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SMOKING AS AN ANTICIPATORY RITE OF PASSAGE: SOME SOCIOLOGICAL HYPOTHESES ON HEALTH-RELATED BEHAVIOUR

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Abstract—Recent evidence on differential rates of smoking between various social groups and over time is reviewed. It is suggested that some of these variations can be explained if smoking (together with certain other forms of behaviour) is regarded as an 'anticipatory rite of passage' used by subordinate social groups to demonstrate an approaching, or hoped-for, improvement in status. Some implications of this view for health education programmes are considered.

Key words—smoking, health behaviour, rites of passage

INTRODUCTION

It is a commonplace of current discussion on health and health education that the crucial need of preventive health programmes, at least in the economically developed societies, is to persuade people to change their life styles, with particular emphasis on giving up smoking, reducing consumption of alcohol, changing patterns of diet and increasing exercise. It is also generally accepted that such programmes have so far achieved limited success and constitute a striking contrast with earlier experiences in the health education field. Of the four areas of change just referred to it is probable that smoking has received the greatest attention [1].

In line with this situation there has been considerable interest in many parts of the world in undertaking campaigns to encourage a reduction in smoking. It is frequently observed that the resources put into such campaigns are substantially less than those used in the advertising campaigns of the tobacco companies. In general these efforts have been unsuccessful; consumption of tobacco on both national and world-wide levels has declined little, if at all, and a good deal of pessimism has been expressed as to the possibilities of health education in the direction of change of life styles [2].

It has, however, recently become increasingly obvious that patterns of smoking behaviour have varied between different populations, and between different subgroups in the same populations. In particular, it has been noted that within some national populations consumption of cigarettes has varied by sex, age, social class and ethnic group. For example, it has been observed that in a number of populations with relatively high levels of economic development smoking has tended to increase particularly among females of all ages but especially in the lower age groups, that increasing numbers of men in the middle aged groups have given up smoking, that the rate of beginning smoking by boys has tended to decline, and that relatively high rates of smoking are found among lower socio-economic groups, and minority ethnic groups [3]. Specifically, it has been noted that young Maori women in New Zealand are probably the highest consumers of tobacco in the world [4]. Although adequate statistical information is lacking, commonsense would suggest that the smoking/economy relationship is probably not linear as at some point on an income scale the cost of tobacco would presumably make it impossible for disadvantaged groups to increase or maintain their level of smoking.

The aim of this paper is to (1) discuss these variations in smoking behaviour, (2) attempt to link them with comparable variations in other forms of social behaviour, (3) suggest a theoretical basis for this linkage, and, (4) consider what implications these theoretical considerations may have for the design of preventive health programmes.

ANTICIPATORY RITES OF PASSAGE

Traditionally in Western societies it has been considered very common for young males during adolescence to demonstrate masculinity and approaching adulthood by displaying a variety of behaviours which often includes smoking [5]. Other behaviours can include swearing, increasing consumption of alcohol and overt concerns with sexual interests. In recent times a somewhat 'reckless' style in handling motor vehicles has often been added to the list. In other cultures and in other times there have probably often been equivalent, though different, behaviours.

Over recent decades there has been a growing tendency for young females in many countries to take over some of the patterns of demonstrating adulthood traditionally used by males. The most obviously visible and measurable case, and the one that has attracted the most published comment is smoking [6]. Recently surveys in several countries have shown that, particularly in the younger age groups, rates of smoking among females equal, or exceed, those among males [7].

Smoking, and the behaviours with which it has been linked in this paper so far (swearing, sexual

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concerns, drinking), in the context of approaching adulthood all seem to have in common certain types of negative moral connotations, though of a somewhat ambiguous kind. For example, all the behaviours are commonly observable, and their practice will be readily admitted and/or displayed by very many people without signs of real shame. On the other hand, they are all behaviours which (even in the case of smoking before the link with cancer was established in 1952) were discouraged among the young [8] (and usually among women), and were often referred to apologetically as 'bad habits' even by those who practised them openly. Also, discussion of these behaviours often reveals notions of the possibility of 'excess' which makes the behaviour really bad even if it is seen as acceptable in 'moderation'. It can be noted that all the groups whose smoking behaviour has been referred to so far are in some sense in subordinate positions in their societies—they are juveniles, women, ethnic and economic minorities.

