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Parental smoking and children's anxieties: An appropriate strategy for health education?

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Abstract

While the prevalence of smoking has declined in the UK in recent years, class differentials in smoking behaviour have become more marked and smoking is increasingly recognised as a causal factor in inequalities in health. Health education initiatives to support both smoking cessation and to teach children about the health risks of smoking remain key initiatives in reducing health inequalities. However, teaching children about the risks of smoking and the impact of parental smoking in their health is not straightforward for children from backgrounds who are more likely to encounter smoking at home and in their local communities. These children have to reconcile the key messages taught at school and reinforced in smoking cessation campaigns with the knowledge that their parents and other family members smoke. In this paper we consider how children from smoking homes make sense of these education and health campaigns as observed by their parents, and the impact that this has on both parental smoking and relationships within the home. The paper thus seeks to challenge assumptions about the delivery of health education and the need to acknowledge family diversity.

Keywords

Parental smoking; health education; home; children's health; health inequalities

Introduction

Geographers' recent contributions to health literature have sought to reveal how current strategies to promote 'healthy' lifestyles cannot be separated from the political economy of space, as increasingly the regulation of behaviour is mediated by the designation of (un)healthy spaces. Critical geographies have engaged with recent political and public discourses around smoking, obesity and alcohol consumption (see for example Evans 2006; Jayne et al 2008; Thompson et al 2007). Though defining the potential and direction of critical health geographies remains 'a flawed and messy task' (Parr 2004: 253); it is possible to discern a movement towards understanding the relationships between society and health that does more than map inequalities in health, but develops a theoretical perspective of how

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inequalities are perpetuated over time and place and the role of spatial practices in the lived experience of health and illness. One way of developing this critical health geographies approach is through considering the role of children. This paper seeks to extend this critical geographical perspective through considering how the spatial context of smoking and smoking control impacts on smoking parents and their families, based on a study of smoking parents in Liverpool, UK.

In recent years in the UK the extension of spatial controls to define indoor public spaces as 'smoke-free' has been heralded as a public health success associated with an overall decline in both the number of smokers and non-smokers exposed to tobacco smoke (Royal College of Physicians, 2010).¹ However this shift towards spatial regulation of smoking has occurred in tandem with an entrenchment of social distinctions in smoking behaviour and smoking is increasingly associated with inequalities in health associated with both children's and adult health. While children's exposure to second-hand tobacco smoke has declined in recent years, particularly just before the introduction of smoke-free legislation, children from deprived households remain most at risk, and this risk factor remains after controlling for parental smoking (Sim et al 2010). Children's exposure to smoke and smoking behaviours is acknowledged as the next frontier in tobacco control (Royal College of Physicians, 2010) and smoking cessation campaigns are increasingly targeting parents and other family members in order to reduce, or eliminate, children's exposure to tobacco smoke and normalisation of smoking behaviours. Children also learn about the health risks associated with smoking through health education programmes at school (Ofsted 2010). However recent initiatives in both the classroom and those targeting parents do not consider how children negotiate the shifting geography of smoking and the bifurcation between smoking and non-smoking spaces. It is potentially quite different to teach 'anti-smoking' messages to children who move predominately between non-smoking private and public spaces (such as schools, shopping and leisure centres which have come under smoke-free legislation) rather than to children who have to come to terms with normative adult smoking at home and in their local communities.

In this paper we build on this emerging critical understanding of the spatial/social unevenness of smoking to assess how both smoking-cessation campaigns directly targeted at parents and the extension of health education in schools, can effectively challenge resistant socio-spatial differentials in smoking behaviours. Drawing on in-depth qualitative research with smoking parents we consider the impact of children's awareness of the health risks of smoking on parent/child relationships in smoking households and communities. This review of how children's knowledge about smoking risks is negotiated within families by both parents and children draws on moral education literature that considers the implication of family diversity, and the need to allow for inconsistencies for values taught at school and those encountered in children's families and communities.

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¹Legislation prohibiting smoking in workplaces and enclosed public places was introduced in England in July 2007 see Bauld (2011)

Context: Moral Landscape of Smoking and Smoking-Cessation Programmes

While the introduction of spatial controls to regulate smoking behaviour has been heralded as a public health success, it also represents an important re-conceptualisation of health and social responsibility, with a discernible shift from individual self-regulation to spatial control of smoking behaviours. From a Foucauldian perspective, the subtle interplay between technologies of power and technologies of the self that increasingly charge individuals with the responsibility to 'stay healthy' has been mediated by this shifting geography of smoking behaviours (Poland, 2000). Prior to the extension of smoking restrictions, smokers were expected to moderate their own smoking in order to reduce non-smokers' exposure to tobacco smoke. However spatial restrictions have effectively challenged smokers' capacity for self-regulation of smoking behaviours.

