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Unclean fathers, responsible men: Smoking, stigma and fatherhood

Lorraine Greaves
Faculty of Medicine, University of British Columbia, Vancouver, BC, Canada

John L Oliffe
School of Nursing, University of British Columbia, Vancouver, BC, Canada

Pamela Ponic
School of Nursing, University of British Columbia, Vancouver, BC, Canada

Mary T Kelly
School of Nursing, University of British Columbia, Vancouver, BC, Canada

Joan L Bottorff
Faculty of Health and Social Development, University of British Columbia, Vancouver, BC, Canada

ABSTRACT

In this article, we report on the experiences of men who are smokers in the context of new fatherhood and explore the intersections of stigma, masculinities, and contemporary fathering. The men in this ethnographic study reveal both internalised and externalised stigma and describe situations and feelings when they became aware of the stigmatising qualities of smoking as new fathers. Fathers, expectant and new, are beginning to experience the focus of a punitive gaze previously reserved for expectant and new mothers. This gaze is gendered, and fathers who smoke are viewed as disrupting their responsibilities of protector and provider. The findings provide detail for understanding men's experiences of smoking-related stigma in Canada where smoking prevalence is relatively low, tobacco is denormalised, and smokers are increasingly stigmatised. To develop effective programming for this underserved group, health professionals must become aware of the unintended consequences of tobacco reduction pressures on new fathers, increasing negative public attitudes, and tobacco policies that have the potential to produce stigma-based psychological harm.

Keywords: smoking; tobacco; fathers; stigma; denormalisation; sociology

Introduction

Expectant and new fathers have been largely ignored in research, health promotion and the intervention planning surrounding smoking that for decades has been aimed at pregnant women. This article begins to address those gaps by exploring the experiences of men who are new fathers with respect to the stigma-related consequences of their tobacco use during pregnancy and postpartum, and in the context of the denormalisation of tobacco use in countries such as Canada, where overall smoking rates are declining.

Stigma and smoking

Stigma is a socially constructed process whereby a person or group is negatively identified and

disapproved of due to a particular attribute or condition (Farrimond and Joffe 2006; Goffman 1963; Reidpath and Chan 2006; Weiss and Ramakrishna 2006). Over the last few decades, tobacco use has become a stigmatised health behaviour in Canada and many other higher income countries where prevalence has declined (Farrimond and Joffe 2006). Kim and Shanahan (2003) suggest that public sentiment regarding smoking in North America first labelled smoking as an immoral behaviour, then as a health risk and, finally, as a 'public enemy', such that smokers have come to be seen as social deviants. The rise in public awareness about the negative health effects of tobacco use (and, more recently, second-hand smoke [SHS] exposure) coupled with an increase in policy developments that 'denormalise' smoking and mark smoking as a public hazard, have contributed to the development of stigma (Bayer and Stuber 2006). Researchers report that measures of smoking-related stigma include conceptions of both smoking and smokers. For example, Stuber et al. (2008) report that smokers are stigmatised by: (1) beliefs that smoking is a voluntary risk; (2) beliefs that smoking harms children, who are innocent victims; (3) experiences of institutional discrimination as a smoker (e.g., employer control and hiring standards); and (4) experiences of family and friends who disapprove of smoking. Farrimond and Joffe (2006) explored the construction of smoking-related stigma with a group of 40 British smokers and non-smokers. They reported three primary stigmas: (1) smokers as polluters and dirty contaminators of the environment; (2) smoking as an anti-social and unacceptable public behaviour; and (3) the identification of the smoker as 'other.' The authors argued that these views were all highly connected to the judgment that smokers irreparably harm themselves, others, and the environment (Farrimond and Joffe 2006). In short, the marginalisation of smokers has multiple public policy and health-based roots, catalysed by anti-smoking campaigns.

Many tobacco cessation strategies have purposefully based messaging upon these stigmatizing assumptions as a means of promoting public health and limiting 'deviant' behaviour (Bayer 2008). Yet, despite the presumption that health-related stigma may lead people to quit, moral condemnation, attributions of weak character and segregation also tends to have a negative effect on already unwell and vulnerable populations (Stuber et al. 2008). From a sociological perspective, enforcing conformity among those deemed deviant imposes and sanctions 'psychological punishments such as feelings of guilt, isolation, and embarrassment' (Kim and Shanahan 2003:348).