Historical changes should also be noted. Traditionally, it is male juveniles who 'celebrate' the approach of maturity with these behaviours. Only during the First World War did smoking, for example, begin to appear to any real extent in the repertoire of female behaviours, and only much later, probably not until after the Second World War, was it displayed with anything like male regularity as a 'rite de passage'.

For a rite of passage to have any effective meaning it must be followed by a real movement from one status to another and it could well be argued that in the traditional male-dominated world the passage from juvenile female to adult female was usually very much more limited in reality than the comparably labelled male passage. There seems to have been a rough correlation between the growth of sexual equality and female participation in the behaviours I am considering [8], though feminists at least would undoubtedly agree that equality in the smoking and related rite of passage behaviours has come very much nearer, very much faster, than equality in more important and fundamental matters.

The other groups I have referred to (the economically and ethnically disadvantaged) have also, over recent periods of time, in many cases, moved into situations where they have been in the process of achieving a greater degree of perceived equality with the hitherto dominant groups. As in the case of women these advances have normally been slow, partial, and in many ways potential or apparent rather than real (not to mention widespread current set-backs in terms of unemployment), but they have been sufficient to give rise to a degree of optimism about the future among large numbers of the members of many of these groups, especially when compared with the situation in earlier generations, and hence to give rite of passage behaviour some greater degree of credibility.

I have so far referred to smoking and other behaviours among the young and some other groups as a 'rites of passage', but it must now be pointed out that they are a rather special case. They are not full and formal rites of passage, they are behaviours which anticipate such a passage, and they are undertaken unilaterally by the dominated group in advance of any legitimating move or permission by the dominant group. What I am suggesting, therefore, is that these are 'anticipatory rites of passage' which will occur only when the group concerned can in due course actually make, or at least have some expectation of making, a real transition from a subordinate status to a status that is at least somewhat more closely aligned with that of the subordinating group (adults, males, dominant ethnic or economic groups) [10]. Unlike fully established rites of passage these behaviours would seem to be directed not towards superordinate groups but to peers or to even more subordinate groups.

These anticipatory rites of passage are, of course, a form of social modelling but the concept implies that the modelling will be displayed by only some groups, under limited circumstances, and that only certain types of behaviour are chosen for these rites. Why should the behaviour chosen for the celebration of the impending, or anticipated, or hoped-for, change be typically behaviour which is morally ambiguous?

Given that women so often criticise men, the young so often criticise their elders, and other subordinated groups so often criticise their dominators for the foolishness of their behaviour (and thereby imply, or even say explicitly, that the critics are capable of much wiser actions), it seems remarkable on any 'rational' consideration that these groups, when celebrating approaching equality, should choose to do so by aping so directly the 'bad' behaviour of the criticised groups [11]. However, I think it can be argued that such a choice is essential to meet the circumstances of the case.

The taking on of fully legitimate and approved behaviours as an anticipatory rite of passage would not do. Doing well at school, or in sport, saving money, and so forth, may bring adult approval to the young. It may also bring more rapid promotion within the adult group after adult status has actually been achieved, but it is unlikely to make the actual or perceived achievement any earlier. Indeed, in some cases (doing well at school, for example) it may even delay the achievement. The anticipatory celebration of maturity, I suggest, represents a kind of attempted seizing of status in advance, a claimed achievement, not the acceptance of something bestowed, and is intended for observation by the peer group rather than by the dominant group.

