke? The problem is how I’m going to live the rest of my life without it and without come back? Because most of the people that are doing something wrong, they repeat it. They could be this long without doing it and sooner or later you go back. What was this thing? AA [Alcoholics Anonymous]. NA [Narcotics Anonymous]. Whatever. “I’m sober for 24 hours.” “Good for you!” Yeah, but then they go and passed by the bar and drink.

But it’s people who’ve been rid of the drink for 40 something years. Clean! But then one day their grandson’s passed away, car accident, or a natural cause and then he just went to buy a drink and he drank. And it’s just happen. How to stop smoking? I don’t know. I guess it’s on you personally. You just hit the bottom. You gotta hit the bottom and you gotta be sick and tired of smoking. But for you to be sick and tired of smoking, something got happen. “Oh! I got cancer on my throat!” “I barely can smoke because it hurts!” “I barely can eat, I can barely drink water and oh my God, it taste so good but I can’t drink it!” It’s a consequence. You get diagnosed with cancer, the cancer will not kill you, what will kill you is the depression, “Wow, I’m not gonna to see my grandkids.” What will kill you is all the regret and the depression.

**Narrative Summary: Guy**

Guy’s narrative again demonstrates that he is **Aware** of the public health pedagogies around the harms of smoking and he is **Accepting** of the message that smoking is harmful to health. He is willing to engage in behaviors that will minimize harm to others such as not
smoking in the car while his children are present and he and his wife both smoke outside the home. In fact, Guy is so accepting of the pedagogies about the harms of smoking that he feels compelled to engage in Avoidance behaviors such as leaving the room when an anti-smoking commercial comes on TV because he can’t reconcile his behavior with the messages he is receiving. Guy also rolls his own cigarettes to avoid the pedagogy of Taxation.

The most consistent thread that runs through Guy’s narrative is that of Playing the Odds and Doubting the Veracity of quitting messages since he doesn’t see any way to quit smoking and stay quit. Because of his background in addictions recovery, he can relate strongly to the experience of relapse that many addicts face and finds this reality discouraging. Finally, Guy also says that it’s better not to know if you have a disease, such as cancer, because he believes that the depression that comes with knowing about the disease is what leads to death after a diagnosis.

Guy’s experience of Playing the Odds is also a major element in Malcolm’s narrative which I will present next. In addition to the “gambling” that Malcolm discusses, his narrative begins the series of participant narratives who are extremely Distrusting of Public Intellectuals. For Malcolm, this distrust leads him to engage in a variety of Rebellious behaviors.

**Introduction to Malcolm**

Malcolm is a 41 year old white male who completed a GED. He is not currently working and is on disability due to a back injury. When he was able to work he did “odds and ends” in the manufacturing industry. In the past 5 years, members of his household have received Supplemental Nutrition Assistance (SNAP). He grew up with both his parents in the home and states that his childhood was “usual”. His dad worked 3rd shift and his mother stayed at home. His parents have been married for nearly 42 years and still live together today.
Malcolm reports that he has made a quit attempt in the past using both nicotine patches and nicotine gum with the longest quit attempt lasting 2 months. He smokes around 60 cigarettes per day which are rolled using a machine, with tubes and filters. He smokes within 1 minute of waking up in the morning. He has neither a positive nor negative overall opinion of using tobacco, he believes that cigarettes are very harmful to health and he sometimes thinks about the harm cigarettes might be doing to his health. In general, Malcolm reports that his health is fair and that he has been diagnosed with depression or anxiety disorders.

Malcolm’s Narrative: Everyone Has Their Addictions

I started smoking when I was about 12. My dad smoked and he wasn’t thrilled with me smoking but I guess he could understand what I was doing. The only thing he really said was that I have to support my own habit because he wasn’t gonna pay for it. Fortunately, I was very creative. I got start-up funds by saving some lunch money and then I bought two packs. At the end of the day, and I’d be down at the Dairy Queen or the Getty, or whatever, selling cigarettes to the other kids that couldn’t get them and I’d charge them a quarter a piece. Since I was making about five bucks a pack, I could buy four more packs at those prices.

Some of kids were buying the promotional items from me too, like the Camel stuff. Whatever promotional items there were, I had them all. I had a flea market with anything from Zippoos to beach towels, carriers for coolers. You could get a whole damn wardrobe and all you gotta do is go buy a pack of cigarettes. I made quite a bit of money selling them things because they were collector’s items especially because they pulled all that commercial stuff at some point (1998, Tobacco Master Settlement Agreement banned promotional items). Especially the Zippoos. I used to be able to get at least $20 or $30 bucks for a Zippo.
I never had a problem getting cigarettes when I was younger. I just went to a Turkey Hill and bought them. But, rules were different back then. Nobody gave a shit. Occasionally if a cop would see you smoking, they weren’t stopping, getting out of their cruiser, and telling you to put the cigarette out. Even if they did they weren’t taking the pack or your lighter. So, it’s like, okay, stub it and then once he leaves, light the damn thing back up. There was this bar I would go into sometimes and just go to the vending machine and get a pack of cigarettes. No one ever said shit to me and by the time I was 13, I got a little brave. They see me in here getting cigarettes out of the machine all the time so one time I went over and ordered a beer. You know what happened? I got a beer…and a pack of cigarettes….and shot a game of pool!

There was only one time that I ever really had a problem buying cigarettes. There was a woman at the store who asked me “Do you have any ID?” I said, “No. I’m getting these for my dad, his birthday’s tomorrow.” And she was like, “How old is he going to be?” And I said, “38”, you know, really fast. And she said, “All right. Well, if they’re for you, hopefully you choke on ‘em,” and she sold them to me. I guess it’s fine that they card kids now but everybody has their own entitlement to do what they want to with themselves. You know? Basically at the age of 12 you’re considered to have the age of reason, so why not? Everybody’s gonna make their own decisions. Just because you tell them not to do it, they’re just going to sneak around and do it anyway.

I had random strangers come up and tell me I shouldn’t be smoking. I’d just bash them. You know like some fat person would come up to me and say, “Oh smoking is bad for you….And I’d go like yeah and all that candy and all that other shit you eat, like you’re healthy!” I would just occasionally have random people make comments and walk by while they
were waving their hands and trying to blow the smoke away. I’m outside you know! Who said you have to walk this close to me?

And you know they have these warning labels on the cigarettes or when people are purchasing a magazine. They don’t give a shit. They don’t want to read that. How many household products did you buy recently? Did you read all the instructions on the pack? You read them from top to bottom to see how far you should hold that spray away from you, or if you should have the windows open? Is it flammable? Nobody does that! It’s just another product people will buy. I guess they can keep putting those labels on the cigarette packs though. Whatever. They might as well put a little extra into the product since we paid the extra tax. Yeah! For how much tax we pay, that label should reflect, glow-in-the-dark, and all kinds of stuff. Maybe make it pop out in 3-D and they could put a little pair glasses in there.

Everybody has their ownaddictions. Some people choose cigarettes, some people choose coffee, some people choose chocolate, alcohol, drugs, gambling… Now Jeffery Dahmer’s addiction was completely different from anybody else’s. That should have had a warning label... Stay away from people like that! So, what’s one of your favorite things in the world? Do you drink coffee? Does it have caffeine? Yes? Oh! That’s not good for you. How many cups of coffee do you drink? About a pot a day? How much sugar do you use?? See? The list goes on. Coffee, chocolate, alcohol, drugs, gambling... they’re all harmful in their own way. I can understand the addiction. I know what it’s like to try to quit cigarettes. It’s not pleasant. Just like a coffee drinker. Somebody that’s drinking to three pots a coffee a day, you know if you try to skip coffee tomorrow, see if you get a headache. See if you don’t just wanna take a hammer and bust something. You know? Or be staring out the window and thinking I wonder how far I could jump.
All this stuff where they’re banning smoking, let’s just say nowadays you can drink more places than you can smoke. Especially when you count your bars and any kind of places that would normally sell alcohol like Applebee’s and those chain restaurants. I mean, hell, you can go to the grocery store and they serve beer in there. And I’m not just talking six packs. You can go in there and get a big 25 ounce cans of beer and drink a beer in the grocery store. I don’t care though because it doesn’t really affect me. Just because they say you can’t smoke there doesn’t mean they’re going to follow that rule. I mean like okay, where we are right now, the signs says no smoking on the whole premises. I don’t know if they count the parking garage or not but I’ve seen other people smoking there. My argument would be you know how many fumes and toxins are coming out of some of these damn mechanical assholes that you’ve got in this garage here? Some of these things here are going to blow off more than what I’m going to do from smoking half a cigarette from walking through the parking garage.

Now, at the hospital the other day, I was picking somebody up, and I was sitting there in my car smoking a cigarette. They were like, “Oh there’s no smoking on the property.” I said, “The car’s on your property, I’m inside my property. Get the hell away from the car!” and I close the window, turn the radio up and continue smoking. To hell with you! I paid for this car. I’ll do what I want with it.

When you go to the hospital, they keep you as long as they want to and if they want they can keep you overnight. Well here one time I went to the hospital and I said, “This is taking a while and I need to smoke a cigarette.” They were like, “Well, you can’t go outside and there’s no smoking on the property”. I sat there for another half an hour and at that point I didn’t care. I thought, “Fuck you! I’m going to have a cigarette.” I walked out the door and I thought anybody tries to stop me, you’re going to find out how mean I can be without a cigarette. I’ve been in
here almost 5 hours and I wasn’t even looked at. So, I went outside and smoked a cigarette and returned. And then they came back and said, “Oh, we were looking for you.” I had a big smile on my face and I said, “I went out and had a cigarette.” The woman just shook her head, left and then five minutes later, somebody came back and they tried to reprimand me. I said, “What the hell are you gonna do to me? You going to spank me? You going to deny me? And turn me away?” Of course not. They got my insurance card, this ain’t a social call and this hospital ain’t built on charity. Go ahead and throw all the tests on my insurance card that you can and “Screw you insurance company!” That’s all it is.

That prevents me from wanting to go to the hospital. Something’s gotta be hanging off of me for me to sit in a hospital for five hours and not have a cigarette. You know? And if you have to be there overnight, if they’re not going to take a guy out for a cigarette, get him a damn patch or something! You know what I mean? Don’t make it that you have to phone down to the pharmacy and go through all that. Have them patches ready! They’re over-the-counter! They got no problem slipping you a Vicodin if you have a headache, but you gotta fill out 10 forms and have it notarized to get a nicotine patch. I bet they do that because most of them don’t smoke and they just want to be assholes. That’s how I look at it. It’s their own form of torture…. Maybe that could be their addiction, they like to torture people.

Besides hospitals, I do go places where you can’t smoke sometimes. I mean, I gotta go to Walmart to get my groceries and I can’t smoke while I’m doing that. I’ve already been in there too long and I park my car up front and go out for a smoke break. If the line’s too long and somebody’s counting out 50 cans of cat food in every different flavor and variety so they can’t just hit scan once and times it by 50… I tell them, “While you’re playing with yourself, I’m going outside to smoke a cigarette.” I’ve already done that at the grocery store.
But all those no smoking ads…People don’t want to see that shit about smoking. Most people fast-forward through those truth commercials they put on with your movie. I’ll tell you right now… You just ordered a Pizza Hut, you threw your disk in and you’re waitin’ for the pizza man. Any commercials that come on you skip ‘em, or fast-forward, or go for a bathroom break. You ain’t paying attention to that. Not unless something comes on there that looks decent like say a new Lethal Weapon, Die Hard, or Rambo is coming…some action-packed movie that might catch somebody’s attention.

People want to take a break. That’s what a movie is. They don’t want preached to. How dare you, you prick? Come into my house and preach to me! I just wanted to watch my movie in peace. You know what I mean? It’s like you know when you’re walking down the street and somebody hands you a flyer a Jehovah’s Witness or whatever the hell. It’s okay to hand it out but don’t try to preach. You’re not supposed to convert me right there on the street. You know? You don’t want them coming into your house and telling you what to do. That person has to find their own reasons for what will make him wanna you know quit, cut back, or make an attempt at something. Just like, for instance, with Jesus. Most people find Jesus in the hospital because they’re on their deathbed. Before that they’re living their life and they don’t give a shit at that point. I mean they probably never even had a conversation with him, but in the hospital on their deathbed, they’re best friends with him. Jesus is just all right with me now.

But everyone has their addictions and everything has its own side effects. We all have addictive personalities and let’s just say if it wasn’t bad for you, it wouldn’t taste so damn good. It goes back to the Bible with Adam and Eve and the apple. She was told not to eat the damn thing and you know what she did? She ate it! It was probably the best damn apple she ever had! That’s what people want in life. They want things that they’re not supposed to have and that
makes it all the better. For me, smoking is one of the few things I enjoy. It’s what helps me get out of bed in the morning. I get up, go to the bathroom, smoke a cigarette on my way and it’s just part of what I do. When it comes to addictions, there’s no guarantee in life, it’s like a lottery and people like to gamble.

**Narrative Summary: Malcolm**

Malcolm is **Accepting** of the harms of cigarettes, but he consistently engages in **Disregarding** and **Avoidance** behaviors because “people don’t want to hear” public health pedagogical messages. He also demonstrates several ways that he **Plays the Odds** because he considers smoking to be just one of the many gambles people take in everyday life and he considers other chemical exposures to also contribute to health risk.

Although Malcolm **Surrenders** to some pedagogies such as clean indoor air laws by smoking in his car, he isn’t entirely willing and he will **Rebel**. For instance, when Malcom was kept at the hospital for a long period of time, he **Distrusts the Intellectuals** there. He experiences **Marginalization** and **Perceives Hypocrisy** at the hands of these healthcare providers who he believes enjoy “torturing” him by not providing him with a patch. In the end, he **Rebels** against the hospital smoking ban and goes outside to smoke since he sees no other option for how to deal with his withdrawal symptoms.

The next narrative is that of Katalea who is not as rebellious as Malcolm but is arguably more distrusting of public intellectuals due to her experience as a Cuban political refugee.

**Introduction to Katalea**

Katalea is a 55 year old mixed race, Hispanic woman whose family came to the United States from Cuba in the 1970s as political refugees. Though she is an American citizen who has lived in the United States for more than 45 years, she strongly identifies with, and is very proud
of her Cuban heritage. She completed school through 9th grade. Katalea currently lives in subsidized housing and in the past 5 years has received Supplemental Nutrition Assistance (SNAP) and Medicaid.

By the time she was 12 years old, Katalea’s parents had divorced due to her mother’s infidelity. Her father was also physically abusive toward her mother. After their divorce, Katalea lived with her mother who she believes favored sister over her and who was physically abusive toward her. Even though her father was an alcoholic, Katalea found great comfort in her relationship with her father and states that he encouraged her, loved her and was a good father to her. Katalea got married at age 15 because she “wanted to get the hell out” of her mother’s house. She had 3 children with the first one at the age of 16.

