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Depressed men angry women: Non-stereotypical gender responses to anti-smoking messages in older smokers

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Depressed men; Angry women:
Non-stereotypical gender responses to anti-smoking messages in older smokers

Debora Brown, Grad. Dip. Marketing

This thesis is presented for the degree of Masters of Business (Marketing) Edith Cowan University School of Business

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ABSTRACT

This qualitative study into the effective use of fear arousal in social marketing advertising, focused on exploring gender differences in smokers' attitudes towards threats in anti-smoking messages in the 40 to 50 year old age group. This age group of smokers has received relatively little attention in the fear arousal literature to date, presumably because their 'hard core' attitudes are perceived as difficult to change by social marketing and medical practitioners.

The key purpose of this study was to explore the attitudinal responses of male and female smokers in the 40 to 50 year old age group to anti-smoking messages and in particular to those using death and non-death threats. Unexpected findings from a previous study (Henley 1997) were the first to indicate that significant gender differences occurred in this age group to anti-smoking messages.

Henley's (1997) study focused on death versus non-death threats in social marketing messages in two age groups of smokers: 16 to 25 and 40 to 50 year olds. Response to the death threat, 'Quit smoking or you'll die of emphysema' was compared to the response of the non-death threat, 'Quit smoking or you'll be disabled by emphysema', in producing change in attitude, motivation and intention to adopt the recommended behaviour. The appropriateness of these threat messages was considered in relation to male and female smokers in two age groups, 16-25 years and 40-50 years.

Henley (1997) found that significant differences occurred between older male and female smokers' responses to death and non-death threats in social marketing messages, and that in general, 40-50 year old males responded more to death threats and 40-50 year old females responded more to non-death threats, with the exception of death threats and loved ones.

Focus groups were the qualitative method used for data collection in this study. Data was collected from four focus groups (2 male and 2 female), that consisted of 40 to 50 year old regular smokers. Group interviews were conducted as free flowing discussions interspersed with questions pertaining to the major objectives of the study.
Projective questioning techniques were used to draw out participants' deeply held beliefs rather than their more easily accessible attitudes. As such, they were not asked direct questions pertaining to attitudes or specifically prompted for response to death and non-death threats. The men and women in this study fitted the characteristics of 'hard core', precontemplative smokers due to their long term smoking behaviour and low-involvement with anti-smoking information.

Data were analysed manually according to themes in relation to the major objectives with special consideration given to gender differences that emerged. Attitudes were examined according to emotional, cognitive and behavioural responses. Gender differences are discussed in relation to how responses were articulated. Significant gender differences occurred in attitudinal response to threats in anti-smoking messages. In particular, gender differences occurred in relation to perceived self-efficacy, and strategies employed to cope with cognitive dissonance and negative emotions that emerged from exposure to anti-smoking messages.

Men in this study revealed low levels of perceived self-efficacy, self-esteem and a sense of helplessness and powerlessness over their smoking behaviour. Discussions revealed the men had adopted maladaptive coping responses such as avoidance behaviour and denial in relation to anti-smoking messages. Women in this study revealed higher levels of self-efficacy and derived more benefits from smoking than men. However, their responses indicated anger towards patriarchal and authoritarian anti-smoking messages. Data also revealed that women had adopted maladaptive coping responses such as defiance, reactance and avoidance behaviour in relation to anti-smoking messages. An unexpected finding in this study was that both genders were clearly more accepting of positively framed anti-smoking messages that engendered self-esteem and higher efficacy.

The implications for practitioners and researchers are that market segmentation is advisable for older smokers. ‘Hard core’ smokers may be a difficult group to reach via negatively framed anti-smoking messages and it is possible that positively framed messages may offer a solution. Further quantitative research is indicated into the relative effectiveness of positively framed messages and 'hard core' smokers.
I certify that this thesis does not, to the best of my knowledge and belief:

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1.1 The Role of Social Marketing

In the past 30 years, the field of social change has evolved rapidly as improved lifestyles, economies, social values and social systems make people eager for change (Kotler & Roberto, 1989). From the early 70s, social reformers and health practitioners were becoming increasingly aware that one-dimensional public service announcements were failing to motivate the desired behaviour change in society. Around this time there were three emerging realisations that helped shape a burgeoning new subsection of marketing. One was the realisation that social reformers and health practitioners, who were expert at determining what the people within a society should do to improve their social problems, were unskilled at communicating how and why they should make the necessary behavioural changes (Kotler & Roberto, 1989). Another influence was awareness of the continual success of commercial marketing techniques which involved systematic disciplines, such as in-depth research, planning, the 4Ps marketing mix, and evaluation of marketing campaigns (Kotler & Roberto, 1989 p.24). A third was the drive by public health practitioners to promote prevention behaviours in relation to the growing prevalence of lifestyle diseases such as cancer and heart disease (Egger, Donovan, & Spark, 1993).

The term “Social Marketing” was first used by Kotler and Zaltman (1971) to describe a more sophisticated approach to social change campaigning that drew from successful techniques used in commercial marketing. In 1971, Kotler and Zaltman (1971) defined social marketing as “the design, implementation, and control of programs calculated to influence the acceptability of social ideas and involving considerations of product planning, pricing, communication, distribution, and marketing research” (p 6). With this definition, the authors suggested that social change practitioners could ‘sell’ ideas, attitudes and
behaviours by borrowing the same successful techniques used by commercial marketers to 'sell' products.

By the late 1970s and early 1980s concerns were raised over assumptions that social marketing differed from commercial marketing in only the aims of the campaign (Bloom & Novelli, 1981; Rothschild, 1979). Suggestions were made that despite the numerous studies already available in the field of social marketing, important aspects had been neglected such as the inherent difficulties that existed in adapting commercial marketing techniques to social problems. A further concern was the relatively small amount of quality research, and underdeveloped audience segmentation guidelines, choices of channels, appeals, and strategies for positioning and management (Bloom & Novelli, 1981). Other concerns raised by Bloom & Novelli (1981) and Rothschild (1979) were:

- Health benefits from behaviour change are generally longer term whilst commercial products offer immediate gratification
- The behavioural changes social marketing attempts to implement often involve more effort and time, and may be initially unpleasant for the consumer (e.g., giving up smoking)
- Social marketing campaigns are frequently aimed at difficult-to-reach, or at-risk target adopters who may feel antagonism towards the idea of change
- The personal and social complexities of negative health behaviours are intrinsically different than purchasing commercial products
- Relations with 'middlemen' involved in commercially marketed products are simpler than with intermediaries in social marketing
- Commercially marketed products are much easier to define than those in social marketing, which may be subject to different expert's views
- It is more difficult to define an exchange process in social marketing
- Social norms and pressures can be inconsistent with social marketing aims
- Changes should also occur in social systems and structures that may function to the disadvantage of the health of the population
Bloom and Novelli (1981) defined social marketing as “the design, use, and control of projects trying to gain acceptance of a social idea or practice among a target group” (p.79). However, they optimistically noted that awareness of the problems cited above would enable practitioners to build effective social marketing campaigns.

By the late 1980's social marketing had been embraced by public health practitioners, signalled by a huge increase in mass media based social marketing campaigns (Kotler & Roberto, 1989). These campaigns were founded on marketing concepts and covered a wide range of social concern such as alcohol and drug abuse, immunisation, heart disease, safe driving practices and nutrition (Egger, Donovan & Spark, 1993; Lefebvre, 1997). In 1989, Kotler and Roberto claimed that social marketing had now evolved into an established subcategory of marketing and a legitimate field of academic study with practical application. They redefined social marketing as “…the design, implementation, and control of programs aimed at increasing the acceptability of a social idea or practice in one or more groups of target adopters” (Kotler & Roberto, 1989 p.24).

Lefebvre (1997) suggested that one of the main reasons health professionals had been attracted to social marketing during the 80s, was because of social marketing’s effectiveness in influencing behavioural change at different levels of the population, such as local, state and national levels. There was also a prevailing high level of interest in effective, population-based social change at the time. Lefebvre and Flora (1988) offered a topical redefinition of social marketing with reference to the values of the time: “In the true spirit of public health, social marketing moves us away from individual-orientated behaviour change and towards population based change”.

In summarising a collection of international practitioners’ descriptions of the meaning of social marketing in the 90s, Albrecht (1997) suggested that the generally agreed consensus of the meaning of the term social marketing is:
...social marketing involves the applications of commercial marketing techniques for individual and societal benefit, rather than financial gain. Social marketing creates induced, yet voluntary behaviour change (through persuasion) and the technique is based on strong research related to segmented audience needs, wants, and perceived barriers. (p.23)

In a review of the 25 years since Kotler and Zaltman’s (1971) first usage of the term ‘social marketing’, Andreasan (1997) metaphorically suggested that social marketing was a young and promising discipline, capable of great contribution to both micro and macro social issues. He asserted that much further research should be conducted to determine the most effective ways to motivate behavioural change in target audiences. According to Andreasan (1997): social marketers should continually strive for more cost-effective and sophisticated research methodologies as well as develop strategies that serve the needs of poorer populations. Andreasan (1997) suggested that possible opportunities for wider social marketing expansion lay beyond health promotion and environmental protection into areas such as justice, criminology and mental health.

1.1.2 Threat Appeals

Social marketing campaigns are generally designed to persuade as well as inform (Egger, Donovan & Spark, 1993). Attempting to persuade by the use of fear or threat appeals has been a common tactic in social marketing, under the assumption that the more fear aroused, the greater the chance of persuasion (Higbee, 1969). Typically, a threat appeal associates a behaviour such as smoking, with a negative consequence such as lung cancer. An integral part of the message is the recommended solution, which is usually a suggestion of behaviour change to avoid the negative consequence, for example ‘Quit smoking or you’ll die of lung cancer!’ (Donovan & Henley, 1997).

Extensive research has been conducted into the effectiveness and appropriate use of fear arousal in public health campaigns and social marketing over the past 50
years, with the focus primarily centred on response to fear arousal. Most studies have indicated that a positive relationship occurs between threat level and persuasion. However other studies have produced conflicting results; some indicated a negative relationship between high fear and persuasion, and others suggesting no relationship (Donovan & Henley, 1997). Ray and Wilkie (1970b) reviewed the complex literature on fear arousal and threat appeals and suggested that a market segmentation approach was advisable when using threat appeals in some situations.

In a study focusing on how the nature of the threat stimulus can impact on the fear response, Henley (1997) empirically tested the effectiveness of adopting a market segmentation approach to advocate a particular health behaviour when using fear (of death) arousal in social marketing campaigns. Response to the death threat, 'Quit smoking or you'll die of emphysema' was compared to response to the non-death threat, 'Quit smoking or you'll be disabled by emphysema', in producing change in attitude, motivation and intention to adopt the recommended behaviour. The appropriateness of these threat messages was considered in relation to male and female smokers in two age groups, 16-25 years and 40-50 years. She found significantly different results by age and gender in smokers responding to death and non-death threats.

Henley (1997) conducted a 2 x 2 x 2 (Death/Non-death threat x age x gender) ANOVA for the dependant measure ‘Response’ (on a six-item scale of attitude, motivation and intention to quit). The Death/Non-death main effect was not significant. However, the main effect for age was significant, as response by younger smokers indicated that they were more impacted by the health threats than the older smokers. No significant differences in response occurred in the 16 to 25 year age group to death and non-death threats. However, in the 40 to 50 year age group, older women responded significantly more to non-death threats than to death threats. Conversely, older men responded significantly more to death threats than to non-death threats (See Figure 1).
One exception found during further exploration of Response to the six individual threats was that older women did respond strongly to the death threat that specified the effect of one’s death on loved ones (Henley, 1997). Henley states that fear arousal correlated positively and significantly with Response, as she expected. However, variations occurred in the levels of fear in relation to Death Anxiety (a twelve item scale of agreement/disagreement with statements about death). Henley (1997) suggested this may have been an indication that death anxiety may relate to trait anxiety, or that the threat of emphysema did arouse death anxiety somewhat, even in the non-death conditions (Henley, 1997). Death anxiety was highest in relation to death of loved ones. Henley (1997) stated that, consistent with other research, few participants in her focus groups admitted to fear of their own death and numerous participants specifically stated they had no fear of dying. In contrast, many participants feared the process of dying. Distinctions were made between ‘good’ versus ‘bad’ deaths and less preferable modes of dying, such as prolonged or violent death (Henley, 1997).

Henley’s (1997) results are significant for social marketing practitioners and researchers because they indicate that health messages may be more effective if segmentation guidelines are used. For instance, both death and non-death threats may be appropriate for 16-25 years olds. However, death threats may be more appropriate for 40-50 year old males and non-death threats may be more appropriate for 40-50 year old females.
This was an unexpected finding. There have been no similar findings in the fear arousal literature to the age/gender interaction found in the older age group in Henley's (1997) study. Henley (1997) suggested that further research be undertaken to investigate possible explanations. Hence, this research was undertaken to further explore responses to threat appeals within the older age group. The main aim of this study was to investigate the response to threat messages in male and female, 40 to 50 year old smokers.

1.2 Significance of the Study

Tobacco is the highest single preventable cause of death and disease in Australia today (English, Holman, Milne et al., 1995). Twenty five percent of the Western Australian population smoke, and around 15% of smokers die prematurely from tobacco-caused disease every year (HDWA, 1998). The cost of tobacco-caused hospitalisation in WA is approximately $52 million per annum (HDWA, 1998). With at least 25% percent of Australians smoking regularly (Hill, White, & Segan, 1995) the toll in smoking morbidity and mortality is expected to remain high and continue to rise, for diseases such as lung cancer and lung and heart disease well into this new century (Hill, White & Segan, 1995).

Cessation of cigarette smoking has immediate health benefits for smokers of all ages whether or not they are affected by a smoking related disease (Clark, Rakowski, Kviz, & Hogan, 1997; Gordon, Kannel, & McGee, 1974; USDHHS, 1989). Therefore, smoking cessation is one of the most critical public health concerns today.

An important aspect of this study is its focus on smokers in the 40-50 year old age group. This age group and age in general have previously received little attention in threat appeal studies. This study contributes to the knowledge of social marketing communicators who seek to develop effective health advocacy messages for smokers in the 40 to 50 year old age group. The original contribution
to knowledge about the differences that occur between genders within this age group, aims to provide segmentation guidelines that will render targeted social marketing messages more effective. This is particularly valuable because this age group has a relatively poor response to anti-smoking messages.

1.3 Purpose of the Study

The key purpose of this study was to explore the attitudinal responses of male and female smokers in the 40 to 50 year old age group to anti-smoking messages and in particular to those using death and non-death threats. Unexpected findings from a previous study (Henley 1997) were the first to indicate that significant gender differences occurred in this age group to anti-smoking messages.

Henley's (1997) research was focused on two age groups of smokers, 16 to 25 year olds and 40 to 50 year olds. One important finding of Henley's (1997) study was that significant differences occurred by gender within the older age group:

The Response of 40 to 50 year old males to death threats was substantially, though not significantly, higher than their Response to non-death threats ($M_s = 3.24; 2.96$), $t(225) = 1.92$, $p = .056$.

Conversely, the Response of 40 to 50 year old females to non-death threats was significantly higher than their Response to death threats ($M_s = 3.39; 2.98$), $t = -2.97$, $p < .01$ (Henley, 1997. p.209).

The purpose of this research was to expand Henley’s (1997) quantitative findings by conducting a qualitative study designed to explore differences in response to anti-smoking messages and in particular to those using death and non-death threats. The main aim was to gain insights and ideas from the 40 to 50 year old participants’ discussions about how they respond to death and non-death threat messages, and why the variation in response by gender might occur.
A qualitative study was conducted using four focus groups consisting of male and female smokers who were 40 to 50 years of age. Gender and socio-economic status delineated participants. The groups were conducted as free ranging discussions, guided by questions pertaining to possible explanations for the variation in response reported in Henley’s (1997) study.

1.4 Research Objectives
The overall objective of the focus groups was to explore the attitudes of 40 to 50 year old smokers by investigating their emotional, cognitive and behavioural responses to threat messages. In particular, the study was designed to explore any apparent differences between older male and female smokers’ responses to death and non-death threats in anti-smoking messages. In addition, the perceptions of older male and female smokers towards the source of the message were explored, as well as any differences in how they described the costs and benefits of smoking.

1.5 Research Questions
1. What are 40-50 year old smokers’ emotional, cognitive and behavioural responses towards anti-smoking messages?

2. Are there differences in the way male and female smokers in the 40 to 50 year old age group articulate their emotions, cognition and behaviour in response to anti-smoking messages?

3. Are there differences in 40 to 50 year old male and female smokers’ attitudes to death and non-death threats in anti-smoking messages?
4. Are there differences in how male and female smokers in the 40 to 50 year old age group perceive the source of the message?

5. How do 40 to 50 year old male and female smokers articulate the costs and benefits of smoking?

1.6 Conclusions

This chapter outlined the need for further social marketing research into segmentation of social marketing messages, particularly in relation to the response of older male and female smokers to threat appeals. Data from previous research that instigated this study, as well as this study's contribution to existing knowledge and its objectives were discussed.

The literature relating to fear arousal and threat appeals, smoking and attitudes is discussed in the next chapter. Chapter 3 presents the theoretical framework and Chapter 4 discusses methodological strategies. Chapter 5 presents the data analysis, and Chapter 6 discusses the major findings, limitations and implications for practitioners and researchers.
Chapter 2: LITERATURE REVIEW

In this section, the literature on persuasion using fear arousal is examined, with reference to major theories that have been proposed to explain how fear works in persuasive communications. The appropriate use of the term ‘threat appeal’ rather than ‘fear appeal’ to describe messages threatening negative outcomes, and the structural components of a threat appeal are discussed. The negative consequences of cigarette smoking as the fear topic are examined, specific reference is made to smoking prevalence by age and gender, and differences in death anxiety by age and gender are discussed. Literature on attitudes is discussed with a particular emphasis on gender, emotion, guilt and shame.

2.1 Fear Arousal in Social Marketing

The literature on persuasion and health advocacy suggests that most researchers believe that the most effective method of persuading people to choose a recommended behaviour is by fear arousal. The assumption is that the more fear aroused, the greater the chance of persuasion (Higbee, 1969, p.18). Fear arousal is widely used in social marketing campaigns concerning drink driving, quitting smoking, safe sex and health generally. The effectiveness of fear arousal has been researched at length over the last 50 years, focusing mainly on how fear works and whether more or less fear is effective. One of the main difficulties in researching the effect of fear arousal is that there is no absolute measurement of
fear. The descriptors 'high', 'moderate' and 'low' hold different meanings for different people (Henley, 1997).

The body of literature on response to fear arousal yields conflicting results, predominantly regarding the effectiveness of threats containing high versus low fear. The early notion that a low threat is more effective than a high threat stems from Janis and Feshbach's (1953) seminal work, which indicated that mild fear arousal was more effective than stronger fear arousal in gaining message acceptance in a dental hygiene study. This was later supported in other studies (Janis & Feshbach, 1954; Janis & Terwilliger, 1962 and Goldstein 1959, cited in Higbee, 1969; Leventhal & Niles, 1965).

Other researchers found conflicting results. For example, some researchers suggested that whilst fear may effectively change an attitude, it may not necessarily lead to a change of behaviour (Leventhal, Singer, & Jones, 1965). However, Leventhal and Watts (1966) reported yet another aspect when they found that high fear influenced more compliant responses to the recommendation to reduce smoking, but lower compliance in relation to having an X ray. Moderate fear was also found to be effective. According to Krisher, Darley and Darley (1973), moderate fear arousal was most effective in a study with inoculation as the fear topic. A similar conclusion was made in a study into condom use and AIDS prevention by Hill (1988).

However, by far the most support has been reported with regard to the positive relationship between high fear and persuasion in a wide range of studies, ie: dental hygiene (Leventhal, Singer & Jones, 1965), tetanus immunisations (Dabbs & Leventhal, 1966; Leventhal, Jones, & Trembly, 1966), safe driving behaviour (Berkowitz & Cottingham, 1960; Leventhal & Niles, 1965), safe driving behaviour (Berkowitz & Cottingham, 1960; Leventhal & Niles, 1965), fallout shelters (Hewgill & Miller, 1965), and smoking (Insco, Arkoff, & Insko, 1965; Leventhal & Niles, 1964; Leventhal & Watts, 1966; Leventhal, Watts, & Pagano, 1967).
As discussed in several reviews of the fear arousal literature (Sutton, 1982; Boster & Mongeau, 1984; Rotfield, 1988) the relationship between the emotional response of fear and persuasion was found to have a certain reliable effect on attitudes, intentions and behaviours, ie: the greater the fear aroused, the greater the effect of persuasion. However, other research produced a curvilinear relationship between level of fear and message persuasion, ie: the best results occurred at some intermediate level of fear arousal between a weak and a strong threat (Janis, 1967; Quinn, Meenaghan and Brannick, 1992). Some authors have warned against counterproductive results occurring from too much fear arousal. Higbee (1969), after reviewing the fear arousal literature, suggested that too much fear could evoke intense feelings of dysfunctional anxiety. Ray and Wilkie (1970a) warned that fear arousal that is too strong may produce avoidance behaviour or maladaptive coping mechanisms because the individual may feel incapable of adopting the recommended behaviour. Job (1988) asserted that too much fear may in fact lead to an individual increasing their negative behaviour (ie: smoking or drinking) to reduce the anxiety caused by high fear. Alternatively, fear arousal that is too weak may go unnoticed or simply be ignored (Ray & Wilkie, 1970b).

2.2 Threat Appeals

In this section, the use of threat appeals in relation to the literature is discussed with reference to appropriate use of the conceptually distinct terms 'fear' and 'fear appeal', 'threat' and 'threat appeal'. The structure and various components of a threat appeal are discussed with specific reference to efficacy and its salience in threat messages. Theories in relation to fear, threat appeals and efficacy in anti-smoking campaigns are discussed.

2.2.1 Threat Terminology

Various researchers have identified that message elements have contributed to conflicting results in the fear arousal literature. For instance, it is possible that the
interchangeable use of the conceptually distinct terms 'fear', 'fear appeal', 'threat' and 'threat appeal' (with the term 'fear appeal' used most frequently), has lead to some confusion over the many conflicting results in fear arousal studies. Witte (1993) argued that the diverse range of results from many studies has occurred because a threat elicits a qualitatively different response than fear. For instance:

...perceived threat (coupled with high perceived efficacy) results in adaptive outcomes where individuals protect themselves against the threat by changing attitudes, intentions or behaviours...fear arousal causes qualitatively different maladaptive outcomes where the individuals control their - fear not the threat - by defensively avoiding, denying or reacting against the threat...(Witte, 1993 p.151)

Therefore, despite the frequent use of the term ‘fear appeal’ in the fear arousal literature, it is inappropriate because it confounds the stimulus (threat) and the response (fear) (Witte, 1993; Donovan & Henley, 1997). Consequently, this has led to a neglect of stimulus factors in the persuasion literature and may have had a significant effect on the contradictory findings (Strong, Anderson, & Dubas, 1993; Donovan & Henley, 1997). Berkowitz and Cottingham (1960) cautioned against relying on previous research indicating the effect of fear arousal in some communications, as it may not precisely relate to the fear topic in question. They suggested that appropriateness and intensity of fear should only be considered in relation to specific situations.

Differences in types of fear may also have contributed to the contradictory findings. For instance, Leventhal and Trembly (1968) suggested that strong fear arousal may evoke two different types of fear response: “inhibitory fear” (p.159) which occurs in response to strong descriptions of destructive situations, and is characterised by a sick, nauseated feeling and reaction to the possibility of damage to the individual; and “anticipation fear” (p.159) which could be described as fear felt in anticipation of attack or approach of a threat agent and characterised by
tense muscles, awareness of the environment and attention to ways to evade danger.

Source credibility has also been found to have an important effect on acceptance of fear-arousing messages. Hewgill and Miller (1965) concluded that attitude change was greater in response to strong versus mild fear arousal when the source of the message had high credibility in a group of parents who listened to messages about the importance of fallout shelters. Insko, Arkoff and Insko (1965) also found source credibility affected message acceptance when they manipulated source credibility in a group of adolescent smokers.

Some researchers indicated that relevancy of the fear topic had a significant effect on the success of the message acceptance. High fear arousal was found to be more successful than low fear arousal when the topic had little relevance to the audience (Leventhal and Watts, 1966; Ray and Wilkie, 1970a). Leventhal and Watts (1966) suggested that greater attention to the message and more personal involvement may be attained by relevancy of the topic to the audience. The ethical use of fear arousal was raised by Spence and Moinpour (1972) in relation to situations when the recommended solution to the feared condition does not satisfy the target's expectations. However, after reviewing the fear arousal research, Ray and Wilkie (1970b) asserted that the level of fear evoked in effective (commercial) marketing messages is not high enough to be unethical. Henley (1998) countered Ray and Wilkie's assertion when she reviewed Leventhal's (1970) note that candidates passed out in a study after reading a booklet that described the negative effects of tetanus.

Personality characteristics of the receiver were found to influence message acceptance (Burnett & Oliver, 1979). According to Rotfield's (1988) review of the fear arousal literature, elements of the individual's thought processes may make response to fear arousal uniquely individual and therefore optimum responses to fear arousal have not been accurately represented by the data.
Although the focus in the persuasion research has predominantly been on fear arousal, there is evidence that fear may not be the only emotion aroused by threat appeals and other emotions may be evoked such as guilt, remorse and anger (Henley, 1997). Some researchers suggest that fear-arousing communications which arouse too much fear are less effective because they can evoke maladaptive coping responses such as denial, rejection or minimisation of the personal risk (deTurk, Goldhaber, Richetto, & Young, 1992). Other emotional and cognitive responses could be effective in facilitating persuasion such as positive emotions (Dillard, Plotnick, Godbold, Freimuth, & Edgar, 1996; Donovan, Henley, Jalleh, & Slater, 1995).

Some researchers suggest that to understand the fear response to a threat appeal it is important to make a distinction between the *threat stimulus* and the *fear response* by focussing on the nature of the threat used, rather than response to the fear arousal (Witte, 1993; Henley, 1997). For accuracy, the terms ‘threat appeal’ and ‘fear arousal’ will be used throughout this study to make a clear distinction between the threat stimulus and the fear response.

### 2.2.2 Components of a Threat Appeal

According to Witte (1993), many scholars who have contributed to the literature on fear and persuasion were not able to precisely define what categorises a threat. She argued that for researchers to have a true understanding of the effect of threat appeals on behaviour, definitions need to be systematically operationalised across studies. Witte (1993) proposed that a threat appeal has three main components: 1) structure 2) style and 3) extra message features (See Figure 2):

1. **Structure**
1. STRUCTURE

Structurally, a threat appeal presents a threat, and then follows it with a recommended response to avert the threat.

THREAT
The threat portion of the appeal contains two message components:

- **Severity of the threat:** eg: “Cigarette smoking causes emphysema which leads to early death.”
- **Audience's susceptibility to the threat:** eg: “You are at risk of early death by emphysema if you continue to smoke cigarettes.”

The structural message components of severity and susceptibility induce perception of threat, which leads to fear arousal (eg: “I am at risk of getting emphysema and this scares me”).

EFFICACY OF THE RECOMMENDED RESPONSE
Two message components relate to the efficacy of the recommended response.

- **Response efficacy:** refers to the effectiveness of the recommended response, eg: “The best way to avoid dying early from emphysema is to stop smoking.”
- **Self efficacy:** refers to the individual’s ability to perform the recommended behaviour, eg: “You can quit smoking. Millions of other people have succeeded. You can too.”

Correspondingly, the message portrayals of response efficacy and self efficacy induce perceptions of efficacy (eg: “But I believe I can stop smoking to effectively lower my chances of dying from emphysema”).

Figure 2. Structural Components of a Threat Appeal derived from Witte (1993) and Henley (1997)
Witte (1993) suggested that the structural component consists of the presentation of a threat followed by a recommended response to avert the threat. It contains two message components:

(a) severity of the threat (eg: “Cigarette smoking causes emphysema that can lead to premature death”)

(b) the audience’s susceptibility to the threat (eg: “You’re at risk of premature death by emphysema if you continue to smoke cigarettes”).

There are two dimensions of the recommended response:

(a) response efficacy (also called solution efficacy) refers to the effectiveness of the recommended response (eg: “The best way to avoid dying early from emphysema is to stop smoking”), and

(b) self efficacy (or personal efficacy) refers to the individual’s perceived level of ability to perform the recommended behaviour (eg: “You can quit smoking. Millions of other people around the world have succeeded. You can too”) (Henley, 1997).

Severity and susceptibility are the structural components that lead to fear arousal by inducing the perception of threat, (eg: “I am at risk of getting lung cancer from smoking cigarettes and this scares me”). Correspondingly, the message components response efficacy and self efficacy induce perceptions of efficacy (eg: “But I believe I can stop smoking to effectively lower my chances of getting lung cancer”). Threat and efficacy are message-based variables; perceived threat and perceived efficacy are receiver-based variables.

2. Style
Style refers to the execution of the message’s words, audio or visual components and includes factors such as intensity, vividness and personalised language and emotional interest (Witte, 1993). These variables are combined to create different levels of fear arousal. A high fear arousal message contains personalised language referring to the audience’s susceptibility to the threat; a low fear arousal message contains less specific, or obscure language referring to the audience’s susceptibility to the threat (Witte, 1993).

3. Extra message factors

Witte (1993) describes extra message factors as the additional variables that assist persuasion, but are separate from the contents of the message. They include the credibility of the source, message sidedness, duration of the message, repetition and medium of the message. These elements can affect or confound message acceptance despite being unrelated to the threat appeal.

2.2.3 Threat Appeals, Theories and Efficacy

There is a large and complex body of literature available on threat appeals and their effectiveness. The theories developed around threat appeals have tended to mirror the foremost perspectives of their time. For instance, the earlier studies into threat appeals were focused on learning theories and perspectives, and fear was characterised as an emotional state that motivates protective behaviour (Hovland, Janis, & Kelly, 1953; Janis, 1967; McGuire, 1968). During the 1970s and 1980s, perspectives on cognitive processing in response to threat appeals were popular (Beck & Frankel, 1981; Rogers, 1975; Sutton & Hallett, 1988; 1989) and reflected the changes in social science at the time. Recent studies into threat appeals have returned to studying the driving force of emotion as a motivator for behaviour change (Dillard et al., 1996; Donovan & Henley, 1997; Henley, 1997; Witte, 1992).