On the other hand, the use of behaviour which is clearly illegitimate in the dominant group would also not do. This would only serve to bring down sanctions which would probably include postponing, perhaps even more or less permanent deprivation of full, legitimate membership of the dominant group. The obvious case of this is the juvenile criminal [12].

On the psychological level also the moral ambiguity probably has a particular relevance. To take on behaviour which is not merely 'adult' (or 'dominant' in some other sense), but has something of the quality of participation in 'adult secrets' has a special value in making the aspirants to high status feel that they are really 'in' to a degree that participation in generally approved 'good' behaviour would not. The fact that the behaviour chosen may be somewhat banal,

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almost meaningless in some cases (e.g. a great deal of swearing) is beside the point. As members of Lodges and other types of secret societies well know, the secrets when finally revealed are for the most part fairly trivial. It is the reward of membership and status in the eyes of the peer group which really counts [13].

THE DECLINE IN MALE SMOKING

If it is indeed the case that smoking and some of the other behaviours mentioned constitute anticipatory rites of passage, and that such anticipatory rites need to be morally ambiguous, can this tell us anything about recent changes in male smoking patterns? I must begin by making it clear that I have no intention of making any claim that the status of smoking as an anticipatory rite of passage constitutes a total explanation for smoking behaviour, though it might constitute an important part of an explanation for beginning smoking.

Because a decline in rates of smoking appears until recently to be specific to males (and especially to males in middle and upper class groups) it is necessary to seek for explanations which do not involve any general impact from health education programmes and similar campaigns. As there seems to be little hard evidence about the reasons for this decline it is necessary to attempt to develop hypotheses on theoretical grounds.

As several writers have noted [2, 3] smoking behaviour can usefully be divided into at least three stages (beginning, continuing and—whether successfully or unsuccessfully—giving up) and there seems to be good reason to suppose that different factors may affect decisions at each stage. The stages, however, are not sharply distinguishable; nor are the causal influences normally simple and specific. In this paper I am concerned primarily with influences encouraging beginning smoking, though particularly when considering health education activities, the question of giving up also becomes important, and a crucial part of my argument is concerned with the relation between role models giving up and their followers refraining from beginning.

Most of the sociological literature on fashion [14] appears to accept the view that an influence regularly working for change is that as new fashions become more widely adopted they lose their value in distinguishing the higher class leaders and innovators who then proceed to disassociate themselves again from the general public by developing new modes. It could be that as women and other subordinate groups take on smoking as a typical behaviour that it becomes devalued in the eyes of aspiring members of the dominant groups and so less attractive as a celebration of approaching maturity. This hypothesis would not imply any change in the morally ambiguous status of smoking, simply a change in its status as a symbol of a dominant group. So far as I am aware there is no empirical evidence recorded in the literature, and little or none from my own observations, to support this hypothesis, but it may be worth investigation.

A second possibility arises from the fact that among male doctors (especially in economically developed countries) smoking is now approaching the characteristic of a tabooed behaviour [3, 7]. It may be that, especially among the better educated, professionally ambitious, young males, those presumably most likely to regard doctors as appropriate role models, this circumstance may have some effect, tending to move smoking from the morally ambiguous category of behaviour to the unambiguously illegitimate, but it is hardly likely that this fact alone would account for the changes in smoking patterns recently observed. It can be noted, in this context, that while doctors (who are largely male) have mostly given up smoking, nurses (usually female) have not, and indeed, it is probable that women doctors have given up to a much lesser extent than men [15].

Assuming the improbability of factors of these two types explaining more than a small part of observed changes, the hypothesis on which I want to concentrate in this paper is that adult males, particularly those of middle and upper class status in economically developed countries, are increasingly, for reasons that do not stem simply or directly from deliberately established health education programmes, giving up smoking, and this fact, by tending to move smoking in the eyes of young males from a morally ambiguous to an unambiguously unacceptable category, significantly reduces the pressures on them to take up smoking. The reasons why the adult males are increasingly giving up smoking then becomes a crucial question.