While this policy has been successful in regulating adults' exposure to smoke in public places, children's main exposure to environmental tobacco smoke remains in the home (Jarvis et al, 2009). There are acknowledged limits to the efficacy of smoking controls in reducing children's exposure to tobacco smoke, as to be effective this would necessitate intervention in the home which is not 'ethically justifiable' (Royal College of Physicians, 2010:187). Rather reducing children's exposure to tobacco is reliant on parents' understanding of their moral duty to safeguard their children's health (Holdsworth and Robinson, 2008). Moreover children need to learn about the risks of smoking and parents need to be aware of the potential health risks that their children might be exposed to, as well as the likelihood of intergenerational transmission of smoking behaviours (Royal College of Physicians, 2010). Thus smoking-cessation campaigns and health education programmes are targeting parents and children not just to educate children about the risks of smoking; but also to raise parents' awareness of the impact that their smoking has on the health of their children; the chances of their children becoming smokers; and, the fears that children have of their parents' becoming ill through smoking (see for example Aspinwall et al, 2004; Robinson and Kirkcaldy, 2007). In England, drug and alcohol education is taught as part of curriculum guidelines on promoting healthy lifestyles.² While children are being taught about the risks of smoking in schools, Department of Health sponsored smoking-cessation campaigns are targeting parents, raising awareness of both the health risks associated with their smoking, as well as the fears and anxieties that children of smoking parents have about their parents' health. Moreover some campaigns are not only raising awareness about children's anxieties but are using the affective potential of children to get the health message across, and in doing so are producing the very anxieties that they seek to expose. In the UK examples of campaigns that directly target parents include the 2008 'scared' anti-smoking campaign. In a widely publicised TV advertisement originally released to coincide with

²Personal, Social, Health and Citizenship education (PSHCE) has been a non-statutory part of the national curriculum in England for primary and secondary schools. In 2010 the Labour Government introduced a proposal, to be introduced from 2011, to include a statutory requirement for children to 'learn about staying safe and how to handle risks relating to issues including harmful relationships, drugs and alcohol, and how and where to get help' (Qualification and Curriculum Development Agency). These proposals were dropped by the Coalition Government in May 2010 and the teaching of PSHCE remains non-statutory. The 2010 Schools White Paper reiterated the government's commitment to PSHCE but proposed an internal review on how it should be delivered (Department for Education, 2010).

Halloween, a child describes how she is not scared of the usual things that children are frightened of (spiders, the dark, clowns and the school 'bully'), but what she is scared of is her mother smoking, and that her Mum might die because of this. In a press release to support this campaign, the Department of Health (no date) claimed:

Most smokers are unaware to what extent their loved ones are concerned and often afraid of the possible consequences of them smoking. This hard-hitting campaign is designed to get them to rethink and be aware of the strong emotional effects it has on those close to them.

The use of children's voices and images to shame parents into quitting smoking marks a distinctive development in anti-smoking campaigns, though one which has synergies with other health education campaigns such as that targeting childhood obesity (see for example Evans 2010). These campaigns seek to manipulate parental anxieties about children's futures; concerns about the 'obesity epidemic' focus on claims that children will die before their parents, campaigns such as the Halloween advertisement present an immediate risk of *parental* premature death from smoking and the threat this poses for children. In her discussion of obesity politics Evans (2010) draws on recent theorisations about childhood (see for example Ruddick 2007a and 2007b; and Katz 2008) that explore how childhood is constructed through a range of 'anticipatory logics' (Evans, 2010: 30). This recasting of childhood serves to underscore future anxieties, so that concerns about the future (whether about health, environment or even the economy) are increasingly expressed as fears for children's futures, thus giving an immediate connection to an anticipated event. This interpretation is resonant for smoking-cessation, in which children's fears that parents *will* die from smoking is expressed in the present tense (or at least immediate future) rather than a more intangible observation that parents have a higher risk of premature death. Parents are thus compelled to change or regulate their own behaviour, not just for the sake of their own health, but to guarantee their children's future and present emotional wellbeing. Moreover the precept of the Halloween campaign is that knowledge will have a causal effect on behaviour, yet as Rich et al (2010) have recently explored with reference to obesity and health education in schools, an approach that treats knowledge and bodies as separate entities, fails to consider how bodies 'become', and as such we cannot assume a direct causality between behaviour and education. Children, and indeed parents, might respond to these more emotive campaigns in unexpected and unanticipated ways. The assumption that children's understanding of and exposure to tobacco smoke is entirely determined by adults, not only ignores children's agency, but also plays down their ability to act in a responsible way and make their own decisions (Colls and Evans 2008).