Health-related stigma, in particular, is critical and pervasive for individuals or groups who are deemed to be personally and morally responsible for their illness or risky health behaviour and manifests both externally and internally in interactive processes. External stigma affects the ways people are seen and treated and determines the level and nature of social control and censure in social settings and daily life, through decision-making in public institutions and through policy-making (Room 2005; Sabo 2005).

Internal or self-stigma refers to the process whereby individuals become aware of, believe and endorse the assumptions that underpin stigmas and apply these beliefs to themselves (Mak et al. 2007; Prilleltensky and Nelson 2002), which results in shame, blame, fear, guilt, stress, social isolation, low self-esteem, loss of confidence and negative self-identity (Chapple et al.. 2004; Major and O'Brien 2005; Rusch et al. 2005). Since externalised and internalised stigmatisation hold potential consequences for the ways that new fathers manage, change and perceive their own smoking practices, better understanding of fathers' experiences can provide important insights.

Fatherhood and masculinities

The dominant ideals of fathering are socially and culturally constructed, alongside evolving

views on masculinity. Contemporary fathers are espoused as retaining the traditional masculine characteristics of provider but are also household helpers and nurturers, actively involved with their children (Barclay and Lupton 1999; Edley and Wetherell 1999; Marsiglio et al. 2000). Although the notion of the father as provider has undergone change and young men can now expect fathering to encompass more involvement inside the home and participation in active childcare with the mother, many continue to identify primarily as the breadwinner, a role aligned with masculine ideals (Williams 2008). Current typologies of fathering include the *work-focussed father* who is primarily identified with being a provider, may be either professional or unskilled, but for different reasons works long hours; the *family men* who are main breadwinners but value family life and participate to some degree; and *hands on fathers* who are heavily involved in childcare, unskilled and underemployed (Brannen and Nilsen 2006). Cultural changes related to fathering and masculinity are intertwined with structural social changes, such as mothers' labour force participation and restructuring in the job market, which in turn may be adapted to differently by different social classes (Brannen and Nilsen 2006).

Dominant ideals of masculinity construct men to be strong, emotionally stoic, resilient in the face of physical danger, and unconcerned with risks to their personal health (Courtenay 2000). Nonetheless, versions of masculinity are dynamic, seemingly contradictory and routinely contested within and across men's lives and history (Connell 1995; Courtenay 2000); likewise, contemporary ideals of fathering can be taken up (or not) in diverse ways (Barclay and Lupton 1999; Dienhart 2001; Lamb 2000; LaRossa 1988).

The commitment to being involved in fathering activities after the birth of a child contributes to men's well-being (Knoester et al. 2007) and men who make fathering a high priority report also more satisfaction in mid-life than men who are less involved fathers (Lamb 2004). Becoming a father can prove challenging for men who align with masculine ideals that rationalise autonomy and embrace risk through practices such as smoking (Bottorff et al. 2006, 2009; Courtenay 2000). Hence, as some fathers spend more time at home, often providing direct care to their child, they strive to protect significant others from SHS by smoking outside the home, by removing their smoking from shared domestic spaces, or by concealing their smoking (Oliffe et al. 2010). Indeed, what it means to be a father directly affects men's smoking behaviours; fathers usually attempt to smoke away from their child and partner, rather than quit (Blackburn et al. 2005). Building on that observation, we focus here on the intersections of stigma, masculinity, and smoking in the context of fathering.

Methods

The findings reported here are drawn from a larger ethnographic study, and are part of a 6-year programme of research exploring smoking patterns and cessation efforts in families during pregnancy, postpartum, and early childhood (Bottorff et al. 2005, 2006, 2009; Johnson et al. 2009; Oliffe et al. 2008). A qualitative approach informed by ethnographic research methods was used to examine the men's smoking and interrogate the explicit interpretation of meanings and functions of that human action (Brewer 2000; Wolcott 1999). Our approach reflected a commitment to mapping the multiple discourses that occur in the social worlds of fathers.