Apart from infectious diseases, which in most parts of the world are no longer a really major hazard, processes involved in determining health status, and especially those that must be considered in developing policies of prevention, are typically of a very long term variety. They may even, in some cases, extend over two generations, for example, in the case of dietary practices among girls, which may have consequences for the health of their children born many years later. Similarly, behaviours and experiences early in life may affect health status in old age, and even age at death. One of the great problems of preventive health policies today is that the lessons on which they are based are not easily learned from personal experience, or at any rate, by the time the individual has learned the lesson it is too late to do much about it personally.

Thus, lung cancer becomes obvious, on average, after something like 30 years of smoking experience. Other smoking-related illnesses and much illness associated with excessive consumption of alcohol may involve comparable time periods. It is also the case that only in societies which have a rather high expectation of life will there be many observable instances of such illness—in economically less favoured societies most people may die from other causes before the smoking or alcohol related diseases become obvious. It is therefore only in societies with a significant history of relatively high levels of expectation of life that there is much possibility of the average citizen becoming aware from personal experience, or the experience of those close to them, of the dangers of the causative behaviour.

There is a good deal of evidence to the effect that the behaviour of the young, including smoking behaviour, is greatly affected by the behaviour of the

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parent of the same sex [16]. It seems a not unreasonable extension of this evidence to hypothesise that an event especially likely to influence people in learning health lessons of the type discussed above would be the death of the parent of the same sex.

This hypothesis also has the advantage of conforming to observed variations between male and female patterns of giving up smoking. Over the past two or three decades increasing numbers of middle-aged males in the economically developed countries will have had the experience of observing their fathers die of lung cancer while knowing what caused this condition. Because of the particular historical time scale in the adoption of smoking by females relatively few women will have seen their mothers die in this way [17]. And it is males, not females, who have been giving up smoking.

When the smoking–cancer link was first described the most usual reaction by smokers was to shrug off the information with the comment 'Well, you've got to die of something'. Death from lung cancer (and from emphysema), however, is usually an extremely painful and unpleasant business, and often quite slow. Few people who have witnessed such a death at first hand are likely to regard it as just another version of the inevitable [18].

If this hypothesis about identification with the parent of the same sex is correct, men will have been affected by this experience, so far, much more than women, and increasing numbers of young males will be growing up under the influence of men (fathers, teachers and others) who are non-smokers, very often perhaps, outspoken ex-smokers. In short, it seems likely that effective pressures on young males in economically advanced societies to refrain from smoking will have been rising steadily in recent years in a way that will not have applied to young females, or to young adults of either sex in populations with lower expectations of life.

ALTERNATIVE HYPOTHESES

The variations in smoking patterns outlined above have not, of course, gone unnoticed by other writers, and other hypotheses to explain these have been advanced. In general, these explanations have tended to be psychologically based and to assume that smoking is usually closely connected with the control of anxiety.

For example, Jacobson [3] argues that women in the modern world are in a particularly uncertain and stressful situation and turn to smoking as a means of coping with the consequent anxiety. With varying emphasis the same type of explanation has been used with reference to other disadvantaged groups [4, 16]. There are, however, some problems with this view, particularly if it is accepted simplistically as a general explanation for rates of smoking.

The most obvious problem appears in the data regarding historical patterns of change. To account for these changes as well as those of recent years the hypothesis requires the assumption that levels of anxiety and stress for women were significantly lower before the First World War than they have been since, that levels of stress for men have recently been falling markedly, and that comparably marked changes over time have been appearing for the other social groups for whom changes in levels of smoking have been noted. While there is probably no hard data available on these topics, these seem on the face of it, to be somewhat improbable assumptions.

Secondly, remembering that the various stages of smoking behaviour may be affected by different factors, it might well be reasonable to assume that for some women stress constitutes a factor in encouraging those who have begun to smoke to continue to do so, or a factor in discouraging them from giving up smoking, but one cannot assume in the absence of definite evidence that men are simply relatively stress free.