The Halloween campaign's attempt to scare children and mobilise an emotional response from parents through stigmatising them as uncaring is controversial. For example early campaigns to prevent the spread of HIV-AIDS also sought to stigmatise patients. However public health practitioners effectively challenged this approach, arguing that it labelled HIV-AIDS patients and thus acted as a disincentive for those with HIV-AIDS to come forward for treatment or care, or for individuals to get tested. Moreover stigmatising HIV-AIDS patients did not offer any support for their carers (Herek 1999; Parker and Aggleton, 2003). Yet the same concerns have not been systematically raised for anti-smoking campaigns (Bayer and

Stuber, 2006). The essential message in these campaigns is that smoking is indicative of weakness and moral degradation, and that smoking parents put their own addiction before that of their children's welfare. The attributes of smoking that make it open to stigmatisation are its association with dirt, pollution and smell; and there are parallels here with how other health conditions, such as obesity, are stigmatised. Moreover it is visible practice and one that, at least until recently, is not confined to private spaces. Smoking itself is not a disease, it is an embodied practice, and it is the nature of this embodiment that has contributed to its stigmatisation. Moreover, the health risks of smoking are not just restricted to those who smoke, but to the 'innocent' victims of passive smoking. As Brandt (1998) argues for the USA, personal risk taking by individuals may be tolerated but imposing risks on others is not. Smokers are therefore 'reasonable' targets for moralised and judgemental public health campaigns.

Yet the acceptability of stigma and shame tactics in smoking cessation campaigns incorporates dominant ethical positions that map onto social distinctions in smoking behaviours. Both the practice of and attitudes towards smoking have undergone important shifts in recent years. In terms of behaviour, while overall consumption in industrialised nations has declined, smoking has become more concentrated in socially-disadvantaged groups and is an important causal factor for social inequalities in health (Graham 1993; Harman et al, 2006). The General Household Survey for England found that in 2006 just under one-third (27%) of manual workers smoke, compared to under one-sixth of non-manual workers (16%) and since 1998 the rate of decline in smoking prevalence has been greater among non-manual groups. Moreover social class differentials in smoking are becoming increasingly gendered. The ratio of manual to non-manual smokers has increased slightly for men from 1.59:1 to 1.61:1 between 1998 and 2006, while for women this class ratio has increased from 1.41:1 to 1.68:1 over the same period (British Heart Foundation, no date). Moreover there is growing concern about young people's smoking, as recent declines in the number of young people smoking have levelled off, to 10% of girls aged 11-15 and 7% of boys aged 11-15 (Fuller, 2007). As with adults, young people from lower socioeconomic groups are more likely to smoke.

This change from mass-consumption to a more socially segmented behaviour is associated with a shift in attitudes towards smoking, as smoking behaviour has become more closely bound up with class identities. While it is too simplistic to claim that negative attitudes towards smoking are recent, as smoking has always had a somewhat risky and rebellious connotation, the cigarette itself has been recast from 'an object of pleasure, consumption, autonomy and attraction to a symbol of personal disregard for health, addiction and weakness' (Brandt, 1998: 165). Increasing awareness of the risks of smoking, not just to the health of smokers but to others exposed to tobacco smoke, have undermined the glamorous image of smoking, though its connotation with rebellion, particularly for young people, continues to have some authenticity. Moreover this shift from smoking being 'sublime' to a 'filthy habit' reflects not just on the individual smoker but on the social groups identified with smoking, as prevailing views on the undesirability of smoking not only castigates those who smoke but accentuates moral repulsion about their class background. This connection between smoking and class is indicative of both the changing perception of smoking and how class membership is perceived and attributed. As Sayer (2005) has argued class

profoundly shapes not just the kind of people we are and the life chances that we have, but how we judge and others and evaluate life chances. Contemporary theorisations about class express how responsibility for individual behaviours and outcomes has been transferred to the self; class identities are no longer seen as the product of forces of capitalism (Lawler, 2005; Skeggs 2004). Yet in order for this transfer of responsibility to take place moral judgements about both identities and behaviours are integral to how class is recognised and acknowledged by others. As Skeggs (2004) suggests the working-class are identified with failing to make the 'right' choices in adopting certain forms of behaviour and identities. Behaviours that are specifically ascribed as 'working class' are increasingly associated with individual failure and moral weakness. Smoking is a germane example of the kind of behaviour that not only demarcates an individual's class background but reinforces moral judgements about their class identity.