Although Katalea tried her first cigarette at the age of 12, she didn’t start smoking regularly until the age of 21 when she was divorced and stressed about being a single mom. She currently smokes 20 cigarettes per day and smokes within 15 minutes of waking up. She has made a quit attempt in the past month that lasted 3 days and she has used nicotine patches to assist quit attempts in the past. Katalea’s overall opinion of tobacco use is negative, she believes cigarettes are very harmful to health, and she sometimes thinks about the harm that cigarettes might be doing to her. Katalea states that her health in general is very good and she has been diagnosed with depression and/or anxiety disorders.

In order to understand how Katalea interprets her smoking and her health, it is important to understand her political perspective. Her narrative begins with an overview of this perspective (in italics) which is heavily influenced by her father’s activism and his experience with the development of communism in Cuba.

Katalea’s Story: A Form of Control
My father was put in jail in the 1960s as a political prisoner for speaking against Fidel Castro and the Cuban government. When Castro first came into power, my father and everybody was for Castro but then all of a sudden, “Boom!” Guess what? Were communist! And that’s when they started repossessing the people’s stuff and, you know, oppression. So of course my daddy was an activist and he spoke against Castro. He worked underground to let people know who we have to fight and he wasn’t nice about it so, they put him in jail.

Before Castro, we were a free country. We had our own money, we had our own resources with the sugarcane, and we didn’t depend on nobody for anything. We had the opportunity to become business owners. We had the opportunity to work hard so you can get your own place, your own house, your own vehicle. We were a free democracy where we voted for the president, or whoever we wanted. Then, here came Castro with socialism everybody is going to be the same. What he didn’t say was that we we’re going to be oppressed and he took everything, from the people that worked so hard to own the business. Their money, everything! He came and took over it and now, they’re starving!

I come from a country that’s a communist country, a country that we’re not allowed to speak. We’re not allowed to say nothing. Period. You can’t give an opinion. You don’t like Castro? They put you in jail and beat you without even having a trial, or it’s a mock trial! We don’t have freedom of religion, we don’t have any type of freedoms. Nothing. When you cannot express your freedom of religion? When you cannot express where you want to take your child to school? When you cannot go to a store like a Turkey Hill, or any store, and buy food? You have to wait for the government to issue it to you? That’s communism. That’s oppression.

My family came to the United States during the Freedom Flights in 1970. My daddy always told me that we came to this country to have the freedom of speech, to be able to have
what we want, and to give back to the country that took us in, because they didn’t have to take us in. It was drilled in my head that this was the least we could do. My dad told me, we come to America we have our own business, we give back to America by owning our own business, and we always have a dream. Cubans are very free enterprise. We want to own our own stuff and be our own boss. We don’t want to work for nobody but we will work for somebody until we can get our own stuff. My daddy always drilled it into me that you should speak what you think and don’t have nobody silence you.

Actually I never voted in my whole life until I voted for Trump. That’s the first time I ever voted in my life. I mean, I was an American citizen but I just didn’t. I didn’t like Hillary, I didn’t like Bill Clinton. The Bush were okay. My favorite president was J.F. Kennedy and Reagan and I was here when Reagan was president... My father was a staunch Republican. At the beginning, with Obama, I was indifferent to him, but when the Democrats started about talking socialism? I remember when my dad used to talk about how Fidel did the same thing. That’s the reason why I believe that Florida turned from blue to red... because of the Cubans. We knew what they were talking about with socialism. Florida, Miami, we have a lot of Cubans. But Florida per se was Democrat and the Cubans in Miami were... “Hey! They’re talking about socialism, you know what that means! Communism and we’re not going to go for it!” That’s why it turned red.

So, this is the reason I say that I don’t think the government should be telling you what to do or not to do, including smoking. At the beginning, it starts as socialism and then it turns to communism, and communism means oppression. We want to do what we want to do, in a way that we want to have a choice. If we want to vote, we vote. If we want to speak out, we speak out. If we want to smoke, we’re going to smoke. Why not? I don’t want the government telling me, “You can’t smoke.” Get the out of here, man! You know? It’s a form of control. When the
government gets that deep into trying to control you, it’s a form of communism. It’s not full-blown communism, but it’s a controlled form of communism. That, I learned from my daddy.

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How did I start smoking? Well, sometimes when my mom didn’t want to go to the store for cigarettes she would send me. And you know, being a nosy 11, 12 year old, I just wanted to know what was all the big deal about smoking. So I tried it and I used to sneak her Benson & Hedges menthol when she wasn’t looking. I guess she found out so that’s when she took matters into her own hands. Well, I got a beating and I quit smoking. I didn’t start smoking again until I was 21 when I was a stressed single mom.

You used to see billboards with the Marlboro man in the Camel man and slowly, they were taking them away. So slowly you didn’t really realize what was going on until everything was gone and then that’s where you go, “Oh wow! What happened to the… the commercials?” And then it was like, “No smoking!” But it was done so slowly. And it’s like the government says, “This is better for you… this is better for you… So were going to take it from you.” That’s the way I felt. The government just decided that we’re going to take the billboards out. You know what? I have a strong-mind, I’m strong. I never drink, I don’t like liquor, and just because people drink doesn’t mean I’m going to drink and follow the leader. The government thinks maybe if we take all this away, they’re going to kinda control the people smoking. If I don’t want to smoke, I don’t smoke. If I don’t want to do this, I don’t do it! I don’t care if you do it. So I kinda think it’s a choice, you know? It’s a choice, so let people choose what they want to do. If you don’t want to do something, you don’t have to do it. It’s not monkey see monkey do. But, if you’re a follower, you’re gonna follow anything, not only smoking but other stuff. I was not a follower because my dad made sure I was always a leader, not a follower.
Let me ask you… has taking away the signs, all the stuff in the commercials, has it made a difference where people stop smoking? Or is it worse now? Because I see more younger kids smoking than before when I was growing up. I don’t know if it’s the way kids are being raised nowadays? Because when I was growing up, it was only grown-ups who smoke. When my mother and father found out that I was smoking at 16 under their roof? It stopped. I really believe that it starts at home with the parents. Things happened at my parents’ houses just because my father or mother said so. I was raised by that. For my kids, just because you see me smoking now doesn’t mean that you can start smoking at 16. No! When you’re 18, and you get the hell out? You can do whatever you want! But in my household you’re not going to do it. And when I was growing up, we respected that.

People nowadays don’t have any type of integrity or anything. You know if you’re out smoking, people constantly, “Gimme a cigarette. Can I have a cigarette? Can I have a cigarette? Can I have a cigarette?” Give me a freaking break! If you smoke, then buy your own cigarettes because I’m on a budget and if I give you a cigarette, and I give you a cigarette, and I give you a cigarette, just being nice? I won’t have any cigarettes! And this is like an everyday thing for people nowadays. I was raised where if you want to do something you worked for it. You didn’t have the money? Then you didn’t get it. Or you save the money and then you get it. I was raised on a budget. I was raised to handle money well. Like right now, I have $40 every two weeks for my cigarettes. So, if I’m giving them to other people because I’m trying to be nice, I’m like, “No!” Buy your own damn cigarettes! I just don’t get it. I don’t get it.

You know what else? I think the government, they just tax and tax. I’m just speculating that they came up with taxing cigarettes as an excuse so people won’t buy cigarettes, which is bullshit. My opinion? It’s just as an excuse, all this banning of smoking here and there, it’s just
an excuse to tax up the cigarettes, that’s all. It wasn’t that they really cared. The government’s off the chain! They just tax and it, and tax and it. “Guess what? Since y’all want to smoke, and I know you’re addicted to it, we’re going to put the price up to $9.00 or $10.00 a box and you either buy it or you don’t.” Everything is tax, tax, tax, tax! I remember when there was no taxation, no representation. We should go back to that.

Right now, what I’m doing is actually buying the tobacco and the cigarette things and rolling them because it’s cheaper. I think it’s like less than $20 and you get 10 to 11 packs on a bag. So I manage it and I’m cutting down because of my budget. So yeah. I feel like it’s off the chain when it comes to, you know, they’re constantly like, a dollar extra for the cigarettes. It’s crazy you pay eight or nine dollars for a pack of cigarettes. I kind of think it’s taking advantage.

When they started banning smoking in places, I was pissed….to say the least. I was like “Dang! I can’t smoke here now?” If I want to smoke now, I have to go all the way down to the parking? In a hospital I kind of understand. It’s okay. But sometimes, you could be anywhere and you can’t smoke. Let’s say you go to the Concert Arena. You can’t smoke! You have to go somewhere else to smoke. You can’t go here and smoke. You can’t sit down in a coffee place, coffee shop and you know outside or something, you can’t smoke. When that happened, I was upset because it was like, “Wow!” You know they are taking kind of everything from the smoker and I think it was kind of unfair to the smokers. But you get used to it. What can you do?

Now, I live in public housing. It’s a brand-new building and you’re not allowed to smoke in because it’s nice there. The regulation there says you have to be 75 feet away from the building to smoke. Some people don’t like the reg and they say, “I’m going to go smoke in the car”. But, the parking space is right in front of the building! So I tell them, “Look, you don’t
want to smoke there because they’re going to kick you out.” They say, “Well I don’t care!” and I say “Okay!” You go ahead and do that homey. You’re bad to the bone. Smoke in your apartment, smoke in the car if you want to, I know I’m not going to do it.

So you know, I try to make people aware that really don’t know and I try to explain to them. First of all it’s wrong because if the reg applies to everybody not only to you, it’s everybody. If you start the habit of being bad then the other followers are going to follow you and it’s going to create a lot of tension and problems in the building. So, you start with smoking the next thing you’re going to start doing different things in there, and there goes the neighborhood for other people that follow the rules. So I tell them, stop being lazy and go outside the house. Plus it stinks in the house, it stains the windows, the walls, and makes your clothes stink.

But then again, we are the consumers and we have a habit so either we can quit or we don’t have to quit. We do have a choice and nobody puts a gun in your head and says smoke. It’s just, you follow the rules, and you take it or not. I don’t feel picked on personally. No. Things like taxes and banning smoking in places, that’s across the board for everybody. Now, if they were like, “Okay Katalea, you have to pay five dollars in taxes…” then, yeah, I’m gonna be mad. But some of these regulations, I kinda understand and I don’t see that I’ve been discriminated. That’s the way it is so you pay the piper. You want to smoke? You pay more taxes and you smoke outside.

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All these health problems though? I think they’re exaggerating. Why? It’s just a monopoly of the government. Like I said before, a form of control, communism. Control! You know, the government’s thinking. “We’re going to tell them that it’s bad and slowly but surely,
even if they don’t want to quit we’re going to make it harder for them to do what they want.”

Then, little by little they start. First with commercials, next we’re going to start with this, and next thing they take it away from you. Not only cigarettes, but anything. And they do it very...

How you say in English?... Subtle! By the time you know what? It’s like, “Boom! What the hell happened?” And I think this is the most wonderful country in the world because you’re free to do what you want. To make a choice. I want to smoke, or I don’t want to smoke. But I don’t want the government to tell me “You can’t freaking smoke because it’s not good for you.” Get the hell outta here, man! Now I make a choice.

**Narrative Summary: Katalea**

Katalea’s narrative is heavily influenced by her libertarian political views and she is highly **Distrusting of Public Intellectuals**. Though she is **Aware and Accepting** of the public health pedagogies about the harms of smoking, she believes that the government “exaggerates” these messages with the intention of **Controlling** people. This leads her to some **Disregarding** beliefs such as **Playing the Odds** (if you want to smoke, smoke. I make a choice) and to some **Avoiding** behaviors such as rolling her own cigarettes.

Although Katalea distrusts public intellectuals, her narrative does not contain examples of rebellion or outright denial of public pedagogies. Rita, the last participant narrative in this chapter, provides the best example of denial of public pedagogies based on a philosophical world view of “control” by public intellectuals.

**Introduction to Rita**

Rita is a 52 year old white female who has a high school degree and has completed some college. Living with her in her home are her nephew, his girlfriend and their child. She currently receives Social Security disability benefits. In the past 5 years, members of her
household have received Supplemental Nutrition Assistance (SNAP), Medicaid, and they receive assistance to pay for their heating bills.

Rita’s parents divorced when she was in kindergarten and she and her sister primarily lived with her mother. They would visit her father on weekends and one day during the week. Although Rita was her father’s favorite (he was disappointed that her sister wasn’t a boy), he was psychologically abusive and would “tear down” her mother during their visits. She describes her father’s behavior at that time as hypocritical particularly since he had “found God” again and was a “Christian”. This situation caused her significant distress and by the time she was in 4th grade she started seeing the school counselor because she had become withdrawn in class, was frequently sick, and started missing school. She decided to stop seeing her father when she was 13 and her father made no efforts to contact her or reconcile with her. Around this time, Rita’s mother re-married to someone she describes as “a nice man.”

Rita currently smokes around 20 non-menthol cigarettes per day and she smokes within 20 minutes of waking up. She states that she is not brand loyal and, due to the cost of cigarettes, she also smokes around 10 little cigars per day. She has made at least 2 quit attempts in her lifetime, but has never used any FDA approved medication to quit smoking. The last time she quit smoking was 23 years ago and it was because she was in a relationship with a man who did not smoke. She didn’t smoke for 4 years during that time.

Rita’s overall opinion of tobacco is neither negative nor positive. She never thinks about the harms that cigarettes may be doing to her health and she believes that cigarettes are only slightly harmful to health. She states that her overall health is fair and that she has been diagnosed with depression and anxiety disorders. She also describes other medical conditions that she is dealing with in her story below. Rita’s story is one of Distrust of Public Intellectuals
and her narrative begins (in italics) with information about her life that contributed to this distrust.

**Rita’s Story: Not a Member of the Snowflake Brigade**

*If I had known what emancipation was when I was 16, I would have petitioned to be emancipated. In the course of my life, probably the only horrible thing I haven’t experienced as a woman is that I haven’t been raped.*

*My parents got divorced when I was 6. My father was emotionally and mentally abusive to me. I had a contentious relationship with my mother...When I was 12 years old, I was taking care of the whole house, cleaning, doing everybody’s laundry, changing the sheets, watching my sister after school, and cooking dinner because my mother and my stepfather both worked. When I was 16, I discovered boys, I was going out, I started having sex, and I was drinking under age.*

*When I was older, I made poor choices for marriages, and I’ve been married three times. I’ve been involved with physically abusive people, I’ve been lied to, cheated on, stolen from, and beaten up. I probably have PTSD and I’ve actually been diagnosed with major depression disorder, slight agoraphobia, fibromyalgia, arthritis all through my major joints and my spine, and I have chronic pain issues.*

*I have issues! And yeah, I’ve made poor decisions and I’ve allowed myself to be manipulated. Here’s the thing...if it can happen to me on a personal level with someone that I trust and that I believed to be honest with me? Yeah, it’s very easy for it to be done by the government or corporations to a member of the masses. For a long time when I was younger I didn’t say “Boo”. But my life experiences have taught me that there’s always an ulterior motive*
to something. There’s always an innuendo and you need to ask, “Why? Really? Explain this to me.”