As researchers who investigate health and gender from the perspective of social context, early in our data analyses we observed the presence of stigma operating in the accounts new fathers offered of their smoking experience. We felt our approach to this topic could be a contribution to understanding some of the competing discourses and arguments in the literature. Tobacco control literature highlights the biomedical risks that parental smoking poses for children's health (e.g., increased respiratory and middle-ear infections, low birth weight) and the fact so many children

under age 12 are regularly exposed to SHS at home. From a gendered perspective, up to 29% of men continue to smoke during the child-bearing years, and men's smoking practices have been theorised as a means of constructing masculine identities (Bottorff et al. 2006). At the same time, a father's smoking status directly affects the ability for women partners to remain non-smoking after pregnancy, but fathers have rarely been addressed in pregnancy and postpartum-specific tobacco cessation campaigns. We endeavoured, therefore, to weave together these issues at the intersection of tobacco as a significant health risk, smoking as a gendered practice, and stigma as a detrimental influence on well-being.

Study participants

University of British Columbia ethics approval was granted and study participants were recruited from prenatal and postpartum hospital units in Vancouver, British Columbia, Canada. Following information about the study purpose, participants signed a consent form that included written details about the procedures, potential risks, and benefits and confidentiality. Participants received a $20 honorarium for each interview (a series of two were completed with 20 participants, and nine participants completed one interview) to recognise their contributions to the study.

Twenty-nine new fathers 20–59 years of age who were living with their partners and continued to smoke during pregnancy and/or postpartum participated in the study. Participants worked in a variety of jobs including labour, skilled trades, and computer and business-related work, and their annual household incomes ranged from less than CA$20,000 to more than CA$100,000. Anglo-Canadian (n = 9), Asian (n = 10), European (n = 5), Middle Eastern (n = 3), and Filipino (n = 2) ethnicities were represented. All participants had smoked during their partner's pregnancy, although four had quit at the time of the first interview. As a group, they had smoked for an average of 16 years, ranging from one cigarette per day (CPD) to over a pack per day (average CPD = 10–12 cigarettes).

Data collection

We conducted in-depth, semi-structured, individual interviews that focussed on the men's experiences of smoking within the context of impending and new fatherhood. Interview questions included, 'prior to the pregnancy, what was your smoking routine like?', 'how did the pregnancy and fatherhood influence your smoking patterns?' and 'what did other people say about your smoking while your partner was pregnant?' Although interviewers followed an interview guide, they encouraged a dialogic environment that respected and encouraged the participants' subjective experiences and personal narratives, using prompts to show interest and elicit additional information when appropriate. The interviews were conducted by trained male interviewers in the participant's home or a coffee shop, took between 45 and 90 min, and were digitally recorded, transcribed verbatim and checked for accuracy. Field notes were completed by the interviewer at the end of each interview to detail the interview location and their interactions with the participant. We believe the use of male interviewers enhanced our recruitment efforts, and helped create a sense of rapport and mutuality within the interview (Oliffe and Mroz 2005).

Data analysis

The field notes were inserted into the interview transcripts and uploaded to NVivo™, a qualitative software program. A coding schedule was developed through systematic reviews of the data conducted by the authors. Early in the analyses, stigma was identified as a recurrent theme and related data were initially organised under one broad code. Independent analyses conducted by each of the authors led to inductively derived categories, the congruence and reconciliation of which were developed in team meetings. Our analyses did not identify any outliers, or

contradictory data regarding stigma and smoking for which we needed to account.

Drawing on the health-related stigma work of Pescosolido et al. (2008) and Connell's (1995) masculinities framework, the themes outlined in the Findings section were conceptually advanced and linked to theory and existing empirical understandings. As such, we understood that the stigma experienced by the new fathers in this study was 'defined in and enacted through social interaction' (Pescosolido et al. 2008) at individual, relational and social levels. Integrating Connell's (2005) masculinities framework into this understanding of stigma highlighted how dominant masculine ideals could shift and influence the men's practices in a multiplicity of ways, to reveal diverse identities both within and between men.

Findings

Pescosolido et al. (2008:433) argue that 'stigma lies at the interface of community and individual factors', a perspective that resonated in the experiences of fathers in this study. Participants reported aspects of stigma that were both external and internal, and at times revealed the dynamics of the interactions between external and internal stigmatisation processes. These experiences of stigma are presented, along with three types of gendered and relational behaviours that manifested in men's practices in response to the stigma associated with smoking (cleanliness rituals, self-removal and self-ostracisation).