Thus as smoking has moved from being socially acceptable to a stigmatised behaviour smokers have been increasingly treated as outcasts, and this moral reprobation is reinforced by the social and spatial unevenness of smoking practices. Smoking has a distinctive spatial distribution that maps onto geographical patterns of social inequalities. Poor neighbourhoods are associated with a high incidence of smoking and a normalisation of adult smoking, in contrast to relatively smoke-free communities in more affluent areas (Bancroft et al, 2003; Stead et al, 2001). There are two processes of stigmatisation in operation that of the individual smoker but also of spaces and communities associated with smoking. Thompson et al's (2007) account of a 'smoking island' in a deprived neighbourhood in Auckland identifies how residents in the case study area are subject to a 'dual stigmatisation', associated with their classed identities and the characteristics of the neighbourhood that they live in. There are clear processes of social distancing occurring here with the middle class establishing an effective 'cordon sanitaire' around disadvantaged areas, and this social distancing is justified by the association of such neighbourhoods with morally reprehensible and, in the case of smoking, 'dirty habits'. As Thompson et al describe, even the very practice of collating statistics on deprived neighbourhoods (such as prevalence of smoking) serves to confound what is already known and underlie the stigmatisation of these areas. This, they argue, is a manifestation of Ó Tuathail's (1996) theorisation of geo-power, or the assemblage of technologies of power to manage and control spatial differentiation. Thompson et al identify the deployment of geo-power with 'the very process of stigmatising a substance or people (which draws implicitly on constructions of 'normal' and 'desirable' behaviours and attributes) by separation, categorisation, definition or confinement' (Thompson et al, 2007: 510). Respondents in the Auckland study reveal how this geographical concentration of smoking practices is not the result of ignorance (i.e. lack of awareness of the risks of smoking) but more subtle processes of resistance and the emergence of outcast behaviours and mentalities (see also Coxhead and Rhodes, 2006). This understanding of resistance of smoking behaviours to public health discourses goes beyond conventional public health interpretation that focus on 'imitation behaviours', particularly within families and that could be challenged through education, as it recognises how 'outcast' identities are formed through this uneven working of geo-power.

The delivery of health education messages in schools cannot ignore class differentials in smoking behaviour and children's exposure to smoke and smoking outside of school. Yet as

Rawlins (2009) observes for healthy eating practices in schools, failure to endorse a holistic approach results in privileging particular styles of parenting. When it comes to smoking, clearly the opportunity for a more nuanced approach would run counter to medical knowledge about the risks of smoking and the need to challenge the inter-generational inheritance of class-based smoking practices, yet as we explore in this paper this does mean that how children and parents accept and respond to 'anti-smoking' messages is predictable.

Methodology

The research study on which this paper explored the lived lives of 12 families resident in a single disadvantaged urban area of the city of Liverpool. The study was conducted as an urban ethnography, using a combination of observation, conversations, and narrative interviews with as many family members aged over 16 as wanted to take part. The families were recruited through a local Sure Start centre to take part in a project on 'understanding smoking in the home' and the criteria for taking part were that all families had at least one smoking parent and one child under five (though the age range of the children in the families studied ranged from 0 to 19). Seventeen people took part in sixteen initial interviews (one couple requested a joint interview) and sixteen of the adults interviewed were smokers. Follow-up interviews were held six months after these initial meetings. The narrative data were elicited using the Biographical Narrative Interpretative Method (BNIM, see Wengraf, 2001), using a narrative-inducing question around their life story, and asking them to talk about their life, their smoking and becoming a parent. Though the interviews had been set up to explore parents' own narrative accounts of being a smoker, the narratives that we collected were not, in most cases, restricted to subjective accounts of individual lives. Rather most parents (and particularly the 12 mothers interviewed) reflected on their relationships with immediate family and friends, and particularly their children. Hence though the data for this paper are taken from parents, and not children, they can give a valuable insight into the negotiation between parents and children and how this is mediated by parents' (and especially mothers') smoking.