I’m an intelligent person and I’ve always asked questions and said, “I’m not going to take you at your word, explain this to me, break it down”. All right? I suppose I’ve adopted this idea about self-determination... that you have to be responsible for your own actions. I mean, advertisements, corporations, the government, they throw information at you, and they shove it down your throat every time you turn around. They tell you what they want you to know in order for you to form the opinion they want you to have.

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Part of what goes on with all this anti-smoking stuff is because a lot of people decided that everybody else should live the way they want them to live. So, they raise a big stink. They get political action committees on board by putting money into politics and they push their personal agenda. So, maybe it’s a result of having had some additional education and being exposed to a different thought process other than just feed me the information… I’m not quite sure how to put it, but I don’t ever take anything at face value anymore. My thought process makes me question and ask why.

I think when I really started to have more opinions about cigarettes was probably when they started having the Congressional hearings and all the whistleblower stuff was being released. I was picking things up on news broadcasts, seeing news coverage on CNN and C-SPAN, in print, documentaries, stuff like that, and I was angry. The cigarette companies have been manipulating the content of a cigarette for over 50 years and their whole purpose in the chemical manipulation was to keep you smoking. The executives all knew that they had chemists on staff actively manipulating the nicotine content of cigarettes. They knew they were actively
experimenting with different chemical compounds to boost the nicotine’s natural effectiveness and its natural attachment to nicotine receptors in the body. They knew it! And they’re getting paid millions of dollars in salary to sit there in front of Congress and lie. Lie, lie, lie, lie, lie!

That they were lying was proven in the documentation that whistleblowers eventually got out to the public. The whistleblowers had to sign non-disclosure agreements at their jobs. Really? What are you doing in your business practice that it is like… a national secret? The whistleblowers had a problem with what they were being told to do and they had a problem with not being able to speak their minds, and I understand that. I have an issue with that too.

I think that there needs to be more transparency in business across the board. It kind of ties into an issue that I have with CEO and CFOs, who are in that upper, upper, upper nosebleed level of management. I have issue with that when it comes to pay equality that’s completely separate from the fact that they were cigarette executives. Really, any executive I have an issue with because, listen...You know what? Unless you started out like in the mail room and really worked your way up and you could absolutely positively do every job in the company that you oversee? I’m sorry Sweetie, I don’t care how many degrees you have. You really are not worth a $5 million a year compensation package. Not when you have people on the very lower levels trying to work their way up that are struggling and have to apply for assistance. No. I have a big issue with corporate pay equality.

I remember when they stopped all of the advertising, when they had the big issue that tobacco must pay. That kinda pissed me off because for me, you know what? I’ve been a smoker for a long time now. I chose to smoke. I didn’t smoke because I thought it would be cool. I didn’t smoke because I love the Marlboro man. Okay? I didn’t smoke because I had a dream where Joe Camel said you must smoke! So, I felt like they were really dumbing it down to act like people
who smoke do it because they’re such sheep-ple that they don’t have the will to make their own decisions. [Whining sarcastically] “I only smoke because the cigarette companies said it was safe.” Bullshit. I was angry at the people who pushed it to the point where they wanted somebody to pay for the results of their own personal decisions. They’re like the slip and fall experts who get $1 million from McDonald’s because there was a French fry under their table. Okay?

As a smoker, the big cigarette lawsuit really pissed me off. I’m not sure where all of the sudden it was this anti-smoking thing. They never had the need to go after alcohol producers or the whisky distillers, or the beer manufacturers. You know, they never said, “I see all these commercials for alcohol, it’s their fault that I drink! It’s their fault that I’m an alcoholic. It’s their fault that I’m a drain on the system and I’m on the list for a liver transplant because I’ve got necrosis of the liver and cirrhosis.” Where’s those people? I never lost control of my car driving with a cigarette and killed somebody. I’m not gonna overdose on nicotine.

What I think is that somebody got it in their head that cigarettes are big bugaboo. Somebody got it in their head that this is a problem and somebody needs to pay. When are they going to start going over to the pharmaceutical companies and going after the doctors who overprescribed all these substances like the big OxyContin and everything else? When are they going to start taking the licenses away from doctors who overprescribed this shit? That’s where the fault lies, but see, it’s easy to just pick one bad thing...okay...smokers!

I don’t really think that it did anything for the FDA to get involved with regulating cigarettes. Now they finally want to regulate the amount of nicotine? Well, were they concerned about the amount of nicotine 20 years ago when they first started this brouhaha about what’s in cigarettes? If cigarettes are dangerous, why didn’t they want to address the nicotine levels then?
That was one of the major things that came out in the paperwork that got disseminated. They knew that nicotine was the thing. They Surgeon General said nicotine’s addictive and it’s as bad as heroin and cocaine. Really? Okay then, so why is it still legal to sell this product? If it’s so flippant dangerous why is it so widely available?

Really, everything you do is dangerous! Walking down the street dangerous! Especially in this day and age. It could be that somebody is having an argument inside their house and one person picks up a gun and shoots the other one and they miss and it comes out the window and kills me... Because I’m standing in front of their house. I think no matter what you do smoking, drinking, driving, whatever you’re going to do, there is an inherent risk involved. You can’t get away from it. But the bottom line is you choose to do it. You choose to do it and I don’t think anybody should have to pay or compensate you for the consequences of your choice.

The experts say you can get emphysema, COPD, it contributes to heart disease, it contributes to stroke, yeah all the big scary stuff, cancers. Okay? Yeah, I’ve never in my life met somebody who says, “I have lung cancer because I smoked.” “I have esophageal cancer because I smoked.” I think these things could be related to smoking, but my theory is that people are predisposed to it, genetically predisposed.

My oldest aunt Andrea, she quit smoking when she was diagnosed with COPD, but her COPD was a result of having worked her entire adult life in the textile industry. Her and her husband owned a clothing factory where they made house coats so she was constantly exposed to those really minuscule particles of fabric and stuff floating in the air. So, that was the thing for her. And you know what? I’ve been smoking since I was 15 and I had pneumonia this year for the first time in my life at 52. I had lung x-rays, my lungs look fine. The doctor tells me there’s nothing in there that shouldn’t be there.
Now of course every time the doctor sees me he says, “You going to quit smoking yet?” And I say, “No, not yet.” Then he says, “Okay, we’ll have this conversation again.” I have a lot of other things that I want to get in control. I’m not ready to stop smoking yet. And you know why he asks me that every time? Because he supposed to! There’s always a payoff somewhere because we’re a capitalist society and greed is the god. The pharmaceutical companies have products like Chantix and Nicoderm and there’s other medications out there too. They’re making just as much money on the nicotine replacement products as they do on the cigarette to begin with.

Those corporations pay taxes on certain things so there’s a payoff somewhere and the tobacco industry is like any other major corporate industry in this country. They pay millions of dollars and hire lobbyists to keep Congress in their back pocket and to manipulate the laws and the regulations as much as they can to their benefit. I don’t think it did anything at all whatsoever to get the FDA involved in cigarette regulation because I believe that there’s part that of the FDA that is just as corrupt as members of Congress who cater to big business and their lobbyists.

In the end, the only benefit to me that I can see to stop smoking is financial. That’s why I smoke the little cigar things now because of the prices in Pennsylvania. Sure, I would prefer to keep smoking my Pall Malls, but I never was brand loyal. Really, what difference does it make what brand it is? If I get a coupon in the mail, I’d smoke that brand because it was cheaper. For me to buy a carton of Pall Malls is almost $70. Instead, I go to the smoke shop and I can get a carton of little cigars for less than $10. There’s 20 in a pack, they look like a cigarette and they taste like a cigarette, mostly. They have plain ones, but they also have ones that are light, fruit flavored, or ones that have a little bit of a vanilla.
So yeah, as a smoker, taxes make me angry. I don’t benefit from those taxes and I don’t have any choice in how Pennsylvania spends those tax dollars either. And the people that signed up for that class action lawsuit, they thought they were going to actually get money. Well, the money isn’t going to them, it’s going to the states. And it doesn’t necessarily go within the state to be put into their advertising for smoking cessation. It’s not.

What’s funny is...okay... my little cigars are made in New York and they have this label... “Warning cigars contain many of the same carcinogens found in cigarettes and cigars are not a safe substitute for smoking cigarettes.” But it’s this California thing that cracks me up. “Contains chemicals known to the state of California to cause cancer and birth defects and other reproductive harm.” But only the state of California knows this which I think is really interesting, because they know everything.

So am I’m just wired different and I know this about me. What these anti-smoking people have to say, it just doesn’t reach me and it doesn’t apply to me. Now other people who are scared of their own shadow, I call them “The Snowflake Brigade,” they’re going to see one of those anti-smoking ads and be like, “Oh wow man! I don’t want to lose my face” (2014 FDA’s Real Cost Campaign, Your Skin). But it doesn’t mean anything to me. For me they’re wasting their money because they are the people that think that we should live the way they want us to live. They’re the ones that want to impose their lifestyle on everybody else because they’re so self-righteous. Maybe they’re at the pinnacle of their health. Whatever. But they’re hand-in-hand with the people who believe that we should worship like they do. They’re hand-in-hand with the people who believe that women’s reproductive rights should be handled according to their personal religious beliefs. To me, cigarette smoking is just a little piece of the chain of personal behaviors that link all of them.
This sounds weird but I think it’s basically about keeping everybody in order and identifying those who refuse to be corralled with everybody else. Now me, I come from farm people. I’m not part of that particular class that wants to make the rules and I see our society headed in a very dangerous direction has nothing to do with the basic principles that our country was started on. But these people like to nitpick the little things and it started with cigarettes because the cigarette was the easy one. And, everybody was like, “Oh yeah, yeah!” Now, somebody somewhere is sitting back and saying, “Okay, well, we pretty much got the cigarette thing handled. What’s next? What are we going to go after next?” As they light their cigars and pour themselves a glass of whiskey.

**Narrative Summary: Rita**

Rita’s narrative is heavily influenced by her *Distrust of Public Intellectuals* which causes her to *Doubt (or Deny) the Veracity* of messages such as those related to the harms of smoking. She also *Plays the Odds* by equating what harms there may be in smoking with all other risks in life such as “walking down the street”. For her, taxation and the cost of cigarettes leads her to *Seek Alternative*, cheaper products (little cigars) and she *Denies* any of the benefits that may come from quitting smoking other than ones that might be financial. The most important theme in Rita’s narrative is how she believes that there is a class of *Anonymous Intellectuals* who are trying to *Control* smokers simply because they believe others should live the way that they do. She also *Perceives Hypocrisy* and *Suspects Corruption* among this “class of people”.

**Chapter 5 Summary**

In this chapter, I presented the re-storied narratives of 10 participants interviewed during this study. I presented themes that emerged from the participant interviews in Chapter 4 but I
have also summarized the themes that participants discuss during their narratives in the summary at the end of each participant’s story. The narratives presented in this chapter demonstrate that the participants can, and do, hold conflicting beliefs about cigarettes and their influence on health. This is the case even when a participant represents one theme more strongly than another (e.g., Rose is generally Accepting of public health pedagogies, but also Learns to Avoid them). Additionally, although there are commonalities between the participants, each one has individual experiences that make their stories unique and contribute to their personal understanding of public health pedagogies (e.g. Katalea is Distrusting of Public Intellects due to her political perspective whereas Rita’s distrust is more related to social class).

In the next chapter, I will integrate the results from both the narrative analysis and the thematic analysis as I discuss the implications of this study and offer insight into how the findings of this study can inform the fields of Adult Education and Public Health.
CHAPTER 6

Conclusions and Implications

At the outset of this study, I sought to understand what low income smokers have learned from a lifetime of exposure to public health pedagogies. I also sought to understand how smokers made meaning of the various public health pedagogies they received and how this information contributed to their smoking behavior. Finally, I wanted to understand if the individual’s perceived position within society contributed to their understanding of public health pedagogies.

There have been several studies that have assessed exposure to individual public health pedagogies including things such as knowledge about the harms of smoking from pack warning labels (Hammond et al., 2007), how smokers perceive the imposition of taxes on cigarettes (Guillaumier et al., 2015; Hoek & Smith, 2016), acceptability of clean indoor air laws (Albers et al., 2004; Crawford et al., 2002; Jones & Williams, 2012; Stillman et al., 2015), and evaluations of mass media campaigns (Duke, Alexander, et al., 2015; Farrelly, Davis, Haviland, Messeri, & Healton, 2005; Farrelly et al., 2017; Farrelly et al., 2002). However, few studies have sought to understand smokers’ perspectives on the field of tobacco control (Frohlich et al., 2010), and to my knowledge, this is the first study to use an adult education perspective to holistically assess what smokers have learned from a broad range of public health pedagogies.

Findings from this study contribute to bodies of literature from both the fields of adult education and public health education in several ways. First, the study data suggest that participants were exposed to a variety of public health pedagogies and that this exposure contributed in a cumulative way to their existing knowledge about the harms of smoking. This knowledge also contributed to smoking related behaviors, some of which were accepting, and
some of which were disregarding or avoiding. These disregarding and avoiding behaviors were not what was “taught” to smokers, or what was expected of smokers to do, based on the messages. Next, since many of these pedagogies were not implemented in the context of traditional “instruction” and knowledge about the harms of smoking that was learned from one pedagogical message was transferred to others which contributed to the meaning that individuals placed on them. Also, social position played a role in how individuals received and made meaning of public health pedagogies including how much the individual trusted the message that was being received and the individual’s perception of the motives of the teacher. Finally, there were some pedagogical messages that I identified as missing from the current public health pedagogy curriculum, most importantly, educational messages that challenged the smokers’ negative experiences of quitting smoking and those that instructed them on ways to successfully quit.

In the following sections, I discuss the study findings above in more detail with a focus on how the results offer insights into the aims of the study. I also place this study into the context of the existing literature. Finally, I discuss the implications of the study for practice and research in the fields of adult education, public pedagogy, public health, tobacco control, and tobacco regulatory science.