Dillard (1994) noted that studies into threat appeals have focused on three major groups of theories: drive theories (such as Hoveland, Janis & Kelly’s (1953) fear-
as acquired model; McGuire's (1969) nonmonotonic models; Leventhal's (1970) parallel response model; and subjective expected utility models (such as Rogers' (1970) protection motivation theory; Beck & Frankel's (1981) threat control explanation; and Sutton's (1982) subjective expected utility model). Drive theories (Hovland et al., 1953; McGuire, 1968) suggested that fear arousal facilitates a drive to motivate actions. However, it was later argued that the drive to control fear could both facilitate appropriate self protective responses and maladaptive or interfering responses such as avoidance of threatening situations (Beck & Frankel, 1981; Leventhal & Watts, 1966; Rogers, 1975; Sutton & Eiser, 1984).

Emotional response versus cognitive response then became the focus of threat appeals. Leventhal’s (1970) Parallel Response Model (PRM) proposed that two distinct processes: emotion and cognition, were used by an individual in an effort to either control the danger of the threat (“danger control” Leventhal, 1970, p.119) or to control the fear of the threat (“fear control” Leventhal, 1970, p.119). Whilst this model was later criticised for being untestable and for its lack of specificity (Rogers, 1975; Beck & Frankel, 1981), it served to separate the emotional process from the cognitive process.

The protection motivation theory (PMT) (Rogers, 1975) identified the elements of a fear appeal and the cognitive mediators that lead to message acceptance. Rogers (1975) asserted that perceptions of high threat and high fear produce the most message acceptance. He indicated that fear related to the perception of severity and likelihood. The protection motivation theory (Rogers, 1975) predicted that threat appeals would be effective when:

- the threat is perceived as severe
- the threat is perceived as likely to occur unless the recommended behaviour is adopted or unlikely to occur if the recommended behaviour is adopted
the individual perceives the recommended behaviour to be effective in averting the threat, ie: **solution efficacy**

A fourth cognitive mediating process, **self efficacy** (when the individual perceives themselves able to perform the recommended behaviour) was included by Bandura (1977) in an effort to further explain the coping process in response to a threat.

Other researchers have agreed that efficacy is important for message acceptance in fear arousal messages (Conditte & Lichenstein, 1981; Leventhal et al., 1967; Maddux & Rogers, 1983; Sutton & Eiser, 1984; Witte, 1993). Maddux and Rogers (1982) conducted a study designed to test self efficacy theory with elements of Roger’s (1970) PMT. They found that self efficacy had a powerful effect on intentions to adopt the recommended behaviour and that self efficacy was a strong predictor of behavioural intentions. They also linked self efficacy influence with two other primary elements of the PMT: the probability or likelihood of the threat occurring and the coping response or solution efficacy.

Although Roger’s (1970) PMT clarified why threat appeals may work, it lacked an explanation of why some threat appeals fail (Beck and Frankel, 1981). In an effort to further define message acceptance and efficacy, Beck & Frankel (1981) reviewed the previous experimental evidence and offered an integrated theoretical approach by suggesting that threat control was mediated by either self efficacy or solution efficacy. They found evidence to support Leventhal’s (1970) previous assumption that it is important to separate the two elements of perceived threat control, ie: danger control coping behaviour and fear control coping behaviour. They suggested that the implicit recommended behaviour in a fear-arousing message is evaluated by the individual’s perceived self efficacy or the perceived solution efficacy. Beck and Frankel (1981) asserted that self efficacy is more important than solution efficacy because the individual weighs their ability to control the threat over the seriousness of the threat based on prior experience of their ability to control similar threats.
Rogers' (1975) protection motivation theory; Beck and Frankel's (1981) explanation of threat control and Sutton's (1982 cited in Sutton & Eiser, 1984) subjective expectancy model (SEU) all focused on cognitive responses as being more important in message acceptance than fear response. Sutton and Hallet (1988) also found evidence that cognitive factors mediate the effects of threat appeals and concluded that fear did not have an independent effect on intentions.

Further studies into the cognition focused models eventually produced low support for the notion that cognitive factors were more influential than fear responses. In a study into the role of cognitive factors and fear in fear-arousing messages, Sutton and Eiser (1984) identified “cognitive variables, particularly confidence” (p.32) as having strong influence on a smoker's response to anti-smoking messages. They proposed that “probability difference” (p.28) (or solution efficacy) and “confidence” (p.28) (or self efficacy) were particularly important after testing the SEU model against smoker's response to a fear-arousing film. However, they also found that an independent effect from the level of fear aroused by the film facilitated intentions. In conclusion Sutton and Eiser (1984) suggested that “it may be premature to discount the level of fear aroused by a communication as having no causal role in the mediation of communication effects” (p.32).

The most recent fear appeal theory, Witte's (1992) extended parallel process model (EPPM), incorporates some components of the earlier fear appeal research by combining danger control and fear control theories. Witte's (1992) EPPM asserted that threat appeals initiate one of three possible outcomes based on the individual's specific evaluation of the message. Firstly, an individual evaluates the threat contained in the message. Depending on their perceived personal susceptibility to the threat, the individual then begins to assess the efficacy of the recommended behaviour. Should the threat be too low or insignificant, there will be no further processing or the threat will be ignored. However, should a threat be considered relevant or serious (eg: “I am susceptible to contracting emphysema”
(Henley, 1997), the individual will become afraid. Their fear will then motivate some sort of coping response to reduce the fear.

Regardless of any specific manipulation, all threat messages involve certain levels of 'solution efficacy' and 'self efficacy' (Witte, 1993). Witte (1993) suggested that one of the significant confounding factors of studies into threat appeals was that many studies ignored the effect of inherent levels of efficacy within the threat message.

Witte (1993) asserted that perceived efficacy determines whether the individual will attempt to control the danger associated with the threat, or attempt to control the fear associated with the threat. For instance, if there is high perceived self efficacy ("You can quit smoking. Millions of other people around the world have succeed. You can too" [Henley, 1997]) and high solution efficacy ("The best way to avoid dying early from emphysema is to stop smoking" [Henley, 1997]), the individual will typically attempt to lessen, remove or control the danger by considering the advocated response and adopting the recommended behaviour.

However, when there is low perceived self efficacy ("I can’t stop smoking") or low solution efficacy ("If every cigarette is doing me damage, giving up won't stop me from getting emphysema"), the individual will attempt to control their fear, because danger control will be considered useless. Consequently, they will attempt to control their fear through denial ("I don’t believe that I will get emphysema from smoking") or through defensive avoidance ("I just block it out and don’t think about it") or reactance ("They don’t have the right to tell me to stop smoking") (Witte, 1993).

All of the above fear arousal theories were recently tested in a meta-analysis conducted by Witte & Allen (2000), when she expanded and updated research into fear arousal in health messages dating back to 1953. Witte & Allen's (2000) meta-analysis assessed data from earlier fear arousal models for relative fit and examined the influence of fear threat appeals against such intended outcomes as
intentions, attitudes and behaviours, and unintended outcomes such as defensive avoidance and reactance.

In her conclusion, she stated that the evidence was not entirely conclusive for any of the fear appeal theories. However, there was some support for Sutton’s SEU model, and for Witte’s EPPM (and innately PMT) suggesting that threat appeals elicit both danger and fear control responses and also that individuals appear more motivated to process stronger threats. Witte & Allen (2000) also concluded that significant or relevant threats, which increase perceptions of susceptibility and severity are more effective when they raise perceptions of self efficacy and solution efficacy. Alternatively, low-threat appeals apparently produce slight or no persuasive effect. Witte & Allen (2000) suggested that “...a persuader should promote high levels of threat and high levels of efficacy to promote attitude, intention and behaviour changes” (p.602).

2.2.4 Threat Appeals and Smoking

A significant proportion of the studies investigating threat appeals have used smoking as the fear arousal topic (Hill & Gardner, 1980; Insko et al., 1965; Janis & Terwilliger, 1962; Keller & Block, 1996; Leventhal & Kafes, 1963; Leventhal & Niles, 1964; Leventhal & Watts, 1966; Leventhal et al., 1967; Maddux & Rogers, 1983; Quinn, Meenaghan, & Brannick, 1992; Rogers & Deckner, 1975; Rogers & Thistlewaite, 1970; Sutton & Eiser, 1984; Sutton & Hallett, 1988; Sutton & Hallett, 1989). In general, literature on fear arousal and smoking supports the notion that fear facilitates persuasion (Leventhal, 1970; Sutton and Eiser, 1984; Sutton and Hallett, 1989), and more specifically, strengthens the intention to stop smoking (Rogers and Thistlewaite, 1970).

The majority of earlier studies into finding a cost-effective means of reducing smoking stemmed from the basic assumption that the anti-smoking message, when repeated in mass media communications would lead to new learning and change in attitudes and behaviour (Leventhal, Singer & Jones, 1965; Dabbs and Leventhal, 1966; Leventhal and Watts, 1966; Leventhal, Watts & Pagano, 1967).
These earlier studies concentrated primarily on two message variables, a) the severity of the threat, for instance fear-arousing information such as scenes of lung cancer surgery and b) personal susceptibility (to the threat), or information that lead to feelings of personal vulnerability to the threat.

In their review of the theory and behavioural modification research into smoking behaviour, Leventhal & Cleary (1980) indicated complex results. The studies involving severity of the threat by Leventhal and colleagues found that vividly portrayed threat messages generated stronger attitudes and intentions to comply with smoking cessation immediately after the communication, but the attitudes and intentions were not persistent over a longer period of time (Leventhal and Niles, 1965). Leventhal and Watts (1966) found that other reactions in smokers may be aroused by strong threat messages, such as total avoidance of the health message or avoidance of the recommended action.

Messages containing information on personal susceptibility to health damage were more successful in stimulating feelings of personal vulnerability and strengthening attitudes to quitting smoking (Hochbaum, 1965; Horn, 1963; Janis & Mann, 1965). However, when personal susceptibility was joined with a strong threat, the combined effects were less than favourable. One suggestion for these results was that the strong threat underpins confidence in self efficacy (Seligman, 1975 cited in Leventhal and Cleary, 1980).

2.2.5 Threat Appeals, Smoking and Efficacy

Leventhal (1970) found that an 'action plan' (contained within the recommended behaviour section of the anti-smoking message and later called self efficacy), combined with a strong threat, had significant effect on behaviour change by strengthening feelings of confidence and assisting attitudes to carry through to the action of quitting smoking. Without a specifically recommended ‘action plan’, a strong threat message was effective in arousing fear and the intention to quit smoking, but would not facilitate behaviour change. An action plan without strong fear arousal had no effect on attitude or behaviour.
Rogers and Deckner's (1974) results supported Leventhal's (1970) findings that high fear was more persuasive than low fear in anti-smoking messages. They also concluded that either low or high fear combined with increased reassurance of the efficacy of stopping smoking (as an effective solution to avoiding lung cancer) was helpful in reducing smoker's daily consumption of cigarettes. They found reassurance on its own was ineffective without some level of fear arousal.

Studies into the effect of fear-arousing communications on quitting smoking have found evidence that self efficacy influences the decision to quit (Condiotte and Lichenstein, 1981; Maddux and Rogers, 1983). Other researchers endorsing this theory have suggested that self efficacy, or one's perceived ability to deal with withdrawal symptoms and perceived willpower to overcome difficulties, has the ability to affect intention and behaviour when making the quitting decision (Sutton and Eiser, 1984; Sutton and Hallett, 1989).

Success or failure of past attempts to stop smoking influence a person's self efficacy in their ability to successfully stop smoking (Sutton & Eiser, 1984; Sutton, Marsh and Matheson, 1987).

Self efficacy was also found to be a salient factor for smokers who have made the decision to quit smoking. Prochaska and DiClemente (1984) described smoking cessation as a process by which smokers move through five different stages:

1) \textit{precontemplation} when there is no thought of quitting within the next 6 months

2) \textit{contemplation} when smokers give serious thought to quitting

3) \textit{preparation} when smokers consider quitting in the next month

4) \textit{action} which describes the period of time 0 to 6 months after actually quitting
5) and finally maintenance which refers to the period of time 6 months after quitting until smoking is no longer a problem.

The first three stages are measures of intention to quit and the last two stages are non-smoking behaviours (Prochaska et al., 1994).

Prochaska and DiClemente (1984) asserted that smokers who are ready to change behaviour or who have changed behaviour have higher self efficacy than those in the precontemplation stage. Similar results were reported in two further studies, which attempted to replicate Prochaska and DiClemente’s (1992) findings:

1) DeVries and Backbier (1994) found that self efficacy expectations were low in pregnant women who smoked when they were in the pre-contemplation and contemplation stages, but self efficacy expectations were significantly higher for those in the action stage

2) Dijkstra, DeVries and Bakker (1996) again replicated Prochaska and DiClemente’s (1992) earlier results with regard to self efficacy expectations in a study with smokers from the general population in Holland.

A further study into low readiness to change and smokers was addressed by Velicer, Hughes, Fava, Prochaska and DiClemente (1995). By using three identifying cognitive variables: the benefits of smoking, the negatives of smoking and temptation to smoke, they identified 3 further sub-groups within the group of precontemplators. They categorised them as:

1) Immotives, or those who typically fitted the profile of smokers who were not ready to change, perceived higher benefits and few disadvantages to smoking and responded to temptations to smoke;

2) Progressives, typically were closer to Contemplators with a higher readiness to change, and perceived higher disadvantage and dangers associated with smoking than Immotives; and
3) Disengaged smokers who scored lower than the other categories on all three variables.

Velicer et al. (1995) further suggested that smokers with different psychological profiles within the large group of precontemplators, may require different types of information to stimulate contemplation of quitting or stages of change in their smoking behaviour.

In a further study Dijkstra and De Vries, (2000) attempted to replicate Velicer et al.'s (1995) findings in a sample of 1,595 smokers from the Netherlands who were precontemplators. They found similar psychological and behavioural characteristics within the Netherlands group. However, in the Netherlands study, they also found a greater percentage of smokers who perceived relatively few disadvantages to smoking but believed they could give up. Dijkstra and DeVries (2000) suggested that the differences were likely due to the difference in social tolerance towards smokers in the Netherlands where 70% of smokers are not planning to quit within the next 6 months compared to the United States where 40% of smokers were not planning to quit in the next 6 months.

Dijistra, DeVries, Roijackers and Von Breukelen (1998) attempted to test if smokers within the precontemplator group would benefit from interventions matched to the possible subtypes identified by Velicer et al. (1995). They developed three outcome-based messages for smokers within this group. One was aimed at smokers who thought they may benefit from quitting, ie: why they should quit; another was aimed at smokers who might benefit from enhanced self efficacy, ie: how they could quit, and another was aimed at smokers who may have benefited from a combination of both messages. Despite finding a better response to all three messages than to no message, they concluded that there was no indication that one of these messages produced a better response than an other.
2.3 Attitudes and Message Acceptance

The literature available on attitudinal response and attitudes in relation to message acceptance is vast and diverse and will be discussed further in Chapter 3, Theoretical Framework. In this section, a cross-section of attitude research, which was considered relevant to the current study is examined. Despite the enormous amount of research available, there is no universally agreed-upon definition. Attitudes are usually discussed as comprising of affect, cognition and behaviour (Ajzen & Fishbein, 1980; Solomon, 1997). Eagly and Chaiken (1992) highlighted the element of evaluation when they defined an attitude as “a psychological tendency that is expressed by evaluating a particular entity with some degree of favour or disfavour” (p.17). Eagly and Chaiken (1992) asserted that attitudes are formed with an individual’s response to some object, and once formed, this attitude predisposes the individual’s evaluation of the object when it is encountered again. Eagly and Chaiken (1992) discussed evaluative responses in terms of them being covert or overt, as well as affective, cognitive or behavioural.

Attitudes have been characterised as comprising of knowledge structures or “associative networks” made up of interconnected evaluations and beliefs (Henry, 1980 p.42). This notion suggests that when elicitation of one attitude or belief occurs, by a process of “spreading activation” (Solomon, 1997 p.87), other related attitudes become more accessible.

Several characteristics of an attitude are considered important in understanding the effect of attitudes, such as accessibility, strength, values and function (Solomon, 1997). Fazio (1990) suggested that the speed or ease, with which an evaluation can be accessed or retrieved from memory, predicts how influential the attitude is on ensuing perceptions and behaviour towards an attitude object. Attitudes which are highly accessible (or top-of-mind) are more likely to bias interpretation of information, and form behaviour consistent with the attitude. In a similar vein to Eagly and Chaiken (1992), Fazio (1990) suggested that when strong pre-existing evaluations of an object exist, and the object is encountered again, those evaluations will be automatically activated.
Strongly-held attitudes can function as sources of self identification, are generally resistant to change, and broadly influence perceptions and behaviours (Petty & Krosnick, 1992). Strength of an attitude can be characterised in terms of one of three levels of involvement with the attitude:

1) **compliance**, is the lowest level of involvement, is superficial and likely to change when another option becomes available

2) **identification** occurs when conforming to another person or group and is important in social situations. Attitudes which form an identification function tend to change with those of the desired social group

3) **internalisation** is the strongest level of involvement and refers to deeply felt attitudes that make up an individual’s value system. Internalised attitudes are very difficult to change and are very important to the individual (Solomon, 1997).

An individual’s attitudinal preferences are potentially determined by values which are related to higher order evaluative standards, such as terminal values or desired end states; or instrumental values or means of achieving the desired state (Rokeach, 1973 cited in Solomon, 1997). Feather (1990) suggested that values affect behaviour when individuals evaluate the consequences of their actions. Values can be influential in how valence (both positive and negative consequences) is perceived in terms of behavioural choices and expectations of the outcome of a behaviour (Feather, 1990). Generally, in approach/avoidance situations, individuals tend to choose positive over negative stimuli, especially when the stimuli differ in hedonic quality (Solomon, 1997).

Katz (1960) discussed attitudes towards objects in terms of their functions, ie: value expressiveness; ego-defensiveness; knowledge and utilitarian functions. Value-expressive attitudes are expressive of the individual’s central values or self concept, ie: attitudes are formed towards an object because the object
communicates something about the person. For instance, a male smoker who wants to be perceived as masculine, may be attracted to Marlboro cigarettes, because the brand image is embedded with stereotypically masculine attributes which express personal values. Ego-defensive attitudes are those attitudes that are formed in order to protect the individual from internal emotions or external threats. For instance a male smoker who is insecure about his masculinity, may also smoke Marlboro cigarettes, but in this case to enhance a weak self image. Knowledge is an attitude function described by Katz (1960) as referring to an attitude held towards an object because it satisfies the need for meaning, order or structure. This could manifest in numerous ways depending on the individual’s needs. For instance, an individual may derive knowledge from a cigarette advertisement, which informs that menthol cigarettes are smoother on the throat, or that a certain brand of cigarettes contain a low nicotine count. Utility is an attitude function described by Katz (1960), which an individual employs to gain reward or punishment or simply for the direct benefits derived from the product. For instance, a person who wishes to be accepted by a desired reference group that approves of smoking, may take up smoking to gain acceptance.

According to some influential researchers, persuasion is inextricably linked to attitudes (Eagly and Chaiken, 1992; Petty & Cacioppo, 1981). People tend to find information that supports their attitudes easier to remember or learn than information which contradicts their attitudes (Eagly and Chaiken, 1992). Two theories dominate current thought about persuasion: Petty and Cacioppo’s (1981) elaboration likelihood model and Chaiken’s (1987, cited in Eagly and Chaiken, 1992) heuristic systematic model. Both models propose that strong attitudes are formed when individuals elaborately process information because they are motivated or highly involved with the topic (Petty, Schuman, Richman, & Strathman, 1993). Consequently, persuasion occurs if the argument is strong, and then the ensuing attitude change will be relatively stable. If the individual is unmotivated or has low-involvement with the information presented, limited problem solving or “heuristic processing” will occur (Eagly and Chaiken, 1992)
Attitudes that change as a result of heuristic processing tend to be relatively unstable or temporary.

Most researchers agree that wide differences occur in individual's responses to emotion-laden stimuli (Larsen & Diener, 1987; Moore & Harris, 1996). Emotionally evocative advertising, whether positive or negative appeals, can influence attitude formation (Bagozzi & Moore, 1994) and due to the wide range of affective responses in individuals, some may experience extreme discomfort when exposed to negative appeals, whilst others may feel only a slight effect (Larsen & Diener, 1987; Moore, Harris, & Chen, 1995). Moore and Harris (1996) found that individuals with a tendency towards emotional intensity responded positively to positive appeals, but were significantly less positive in their response to a non-emotional or negative appeals. Moore and Harris, (1996) suggested that individuals who tend to be emotionally intense tend to dislike exposure to intensely negative stimuli because they are less able to tolerate greater intensity in their emotions.

2.4 Emotion and Gender

Emotions serve crucial functions to daily social life. Regulating emotional responses serves to channel emotions in a way that is appropriate within a given context (Saarni, 1984). The belief that women are more emotional than men, is one of the most common findings in gender stereotype research. Women are thought to experience more frequent and more intense emotions, whereas men are thought to be emotionally inexpressive and to have less intense emotional experiences (Brody, 1997; Buntaine & Costenbader, 1997; Kelly & Hutson-Comeaux, 1999; Kring & Gordon, 1998; Robinson & Johnson, 1997).

Overall, the literature reviewed indicated no simple association between gender stereotypes and levels of experienced emotion. In a review of research that
focused on the gender-emotion relationship, LaFrance and Banjai (1992) defined emotions as “multidimensional constructs including expressive and behavioral, experiential, and physiological components” (p.195). LaFrance and Banjai (1992) concluded that the evidence suggests that women are:

- generally more demonstrative with their emotions than men in terms of facial expression
- apparently more emotional than men when asked to directly report on their own emotions in an interpersonal context
- more openly expressive when asked about general emotions
- are more overtly expressive in certain contexts, ie: in public.
- no different to men in terms of physiological indicators of emotionality.

In terms of gender stereotypes and emotional intensity, both Johnson and Schulman (1988) and Grossman & Wood (1993) reported a tendency for people to attribute more intense emotions to women than to men. However, men are attributed with more tendency towards stress than women (Brody & Hall, 1993; Fujita, Diener, & Sandvik, 1991; Grossman & Wood, 1993; Robinson & Johnson, 1997).

However, Robinson & Johnson (1997) found a divergence from the gender-emotion stereotype occurred when participants completed self-reports of their own responses to highly intense, real-life events. Robinson & Johnson (1997) reported that self-reports of actual situations (as opposed to hypothetical situations) were rated as less extreme than previously measured results to hypothetical situations, in the average man or woman. Robinson & Johnson (1997) also noted that real life situations which induced emotions in the average female, induced stress in the average male.
The traditional stereotypes concerning gender and emotional expression were refuted by Brody (1997) as somewhat misleading, because they often fail to acknowledge situational, individual and cultural differences in males' and females' emotional expressiveness. Brody (1997) argued that when gender differences occur in emotional expression, they may originate from processes such as dissimilar societal gender roles, power or status imbalances, and cultural differences in the socialisation of males and females. Brody (1997) suggested that these factors may have been neglected in the traditional research into gender stereotypes and emotions.

In a study which tested men and women for emotional response to stress by self report, gender differences in emotional response were shown to relate to the extent to which the individual's specific emotions display either power or powerlessness (Fujita, Diener & Sandvick, 1991). Context may also produce certain emotional responses. Some researchers indicate that expressions of emotion may be characterised forms of appraisal, and others as states of action readiness that are related to power, control, or vulnerability (Fujita, Diener & Sandvick, 1991; Timmers, Fischer & Manstead, 1998). For example, low perceived self efficacy may lead to negative emotions about the self. If an individual evaluates a negative stimulus to be caused by unknown elements, as being out of their control, and as beyond his or her ability to cope, the emotion likely to be experienced is sadness or fearfulness. These emotional expressions denote vulnerability or powerlessness in relation to the negative stimulus (Frijda, Kuipers, & terSchure, 1989; Manstead & Tetlock, 1989; Roseman, 1984). Conversely, perceived self efficacy may lead to more positive emotions. For instance, if an individual perceives a negative stimulus to be caused by external elements, as being within their control and ability to change, the emotion likely to be experienced is contempt or anger towards the negative stimulus. These emotional expressions denote power (Frijda, Kuipers and terSchure, 1989; Roseman, 1984; Manstead and Tetlock, 1989).
Further to context being given consideration in gender and emotion research, Kelly & Hutson-Comeaux (1999) suggested that context also has an effect on perceptions of emotional expression or gender-emotion stereotypes. For example Kelly & Hutson-Comeaux (1999) found that in a happy or sad context, women were considered to be more overactive than men. Men were perceived to be stereotypically more overactive in an achievement context, and in angry situations.

Various studies report gender differences in perceptual styles, ego strength and defence mechanisms (Block & Keller, 1996; Brody & Lovas, 1995). In these studies males tend to score higher than females in measures of independence, ego boundary strength and external measures of defence (such as aggression). Females tend to defend against anxiety more than males by internalisation of anxious feelings and self criticism (Block & Keller, 1996; Brody & Lovas, 1995).

Emotions shape patterns of interaction, such as establishing guilt or shame (Frijda, 1994). Defensiveness and anxiety have been linked to feelings of guilt and shame (Ferguson & Crowley, 1997; Lewis, 1971; Lindsay-Hartz, de Rivera, & Mascolo, 1995). Researchers tend to agree that both genders feel guilt and shame, but there are differences in how men and women adopt these emotions. Lewis (1971) asserted that females tend to develop a shame prone emotional style. Shame is understood to be a contrasting, "dejection-based emotional state in which the person’s entire sense of self worth is under attack because of abject failures to present the self in a desirable light" (Ferguson & Crowley, 1997).

Shame can induce efforts to escape uncomfortable, humiliating feelings and the susceptible person may withdraw from further social contact. Lewis (1971) contended that the more communal, cognitive enculturation of females in early childhood, makes them more susceptible to traditional socialisation pressures to conform to a passive and feminine standard. According to Lewis (1971), this consequently impedes development of strong ego boundaries, and females tend to develop internalised self defence mechanisms. Furthermore, should the woman
violate a standard of behaviour, the results are feelings of anxiety and hostility, which ultimately can lead to a sense of shame in which the woman negatively evaluates her basic sense of self worth.

Shame has been linked to more covert expressions of hostility in women, but to more overt expressions in males (Ferguson & Crowley, 1997; Tangey, Wagner, Hill-Barlow, Marschall, & Gramzow, 1996). For instance, Tangey et al (1996) found that in response to shame-provoking stimuli, female college students showed more tendency to hold anger in or walk away from the stimulus, and to cognitively assess their own role in the situation. However, the males’ response was more outward, ie: symbolic aggressiveness such as shaking the fist at the target or minimising the situation.

Males are thought to develop a more guilt-prone emotional style. Guilt has been defined as a negative state in which a person feels anxious for acting in a wrongful way, and desires to change the circumstances (Lindsay-Hartz, de Rivera & Mascolo, 1995; Ferguson and Crowley, 1997). Guilt in men was hypothesised by Lewis (1971) as orientating from a more independent, perceptual style of enculturation. She contended that males develop strong externalised ego-boundaries and defensive styles in early childhood as a result of rewards for traditionally masculine behaviour. Lewis (1971) contended that males’ early experiences of assertiveness, autonomy and competitiveness provided them with frequent situations in which they could hurt others, either psychologically or physically, and therefore have many opportunities to experience feelings of guilt.

Lewis (1971) proposed that males learn to reduce feelings of guilt by encapsulating or isolating the emotion or by deflecting the emotion outwardly, thereby recreating the cycle. Frequent exposure to guilt or shame-inducing messages can produce a “surfeit pathology” Malatesta and Wilson (1988 p.99); or too much emotion, which the individual then chronically uses to organise and interpret their experiences (Zahn-Waxler & Robinson, 1995).
2.5 Emotion and Age

There is relatively little information in terms of how aging effects emotional development. Studies on emotion from adulthood to old age have produced complex results. Emotional intensity has been found across the life span in adolescents as well as middle-aged adults (Deiner, Sandvick and Larsen, 1985). Older people place similar levels of importance on emotion to younger people and older people's descriptions of emotional intensity is similar to younger people's, according to Carstensen and Turk-Charles (1994). However, emotion is also believed to diminish with age, which has been connected with reduced interest in social activity in elderly people (Malatesta & Kalnok, 1984).

Age is related to increased ego development as a result of reorganised and integrated affective and cognitive reasoning (Labouvie-Vief, Hakim-Larson, DeVoe, & Schoeberlein, 1989). Older people are thought to have a greater understanding of emotion and are thought to regulate their emotions with more awareness than younger people (Labouvie-Vief et al., 1989). Older adults are believed to assign less blame, be less hostile, be more altruistic and cope with their emotions with more maturity than younger adults (Blanchard-Fields & Irion, 1988).

In a study that focused on the importance of emotions in people aged from 20 to 83 years, Carstensen and Turk-Charles (1994) found that salience of emotion increases with age. Carstensen and Turk-Charles (1994) measured subjects' neutral versus emotional information recall after reading a one hour narrative. They found that whereas recall for neutral information reduced in relation to age, emotional information remained salient. In their study, younger people similarly processed emotional and neutral information. However, older people assigned more cognitive processing to emotional information. Carstensen and Turk-Charles (1994) suggested that this indicates a bias in older people towards recalling emotional information.
2.6 Smoking and Gender

Consumption of cigarettes by gender has changed dramatically in Australia over the past 55 years. For instance in 1945, 75% of men smoked and 26% of women smoked (Bardsley & Olekalns, 1999). By 1992 consumption had decreased to around 28% of men and 24% of women (Bardsley & Olekalns, 1999).