A parallel argument that 'lack of self-esteem' and 'insecurity' among relatively deprived groups encourages smoking [19] raises problems about demonstrating that changes in smoking rates have been accompanied for these groups by changes in the other factors over specific historical periods and in ways that have not affected groups with different rates of smoking.

In general these questions raise problems that are in principle very similar to those discussed by Durkheim in the early chapters of *Suicide* when reviewing alternative theories directed at explaining variations in rates of self-destruction [20].

PRACTICAL IMPLICATIONS

If the hypotheses advanced earlier in this paper (namely, that there are forms of behaviour that can be identified as anticipatory rites of passage, that these are of necessity morally ambiguous in nature, and that these facts can be used to account for some observable variations in rates of smoking among certain social groups) are reasonably correct, then they should have some implications for health education programmes concerned with smoking and possibly with other health related behaviours such as use of alcohol.

There have been common assumptions among health educators that prevention is better than cure and that the young are more readily influenced in their behaviour than the old. As a consequence there has been a tendency for anti-smoking campaigns to be directed especially at the young with the idea of persuading them to refrain from beginning to smoke. The common failure of such campaigns has been one element in the growth of the considerable pessimism noted early in this paper about the efficacy of efforts to change life-style in the interests of health.

The recent observations of unexpected and fairly substantial reductions in smoking rates among some groups of males suggests that the pessimism may have been somewhat exaggerated. At the same time, the suggestions advanced in this paper imply that while orthodox propagandist methods of health education may have had little effect [21] forces have been at work which have tended to result in increasing numbers of young males perceiving smoking, not as a morally ambiguous symbol of adulthood but, as unambiguously illegitimate behaviour and hence unattractive as an anticipatory rite of passage.

This, of course, raises the question as to whether we are at the beginning of a long-term process of

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demographically based change in which, slowly, first women, then ethnic minorities and other disadvantaged groups will follow along the same path to a smokeless, perhaps even non-alcoholic future. At this point one could only regard such speculations as converting a reasonable hypothesis into science-fiction fantasy. What is much more important about the hypothesis is that it does draw attention to the likelihood that counter-measures for long-term processes (such as the development of lung cancer from smoking) will themselves have to be long-term.

Historically it seems that changes in public attitudes and behaviour in regard to health have not generally come about as a result of short-term 'education' of a pedagogical kind. This is often true even in the case of doctors, as is clear if one considers the history of the campaigns for surgical asepsis, or the use of vitamin therapy in pellagra, for example [22]. Yet when health educators, social scientists and others have experimented with health education measures these experiments seem commonly to have been based on ideas drawn from such areas as pedagogical practice and learning theory.

Past changes in health-related behaviour have frequently been different from those sought today. Often they have involved the relatively short time-spans of acute infectious diseases with the result that consequences of behaviour were easier to demonstrate convincingly. Also they have often been changes that did not deprive people of valued enjoyments, or make a profound impact on their central social relationships. Often they have been changes required by organisations (such as local government or business firms) rather than individuals, and often they have been relatively easily enforceable by official inspection and legal process. In all these senses the changes have been easier to achieve than some of those being sought in life-style patterns in developed countries today.

Given these considerations it seems that we need to examine more carefully the mechanisms that have operated in the recent relatively successful case (i.e. smoking among certain groups of males) and to consider how far these mechanisms can be brought into play with other groups and other forms of health-related behaviour.

If the earlier analysis is correct it seems likely that in encouraging people to give up smoking a clear-cut anxiety over personal well-being and safety, aroused in a fairly vivid and immediate way (e.g. through observation of the experience either of onself or of someone with whom there is a close identification) may well be an important factor. Jacobson [3, pp. 70–78] observes, for example, that pressure on women to give up smoking because of its future effects on their yet unborn children, has had at best a very limited effect (typically they give up only during pregnancy, if at all), and other appeals to altruism (e.g. by drawing attention to the effects of so-called 'passive' smoking on workmates and other family members) seem to have been similarly ineffective with smokers of all ages and both sexes.