Public Pedagogy Exposure

The first aim of this study was to identify what public health pedagogies smokers were exposed to throughout their lives. The most commonly discussed pedagogies, were those in the category of Dominant Societal Discourse (44% of all discussed) which included laws (e.g. clean indoor air, taxes, and age of sale laws), litigation, and Congressional testimony. One reason this category may have been so frequently discussed is that some smoking-related laws are uniformly
applied to cigarettes and public spaces such that nearly all individuals in the study were exposed to them. For instance, every smoker who purchases cigarettes is exposed to the cost of the cigarettes and is aware that costs are going up due to taxes. Likewise, the ubiquity of clean indoor air laws in public spaces makes it virtually impossible for a smoker to carry out their public activities of daily life without encountering a smoking restriction at some point during their day.

In contrast, the participants only brought up two examples from the category of Informal Institutions and Public Spaces, which were hospital campus smoking bans and CVS pharmacy, and these were brought up during the interviews because a participant had been to these locations personally. Likewise, participants who lived in, or knew someone who lived in, public housing were aware of the 2016 public housing smoking ban. In these instances, the participants needed to be physically present to be exposed to the pedagogy and this may have contributed to why there was such limited exposure to these pedagogies.

The difference between public health pedagogies that require physical presence and those that are more omnipresent in society, such as laws and taxes, highlights the importance of considering what constitutes a “public”. Savage (2010) has criticized public pedagogy scholars for failing to define “public” when engaging in this type of research and suggests that socioeconomic privilege can create “different social worlds” and “multiple and disparate publics” (p. 104). This idea is important for scholars to consider when thinking about how people came to have access to a particular “public” pedagogy. As I found in this study, not all “publics” were equally accessible and participants described disparate publics even though all of them were of low socioeconomic status. For instance, Johnny worked full time and was able to receive smoking cessation medications and counseling free through a work insurance program while
Vince, who also worked, did not have any insurance. Similarly, Rita followed the Congressional testimony of the tobacco CEOs (1994) on C-SPAN (a paid cable channel) while Tina stated that she can’t afford to have cable.

A large proportion (20%) of the participants’ interview discussions focused on the category of Popular Culture and Mass Media with the main focus on paid mass media campaigns. This finding is in agreement with other studies that have measured campaign reach of the current nationally funded campaigns. Investigators who have examined data from both the CDC’s Tips from Former Smokers campaign and The Real Cost Campaign found that the majority of the participants had a general awareness of the campaign messages (Davis, Duke, et al., 2017; Duke, Alexander, et al., 2015; Farrelly et al., 2017). Nearly half of the participants in this study remembered, and were able to describe message content from, truth initiative ads, some of which were viewed during their high school days (e.g., “Tobacco Kills”, 2003). These historical accounts are consistent with the timeline of the truth initiative campaign launch in the early 2000s (Sly et al., 2001; U. S. Department of Health and Human Services, 2014) and offer encouraging evidence that long term learning can be achieved through mass media campaigns.

Twenty-nine percent of the discussion centered on public intellects and this was largely driven by Anonymous Intellects (“they”) that participants would refer to during the course of the interview. Although the focus of this study was on smoking and the field of public health, it was not always clear to me exactly who “they” might be that smokers were referring to and often the individuals’ references were actually metaphors for deeper assumptions and world-views. For instance, Frohlich et al. (2010) conducted a study of low income smokers and observed that individuals would reference anonymous intellectuals and identify a connection between the “they” of tobacco control, and the “they” who would bring about communism. There were
similar connections drawn in this study which participants used to provide evidence that “they” cannot be trusted. This is a finding that reveals the “political nature of health problems” (Eakin et al., 1996, p. 163) which I will discuss further in later sections.

In summary, this study found that that smokers were most commonly exposed public health pedagogies in the category of Dominant Societal Discourse possibly because of the broad and uniform way that they were disseminated in society. The next most frequent categories were Popular Culture and Mass Media and Public Intellects. The category that was least discussed was Informal Institutions and Public Spaces possibly due to the requirement that individuals must be physically present at a specific location in order to be exposed to them. This finding in particular, supports Savage’s argument that not all public pedagogies are equally “public” and suggests that scholars using public pedagogy as a framework for empirical work should carefully consider whether all their participants have access to the pedagogies they are studying. In the next section, I will discuss what smokers in this study learned from the public health pedagogies they identified.

**Learning that Occurred**

The second aim of this study was to gain an understanding of what smokers learned from their exposure to public health pedagogies and to understand how they interpreted this information. Here, I will discuss primarily factual, technical knowledge (Terry, 1997) that the participants identified and although much of the knowledge that they acquired prompted them to behave in new or different ways, I will discuss the behaviors that were prompted by this knowledge in a separate section.

There are four main findings related to knowledge that the smokers in this study learned from public health pedagogies. First, participants were aware of public pedagogies about the
harmfulness of smoking, and they had technical knowledge about diseases that were caused by smoking. Second, there was evidence that this knowledge accumulated over the course of the participants’ lives and this reinforced the messages they received. Third, the knowledge that smokers accumulated over time about the harms of smoking was applied to pedagogies that did not have overt instructional messages. For instance, the implementation of pedagogies such as cigarette taxes or clean indoor air laws are not accompanied by instructional materials, however participants transferred their knowledge about the harms of smoking to pedagogies like taxes and this transference of knowledge contributed to how they made meaning these pedagogies.

Fourth, some public health pedagogical messages were so familiar to the participants that “non-learning” occurred (P. Jarvis, 2006) and some learning that occurred was counter to the pedagogical message because the participants’ experiences were mis-educative (Dewey, 1938). The most common mis-educative experiences the participants described were those related to quitting which almost always resulted in reinforcing their belief that they could not quit.

**Technical Knowledge**

Data from this study suggest that the participants had specific knowledge about many smoking-related harms, and for the most part, they took a general view that smoking is “bad”. That most people are aware that smoking is “bad” for health is not a surprising finding and confirms previous studies which found that the vast majority of the population in the U.S. knows that smoking is harmful (Leidner et al., 2015; Schudson & Baykurt, 2016; U. S. Department of Health and Human Services, 2014). In addition, all the participants interviewed for this study had technical knowledge about specific harms of smoking and they connected this knowledge with their exposure to a variety of public health pedagogies. These findings are also in agreement with many other studies that have documented an association between public health
pedagogies and smokers’ awareness of smoking related-harms (Davis, Patel, et al., 2017; Dietz et al., 2008; Duke, Alexander, et al., 2015; Farrelly et al., 2017; Hammond et al., 2006; Neff et al., 2016; Richardson et al., 2010). More specifically, participants were able to connect their knowledge of lung cancer, heart disease, emphysema, and birth defects to information on cigarette pack warning labels and they connected a variety of harms to themes from national mass media campaigns. These included death (truth initiative, “Tobacco Kills”, 2003), gum disease, (FDA The Real Cost campaign, “Your Teeth”), skin damage (FDA The Real Cost campaign, “Your Skin”, 2014) and, cancer, heart disease, and amputations (Tips from Former Smokers, 2012, Terrie, Brian, Shawn, and Bill or Brandon).

Historically, the curriculum of tobacco-related public health education has been focused on how cigarettes harm health (Kozlowski & Abrams, 2016) with the expectation that knowledge of harm will be sufficient to motivate individuals to quit smoking (National Cancer Institute, 2008). During the course of this study, participants demonstrated that they have acquired a substantial amount technical knowledge about the harms of smoking. However, as I will discuss later, few of the behaviors that these pedagogies contributed to included quitting.

**Cumulative Knowledge, Experience, and Meaning Making**

Results from this study also suggest that the knowledge that the participants acquired about the harms of smoking was cumulative and that personal experiences either reinforced the pedagogical messages they received or caused the participants to doubt the veracity of some messages. The cumulative nature of their knowledge acquisition is best laid out in the narratives because the participants often discussed the differences between what they knew in the past, and how they made meaning of that event in the present. Many of the participants described their first learning experiences about the harms of smoking as forms of familial disapproval. For
instance, Katalea describes how she received a beating when her parents found out that she had been smoking. After describing parental disapproval, the participants then progress in time to other events such as how they acquired specific technical knowledge about the harms of smoking through learning experiences they had at school, at work, and throughout their daily activities. For instance, Rose learned in health class how smoking harms to the “little air sacks” in the lung, Katalea remembers Surgeon General C. Everett Koop talking about the addictiveness of nicotine, and Zach reflects on the harms of smoking he learned about through mass media campaigns (e.g., throat cancer, lung cancer, heart disease, breathing problems).

Clark and Rossiter (2008) remark, “learning in adulthood is integrally related to lived experience” (p. 63) and the participant narratives demonstrated that there was an “interrelationship between time and meaning” (Rossiter, 1999, p. 82). As the participants shared their stories and described how they understood the harms of smoking, their stories were not isolated to describing their exposure to a single pedagogy (e.g., a warning label). Rather, their exposures to public health pedagogies were combined with their life experiences and they made new meaning of these previously separate entities. For instance, in Courtney’s narrative, she describes how Terrie’s Tips from Former Smokers ad reminded her of the many friends and family members she watched die from lung cancer and other cancers. Courtney’s knowledge of cancer included an awareness that the disease is related to smoking but, for her, the meaning of Terrie’s ad also included all the other experiences that occurred throughout her life. In addition, because she watched so many loved ones suffer from cancer she also believes that she is “high risk” for cancer; a belief that contributes to her general outlook on life.

Considering how individuals learn and make meaning of both public health pedagogies and their life experiences is in direct contrast to the methods that are often used by the field of
public health to evaluate knowledge. These evaluations are almost exclusively focused on technical knowledge or awareness of isolated public health pedagogies such as warning labels (Hammond et al., 2007) or mass media campaigns (Duke, Davis, et al., 2015). For instance, Hammond et al. (2007) conducted a study to evaluate smokers’ knowledge of information on cigarette pack warning labels where the authors asked smokers to state whether they believed smoking causes heart disease, stroke, or lung cancer using the possible responses of “yes”, “no”, or “don’t know”. They found that 94.3% of respondents in the U.S. believed that smoking caused lung cancer, and concluded that this information was confirmation of knowledge. Certainly these types of evaluations confirm technical knowledge, but they do not assess all the other meanings that an individual may place on that particular piece of knowledge. Courtney would definitely say “yes” if asked on a quantitative questionnaire whether smoking caused cancer, but her lived experience of cancer is “integrally related” to her knowledge of cancer (Clark & Rossiter, 2008) making its meaning deeper, and more complex than her “yes” response. For her, she is “high risk” for cancer, and she believes there isn’t much she can do to prevent the disease. This is because she has personal experiences of people who had cancer; some of whom smoked and some of whom didn’t smoke. Thus, although the field of public health often assesses technical knowledge that has been acquired from individual public health pedagogies using isolated assessments, findings from this study, viewed through the lens of public pedagogy and adult learning, suggest that previous exposure to multiple pedagogies contributes to knowledge in a cumulative way and meaning is more complicated than simple awareness.

**Transferring Knowledge and Putting it Together**

A new finding from this study that, to my knowledge, has not been previously documented is that the smokers in this study were able to explicitly state the purpose of several
public health pedagogies such as clean indoor air laws (to limit others exposure to second-hand smoke), taxes (to decrease cigarette consumption), and age of sale laws (to restrict access of cigarettes to children), and advertising restrictions (to restrict marketing to kids). Though this seems like a detail that would have been previously studied, other studies have not assessed participants’ knowledge of why these pedagogies were implemented. Instead, they assessed things such as whether smokers were supportive of clean indoor air laws and smoking bans (Jones & Williams, 2012; Stillman et al., 2015), or how they managed increases in cigarette prices (e.g., taxes) (Guillaumier et al., 2015; Hoek & Smith, 2016).

The participants’ narratives suggest that they transferred information from public health pedagogies to help make meaning of their personal experiences and this combination contributed to new learning or reinforced existing knowledge. For instance, Frances initially responded to Terrie’s Tips from Former Smokers ad with tears and sadness because she believed that what happened to Terrie could happen to her or others. This was an experience that was reinforcing of her existing technical knowledge about the harms of smoking. She then said that after seeing the ad, she “put it together” that an acquaintance of hers who a tracheotomy, must have had throat cancer due to smoking. This was the creation of new knowledge for her that placed her lived experience at the forefront and provided greater meaning to the ad’s message since she personally knew the challenges that this individual faced as they lived with the consequences of their smoking. This experience also left her with a sense of helplessness as she realized that she too could face this outcome, but she did not see any way to successfully quit smoking.

These findings are in agreement with other studies that also found that public pedagogies “teach” by helping participants put together pieces of information (C. Jarvis & Burr, 2011; Popova et al., 2017; Wright, 2010). For instance, two previous studies assessed how TV taught
viewers and found that when individuals watched TV shows, they related to the shows by connecting pieces of their own lives to what was occurring in the scenes (C. Jarvis & Burr, 2011; Wright, 2010). As these fictional TV scenes played out on the screen, they either reinforced the individual’s existing beliefs (C. Jarvis & Burr, 2011), or challenged their existing beliefs and social norms (C. Jarvis & Burr, 2011; Wright, 2010). In addition, in a study about perceptions of tobacco and marijuana use, participants transferred the information they received from a cancer-related warning label on marijuana blunt wraps to the experience of the death of a loved one from cigarette-related cancer (Popova et al., 2017).

However, though there may be evidence that the participants “put together” the purpose of taxes, advertising and marketing restrictions, and clean indoor air laws, how this process occurred was not explicitly stated by study participants. Complicating the matter is that pedagogies such as taxes, clean indoor air laws, and marketing restrictions do not come with instructional leaflets stating exactly why they are being implemented. Nonetheless, every participant who discussed these things was able to state what the intention of these pedagogies was in terms of public health.

Using taxes as an example, I propose that there are at least two possible explanations for why participants did not describe how they “put together” the intentions of this type of pedagogy. One possible explanation is that the participants were exposed to this type of learning experience, but they did not bring it up during the course of the interviews because they forgot where they learned it. Certainly, it is possible that participants saw information about the purpose of cigarette taxes on the evening news, or it was discussed with individuals in their social circle, but they don’t remember the specific event that caused learning. P. Jarvis (2006) describes this type of learning as pre-conscious and suggests that it may occur before the individual is even
conscious of the event. In this way, these unexplored learning experiences could have contributed to the participants’ knowledge of taxes and other public health pedagogies.

Another plausible explanation is that smokers transferred their technical knowledge of the harms of smoking to new pedagogies as they encountered them. This type of transference of knowledge is at the center of experiential learning and constructivist learning theory which assumes that “previously learned knowledge and experiences influence new learning” (Caffarella & Barnett, 1994). In this case, it is possible that smokers who had previous knowledge of the harms of smoking applied this knowledge to new public health pedagogies, such as cigarette taxes. Another very likely possibility is that both of the above scenarios occurred at some point during the course of the individuals’ lives which contributed to their current knowledge of several public health pedagogies.