In Western Australia in 1997, 25% of adults smoked, with more ex-smokers than smokers in the adult population (HDWA, 1998). More males than females smoked (28% compared to 22%), and more men than women were ex-smokers (34% compared to 27%). Just over half (52%) of females had never smoked, compared to just over one-third (38%) of males (HDWA, 1998 p.38) (See Table 2). In Western Australia, there has been a decrease in smoking by gender since 1984, when 36% of males smoked compared to 28% in 1997. Cigarette smoking by females has decreased from 32% in 1984 to 25% in 1997.

<table>
<thead>
<tr>
<th></th>
<th>Total Sample % (n=2814)</th>
<th>Males % (n=1223)</th>
<th>Females % (n=1591)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Smokers</strong></td>
<td>25.1</td>
<td>28.5</td>
<td>21.6</td>
</tr>
<tr>
<td><strong>Ex-smokers</strong></td>
<td>30.2</td>
<td>33.8</td>
<td>26.6</td>
</tr>
<tr>
<td><strong>Never smoked</strong></td>
<td>44.7</td>
<td>37.6</td>
<td>51.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

*Source: Public Health Division, Health Department of Western Australia. Smoking and Health in Western Australia, 1998 Resource Book. Development and Support Branch, Public Health Division, Health Department of Western Australia, 1998 p.38.*
Population statistics from both Australian and American studies show that men have always smoked more than women (Bjornson, Rand, Connett, et al., 1995; HDWA, 1998; Hill et al., 1995; USDHHS, 1989). However, there are significant differences in how men and women cope with quitting smoking and how they ascribe the benefits of smoking. Recent research has found that while men and women were equally likely to maintain short term abstinence, women were three times more likely to relapse (Ward, Klesges, Zbikowski, Bliss, & Garvey, 1997). Over longer periods such as 12 months or more, men were significantly more likely than women to be sustained non-smokers (Bjornson, et al., 1995).

Reasons attributed to gender differences in cessation success include:

- women tend to place greater importance on the benefits of smoking than men, particularly in terms of mood management and weight control (Pirie, McBride, & Hellerstedt, 1992; Ward et al., 1997)

- women have less confidence in their ability to give up smoking and anticipate greater difficulty in quitting (ie: low self efficacy) (USDHHS, 1980; Blake, 1989 cited in Bjornson, et al., 1995; Ward et al., 1997)

- women report higher levels of life stress and have a greater reliance of smoking as a coping aid (Gritz & Berman, 1993).

Differences in education and income are factors found to contribute to larger differences between genders in relation to dependency on smoking (Bjornson, et al., 1995). Adults with lower levels of education tend to be more dependant on smoking than adults with higher levels of education. Women with lower than a high school education were significantly less likely to give up than men with similar education (Bjornson, et al., 1995). Low income has been found to factor more significantly for females than males in their decision to continue smoking and their decreased attempts at quitting (Harris & Harris, 1996).
Teenage girls were found to be less likely to give up smoking than teenage boys in a recent study on smoking behaviour and high school students (Patton, Carlin, Coffey, et al., 1998). Patton et al. (1998) found that teenage girls find it much harder to quit than teenage boys, and girls who smoke daily are half as likely as boys to give up the habit by the time they leave school. Some suggestions given by Patton et al. (1998) as to why this occurs were that girls partake of less sport and exercise, are more anxious, and are more vulnerable to dependence on nicotine.

2.7 Death Anxiety and Gender

One of the major objectives of this study was to investigate gender responses to death and non-death threats in fear-arousing messages. Understanding the emotional response that occurs in relation to death anxiety or fear of one’s own death is particularly relevant to research into the use of death threats in persuasion (Henley, 1997). Henley (1997) summarised death related anxieties previously identified in the literature:

- fear of ‘not being’, extinction
- fear of bodily disintegration, decomposition
- fear of life’s meaningless, rootlessness, absurdity
- fear of curtailment, inability to accomplish purpose
- fear of the afterlife, punishment, eternal damnation, purgatory, divine rejection
- fear of the process of dying, ie: pain, suffering, discomfort, dependence, loss of dignity, loss of control
• fear of the effect of one’s death on loved one’s, ie: failure to have provided for partner and children; concern over who will look after one’s children or parents

• fear of the death of loved one’s separation, abandonment, vulnerability

• fear of the death of loved ones involving vicarious experience of all of the above (Henley, 1997 p.66)

Henley’s (1997) study was the first to consider differences in gender response to death and non-death threat appeals. However, there have been numerous studies on gender differences and death anxiety (Conte, Weiner, & Plutchik, 1982; Thorson & Powell, 1993; Westman & Canter, 1989). Some of these studies found conflicting results, particularly with regard to some dimensions of death anxiety, with some studies finding no difference between genders (Conte, Weiner, Plutchik, 1982). Other studies indicated more anxiety occurred in females with respect to certain aspects of death (Thorson & Powell, 1990) and another indicated that personality types within genders were more likely to experience higher levels of death anxiety (Thorson & Powell, 1993).

Gender differences were not found in relation to denial of death or frequency of thinking about death, but females were found to be more practical in their preparation for death, such as making a will (Westman and Canter, (1989). Females tend to have more death anxiety with regards to pain and decomposition (Thorson and Powell, 1993) and death anxiety related to the self (Keller, Sherry, & Piotrowski, 1984). However, women tend to have more belief in an afterlife and be less concerned with their own deaths and dying than men (Westman & Kamoo, 1990).
2.8 Smoking and Age

Demographic effects in terms of age have had a strong influence on cigarette consumption figures in Australia since World War II, when a high percentage of men smoked (Bardsley and Olekalns, 1999). In 1940, the adult population who smoked comprised around half of the population (75% women and 26% women). Since that time, many in this group have died and it now only comprises around 10% of the Australian population (Bardsley and Olekalns, 1999).

There has been an overall decrease in the prevalence of smoking in Western Australia since 1984 when 32% of the population smoked, compared to 1997 when 25% smoked (HDWA, 1998). Of those smokers, younger adults were more likely to smoke than older adults. There is a marked difference within age groups as smoking decreases with age. One in three (32%) of people smoke within the 18 to 24 year age group compared to one in nine (11%) among people aged 65 or more (some of whom have died) (See Table 2.2).

<table>
<thead>
<tr>
<th></th>
<th>Total% (n=2814)</th>
<th>18-24% (n=360)</th>
<th>25-40% (n=1222)</th>
<th>45-64% (n=793)</th>
<th>65+%(n=430)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smokers</td>
<td>25.1</td>
<td>32.4</td>
<td>30.0</td>
<td>20.7</td>
<td>11.2</td>
</tr>
<tr>
<td>Ex-smokers</td>
<td>30.2</td>
<td>16.2</td>
<td>27.6</td>
<td>35.2</td>
<td>42.1</td>
</tr>
<tr>
<td>Never smoked</td>
<td>44.7</td>
<td>51.4</td>
<td>42.3</td>
<td>44.2</td>
<td>46.7</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>
One suggestion for the decreased prevalence of smoking with increased age is that as one grows older, there is more likelihood of quitting due to the perceived positive health benefits and lower costs (Harris and Harris, 1996).

Other researchers have suggested that substance abuse increases in adolescence and declines in the mid 20s (Kandel & Logan, 1984). These declines seem to relate to the assumption of adult roles and increasing psychological conventionality (Kandel and Logan, 1984). It has been theorised that substance abuse abates in adulthood because it is incompatible with the higher demands and responsibilities of marriage, work and parenting (Yumaguchi & Kandel, 1985). Age-related trends in cigarette smoking parallel those for other drugs, ie: significant increases of cigarette usage occur in adolescence and young adulthood (Chen & Kandel, 1995). However, unlike other drugs, cigarette smoking has not been found to decline in the mid 20s, and smoking behaviour is relatively persistent compared to other forms of drug use (Chassin, Presson, Rose, & Sherman, 1996). Possible explanations for this persistence include the suggestions that:

- nicotine dependence lowers cessation rates (Ward, Klesges, Zbikowski, et al., 1997);

- the negative impact of smoking may not be experienced until later ages and therefore does not motivate cessation attempts (Ward, et al., 1997);

- smoking is a legal behaviour and its effects are not incompatible with daily demands of adult roles (Chassin et al., 1996); and

- perceived dependence on smoking is less sensitive to role socialisation pressures than other forms of drug use in the 20s (Chassin et al., 1996).
People usually take up smoking when they are young, and adults who don’t smoke are rarely persuaded to begin (HDWA, 1998). American studies show that 90 percent of all new smokers are under 18 years old (Chassin et al., 1996). In Western Australia, two thirds of people who take up smoking do so before the age of 18 years, and around 89% of people who take up smoking commence before the age of 21 (HDWA, 1998).

Statistics indicate that the younger smokers are when they start smoking, the more likely they are to continue smoking into adulthood. Even infrequent experimentation in early adolescence has been associated with significantly higher levels of adult smoking (Chassin, et al., 1996). For example, in a comparison, people who started smoking before age 13, were still smoking in adulthood, but people who started smoking at a later age had quit earlier (HDWA, 1997).

The age group that poses the greatest challenge to anti-smoking campaigners is the group 50 years and over (Clark et al., 1997; Kviz, Clark, Slezak, & Davis, 1999). In a study concerning smoking-related attitudes and stage of readiness for smoking cessation, Clark, et al. (1997) reported that older smokers (50-74) and especially those who smoked one or more packs per day, were the least likely to express attitudes favourable to quitting. They found older smokers made the weakest association with statements about the harms of smoking and were least likely to perceive smoking as addictive or harmful to their health. Compared to younger adults (21 to 49 years), older adults (50 to 74 years) perceived more benefits from smoking and underestimated risks associated with smoking.

Beliefs such as these reflect cognitive dissonance, or the conflict between one’s knowledge or beliefs and one’s behaviour (Solomon, 1997). Cognitive dissonance was observed in a study which compared beliefs about health in current, former and never smokers (Halpern, 1994). Halpern (1994) found that in order to reduce dissonance, smokers will deny, minimise or avoid information about the dangers of smoking. Furthermore, Halpern (1994) found that smokers
who were likely to be at greater risk of disease through their heavy smoking behaviour, were more inclined to express cognitive dissonance than light smokers.

There is evidence that older smokers, who have survived smoking-related health threats and still smoke despite unavoidable public health messages, may suppress or deny awareness of smoking related symptoms (Orleans, Jepson, Rimmer, & Resch, 1994). A possible explanation for this is that the longer a person smokes, eg: 20-25 years, the less likely they are to quit because of the increased dependency and costs associated with overcoming the addiction (Harris and Harris, 1996).

2.9 Death Anxiety And Age

One of the major objectives of this study was to investigate older smokers’ responses to death and non-death threats in fear-arousing messages. A further dimension to understanding the response to death threats used in persuasive messages is understanding how people of different ages experience death anxiety (Henley, 1997). Little work has been done in the persuasion literature in terms of differences in age and response to death and non-death threats, but fear of death may vary across the lifecycle. Generally, death anxiety is understood to remain reasonably uniform through maturity and then slowly abates with age (Thorson & Powell, 1993; Wong, Reyker and Gesser, 1994, cited in Henley, 1997). Some contradictory results have been found with regards to common assumptions about age interaction with death anxiety. The following research was noted by Henley (1997):

- Some evidence has shown that adolescent males are greater risk takers. However the death anxiety research does not support the commonly held belief that they think they are immortal (Trimpop, 1994 cited in Henley, 1997).
• A ‘symbolic sense of immortality’ can assist in coping with death anxiety. Older people (33 to 39 years) have a greater sense of symbolic immortality than younger people (19 to 25 years). Lifton (1977, cited in Henley, 1997, p.68) suggests that a ‘symbolic sense of immortality’ is the perspective that “…one lives on through one’s children, or through one’s creative efforts, or through religious or other spiritual beliefs or experiences…”.

• Death anxiety remains relatively constant once the concept of death is understood from childhood to maturity then gradually reduces with age. Lester (1972) and Pollack (1980 cited both in Henley, 1997) found that in people under 50 years, there were no significant differences between death anxiety scores and age. However, Templer (1971, cited in Henley, 1997) found that people in the 60 to 83 year age group tested significantly lower for fear of death than adults in younger age groups.

2.10 Market Segmentation and Anti-Smoking Messages

Some researchers have found that market segmentation is an appropriate and effective approach for fear arousal communications in some situations (Burnett & Wilkes, 1980; Henley, 1997; Ray & Wilkie, 1970a). Market segmentation is a key concept in marketing and has been suggested for use in social marketing and health promotion (Burnett & Wilkes, 1980) and more specifically promotion of anti-smoking campaigns (Quinn et al., 1992).

In a study into the appropriateness of a segmentation approach when using fear arousal and anti-smoking messages, Quin, et al., (1992) tested a population of secondary and post-graduate students for age, gender and education differences. They found significant differences in self efficacy and education levels, and that older smokers (above the age of 16) believed themselves less capable of stopping smoking. These findings supported Burnett and Wilkes’ (1980) conclusion that
fear appeals are more powerful when the message elements are specifically targeted at an identified market segment.

Henley’s (1997) recent findings, which indicated age and gender differences occurred in response to death and non-death anti-smoking threats, supported the appropriateness of a market segmentation approach when arousing fear of death in health promotion campaigns.

### 2.11 Other Factors Relevant to Smoking

The decision to end the smoking addiction is usually viewed as a health-related choice. However, Harris and Harris (1996) argued that the decision to quit can be a “relatively predictable and rational economic act” (p.602) based on the calculation that smokers will continue to smoke until the costs of smoking exceed the perceived benefits. Harris and Harris (1996) identified two main cost factors related to cigarette smoking:

1) the immediate and direct financial expense of buying cigarettes which traditionally has been understood to have little influence on older smoker’s smoking behaviour; and

2) the delayed and indirect cost which relates to the well-known fact that smoking is likely to lead to an earlier death.

Harris and Harris (1996) identified three main benefits smokers expect to receive from smoking:

1) the stimulation of the nicotine on the central nervous system;

2) the social aspects of smoking; and

3) avoiding the unpleasant withdrawal symptoms when trying to end an addiction later in life (p.607).
Mausner (1973) found that the decision to quit is made not only because people have a heightened fear of the consequences of continuing to smoke, but also because they have an increased expectation of the benefits of stopping. Becker and Murphy (1988 cited in Becker, 1988) argued that smokers who feel they have the most to gain from quitting are the ones most likely to quit, ie: individuals who have higher incomes and potentially stand to lose the most from premature death are the ones most likely to quit.

A further benefit that has been identified is the belief that smoking relieves stress and reduces anxiety (Frith, 1970; Speilberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983). Researchers have found that smokers have an increased desire to smoke under stress, tend to smoke more under stress and use cigarettes as self-medication to reduce stress (Perkins & Grobe, 1992; Pomerleau & Pomerleau, 1987). However, there appear to be no results available to support the notion that smoking is genuinely connected to reducing anxiety. Following a study into the anxiety relieving effects of cigarettes, (Kassel & Shiffman, 1997) suggested that rather than having any pharmacological effect on anxiety, smoking enhances the power of distraction to divert smokers from worries that might otherwise produce anxiety.

A recent study into depression, anxiety and smoking initiation (Patton et al., 1998) indicated younger people also tend to use cigarettes as self medication to reduce symptoms of stress. In a study of 14 to 15 year old high school students, peer smoking, depression and anxiety were common and moderately strong predictors of smoking initiation. Although smoking behaviour tended to follow peer group influence, depressive and anxiety symptoms magnified the effect of peer group behaviour, particularly for females.
2.12 Conclusion

This review of the literature has covered a number of areas that have implications for this thesis topic. The effective use of fear arousal in persuasive communication has been the focus of consistent research over the past 50 years, often producing contradictory results. Some of the confounding factors contributing to these results are lack of precise definitions and interchangeable use of the terms 'fear', 'fear arousal', 'threat' and 'threat appeal', resulting in more emphasis on response than stimulus.

The threat appeal has been deconstructed into three major components, structure, style and extra message features. The main components of the structure include threat, severity and personal susceptibility to the threat; and efficacy of the recommended response including response efficacy and self efficacy.

Smoking has often been used as the fear topic in research into threat appeals with earlier studies focussing on severity and personal susceptibility to the threat. Earlier results supported the notion that fear strengthens the intention to stop smoking and suppresses cigarette consumption. However these attitudes were generally not persistent over long periods of time. Some research also indicated that reactions other than fear were evoked such as the total avoidance of the message or the health recommendation.

Studies into efficacy concluded that self efficacy is powerful for smokers who are contemplating or preparing to quit. Response or solution efficacy such as reassurance of improved health is also powerful, especially for smokers concerned about becoming seriously ill. Males smoke more than females, but studies consistently find that it is harder for females to quit successfully. Females tend to perceive greater benefits of smoking, especially concerning weight control, mood management and stress relief.

Smoking is more prevalent in younger people, especially in the mid 20s and earlier uptake of smoking tends to indicate long term usage. Prevalence of
smoking is significantly lower in older age groups. However older, long term smokers have the least interest in quitting and present the greatest challenge to anti-smoking campaigners.

Attitudes comprise of emotion, cognition and behaviour. An attitude can function as a source of self-identification and strength of an attitude can be characterised as one of three levels of involvement: compliance, identification and internalisation. Attitudes perform functions which are either value-expressive, ego-defensive, knowledge forming or utilitarian. Persuasion is inextricably linked to attitudes and people are inclined to find messages that support their attitudes easier to remember or learn than conflicting information.

Emotions are crucial to self-expression. Gender stereotypes tend to portray women as more emotional than men, but some researchers have shown that in certain contextual situations, this may not be true. Although there is no simple association between gender stereotype and levels of experienced emotion, researchers tend to agree that both genders feel guilt and shame, albeit in different ways.

Anxiety about dying may vary between genders and across the lifecycle with females tending to be more practical about dying and less concerned with their death than men. Older people generally cope with death anxiety better than younger people as they tend to have a stronger sense of 'symbolic immortality'.

Research has not confirmed the belief of many smokers that smoking eases the effects of anxiety and stress. The increasing financial cost of smoking has been identified as one factor which leads to smoking cessation, as one grows older.

In the next chapter, the theoretical framework of this qualitative study is discussed in relation to Attitude Theory, the Theory of Cognitive Dissonance and Source Credibility.
Chapter 3: THEORETICAL FRAMEWORK

The underlying theories on which this qualitative study is based are Attitude Theory, the Theory of Cognitive Dissonance and Source Credibility. These theories formed a conceptual framework for data collection. The relevance of each theory is described in the following section.

3.1 Attitude Theory

In this study, general attitudes and gender differences in attitudes were considered by examining participants' affective, cognitive and behavioural evaluations in response to threat messages and in particular, death and non-death threats in anti-smoking advertising.

Attitudes have been researched extensively by social psychologists for more than a century. The term attitude was defined by Krech & Crutchfield (1948 cited in Ajzen & Fishbein, 1980 p.20) as, "an enduring organisation of motivational emotional, perceptual and cognitive processes with respect to some aspect of the individual's world". Rosenberg and Hovland (1960 cited in Ajzen & Fishbein, 1980 p.20) developed a three-component view of an attitude, implying that a complete assessment of an attitude must include measures of three response classes: affective (sympathetic nervous responses and verbal statements of affect); cognitive (perceptual responses and verbal statements of belief), and behavioural or conative (overt actions and verbal statements concerning behaviour) (See Figure 3).
Figure 3  Three-component view of attitude.
Attitude has also been defined in terms of evaluation. Eagly & Chaiken, (1992. p.21) described an attitude as "a psychological tendency that is expressed by evaluating a particular entity with some degree of favour or disfavour". They also contended that attitudes are formed only after an individual has responded to an object, and that when formed, an attitude predisposes evaluative response when the attitude object is encountered again (Eagly & Chaiken, 1992).

In an extensive review of attitude theories and attitude change, Olsen and Zanna (1993) explained the three primary elements of an attitude:

a) evaluation constitutes a central, perhaps predominant, aspect of attitudes, b) attitudes are represented in memory, and c) affective, cognitive, and behavioural antecedents of attitudes can be distinguished, as can affective, cognitive and behavioural consequences of attitudes (p.118).

These elements guided the data collation and analysis of this qualitative research study.

### 3.2 Theory of Cognitive Dissonance

The way an attitude object is evaluated can be determined by how it fits with other related attitudes already held by the consumer (Ajzen & Fishbein, 1980). In this study, the Theory of Cognitive Dissonance was identified as a potential mediating variable for gender differences in attitudes to death versus non-death threats in anti-smoking messages.

The Theory of Cognitive Dissonance (Festinger, 1957 cited in Ajzen & Fischbein 1980) is known as a 'consistency theory' and assumes that consumers value harmony amongst their thoughts, feelings and behaviours. Cognitive dissonance theory asserts that when an individual is confronted with an inconsistency between two cognitive elements (ie: 'I know smoking causes emphysema" and 'I
smoke cigarettes.') whether they are beliefs, attitudes or behaviours, the result is an unpleasant state of 'dissonance'.

In order to eliminate the dissonance, the individual will then be motivated to change one or more of the cognitive elements by rationalising his or her attitude to fit the behaviour or modifying the behaviour to fit the attitude. Festinger (1957 cited in Ajzen & Fischbein 1980) contended that to do this the individual will cognitively rationalise their behaviour and eliminate the inconsistent element (ie: stop smoking); change the element (ie: refute research results that connect smoking with cancer); or add to the elements (ie: cite someone who has smoked for 50 years and is still healthy).

An underlying assumption of this study was that anti-smoking messages, which contravene personal beliefs regarding what is wise, appropriate and true, could create cognitive dissonance. It was expected that participants would reconcile inconsistencies regarding their personal beliefs about their smoking behaviour that conflicted with threatening anti-smoking messages, and use rationalisations to provide a psychological defence to justify their behaviour.

3.3 Attitude Towards the Source

All messages are assumed by the target audience to have a source (Egger et al., 1993). Under many conditions, the source of the message can have a strong impact on the acceptance of the message by the target audience (Solomon, 1997).

Source credibility is the degree to which the receiver perceives the source to have relevant knowledge and/or experience, and consequently trusts the source to give impartial information (Mahoney & Meenaghan, 1997/98). Source credibility is made up of two distinct components: expertise and trustworthiness. Source expertise refers to the receiver's perception of the source's ability to make valid assertions (Hovland & Weiss, 1951). Source trustworthiness refers to the
receiver’s belief that the source is willing to make valid assertions (Hovland & Weiss, 1951).

3.4 Conclusion

There are three underlying theories that form the conceptual framework of this qualitative study:

1) Attitude Theory, which asserts that an attitude comprises three major components: emotion, cognition and behaviour;

2) The Theory of Cognitive Dissonance which asserts that people value harmony amongst their attitudes, and inconsistent elements will be rationalised in order to eliminate unpleasant dissonance;

3) Source Credibility which refers to the receiver’s perception of the source and comprises of two main components: expertise and trustworthiness.

Application of these theories is discussed in Chapter 5 Data Analysis. In the next chapter, the methodological framework is discussed.
Chapter 4: METHODOLOGY

The purpose of this research was to expand Henley's (1997) unexpected quantitative findings by conducting a qualitative study designed to explore differences in response to anti-smoking messages and in particular to those using death and non-death threats. The main aim was to gain insights and ideas from the 40 to 50 year old participants' discussions about how they respond to death and non-death threat messages, and why the variation in response by gender might occur.

Focus groups were the qualitative method used in this study. Four focus groups were conducted each consisting of male and female smokers who were 40 to 50 years of age. Gender and socio-economic status delineated participants. The groups were conducted as free ranging discussions, guided by questions pertaining to possible explanations for the variation in response reported in Henley's (1997) study.

The overall objective of the focus groups was to explore the attitudes of 40 to 50 year old smokers by investigating their emotional, cognitive and behavioural responses to threat messages. In particular, the study was designed to explore any apparent differences between older male and female smokers' responses to death and non-death threats in anti-smoking messages. In addition, the perceptions of older male and female smokers towards the source of the message were explored, as well as any differences in how they described the costs and benefits of smoking. These objectives were operationalized by the following research questions:
1. What are 40-50 year old smokers’ emotional, cognitive and behavioural responses towards anti-smoking messages?

2. Are there differences in the way male and female smokers in the 40 to 50 year old age group articulate their emotions, cognition and behaviour in response to anti-smoking messages?

3. Are there differences in 40 to 50 year old male and female smokers’ attitudes to death and non-death threats in anti-smoking messages?

4. Are there differences in how male and female smokers in the 40 to 50 year old age group perceive the source of the message?

5. How do 40 to 50 year old male and female smokers articulate the costs and benefits of smoking?

This section focuses on discussion of the research design, which was developed to explore responses to threats in anti-smoking messages from 40 to 50 year old smokers in relation to the major objectives of this study. First, the relevant literature pertaining to the choice of qualitative research and specifically, focus groups is presented, as well as limitations of the qualitative method. The sampling frame, sample size and procedure are presented.

4.1 Qualitative Research

As discussed in Chapter 2, there is vast amount of complex literature from the past 50 years concerning the effects of fear arousal in social marketing messages. Henley’s (1997) study was the first to investigate gender differences in response to different types of threat messages and her study yielded unexpected results. Hence, the overall objective of this study was to focus on a group of 40 to 50 year old smokers to gain insights and ideas in their own words regarding their response to death and non-death threat messages and to investigate reasons why the gender variations in response occur. Consequently, this qualitative study aimed to gain a
deeper understanding of the underlying attitudinal differences between male and female smokers in the 40 to 50 year old age group, in response to threats in anti-smoking messages.

The qualitative paradigm in research has been termed constructionist or naturalist (Lincoln & Guba, 1985), postmodern (Sherry, 1991), and interpretivism or "interpretive approaches to knowledge" (Holbrook, 1995 p.17). According to Denzin and Lincoln (1994) the word qualitative implies an emphasis on processes and meanings that are not rigorously examined or measured in terms of quantity, amount, intensity or frequency. Qualitative researchers study social or human problems and attempt to make meaning or offer interpretations of phenomena in terms of the meanings people bring to them. In qualitative research, understanding occurs through the building of a complex, holistic picture and through words from detailed accounts by subjects (Brown, 1996). Qualitative methods have been identified as appropriate for examining the reasons behind why people demonstrate certain types of behaviour (Basch, 1987).

Calder (1977) outlined three main approaches of quantitative research and more specifically, focus group procedures which each produce specific types of data:

1) the exploratory approach, which is used when information is required prior to a scientific study, may be employed to test a hypothesis or pilot test a larger study;

2) the clinical approach, which uses existing scientific theories and constructs to generate quasi-scientific information; and

3) the phenomenological approach, which is predominantly concerned with the everyday information generated by shared perceptions of sub-groups of people.
Specifically, this study required a methodology that could:

- offer an environment conducive to subjects freely expressing their perceptions and opinions regarding anti-smoking messages in their own words;
- enable the researcher to gain a high level of insight into how the subjects articulated their responses and ask participants to elucidate their response if necessary; and
- conduct the interviews in a relatively brief period of time, in an appropriate venue and one that was relatively inexpensive.

Hence, phenomenological focus group methodology was chosen as the most appropriate approach to satisfy these requirements.

However, there are limitations to qualitative methodology. Although qualitative research methods are capable of producing rich and detailed data that can facilitate a researcher’s deeper understanding of a problem, this methodology brings certain limitations to the research process. For instance, qualitative research is subjective in nature and therefore is not appropriate for making deductions about an entire population. It cannot provide data for statistical analysis or take the place of quantitative research (Zikmund, 1997).

4.2 Focus Groups

Focus groups were described by Fontana and Frey (1994 p.364) as “a group interview or the systematic questioning of several individuals simultaneously in formal or informal settings”. The use of the qualitative focus group technique is considered appropriate when feelings and opinions are required about a given problem, experience or other phenomenon (Basch, 1987). The term ‘focus group’ was originally coined to describe a situation in which an interviewer asks particular questions of an assembled group regarding a topic, which has already
undergone substantial research (Fontana & Frey, 1994). Focus groups are usually conversational or unstructured in format and questions are designed to address a given topic (Pollit & Hungler, 1993). The technique originated from commercial marketing research but began to gain popularity by social scientists as early as the 1940’s (Basch, 1987). Since then focus group methodology has proven useful for improving knowledge in health education and research. It has gained wide acceptance in the areas of health and education (James, 1997; Livingstone, 1998; Manfredi, Lacey, Warnecke, & Balch, 1997; Moreno, 1997) and is considered an effective method of collecting information about a selected audience and thus increase a health program’s chances of success (Moreno, 1997).

There are several advantages of using focus groups which helped to determine the choice of methodology for this study. Focus groups have been recognised as useful for identifying motivations for and barriers against change in target adopters (Egger et al., 1993) and they can provide a relatively simple method of uncovering subject’s opinions and ideas (Basch, 1987). The usually casual environment of a focus group can stimulate free flowing discussion where participants willingly share their views and can assist in uncovering a subject’s thoughts and preferences on certain issues that would not emanate from deductive methods (Churchill, 1996). A focus group can allow flexibility, be data rich, and aid in elaboration of responses over and above individual face to face interviews (Denzin and Lincoln, 1994). Focus groups are also a time and cost-effective way to generate qualitative research information (Churchill, 1996).

A specific limitation of focus group methodology lies in the capability of the moderator. The moderator plays a key role in facilitating the focus group and creating an open environment in which participants share their views and interact with one another (Fontana & Frey, 1994). Without an effective moderator who is sensitive to the special requirements of group interviews, group dynamics may interfere with individual expression and result in biased data (Fontana and Frey, 1994). For example, if a more vocal member of the group is permitted to dominate discussions, 'group-think' could occur (where all participants agree with
the dominant person’s opinions), or other participants may react negatively towards the dominant member (thereby skewing opinions) or conversely, induce more inhibited members to withdraw from conversation (Fontana and Frey, 1994).

The possibility of interviewer bias is a limitation in relation to the moderator that was given attention in this study. Interviewer bias is a form of response bias that can occur when participants consciously or unconsciously, misrepresent the truth in their answers (Zikmund, 1997). In a focus group, interviewer bias can occur as a result of the moderator’s interaction with the participants. According to Zikmund (1997), participants may provide socially acceptable answers to “save face” (p.211) in the interviewer’s presence, if they feel embarrassed by their unspoken opinions.