Externalised stigma

The men described numerous examples of the ways in which they were stigmatised and/or judged by others, whether family, friends, strangers, or the media. The comments revealed the pervasiveness of pressure and judgment regarding smoking, at home, at work and in public. Men revealed their sensitivity to presumed judgments, non-verbal communication and, for many, the pressures of belonging to a visible minority group. A 44-year-old father explained his perceptions of external stigma:

> I felt that myself. Smokers seem to be discriminated. Like sometimes when I go to the mall and had to stand outside to smoke, when other people walk by and smelled me, they often have a look of annoyance on their face. So I guess the dynamic here certainly put some pressure on smokers, so smokers will reduce … Smokers are scarce. So are the locations where you can smoke. One can't smoke indoors and when you walk on the street, you hardly see any smokers.

This man's sense of being discriminated against and a source of annoyance to others echoes other research that positions smokers as deviants, polluters of the environment and a health-risk to others (Farrimond and Joffe 2006; Stuber et al. 2008). This experience of stigma was not always explicit, and some men described how stigma operated on an implicit level in public venues. For example, one man who reduced from a pack and a half to a pack a day said, 'Nobody says anything … nobody today will actually come up to you and say it, but you can see it in their eyes when they look at you'. A 38-year-old father emphasised how pronounced this kind of externalised stigma is in this particular region of Canada, where smoking has become increasingly denormalised:

> I remember walking into my apartment and as I was walking by … I couldn't stay far enough away, I know the smoke, four to six feet, if you get within that you can smell it, the smoke, and he [the landlord] said something kind of rude … like I smelled like an ashtray or something like that and that was kind of upsetting to know that people might think that.

Dominant masculine ideals have long been influenced by the interaction of structure and agency, and comments from a 35-year-old first-time father revealed how his wife, friends, and work buddies aligned with anti-smoking structures to position him as a parody, old fashioned and outmoded in terms of contemporary fatherhood discourses. He said:

> I'm mocked by my wife. I'm mocked by my peers. Nobody appreciates a good cigarette anymore. Whatever happened to this planet, it used to be at one time smoking was cool, not anymore.

This man's social network accepted his smoking without judgment before he became a father, and although the morally loaded banter was intended as a form of positive discrimination, this quote also affirms masculinity as co-constructed and reveals how external stigma can result when men operate outside shifting masculine norms (Connell 2005).

Internalised stigma

The fathers also internalised and developed processes of self-stigmatisation and secondary deviant identities. Internalised stigma embodied emotions such as guilt, embarrassment, regret, self-blame, self-loathing, and shame. A 35-year-old man offered a poignant example of this internalisation process:

> Participant: You keep giving me that evil look.
> Researcher: Oh that was my thinking actually … that was my remembering correctly look, no, not an evil look.
> Participant: Okay, I thought that was me, a pack a day – *disgusting*, did he say 'pack or a pack a day, oh my god'.

In this scenario, although the participant had reduced the number of cigarettes he smoked daily since learning he would become a father, he remained sensitive to the interviewer's perceived judgement. The perception of an evil look led him to contest that judgment; after all, he had reduced and was not willing to have his past misdemeanours (the other me) be the site of further stigma. The participant did not contest the stigma around smoking, but contested any subordination in this interaction, because he could bracket his previous smoking behaviour as a time past and nearing a complete end. A 24-year-old father conveyed the notion of a secondary, stigmatised identity:

> Researcher: Describe what you think your life would be like if you weren't smoking anymore.
> Participant: Um, I would feel like anybody who is completely normal and functioning in a normal life.
> Researcher: Okay so if you quit you'd feel more normal?
> Participant: Yeah, because you know I wouldn't have to go out of the mall – I wouldn't have to smoke you know. I wouldn't have to you know go out of indoors to smoke. I wouldn't have to worry about my wife and kids – my baby's health.

Another man illustrated how the experience of smoking-related stigma was heightened by his wife's pregnancy, making his smoking further taboo. He stated that smoking 'certainly wasn't as pleasurable' due to 'the guilt of knowing what I was doing to myself [because] now I'm a father and I've got someone to take care of in a while'. The guilt this father experienced indicates how internalised stigma becomes a process of self-regulation and self-denigration. In the uptake of his role as father and family provider, his admission of guilt signals that he has begun to blame himself for being a 'bad father' because he smokes. Such responses to stigma and smoking were common among the participants who also referred to themselves as 'not good', 'embarrassed', 'regretful', 'guilty', 'ashamed' and 'disgusting'. These responses illustrate the ways in which participants internalised the external messages of stigma and how they turned this perception back on to themselves.