Analysis: Parents and Children in Smoking Neighbourhoods

Although the cultural context is distinctive, there are parallels between the study area considered here and that in Thompson et al's (2007) study of a 'smoking island' in Auckland. As in the New Zealand study we interviewed resilient smokers who enjoyed smoking and were critical of smoking cessation campaigns and in particular the 'shock' tactics that these used. Other respondents described themselves as reluctant smokers, regretting the day they first started smoking and left feeling inadequate and/or frustrated by their inability to give up. Parents constructed their own evidence base of the dangers of smoking and narratives include references to both adult family and friends who had suffered ill-health associated with smoking as well as those who had enjoyed longevity despite heavy smoking. There was particular ambivalence to the health risks associated with smoking during pregnancy (see Holdsworth and Robinson 2008 for further discussion); for example the association between smoking and low-birth weight was acknowledged as an advantage of smoking by one respondent.

One of the most striking themes in the interviews with the 16 smokers is how their smoking was situated with reference to family and friends. As noted above the biographical narrative interviews were not individualised accounts, as respondents drew on their embedded family and community ties in making sense of their smoking. The following extract from Pauline's narrative, illustrates the family and community context of smoking that we encountered in the research study:

Yeah err ... me Mum and Dad used to smoke, they haven't smoked now for about 15 years, they've done really well and they've never ever relapsed either, as far as I know. Erm ... me brothers a heavy smoker, really heavy smoker erm ... he always has been. My Uncle on my Mums side, he suffers with his nerves really bad and he's really shaky and stuff, he smokes a hell of a lot. His sister, me Mum's sister as well, smokes about 50 a day, me Dad's sister smokes ... she's the one that smokes the 80 and stashes them. Erm ... our Tricia doesn't smoke, me Nan was terrible for smoking, she used to constantly have one dangling out of her mouth, me Mum's Mum, she was terrible. Erm ... me Granddad was the same, the house was just yellow, me Nan and Granddad's house err ... and it stunk when you walked in. Who else is there? All me Cousins smoke, our Michelle smokes, our Jane doesn't, she's dead set against it erm ... our Alec smokes, our Owen's wife smokes, it's just everywhere you go, everywhere someone smokes. All me friends smoke, I just can't escape from it, I can't even say well, I go and sit in such and such house because ... to get away from it because they smoke, everyone I know smokes or the partners smoke ... or the Mum and Dad smoke. So ... but when you're out and about, say in town and you say to someone have you got a light, you can never get a light off anyone, no one seems to smoke.

Pauline's account is revealing, not just in her lively account of her family and friends smoking, but, with the exception of Jane and her parents, that everyone she knows smokes and that as a consequence she cannot get away from smoking. However she contrasts smoking behaviours where she lives and among her family networks with that encountered when out and about in Liverpool city centre, which she identifies as a non-smoking space, where no one 'seems to smoke'. For Pauline smoking is essentially social and is bound up with her relationships with families and friends, smoking is more than a personal choice but rather reveals her connectivities with others.

Yet Pauline's account is clearly not just relevant for her, but for her family as well. Pauline herself seems confused by the polarisation in smoking behaviours between where she lives and the city centre, it seems reasonable therefore to assume that children are also confronted with the same socio-spatial distinctions. Moreover children will also experience this bifurcation of smoking/non-smoking space on a daily basis, as they move between 'smoking' homes/communities and designated smoke-free schools.³ This social and spatial patterning of smoking behaviours is pertinent to understanding how children respond to

³Achieving smoke-free school status does not just refer to banning smoking in school grounds but also informs education and, where appropriate, the promotion of smoking cessation treatments. The accreditation is usually awarded as part of the National Healthy Schools Programme (see Ofsted, 2006). However this does not mean that young people do not create their own 'smoking spaces' within the schools.

public health programmes, as children's exposure to smoking outside of school will be largely determined by their class background and locality. The majority of children who live with non-smoking parents will have very little exposure at home, school and other public spaces to smoking, and these experiences will contrast sharply with children who move between the smoke-free environment of the school and their homes and neighbourhood where smoking is normalised (Jarvis et al, 2009). Thus Pauline's account of the pervasiveness of smoking in her local community presents a significant challenge to the delivery of health education targeting behaviours such as smoking.