The interviewer’s presence may also have an effect on response, i.e.: physical appearance of the interviewer, how they are dressed, their sex, voice tone, age or facial expressions. Other non-verbal communications may also induce bias, i.e.: if the interviewer expresses approval, smiles or nods after answers, participants will be more likely to give similar responses to further questions (Zikmund, 1997). Temporal factors may also lead to bias. If participants feel their time is being wasted, they may answer abruptly or answer with limited cognitive processing (Zikmund, 1997).

The researcher moderated all focus groups in this study. Participants were ensured that conversations were strictly confidential, as were their names and details, and that all transcripts and interview materials such as video and audio tapes would remain the property of the researcher. They were assured that transcripts would only be accessible to the researcher and her supervisor. A one hour time limit was stated at the beginning of the interview and participants were given the option to leave at any time during the focus group if desired. Moderation was performed whilst bearing in mind Basch’s (1987, p.415) description of the moderator as “the instrument”, who offers a flexible guide to the
discussion. Also taken into account were Basch’s (1987) suggestions that the moderator must:

a) assume responsibility for encouraging all group members to become involved;

b) interject probing comments in a clear and non-threatening way; and

c) remain non-judgemental either verbally or non-verbally.

In addition, the moderator followed Robson’s (1993) moderator’s guide which suggests easy, non-threatening questions be used to ‘warm up’ participants and create a suitable rapport, and to allow a cool off period to diffuse any built up tensions when appropriate. The moderator also observed Robson’s (1993) suggestions regarding an appropriate questioning technique, and avoided leading, long or doubled barrelled questions.

4.3 Sampling Frame and Target Population

Four focus groups were conducted for this study in August, 1999. The focus groups were held at the premises of a professional market research company in Perth, in the company’s designated discussion room. The company’s professional field workers were employed to select participants for this study from the research company’s database. In addition, one snowball referral per selected participant was permitted. Participants were screened for regular smoking behaviour (ie: more than 3 per day), age and occupation. (The screening questionnaire is attached in Appendix A). People who fitted the demographic profile and who acknowledged they smoked on a regular basis were invited to attend a focus group on ‘various health issues’.

A non-probability, purposive sampling technique as appropriate to qualitative methodology was used to choose participants for their representativeness of the
population of interest, ie: men and women who were 40 to 50 years old and smoked regularly. Participants were classified by their socio-economic status, ie: white or blue collar. They were initially characterised by their occupation, followed by the area in which they lived. When an unemployed person was contacted, their previous occupation or the occupation of another member in the household was used to determine their status.

4.4 Sample Size
Each group consisted of 7 to 8 participants and were delineated by gender and socio-economic status as follows:

- 1 group of women, blue collar
- 1 group of men, blue collar
- 1 group of women, white collar
- 1 group of men, white collar

The participants were classified according to their socio-economic status to ensure homogeneity within groups. However, it was noted during the interviews and later during the data analysis, that no apparent differences occurred in response between the blue and white collar groups. Accordingly, throughout the data analysis reference is given to gender rather than socio-economic status.

4.5 Procedure
The focus groups each lasted approximately one hour in duration. All groups were audio-taped and videoed for further analysis with the research company’s
Participants were reimbursed $30 for their attendance expenses and they were served refreshments during the interviews.

4.5.1 Questioning Techniques and Topic Guide

Participants were asked to discuss a range of topics introduced by the moderator pertaining to possible explanations for the different responses found in the 40 to 50 year age group, in Henley’s (1997) study. Projective questioning techniques were used in the hope that participants would freely discuss their deeply held beliefs. As such, they were not asked direct questions pertaining to attitudes or specifically prompted for response to death and non-death threats, but were prompted for expansions (ie: tell me more about …) and explanation (ie: what do you mean by …) of their comments. According to Zikmund (1997) projective techniques are used to “…discover an individual’s attitudes, motivations, defensive reactions and characteristic ways of responding” (p.118).

The underlying assumption for the use of unstructured projective questioning is to avoid the respondent attempting to please the interviewer with the ‘right’ answer. For instance, direct questions asked in an interview situation may elicit embarrassment if the answer reflects poorly on the respondent’s self-concept or participants not consciously aware of their true feelings on a particular subject (Zikmund, 1997). A respondent may withhold some aspect of their response and try to please the interviewer by answering with what they think the interviewer wants to hear.

In line with Zikmund’s (1997) recommendations for using projective questioning techniques, participants were not required to provide answers in response to a structured format, but were encouraged to describe situations in their own words. There was little intervention from the moderator other than to introduce filter questions from the topic guide (to be discussed in this section); prompt for expansion on comments if necessary; or ask for further explanation of a comment in order to elicit deeper beliefs rather than top-of-mind attitudes. Participants were encouraged to discuss their response to anti-smoking messages freely in the
hope that their deeply held beliefs would emerge, and a deeper understanding would occur of the underlying attitudinal differences between male and female smokers in the 40 to 50 year old age group, in response to threats in anti-smoking messages.

A topic guide was used to filter questions relevant to the main aims of the study. (A copy of the topic guide is attached in Appendix B). Participants were asked to discuss their attitudes in relation to health messages in general. Filter questions were asked pertaining to:

- how they felt about anti-smoking messages;
- what they thought about anti-smoking messages;
- what their behaviour was in response to anti-smoking messages;
- their general response to other types of health messages (ie: positively framed messages); and
- the perceived benefits of smoking.

Once the data were collected, the audio tapes were transcribed and colour coded according to group sequence. Transcripts were then laboriously examined for themes in relation to the major objectives with special consideration given to gender differences that emerged, such as:

- differences in the men’s and women’s emotional, cognitive and behavioural responses to anti-smoking messages;
- differences in the way the men and women articulated their thoughts and feelings in response to anti-smoking messages;
• differences in attitudes to death and non-death threats in anti-smoking messages;

• differences in how the men and women perceived the source of the message; and

• differences in how the men and women articulated the costs and benefits of smoking.

4.6 Conclusion
This chapter has presented the qualitative research design. The following section presents a comprehensive analysis of the data obtained.
Chapter 5: DATA ANALYSIS

The following chapter discusses data from the focus groups in relation to the research objectives. Data were analysed manually according to themes in relation to the major objectives with special consideration given to gender differences that emerged. Attitudes were examined according to emotional, cognitive and behavioural responses. Gender differences are discussed in relation to how responses were articulated. Some reference to relevant literature is discussed in this section, but the main findings are discussed further in Chapter 6 Discussion.

Social marketing messages targeted at social concerns such as drink driving, road safety, AIDS and drugs received generally favourable attitudinal response from all groups in relation to their relevancy and usefulness in society. Response towards threats in anti-smoking messages was generally negative, which could be expected from a group of older smokers. However there were differences in how the men and women articulated attitudes and efficacy responses. For instance, the women's responses tended towards expressions of anger in relation to value-expressive attitudes regarding their right to smoke, and they expressed higher perceived self efficacy in relation to their smoking behaviour. The men's responses expressed symptoms of depression and ego-defensive attitudes in relation to their feelings of helplessness over their addiction to nicotine and their low perceived self efficacy. More positive responses from both men and women emerged in relation to efficacy contained in positively framed messages.
5.1 Attitudinal Response to Anti-Smoking Messages

In this section the emotional, cognitive and behavioural responses will be discussed in separate sections. Gender differences are discussed. Some similar gender responses have been grouped together in this section due to their similarity, but gender is identified by M (male) and F (female) where appropriate.

5.1.1 Emotional Response to Anti-Smoking Messages

In this section, participants’ emotional responses have been grouped into two parts:

1) Negative emotional response to anti-smoking advertising in general

2) Positive emotional response to positively framed anti-smoking messages.

5.1.1.1 Negative emotional response to anti-smoking messages.

Leventhal and Trembly’s (1968) study into fear appeals suggested that the more vivid, gruesome images contained in some fear-arousing social marketing messages, could evoke two different types of fear:

a) “inhibitory fear” (p.159) characterised by a sick, nauseous feeling in reaction to potential damage to the self; and

b) “anticipatory fear” (p.159) characterised by tense muscles, awareness of the environment and attentiveness to ways to evade potential danger.

The dominant emotional response expressed in all groups towards fear-arousing anti-smoking messages was negative and ranged from moderate to extreme in intensity. The generally negative response to anti-smoking messages emerged early in the interviews when participants were asked to discuss how they felt about health messages in general. Although the term ‘health message’ could refer to any general message about health, response was mainly in reference to anti-
smoking campaigns. However, it is possible that anti-smoking messages were
top-of-mind in these participants because they knew that they were selected to
participate in the focus groups because of their smoking behaviour.

Different emotional responses occurred by gender. The negative emotions
expressed towards strong fear-arousing messages by the women indicated
inhibitory fear, guilt and shame. Inhibitory fear was also expressed in the
women’s groups towards other strong fear-arousing messages that depicted blood
and gore, such as road safety or diabetes messages. The negative emotions
expressed towards strong fear-arousing messages by the men indicated inhibitory
fear, anxiety and humiliation, guilt and dismay.

The most extreme and intense emotions were expressed in the women’s groups
when they recalled their response to some graphic fear-arousing messages. Strong
aversion and inhibitory fear were expressed in relation to the more ‘gory’ anti-
smoking threats that depicted scenes of damaged body organs or blood; ‘hate
it...hate it...’; ‘I hate seeing them...with the fat coming out of the thing [aorta]’
and ‘the one with the clogged arteries...that makes me feel quite sick’; ‘I’ve got a
terribly weak stomach...I just do not like it...anything that goes into detail about
organs and stuff’.

Some women expressed revulsion for all fear-arousing messages that contained
graphic scenes. ‘It’s the blood and guts...anything like that is oo hoo yuk! There
could be no message, but that is scary to me’; ‘it could be gangrene through
diabetes...I just don’t like things like that...I’ve got a weak stomach and can’t
hack anything like that’ and ‘once there’s blood and guts in it ...that’s it’. The
women described actively avoiding exposure to these advertisements by blocking
them out to protect themselves from further emotional distress.

Emotional reaction in the men’s groups was mixed. Some men admitted to being
repulsed by some of the more graphic advertisements; ‘I don’t like all the
guts...It’s particularly horrible’ and ‘I don’t like looking at that stuff’. Other men
denied being affected and made more ego-defensive, stereotypically masculine comments; 'It doesn’t bother me either way. You could put it in colour; it doesn’t mean a damn thing'; 'Even if I was there when they filmed it in the room it wouldn’t make any difference. It wouldn’t make me stop smoking'. Some declared themselves desensitised to graphic or bloody scenes because of previous experience slaughtering animals; ‘I’ve gutted a few sheep in my day’; ‘Yeah a few cows and things’; ‘I’ve killed kangaroos and everything else’.

The strongest emotions expressed by the men were anxiety and humiliation felt as a result of feeling discriminated against by society because they are smokers. Anxiety could be heard when the men expressed feeling alienated and condemned by society as a result of negatively framed anti-smoking advertising; ‘They’ve alienated us with these advertisements’; ‘you become a social outcast because of them’; ‘the thing is with smoking ads, they make you a second class citizen’.

Humiliation as a result of being criticised was heard when the men described anti-smoking advertisements as ‘sanctimonious’ ads that contained implicit judgements that smokers are ‘bad people’; ‘I don’t smoke because I’m bad, I smoke because of other reasons and you know there’s a kind of inference that you’ll be good if you give up and if you don’t, well... draw your own conclusions. I don’t like those campaigns very much’ and ‘being this perfect idealised creature that doesn’t smoke and lives to be 100 might not do the world much good anyway’.

Concern was expressed that society placed a higher value on non-smokers, simply because of their non-smoking behaviour; ‘I feel that those sort of ads are a product of the ‘me’ generation. Like the individual that they are targeting is so self important that their own self and extending their own life is so very, very important.... But this person might be totally healthy, totally non smoking, doesn’t drink very much and in the best physical shape and they might do nothing for the world or their family and they might be a selfish, self obsessed, self contained person...’
In the women's groups, shame was felt emotion as a result of family or social pressure not to smoke. Mothers discussed how they felt shame as a result of normative pressure applied by their children; 'every time there is a new smoking ad I feel tremendous pressure on me...my kids pick up on them...they say “do you know what you are doing to your lungs”' and ‘Even my six year old grandson tells me off for smoking. “You’ll get a hole in your throat...”’.

Feelings of pressure and shame were exacerbated when new anti-smoking campaigns are launched. Women discussed feeling under pressure and more resentful towards new campaigns as they gave non-smokers a 'licence' to reiterate anti-smoking messages; ‘they enjoy those ads because they can rub it in ... “see that’s you, see”. There’s nothing worse than a reformed smoker!’ and ‘the ads are more ammunition for non-smokers than a deterrent from smoking’.

Some women revealed that guilt was evoked by remarks from non-smokers in public places than from seeing anti-smoking messages on TV; ‘looks don’t bother me, it’s the comments’; ‘yeah, it’s a guilt thing: “Do you realise what you are doing to me?” and “Do you realise what you are doing to your lungs?”’.

Others were resigned to feeling guilty in response to comments from non-smokers. However, they denied that the comments had any influence over their feelings about smoking; ‘I feel guilty until I light my next cigarette and then the guilt is gone. I feel that when I get that first drag... I lose any guilt’ and ‘If I’m sitting in a room with them [when an anti-smoking ad comes on], it’s like “Yeah, that’s you isn’t it Mum?” Yeah fine, where’s my smokes?’

The women also discussed feeling uncomfortable with internal conflict caused by anti-smoking messages; ‘...’cause you know you shouldn’t”; ‘I love smoking...I enjoy it...I hate being told not to do it’ and ‘I don’t want to die...but I enjoy smoking...they are always making me feel bad about my health’.
Loving or liking cigarettes were common emotions that conflicted with anti-smoking messages. However, some participants indicated extreme feelings of emotional dependence on their addiction to cigarettes; 'if I didn't smoke I would be a lunatic...I hate being told not to do it' (F); and in reference to severe depression: 'a fag certainly helped me along. I might be smoking but I'm still here...sometimes these addictions carry us through some rough times' (M).

Dismay could be heard as the men discussed being pressured and 'bombarded' by glib anti-smoking messages; 'They are hammering it home to everybody,...they are pushing...pushing...pushing'. Comments indicated that in addition to feeling under pressure from frequent exposure to anti-smoking messages, the men experienced more guilt and dismay when they heard anti-smoking messages, unrealistically promoting that they could give up instantaneously, 'if they wanted to'. They vehemently denied that this was possible. The guilt and dismay resulted in lowered self-esteem in these men; 'You just feel so desperately bad about how you feel, that a smoke is like something good you can do for yourself. Then these ads make you feel bad about yourself. Anyway it's no wonder we don't want to know about them'; 'It's like they are saying be good and just give up; otherwise there is something wrong with you'; '...the ads generally make you feel ostracised...'; 'Yeah, rather than helping you'.

These negative emotions and their low self-esteem led to the men avoiding all anti-smoking messages; 'I'll tell you straight, the thing that would give me the most likelihood of stopping is if they had none of them. Their constant presence on the TV makes me say, oh just stuff you, and I keep doing it, you just get desensitised to it'. Anti-smoking was equated to nagging by one man; 'All the negative ads that you see on the TV, most smokers will either get up and leave, switch off, don't look, veg out, avoid it, have a cigarette, a drug, anything but pay attention to the real messages being given to them. As soon as you see that it's negative ... it's like someone nagging at you. Like my wife, when she comes in and nags at me that I'm smoking. She can go through 5000 reasons why I shouldn't smoke, and I just walk out of the room, pissed off. And I'll chain smoke 5 or 6
until she stops, so she shouldn't have opened her mouth. So I don't think nagging stops smoking'.

Discussion around this theme revealed that many of the men felt low self efficacy towards their ability to give up smoking (this is discussed further in 5.2.2). Responses indicated that the men felt most anti-smoking messages reinforced feelings of powerlessness over their addiction; 'you are on your own and that really sucks'; '…they say the best way to go is cold turkey. But that is so hard especially if you are a 20-30 a day smoker. You need help to get down to a moderate smoker and then sort of quit from there'.

Some men and women expressed regret when they reflected on how they would have responded to anti-smoking campaigns, had they been exposed to them during their school years. They generally felt their desire to take up the habit would have been reduced; 'No one told me they were bad, I enjoyed it'; 'I wouldn't have smoked then if I'd known what they know now' and 'I wouldn't have smoked if I heard all this negative stuff when I was a kid'. Interestingly, these feelings were reflected by generally positive attitudes towards anti-smoking messages targeted at children or young people (as discussed in 5.1.2.2).

Uncomfortable negative emotions evoked by anti-smoking messages appeared to largely contribute to the negative attitudes evident throughout this study. Such responses are congruent with comments by Moore & Harris (1996), who found that the arousal of negative emotions in response to an ad may be an important factor in attitude formation. Other researchers have found that ad-induced emotions can have a direct impact on attitude formation (Batra & Holbrook, 1987; Batra & Ray, 1986) and furthermore, can lead to an avoidance response when the intensity of the message exceeds normal thresholds of severity (Ray & Wilkie, 1970b). Negative responses in relation to message acceptance is discussed further in Chapter 6.
5.1.1.2 Emotional response to positively framed anti-smoking messages

Higher perceived efficacy in relation to positively framed anti-smoking messages was indicated by less extreme and more positive emotions. Positive advertisements were described as 'more appealing', 'encouraging', 'reassuring', and 'made you feel better about yourself'.

A positively framed Quit WA campaign, 'I Can Do It', was being aired on TV at the time of this research. The campaign depicts ex-smokers celebrating improved physical abilities as a result of quitting. The 'reassuring' and 'encouraging' self efficacy of this message was a central topic of most of the discussions about positive advertising.

Generally, some participants 'felt a bit reassured' because they could relate to the 'ordinary looking people' featured in the ad that had made the difficult decision to quit and had succeeded. Some appreciated the lack of implicit shame; '...it was still about giving up smoking, but it wasn't about how bad I am for smoking or that I should feel guilty'. Others felt encouraged; 'Yes I like the ad about how I can do things I couldn't do before...out of all the ads recently I suppose it encouraged me' and 'the one where they do the short takes of people: I can kiss my wife, I can make love longer...I think that sends a pretty positive message...It's trying to let you know that you can do it, I quite like that particular ad'.

Positively framed messages have been found to evoke more heuristic strategies and limited mental processing, whilst not evoking self-protective feelings. Rather, they tend to stimulate emotional benefits such as good feelings (Monahan, 1995). Response in this study to the 'I Can' Campaign indicated that participants had more positive feelings towards the anti-smoking message contained in the ad. It may be possible that this occurred because this ad induced perceived self efficacy, and therefore positive feelings about the self, rather than the expected bad feelings the participants usually associated with 'being told to stop smoking'. With reference to hard to reach audiences, Monahan (1995) stated that
If the target audience does not have the motivation to think carefully about the merits of a campaign, the repeated presentations of a positive cue with the campaign may be one of the few ways to induce an audience to engage in processing information (p.87).

A comment about the ‘I Can’ Campaign indicated a mildly positive response, but simultaneously acknowledged that some residual processing had occurred; ‘I suppose it just washed over me like the rest of them but it did leave a residue’. In addition to positive feelings that are engendered towards a heuristic appeal, these feelings might eventuate in approach behaviours such as open-minded associations and deeper thought about the issue presented (Monahan, 1995).

5.1.2 Cognitive Response to Anti-Smoking Messages

Participants’ cognitive responses were determined by their perceptions and beliefs about anti-smoking messages. Responses have been organised according to five main themes:

- Cognitive response to anti-smoking messages in relation to participants' own smoking behaviour
- Cognitive response towards anti-smoking messages in relation to other people’s smoking behaviour, (especially young people who smoke or who could potentially begin smoking)
- Cognitive dissonance and rationalisations in relation to anti-smoking messages
- Cognitive response to positively framed anti-smoking messages
- Cognitive response relating to early developed self-concept and smoking.
5.1.2.1 Cognitive response and participants' own smoking behaviour

Cognitive response to anti-smoking messages was generally negative. However, the negative response was expressed by a variety of perceptions and beliefs. The most dominant negative cognitive responses that emerged in the women's groups were firstly, their antagonism towards anti-smoking advertising because it was perceived to be in opposition to their 'right' to smoke. The women were highly involved in their belief that they were free to choose to either continue to smoke or to give up smoking 'when I want to'. Similar comments punctuated discussion; 'It's my choice and if I want to do it, I will'; 'it's my own lungs'; 'it's an individual thing'; 'It's my decision in the end you know, like I'm the only one I'm doing this, it's my decision, it's just something that you choose for yourself'. A number of women stated they believed anti-smoking messages had little or no influence over them; 'it is a personal choice,...if I choose to do it then I choose to do it, and if I choose to stop then I choose to stop. I'm past listening to them' and 'it won't happen because someone is telling us we should'.

The second most dominant cognitive response in the women's groups was how they rationalised feeling guilty in response to anti-smoking advertising. Although admitting to initially feeling guilty when first hearing anti-smoking messages, the women quickly rationalised guilt in favour of their right to smoke, 'I feel guilty, but at the same token I think, well, this is my choice. [My attitude is] we are in fresh air here. This is my wee bit of space and if you don't want to be in it, it's best to choose another bit. You know I'm not obstructing to you in anyway'; 'the choice is ours if we accept the guilt that goes with it or whatever, that's our personal choice, like it is to smoke' and 'I feel guilt when I see them on television and the kids are in the room...they will always make a comment, I expect it. I sort of talk around it or talk over it cause you know you think, here they go again...but, it is a personal choice'.

Some admitted to initially feeling guilty, but they deliberately ignored the guilt; 'I feel pretty guilty... you know, isn't this disgusting what I'm doing to myself and do
my lungs really look like that? But over a period of time, like, you get used to seeing it, it didn’t make me feel comfortable but you learn to walk away and ignore it’ and ‘I do feel guilty. These ads can inspire me. But then … I sort of move that message aside’.

Some women denied feeling guilty at all and asserted their right to smoke; ‘I don’t feel guilty about it – it’s my choice. I don’t feel guilty about it, I don’t feel guilty when I see any of the adverts, I think that if I choose to do that, that’s what I choose to do. I don’t ram it down anybody else’s throat, I don’t smoke where I’m not supposed to. I give the person the option who is sitting next to me: “I am a smoker do you want to move?” If I was already sitting there... I don’t feel guilty about what I do, it’s my body it’s my responsibility it’s no one else’s, and I don’t think that anyone else has got the right to tell me that I should feel guilty about what I do’.

The women weighted their freedom of choice to smoke with more significance than the potential of damage to their health from smoking; ‘I don’t think smoking is great, but it’s an addiction and it’s bad for you. But by the same token it’s what I choose to do’.

Defensive counter arguments against anti-smoking messages figured strongly in the women’s groups. Negative response was especially evident when the women expressed what they thought about ‘being told’ not to smoke; ‘it’s not so much sending the message to stop smoking,...it’s dictating to me not to have a smoke, especially in open places’. Being told how they should feel about smoking was considered intrusive; ‘I think that if I choose to do that, that’s what I choose to do...I don’t feel guilty about it – it’s my choice’ and ‘I think personally how you hear them and how you absorb them or what you do with them is your own choice’.
One woman made a less confident suggestion in relation to the age of these smokers: ‘Maybe we’re a lost cause?’ However, this was vigorously opposed: ‘I’ll give up when I want to ...when I’m ready, I will!’

The men also revealed generally negative thoughts about anti-smoking messages. However their responses were generally milder than the women’s groups; ‘I’m a bit blasé about it really. You hear it. That’s about all’; ‘I think people that have been smoking as long as I have...nah, I don’t think it does too much’; ‘the ads are not telling us anything we haven’t been told before’ and ‘...basically the ads are a flop...they are making them too negative...not everyone want to be a non-smoker’.

The most dominant negative cognitive response in the men’s groups was in relation to low perceived self efficacy. Although the men expressed less intensely negative thoughts about anti-smoking advertising than the women, they expressed lower perceived self efficacy regarding their ability to give up smoking.

Some men generally expressed low self efficacy by declaring that the notion of giving up was an almost impossible expectation and well beyond their perceived abilities. There were comments stating that anti-smoking messages were redundant without a miraculous cure; ‘I think they’ve got the message across that it’s not good for us, so we understand all that. At our age we know all that we want now is a magic cure, that’s basically what we want. To say: right, tomorrow we can wake up and we don’t smoke. That’s what we want’; ‘We want a cure, we don’t want to be told (not to smoke) all the time, telling you doesn’t mean a thing, it’s not worth the paper or the video it’s on’; ‘smoking is virtually almost impossible to give up if you’ve been used to it. You’ve got to have some quick cure’; ‘How about if they come up with a little injection when they shoot you in the arm and for the next six months every time you want to have a cigarette you want to throw up?’

Consequently, hearing anti-smoking messages increased counter-arguments; ‘I think it goes beyond that [the ads], it’s just not a matter of willpower...it’s a very
nasty addiction’ and ‘you should give up smoking basically, but even when you know there’s something wrong [with it], smoking is such a horrible addiction that it’s really hard to give up, it really is. So even though you may want to, it’s still a very hard thing to do’.

5.1.2.2 Cognitive response and other people’s smoking behaviour

In contrast to participants’ negative attitudes towards anti-smoking messages and themselves, there was a common belief that smoking was undesirable for young people; ‘I’m past giving up now, but if it works for the younger ones that’s great’; ‘when they are on I just talk over them, but they are terrific for the kids’; ‘obviously kids today should have more sense, it’s not cool for them now’.

Parents preferred their own children not to smoke; ‘...because I can see they are wasting the best times...’ and expressed generally favourable cognitive responses towards anti-smoking messages that targeted or reached children and youth; ‘I think that it’s a good thing that there are campaigns to make young people stop. Anything that doesn’t encourage young folks to smoke, that’s good. I smoke, but I don’t want any young people like my family to smoke. The fact that they don’t, generally has I think, got something to do with the advertising probably’ and ‘I think it is important to get the message across to underdeveloped lungs. I think you stand a better chance to be fit etc if you never smoke’.

Some men discussed negative beliefs towards advertisements that targeted children and young smokers after a father stated he believed that some anti-smoking messages were discriminatory;

‘...but the campaign is saying that one group of kids is not cool or lesser human beings because they smoke’

‘Like the ones where the kids are in the toilet and one kid says, “Do you want a fag?” and the other kid sneers at him and says, “You know, I’m not an idiot like you...’
‘You might as well say that I’m not a slant-eyes like you or a nigger like you, that’s just as disgusting’.

5.1.2.3 Cognitive dissonance in relation to anti-smoking messages

The Theory of Cognitive Dissonance (Festinger, 1957 cited in Ajzen and Fishbein 1980) asserts that people value harmony amongst their thoughts and behaviours and when an individual is confronted with an inconsistency between two cognitive elements (ie: ‘I know smoking causes lung cancer’ and ‘I smoke cigarettes’), an unpleasant state of ‘dissonance’ occurs. In order to avoid or eliminate dissonance, the individual will use rationalisations to provide a psychological defence that justifies their behaviour. To do this, the individual will use rationalisations to:

- change the elements (ie: refute research results that connects smoking with cancer);

- add to the elements (ie: cite someone who has smoked for 50 years and is still healthy);

- rationalise their behaviour to eliminate the inconsistent element (ie: stop smoking).

In this section, participants’ rationalisations to eliminate cognitive dissonance by changing or adding to the elements are discussed. Behaviour to eliminate dissonance is discussed in the following section, 5.1.3.

Both genders rationalised that the effort and discomfort involved in going through the process of giving up would not be worth the longer term health benefits; ‘life is too short to make yourself miserable by giving up’. Others bargained (ie: changed the elements) that cutting down would sufficiently stave off damage to health; ‘In moderation you can do anything...it’s no good giving away everything in life’ and ‘I’m of the opinion that a little of what you fancy does you good’ and ‘nothing hurts in moderation if you try and control it. It’s like eating, drinking,
Perceived difficulties involved in giving up were consciously rationalised to reduce dissonance associated with the harmful effects of smoking; 'I gave up a few times and it was always easier when I was younger... and over the years I've made this conscious decision that smoking isn't such an evil thing'.

Dissonance was reduced by rationalising (ie: changing the element) that other negative social issues were worse than smoking. For example, it was suggested that alcohol and gambling addictions were more important social issues than smoking; 'Alcohol I consider worse, gambling is worse, you affect the family more, with alcohol you affect the family more, with gambling you can lose everything' and 'overall there are more people being killed, more homes and more hearts broken and more destruction through alcohol than there ever has been through cigarettes'.

Pollution from car exhausts and diesel fuel were used to counter-argue (ie: change the element); '...they try to get us to stop smoking...yet you get these bloody cars going up and down the road with their bloody exhausts putting pollution all over the place' and 'They have all this crap going on...like diesel trucks spewing rubbish everywhere and then they have a go at the smoker, it's rubbish'. Other pollutants were also used as counter-arguments; 'But there is more harm from the bacteria in air conditioning than in a cigarette'; 'Everything you are breathing in hurts you these days'.

Some changed inconsistent cognitive elements by suggesting that AIDS was a more important social issue than smoking, but it received little attention; 'Apparently within a year AIDS is going to be such a large contributor to public health problems... More than smoking and speed and drink driving. More than everything else, but they are doing nothing about it. There is no money going into AIDS, but they are still spending all the money on trying to tell people to stop smoking'.

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Some offered anecdotal evidence (ie: added to the element) to reduce dissonance. For instance, elderly people who had smoked their whole lives, but lived to old age, were cited as evidence that one could smoke and live a long and happy life; ‘I know it can’t be wonderful for your health but then you’ve also got the people who have smoked every day for their whole lives and they live to 95’.

Dissonance was eliminated by rationalisation that one could possibly die from other causes (ie: adding to the element); ‘You could die of something else before you die of smoking...’; ‘Someone the other day, I heard, had throat cancer and had never smoked. So that wasn’t caused by smoking’; ‘You can get disease from anything, you can get cancer by just having it in your system and if you’re going to get cancer you’re going to get cancer, so...’ and ‘My mother never smoked, but she died at 82 of a heart attack’.