While this form of self-denigration or 'psychological punishment' (Kim and Shanahan 2003) may have resulted in some men quitting or reducing their smoking, it also has the further potential to harm their health. Stigma, particularly self-imposed stigma, has been labelled a secondary health condition by the World Health Organization, and the US Department of Health and Social Services have identified stigma as a

leading impediment to health promotion globally in that it creates stress that exacerbates existing health conditions (US Department of Health and Human Services 1999; World Health Organisation 2008). A 22-year-old father illustrated how external and internal stigma created additional stress for him and contributed to his struggles to quit smoking:

> Participant: Well, like we were standing there at the light waiting to cross, oh what a nice baby, blah, blah, then they casually get into a conversation at the end they're pretty much like, 'do you smoke', it's like is it your business? I regret it enough. I don't need you on my ass.
> Researcher: Okay, so does it make you feel guilty when they say that or …
> Participant: Oh yeah, because then I have the kid in front of me too, right … I hate being judged but I guess no one can really judge me. But they do and it gets to me and, yeah, another reason I want to quit. I've got tons of reasons to quit but I just haven't found them … the drive to quit.

This man's reaction to being stigmatised as a father who smokes is complex: he feels judged by other people, resists their judgment by attempting to 'own' his decisions when he says 'no one can really judge me', but then turns the judgment and blame back on himself. He 'knows' that he should quit, 'regrets' smoking as a father, but has not found the 'drive' to quit, which positions his smoking as an individual endeavour ideally removed from broader social commentaries.

The effects of stigma on new fathers who smoke

The externalised and internalised stigmas surrounding smoking manifest in a range of behaviours, grouped as cleanliness rituals, and self-ostracisation behaviours. These behaviours are relational, linked primarily to the health and welfare of the infants and potential dis/approval of the mothers, friends, and co-workers.

Cleanliness rituals

Cleanliness rituals that result from the stigma that smoking is dirty became exaggerated because the men wanted to protect their children from SHS. Some men, including a 38-year-old father who felt that SHS might harm his pregnant wife, became almost obsessive about these rituals in his efforts to maintain the role of father as protector:

> Again, it's so taboo. I'm kind of alert to it too and I realise that the smell lingers and even though I can't smell it if I'm smoking. Um, she was remarkably forgiving because if I kissed her goodnight I would stay up later because I knew that I couldn't cover that [smoking]. But I do have a ritual. When I come back in [after smoking] and I wash my hands and wash my face and swish some water or mouthwash or something. But that won't cover it up unless I really brush my teeth and use mouthwash but she's pretty good with that.

A 30-year-old father who was pursuing a career in banking revealed how concern over the negative effects of stigma could push him to extreme compensatory behaviour:

> Well, whenever I finish the smoke I always go to the washroom and wash my hands and I, you know, spray Febreeze on myself, [laughter] yeah, so it doesn't offend clients or anybody else, so I think it's okay.

In this instance, the man hoped for a promotion within the finance organisation to coincide with his new responsibilities as a father, and he feared recrimination from white-collar professionals due to his smoking. The chosen behaviour to spray his entire body becomes symbolic of these competing interests and discourses when considered within this context.

In addition, throughout our research programme we have noted similar efforts men and women make to become 'clean' in the presence of infants and non-smokers (Bottorff et al. 2005). These cleanliness rituals will likely be magnified

further in the lives of mothers and fathers who smoke as they begin to grapple with emergent messaging about the dangers of third hand smoke (Winickoff et al. 2009).

Self-ostracisation

A common strategy participants described was to engage in smoking alone. Their accounts revealed internal and external stigma as propelling men toward designing situations where they could smoke undisturbed and unobserved. In these private places, such as alleys, balconies, or alone in their car, the men minimised their shame and guilt as smokers, while revisiting the pleasures of smoking in relative peace. A 41-year-old father enjoyed smoking alone on his front porch, but his favourite spot was a park bench with a view where he stopped for a smoke on his way home from work. He stated:

> And recently here general climate in society there is that smoking is, 'oh look at him, he smokes it's terrible' so, uh, not really that it bothers me a lot but, uh, it just spoils enjoyment. So I prefer places where I'm by myself.