The data I presented in this study provide evidence that knowledge about the harms of smoking is acquired through public health pedagogies and new information accumulates throughout the course of their lives. For some pedagogies, such as mass media campaigns, participants associated the information in the ads with personal experiences that either contributed to new knowledge or reinforced old information. In addition, they used knowledge about the harms of smoking, acquired over time, to construct meaning for new pedagogies to which they were exposed. In this way, they understood the intentions of many public health pedagogies (such as taxes), and for the most part supported them, even if the purpose of the pedagogy wasn’t explicitly stated.

**Experience as Non-learning or Mis-Educative**

While it is encouraging to me that smokers in this study learned new information and were able to transfer this information to other pedagogies, some of the pedagogies to which they
were exposed did not contribute to new knowledge and some of them contributed to learning that was contrary to the intentions of the pedagogy. The narratives and the thematic analysis I present in this study demonstrate that participants received the public health messages that smoking is “bad” and they further understood that these pedagogies were encouraging them to quit. In fact, the information about the harms of smoking was so commonly understood that Katalea stated that knowledge about the harms of second-hand smoke is “common sense”. And, messages about quitting were responded to with frustrated exclamations of, “We know!” about the harms of smoking and “I’m doing it anyway!” (Melody). These reactions suggest two types of learning. The first, is non-learning (P. Jarvis, 2006) and the second is mis-educative learning (Dewey, 1938).

P. Jarvis (2006) describes how learning occurs by setting up three steps. First there is “presumption” which is where knowledge has been acquired and it does not change. From here, in order for new learning to occur, there must be a “disjuncture”, or some kind of new information that does not fit with the presumptive knowledge. This disjuncture initiates a transformation of old knowledge into new knowledge. But, sometimes new information is so commonly known that it no longer contributes to a transformation of action, a process P. Jarvis (2006) calls non-learning. Branstetter et al. (2015) conducted a series of focus groups to evaluate perceptions of tobacco-related media among smokers in Appalachia and concluded that participants were “unaffected” (p. 5) by media messages. Similarly, Baillie et al. (2005) found that even teen smokers could “easily recite all the harmful effects” of tobacco. Individuals who are “unaffected” or know something so thoroughly that it is “common sense” are unlikely to develop new knowledge that will result in behavior change. The data from this study suggest
that smokers were so familiar with public health pedagogical messages about harms of smoking that new information about more specific harms resulted in non-learning.

Along a similar line with non-learning is the concept of mis-education (Dewey, 1938). Mis-education is when experiences are negative and the experiential learning that occurs hinders new growth, leads to resistance, or results in the learner learning the wrong things. There are many documented mis-educative experiences in the smoking literature (Baillie et al., 2005; Dunn, 2004; Hammer & Inglin, 2014; Hoek & Smith, 2016; Popova et al., 2017; Sterling, Majeed, Nyman, & Eriksen, 2016; Wigginton & Lafrance, 2014) and there were several examples of mis-education in this study as well. Some of these include Johnny’s experience of marginalization when he was rebuked for smoking on a public street, Colorado’s experience of having his intentions doubted by his doctor when he requested help to quit, or several of the participants’ experiences of the cancer-related deaths of non-smoking loved ones. Each of these experiences caused the individual to question the outcome of a particular public health pedagogical message and offered the individual evidence with which to contest, doubt, or resist these messages.

Perhaps the most important mis-educative experiences were the participants’ many negative experiences of quitting smoking that lead them to conclude that they were not able to quit. Making a quit attempt and not succeeding in remaining tobacco-free is common. It has been estimated that only 9% of smokers who make a quit attempt without professional assistance will remain tobacco free 1 year later (Fiore et al., 2008), and the proportion of those who successfully remain quit jumps to 35% if an individual receives intensive treatment such as counseling and a medication (Anthonisen et al., 1994). Duke, Davis, et al. (2015) conducted an assessment of the Tips from Former Smokers campaign and found that although exposure to the
campaign contributed to health-related worries, it did not increase intentions to quit. One possible explanation for this finding may be that the participants’ mis-educative experiences of quitting made them resist messages that attempted to compel them to quit. Furthermore, in the present study, some participants had experience with other drugs such as alcohol, cocaine, or heroin (Tina, Johnny, Guy, Courtney) that made them especially aware of the cyclical nature of addictions treatments that often result in relapse. Unfortunately, none of the public health pedagogies discussed by the participants in this study challenged any of their mis-educative experiences, a finding which suggests that new strategies are needed to counter this resistance and to encourage smokers to continue to try to quit.

In this section, I have discussed what participants learned from public health pedagogies over the course of their lives and this included a broad range of information about the harms of smoking. There were some cases where information about the harms of smoking was so well known that non-learning occurred and new information did not contribute to new knowledge. In addition, participants used information from either their personal experiences or other pedagogies and transferred, or put together, pieces of information to make new meaning of both their experiences and new public health pedagogies they encountered. Although the participants’ personal experiences were occasionally supportive of pedagogies, some experiences were also mis-educative and led them to either doubt or resist the messages. Importantly, participants did not identify any public health pedagogies that challenged their mis-educative experiences with attempting to quit smoking.

Though educating the public about the harms of smoking is an important goal for the field of public health, ultimately, the hope of education is that it will lead to some sort of positive
behavior change. In the next section, I will discuss behaviors that participants describe as being instigated by the public health pedagogies explored in this study.

Behaviors Related to Learning

Traditional methods for evaluating knowledge and learning in the field of public health often begin by quantitatively assessing what an individual knows about a specific fact or whether they responded in a specific way as a result of a public health pedagogy (National Cancer Institute, 2008). A weakness of this method is that unintended knowledge and behaviors are often not assessed. The qualitative methods I used in this study allowed me to systematically collect information about learning and behaviors related to public health pedagogies from the participants whether they were what the pedagogy intended to teach or not. As a result, there were a range of accepting behaviors reported by participants which were, indeed, in line with the intention of the pedagogies but, more significantly, there were also behaviors that led to unintended learning and subsequent behaviors. I describe the latter below as avoiding, or rebelling behaviors.

Accepting Behaviors

For the most part, participants in this study were accepting of the majority of public health pedagogies and they attempted to comply with the messages they received. In addition, they often cited their knowledge about the harms of smoking as the rationale for these accepting behaviors. Many participants stated that they were willing to comply with clean indoor air laws, or pay more taxes for cigarettes and, while they acknowledged that it was inconvenient for them, they supported these things out of a desire to reduce harm to themselves or others. The findings from this study, specifically on taxes, are consistent with those of Guillaumier et al. (2015) who interviewed low income Australian smokers to understand how they managed cigarette tax
increases. In their study, the authors found that some participants supported tax increases because they believed it would prevent initiation of smoking among kids, and because they felt that higher cigarette prices may encourage them to quit. All of these accepting behaviors are directly related to their knowledge of the harms that smoking can cause.

In addition to accepting the pedagogy of paying more taxes, smokers in this study were also supportive of a variety of smoking bans and this argument revolved around their knowledge about the harms of second-hand smoke. In fact, several participants refrained from smoking in their home to protect their children, and one participant even smoked outside to protect his cats’ lungs. Many studies have documented that smokers are generally supportive of these types of smoking bans (Albers et al., 2004; Crawford et al., 2002; Jones & Williams, 2012; Stillman et al., 2015) and the findings from this study are generally in agreement with these. However, it is important to note that the participants’ rationale for complying with these pedagogies was a desire to not harm others and this rationale will also be important when I discuss rebelling behaviors.

Although participants in my study expressed sentiments that were accepting of several public health pedagogies, as Guillaumier et al. (2015) noted, the ultimate goal of these pedagogies was to encourage quitting and none of the participants in these studies had actually quit permanently. Nonetheless, the participants acknowledged that they should quit. Of course, agreeing with a public health pedagogy that is encouraging an individual to quit is one thing, and actually quitting is entirely different. As I discussed in the previous section, what participants in this study learned from their previous quit attempts was that they would inevitably relapse. These experiences severely dampened their hopes for future success and cast a shadow of doubt as to whether quitting would be worth the effort at all.
Other studies that have examined smokers’ perceptions of public health pedagogies (Guillaumier et al., 2015; Hoek & Smith, 2016) have had similar findings about the hopelessness of attempting to quit. In particular, Frohlich et al. (2010) compared the perceptions of both low and high income smokers related to specific tobacco control policies and found that low income smokers felt that their smoking was largely out of their control and just a “fact of life” (p.41). In the present study, perhaps Vince best described the longing that these smokers had to be rid of the burden of nicotine addiction when he said that smoking “makes one feel trapped”.

Expressing a desire to quit but not being able to do so is a hallmark of drug addiction, including nicotine addiction (Fiore et al., 2008; U. S. Department of Health and Human Services, 2014). So, although the participants in my study, and others (Frohlich et al., 2010; Guillaumier et al., 2015; Hoek & Smith, 2016) were accepting of public health pedagogical messages that encouraged them to quit, they learned through their lived experiences that they would not be successful which made them unwilling to follow through with their intention.

Avoiding Behaviors

Although many participants in this study were accepting of public health pedagogies, this was not always the case and not everyone was willing to fully comply with them at all times. In fact, there were many strategies that the participants employed to avoid some of the pedagogies they encountered. The avoiding behaviors that were identified in this study include “blocking out” public health pedagogies and seeking alternative ways to engage with them.

The strategy of “blocking out” was frequently employed with mass media campaign ads and it was the simplest strategy that smokers learned. This strategy was easily employed by leaving the room, fast forwarding through ads, or turning off the TV. P. Jarvis (2006) would consider this type of avoidance behavior to be “rejection and non-consideration” (p. 28), a
situation where an individual has an opportunity to learn but then purposefully rejects it for some reason. In this case, the participants were clearly aware that these ads were prompting them to action, however many of them rejected the message by stating that they were “not ready” to quit and employed a “blocking out” strategy.

Other avoidance strategies were more complex as they required more effort and forethought than simply turning off the TV. In particular, strategies for avoiding taxes, or attempting to pay the minimum amount possible, were the most frequently discussed by participants. It has often been thought that smokers are “brand loyal” (Zacny & Stitzer, 1988) and unwilling to switch cigarette brands. However, evidence from this study suggests that the participants were willing to switch brands in order to economize and that they learned several strategies to avoid increases in taxes. These included price shopping, switching to discount brands, sharing coupons with friends, butting out and relighting cigarettes, and switching to products that aren’t taxed as much (e.g., roll-your-own cigarettes and little cigars).

A particularly interesting finding from this study in terms of adult education is that that smokers learned new ways to avoid public health pedagogies from other smokers; an observation that has been made in other studies as well (Frohlich et al., 2010; Guillaumier et al., 2015). In particular, Guillaumier et al. (2015) described smokers having “a shared experience that established a sense of community” (p. 604) as the participants described working together to help each other manage their nicotine addiction in the face of financial constraints. In the field of adult education, the idea of a “shared experience” is grounded in situated learning theory (Lave, 1988) and communities of practice (Brown et al., 1989). In a community of practice, learners (or smokers) participate in context-specific activities (e.g., avoiding smoking restrictions or taxes), they engage in dialogue with members of the community (e.g., other smokers), and they learn the
norms, beliefs, values, and practices of people who operate in that community (Brown et al., 1989). In addition, the learning that occurs is “realized through action” rather than cognitive reflection (Fenwick, 2000).

There were several examples of learning through action I identified in the present study including how Johnny learned from his boss where to smoke that was out of sight of the workplace cameras, how Damien learned to roll his own (cheaper) cigarettes at his local smoke shop, and how Tina turned to a friend for tobacco and materials to roll her own cigarettes when she didn’t have the money to purchase them. These examples suggest that smokers in this study participated in a community of practice where they engaged in problem solving, interpreted situations, and made decisions as part of a culture that is uniquely focused on avoiding public health pedagogies.

**Rebelling Behaviors**

In addition to the accepting and avoiding behaviors I discussed above, there were some instances where participants in the study felt justified in rebelling against public health pedagogies; although these instances were rare. In fact, those instances of outright rebellion that they shared were directly related to the individual’s awareness that the pedagogy was being enforced without adequate justification and that they would not harm others by rebelling. The best example of this rebellion was Malcolm’s story of being constrained at a smoke-free hospital on a smoke-free campus for 5 hours without being offered any nicotine replacement; an act he considered a purposeful “form of torture”. In this case, Malcolm was aware and accepting of the rationale for clean indoor air laws so that did not rebel to the point where he smoked inside the hospital. But, he was also aware that he would not cause direct harm to anyone if he went outside and smoke on smoke-free hospital grounds.
Regardless of the rationale for rebellion, individuals who may have rebelled due to being unjustly treated are not learning what was intended by public health pedagogies. Frohlich et al. (2010) and others (Stuber et al., 2008) have suggested that public health pedagogies may be having the unintended consequence of marginalizing low income smokers and unintentionally contributing to health disparities (Frohlich et al., 2010; Stuber et al., 2008). The data from this study suggest that it was not the smoking ban itself, but rather it was the participants’ experiences with others, such as medical professionals, that contributed to their perception of stigmatization. In particular, from the participants’ perspective, they believed that medical professionals, and others with authority, treated them unfairly, judged them, or provided them with suboptimal care. These negative experiences, in turn, prompted them to distrust “public intellects”, resist public pedagogies, and to avoid seeking medical care except in the most extreme cases. As Colorado said, “I hate doctors” and Malcolm said, “I have to have something hanging off of me” in order to seek medical care. Thus, while it has been documented that health disparities are associated with low levels of income and education level (Frieden, 2010; Marmot, 2005), it is also possible that perceptions of stigmatization due to mis-educative, negative experiences with a broad range of “public intellects” are further contributing to these disparities.

In this section, I have discussed a variety of behaviors that were prompted by public health pedagogies. For the most part, smokers in this study were accepting of the vast majority of public health pedagogies and were willing to comply with their messages. However, there were many behaviors that smokers learned, some through engaging in communities of practice (Brown et al., 1989; Lave, 1988), that helped them to avoid pedagogies such as anti-smoking advertising, taxes, and clean indoor air laws. Finally, occasionally, smokers rebelled against a public health pedagogical message, although this was infrequent. Importantly, rebellion came
when there was a difference in perspective between the smoker and those who they perceived to be enforcing the pedagogy and this led the smokers to be distrustful. There was also evidence that the distrust of “public intellects” that the participants expressed was due to social class, or the participants’ perception of their position in society. In the next section, I will further discuss how data from this study demonstrated ways in which social position contributed to the participants’ learning and their interpretation of public health pedagogies.