Conflicting solution efficacy contained in two anti-smoking messages had led to cognitive dissonance and confusion in some participants. The first message was a threat appeal, ‘Every Cigarette Is Doing You Damage’, which was compared to the second message, a positive appeal, ‘Your Body Can Repair Itself’. Participants rationalised that one message cancelled the other out; ‘I mean it feels to me that they are saying that there is no hope if I have smoked for 25 years...if every smoke is doing me damage, how would I recover?’; ‘... from what they’ve said I’m still quite capable of recovering...I don’t know...but at what age am I too old to do that?’ and ‘if you could still recover that would be some reason to think about it. But the one that says “Every cigarette is doing you damage” ...I feel that the damage is already done’.

The message, ‘Your Body Can Repair Itself’ was also negatively compared to the notion that passive smoking is potentially dangerous for non-smokers; ‘When they tell you your body repairs itself after six months and then they tell you everybody can get cancer from passive smoking, it’s just as bad as smoking so...’; ‘So even if you don’t smoke you’re still going to get lung cancer’; ‘So they’re telling me on one hand to give up smoking, and telling me on the other hand, if you don’t smoke
you're a passive smoker. It's still just as bad as if you do smoke, so the two things fight each other'.

5.1.2.4 Cognitive response to positively framed anti-smoking messages

Participants' cognitive responses indicated that messages which stimulated positive feelings about the self induced more favourable beliefs; 'Positive ones are definitely more appealing... they tell you who you can be... when you see the negative ones, they are telling you that this is what or who you are'. Participants acknowledged their approach response towards positively framed ads by suggesting that advertisers should use more positive appeals to gain attention; 'Instead they should be really positive and use real stories of people who have actually given up... ones that you can relate to'; 'I think if they went about it in a more positive way you might get a better reaction'.

Some women suggested that practical strategies could lead to greater message acceptance; 'they should be pushing the positive way about giving up. Like how to channel your anger in some way or deal with the stuff that comes up when you're trying to give up'. Some women believed that greater anti-smoking message acceptance could occur by advertisers employing an approach similar to the positive appeals used to market commercial products, such as weight loss programs; 'Like the ones about losing weight. Show someone who has improved from giving up smoking'; 'Yes! So maybe they need to use lots more positives and then maybe they'll get people like us saying I'm down to 2 a day and my oxygen level has lifted, or my breathing has improved because I'm four weeks off quitting, etc, you know what I mean?'

In contrast to the various comments indicating participants' preferences for positively framed messages, there were some negative responses from some men. These men refuted all anti-smoking messages and argued that positively framed ads were as futile as negatively framed ads, in the absence of an effective cure to help them stop smoking. These comments gathered momentum in the men's groups as vigorous discussions occurred, giving further weight to the observation
that their negative responses were fuelled by low perceived self efficacy; 'They've told us for years and years...we know it's not good for you. We want a cure — telling us doesn't mean a thing'; 'they all mean nothing until they come up with a way for people to give up like that' and 'These ads just keep telling you how bad it is but they don't take into account what's happening in your life, they might be telling you you'll die from smoking, but what does that mean to you when you can't work out a way to stop?'.

5.1.2.5 Cognitive response from early developed self-concept and smoking.

Some women recalled pleasant, nostalgic memories about their early smoking experiences. They discussed starting to smoke during their teenage years to enhance their early self-concept; 'I used to do it in front of the mirror and I thought it looked pretty cool'; 'We were cool, it was sexy to smoke'. They used smoking to demonstrate a sense of fashion; 'it was the thing at the time'. Some women recalled how certain 'cool' brands were associated with value-expressive, ideal self-concept; 'I mean Marlboro, you had to get off your horse, but Salem, boy, you had class if you smoked Salem, you really had it!' and 'I smoked Virginia Slims because it sounded so good...You've come a long way baby'.

Taking up smoking was a value-expressive personal act which led to acceptance by desirable peer groups; 'I was a Catholic girl in a public school area...if we wanted to be tough...you had to sit and have a cigarette...I was accepted'; 'You'd be all right sitting on the bus if you smoked. My friends did it, so I did it too. And I thought I looked pretty good too'.

Some nostalgic memories indicated that at times, the entire consumption experience of smoking was value-expressive. From the pre-purchase environment; '...I used to go to a tobacconist [to get special cigarettes]. He's still there in town'; to the symbolic reasons for the purchase; 'I had to go to a school ball...they used to come in a little cardboard box and each cigarette was a different colour, like pink and blue you know, with the gold filter. Tasted like
horse shit, but jees, they looked good! I used to go to the balls and they looked really good, but they tasted terrible.

Others found smoking became a function of their ‘looking-glass’ self by engendering a perception that other people saw them as they wanted to be seen; ‘you were always lying about your age because you couldn’t get into a club unless you were 21...You’d light a cigarette and that’d get you in, then you were dolled up’.

For many of the women, these beliefs were internalised, enduring and difficult to detach from; ‘I had a great time then and I still like smoking, I don’t want to give up. I suppose smoking still makes me feel good because it goes back to being younger and being a rebel’. Another said she still thought smoking gave a woman ‘class’.

However, other comments revealed that current knowledge about smoking had changed their earlier perceptions. Regret was expressed that early perceptions were not influenced by anti-smoking information; ‘No one told me they were bad, I enjoyed it’; ‘I wouldn’t have smoked then if I’d known what they know now’.

When asked what she thought of her image as a smoker now, one woman said ‘Shocked as hell! I don’t like looking in the mirror now’.

5.1.3 Behavioural Response to Anti-Smoking Advertising.

Behavioural response to anti-smoking advertising was expressed by participants’ descriptions of their behaviour in response to anti-smoking advertising. Numerous themes emerged in relation to general behavioural response and in this section, the data have been organised according to the five most dominant general themes:

1) Behaviour to avoid exposure to anti-smoking advertisements

2) Behaviour to avoid cognitive dissonance
3) Behaviour in response to pregnancy

4) Behaviour in response to positively framed themes

5) Behaviour in response to rising costs of cigarettes

Behavioural response also occurred in relation to specific death and non-death threats in anti-smoking messages. Because exploring response to death and non-death threats was a major objective of this research, response to specific threats will be interpreted separately in section 5.3 to avoid repetition.

5.1.3.1 Behaviour to avoid exposure to anti-smoking advertisements

Participants revealed that they automatically acted to avoid negatively framed anti-smoking advertising by not watching or by turning off the TV, or by leaving the room. These were the ways they coped with the uncomfortable negative emotions they closely associated with the more 'gory' advertisements depicting blood or body organs; 'I hate it. I won't watch it. I turn it off'; 'I just don't look at them'.

Behavioural response was mixed in the men's groups. Initially the men were quite dismissive and flippant about the impact of anti-smoking threat appeals on their smoking behaviour; 'Yes. I must admit when I do see the ads for smokes [meaning anti-smoking ads] though, it makes me want to light one up'; 'It just reminds me I haven't had one for a while'. However, further into the interviews some men also revealed that certain threat appeals instigated uncomfortable reactions, which led to avoidance behaviour;

'The one that gets me is the one where they are squeezing all the fat out of someone's artery'
'Yeah I have to walk out'
'Yeah I hate that'
'Don't you have a remote or what? I just zap it off!'
5.1.3.2 Behaviour to avoid cognitive dissonance

Some participants discussed how they made changes to their smoking behaviour in order to avoid or reduce cognitive dissonance. Some women discussed temporarily cutting down as a common behaviour that briefly quelled dissonance felt in response to anti-smoking messages; ‘I look at the ads...and I cut down a little bit for a couple of days or maybe a couple of weeks but I go back again. Because I enjoy it, it’s very satisfying’ and ‘I’ve cut down a bit so I feel better about it’. A woman who was asthmatic reduced dissonance by drinking milk; ‘I drink milk coffee ‘cause I think that lines my stomach and that’ll protect me from the toxins. And I’m asthmatic’.

Some men discussed how cutting down and smoking low tar cigarettes allowed them to rationalise away anti-smoking messages; ‘I’ve cut down. A lot of people say to me that 2-3 packets a week is not real savage anyway. And I’m only smoking light ones, so that’s ok’ and ‘Well, I’m on two or three packets a week of about 4 milligram, so I don’t think that’s not too bad. It’s not like heavy smokers’. Some men had replaced tailor-made cigarettes with ‘roll your own’ tobacco. They rationalised that smoking ‘rollies’ would help them avoid the poisons in their usual cigarettes; ‘There aren’t so many toxins in a rollie, cause it doesn’t burn by itself...I prefer rollies actually’ and ‘...all those chemicals... For a while there I went back to the real tinny, rollly stuff...’

5.1.3.3 Behaviour in response to pregnancy

The anti-smoking threat that smoking is potentially harmful to an unborn baby was a particularly strong deterrent from smoking during pregnancy for men and women. Women discussed how the responsibility for someone else’s health was a strong deterrent; ‘...when I was pregnant I thought, oh this is terrible what I’m doing, and I stopped for a period of time’ and ‘Yeah I didn’t smoke. I just thought you know, this isn’t right’; ‘I stopped smoking when I was pregnant’ and ‘I obviously stopped while I was pregnant. I think you’re responsible for someone else’s health, you know it’s not just yourself when you are pregnant’. Some
women found the desire to smoke left them when they were pregnant; ‘...when I fell pregnant I couldn’t smoke...So I didn’t smoke’. However they resumed smoking afterwards ‘...I never made that conscious effort, it just, it was just like that. Both pregnancies, both breast feeding, not a problem. But when I stopped breast feeding, I needed a cigarette. It was just gone’ and ‘I started smoking again after’.

Men also ceased smoking during their wife’s pregnancy; ‘Hubby said we’ve got to give up smoking, it’s not good for the kid. So I thought yeah, well, fair enough, so we did, stopped smoking, both of us’; ‘I gave up once when my wife was pregnant’ and ‘My wife was pregnant and I felt I should [give up] because of my kids’.

5.1.3.4 Behaviour in response to positively framed themes
Some participants recalled temporarily changing their smoking behaviour in response to positively framed ads. A woman said the ‘I Can’ ad had positively influenced her attitude towards giving up. The message had been recalled during a sporting game and triggered a decision not to smoke during half time; ‘I thought, if it’s going to make my game better I might do something about it. When you actually see somebody doing it, I said OK then... so I didn’t smoke at half time’.

The positively framed message, ‘The Body Can Repair Itself’ after damage from smoking, was specifically recalled as a message that instigated changes in behaviour; ‘I gave up for 6 months because I heard that your body can repair itself in that time’; and ‘...by cutting my smokes by half my body has repaired itself, that was a fair whack, so that was a good positive ad’.

These behavioural responses are consistent with participants’ emotional and cognitive response to positively framed advertisements. However, those who had stopped smoking also later commented that they resumed smoking, making them eligible for these groups.
5.1.3.5 Behaviour in response to rising costs of cigarettes

It became evident in discussions that the rising cost of cigarettes was a top-of-mind concern for the men and women. Cost had rated as a powerful factor in participants' past attempts to give up; 'The only thing that's made me give it up, or think about giving up is the cost'. Cost was thought to be one of the strongest deterrents in the future; 'I would give up. I mean I just wouldn't be able to afford it'; '...cost is the main thing for me'; 'Just the cost'; 'The cost would be the only thing that would stop me, only, nothing else'.

Some participants' anecdotal dialogue illustrated how rising costs caused them to adjust their lifestyle to accommodate their smoking addiction. A woman who had expressed strong resistance to anti-smoking threats, believed that her smoking behaviour would change only when costs made cigarettes prohibitive to her. She revealed that she had begun to sacrifice aspects of her lifestyle to afford cigarettes; 'It's already affected me because I don't go and buy clothes so much, and my dressing standard has lowered because I don't work any more since I've been married. But I'd spend well over $100.00 a week just on cigarettes just for myself...I always make sure my kids have food etc., but yeah, I think the increasing cost will stop me in the future'.

A man revealed that he recently consider giving up smoking after inadvertently being exposed to the cost when he, instead of his wife bought the household's cigarettes; 'I went to get a carton from the supermarket...I couldn't believe the cost...it was something like $44.00. There's a $50.00 note and it's stuffed'. Another man revealed that cost placed limits on his intake and he consequently smoked only as many as he could afford; 'Well it's a cost factor of about 30 a day, that's pretty expensive; I smoke about a packet of rollies a fortnight. If I smoked any more I wouldn't have any beer money left'.

The combined effect of costs and health warnings instigated cutting down for another man; 'A bit of cost and health. Yes I had problems with my health but I've cut down to two small packets of Drum a week [because of the rising cost of
Another said he thought that the rising cost of cigarettes would stop him smoking long before he experienced health problems, but this man thought himself immune to emphysema because it was 'an old person's disease'.

5.1.4 Conclusion

The focus of this section was on attitudinal response to anti-smoking messages. Specific focus was placed on participants' emotional, cognitive and behavioural responses to anti-smoking messages, cognitive dissonance used to eliminate elements inconsistent with those attitudes. Responses to positively framed advertisements were discussed and various types of behaviours in relation to negatively and positively framed anti-smoking messages.

In the following section, the differences in the men's and women's responses are discussed.

5.2 Gender Response Differences to Anti-Smoking Messages

Men and women in this study had some similar responses towards anti-smoking messages. For instance, their attitudes towards anti-smoking threat appeals were generally negative, which is not surprising considering that they were all smokers. They had similar general concerns for young smokers and their welfare, and expressed similar positive attitudes towards anti-smoking campaigns that targeted the teenage market. Both genders believed that cigarettes would inevitably cost more than they were willing to pay and this was considered a likely factor in their eventual cessation.

However, distinct differences emerged as the men and women articulated their feelings and thoughts in relation to some topics under discussion. In this section the gender differences have been organised according to the following five themes:
1) Differences in emotional response to graphic imagery in threat appeals

2) Differences in self efficacy response

3) Different responses to portrayal of smokers in anti-smoking advertising

4) Early developed self-concept around smoking

5) Guilt and shame

5.2.1 Differences in Emotional Response to Graphic Imagery in Threat Appeals

Both genders expressed intensely negative feelings regarding repeated exposure to high fear-arousal in anti-smoking threat appeals. Avoidance thinking and behaviour were frequently expressed by both genders. However, there were differences in how the males and females articulated their emotional response.

Inhibitory fear was expressed in the women's groups by intense negative emotions such as 'hate' for gruesome images of the potential damage smoking could cause to their bodies. Women expressed feeling squeamish and 'sick' in response to exposure to strong, fear arousal images used in television or in print media. They blocked out and avoided these advertisements to protect themselves from emotional distress. Men expressed lower levels of inhibitory fear towards graphic images. However, comments indicated they also acted to avoid exposure.

5.2.2 Differences in Self Efficacy Response

One of the most distinct differences between men and women was how they expressed self efficacy in response to generic anti-smoking messages-smoking messages, rather than to specific threats. Self efficacy was generally higher in the women’s groups. Women expressed more power over their smoking behaviour by confidently expressing their ability to give up if and when they wanted to; 'I see the ads and I think no, that doesn't apply to me really, I can give up if I want to';
'...when I'm ready I will' or if they needed to: 'If I got sick from smoking I'd give up straight away'.

The women's self-esteem also appeared higher. Their attitudes were value-expressive, internalised and they were inclined to express anger if their 'right to smoke' was threatened. They strongly defended their 'choice' to smoke (and to give up) when they wanted to; 'it's up to you if you want to do it' and objected to 'being told' not to smoke. Some women expressed contempt towards anti-smoking messages that they perceived as authoritarian or dominant; 'I'm past listening to them' and 'it won't happen because someone is telling us we should give up'. Others applied their internalised, independent attitudes to anti-smoking advertising; '...how you absorb them...is your own choice'.

Women also expressed a stronger enjoyment of cigarette smoking; 'I love smoking'; 'I enjoy smoking' and a general lack of desire to give up smoking; 'In my head I don't really want to [give up smoking]; '...there's never been a time actually that I've even thought that I'd want to give up. So until there is I won't'.

Men expressed lower perceived self efficacy than the women. Low self efficacy was indicated in the men's groups when they appealed for a quick, 'magic cure', 'needle' or 'pill' to cure their smoking addiction, which they felt powerless to control; 'nicotine is such a nasty drug, it's impossible to give up'; 'it's not just a matter of willpower'. They expressed strong, ego-defensive attitudes tending towards depression in response to anti-smoking messages that 'bombarded' them with unrealistic expectations that they could simply give up 'if they wanted to' and low self-esteem; 'they just make you feel worse about yourself'. These advertisements were perceived as admonishments and continual reminders that they did not have power over their smoking addiction.
5.2.3 Different Responses to Portrayal of Smokers in Anti-Smoking Advertising

Men and women expressed similar rationalisations that smoking was an issue generally blown out of proportion and that other social issues such as gambling, road safety and alcoholism deserved more attention. The image of smokers was not discussed in the women's groups, but it received considerable attention from the men. Men felt hounded by poor images associated with smokers. They felt discriminated against and victimised by non-smokers' values regarding smoking and felt smokers were portrayed as 'weak', 'bad people' and 'second class citizens'.

Both genders were generally positive regarding young smokers receiving anti-smoking information that could lead to them not taking up the habit or giving up. However, differences occurred in their attitudes to some threat appeals targeted at young smokers. The women were positive towards hard-hitting negatively framed messages for children; 'I think for them that it is terrific ...if it works for them then it is great'. They were supportive of contemporary messages that educated against smoking; '...kids know now... if we had this advertising and education the kids are getting these days we wouldn't have smoked' and were supportive of messages that negatively depicted young smokers, such as the 'Only dags smoke fags' promotion.

Men were concerned that negative images of young smokers could lead to lowered self-esteem and discrimination by their peers. Some advertising campaigns were described as 'disgusting' because they were perceived as
depicting teenagers who smoked as idiots and 'not cool or lesser human beings' than non-smokers their own age.

These differences in gender response appear to be reflected by the men's and women's responses to anti-smoking messages and their own smoking behaviour; that is the women's positive attitudes to stronger appeals may have been due to their expectation that, like them, children and younger people chose to smoke, but were able to give up if they wanted to. However, the men's attitudes appear to be extensions of their own feelings of helplessness and low self efficacy. Consequently, they may have expected that children and young smokers would similarly feel low self-esteem as a result of exposure to anti-smoking messages.

5.2.4 Early Developed Self-Concept and Smoking

Both genders recalled starting smoking when they were teenagers. The women associated hedonic feelings with their early smoking experiences. They nostalgically discussed their early-developed self-concept in relation to taking up smoking and revealed that some of their earlier positive attitudes towards smoking were still relevant to them. During the discussions, these positive attitudes were easily accessed and smoking was recalled in relation to 'good times', a sense of 'independence' and rebellion, and using smoking to enhance sexual attractiveness and social acceptance. There were no similar discussions in the men's groups, although when they discussed their perception of 'cool girls' today, they believed they were 'the ones that smoke'.

5.2.5 Guilt and Shame

Feelings of guilt and shame were experienced differently by men and women. Women openly expressed feeling temporarily guilty as a result of normative pressure applied by their children to give up smoking and when they smoked in front of their children. Pressure and temporary feelings of shame (as a result of the imposed guilt) tended to increase when new anti-smoking campaigns were launched and their children saw them smoking.
The temporary feelings of guilt or shame dissipated with consequent rejection of
guilty feelings, and the women denied that normative pressure had any long
lasting influence over their attitudes towards smoking; ‘I feel guilty until I light up
the next one...’; ‘I feel guilty initially, but over a period of time you get used to
seeing it, you learn to walk away and ignore it’ and ‘when I get that first drag...I
lose any guilt’. When guilt was felt in response to anti-smoking advertising, it
was quickly rationalised with value-expressive counter-arguments in relation to
their right to choose to smoke; ‘I don’t feel guilty about what I do, it’s my body
it’s my responsibility it’s no one else’s, and I don’t think that anyone else has got
the right to tell me that I should feel guilty about what I do’.

However, guilt, social pressure and feeling responsible for their unborn children’s
health motivated women to temporarily give up when pregnant and breastfeeding.

Shame appeared less resolved in the men’s groups. Residual feelings tending
towards depression indicated that the men employed few coping strategies in
relation to feelings of shame; ‘They [the ads] really make you feel worse about
yourself. I actually go down on [criticise] myself more when I hear them, rather
than thinking I’ll give up, you know?’

5.2.6 Conclusion

In this section, discussion focused on the differences in how the men and women
articulated their: emotional response to graphic imagery in threat appeals; self
efficacy; responses to how smokers are portrayed in anti-smoking messages; their
early self concept in relation to smoking and the guilt and shame they experienced
in relation to anti-smoking messages.

In the following section death and non-death threats in anti-smoking messages are
discussed in relation to the participants' emotional, cognitive and behavioural
responses. There is also discussion of the types of death threats discussed
including effects of death on loved ones, denial of death anxiety and reasons for
resuming smoking.
5.3 Gender Differences in Response to Death and Non-Death Threats

One of the major objectives of this study was to further explore qualitatively, Henley's (1997) quantitative research, which indicated that significant differences occurred between older male and female smokers' responses to death and non-death threats in social marketing messages. Henley (1997) found that in general, 40-50 year old males responded more to death threats and 40-50 year old females responded more to non-death threats. There was one exception: women did respond to the death threat involving the effect of their death on loved ones.

Participants in this study were not aware of this objective of the study and were not asked specifically how they responded to death or non-death threats, as it was believed that an explicit question on what is an intellectual taxonomy could affect the free flow of discussion. Instead, they were encouraged to discuss their response to anti-smoking messages freely so that deeply held beliefs would emerge. Generally, the men and women did not make distinctions between death and non-death threats, apart from specifying a death threat dealing with the consequence of their own death on loved ones. However, death threats were implicit in many specific messages under discussion and gender differences were apparent when the men and women articulated their response to these messages.

In this section, the emphasis is on response to death and non-death threats. Some repetition of previously used verbatims was necessary to symbolise the relevant themes that emerged. This section had been organised according to the following themes:

1) Response to death threats including emotional, cognitive and behavioural responses, types of death threats discussed, the effect of death on loved ones and denial of death anxiety;
2) Response to non-death threats including emotional, cognitive and behavioural responses, and reasons for resuming smoking; and

3) Response to information only advertisements.

5.3.1 **Response to Death Threats**

When the general threat of death as a consequence of smoking was discussed, it was generally rationalised or denied. The specific death threats recalled were:

- 'Blood Clot' a television advertisement which showed a blood clot in a dissected brain that had belonged to a 32 year old smoker

- 'Cats in the Cradle' a television advertisement which showed a young boy watching his dead father (who died from smoking-related causes) on video and later standing at the gravesite with his mother.

- Other specific death threats made by participants’ doctors were also mentioned.

5.3.1.1 **Emotional response to death threats**

A specific death threat that evoked a strong emotional response, was a direct threat from a doctor, and related to the effect of death on loved ones. This threat evoked strong fear in one woman; ‘When he said, “Who will look after your kids when you die of smoking?” I thought, there is no-one who can look after my kids like I do ...I couldn’t stand the thought of leaving them when they were so young...that really got to me’. This response resembled findings from Henley’s (1997) study in which she reported that the only death threat that older women responded to was the death threat involving the effect of their death on loved ones.

Two specific death threats, 'Blood Clot' and 'Cats in the Cradle' evoked emotional response in the men’s groups. A man who had suffered from blood clots in his lungs after an operation responded with mild emotion; 'I didn’t like that one...blood clot in the brain...'. A father recalled stronger emotions in
response to ‘Cats in the Cradle’; ‘That song has always had an impact on me since it first came out. It didn’t make me give up smoking, but it certainly evoked emotions’.

5.3.1.2 Cognitive response to death threats

The general threat of death as a consequence of smoking was the subject of strong expressions of beliefs and cognition in both men and women. The women’s internalised, value-expressive attitudes regarding their ‘right to smoke’, generally overpowered the threat of death as a consequence of smoking; ‘because you know you shouldn’t. You know you can die of cancer because you smoke, but you do what you want to do and it’s up to you if you want to do it’.

Women vigorously defied and denied death threats; ‘I don’t want to be told that I’m going to die of it because I like it, and I don’t think I’m going to die from it anyway’; ‘My husband died from lung cancer that came from smoking unfiltered camels from age 14 to 52...I never thought that I could get his disease, I’m still smoking and I feel fine’.

The men’s responses indicated that some were aware that death was a possible consequence of smoking. However, they expressed ego-defensive beliefs that giving up smoking was beyond their capability. Some plaintively negated death threats by rationalising that giving up was almost impossible for them; ‘Smoking does cause cancer but it’s pretty hard to give up smoking if you’ve been smoking a long time... You can’t just pack it in like that’; ‘I know myself they’re about the only thing we do that we know is killing us but we haven’t got the willpower to stop it. Everyone knows it’s killing you’; and ‘These ads just keep telling you how bad it is but they don’t take into account what’s happening in your life, they might be telling you you’ll die from smoking but what does that mean to you when you can’t work out a way to stop?’

Consequently, some men experienced the death threats as depressing; ‘...for our age group we’re not going to listen to some depressing ad about dying or
whatever, from something we’ve been doing for most of our lives’. In fact, death threats were negated by some men because they believed that smoking had sometimes helped them through potentially suicidal depression; ‘... there have been times in my life where I’ve been pretty depressed and you know a fag certainly helped me along... I might be smoking but I’m still here you know...sometimes these addictions carry us through some rough times’.

Death threats in anti-smoking messages evoked cognitive dissonance in the men. They coped with dissonance by denial. Some men simply denied death threats to eliminate dissonance; ‘They say smoking causes death, which is a load of rubbish...’. Some denied that ads were based in exhaustive research; ‘Well the death part: they say that there are people who die and they say smoking causes it, but they can’t really prove it’ and ‘it’s not as bad as they try and tell you... some people smoke for many years and survive’.

Death threats associated with cancer and smoking were denied; ‘No I don’t think it’s true... that smoking causes cancer’; ‘Any version of cancer just needs something to start it off. You can bump yourself and it might start it off’ and ‘I don’t think smoking does it. They can’t blame every cancer on smoking. Most young people die from other cancers...unless you’ve got cancer in you that’s maybe activated by smoking, but most of the time that cancer’s been activated by something else or it’s been there just waiting and the smoking hasn’t really bothered it’.

The terminal values of gaining a longer, healthier life implicit in some anti-smoking messages were refuted by some men when they denied that living to old age was appealing. ‘We don’t treat the old people in society nicely anyway, so who wants to go through that? It doesn’t make you want to live a particularly long life’; ‘... in other cultures they really respect and revere old age, like in eastern cultures. We don’t. To us they’re sort of useless’; ‘The old ‘use by date’ makes you think – who wants to live like that?’ and ‘The thought of growing old is not a pleasurable thought anyway in Australian society’.
Some men who believed they would not be happy or secure in old age refuted the threat of early death from smoking; 'My point is that I'm not going to be rich when I retire. I'll be lucky to get the pension anyway, so I might as well smoke as much as I like and enjoy myself rather than try to give up and be miserable. So what if I don't live until I'm 80! It will probably be a shithouse time anyway. Forget that. I'll do what I want now and be damned with the old years. I don't want to be old and uncared for anyway'.

Both genders similarly rationalised that the misery associated with quitting was not worth the health benefits; 'I'd rather die and live a full life than do nothing or be miserable and live to a ripe old age'; '...it's how you live your life and whether or not you are happy...because it can be taken away just like that. Are you any better off by depriving yourself of every thing that feels good...and being miserable?'.

These comments are in line with Harris and Harris's (1996) study that focused on smokers' perceptions of costs versus benefits of smoking in relation to quitting. Harris and Harris (1996) suggested that the decision to quit smoking may be a rational choice, and that smokers who have the most to gain from stopping will be more likely to quit. For instance, in Harris and Harris's (1996) study, people who expected to live longer and have comfortable, affordable retirements expected to quit, but those with poor expectations of longevity, discounted health costs associated with smoking.

Both genders reduced cognitive dissonance by rationalising that other potentially fatal social issues were more important than anti-smoking issues; 'Smoking ...is not killing the person next to you like some drunk on the road'; 'the difference is when people drink and drive they may kill someone'; 'overall there are more people being killed, more homes and more hearts broken and more destruction through alcohol than there ever has been through cigarettes' and 'it doesn't really hurt anyone else...whereas if I drank I could kill you in my car...or be an abusive alcoholic and bash you...'.

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Some believed anti-smoking death threats were exaggerated; ‘A car burns off and just about kills us all and they’re worried about a bit of smoke coming out of a cigarette’; ‘There are more carcinogens in unleaded petrol than there is in leaded petrol...what comes out of the exhaust pipe is a lot worse than smoking’.

Bother genders eliminated cognitive dissonance from death threats by comparing the chances of dying from smoking with accidental or unforeseen deaths; ‘I’m a bit pessimistic as far as being told that cigarettes will kill me or whatever. I look out there and see what’s happening out there now, we can all do these really good things, like give up smoking and jog every day and be killed in a car accident’; ‘Heaps of people I know have died, but not from cigarette smoking. So when they say it has that deadly effect, other things have a deadly, effect too’.

5.3.1.3 Cognitive response to death threats in relation to passive smoking

Passive smoking and the message that non-smokers die from exposure to cigarette smoke was generally denied by both genders; ‘This passive smoking... I think is a lot of shit!’; ‘I think 90% of non-smokers think that’s a load of rubbish’; ‘I think it’s a bit of urban mythology going around about passive smoking’; ‘I don’t believe in passive smoking’. However, concern for the health of their children motivated some parents to smoke outside rather than expose their children to cigarette smoke; ‘I don’t smoke near the kids, I go outside’.