The man was sensitive to potential stigma and, although the park was a public place, by stopping there to smoke he avoided the scrutiny of family and neighbours on his porch. In this way, he triaged the amount of stigma he was willing to bear, and perhaps reduced possible internal experiences of self-blame and guilt by smoking away from home and child. A 30-year-old father explained how the experience of the mother's pressure on him to quit smoking resulted in self-ostracisation, and further, how that was stressful:

> Researcher: Does the fact that she's not a smoker affect your smoking, the constant quit requests?
> Participant: Um, I don't know if it's really affected it all that much, you know, like I was mentioning earlier, it's still stressful, you know, so it's definitely in a sense almost keeping me smoking, because it is a sense of relief, you know, to smoke right but, I just find myself hiding it … like kind of sleuthing around a little bit which kind of sucks.

Being a good father

The men reported on and acknowledged various gendered expectations related to masculinity and fatherhood (e.g., father as protector, father as provider). Some of these expectations created stress for the fathers, highlighted stigma, and may have perpetuated their smoking. In short, the fathers' narratives contained emerging norms that indicated a good father does not smoke. A 35-year-old man explained the inherent conflict experienced in attempting to be a 'good father', positive role model, and responsible smoker:

> I mean I know for me smoking it's not good, again it's bad for my health. I don't really need to be smoking and it's expensive and the baby doesn't need it going around, right? And you want to be a good example for your baby when it comes out, you don't want to be smoking even around, and like [mother] is always complaining that even though I'm smoking outside you bring that smell in with you. It's in your clothes and then you'll be holding onto the baby with stinky, smelly, smoky clothes and on and on, right?

This man positioned good fathering as involving direct contact with his child; the combined discourses of father as role model, protector, and nurturer are intertwined in his narrative, but it is the father as nurturer that is most incompatible and discordant with the aftermath of having a smoke. Most men also referenced the financial and guardianship responsibilities of fathering as being incompatible with smoking. For example, a 39-year-old office worker explained how his perception of the costs and risks of smoking had changed since becoming a father:

> Well it's [smoking] not good for my health, you know, which I think is true, and so, you know, long term as I am a dad, you know, and I've got

> more responsibilities now. … If I can stop now it's going to be better for my health, you know. I don't want to get lung cancer and die so, and leave the little kid without a dad. … And secondly on the money side of it is, I've begun to feel a little bit, well I mean there's a lot more expenses having a baby and, you know, that's really where the money should be going, I believe, you know. So I'm feeling probably, kind of feeling guilty to myself actually that it's not good for me.

Although many men referred to aspects of masculinity that revolved around being a reliable provider, and struggled with the external and internal stigma of being a smoking father, they also found ways to resolve this issue with the approval of other men. A 27-year-old man who reduced from a pack to half a pack a day explained the solution:

> Having to go outside to smoke is basically part of being a father who smokes type thing, that's basically how they [my co-workers] put it. … At work there's a bunch of guys that smoke and well I haven't really talked to them about quitting because I haven't really been working there that long but, they know about the fact that I do smoke outside and then they just tell me it comes with the territory basically.

This man's comments may be read as a refutation to perceived stigma. Inherent in this passage is the assumption and argument that a 'working man' needs and deserves to smoke, and while this man acknowledged smoking as problematic for a good father, by smoking outside he rhetorically insisted that a man should no longer feel guilt or receive judgment from others because he was smoking responsibly.

Other men talked about the burdens of traditional masculine scripts, and felt the pressures and stresses of fathering as breadwinner and provider contributed to their need to smoke, despite the stigma. A 31-year-old father, recently unemployed, described how this stress put him in a state of constant agitation:

> I just got laid off, waiting to hear from my union back to see whether I get a placement. I mean if they can't give me a place by Tuesday I've got to look for a job right … I've got a kid and a wife to feed, you know. … It's just added stress, you know what I mean. I have more stress on my life, bigger work load on myself and that won't help me quit at all. That will just, in fact, increase my, you know, increase my agitation and the only way I'm going to get rid of my agitation is to have that cigarette, you know, things will get to be a lot easier.