**Positionality and Learning**

The final aim of this study was to evaluate how class and positionality within society may have influenced how low income smokers constructed and made meaning of smoking and their health. This aim fits well within a critical theoretical framework which assumes that Western societies are economically unequal and that widespread, structural class discrimination is a reality (Brookfield, 2005). These inequities play out in society by allowing the group with more power (public health) to create structures that benefit them at the expense of groups with less power (smokers), usually minority groups. In addition, those with power use the money and influence at their disposal to place their values and cultural norms at the forefront of public life (Habermas, 1987).

Smokers in this study clearly recognized the inequitable structure of society and described an oppositional “us” (e.g., smokers) versus “they” (e.g., individual, collective and anonymous public health intellects) dichotomy where “they” are trying to control “us”. In some instances, participants said they “hate doctors” and would avoid these professionals because they “felt judged” while for others, they had to “have something hanging off” of them to actually go see a doctor. In other instances “they” were some unnamed government agency, a politician, a political donor, or some other figure of authority perceived as having power within society. Also
included in the “us” versus “them” dichotomy was an assumption that “they” were using their power to benefit themselves so “they” cannot be entirely trusted. Frohlich et al. (2010) also found that low income smokers described the field of tobacco control in oppositional terms and positioned themselves as “victims of excessive use of control by tobacco interventions” (p. 43).

Participants in this study clearly understood and articulated critical theory assumptions about how societies are unequal structures where those with power tend to oppress those without (Brookfield, 2005). Further, participants used experiences from their daily lives to support these claims, the most damning of which were those that demonstrated how public health pedagogies, and those with the power to create them, acted in hypocritical and corrupt ways. The distrust described by participants in this study colored their interpretation of public health pedagogies, opened the door for doubt about the veracity of “their” knowledge, and allowed the smokers to question “their” motives. All of these elements of distrust ultimately undermined the pedagogical messages and gave rise to equivocation about the usefulness of quitting in the minds of the smokers who received them.

In a recent review of the literature, Schmidt, Ranney, Pepper, and Goldstein (2016) found that the credibility of the source delivering a message influences an individual’s willingness to accept, or reject a message and that credibility is lower when the source is perceived to have a profit motive. There were many examples were participants believed that people in influential positions in society were profiting monetarily from public health pedagogies. For instance, Zach suggested that politicians were looking out for the interests of tobacco companies (not their constituents) because of bribes they received, Tina believed that her step-father received sub-optimal cancer treatment because they didn’t “have the right kind” of money, and many
participants believed that warning labels are only put on cigarette packs to keep the tobacco companies from getting sued.

From a critical theory perspective, that people with money and power in society are benefiting more than people without is not surprising. However, different from many studies about tobacco users, this study highlights the perspective of the smokers are observing those with power to say one thing and do quite another. One of the best examples of this public health hypocrisy, brought up by several participants, was that of taxes. Although many participants identified that taxes were intended to encourage smokers to decrease their cigarette consumption, it was not a huge leap for them to question whether “they” were interested in helping smokers quit or interested in using tax money as a revenue stream. Habermas (1987) and Giroux (2010) have argued that our society is dominated by capitalistic perspectives that place economic prosperity above all other possible societal activities. Participants in this study and others (Guillaumier et al., 2015; Hoek & Smith, 2016) accepted this argument and in turn applied it to the public health pedagogies of taxes, smoking cessation medications, medical insurance, and many others.

In addition to the idea of source credibility, the field of adult education has debated the importance of educators approaching their students with “authenticity” (Cranton & Carusetta, 2004). Being an authentic educator requires that the educator’s actions are in congruence with their words and that they approach their students with the goal of helping them to learn. A particular challenge to the authenticity of public health pedagogy is that the educator is not an individual. Approaching public health from a critical perspective, Eakin et al. (1996) notes that “economic, political, cultural and organizational forces in any society shape the everyday lives of individuals and groups”. As this study found, many of the most accessible public health
pedagogies are laws and regulations, and because of the nature of developing laws, politics are often deeply embedded in smoking-related public health pedagogies.

Again, using taxes as the example, there are economic, political and organizational forces that shape how taxation is implemented. Though the field of tobacco control may see taxes as a way to encourage decreased cigarette consumption, the state legislature likely sees taxes as a revenue stream. For instance, in 2016, Pennsylvania raised cigarette taxes by 65% and the rational reported in a local Pennsylvania newspaper was not that these taxes would be used to help smokers to quit, but rather they would be used to balance the state budget (Gleiter, 2016). Similarly, of the millions of dollars that were allocated to Pennsylvania in 2013 from the Tobacco Master Settlement Agreement, only 4.5% of the funds were used for smoking cessation services, down from 12% in 2001 (PA House Appropriations Committee, 2017). Thus, smokers are right about the inauthenticity that they see among policy makers and these perceptions compromised the integrity of the messages that they received and provided them with a rationale to reject those messages.

This calls into question whether authenticity may be restored among public health educators if they work on fostering the trust of their students. Critical theorist Horkheimer (1972) would argue that though public health experts have the ability to exert power over society, their goal should be to dialogue and seek input from those in society with whom they are attempting to engage. Similarly, Eakin et al. (1996) suggest that researchers who are attempting to work on health promotion should take a “reflexive posture” toward creating public health promotion (p. 158). This posture does not seek to criticize the way that individuals understand their world, but rather it seeks to acknowledge that individuals who are being studied may understand their world differently from those in academia and, presumably medicine or public
policy. It further recognizes that activities at the “macro-level” (e.g., societal, political, economic) can create contradictions for those experiencing them at the “micro-level” (individual). The participants in this study clearly described Eakin et al.’s (1996) “macro” versus “micro” dichotomy and, the participants perceptions of hypocrisy and corruption negatively influenced how they interpreted and understood public heath pedagogies. Fortunately, a reflexive posture for public health intellects can begin simply with public health professionals listening to the lived experiences of smokers, attempting to understand how the messages they are creating are being interpreted in unintended ways, and identifying ways to make these messages more authentic.

Strengths, Limitations, and Future Areas of Study

As with all studies, this study has both strengths and limitations. A strength of the study is the narrative methodology which was necessarily retrospective and allowed me to understand how the participants came to made meaning of their smoking and health. Because of the temporal nature of narrative inquiry, I was able to document how smokers constructed knowledge over time and how they applied this knowledge to smoking-related behaviors. However, as Riessman (1993) notes, the retrospective, reflective nature of narrative can present a limitation in that experiences are interpreted many times which can open the door for misinterpretation of the meaning the participant attempted to convey. Each of these misinterpretations can potentially occur during the “telling” of the story by the participant, the “transcribing” of the story by the researcher, and the “reading” of the story by the reader. I have attempted to overcome some of these limitations by having the participants read their narratives (member checks) after I compiled them, however, it is certainly possible that interpretive errors occurred.
In addition, all the participants in this study elected to meet me at the medical center where I worked. The interviews were conducted in conference rooms and medical school classrooms, some of which had cameras and microphones installed in the room so that classes could be teleconferenced to other campuses. In fact, one participant who had been in jail, quickly noticed the cameras in our meeting room and wanted to know if our session was being video recorded, which I assured him it was not. Though this environment is one in which I am very comfortable, it is possible that my participants were not and this could have influenced the stories they chose to share with me and the details that they offered.

A strength of this study is that by using the framework of public pedagogy and by applying it to the field of public health, I was able to assess how smokers made meaning of the public health pedagogies to which they were exposed in the context of the intention of the pedagogue. This is an important strength and one that has not frequently been employed in adult education studies using public pedagogy. Thus, this study offers a potential method for future studies to employ when considering public health pedagogy as a framework.

A major limitation, particularly for the field of public health, is that this study was conducted with a small number of participants and the results cannot be more broadly generalized to all low income smokers. However, despite the small sample, some of the findings, particularly those related to strategies for avoiding taxes and brand switching, have been found in other studies (Frohlich et al., 2010; Guillaumier et al., 2015; Hoek & Smith, 2016; Stuber et al., 2008) and offer “hypothesis generating” data that should be further explored in future research studies.

Implications for Practice and Research
Conclusions from this study suggest a number of implications for practice and research in the fields of adult education and public pedagogy. In addition there are a number of implications for the field of public health broadly, but also tobacco control and tobacco regulatory science more specifically.

**Adult Education and Public Pedagogy**

While it is interesting to consider that people learn through public spheres, the idea that it actually happens is only a theory without empirical evidence to demonstrate that learning has occurred. As Sandlin et al. (2011) point out, frequently absent in the public pedagogy literature “are studies of how these educational sites and practices actually work to teach the public and how the intended educational meanings of public pedagogies are internalized, reconfigured and mobilized by public citizens” (p. 359). This study provides one method for assessing these reconfigured meanings and provides clear insight as to how a well-defined group of students learned from specific public pedagogies.

Understanding what the pedagogue’s intention was for the “lesson” (e.g., the intended education meanings or curriculum) and knowing who the students are that they are addressing are especially important for researchers when they are conducting research using this framework. The design of this study gave me the benefit of being able to identify three of the important elements of the public “classroom” which included the students (e.g., smokers), the pedagogue (e.g., public health), and the intentions of the pedagogue. Part of the study design included a review of the literature from within the field of public health largely because public health professionals have written extensively about, not just their intentions for education, but also about their pedagogical strategies, and behavioral outcomes of their “lessons” (National Cancer Institute, 2008; U. S. Department of Health and Human Services, 2014). Being able to identify
the students, the pedagogue and the pedagogue’s intentions gave me a basic starting point from which to work as I evaluated what smokers may have learned and whether it is similar or different that the intention of public health professionals. With these thoughts in mind, future scholars may want to consider how they can more concretely identify these three elements of the public classroom when developing studies that evaluate learning from public pedagogy.

However, even knowing all of the above information does not remove all of the challenges for conducting empirical research using public pedagogy as a framework. Although the idea of something being public may bring to mind a utopian state where everyone has access to the pedagogy being displayed, in reality, this is not the case. As Savage (2014) notes, regardless of the type of pedagogy, an important consideration when discussing what is “public” is how people came to gain access to a particular public pedagogy. For example, when considering smoking bans, only those who actually have physical, geographic access to locations where smoking is banned, or practical access, such money for the entrance fee for those that are not free, are able to learn from it. This makes the definition of public murkier and suggests that some forms of public are more public than others.

Savage (2010) takes up the issue of access related to public pedagogy as he discusses his attempts to use this theory for his research. He explains what he believes to be a false public because even though something may be “out there” in the public space, it is not necessarily accessible to all citizens. He concludes that “access to forms of knowledge is no doubt uneven and bound up in complex power relations and structures, which means… access to pedagogical flows is conditional and contingent upon myriad contextual factors” (p. 106). He also notes that whether something is public is a matter of scale (Savage, 2010). For instance, when CVS pharmacy announced they would stop selling tobacco products, only smokers who had access to
these stores and had the intention to purchase cigarettes in them noticed that they had made a change in their policy. In this way, although CVS pharmacy is accessible to anyone who cares to go to the store, the scope of the pedagogy is limited to those who live close enough to the store and have the intention of going there. The data from this study suggest that both access and scale were issues in terms of how the participants learned from public pedagogies and these issues should be considered by scholars who attempt to take up this type of research.

A final concept that public pedagogy scholars may want to consider in future research is how to map “the terrain through which pedagogical forces are claimed to be operating” (Savage, 2014, p. 80). For instance, in this study, I categorized clean indoor air laws as “dominant societal discourse” because the original source of this pedagogy is a law. However, the narratives demonstrate that smokers made meaning of smoking bans by transferring their knowledge about the harmfulness of second hand smoke to clean indoor air laws. Knowledge about the harmfulness of second hand smoke originated in the category of public intellects but the meaning of clean indoor air laws could not be made clear without that previous knowledge from public intellects. This complexity sets the stage for a debate on how scholars should categorize public pedagogies so they can successfully map the terrain through which individuals learn.

**Public Health Education**

There are three major implications that this study has for the field of public health education. First, smokers are aware of the harms of smoking, but have received little education on how to successfully quit smoking. Second, the lived experiences of the prevalence of smoking and smoking related harms that the smokers described (e.g., prevalence of people who smoke and frequency of disease) was very different from that of the population as a whole which
may be impacting how they interpret and act upon public health pedagogies. Finally, many of the smokers in this study had mis-educative, negative experiences with medical professionals and other public pedagogies. Not only did this distrust negatively influence how public health pedagogies were interpreted, but it caused some participants avoid medical care altogether.

**Teaching Successful Quitting.** Although the field of public health has extensively documented that smokers are aware of the harms of smoking (Brandt, 2007; Hammond et al., 2007; Schudson & Baykurt, 2016; U. S. Department of Health and Human Services, 2014), the majority of public health pedagogies identified in this study were focused on the many ways that smoking harms health. This method of teaching the public is directly in line with the historical purpose of public health (Institute of Medicine, 1988, 1994) and the field of tobacco control (Brandt, 2007; Kozlowski & Abrams, 2016). However, the prevalence of smoking is not decreasing among low income smokers at nearly the same rate as in other groups which suggests the need to identify new educational strategies that will help encourage this population to quit.

There have been some tobacco control scholars who have suggested that the remaining smokers in the United States are *hardened* smokers who are willfully unresponsive to current public health messages (Bonnie et al., 2007; Costa et al., 2010; Hughes, 2011; Warner & Burns, 2003). However, this is not how the participants in this study presented themselves to me. They were responsive to public health pedagogies, for the most part they were willing to comply with them, and many people even hoped that they would quit smoking eventually. Unfortunately, the majority of the experiences that the smokers in this study had with quitting were mis-educative experiences.

Fortunately, the FDA recently announced the launch of a new public health education campaign called “Every Quit Counts” which “seeks to celebrate each quit attempt as a positive
step toward quitting” (U. S. Food and Drug Administration, 2017b). This is an encouraging pedagogical message, however, a single mass media campaign is not likely to be sufficient and much more research will be needed in order to develop new pedagogical messages to effectively educate smokers on how to successfully quit.

Thus, the most obvious implication for practice among public health professionals is to create additional educational messages that acknowledge smokers’ past negative experiences with quitting and offer them new information on how to make future quit attempts more successful. This would include seeking treatment from medical professionals (a barrier I will discuss next) and using FDA approved medications that have been proven to be effective (Fiore et al., 2008). A potential avenue for further research would also be to explore ways that public health pedagogies, aside from one-on-one treatment, may be able to convey information about the difficulty of quitting and the importance of continuing to try to quit on broader scale while not being overly negative or discouraging.

**Distrust of Public Intellects.** The mis-educative experiences and stigmatization that the participants described in this study led them to distrust a variety of “public intellects” and this finding should be disappointing to those in the field of public health education. In this regard, perhaps the most important finding that I identified in this study was that the participants did not believe that public health professionals had their best interests at heart. This is a particularly troubling finding since many public health professionals have been earnestly working for decades to decrease the prevalence of smoking and reduce the number of premature deaths that smoking causes. Knowing that many in the field can, and should be trusted, I was tempted to dismiss some of the participants’ most damning comments. However, if we as a public health community are truly earnest in our efforts to continue to decrease the prevalence of smoking, it is
worth taking a “reflexive posture” (Eakin et al., 1996) and consider why individual smokers may be questioning our authenticity and collective motives.