Some participants used conflicting anti-smoking messages as evidence that giving up was futile. The positively framed message, “Your Body Can Repair Itself” was compared unfavourably to the death threat that non-smokers can die from passive smoking. The inconsistency served to endorse the futility of giving up; ‘When they tell you that once you quit you have to wait 5 years to have really healthy lungs, then they tell you passive smoking is bad for you... how do you win? Whether you smoke or not smoke you’re still going to lose. You’re still going to die’.
5.3.1.4 Behavioural response to specific death threats and loved ones

When participants were asked if they could recall any specific messages that had lead to a change in their smoking behaviour, they recalled one specific advertisement which contained a death threat, 'Cats in the Cradle'. This advertisement was recalled by parents of both genders, who had wanted to avoid early death for their children's sake. 'Cats in the Cradle' affected behavioural change for one father; 'I think the Cat's in the Cradle advert actually did make me give up smoking. I gave it up for 6 years...for my kids really. They wanted me to stop and I was a bit sucked into the thought of dying before they grew up. I didn't like that idea, so I stopped'.

Death threats from doctors had also instigated behavioural change. As described in the section on emotional response, a woman who had resisted to all other death threats, said that the only message which had affected her enough to attempt to give up was when her doctor asked, ' “Who will look after your kids when you die of smoking?” I thought, there is no-one who can look after my kids like I do ...I couldn’t stand the thought of leaving them when they were so young'.

A man was influenced to cut down the number of cigarettes he smoked when he received a death threat from his doctor. He gave consideration to this threat as he also had a desire to improve his fitness level; '[the doctor said] "You're fine now, but you need to cut down, or it'll kill you". So I started cutting down. I also started an emergency service with work and we do a lot of abseiling. Your breathing gets to you when you do a lot of that...So I thought it was a good idea to cut down'.

5.3.2 Types of Death Threats

When the transcripts were examined for this study, all types of death threats that had emerged in Henley’s (1997) study were compared to the data. They were:
• Fear of the effect of one’s death on loved ones, i.e.: failure to have provided for partner and children; concern over who will look after one’s children

• Fear of the process of dying

• Fear of death itself

• Fear of the death of loved ones

• Fear of curtailment

• Fear of the afterlife

• Fear of life’s meaninglessness

However, the only dimensions of death that received protracted attention were fear of the effect on loved ones (children).

5.3.2.1 Effect of death on loved ones

Clearly, the effect of death on loved ones and especially children, was more salient for parents from both genders. One woman said she felt more responsible for her own life because she had recently had a second child; ‘I have to live longer now because I have another baby ...before I didn’t mind going out at 60, 65...but now I want another 10 years with her’. The woman previously mentioned who had been resistant to all other threats other than a death threat from her doctor, said “there is no-one who can look after my kids like I do ...I couldn’t stand the thought of leaving them when they were so young’.

Another woman who said she and her husband were deeply affected by the thought of dying early and gave up smoking temporarily to live longer for her children; ‘they really hit us hard with those sponges and heart ads....I think it was
possibly the thought of dying early as opposed to living longer and seeing your kids grow up...'.

Fathers were motivated to give up when their children were small to ensure they could care for them longer; '...if you've got kids and they're only little...and you think, if smoking is killing me and leaving them without a father... it does make you think...'. The thought of dying before his children grew up coupled with his children's wishes that he gave up was important for another father; '...gave it up for 6 years... for my kids really. They wanted me to stop and I was a bit sucked into the thought of dying before they grew up. I didn't like that idea, so I stopped'.

5.3.3 Denial of Death Anxiety

A theme that became apparent in relation to emotional and cognitive response to death threats was participants' denial that they feared their own death in general and denial of fear of one's own death from smoking-related disease in particular. As might be expected in line with literature reviewed in Henley's (1997) study, denial or repression of the fear of one's own death is the norm. In this study, few participants acknowledged being afraid of their own death or that their own death was important to them. Generally, participants' attitudes in relation to their own death were expressed with fatalistic comments such as 'we are going to die anyway', 'it's inevitable' and '...when your time is up you're going to go anyway...'. They also expressed ambivalent attitudes about dying; 'I think at our age once you get over 40 you realise your own mortality and you know that somewhere ahead there is a tombstone with your name on it... In a few years we are all going to go, that is how I feel about it. When you go you go'.

As the subject of this study was cigarette smoking, many of the expressions of denial of death anxiety were in relation to death from smoking-related disease. Dying from other causes was also used frequently to express denial of death anxiety from smoking. For instance, the possibility of being killed at any time by a random accident functioned to express denial of death anxiety and strengthened
the rationalisation that giving up was futile; ‘All these bombs dropping around the world and earthquakes and things, who wants a long drawn out age?’; ‘I’ve lost lots of mates, killed in motor bikes and car accidents. When I got to 25 I thought I’m laughing, I’ve done it. It’s a bonus from here on in’; ‘Life is too short. What is the matter with enjoying it while you’re here? If having a smoke feels good, go for it! You could be killed in a car accident, you could be hit by a bus while out shopping...’.

Some people told humorous anecdotes that expressed their denial of death anxiety; ‘One of my friends said that if he cut his life down by five years by smoking, that would be good because then he would miss out dying from emphysema’; ‘I dropped a cigarette on the floor and it nearly killed me because I rolled the car’ and ‘This man he felt sick one day and he said to his wife “I don’t think I’ll go to work today, I feel a bit off”. He was sitting there and something fell off the mantelpiece and hit him on the head and he died... It doesn’t matter what you do, when your time is up you’re going to go anyway. So enjoy life and smoke your head off!’.

5.3.4 Response to Non-Death Threats

In this section, discussion focuses on specific and general response in relation to non-death threats including emotional, cognitive and behavioural response by gender. Gender differences are indicated and the temporary nature of behavioural response to death and non-death threats is discussed. Anti-smoking advertisements containing non-death threats were:

- ‘Aorta’ in which fat is squeezed out of a smoker’s main artery (M & F)

- ‘Sponge’ in which a large amount of tar is squeezed from a sponge to depict how much tar a smoker accumulates in the lungs (M & F)
• ‘Every Cigarette Is Doing You Damage’: A campaign that consisted of a series of graphic ads depicting various scenes of damage to the body caused by cigarettes (F)

• ‘2000 Toxins’: An explicit message that presented how many toxins are in each cigarette (F)

• ‘Pretty Face’: which shows a pretty, young female smoker rapidly aging as she smokes cigarettes (M & F)

• ‘Baby/Children in Car’: shows adults smoking in a closed car and a baby breathing the smoke (M & F)

• ‘Only Dags Smoke Fags’: cartoon execution targeted at image of young smokers (F)

• ‘Idiot to Smoke’ which shows teenage smokers refusing a cigarette and calling the smoker an idiot (M)

• ‘Coach’ which shows a teenage football played put off the team because he is a smoker and consequently unfit (M)

• Messages printed on cigarettes packs, ie: ‘Smoking Causes Heart Disease’; ‘Smoking Can Harm Your Unborn Baby’ and the information on the side of the pack listing the carcinogens and poisons in cigarettes (M & F)

Other specific, non-death threats included social pressure not to smoke when pregnant, anti-smoking messages from family and friends, and publicly available anti-smoking literature. Although much of the discussion centred on specific television advertisements, there were some non-death threats recalled from medical sources and from accidental exposure to people in hospital who had smoking-related diseases.
5.3.4.1 Emotional response to non-death threats

Gender differences occurred in emotional response to the non-death threats: 'Aorta', 'Sponge', 'Baby in Car', 'Idiot' and 'Coach'. The emotional responses were mixed. Some men expressed inhibitory fear in response to graphic images portrayed in 'Aorta' and 'Sponge'; 'What about the lung one where they wring it out? I hate that one, it freaks me out'; 'they're horrible' and 'I don't like all the guts I just think it's particularly horrible and that they go over the top in that advertisement'. Some men had a milder emotional response; '...when you see someone squeezing bits out of an artery I really didn't like that'.

Women expressed stronger inhibitory fear than the males in responses to the more graphic anti-smoking advertisements, 'Aorta' and 'Sponge', because of the 'gory' and repulsive images; 'I don't like that one with the clogged arteries...it makes me feel quite sick' and 'I didn't like the one with lungs and the tar'.

Men's responses to the specific advertisement 'Baby in Car', 'Idiot' and 'Coach' were ego-defensive and negative; 'I'm not going to put a baby in a car and smoke, am I? They make smokers out to be bloody monsters, that really shits me'; Some ads were perceived as discriminatory; 'I don't like them'; 'Like the ones where the kids are in the toilet and one kid says do you want a fag and the other kid sneers at him and says you know, I'm not an idiot like you...'; 'Oh, that one when the student who can't play basketball because he smokes too much or the coach tells him he can't play but it's not targeting us, it's targeting the young ones'; 'You might as well say that I'm not a slant-eyes like you or a nigger like you, that's just as disgusting'.

Women's comments regarding 'Baby in Car' and a specific encounter with an emphysema patient in hospital indicated value-expressive responses. '...the kids would be coughing and sputtering... that always got to me. Yeah, I as an adult have a choice and I'll smoke in my car if I want but not when someone doesn't have a choice'.

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A woman who had refuted other anti-smoking messages as ineffective, reported being deeply affected by an encounter with an emphysema patient in hospital. She recalled a strong, compassionate response to seeing the severely disabled emphysema patient smoking from a hole in his throat; ‘...he was actually smoking from his trachea...I thought to myself, “Oh you poor wee thing, ...you’re desperate for a fag and you’re still desperate even when you’re like that”’. She then reflected on her initial response and, consistent with her previously expressed beliefs in relation to the individual’s right to choose, she responded cognitively; ‘...I just thought to myself, by the same token, well you know, why you should he stop smoking?...he still chooses to do that. I thought, who am I to turn around and say look, take a good look at yourself? Whether I smoke or not’.

5.3.4.2 Cognitive response to non-death threats

Cognitive response to non-death threats was varied. The most dominant cognitive themes emerged in relation to disablement. Disablement from emphysema was the non-death threat chosen by Henley (1997) as an appropriately severe non-death threat to compare with death threats.

Men’s reactions to the threat of disablement fell into two main types of response: belief that disablement was worse than death and denial that threats about the disease were relevant to them. Disablement was considered worse than early death; ‘Disablement would be worse. Because you know you’re going to live and you’re going to have it...’; ‘so maybe you die when you’re...60 but you don’t have to be so careful...in old age you’ve got to worry about your bones breaking. If you have a little fall you’d be horrendously disabled’. The threat of disablement from disease was powerful; ‘I work in a hospital I see all sorts of people with emphysema. They always ask, “Do you smoke?”...they say not to. That gets me more than anything I see on TV. I’d hate to be like that. They can’t even get out of their wheelchairs or walk up the hall’.

Some men recalled a picture of a man in advanced stages of disablement from a smoking-related disease. They believed the picture was stronger than an
advertisement; ‘it doesn’t relate until you actually see the person’; ‘What had the most impact on me wasn’t an advert it was just a picture in the paper. I think he was about 40 years old, he looked like he was quite healthy until a couple of years ago and he developed cancer and he ended up looking like a Belsen victim. The memory has faded now, but at the time it had a great impact’; ‘Yes! ...the fact that he had deteriorated so badly in such a short time’.

Interestingly, some men believed emphysema was an ‘old person’s disease’ and therefore too remote to be of concern to them; ‘I don’t like the thought of being a burden on my family, but emphysema is still a long-term disease. It kills old people’; ‘It’s an old person’s disease. A lady up the street has it and she’d be 85+’; ‘The ads on TV about emphysema don’t affect me, that’s long term and always happens old people’; ‘it’s always old people that you see in hospital with emphysema’. Others dismissed threats they could not relate to; ‘I think what it really boils down to is I think you think that I’ll never get it’ and ‘That’s right... you’ve got to really have something that relates to what you’re going through at the time’.

Non-death threats that were relevant due to symptoms appearing had more impact; ‘... the emphysema ad, I could relate to because...I thought yes that’s what I’ve got... it was actually the same as I was feeling at the same time’; ‘I could relate to that (ad) ‘cause when it was happening...I thought yes, that’s what I’ve got...’

However, one man who initially had a fear response to the same threat, quickly eliminated fear by rationalising that he felt well; ‘The artery ad....It sort of made me, oh god.... I suppose my arteries would be full of that stuff...I thought about it but I actually feel ok physically so I didn’t worry about it after that’.

One man casually acknowledged a mild concern that disablement from smoking or other causes could lead to burdening family members; ‘I suppose the only way I’ll be around with my kids when I’m older and not be a burden to my kids is to give up smoking. And then make sure I don’t die of AIDS or fall out of a tree or cut my arm off from a chainsaw...’
Although ‘Aorta’ and ‘Sponge’ were non-death threat appeals, they were interpreted as messages about dying early by one woman; ‘I remember it was at the time that they really hit us hard with those sponges and heart ads. Hubby and I had a bit of a chat and I said, well, I’ll stop if you stop, and he said, all right, I’ll stop if you stop. I think it was possibly the thought of dying early as opposed to living longer and seeing your kids grow up. Because my husband’s Italian and very family orientated and living long lives is all part of the plan’.

Women responded positively towards a non-death campaign ‘Only Dags Smoke Fags’ that targeted children or young smokers. One woman believed this ad contributed to her children’s anti-smoking attitudes; ‘the one about ‘Only Dags Smoke Fags’, it’s turning around, it is turning around’.

‘Pretty Face’ was another non-death threat vividly recalled by both genders as an ad that made them think deeply about their smoking behaviour; ‘...the pretty face of that woman wrinkling... bothered me and made me really think about giving up’(M); ‘She grows I saw that and I thought oh, my God’; ‘My niece told me that was me, she says you know you used to be so pretty and look at you now’(F); ‘I can’t even watch the gory ads, but when you see this beautiful woman and then she ends up looking like that, that made me very aware’(F).

5.3.4.3  Cognitive response to anti-smoking messages on cigarette packets

Men and women expressed similar responses in relation to specific threats on cigarette boxes. Most comments were negative and generally dismissed these messages them as weak or irrelevant; ‘like the one...‘Smoking causes heart disease’ on the top. Like as if that was going to stop anyone!’(F); ‘Oh yeah cigarette boxes, the ones that say you might get pregnant or something....When I get pregnant I’ll let you know’(M); or humorous; At my local newsagent... there might be a queue of us. And the first person says, “give me a packet that says “‘Smoking Kills’, it’s my favourite”. The next person says, “Oh, have you got any that says ‘Smoking harms your unborn baby?” ’; ‘... it’s a joke...the health
warnings on the cigarette packets... you can buy funny little stickers to put on them’.

5.3.4.4 Behavioural response to non-death

Participants were asked if they could recall any specific messages that had led to a change in their smoking behaviour. Various ads or encounters had instigated quitting attempts. A television advertisement ‘2000 Toxins’ had instigated a change in behaviour, but not quitting. The ad motivated some people to change from smoking tailor-made cigarettes to ‘rollies’, because they believed roll your own tobacco contained less toxins; ‘I switched to rollies...I feel better about that’. ‘That actually had more effect on me, finding out about those chemicals...I went back to the rollies for a while’.

An emphysema ad was particularly relevant to one man who was suffering from the early symptoms of emphysema when he saw it; ‘So that’s why I cut them down...I could relate to that (ad) ‘cause when it was happening... I thought yes, that’s what I’ve got...’

An anti-smoking booklet, which contained graphic pictures of people who had been disabled from smoking related-disease, was inspirational for one woman. She commented that she ‘drags’ it out to read whenever she needed inspiration to give up smoking; ‘... it’s got all these stories of ex-smokers and one of them that always gets to me is this woman who because of the lack of circulation she’d lost limbs, and in the end she was a double amputee and still smoked and I think I don’t want to be like that. So that was quite a strong deterrent’.

Seeing an emphysema patient smoking a cigarette from a hole in his throat, shocked a woman into giving up for 12 months; ‘because at that stage in my life I was a very physically active person...I worried about not being able to do those things any more... the fear actually made me think about it. Yeah it was the fag hanging out of his throat like that it was pretty yuk’.
5.3.5 Response to Information-Only Messages

A strong cognitive response from the women was their reaction to information about the amount of toxins in each cigarette, recorded on the side of cigarette packets. When asked if they felt this information was more relevant to them than other ads they replied positively; 'I felt it was...Yeah' 'That was actually more effective for me, finding out about all these chemicals'; 'I bet when they first brought them out you went, gawd that’s terrible...'; 'Yeah just listening to them say the amount of poisons in it...especially because you think that Australia has one of the worst heart rates etc'; 'I think that on there is good, really'.

Interestingly, the information regarding the amount of poisons contained in a cigarette does not contain an overt threat, and this ad was the only ad containing potentially negative information in relation to their smoking behaviour that the women responded positively to. One of the significant findings in Henley's (1997) study was that women in the older age group of 40 to 50 year olds, recorded a greater response to the information-only control messages than to any of the threats.

5.3.6 Reasons for Resuming Smoking

Despite some death and non-death messages instigating cessation attempts, these participants resumed their smoking behaviour in time, and as such, made them eligible for selection for these focus groups. The woman and her husband who had quit after being motivated by 'Aorta' and 'Sponge' resumed smoking after 6 months. The reason they resumed smoking was to maintain harmony in the home; '...the tension was just so tight between us that if we hadn’t started smoking again we would have ended divorced. We had shocking arguments, the kids were upset and on edge. It just wasn’t right, so we went back to smoking. We are still together 25 years later'.

The man who abstained for 6 years after seeing 'Cats in the Cradle', said that, although he had intended to terminate the behaviour he had never completely
made the choice; 'I thought that I'd never have another cigarette...but it was always in the back of my mind...'. He resumed smoking after a divorce when he no longer lived with his children; 'Then I got divorced and the kids moved away and things were pretty hard. Then one day ...that was it...30 straight up...I couldn't believe that I was totally addicted again'.

The woman who was motivated to give up because of the effect of the threat of her death on her children resumed smoking after a day; 'I was hypnotised and it actually worked. But the next day... I don't know what happened, I woke up and I got into it again. That was years ago...I'm still smoking and still here'.

The woman who said she 'drags' out a booklet of pictures of people who had limbs amputated due to smoking related disease to gain inspiration to give up, succumbed to her addiction; 'But after a while, like because the addiction is so powerful, I think I don't really want to do this any more, you know this is just too hard. So I sort of move that message aside and kick myself, I'll just have a few, and then I'm back on them again'.

A stay in hospital had been motivation for one woman to give up for one week; 'I figured whilst I was in there...there would be no temptation...but then I came home and hated every day (without them)'.

Fear of social disapproval and loneliness persuaded another woman to resume smoking; 'I got to be annoying to my friends...really pathetic...like "why are you smoking in my house?" I lost a lot of friends from not smoking, and then I started to think to myself that's stupid. "Do what you want, you can't lose all your friends and be miserable." '

5.3.7 Conclusion

In this section, the emotional, cognitive and behavioural responses to death and non-death threats, and to information only advertisements have been discussed as
well as the types of death threats mentioned, and the effect of death on loved ones. Denial of death anxiety and reasons for resuming smoking were also discussed.

In the next section, participants' perceptions to the source of the message are presented.

5.4 Differences in Perception to the Source of the Message

The source of the message has been identified as having a strong impact on message acceptance by the target audience (Solomon, 1999). Participants in this study were instructed that 'source' referred to the sender of a message. They were asked to express their perceptions of sources of anti-smoking messages to gain insights into whether perceptions of the source affected their acceptance of the message.

Participants identified three main sources of anti-smoking messages throughout the discussions. They were:

1) government sources who were generally perceived to be senders of anti-smoking messages;

2) specific Quit! WA Sponsorships that were perceived to be senders of anti-smoking messages; and

3) medical sources.

Although not identified as such by participants, a fourth source was identified during data analysis when it became evident that some parents had acted as sources of anti-smoking messages to their children.

Source credibility occurs in relation to trustworthiness and expertise. Miller and Hewgill (1965) found that, when the source is presenting a threatening message,
source credibility is an important factor in message acceptance and attitude change. They indicated that when a source with high credibility delivers a fear-arousing message, the most effective way for a receiver to resolve the cognitive imbalance that occurs is to accept the message. However, if the source delivering the fear-arousing message is perceived to have low credibility, the receiver may discredit the source by emphasising negative attributes to resolve the cognitive imbalance and reject the message (Miller and Hewgill, 1965). This section has been organised according to the specific sources mentioned and themes that emerged in relation to participants’ perceptions of those sources. Gender differences occurred in relation to specific sources and are discussed where appropriate.

5.4.1 Perceptions Towards Government Sources

Government sources were perceived by both men and women to possess low credibility as senders of anti-smoking messages. Some gender responses have been grouped together in this section due to their similarity, but gender is identified by M (male) and F (female). Gender differences are also discussed. Various negative perceptions were expressed in relation to low credibility and the government's ‘dubious’ intentions in sending anti-smoking messages. The government’s credibility as a source was doubted by both genders as participants revealed their perceptions that the government was a greedy beneficiary of high tobacco taxes; 'the government don't want you to give up smoking. Where would all the taxes go?'(F); '...they don't want people to give up smoking. Too much of our taxes will be lost'(F); 'while the cigarette companies keep putting out their smokes they can just keep putting up the taxes. They're making big dollars for the government, so they can't be serious. There's just much too much revenue' (M) and 'the thing with the government here is that they're not doing anything serious. There's too much money coming in for them' (M).

Tobacco taxes were perceived to be so important to the economy that some men and women could not conceive of the government’s authenticity as a source.
‘...it’s like a double edged sword, I mean on the one hand they have to put out the education programs, but on the other, if we all stopped smoking there would be this economy problem’ (F) and ‘There was an article a few years ago where they said that smokers were paying such an enormous amount [in taxes] they could never [let them] stop smoking...because the revenue would have to come from other places...Even now we are finding that the money’s not there as much because people have stopped smoking. It has really reduced it down’ (M).

In the men’s groups the government’s trustworthiness was questioned in relation to handling and distribution of tobacco taxes; ‘they get heaps of money from the [smoking] revenue...but it’s not as though we are seeing more hospital beds...’; ‘why isn’t it being generated back into the health system?’; ‘...the same people [government sources] are the ones who hold the purse strings on the hospitals, and there are people waiting for elective surgery. But they are told, not tomorrow, not tomorrow’.

The men also expressed doubt over the government’s credibility because of the perceived lack of assistance for smokers who needed to overcome severe addictions. There was also an underlying suspicious resentment that the government could facilitate a ‘quick fix cure’ for nicotine addiction ‘if they really wanted to’; ‘There must be some way the government...can come up with some sort of tablet that dulls this part of the brain so at least you don’t get the high of it for a while’. The men’s desire for a quick and simple cure ‘like a needle or a pill’ revealed low self efficacy and a sense of helplessness over their addiction.

A woman asserted that the government used anti-smoking messages as a political stunt and questioned their ulterior motives; ‘Well I always wonder what the ulterior motive is here...All they want to do is to be seen to be doing something’; ‘it’s just really a political thing. They have to react to the pressures of society’.

Gender differences occurred around credibility issues. Men were more negative and disparaging about the government’s lack of credibility as a source. Some men
felt victimised by the government; 'they’re not doing it to save us... they’ve got smokers to push around and now they’re on a roll. They won’t give up'; 'the government is going around saying that some of its citizens are less than other citizens. If it was a black person, a Chinese person or some person of obvious racial difference and they said the same things about these people as they do about smokers, you’d have a chance to take them to court for vilification, for implying that they are worse in some way...'.

Some men asserted that neglect to provide practical or clinical support to overcome their addiction was an indication of the government’s lack of ‘seriousness’ about anti-smoking campaigns; ‘there are no viable stop smoking programs available; ‘I feel all the money they are putting into those ads is useless because they still won’t come up with a program that helps you stop’. (At the same time, Quit smoking programs were considered ineffective and are discussed in the following section.)

Men perceived that as the government provided no financial relief or incentive for smokers to reduce high costs associated with buying anti-smoking aids, they lacked trustworthiness; ‘They really are not serious about what they’re doing. If they really wanted to get serious with smoking Nicotine patches would be free’; ‘if they were really serious, they would subsidise Nicotine patches or hypnotism or whatever, whatever fixes you or me or whatever'; ‘I’m spending $60 to $80 a week on cigarettes...then it’ll cost the same amount to buy Nicorettes...both together is too much’; ‘the government won’t pitch in to give you a hand...you’re on your own and that really sucks’.

There was acknowledgment that some financial concessions had been offered by the government but these concessions were not enough to make a difference, ‘the only thing they’ve made easier ...is that you don’t have to do go to the doctor to get the patches any more...but you still have to pay the chemist’s fees’.
Some men's expressions of their low perceived self efficacy, indicated they believed themselves incapable of taking total responsibility for their addiction and they asserted that the government, 'should' provide both support and financial relief; 'It's not that easy to give up'; 'Why don't they come up with a total package, for giving up smoking? I mean they give you little bits, but there's no total package as such to help you totally give up. For me to give up smoking I would find it very difficult, I'd need a lot more than nicotine patches...for me to give up I would probably need everything as well as willpower, and that'd cost a fortune to even be serious about it. But we look at the ads, and there's no real total package to say you can try hypnosis, you can try this, you can try that. If you add up all the things you can try, you're talking quite a substantial amount of money'.

Interestingly, it was reported in the West Australia Newspaper ("Government", 2001) that the government had recently subsidised an anti-smoking aide, Zylon. This medication is self-administered by swallowing a pill, and it is believed to reduce the craving for nicotine in a smoker attempting to cease smoking. The medication, which had previously cost over $200 per month to purchase, was now priced at $22 per month. However, this development occurred after the focus groups were held.

The government's expertise as a source was a credibility issue under fire in the men's groups. Disparaging comments were made revealing a general intolerance for government directed anti-smoking messages; 'They are hypocrites'; 'Most of them are reformed smokers'; 'They are ex-smokers who want everybody else to stop because they have'; 'Keireth for instance was a big smoker...but he jumped up and down because his kids were injured in some way from smoking. Now he's a mad non-smoker' and 'I'm sure none of them have haloes, probably half of them go home and have a smoke themselves'.

Some men felt that cigarette smoking was an issue blown out of proportion by officials who frequently made misleading statements regarding problematic
situations concerning the environment; 'there are more carcinogens in unleaded petrol...yet have they stopped cars?'.

A positive comment regarding the genuineness of campaigns was made by a male who had experienced the death of a loved one from smoking-related illness, 'I believe their motive is genuine. I think the ultimate aim is for the betterment of everybody'.

In general, the women were relatively positive regarding the government's anti-smoking initiatives, especially campaigns that target youth. However, they expressed strong, negative attitudes in relation to the government's authoritarian and patriarchal interference with their own smoking behaviour. Some women were resentful that the government was telling them 'what to do'; '... to try and take smoking out of hotels and public bars, really, who do they think they are?'; 'It's not so much sending the message to not smoke or whatever, it's dictating to me not to have a smoke, especially in open public places'; 'it's like being treated like a child...I don't like that'; 'They should get off our backs, let us do what we want and leave us alone' and 'they think they are God...Hitler, trying to dictate'; 'they should mind their own business'.

5.4.2 Perception of Quit! WA Campaigns

Both genders expressed negative comments about events chosen to receive Western Australian Quit! WA Sponsorships. Sponsorship for events such as horseracing were perceived as incongruous and hypocritical; 'the government's pushing in so many ways, but it doesn't make much sense...they stop cigarette advertising, but they are pushing racing... they sponsor the Quit Cup!'; 'The Quit Cup...you can gamble all your money away but you can't smoke there'. Sponsorship of the Claremont Speedway was also criticised;

'What about places like the speedway?...They're sponsored by the Quit Campaign'.

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‘That’s stupid’

‘What about all those toxic…hi-octane fumes coming off those cars?’

‘Wheels flying off killing people… but don’t you smoke!’

Others criticised Quit! Campaigns for sponsoring racing car drivers who they perceived as untrustworthy characters; ‘You get a bit cynical about it when you see that most of the big racing teams, have the big trucks with ‘Quit’ campaigns on the sides of them…they belong to just about all of the major drug dealers in the city. It makes you take it with a grain of salt’; ‘Yeah, how do you think they’re going to pay for those big racing cars…?’

Quit! Sponsorships were readily accepted when children’s sporting teams benefited; ‘I disagree with the football…because that’s adults playing. But some of the kid’s teams are sponsored by the Quit campaign, so I can understand why they won’t let people smoke there when they’ve been sponsored by them’.

5.4.3 Perception Towards Medical Sources

Anecdotes were offered to illustrate how some participants had ascribed medical sources with higher credibility. However each medical source was discredited. The women who reported that the only time she had made an attempt (albeit brief) to give up smoking was after her doctor said, “Your kids are little and who’s going to look after them?”. She followed this by saying, ‘I think my doctor has the little man’s syndrome’.

A man said he cut down after his doctor said; “You’re fine now, but need to cut down, or it’ll kill you”’. However, this remark was closely followed by comments generally discrediting doctors who were thought to make routine threats about smoking;
'But it doesn't matter what is wrong with you they always say to cut down your smoking'

'They all say you smoke too much'

My doctor, no matter what I go in for he says, "Oh you've been smoking you should cut down".

5.4.4  Parents as a Source of Anti-Smoking Messages to Their Children

During the data analysis it became evident that some parents had acted as sources of anti-smoking messages for their children and had tried financial incentives to dissuade children from taking up smoking. Some parents had attempted to bribe their children; 'I paid him $500.00 once to give up smoking'. A father recalled surprise that his son had started smoking after he had offered him money not to smoke; 'I said to him don't smoke. Whatever you do, don't smoke. He said oh no, there's no way I'm going to smoke and then he got to about 14 years old and there he was smoking. And I said, what happened? You said you weren't going to smoke? I was going to give you a hundred dollars if you could say you weren't smoking'.

Some parents attempted to stop their children from smoking by coercive measures; 'I fined them $100 for smoking'; 'I started smoking their cigarettes, trying to make them pay in an attempt to try to find some leverage over them. I made them feel guilty. I made a little deal with them; I told them that when I die of lung cancer it'll be their fault'; 'I said to the boys, start smoking, you get no pocket money, I'm not giving you money to smoke. You don't waste your money on that, you get your pocket money to do the things you want to do but if you're going to smoke or drink with it, I'm not paying for your smokes or your drinks'.