Discussion and Conclusion

These findings indicate clearly that stigma toward and among new fathers who smoke is a critical aspect of their experience, affecting their self-image, smoking behaviour, social reputation, fathering practices, and relations with others in their lives. The men in this study were cognisant of the social trends toward the denormalisation of tobacco use and the consequent effects on smokers. They were conscious of stigma, both external and internal, and this awareness affected their practices around smoking. Further, they offered insight in reflecting upon the gendered expectations of new fathers and how their fatherhood might measure up. Most participants manipulated and adjusted their smoking locations and practices, and ameliorated their smoking with new rituals regarding cleanliness, and self-removal and segregation.

Participants struggled with the adoption of norms and values surrounding contemporary fatherhood, in the context of continued smoking, thereby creating internal conflict and dissonance. Incorporating fatherhood into an ongoing identity as (an increasingly marginalised) smoker, in the context of masculine assumptions about smoking, is a complex process that has clearly caused new behaviours and rationalisations to emerge. For example, the hedonistic practices of men may refute and contest the external stigma. In addition, there seems great potential to weather the 'stigma' storm by 'lying low' and

continuing to smoke until the child has grown and protection from SHS is less a concern. Much of the internalised stigma seems to relate to the lack of protection afforded to a defenceless child by being in an environment containing SHS.

Two main points emerge from these findings. Fathers, both expectant and new, can also experience the focus of a disapproving and punitive gaze previously reserved solely for expectant and new mothers. However, this gaze appears to be gendered. Whereas women are often blamed for hurting or damaging the foetus or the infant through smoking or exposure to SHS (Greaves and Poole 2005), men who smoke are viewed as threatening and undermining their masculine identities and responsibilities of protector and provider. Further, focusing tobacco cessation on staying healthy for the long term is rarely primary when focussed on women in the context of smoking during pregnancy and postpartum; it is an aspect of masculinity in fatherhood that appears to affect men and new fathers.

Stigmatizing individuals who already suffer from ill-health serves to blame the victim, a dynamic that has been heavily critiqued in the health promotion literature because it fails to acknowledge the social circumstances that shape socially determined mortality and morbidity rates (Buchanan 2006; Minkler 1999; Ponic 2007). Victim blaming predominated early commentaries about men's health in which men's poor health outcomes (i.e., lower life expectancy in large part attributed to preventable causes including motor vehicle accidents, addictions, etc.) were positioned as direct by-products of men's behaviours (Charmaz 1995; Lee and Owens 2002; Sabo 2005). Careful consideration of the emotions experienced by new fathers through both external and internal stigmatisation processes, and their behavioural responses should be thoughtfully considered in tobacco reduction initiatives targeted to fathers. There is a growing body of literature debating the ethics of public health promotion strategies and messaging (Guttman and Salmon 2004; Johnson et al. 2009). On the one hand, Bayer (2008:470) suggests that stigma is appropriate in the realm of tobacco control because public health 'bears a unique moral responsibility' to implement programmes to promote the health of the broader population and therefore serve the greater common good. On the other hand, Burris (2008:475) suggests it is unethical to use stigma in any health promotion efforts because it is an oppressive form of social control that undermines identity and self-esteem, and worse yet, becomes internalised 'to turn the individual into his own jailor, his own chorus of denunciation, [and] takes inhumanity to an ultimate pitch'. Burris' argument is especially important with respect to smoking in high income countries such as Canada, where overall prevalence rates have declined and smoking is increasingly located in groups who already experience social, economic, and related health inequities (Barbeau et al. 2004). Given this socioeconomic trend, using stigma as a health promotion strategy runs the risk of further marginalizing already vulnerable populations without remedying existing health disparities (Guttman and Salmon 2004; Phelan et al. 2008; Scambler 2009). In fact, there is little evidence to suggest that it is an effective form of tobacco control (Blackburn et al. 2005; Burris 2008), and our findings show that participants tended to adjust their smoking practices in respond to stigma, rather than quit.

In conclusion, while fathers who smoke are an underserved population deserving of attention, the resolution of questions regarding the most ethical and preferred approach to supporting them is critical. Pregnant women smokers were the focus of a disproportionate gaze for decades in health promotion and tobacco cessation interventions, shamed, blamed and stigmatised, resulting in temporary behaviour changes but high postpartum smoking relapse rates. It is critically important to avoid these errors with expectant and new fathers, and to focus on generating gendered and men-centred approaches that address and respect the lived realities of men who smoke in the context of new fatherhood.

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