Being reflexive would be strengthened if the posture were coupled with the principles of critical theory and though they can be complex, Brookfield (2005) offers many ways to make these sometimes dense concepts more understandable. Future research should consider ways to use critical theory perspectives that recognize the inequity of society and use this as a starting point for understanding differing perspectives on health priorities. The field of public health has consistently identified poverty and low education levels as being associated with poor health outcomes (Frieden, 2010; Marmot, 2005; U. S. Department of Health and Human Services, 2014). However, what has been less frequently addressed is how to engage in dialogue with this population, a process that many public health professionals have encouraged (Eakin et al., 1996; Frohlich et al., 2010; McLeroy, Bibeau, Steckler, & Glanz, 1988; National Institutes of Health & National Cancer Institute, 2017; Poland et al., 2006). Data from this study may not offer new suggestions for interventions that may resonate with this population, but they do offer a critique of how some members of the field are interacting with smokers and point to avenues for improvement.

In particular, his study provides a window into the lives of the smokers who are most in need of help to quit and the view through that window is that too often they are not treated with respect or kindness. From a critical theory perspective, not only did the participants in this study recognize inequalities within society, they highlighted many situations where they personally perceived themselves as not being treated equitably. Thus, a very simple practice implication for those in the field of public health is to listen to the perspectives of smokers. Their narratives are their realities and knowing that they distrust those of us who work in the field of public health
places the onus us to demonstrate the authenticity required to re-gain their trust. Listening to these perspectives can also provide starting points for researching public health interventions designed to foster that trust. For instance, a particularly obvious need is to train medical professionals on how to manage nicotine dependent smokers who present to emergency departments that are situated on smoke-free campuses (offer a nicotine patch!). More importantly, rather than dismissing the smokers’ perceptions of marginalization, a major step toward fostering trust would be to actively seek input from the smokers we seek to help so that their perceptions can help us create better public health interventions that are relevant and authentic to smokers’ lived experiences.

**Differing Lived Experiences.** A final idea that this study brings to the forefront is how the experiences, or facts, that the participants described differed from what may be considered as known in the field of public health. Often, the statistical facts that are calculated by public health professionals group or stratify individuals by characteristics such as gender (male/female), race (black/white/Asian), or income (above/below poverty). However, even the small sample of participants I interviewed for this study demonstrates that these groupings are overly simplistic when attempting to understand an individual’s personal experiences. Although the main focus of this study was to interview low income smokers who had less than a college degree, many participants had other risk factors for smoking such as histories of substance abuse, physical, sexual, or psychological abuse, and mental health conditions.

These additional characteristics provide ample evidence to suggest that the participants’ lived experiences were very different than statistics imply. For instance, in Tina’s narrative, she states that “half the world, half the United States of America smokes cigarettes! Everybody smokes cigarettes!” Her estimate is in stark contrast to the most current estimate of 15% for the
overall prevalence of smoking and the 26% estimate of smoking for those who are living in poverty (Jamal et al., 2015). So, why is her estimate so different from the statistical facts used by the field of public health?

One possible reason is that Tina’s *lived experience estimate* of how many people in her social circle smoke may actually be accurate. Higgins et al. (2016) recently conducted a study to attempt to reconcile the statistical prevalence of smoking with the lived experiences of individuals like Tina. The authors found that there are a handful of co-occurring risk factors that are related to an individual’s likelihood of being a smoker and that after age, the most common factors were drug abuse, race, low levels of education, and poverty. In addition, they found that these risk factors are summative which means the more risk factors an individual has, the more likely they are to be a smoker. Based on a sample of nationally representative smokers, they estimated that if there were a group of individuals just like Tina (white men or women with less than a high school degree and a history of drug abuse), it is likely that more than 70% of them would be smokers. Given this estimate, it is possible that the current public health strategies being employed to encourage smokers to quit are not working simply because they do not resonate with individuals who live in communities of practice where 70% of the people are smokers.

Over 20 years ago, Davison, Smith, and Frankel (1991) expressed concern that the current methods for conveying population based risk messages may have bearing on how individuals view these messages in terms of plausibility. They coined the term “lay epidemiology” to describe a phenomenon they observed whereby patients were gathering their own personal data based on their lived experience and privileging this over that of expert data. While acceptance of lay epidemiology is often considered an irrational action by public health
experts, Davison et al. (1991) provided an alternative perspective. They argued that individuals who do not respond to traditional health messages are not irrational, but rather their understanding is “considerably more sophisticated than is generally appreciated by health educators” (p. 430). Lay epidemiology accepts that people understand the reality of public health messages as only a “partial presentation of the risk factors” (p. 428) and they use these partial messages to develop their own personal epidemiology that applies to them as an individual.

Examples such as Tina’s perception of the prevalence of smoking in her community support the concept of lay epidemiology and further suggest that rather than disputing smokers’ perceptions, in practice, the field should explore alternative ways of engaging with them. Allmark and Tod (2006) provide an extensive overview of how they believe public health professionals should engage with lay epidemiology. They conclude that in many cases, the ethical approach is not to dismiss the lay perspective, but rather it is to understand the culture through which an individual interprets the importance of health and participate in the process of encouraging improved health within the context of that culture.

While Allmark and Tod (2006) comments were made in the context of clinical practice, their comments also have implications for the field of public health. The present study was observational and descriptive in nature. Future studies should consider ways to understand low income smokers’ perceptions of public health pedagogies and explore ways that lay epidemiology can be effectively utilized or appropriately challenged when necessary.

**Tobacco Regulatory Science**

This study has several implications for the field of tobacco regulatory science including things to consider regarding nicotine reduction in cigarettes, tobacco product usage, and public
health education. In August of 2017, the FDA announced its intention to pursue a nicotine reduction strategy that would decrease the nicotine levels in cigarettes to non-addictive levels (U. S. Food and Drug Administration, 2017a). One of the responsibilities of the FDA’s Center for Tobacco Products is to educate the public about its regulatory actions and in order to do this well, they will need to better understand what smokers know about nicotine and addiction.

Although participants for this study were recruited and interviewed within 3 months of the FDA’s announcement, only one participant (Rita) was aware of the FDA’s intentions and only those who had a history with drug or alcohol abuse had a comprehensive understanding of the powerful addictive properties of nicotine. This suggests the need for further research on how to present the FDA’s nicotine reduction strategy to the general public.

In addition, participants in this study were not brand loyal, were highly cost sensitive, and had a fluid attitude about which products they smoked. Many participants were willing to switch to roll-your-own cigarettes or little cigars when they didn’t have the funds to purchase their preferred brand of cigarettes. This suggests that as the FDA considers how to implement a nicotine reduction strategy, further research should be done to understand how pricing and availability of other smoked high nicotine products may impact the policy’s effectiveness. For instance, if reduced nicotine content cigarettes are placed in the market at a higher price than other, fully nicotinized smoked products (e.g., little cigars or pipe tobacco rolled into cigarette tubes), it is possible that this scenario would encourage smokers to switch to little cigars thus sustaining their nicotine dependence on another equally harmful, smoked product.

A final observation I made of regulatory relevance was the participants’ comments about discount brand cigarettes. Wasserman et al. (2018) recently conducted an analysis of premium and discount brand cigarette smokers and found that smokers of discount brand cigarettes were
exposed to higher levels of harmful chemicals than those who smoked premium brands. In the present study, participants often discussed smoking discount cigarettes (e.g., Pall Malls, Wings, and Mavericks) or rolling their own cigarettes using pipe tobacco and mentioned experiencing different physical side effects (e.g., coughing, headaches, sore throat) when smoking discount brands as opposed to their preferred brand of cigarettes. Although no level of exposure to the chemicals found in cigarettes can be considered safe, it may be useful to study whether the already disproportionate harm that low income smokers experience due to smoking is further exacerbated by greater exposure to harmful chemicals from discount and roll-your-own cigarettes.

Final Reflections

Little did I know when I started this project, how much I would come to enjoy talking with individuals whose life experiences were so very different from my own. And, as I talked with them, it became clear that not only did I not understand how their lived experiences differed from my own, but that many in the field of public health do not seem to understand either. Words such as “vulnerable populations”, “health disparities”, or “disproportionately affected” hardly begin to convey challenges that the participants I interviewed face on a daily basis. I expected to hear stories of how income created difficulties in obtaining cigarettes, but I did not expect to hear how mental health problems, drug abuse, physical abuse, sexual abuse, and childhood neglect all intertwined to form the narrative of my adult participants’ daily lives. These are their day to day burdens that they carry with them. They are heavy burdens and they color every past experience the participants had and every future action that they take. I know that I cannot fix the many challenges that are present in the daily lives of those I met. What I
can, and will, do is heed their stories and work to improve those things that may be within my reach.
APPENDIX A

Semi-Structured Narrative Interview Guide and Script

Thank you for coming. As you know, I am interested in hearing stories about what you, as a smoker, have learned from public health education. But, before we start, I would like to get to know you a little more.

General information about the individual

5. Can you tell me a little about your life and your smoking? Start your story wherever you would like.

6. Once the participant has completed their narrative, follow up questions may be:

   a. Can you tell me more about when you started smoking?
   b. Can you tell me more about why you started smoking?
   c. Can you tell me more about your family, their smoking, and what you learned from them about smoking?
   d. Can you tell me more about why you smoke now?

Next, I am going to show you a written timeline and have you watch a short video about things that have happened in the past few years related to cigarettes and smoking. As you watch the video, think back to these times in your life. Did these things have anything to do with smoking? Where were you? What were you doing? Who were you with? What was going on around you? How did you feel? What did you learn?

When you are done watching the video, I would like you to tell me the stories you thought of for the things that struck you as important. You may also tell me about things that are not on the timeline. [move to questions once video is done]

Public Pedagogy Interview Guide
7. Are there any events or experiences that struck you as meaningful to you when you were watching the video or reading through the paper timeline? Please tell me about them. Take your time and start your story wherever you would like.

8. Once the participant has completed their narrative, follow up questions may be:
   a. Can you tell me more about where you were?
   b. Can you tell me more about what you were doing/why were you there?
   c. Can you tell me more about what else was going around you?
   d. Can you tell me more about who you were with?
   e. Can you tell me more about what you thought/how you felt?
   f. Can you tell me more about what you did because of this (smoking related)?
   g. Can you tell me more about what this means to you/what you learned/how you have used this information?

9. What do you remember learning about nicotine, nicotine addiction or the FDA regulation of cigarettes?
APPENDIX B
Timeline of Public Health Events Since 1964

1960s

1964
- Surgeon General announces that cigarettes cause lung disease

1965
- 1st cigarette warning labels appear on cigarette packs "CAUTION: Cigarette smoking may be hazardous to your health"

1969
- Cigarette advertising is banned on TV and radio
- Warning labels are placed on print advertising
- New warning label "Warning: The Surgeon General has determined that cigarette smoking is dangerous to your health"

1970s

1976
- Non-smokers rights grassroots movement begins which will eventually lead to smoking bans in public places

1977
- First national Great American Smokeout from the American Cancer Society
**1980s**

1984

- **New Warning labels** on cigarette packs:
  - SURGEON GENERAL’S WARNING: Smoking Causes Lung Cancer, Heart Disease, Emphysema, and May Complicate Pregnancy
  - SURGEON GENERAL’S WARNING: Quitting Smoking Now Greatly Reduces Serious Risks to Your Health
  - SURGEON GENERAL’S WARNING: Smoking By Pregnant Women May Result in Fetal Injury, Premature Birth, and Low Birth Weight
  - SURGEON GENERAL’S WARNING: Cigarette Smoke Contains Carbon Monoxide

1986

- **Second hand smoking found to contain cancer causing chemicals**
- The U. S. Environmental Protection Agency (EPA) will also say this in 1992

1988

- **Cigarette smoking is no longer allowed on airplanes** starting with short flights less than 2 hours.
- By 2000, this smoking restriction be on all U.S. flights and international flights.
- **Cigarettes as addictive as heroin and cocaine** says Surgeon General C. Everett Koop.
1990s

1992
- **Age of sale laws are enforced** so that smokers under 18 cannot buy cigarettes, Synar Amendment.

1994
- **FDA commissioner David Kessler testifies before Congress.** He wants cigarettes to be regulated as drugs
- **Tobacco Company CEOs testify before Congress** and swear under oath that they do not believe cigarettes are addictive

1996
- **Nicotine gum and nicotine patch become available over the counter**
- **Target retail stores stop selling tobacco products**

1998
- **48 States win a law suit against tobacco companies.** Tobacco Master Settlement Agreement. Tobacco companies must:
  - Pay states to cover health care of smokers
  - No more cartoon advertisements (Joe Camel)
  - No more sports sponsorships
  - No more payments to place cigarettes in movies

1999
- **The Truth initiative begins** in Florida and goes nation wide in 2000.
2000s

2000 • The FDA loses a Supreme Court case and they are not allowed to regulate cigarettes as drugs.

2008 • Pennsylvania bans smoking in public places and no smoking signs are posted.

2009 • The FDA receives the authority to regulate cigarettes when President Obama signs a law
• Federal cigarette taxes increase by $0.62 to $1.01 per pack.

2012 • Tips from Former Smokers advertising campaign starts

2014 • The Real Cost advertising campaign starts
• CVS announces: no more cigarette sales

2016 • Public Housing will go smoke free announcement from the Department of Housing and Urban Development (HUD)

2017 • National parks go smoke-free
• The FDA says they will work on reducing nicotine in cigarettes
APPENDIX C

Screening Questions

Use this paragraph for participants who contacted through IRB #2213 as a first contact:

Hello, this is Susan Veldheer from the Penn State College of Medicine. You contacted us and expressed an interest in a research study being conducted in about cigarette smoking and you indicated that you would be willing to participate in future research. I am currently working on a new study that you might be interested in. Do you have a moment to talk?

If no:
- Ok, thank you for your time.

Begin here for participants who were contacted via email through IRB #2213 or any other participants:

If yes:

This study is being conducted to understand what smokers learn about their health and smoking from different types of public health education. I would like to get your perspective and understand your experience of being a smoker in the U.S. by interviewing you and asking you to tell me about your life. If you are willing to participate in this study, you will be asked to watch a short video (10 minutes) about cigarette-related public health education and events that have happened in the U.S. over the past several years. Things covered in the video would include things like anti-tobacco ad campaigns, smoking restrictions in public places, cigarette taxes, tobacco court cases, FDA regulation of tobacco, Surgeon General’s reports on tobacco, Congressional testimony, and a number of other things.