Other parents warned and pleaded with their children not to smoke; 'But I preach to my kids, don't ever take it up, it costs too much money or look what's it's done
to my face, I've got nicotine stains on my fingers. I give them the whole book. I do... you can't breathe, you've got to use a puffer, you can't get up the stairs, I let them know the whole bit'.

The effectiveness of these parental anti-smoking messages was mixed. Some were successful; 'So now they don't smoke' and others had no effect: 'There was no effect whatsoever'. Interestingly, these coercions reflected the parents' beliefs that rising financial costs were the most likely 'costs' to instigate quitting their own smoking habit. Further comments with regards to costs are detailed in the following section.

5.4.5 Conclusion

In this section, gender differences were discussed with a focus on perception of the source of anti-smoking messages. Participants' perceptions of three main sources were discussed: government sources, Quit! WA Sponsorships and medical sources. There was also discussion in relation to the fourth source being parents, which had been identified during the data analysis,

In the next section, how participants rate the costs and benefits of smoking is discussed.

5.5 COSTS AND BENEFITS

An objective of this study was to explore how male and female smokers within the 40-50 year old age group articulate the costs and benefits of smoking. Harris and Harris (1996) predicted that the decision to end the smoking addiction occurs when the costs of smoking exceed the benefits. They identified two main costs attributed to stopping smoking:

1) the immediate and direct financial expense of buying cigarettes; and
2) the delayed and indirect cost which relates to the notion that smoking is likely to lead to an earlier death.

A well documented benefit that smokers expect to gain from smoking is reduction of stress and anxiety (Frith, 1970; Speilberger, Gorsuch et al., 1983). Harris and Harris (1996) identified another three main benefits that smokers expect to get from smoking cigarettes:

1) physical stimulation from nicotine;

2) the positive social aspect of smoking; and

3) avoidance of unpleasant symptoms of withdrawal after long term smoking behaviour.

In this study, financial costs were clearly seen as a strong contributing factor in determining current and future consumption. However, the perceived benefits of smoking far outweighed the costs. In this section, participants' comments regarding costs and benefits of smoking are organised according to the following themes and gender differences are noted:

Costs:

- Impact of rising financial costs of cigarettes on consumption

Benefits:

- Smoking as self-medication for stress

- Avoidance of unpleasant withdrawal symptoms

- Physical stimulation from nicotine

- Smoking as a utilitarian benefit (ie: pleasure, reward)
• The social benefits of smoking

5.5.1 Impact of Rising Financial Costs of Cigarettes on Consumption

The direct financial expense of buying cigarettes clearly emerged as a dominant negative cost associated with smoking. Various participants spontaneously declared that the only negative cost factor that would lead to them quitting would be when higher taxes made cigarettes too expensive to afford; 'The only thing that's made me give it up, or think about giving it up is the cost'; '...cost is the main thing for me'; 'Just the cost'; 'The cost would be the only thing that would stop me, only, nothing else'.

Another woman had recalled giving up because she was broke; 'I ran out of money and I was pretty broke for 3 weeks. The pride got the better of me and I did not want to ask for a smoke. I gave up slowly and I quit for a long time'.

These comments are congruent with current findings in cigarette consumption studies. Price elasticity began to significantly contribute to a fall in cigarette consumption in Australia after, 1982 when State and Federal tobacco taxes increased rapidly (Bardsley and Olekalns, 1999). Other studies have found that price increases decreased the prevalence of smoking and the number of cigarettes smoked by younger and older smokers (USDHHS, 1994).

In a recent study, Bardsley and Olekalns (1999) aggregated data from anti-smoking policies and cigarette consumption in Australia from 1962 to 1996 against an analytical framework of Becker and Murphy's (1988 cited in Bardsley and Olekalns, 1999) rational addiction model. Bardsley and Olekalns (1999) found that price increases (from higher taxes) have had the highest impact on falling consumption rates in Australia, higher than advertising bans, health warnings on cigarette packs, 'Quit' anti-smoking initiatives and workplace smoking bans. Bardsley and Olekalns (1999) suggested that cigarette taxes must continue to rise in line with income growth in Australia to continue to have a similar prohibitive impact as the population ages.
5.5.2 Smoking as Self-Medication for Stress

The reduction of stress as a consequence of smoking was seen as a benefit. Some participants considered the ill effects of stress to be worse than smoking and described smoking as a way to reduce stress in their lives; 'I know what stress can do to you physically. I've witnessed it and had health problems due to stress...Cigarette smoking to me, helps me with the stress. So I think if it's going to calm me down a little bit, I would be stupid to give up and deal with more stress...' and '...I know from personal experience that stress is worse than cigarettes...they help me with calming down'.

5.5.2.1 Cigarettes administered as medication for stress

A particularly interesting comment regarding cigarettes as medication for stress, was expressed by one man whose wife administered cigarettes according to the potential stress in his day; '...when I go to a stressful job the wife puts an extra couple of smokes in the packet cause it's going to be a stressful day. If the she knows the job is not as stressful I get a couple of smokes taken out...'. Other comments indicated smoking was used to reduce stress;'My smoke at the end of the day is good for me because it helps me wind down and I'm better with the kids and all that' and 'I've got a stressful job...with a cigarette I can just sit back there and just ponder about the day...'.

5.5.3 Avoidance of Unpleasant Withdrawal Symptoms

Women's comments revealed their strong attachment to cigarettes which increased if they attempted to withdraw; 'Someone actually recommended that I start smoking again because I was just so stressed and I mean I cry, I just can't cope' and '...So for six months we stopped. But the tension was just so tight between us that if we hadn't started smoking again we would have ended divorced'.

Women described how intense negative emotions occurred when they attempted to withdraw. They resumed smoking to resolve these unpleasant emotions. A
woman described resuming smoking after a week because she was ‘miserable’ without her cigarettes; ‘For the week I just hated every day, hated every day, I did. My husband doesn’t smoke and he said, “Do you want me to go and buy you a packet?” I said, “why didn’t you ask me two weeks ago?”...’Cause I usually buy a carton a week and I smoke myself into oblivion’.

Another woman described a frenzy of emotions when symptoms of withdrawal occurred as a result of running out of cigarettes; ‘I’ve run out of cigarettes and my husband’s come around the corner with them and I’m yelling at him – “You’d better have my bloody shitting cigarettes.” I’d be bloody f-ing and shitting and c-ing until I get my cigarettes, that’s what I’m like’.

Another woman preferred to smoke rather than experience painful emotions that emerged during withdrawal; ‘...when I do give up I have to deal with all this emotional stuff that comes up...I get very teary, so smoking actually keeps me together...it’s like a smoke screen which keeps your emotions down’. She expressed grief in relation to giving up; ‘when I give up it’s like I lost my best friend. I know cigarettes have been my best friend for all these years, and when I give up I don’t have this best friend any more...so I smoke...that’s what I have to go through’.

5.5.4 Physical Stimulation from Smoking

Some men’s comments revealed that they linked smoking with alleviating symptoms of depression. A man who revealed he had experienced desperate, suicidal times in his life, described smoking as an aid for depression; ‘there have been times in my life where I’ve been pretty depressed and you know a fag certainly helped me along...I might be smoking but I’m still here you know...sometimes these addictions carry us through some rough times’. Another man explained how smoking acted as self-medication to avoid depression; ‘...in a strange sort of way it’s a sort of self-medication...You just feel so desperately bad about how you feel that a smoke is like something good you can do for yourself’.
Some men smoked cigarettes to modify negative emotions; 'You know if you’re really upset and you go and have a cigarette and you calm back down...'.

A major benefit of smoking for some women was the sense of elation they derived from smoking; 'I enjoy it, it makes me feel good' and 'I think it’s just something that I enjoy, I mean there is not a lot of things in life that you actually enjoy is there?...Jobs, raising kids, that’s hard. But this is actually something I enjoy, there’s times when you really enjoy one and that’s the best time'.

5.5.5 Smoking as a Utilitarian Benefit

Smoking provided a variety of functional benefits to participants. Women tended to express smoking in terms of enjoyment and described it as an important and rewarding personal ritual linked to self-concept; 'I just love smoking, I think as a main thing, it’s something that I do on my own with me for me...I do everything else for the kids and I work' and '...at night time when my kids go to bed it’s just me, I go out and have a quick fag and I enjoy it, I think it’s a me thing, it’s mine and no one’s going to take it away'.

Personal rituals associated with smoking were particularly pleasurable for some women; 'I look forward to my cigarette in the morning and on a weekend. If I have a sleep-in or something, I wake up and think oh, just in cigarette time, and then of an evening, it’s just like first thing I do is walk in the door, grab a cup of tea and go into the back and have a cigarette. I look forward to that time, I don’t know whether it’s a quiet time or a thinking time or an unwinding time'.

Men tended to describe the benefits of smoking in terms of comfort; 'It’s a comforting sort of thing' and 'I still get comfort out of it, I’d find it very hard to give up'. Some described it in terms of completion; 'Straight after a meal, there’s nothing better. You can sit back and relax and have a smoke'; '...sitting down and having a coffee and a smoke after a meal...it just feels good then'; 'A smoke after sex is good'; 'it’s a completing thing...‘there’s nothing better than after good sex'; 'I must admit, after sex, it’s great'.
Men also considered that they benefited from the calmyative effect of cigarettes; ‘Well it calms me, I’m a pretty calm person anyway but it calms me even further’. Some said they benefited from the relaxing effect of cigarettes; ‘I enjoy the relaxation. I sit down and have a cigarette...I smoke rollies, so relaxation is part of the action of rolling, it’s part of the build-up to actually having it...I work night shift...and yeah, I look forward to it’.

One man felt he could solve problems whilst smoking; ‘When I’ve got a problem it’s easier to work it out with a couple of smokes than to stand there just thinking. You know when you have a smoke it seems to lift you a bit and you can work your way through it...’

5.5.6  The Social Aspect of Smoking

Smoking functioned as an important social benefit for women. They treasured the sense of belongingness associated with fitting into sub-groups of smokers at work, made egalitarian by members’ common smoking behaviour; ‘It’s like a membership to a club. Because you have to find that place, and when you get in there it doesn’t matter who you are, you’re all the same’; ‘Well I work in a hospital and we’ve got one little section you’re allowed to smoke in.... We’re all puffing and chatting away...you can be a doctor, as long as you smoke, you’re in. I think we all look ridiculous but it’s social’ and ‘I help out in the school canteen on a Wednesday. You should see all the teachers who come around and have a smoke. And they say, oh, you smoke too, you become a social life on your own, it’s great’; ‘You could be a rocket scientist or a cleaner...normally you’re not going to talk to each other but when you’re sitting there in a little smoker’s space, it’s a social life’.

A lively discussion among some women revealed appreciation for how smoking functioned to break down social barriers in unfamiliar settings;

‘It’s true isn’t it? You’re a smoker, you’re standing outside and other smokers always talk to you, “How you going, you’re a smoker”. But
you get four people sitting in a waiting room and they won’t talk. Put them outside for a smoke and off they go’

‘It’s true. About 4 weeks ago I had to take one of my friends to the Swan Districts Emergency and I was talking to people who were outside smoking, but when I went back inside they wouldn’t say a word. But sitting outside we were chatting. And no one else would speak to me inside…..’

‘Exactly. I took my neighbour to the Swan Districts Hospital and she was having a panic attack and we went out there for a cigarette and there were two guys and a lady and we were chatting away’

‘You go inside and no-one speaks to you’.

5.5.7 Conclusion

Given that costs need to outweigh perceived benefits for people to quit smoking (Harris & Harris, 1996), it is not surprising that these participants still smoke – as they perceive the benefits of smoking to clearly outweigh the costs.

In this section, the data analysis was discussed in terms of how the men’s and women’s attitudes to anti-smoking messages and specifically to death and non-death threats, the source of the message and their comments in relation to the costs and benefits of smoking. Gender differences in response were discussed.

In the following section, the data analysis is discussed in relation to the literature covered in Chapter 2 and to further literature searches, possible explanations for the responses are presented.
Chapter 6: DISCUSSION

The following chapter further examines the major findings discussed in Chapter 5 and their relationship to the primary objectives of this research, which were to explore:

- 40-50 year old smokers’ attitudes to anti-smoking messages, via their emotional, cognitive and behavioural responses;

- whether there were any differences in the ways male and female smokers in the 40 to 50 year old age group articulated their thoughts and feelings in response to anti-smoking messages;

- whether there were any differences in 40 to 50 year old male and female smokers’ attitudes to death and non-death threats in anti-smoking messages;

- whether there were any differences in how male and female smokers in the 40 to 50 year old age group perceived the source of the message; and

- how 40 to 50 year old male and female smokers articulated the costs and benefits of smoking.

The main finding of this study was that gender differences occurred in relation to the first four objectives. These gender differences primarily emerged in relation to the men’s and women’s levels of perceived self efficacy; how they coped with their response to negatively framed threats in anti-smoking messages; to specific
death and non-death threat messages; and to the source of the message. An unexpected finding of this study was that positively framed messages engendered more positive attitudes and greater message acceptance in both genders.

These main findings and their relationship to the major objectives of this research will be discussed in this chapter. References are made to the literature reviewed in Chapter 2 and to further literature searches undertaken in relevant areas. Possible explanations are offered for the findings and then the limitations of this study are discussed. Implications for social marketing researchers and health promotion practitioners are then presented. Suggestions are made for further research.

6.1 Gender Differences in Response to Threats in Anti-Smoking Messages

Both men and women in this study held negative attitudes towards anti-smoking messages that attempted to arouse fear. They widely rejected and avoided these messages. Typically, defensive avoidance limits the impact of a fear appeal when the threat is perceived to be excessive; it may also be linked to a negative attitude toward the ad itself (Ray and Wilkie, 1970b). As previously noted, this is not surprising considering that participants were chosen because of their current smoking behaviour. However, a significant finding from this study was the distinctly different ways in which the men and women responded to the anti-smoking messages under discussion. When participants articulated their response to threats in anti-smoking messages, clear gender differences emerged in self esteem, perceived self efficacy and the different coping strategies employed to deal with negative emotions. Men tended to express low self esteem, anxiety and shame, low self efficacy and symptoms of depression such as feelings of powerlessness and helplessness over their smoking addiction. Women tended to express higher self efficacy but with angry reactant emotions such as resentment.
Discussion in this section focuses primarily on the gender differences in response to threats in anti-smoking messages. In 6.1.1 men's responses such as low self-esteem, anxiety, shame, low self efficacy and symptoms of depression such as powerlessness and helplessness over their smoking addiction are discussed, with reference to the literature review and to further literature searches. Possible explanations are then presented to suggest reasons why these responses occurred. In 6.1.2 women's responses such as higher self-esteem and self efficacy, and angry reactant emotions such as resentment possibly for patriarchal and authoritarian messages are discussed, with reference to the literature and to further literature searches. Possible explanations are then presented to suggest reasons why these responses occurred and suggestions are made for further research.

6.1.1 Men's Responses

Self-esteem has long been considered a moderating component of threatening messages since Kornzweig (1968 cited in Leventhal and Cleary, 1980) identified that subjects may fail to make an appropriate response to fear appeals when they are made to feel overly fearful. Leventhal and Cleary (1980) noted that self-esteem may be related to a sense of helplessness when:

a) the individual is exposed to messages conveying information about their vulnerability to damage; and

b) when the individual believes they are incapable of controlling their urge to smoke.

This appears to be the case with the men in this study.

When too much fear is evoked by an ad, intense feelings occur resulting in dysfunctional anxiety (Higbee, 1969) and maladaptive coping responses, such as those employed to avoid cognitive dissonance (Stuteville, 1970; Job, 1988). Maladaptive coping responses such as anxiety, defiance and defensive avoidance (Janis and Feshbach, 1953; Higbee, 1969; Ray & Wilkie, 1970b; LaTour and Pitts,
1989) are generally accepted by researchers as indicators of lack of message acceptance. They tend to occur in response to fear arousal with high threat/low perceived self efficacy (Witte, 1993; Rogers and Deckner, 1975). Maladaptive coping responses may also lead to an increase in the negative behaviour (Stuteville, 1970). Various researchers have warned that high fear arousal may induce excessive levels of anxiety which may be a threat to the psychological well-being of the receiver (Henthorne, La Tour, & Natarajan, 1993; Hyman & Tansey, 1990).

Clusters of emotionally charged responses from the men in this study, indicated low levels of perceived self efficacy and a belief that giving up smoking was an almost impossible task. Generally, the men indicated that although they were somewhat willing to give up smoking, their willingness was thwarted by feelings of helplessness and powerlessness over their smoking addiction and low confidence in their ability to give up; ‘nicotine is such a nasty drug, it’s impossible to give up’. Researchers have found that previous unsuccessful attempts to give up smoking erode perceived self efficacy (Witte, 1993; Snipes, LaTour and Bliss, 1999). These men generally deemed anti-smoking messages ineffectual. They perceived that anti-smoking messages issued glib directives to stop smoking but simultaneously ignored the insurmountable difficulties they associated with giving up smoking; ‘...it’s not just a matter of willpower’.

The men’s responses resemble Witte’s (1992) extended parallel process model (EPPM) explanation of what happens when an individual feels unable to control danger and instead acts to control fear. For instance, these men appeared to feel unable to control the danger threatened in the negatively framed anti-smoking messages under discussion, because of their low belief in their ability to give up smoking. So they acted instead to control their fear through denial of the threat; ‘No I don’t think it’s true... that smoking causes cancer’ and defensive avoidance; ‘All the negative ads that you see on TV...I just walk out of the room, pissed off’.
Although the fear arousal literature offers explanations as to why maladaptive coping responses occur when threat appeals induce too much fear, these explanations do not explain why the men reacted this way, when the women did not. Therefore, possible explanations were considered for:

a) why the men and women appeared to have significantly different perceived self efficacy to threats in anti-smoking messages; and

b) why men tended to express symptoms of depression and why women expressed symptoms of anger to threats in anti-smoking messages.

In this study, the men appeared to have higher levels of dependence on smoking and lower levels of self-esteem and perceived self efficacy than the women. These emotions appeared to result in symptoms of depression such as powerlessness and sadness. The men’s responses appear to differ from much of the previous research into gender and emotion, and gender and smoking cessation. For instance, men are generally thought to be less emotional and emotionally expressive than women, and have less intense emotional experiences (Brody, 1997; Buntaine & Costenbader, 1997; Kelly & Hutson-Comeaux, 1999; Kring & Gordon, 1998; Robinson & Johnson, 1997).

Some research has shown that individual’s attitudes towards emotionally provocative appeals vary widely (Larsen & Diener, 1987). Larsen and Deiner’s (1987) study indicated that certain individuals who could be classified as having ‘high affect intensity’ were predisposed to respond with significantly greater emotional intensity than others, when exposed to emotion-evoking stimuli. These results were later supported by Moore and Harris’s (1996) findings, which indicated that whilst some individuals were more indifferent than others to “shock” ads (p.46) other individuals experienced anxiety and potential psychological harm, ie: shame, as appears to be the case with the men in these groups.
It is possible that some of the men’s feelings of shame may have reduced their self-esteem. Some fathers expressed feeling humiliated by anti-smoking messages: ‘They make smokers out to be monsters’ or victimised for their smoking behaviour: ‘you become a social outcast’. Feelings such as anxiety, sadness and shame are depression based emotions (Ferguson & Crowley, 1997). Shame tends to refer to a “dejection based emotional state in which the person’s entire sense of self-worth is under attack because of abject failures to present the self in a desirable light” (Ferguson & Crowley, 1997 p.19). Shame also involves criticising the self for failing to live up to the ideals of others (Lewis, 1971). A possible explanation for the men’s sense of shame is that men more than women, may feel that society has higher expectations of them than they can live up to, and the feeling of failure may result in feelings of shame.

Some researchers recognise that when shame is chronically used to organise and interpret experience, it may eventually lead to excessive emotion that indicates an affective style which the person persistently uses to interpret and organise experiences (Malatesta & Wilson, 1988; Zahn-Waxler & Robinson, 1995). Response to feelings of shame may include attempts to avoid the discomfort of further humiliation by withdrawing from further social contact (Lewis, 1971). In this study, participants have withdrawn from anti-smoking messages that may evoke further feelings of shame.

Fagerstrom, Kunze and Schoberberger et al.(1996) collected international data on nicotine dependence and measured it against the “Fagerstrom test of nicotine dependence”. Fagerstrom et al., (1996) found that men consistently scored higher in terms of dependence on smoking than women, as would appear to be the case in the present study. In a further study that attempted to measure the possibility of an association between nicotine dependence and depression, Breslau and Johnson (2000) suggested that “nicotine dependence might drive the association with major depression” (p.1126). However, Breslau and Johnson (2000) also noted that the reverse might be true: that dependence on smoking may be a function of depression.
It may be possible that some of the men in this study were predisposed to general depression. According to Pollack (no date, cited in Boldt, 1997) “Up to 70% of depression in men goes undiagnosed...depressed men act differently than depressed women...Depressed men often deny pain, sadness and don’t cry...”. According to Jolkovski (no date, cited in Boldt, 1997) “Unlike women, guys won’t complain if they are unhappy...Most of them don’t expect their lives to be great. So when problems arise, they think it’s their duty to handle the burden”.

During the discussions in the present study, some men revealed awareness of negative feelings as a result of deeply emotional or difficult periods in their life. For example, ‘I’ve been pretty depressed...’; ‘...sometimes these addictions carry us through some rough times’; ‘...You just feel so desperately bad about how you feel’: ‘I had a son, and he recently committed suicide... that was a tragic thing for me’.

Depression may also account for some of the unusual findings regarding the low-self efficacy and powerlessness in the men in this study. A number of authors have discussed the links with depression and smoking (Boldt, 1997; Breslau & Johnson, 2000; Haukkala, Uutela, Vartiainen, McAlister, & Knekt, 2000; Kinnunen, Doherty, Militello, & Garvey, 1996; Rabois & Haaga, 1997). Depression can lead to increased smoking behaviour (Breslau, 1993). Kinnunen et al. (1996) found that depression and negative feelings about the self can result in low self efficacy or expectations of failure in an attempt to quit smoking. Rabois and Haaga, (1997) found that depressed people may have less efficient coping strategies than others, which makes them vulnerable to relapse after a quitting attempt. Haukkala et al., (2000) suggested that depressed people tend to be more sensitive (than non-depressed people) to evaluations between external and internal control over situations, and depressed people are less likely to quit smoking.

Depression in men has been linked to midlife crises or “male menopause” in men over 40 (Boldt, 1997 p.100), and may trigger decreased sexual performance,
muscle and bone loss. Unlike women who experience hormonal changes in midlife, men do not experience significant hormonal changes (Boldt, 1997). According to Goldberg (1997 cited in Boldt, 1997), male midlife depression is mainly caused by smoking, fatty foods, low levels of exercise and coming to terms with their own mortality "Many men are dealing with their bad habits catching up with them...an affection for smoking, sofas and fatty food" (p.100).

In the present study, the men's low self efficacy and symptoms of depression also resemble findings in a recent study into gender, depression, education and smoking cessation. Haukkala et al. (2000) tested a random sample of Finnish men and women who were between the ages of 25 to 64. The sample consisted of 1,547 men with 34% smokers; and 1,856 women with 21% smokers. Haukkala et al. (2000) found that higher depression scores were linked to lower self efficacy in male smokers, but higher depression scores were indicators of motivation to quit in female smokers. Another interesting finding from Haukkala et al.'s (2000) study was that men who currently smoked were found to be more depressed than former smokers and non-smokers. Women who currently smoked were also found to be more depressed than former smokers. These variations remained similarly significant after age variations and education were tested.

6.1.2 Women’s Responses

Responses from the women in this study indicated higher levels of self-esteem and perceived self efficacy than the men; 'I can give up if I want to'. However, the women were clearly unwilling to contemplate giving up; 'I love smoking'; 'I don't want to give up smoking'. Exposure to unwelcome, threatening anti-smoking messages about their smoking resulted in cognitive dissonance and rationalisations to distance themselves from the threat; 'I see the ads and I think no, that doesn't apply to me really'.

Like the men in this study, the women exhibited maladaptive coping responses to threats in anti-smoking messages, such as denial; 'I don't believe I will die from
'smoking' and defensive avoidance; 'I just block them out'. However the most prevalent maladaptive coping response in the women was angry reactance. According to Solomon (1997, p.349), reactance is "the deep seated need to preserve freedom of choice" and is more likely to occur "when the perceived threat to one's freedom increases and as the threatened behaviour's importance to the consumer increases" (Solomon, 1997, p.349).

There does not appear to be any literature available in terms of fear arousal, anti-smoking advertising and reactance, but studies into consumer products and reactance have found that reactance can occur when a person's freedom is threatened. For instance, attempts to censor films, rock music and television shows may result in the public's increased desire for these products (Solomon, 1997). Furthermore, overbearingly strong commercial promotions that tell consumers they should or should not use a product, may also result in lost customers, regardless of previous brand loyalty (Solomon, 1997).

The women in these groups fervently reacted against threats in anti-smoking messages, which clashed with their internalised beliefs about their 'right to smoke'. The women's freedom and their right to choose to smoke (or choose to give up) emerged as a highly valued component of their attitudes towards anti-smoking messages. They generally declared they would give up smoking only 'if' and 'when' they wanted to, and expressed angry emotions such as defensiveness and indignant resentment at 'being told' to stop smoking.

The literature available on anger and gender is relatively inconsistent. Some studies have found men more likely to be provoked into anger, to have higher levels and more frequent anger than women (Biaggio, 1980; Doyle & Biaggio, 1981). Others studies have found that men and women experience similar levels of anger (Averill, 1982; Buntaine & Costenbader, 1997; Stoner & Spencer, 1987). For instance, in a study that tested traditional research into anger and emotion against socially constituted emotional responses, Averill (1983) stated that "women report becoming as angry as men. as intensely and for much the same
reasons" (p. 1152). Stoner and Spencer (1986) found that there were no age or
gender differences between adult men or women in either intensity of anger, or the
disposition to experience anger. Buntaine (1997) found similar levels of anger in
males and females to ten hypothetical situations, but found that the genders
expressed their anger differently. Girls appeared to have more ability to moderate
their anger according to intent and social cues in various situations, whereas males
were found to be more outwardly expressive of anger.

The angry responses from the women in this study, appear to be different from the
traditional gender emotion stereotypes that were discussed in Chapter 2. For
instance, women are thought to experience more intense emotional experiences
and express more anxiety and sadness than men (Brody, 1997; Buntaine &
Costenbader, 1997; Kelly & Hutson-Comeaux, 1999; Kring & Gordon, 1998;
Robinson & Johnson, 1997). However, these stereotypes have been refuted.
Brody (1997) suggested that the traditional stereotypes concerning gender and
emotional expression may be somewhat misleading, because situational,
individual and cultural differences in males’ and females’ emotional
expressiveness have been ignored. The level of anger expressiveness learned in
family situations has also been found to influence male and female’s expressions
of anger (Kring & Gordon, 1998).

A sense of power may be related to feelings of mastery over certain situations, and
perceived self efficacy can lead to positive emotions about the self (Fujita et al.,
1991; Timmers et al., 1998). For example, if a negative stimulus is perceived to
be caused by external elements that are within the individual’s control, and within
their ability to change, the emotion likely to be experienced is contempt or anger.
These emotional expressions denote power (Frijda, Kuipers and terSchure, 1989;
Roseman, 1984; Manstead and Tetlock, 1989).

Interestingly, the effect on emotion of power/powerlessness control or
vulnerability (Fujita et al., 1991; Timmers et al., 1998) is characterised by
emotions such as sadness or fearfulness. These emotions may be experienced by
an individual who has low perceived self efficacy in relation to a negative stimulus perceived as being out of their control, and as beyond his or her ability to cope (Fujita et al., 1991). This bears a resemblance to the responses from the men in these groups. However, it also begs the question: Why did the women in this study express power and the men powerlessness?

In terms of negative emotions, results have been fairly consistent in relation to gender differences. Women are generally found to have higher levels of negative affect and depression than men (Gove & Tudor, 1973; Nolen-Hoeksema, 1987) and to have higher levels of fear and sadness (Scherer, Wallbott, & Summerfield, 1986), which was not the case in this study. However, some studies have found that cross-gender role characteristics also contribute to a significant effect in the quality of emotions. For instance, Fischer, Shaver and Carnochan (1989) found that stereotypical feminine, communal characteristics (i.e.: fostering harmonious relationships and affiliation) can occur in men, and masculine, agentic characteristics (i.e.: mastery and self-assertion) can occur in women.

Older women were found to be more angry than men in a hypothetical situation when confronted with a male protagonist (Brody and Lovas, 1995). Brody and Lovas (1995) considered gender differences and expressions of anger and fear in response to a three-way, gender typed situational context across three age groups: 6-12 year olds, 14-16 year olds and adults over 30. The fear context consisted of 8 hypothetical situations which figured a male or female protagonist. They found that females across all age groups reported more fear than the men. However, in the anger context, no gender differences occurred in the intensity of anger expressed in the 6-12 year old group; but females in the 14-16 year old group reported more anger than males in relation to male negative situations. In the 30+ group, females reported more anger than males across all situations (Brody and Lovas, 1995). Brody and Lovas (1995) suggested that the anger expressed by the older females in their study may be attributable to changes in the socialisation of women within the context of feminism.
The suggestion that the influence of feminism may be a mediating factor in women’s willingness to express negative responses to authoritarian messages, was also suggested by Henley (1997). Henley (1997) suggested that the strongly negative reactions to authoritative messages of 40 to 50 year old females who are still smoking, may be a function of this particular generation of women, rather than a function of age per se. Research from the late 70’s suggested that there were existing normative rules or socialisation guides which governed feelings, expressions and emotional displays - especially anger in women (Hochschild, 1979). Hochschild (1979) contended that socialisation standards and rules required women to suppress anger more than men due to their lesser power and status.