Leventhal and Cleary [2, p. 377] suggest that arousal of fear produces effective action only if there ; also a perception of positive benefits from taking action. The present analysis attempts to meet this requirement with the suggestion that it is the observation of the benefits to be gained from being able to avoid a specific and unpleasant form of death which is at present providing the mobilisation to action in the case of the category of middle-aged male smokers in societies with a relatively long expectation of life.

Following on from this is an hypothesis of an indirect impact of a different kind (the reduction of the attractiveness of smoking as an initimation of adulthood) that encourages the younger males not to take up smoking (or at any rate, only briefly and experimentally). Leventhal and Cleary [2, p. 381] further suggest that the extension and enforcement of rules prohibiting or restricting smoking in public situations together with increased militancy from non-smokers will have a cumulative effect in encouraging a reduction in smoking by creating a situation in which one of the positive benefits of giving up smoking is increased community approval. In terms of the present analysis the major effect of this kind is likely to show at present among males. indeed, it is even possible that in some situations women and minority-group males who regard such rules as unwarranted restrictions on behaviour which they have not come to see as illegitimate may be encouraged to continue as a form of defiance [23].

The most recent data available for New Zealand suggest that by 1981 there were signs that females in the middle aged groups (25–59), and as in the case of males, particularly in middle and upper classes, may have begun to reduce, or at least to stabilise rates of smoking [3]. If this proves to be correct it will be consistent with the earlier analysis and according to the hypothesis advanced should in due course be followed by a decline in rates of beginning smoking by young females. This in turn would support the idea that the most efficient means of reducing smoking may be to concentrate the influence of health education measures, not on those beginning smoking but on the socially dominant and influential groups among established smokers. Success with these groups would have the effect of tending to remove smoking from the group of behaviours appropriate as anticipatory rites of passage and so reduce pressures on subordinate groups to take up smoking.

If this analysis is accepted as a reasonable basis for further work and if it is assumed that patterns of smoking need to be changed more rapidly than might result from the working out of the demographic processes described earlier, then the appropriate tasks of health educators are (1) to identify those groups whose behaviour is most likely to influence the heavily smoking subordinate groups, and (2) to devise forms of health education which will make an impact on these dominant or influential groups [2, Alacay, p. 92].

The first task draws attention to the fact that the various groups to be considered are not clearly distinguished, separate entities. The variables of sex, age, class and ethnicity overlap in a variety of ways and it may therefore be presumed that lines of influence will be correspondingly complex [24]. There will also be no reason to suppose that these various patterns will be identical in all societies, but will need to be analysed in terms of varying national social structures.

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These considerations also emphasise the obvious point that it would be exceedingly unwise to assume that any single approach to the reduction in smoking behaviour will be effective, or that the same tactics will continue to have the same effects in different circumstances. As a parallel to Leventhal and Cleary's statement about public restrictions and non-smoker militancy one might suggest that in a situation where smoking is beginning to decline traditional anti-smoking propaganda campaigns, substantially increasing the price of cigarettes, and other techniques which have failed in the past, might well begin to contribute significantly to success.

The very limited success so far achieved in deliberate attempts to change life-style practices, together with the unanticipated success in the particular case of specific groups of male smokers, certainly suggests that some re-thinking of underlying theory and some new lines of experimentation in devising programmes might be worth attempting.

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23. Jacobson, see Ref. [3], pp. 78–79, describes the failure of the women's movement (including most women's health collectives) to take any account of smoking as a health problem for women. She also notes (pp. 74–75) that nearly all anti-smoking campaigns directed at women have been devised by men, with a consequent absence of female role-models for the women.
24. The case of the heaviest smoking group so far recorded (young Maori women) who may have membership in up to four of the seriously-at-risk catalogues (female, young, ethnic minority, working class) is an illustration of this.

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