After you have thought about these events that have happened in your life, I will ask you to tell me what the events in the video mean to you and what you may have learned. Depending on how much you want to share, the interview will last 1-2 hours. Once we are done meeting, I will use the notes from our interview to write up a story about you and your smoking. You will then be asked to read the story and talk with me again (either in person or over the phone) to provide comments about your story.

You will be compensated with a $20 gift card for your participation in the study and an additional $20 gift card for transportation if you are willing to meet with me at the Penn State Hershey Medical Center campus. Is this something you might be interested in participating in?

If yes, read the following statement:

Great, I have a few questions for you which will help to determine if you are eligible for this study. By answering these questions, you are consenting to allow me to use this information to pre-screen you for the study and to understand the reasons people cannot participate in the study. With your permission I will retain this information in a secure database until the completion of
study. Your information will not be shared with anyone outside the research team. Do you want me to go ahead with the questions?

If no:
Ok, thank you for your time.

If Yes, proceed to screening questions:
Great! First, I am going to ask you several questions about your tobacco use.

How old are you? ______  (Inclusion at least 25. Also two groups 25-35 and 36+)

In what year were you born? (Inclusion at least 1992)

Are you male or female?
1, Male
0, Female

Can you understand, read, write, and speak in English?
1, Yes
0, No (exclusion)

Do you have any problems with your vision that would make it impossible for you to watch a short (10 minute) video?
1, Yes (exclusion)
0, No

Have you smoked at least 100 cigarettes in your entire life?  
(Note to interviewer: 100 cigarettes = approx. 5 packs)
1, Yes
0, No

Do you currently smoke cigarettes?
1, Yes
0, No

Do you now smoke cigarettes every day, some days, or not at all?
1, Every day  (every day or some days required)
2, Some days
3, Not at all
4, Don’t Know / Refused

Have you smoked cigarettes for the past 10 years (even if you have quit some of the time)?
1, Yes (required)
0, No
How many people live with you in your household? _______ (enter number to identify poverty level guideline)

Is your current household income more or less than (see chart below and state the 185% number on the phone):

Is your current household income more or less than (see chart below and state the 100% number)?

2017 Poverty Guidelines for the 48 contiguous states and the district of Columbia, Persons in family/household poverty guideline

<table>
<thead>
<tr>
<th>Number of persons in household</th>
<th>100% of poverty</th>
<th>185% of poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$12,060</td>
<td>$22,311</td>
</tr>
<tr>
<td>2</td>
<td>$16,240</td>
<td>$30,044</td>
</tr>
<tr>
<td>3</td>
<td>$20,420</td>
<td>$37,777</td>
</tr>
<tr>
<td>4</td>
<td>$24,600</td>
<td>$45,510</td>
</tr>
<tr>
<td>5</td>
<td>$28,780</td>
<td>$53,243</td>
</tr>
<tr>
<td>6</td>
<td>$32,960</td>
<td>$60,976</td>
</tr>
<tr>
<td>7</td>
<td>$37,140</td>
<td>$68,709</td>
</tr>
<tr>
<td>8</td>
<td>$41,320</td>
<td>$76,442</td>
</tr>
</tbody>
</table>

For families/households with more than 8 persons, add $4,180 for each additional

In the past 5 years, have you or anyone in your home received assistance from any of the following programs (select all that apply): (yes to any of these or income <185% required)

1. Federally subsidized housing assistance programs
2. Supplemental Nutrition Assistance Program (SNAP)
3. Women Infants and Children (WIC)
4. Head Start
5. Children’s Health Insurance Program (CHIP)
6. Medicaid
7. food bank/pantry
8. Free medical or dental clinics
9. Charity organizations (e.g., homeless shelter, rescue mission, St. Vincent DePaul Society)
10. Free or reduced school breakfast/lunch program eligibility
11. Any other program designed to aid low income individuals and families.

(If other) Please describe the program: (open text)

What is the highest level of education you have completed?
1. 7th grade or less
2. 8th grade
3. 9th grade
4. 10th grade
5, 11th grade
6, 12th grade (not graduated)
7, GED
8, High school diploma
9, Some college
10, Associates degree
11, Bachelor’s degree or more (exclusion)

If eligible collect:

What is your first name?  text

What is your last name?  text
   Address
   City
   State
   Zip code
   County

What is the best phone number for us to use to reach you?  Phone number with area code

What is the best email to use to contact you?  Email field

Would you be willing to meet me at the Penn State Hershey Medical Center Campus?
   1, yes (if yes, eligible for second $20 gift card)
   0, no
APPENDIX D
Demographics, Health, and Smoking Questionnaires

DEMOGRAPHICS

Do you consider yourself Hispanic/Latino?
1, Yes
0, No

Which race best describes you?
1, Caucasian/white
2, African American/black
3, Asian
4, Native Hawaiian or Pacific Island
5, Mixed race
6, American Indian/Alaskan native
7, Other

Are you currently enrolled in a degree program?
1, Yes
0, No

(if yes) Is it a technical or vocational program, a 2-year degree program, or a 4-year degree program, or a graduate or professional program?
1, Technical/vocational program
2, 2-year degree program
3, 4-year degree program
4, Graduate/professional program

Which of these best describes your current employment status?
1, Working now full time
2, Working now part time
3, only temporarily laid off, on sick leave, or maternity leave
4, Looking for work, unemployed
5, Retired
6, Non-working, disabled, permanently or temporarily
7, Keeping house
8, Military
9, Non-working student

(female) Do you think of yourself as...
1, Heterosexual or straight (that is, sexually attracted only to men)
2, Homosexual or lesbian (that is, sexually attracted only to women)
3, Bisexual (that is, sexually attracted to men and women)
(male) Do you think of yourself as...
1. Heterosexual or straight (that is, sexually attracted only to women)
2. Homosexual or gay (that is, sexually attracted only to men)
3. Bisexual (that is, sexually attracted to men and women)
4. Something else
5. Not sure

What is the highest grade or level of school your mother has completed or the highest degree she has received?
1. Less than 8th grade
2. 9th grade
3. 10th grade
4. 11th grade
5. 12th grade/no diploma
6. High school graduate
7. GED or equivalent
8. Some college/no degree
9. Associate degree
10. Bachelor's degree
11. Master's degree
12. Professional Degree (ex: MD, DDS, DVM, JD)
13. Doctoral degree (ex: PhD, EdD)

What is the highest grade or level of school your father has completed or the highest degree he has received?
1. Less than 8th grade
2. 9th grade
3. 10th grade
4. 11th grade
5. 12th grade/no diploma
6. High school graduate
7. GED or equivalent
8. Some college/no degree
9. Associate degree
10. Bachelor's degree
11. Master's degree
12. Professional Degree (ex: MD, DDS, DVM, JD)
13. Doctoral degree (ex: PhD, EdD)

What is the highest grade or level of school your partner/spouse has completed or the highest degree he/she has received?
1. Less than 8th grade
2, 9th grade
3, 10th grade
4, 11th grade
5, 12th grade/no diploma
6, High school graduate
7, GED or equivalent
8, Some college/no degree
9, Associate degree
10, Bachelor's degree
11, Master's degree
12, Professional Degree (ex: MD, DDS, DVM, JD)
13, Doctoral degree (ex: PhD, EdD)

Do you live in a rural area?
1, Yes
0, No

Do you consider yourself to be Appalachian?
1, Yes
0, No

CIGARETTE DETAILS (researcher entered form)

Do you usually smoke menthol or non-menthol?
1, menthol
2, non-menthol

Do you usually purchase your cigarettes by the pack, carton, or roll your own?
1, pack
2, carton
3, roll your own

(if 3, roll your own) Do you hand-roll your cigarettes or are they made by a machine?
1, I hand roll my cigarettes
0, They are made by a machine (e.g. at-home machine or large automatic machine)

(if yes) Do you use filters with roll-your-own cigarettes?
1, Never
2, Sometimes
3, Always

What brand do you usually smoke? _________

What is the length of these cigarettes? _________
Is this a hard pack or soft pack?
1, hard pack
2, soft pack

OTHER TOBACCO PRODUCT USE

Have you used any of the following even one time?
1, Cigars
2, Pipes
3, Snus/Snuff/Dip
4, Chew
5, Electronic Cigarettes (also: Vapes, vape pens, e-hookahs, Personal vaporizers, PVs)
6, Hookah/water pipe
7, Dissolvable tobacco (lozenge, strips, or sticks)

(based on response above) Have you these in the past 30 days (Please mark all that apply)?
1, Cigars
2, Pipes
3, Snus/Snuff/Dip
4, Chew
5, Electronic Cigarettes (also: Vapes, vape pens, e-hookahs, Personal vaporizers, PVs)
6, Hookah/water pipe
7, Dissolvable tobacco (lozenge, strips, or sticks)

(for each above) If yes, have you used any of these products in the past 7 days? ___

How many days in the last 7? (max=7) _____

On average, how many times per day do you use this product? ______

NICOTINE DEPENDENCE

How many cigarettes per day do you usually smoke? ________ cigarettes/day

On days that you can smoke freely, how soon after you wake up do you smoke your first cigarette of the day? _______ minutes

Which cigarette would you hate most to give up?
1, the first in the morning
0, any other

Do you smoke more frequently during the first hours after awakening than during the rest of the day?
1, yes
0, no
Do you smoke even if you are so ill that you are in bed most of the day?  
1, yes  
0, no  

Do you sometimes awaken at night to have a cigarette?  
1, yes  
0, no  

If yes, how many nights per week do you typically awaken to smoke? _______ times  

Do you smoke now because it is really hard to quit?  
1, yes  
0, no  

Do you ever have strong cravings to smoke?  
1, yes  
0, no  

Over the past week, how strong have the urges to smoke been? (check one)  
1, No urges  
2, Slight  
3, Moderate  
4, Strong  
5, Very strong  
6, Extremely strong  

Is it hard to keep from smoking in places where you are not supposed to?  
1, yes  
0, no  

When you haven’t used tobacco for a while… OR when you tried to stop smoking…  
…… did you feel more irritable because you couldn’t smoke?  
1, yes  
0, no  

…… did you feel nervous, restless or anxious because you couldn’t smoke?  
1, yes  
0, no  

SMOKING HISTORY  

How old were when you first started smoking cigarettes fairly regularly?_______  

At what age did you first start to smoke cigarettes every day? _________
Before the age of 18, did any family members living with you smoke on a daily basis for one or more years?
1, yes
0, no

Which of these best describes rules about smoking in your house:
1, not allowed anywhere inside your home
2, allowed in some places and at some times
3, allowed anywhere in the home
4, there are no rules about smoking inside the home

Do you sometimes "butt out" or extinguish and relight your cigarettes?
1, yes
0, no

In the last week, on average, how many out of a pack of 20 cigarettes that you smoke, do you typically re-light? __________

How would you describe your overall opinion of using tobacco? Is it...
1, Very positive
2, Positive
3, Neither positive or negative
4, Negative
5, Very negative

QUITTING HISTORY
In the past, have you ever made a serious attempt to quit smoking? That is, have you stopped smoking for at least 1 day or longer because you were trying to quit?
1, Yes
0, No

When was the last time you tried to quit for at least 1 day or longer?
1, Days → how many days ago?
2, Months → how many months ago
3, Years → how many years ago

Of all the quit attempts you have made, how long did your longest quit attempt last? Was it days, months, years?
1, days
2, months
3, years

How many days/months/years was your longest quit attempt? ________
During any of your past quit attempts, did you use any of the following products: nicotine patch, nicotine gum/lozenge, nicotine nasal spray, nicotine inhaler, electronic cigarette, Chantix or Varenicline, Zyban, Bupropion or Wellbutrin or any other product?
1, yes
0, no

(If yes) Which product have you used? (check all that apply)
1, nicotine patch
2, nicotine gum/lozenge
3, nicotine nasal spray
4, nicotine inhaler
5, electronic cigarette
6, Chantix or Varenicline
7, Zyban
8, Bupropion or Wellbutrin
9, any other product

What other product have you used? ________

MENTAL HEALTH HISTORY
In your lifetime, have you ever had two weeks or more when nearly every day you felt sad, blue, depressed?
1, yes
0, no

Have you ever been diagnosed with general anxiety, depression, dysthymia, panic disorder, obsessive compulsive disorder, post traumatic distress disorder (PTSD), phobias, bipolar, schizophrenia, or other mood disorder?
1, Yes
0, No

In the past year, have you felt that you may have had one of these disorders?
1, Yes
0, No

Would you say that in general your health is:
1. Excellent
2. Very good
3. Good
4. Fair
5. Poor
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CURRICULUM VITAE
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Doctor of Education, Lifelong Learning and Adult Education, May 2018
   Penn State University Harrisburg, Middletown, PA
   Dissertation: “What have low income smokers learned from a lifetime of exposure to public
   health pedagogy: A Narrative Inquiry?” (Chair, Robin Redmon Wright)
Master of Science, Public Health Science, 2012
   Penn State University College of Medicine, Hershey, PA
Bachelor of Science, Human Nutrition, 2005
   University of Illinois at Chicago, Chicago, IL. Graduated Cum Laude.
Bachelor of Arts, Communications, 1995
   Marquette University, Milwaukee, WI. Received Scholarship for Academic Distinction.

PRE-DOCTORAL TRAINING
Penn State College of Medicine, Tobacco Center of Regulatory Science Pre-doctoral Scholar,

DIETETIC INTERNSHIP TRAINING
University of Illinois at Chicago – Chicago, IL 9/2003 – 12/2005

PROFESSIONAL EXPERIENCE
Penn State University, College of Medicine – Hershey, PA 3/2011 to present
   Research Project Manager for Jonathan Foulds, PhD
Penn State Milton S. Hershey Medical Center – Hershey, PA 1/2006 – March 2011
   Clinical Dietitian-Bariatrics
Capital Fitness/XSport Fitness – Chicago, IL 7/2001 – 12/2005
   Manager, Human Resources 7/2001- 6/2003
   Personal Trainer/Group Fitness Instructor 6/2003 – 12/2005
Spherion Corp. – Chicago, IL 6/1998 – 7/2001
   Sr. Consultant, Finance and Accounting, Chicago, IL 1/2001 – 7/2001
   Communications Assistant

TEACHING ACTIVITIES
Penn State Dietetic Internship Preceptor: Research Rotation 2014-present

LICENSE/CERTIFICATIONS
Registered Dietitian by the Commission on Dietetic Registration since 2006
Licensed Dietitian in the state of Pennsylvania since 2006
Certified Tobacco Treatment Specialist 2013-2015
ACE Personal Training Certification 2003-2011
AFFA Group Fitness Certification 2003-2009