Henley (1997) suggested that the generation of 40 to 50 year old women in her study had encountered the Women’s Movement in the 70’s and its ensuing effect on societal change. These encounters included promises of increased lifestyle benefits for their generation, which were cleverly echoed in cigarette advertising such as the Virginia Slims cigarettes slogan, ‘You’ve Come a Long Way, Baby’. Henley (1997) suggested that women, who do not perceive that positive lifestyle changes have actualised in their own lives, may smoke as a surrogate symbol of independence. Thus, it is possible that continued smoking behaviour and the refusal to conform to perceived authoritarian impositions in threat messages, may serve to bolster surrogate feelings of independence in these older women.

Henley (1997) suggested that exposure to feminist ideas and a rejection of authoritarian styles may be why the older women in her study did not respond to threat appeals. Similarly, Agronick & Duncan, (1998) explored the personality changes of 33 year old and 43 year old women, in relation to the Women’s Movement in the 1970’s. Agronick and Duncan (1998) reported that one of the effects of the Women’s Movement on women of today, was increased measures of dominance such as self-assurance, confidence, initiative and sense of direction and increased questioning of social norms.
Women in this study responded angrily to threatening anti-smoking messages which they interpreted as paternalistic and authoritarian; e.g. 'it's like being treated like a child'; 'they think they are God, Hitler trying to dictate'. These responses are similar to expressions of righteous feminist anger and moral indignation that have been reported as a common backlash response to the perception of patriarchal authority (Hercus, 1999). In a study into female identity, emotion and collectivist action, Hercus (1999) found that forty percent of females responded angrily to awareness of patriarchal oppression. Hercus (1999) suggested that suppression of anger in women is a possible consequence of emotionally limiting socialisation rules that can lead to emotional deviance. She found that anger was reported as a common emotional response in women as they became increasingly aware of experiencing forms of social control, patriarchal and sexist oppression.

Anger towards the source of injustice is legitimised when the judgement is considered unjust or inequitable (Gamson, 1995; Hercus, 1999). In a review of anti-smoking campaigns, Logan and Longo (1999) suggested that a consumer backlash to anti-smoking initiatives might be a reaction to the inadvertent paternalism contained in anti-smoking messages. They suggested that an emphasis on conceptual campaign strategies might have resulted in neglect of external or social environmental factors that may impact on the audience.

Women in this study appeared to have higher levels of self efficacy than the men, a finding that appears dissimilar to other studies that reported on gender differences and confidence in smoking cessation (USDHHS, 1989; Blake, Klepp & Pechak, 1989; Lando et al., 1991; Ward et al., 1997). A possible explanation for this finding is that in at least one of these studies (Lando et al., 1991), the sample predominantly consisted of smokers who wanted to quit smoking, unlike the present study. For instance, in Lando’s (et al., 1991) study more than 70% of respondents reported that they either definitely or probably wanted to quit. Another study (Ward et al., 1997) found women had much higher rates of relapse after cessation attempts than men, but the women scored much higher than the men when tested for motivation to smoke. In Ward et al.'s (1997) study, the
women and men were not specifically tested for desire to quit as an independent variable, but the women indicated weight control, mood management and stress relief as strong motivators to smoke. Data in this study revealed that the women were generally unwilling to consider giving up smoking at the time of the research due to the numerous benefits they associated with smoking. This far outweighed any threatened negative consequences in the anti-smoking messages.

6.1.3 Conclusions on Gender

Whilst results from this present qualitative study cannot be generalised, it appears that the men in this study had distinctly different affective and cognitive responses to threats in anti-smoking messages than women in their own age cohort. Beck and Frankel (1981) concluded that “particularly strong health threat communications may cause a helplessness reaction in certain individuals by emphasising the danger and failing to emphasise clear ways in which to control the danger, thereby creating the expectation that the threat is beyond personal control” (p.211). It may be that the high expectations our society puts on men leads to an increase in negative feelings of anxiety, guilt and shame, and ultimately depression. The men's negative feelings appeared to be exacerbated by continual exposure to threats in anti-smoking advertising and failure to quit resulting in counterproductive responses such as defensiveness, avoidance behaviour and denial of all anti-smoking messages to reduce cognitive dissonance. These maladaptive responses also appeared to increase the sense of powerlessness over their addiction. Although women would also have experienced negative feelings over failure to quit, it is possible that their anger towards authority protected them against depression and resulted in a strong, defensive self efficacy.

It was widely apparent in this study, that the men and women generally rejected and avoided negatively framed anti-smoking messages. This could be expected from a group of 40 to 50 year people who are still smoking, but an unexpected efficacy/gender interaction emerged in how the men and women articulated their emotional responses, their self efficacy and their coping strategies. As no similar
findings in terms of gender and response to threats in anti-smoking messages appear to exist, further research is suggested to determine if the findings can be replicated in a quantitative study regarding:

- powerlessness, low-self efficacy and low self-esteem in response to high fear-arousing threat appeals in older male smokers; and

- reactance to patriarchal and authoritarian anti-smoking messages, higher self-esteem and self efficacy in older female smokers.

6.2 Older Smokers

Much of the previous discussion gives consideration to the gender differences in self efficacy that were apparent in these findings. Although there is a large body of literature devoted to threat appeals and efficacy, relatively few studies have focused on the variable of age and its relationship to efficacy. A possible explanation for this is that many of the earlier studies into fear and persuasion did not include a wide age range; sample groups usually consisted of school or college students. Consequently, few studies have considered the cumulative effect of threats used in anti-smoking advertising on older smokers. Studies that have focused on older smokers have produced a range of findings.

Burnett and Oliver (1979) found that older subjects (40 to 50 year olds) were more responsive to high threat appeals than their younger subjects (30 to 40 year olds). Quinn, Meenahan and Brannick (1992) reported that younger secondary school students responded to higher levels of fear than older post-graduate students to anti-smoking messages threats. Henley (1997) found a significant difference between younger and older smokers. In her study, younger smokers (16 to 25 year olds) responded more than older smokers (40 to 50 year olds) to all threats. To the researcher’s knowledge no further research exists after Henley’s (1997) study that focused on older smokers and efficacy.
Older smokers appear to be generally overlooked as potential targets of anti-smoking campaigns (White, 1997). Yet, older people represent the fastest growing segment of the population in the western world (White, 1997). Although a lower percentage older people smoke than in most adult age groups, the sheer numbers of older smokers ensures that this group will eventually become a major contributor to health care costs (Orleans, 1997, cited in White, 1997).

One possible reason for not targeting older smokers is the prevailing belief that it is not easy to influence older, long-term smokers. In 1992, 40% of elderly smokers in the United States were not given any advice by their doctors to give up smoking (White, 1997), although it is possible that some older smokers will quit. Age and stage of readiness to change are factors associated with change in smoking behaviour (Kviz et al., 1995). According to Kviz et al., (1995), within the group of smokers who are planning to quit some day, smokers over 50 are more likely to be planning to quit sooner (in the next 3 months) than those under 50. However the reverse may also be true: in 1990, smokers over 50 or more were found to be less likely to have attitudes favourable to quitting than younger smokers (USDHEW, 1990).

Some health care providers such as nurses and general practitioners may have attitudinal barriers such as pessimism and a lack of confidence in the effectiveness of smoking cessation interventions, and older smokers' ability to successfully quit their smoking habit (Cummings, Giovino, Sciandra, Koenigsberg, & Emont, 1987). Interestingly, another contributing factor to these negative attitudes in health care providers, may be their own low perceived self efficacy, that they do not have the ability to assist older smokers, or their perception that they do not have enough time to provide adequate assistance after issuing anti-smoking warnings (Kviz et al., 1999).

A problem likely to contribute to the ineffectiveness of some anti-smoking campaigns and initiatives in older smokers is the existence of a sub-group of "hard-core smokers" characterised by Pierce, Davis, Fiore, et al., (1989 p.61) as
those smokers who are least likely to quit because they a) have never thought about it, b) would not make the choice to quit even if there was an easy method and c) have become discouraged from past failed attempts (Pierce et al., 1989). Hard core smokers are more likely to deny that smoking has harmful consequences and are also likely to have increased cognitive dissonance (Halpern, 1994).

Although the group of smokers who participated in this study were not tested for all of the above characteristics, their discourse suggests that some of these men and women closely resemble Pierce et al’s (1989) hard-core smokers. The transtheoretical model (Prochaska et al., 1994) identified such a group of smokers as “precontemplators” (p.40) who, because they have no intention of quitting in the next 6 months, are least likely to quit. Emery et al., (2000) defined hard-core smokers as a sub-group within a group of “low-probability quitters” (p.387) who are predominantly older (the greater proportion are over 44), highly addicted (smoke more than 15 cigarettes per day), with no recent quitting attempts, and no intention of quitting in the future.

Decreased smoking prevalence over the past 3 decades has been attributed to national tobacco control efforts and an increased intolerance for smoking (Pierce, et al., 1998). Some of the decrease in smoking can be related to lower uptake rates. However, according to recent research (Pierce, et al., 1998), most of the decrease is attributable to more adult smokers quitting, with at least 75% of smokers attempting to quit and at least 70% to 95%, saying they would like to quit (Pierce, Gilpin, Emery, 1998). Bardsley and Olekans (1999) suggested that increased tobacco taxes have been most significant in influencing the reduction of tobacco consumption.

However, Emery et al., (2000) suggested that the decrease in smokers may not be sustainable due to the relatively large group of hard core, precontemplative smokers who never intend to give up. Rather, this number is in the vicinity of 40% of current smokers or possibly more (Emery et al. 2000; Bardsley and
Olekans, 1999). However, Emery et al. (2000) also cautions that the number is currently difficult to define because relatively little research has been undertaken to define hard core smokers. This group may shape future tobacco control activities.

Emery et al. (2000) suggested that this hard-to reach, unique population of hard-core smokers may require specifically designed anti-smoking efforts, and with the right stimuli may be able to quit. Other researchers have suggested that as smoking prevalence rates decline, different and perhaps more intensive types of anti-smoking interventions may be required to reach highly addicted smokers (Bardsley & Olekalns, 1999; Fagerstrom et al., 1996).

Based on the gender and age differences she found in response to death versus non-death threats, Henley (1997) suggested that a market segmentation approach is advisable when using threat appeals. The findings from this study appear to support Henley’s (1997) suggestions as well as those by other researchers who also assert that anti-smoking programs may be more effective if tailored towards gender and age (Morgan, Noll, Orleans, Rimmer, & Bonney, 1996; Orleans et al., 1994; Rimmer, Orleans, & Fleisher, 1994) and to the specific needs in a population of smokers (Scwartz, 1991).

Taking into account the findings in relation to older smokers, there appears to be a significant need for further research that investigates which specifically designed anti-smoking efforts successfully increase perceived efficacy in older smokers’ ability to quit smoking. The basis for this research may lie in Velicer et al’s (1995) findings. In Velicer et al’s (1995) study into low readiness to change and smokers (previously discussed in Chapter 2), the researchers identified 3 subgroups within a group of precontemplators:

1) Immotives, who typically fitted the profile of smokers who were not ready to change, perceived higher benefits and few disadvantages to smoking and responded to temptations to smoke;
2) Progressives, who typically were closer to Contemplators with a higher readiness to change, and perceived higher disadvantage and dangers associated with smoking than Immotives; and

3) Disengaged smokers who scored lower than the other categories on all three variables.

Velicer et al. (1995) found smokers with different psychological profiles within the large group of precontemplators, and suggested that the separate groups may require different types of information to stimulate contemplation of quitting or stages of change in their smoking behaviour. It would be interesting to investigate how:

- these sub-groups respond to the effect of manipulated efficacy levels on response to negatively versus positively framed anti-smoking messages; and

- responses from groups delineated from these subgroups measure against depression and reactance in relation to high fear arousal in anti-smoking messages.

A suggested strategy for targeting anti-smoking messages towards older, hard-core smokers that appears to relate to this research, is that positively framed messages may produce a more positive effect (Monahan, 1995). In the following section, participants' responses to positively framed messages in relation to the relevant literature are discussed.

### 6.3 Positive Messages

An unexpected finding from this study was that both genders responded positively and were clearly more accepting, of positively framed anti-smoking advertisements. These advertisements contained high efficacy and were designed to encourage beliefs that improved health is a consequence of quitting. The
significance of these contrasting responses to positive versus negative appeals in this study lies in its potential contribution to the design of specifically targeted campaigns for older smokers who have different psychological profiles (as discussed in the previous section). In this section, participants' responses to positively framed anti-smoking messages are discussed in relation to the literature and further research is suggested.

In the present study, participants' positive responses to positively framed messages had obviously not resulted in them quitting smoking. However, they were more compliant with the recommended behaviour when the possibility of improved health or recovery from damage from smoking was included in the message; 'they made me think about it more'. This response resembles Monahan's (1995) suggestion that positive affect messages evoke a more compliant attitude towards accepting a recommended behaviour than negative affect messages.

Although there is a vast body of literature available in relation to negatively framed threat appeals, positive versus negative appeals have received little attention (Donovan & Jalleh, 2000). As discussed in Chapter 2, negative message framing is generally thought to be the most persuasive form of health advocacy. However, doubt has been raised over the effective use of high levels of fear in social marketing messages from the 1960s due to the possibility of maladaptive coping responses in the target audience (Higbee, 1969; Stuteville, 1970; Ray & Wilkie, 1970b; Job, 1988; Monahan, 1995). This doubt was supported by participants' responses in this study.

Research into the effectiveness of positive versus negative framing in social marketing advertising has mainly focused on involvement and results have been mixed. Most studies have found that negatively framed appeals are more effective than positively framed appeals in high involvement situations. For instance, Maheswaran and Myers-Levy (1990) concluded that negatively framed messages were more effective with high involvement recipients, and positively framed
messages were more effective for low involvement recipients. Maheswaran and Myers-Levy (1990) based their study on Petty, Cacioppo & Schumann’s (1983) elaboration likelihood model (ELM). The ELM explained high versus low involvement processing by illustrating that messages are processed depending on the recipient’s high or low level of need for cognition at the time of the ad exposure (Petty et al., 1983). By manipulating involvement conditions in a study focusing on gain versus loss framing in a blood-cholesterol test, Maheswaran and Myers-Levy (1990) found that negatively framed messages were more effective for highly involved subjects who tended to use more comprehensive processing. Positively framed messages had a much greater effect on low involvement subjects who used less cognitive processing.

Certain cognitive conditions were found to effect persuasion in negative message framing situations. For instance, in a study that used sexually transmitted disease and skin cancer self-examination as the focus to test message acceptance, Block (1998) found that negatively framed messages were more persuasive when subjects’ processing was more in-depth. She concluded that low solution-efficacy motivated greater in-depth processing. Conversely, positive messages were more persuasive in high-efficacy situations when there was little emphasis on detailed processing.

Context has appeared to influence acceptance of positive versus negative messages. For instance, the target audience appeared to be more motivated by negatively framed messages that focused on preventative behaviours in a study into breast cancer self-examinations (Meyerwitz and Chaiken, 1987) and testicle cancer self-examinations (Steffen, Sternberg, Teegarden and Shepard, 1994).

Rothman, Salovey Antone, Keough and Martin (1993) found that positively framed messages could be more effective for preventative health messages such as using sunscreen to prevent skin cancer, and negatively framed messages could be more effective for promoting self examination to detect health behaviours. They found women more responsive to the negative messages and men more responsive.
to the positive messages. Rothman et al. (1993) suggested that this was probably due to the women’s higher involvement with the subject.

After reviewing the small amount of literature on positive versus negative appeals, Donovan et al. (1995) suggested that the research was insufficient to support conclusions in relation to the relative effectiveness of these appeals. In a more recent study designed to explore anomalies in the positive versus negative message framing literature, Donovan and Jalleh (2000) expanded Maheswaran and Myers-Levy’s (1990) findings by manipulating involvement conditions in a loss versus gain situation. They presented a hypothetical, new infant immunisation product to a randomised sample of women who had high and low involvement with the topic. Donovan and Jalleh (2000) found no evidence that negative framing involved more cognitive processing than positive framing for messages in high involvement conditions. In particular, they found that significantly greater processing occurred in response to positive rather than negatively framed messages. Donovan and Jalleh (2000) suggested that positive message framing may attract more cognitive processing in some situations because it is unexpected. They concluded that either positive or negative messages may be equally effective for high involvement subjects. However, positive messages may have more effect when targeting preventative behaviours in low-involvement subjects. In this study, the findings regarding low involvement and positive response to positively framed messages resemble this conclusion.

Studies into positively framed messages for commercially marketed products, have found that arousing positive affect can lead to positive feelings towards commercial products (Smith, 1996; Zhang & Buda, 1999). These positive feelings resulted in more intention to buy the product, and to comply with the recommended behaviour.

Participants in this study indicated that positive messages with a focus on efficacy, were apparently more salient and generally more acceptable; ‘Positive ones are
definitely more appealing... they tell you who you can be’. Two positively framed advertisements were specifically mentioned:

1) ‘I Can Do It’, in which self-efficacy was used accentuated the positive aspects of quitting by showing ordinary people celebrating improved lifestyle benefits; and

2) ‘The Body Can Repair Itself’, in which solution efficacy was used to encourage the belief that the body could repair itself from any damage caused by smoking after cessation.

These two advertisements can be described as “affective appeals” (Monahan, 1995 p.82) which appear in two forms: “emotional benefit appeals and heuristic appeals” (p.82). Emotional benefit appeals include both affective and rational components and evoke emotional responses by creating affective states, which illustrate the psychological, experiential or emotional benefits of adopting the recommended behaviour (ie: ‘I Can Do It’). Heuristic appeals are primarily affective and use a more indirect approach. They are used to target low-involvement individuals or those less likely to evaluate the benefits and attributes of the recommended behaviour (ie: ‘The Body Can Repair Itself’).

Both men and women in this study commented that positive appeals had some effect on their attitude towards smoking cessation; ‘if it’s going to make my game better I might do something about it. When you actually see somebody doing it, I said OK then... so I didn’t smoke at half time’ and ‘I gave up for 6 months because I heard that your body can repair itself in that time’. In line with Donovan and Jalleh’s (2000) suggestion, a possible explanation for this response is that for these long-term smokers, exposure to encouraging efficacy in an anti-smoking message was a pleasant surprise and consequently, they responded with more in-depth cognitive processing and a more compliant attitude.

Monahan (1995) suggested that because efficacy in positively framed messages creates a positive affect, repetition of a positive message could be an effective
strategy to break through to harder to reach target audiences. Monahan (1995) also suggested that positive messages might be one of the few ways to induce approach behaviour, and conciliate open mindedness in a target audience that lacks motivation to carefully consider the benefits of a recommended behaviour.

It appears that the men and women in this study had developed self-protective heuristic responses (albeit differently), and habitual avoidance behaviour to threatening anti-smoking messages. Given that positive messages are likely to engender positive affect (Monahan, 1995), another explanatory factor for the positive responses to positively framed messages in this study, is that the participants' automatic self-protective behaviour was temporarily deactivated, and the positive messages bi-passed their usual barriers which resulted in greater message acceptance.

This may also explain why confusion and annoyance occurred as a result of another heuristic appeal, containing the threat 'Every Cigarette is Doing You Damage'. This appeal appeared to create an approach-avoidance conflict with the message 'The Body Can Repair Itself', and acted to neutralise the positive message '...if every smoke is doing me damage, how would I recover?'.

It would appear from these results that further quantitative research is necessary to determine two main elements regarding older smokers' response to positively framed anti-smoking messages:

1) Are positively framed messages which are designed to activate good feelings and increase solution-efficacy more readily received by older smokers?

2) Do positively framed messages have an effect on older smokers' intentions and behaviours in relation to their smoking behaviour?
6.4 Conclusions

In summary, this study was designed to qualitatively explore Henley's (1997) quantitative research, which empirically tested the effectiveness of adopting a market segmentation approach to advocate a particular health behaviour when using fear (of death) arousal in social marketing campaigns in two groups of male and female smokers: 16-25 year olds and 40-50 year olds. Henley (1997) compared the death threat, 'Quit smoking or you'll die of emphysema' to the non-death threat, 'Quit smoking or you'll be disabled by emphysema'. Response was measured for change in attitude, motivation and intention to adopt the recommended behaviour. Findings in relation to the older group indicated that significant differences occurred between older male and female smokers in response to the death and non-death threats. Henley (1997) found that in general, 40-50 year old males responded more to death threats and 40-50 year old females responded more to non-death threats. There was one exception: women did respond to the death threat involving the effect of their death on loved ones.

The main focus of this study was to obtain rich data that might explain why those differences occurred. The main aim of this study was to gain insights and ideas from 40 to 50 year old, male and female smokers and investigate how they articulated their response to threat appeals, and whether a variation in response by gender occurred.

The most significant finding from this study was that gender differences were found in response to threats in anti-smoking messages, as in Henley’s (1997) study. There were no explicit differences articulated in response to death and non-death threats between the men and women. However, death threats were implicit in many specific messages under discussion and gender differences were apparent when the men and women articulated their response to these messages. A specifically-mentioned death threat, the consequence of death on loved ones and in particular children, had affected both genders and in some cases had influenced a temporary behavioural response.
One of the significant findings in Henley's (1997) study was that women in the older age group of 40 to 50 year olds recorded a greater response to information-only messages than to threats in general. There was a similar finding in this study. The women responded positively to an information-only message printed on the side of cigarette packets advising that cigarettes contain poisonous substances.

Specifically, the men's responses in relation to threats in anti-smoking messages, indicated lower perceived self efficacy and self esteem than the women, and a sense of powerlessness over their smoking behaviour. Discussion indicated that the men had adopted maladaptive coping responses to the threats, such as avoidance behaviour and denial in relation to anti-smoking messages.

The women's responses revealed higher levels of perceived self-efficacy in relation to anti-smoking messages and they derived more perceived benefits from smoking than the men. Women's responses indicated anger and resistance towards anti-smoking messages. Discussion also revealed that women had adopted maladaptive coping responses such as defiance, reactance and avoidance behaviour in relation to threatening anti-smoking messages.

An unexpected finding of this study was that both genders were clearly more accepting of positively framed anti-smoking messages. Participants discussed positive emotional, cognitive and behavioural responses to messages which engendered self-esteem and higher efficacy

6.5 Limitations

The main limitations of this study are presented in terms of *method*, social marketing context and geographic limitations.
6.5.1 Methodology

As discussed in Chapter 4, there are limitations to the qualitative method used in this research. It cannot provide data for statistical analysis or take the place of quantitative research. Qualitative research is not generalizable across an entire population. It is subjective in nature, and there are no rigorous statistical or mathematical methods used to analyse data. In addition, the non-probability, purposive sampling technique used is inappropriate for making deductions about an entire population.

6.5.2 Social Marketing Context

In addition to the limitations of qualitative methodology, the social marketing context of this study also renders findings un-generalizable across other social marketing contexts. This study was based on how 40 to 50 year old male and female smokers responded to threats in social marketing advertising. The smoking context presents a limitation to the findings of this study given that the results relate only to smokers and their smoking behaviour. Response to threats in other social marketing contexts may have other outcomes, ie: response to the threat of disablement as a result of speed in road safety advertising, or the result of death as a result of AIDS and unsafe sex.

6.5.3 Geographic

The geographic limitations of this study are that all participants resided in the metropolitan area of Perth, Western Australia. It is feasible that findings may differ in other areas of Australia, and in particular areas that have had different types of anti-smoking initiatives than the ones discussed in this study. It is also possible that results may differ in other countries and cultures that have different values and beliefs regarding smoking.
6.6 Implications for Social Marketing Practitioners

The extremely high costs associated with health care and hospitalisation of people with smoking related diseases have made smoking cessation one of the most critical public health concerns today. Anti-smoking initiatives designed to reduce the prevalence of smoking include anti-smoking social marketing campaigns. The findings from this study are particularly significant for social marketers who design mass media based anti-smoking campaigns for two main reasons. Firstly, as in Henley’s (1997) study, the men and women in this study clearly responded differently to negatively framed anti-smoking messages. Of further importance was evidence that the men’s low perceived self efficacy, and low self-esteem appeared to be exacerbated by repeated exposure to threats in anti-smoking messages. This resulted in them developing maladaptive coping responses such as avoidance of all negatively framed anti-smoking messages and was expressed in depressive terms. The women also had developed maladaptive coping responses to anti-smoking messages but they expressed angry reactance and defiance while avoiding negatively framed anti-smoking messages.

The second important finding for social marketing practitioners was the unexpected positive response from both genders to positively framed anti-smoking messages, which contained high efficacy.

An important aspect of this study was its focus on smokers in the 40-50 year old age group. These older smokers have previously received little attention in threat appeal studies to date, and appear to be overlooked by many anti-smoking campaigns. The sheer numbers of precontemplative older smokers make this group a potentially formidable contributor to health care costs in the future. The presumption that older, long-term smokers are unlikely to respond to anti-smoking campaigns, was born out in this study in relation to threatening anti-smoking messages. However, there may be a window of opportunity to engage response from this group with positively framed anti-smoking messages.
For social marketing practitioners wishing to target older smokers, the findings of this study suggest that, if using negatively framed messages, market segmentation is advisable to target men with messages designed to increase perceived efficacy and self esteem; and to target women with messages designed to neutralise anger and reactance. However, the same positively framed messages may be used to reach both genders.

6.7 Implications for Further Research

Due to the qualitative nature of this study, findings are not generalizable. Therefore, in order to establish validity in relation to these findings, there is a need to quantitatively test the results. In summary, findings from this study indicate that further quantitative research may be useful in the following areas:

- **Gender differences to threat messages**
  - Confirm whether older men’s and women’s emotional, cognitive and behavioural responses to anti-smoking messages are significantly different

- **Threat messages**
  - Confirm whether low-self efficacy, low self-esteem and powerlessness, is a response to fear-arousing threat appeals in older male smokers
  - Confirm whether higher self-esteem, self efficacy, and reactance to patriarchal and authoritarian anti-smoking messages is a response to threats in anti-smoking messages in older female smokers
  - Test older women’s response to information-only messages versus negatively framed threats in anti-smoking messages

- **Positive messages**


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APPENDICES
SMOKING FOCUS GROUPS
SCREENING QUESTIONNAIRE

Interviewer .................................. ID
Time Started .................................. Am/pm
Time Finished ................................. Am/pm
Time Taken ................................. Mins
Date ....../....../99...

INTRODUCTION
Hi. I'm calling from on behalf of Edith Cowan University. We are doing a survey on various health issues. We hold group discussions where 7 or 8 people like yourself sit around and talk about the research topic. We several few drinks and snacks, and pay people $30 for their time. The groups last about an hour and are held in the day or evening. Are you interested?
We are holding groups of different types of people. I have to ask you a few questions to find out if you fit the types we want.

(note as appropriate) M ( )
F ( )

Q1: Firstly, I'd like to check your age? _______ years

IF UNDER 40 OR OVER 50, THANK POLITELY AND DISCONTINUE
(“Thanks, but according to this method of the survey, we need to talk to people in the age range 40-50 years.”)

Q2: Do you smoke cigarettes? Y ( )
N ( )

IF NO, DISCONTINUE

Do you smoke most days? Y ( )
N ( )

IF NO, ie: SOCIAL SMOKER ONLY, DISCONTINUE.
Q3: Are you currently in paid employment? Y ( )
    N ( )

    IF YES CONTINUE WITH THIS QUESTION AND THEN SKIP TO THE END.

Part time or fulltime? PT ( )
    FT ( )

What sort of work do you do? ________________________________

Allocate appropriate category: Blue collar ( ) > skip to end
    White collar ( ) > skip to end

Q4: What do you do? Student ( )
    Unemployed ( )
    Home duties ( )
    Other ( )
    Refused ( )

Q5: Is someone in your home in paid employment? YES( )
    NO ( )

    IF YES, CONTINUE WITH THIS QUESTION AND THEN SKIP TO END.

Part time or fulltime? PT ( )
    FT ( )

What sort of work? ________________________________

Allocate to appropriate category: Blue collar ( ) > skip to end
    White collar ( ) > skip to end

Q6: What suburb do you live in? ________________________________

Allocate most likely category: Blue collar ( )
    White collar ( )

END
TOPIC GUIDE

1 Top of mind associations & general attitudes
(To instigate general discussion about health and anti-smoking messages.)
1a How do you feel about health messages in general (that you see advertised?)
1b How do you feel about anti-smoking messages? Eg: those in the newspaper, on TV or on cigarette boxes?
1c What do you think about them?
1d How do you feel about other types of health messages, such as road safety ads?
1e What do you think about them
1f Do you believe any or all of these messages?

2 Attitude to source
2a Who do you think the senders of the ads we are talking about are targeting generally?
2b How do you feel about the people who send the messages?
2c Do you think they have the right to send these messages to you or your family?

3 Affective response
3a Do you remember any messages about smoking that were particularly significant or touched you in some way?
3b Why?
3c What were the feelings that came up when you first heard those messages?
3d How did you feel when you saw the messages after a few times, and/or now?
4 Behavioural response

4a Did it instigate any change in your behaviour with regards to smoking?
4b If so, what happened?
4c Have you ever tried to give up smoking? / Is there anybody in the room trying to give up?
4d What was or is your motivation to give up?
4e When you tried to give up, was there any particularly significant message that you associate with the attempt?
4f Do you feel any different about that ad now?

Note: Moderator to be aware of which types of threats are being discussed and which threats are being weighted with more effect.

5 Information-only/positive message response

(To explore the emotional, cognitive and behavioural response to different types of threats.)

5a Most of the messages we've talked about have referred to harmful consequences. Are there any other kinds of messages that might be important or effective?
5b What does the rest of the group think about that?

If positive message does not come up:

5c Sometimes there are anti-smoking messages that are more positive...
5d What do you think about this kind of message?

6 Best possible world scenario

If you could create an anti-smoking message or advertisement that would appeal to someone like you, in your age group, what would it be like and what would it say?
7 Death/dying response

(Instigate general discussion about death to explore male and female responses to different types of death threats.)

7a We've talked a lot about the different types of health messages. Some of those messages used dying as a consequence of smoking. How do you feel about that?

(Omit next question if time is short.)

7b When we talk about death and dying, what thoughts about death concern you more than others?

8 Benefits of smoking

Just to end on a more positive note, could you tell me what you get out of smoking, or why you do it?