That health education has a role in challenging the kinds of behaviours that some children are exposed to outside of school is explicitly acknowledged in the recent independent review of the primary curriculum (IPRC 2008):

Possibly more than any other aspect of the remit, personal development has been subject to piecemeal treatment. This is borne of disparate elements being added to it as deep societal concerns about such critical matters as drug abuse, obesity, sex and relationships, violent behaviour, 'e-safety', financial capability and so forth, press for an educational response in primary schools with children at an ever earlier age. Sadly, society at large, which looks to schools to address these concerns, does not always live up to and exemplify the standards of behaviour that it expects of its children. (IPRC 2008: 45)

The delivery of PSHCE education in schools is therefore explicitly targeted at challenging behaviours which children might encounter outside of the classroom. In addition to health education delivered within the classroom, many schools have incorporated drugs, alcohol and anti-smoking education as part of their local healthy schools initiative. This initiative seeks to locate schools at the front line of community interventions in health. Healthy schools accreditation does not just target what is taught within the classroom but seeks to build partnerships between schools and local communities, particularly parents. Hence healthy schools in theory should extend beyond simply imposing smoking bans throughout the school premises and delivering the PSHCE curriculum, but rather it should provide a platform for the delivery of inter-generational health education.

Yet this assumption that PSHCE educational programmes and the healthy schools initiative can challenge established behaviours does not consider how children themselves respond to the moral contradictions between school and community. If parents like Pauline find the distinction between smoking and smoke-free places confusing, how do children respond to this bifurcation of smoking and smoke-free spaces? Current thinking, as outlined above, would suggest that schools have a duty to challenge the behaviours that children encounter outside of school, yet this may potentially be counterproductive, as this is asking children to challenge their parents' own behaviour. For health education this can be considered morally justifiable, that children should be given the opportunity to break away from generational cycles of deprivation and health inequalities. Yet how this achieved is less clear. The dilemma of how schools can effectively challenge behaviours and values outside of the classroom is considered by Halstead (1999) in his review of family diversity and moral education. While acknowledging that some diversity is educational enriching (for example ethnic and cultural diversity can be readily embraced within schools) he argues that other

aspects of diversity are problematic and particularly those values that ‘are in serious conflict with the values which underpin moral education in the common school’ (Halstead, 1999: 275). Rather than recognising the right of schools to impose a moral superiority Halstead suggests that moral education needs to identify three rights:

1. That of the family to transmit its own moral code
2. That of the school to educate about community or social mores
3. That of the child to develop into an autonomous moral agent.

Halstead’s challenge for moral education is, we argue, pertinent to understanding how children respond to health education, such as those targeting smoking, for unless children can resolve the moral contradiction between smoke-free schools and smoking homes, their ability to make their own health decisions may be limited. Yet this does not assume that parents and children’s moral codes are antagonistically opposed; echoing Ruddick (2007a and 2007b) we need to acknowledge inter-subjectivity in parent-child relationships, that children’s agency is bound up with their connectivities to other people and places. The imperative for health education is how to support children from smoking homes and communities to learn to articulate their own views on smoking which is not antagonistic to their embedded relations with others, particularly smoking parents

This observation of the difficulties that children face in reconciling health education with parental smoking was a common theme in parents’ accounts of family relations in smoking homes. Respondents were very aware of what they perceived their children to know about smoking and the health risks associated with it, and how this knowledge varied by age. In particular parents were aware of how children’s awareness of the risks of smoking changed, contrasting toddlers, with middle childhood and early teens.

For toddlers and younger children mothers observed how their children mimicked their smoking behaviour. For example, when Alison was asked if her daughters (Darcy aged 2 and Kerry aged 4) knew that she smoked she replied that

Yeah, they do because they’ll get my ciggies, well not Darcy, Kerry does because she’ll say “are they your ciggies, Mum? Your ciggies. I have a ciggy”, “no you don’t have a ciggy”, “I have a ciggy. I have a ciggy as well”, “no, you don’t, no”, so she does know, like, so she must think it’s what people do and she wants to do it as well. I say “no, dangerous, naughty, you don’t bad for you” but then it’s probably confusing, isn’t it, if it’s bad for you, why are you doing it? I suppose we’ll get that when she gets a bit older but, yeah, she does know.

Alison’s observation that her daughters were mimicking her smoking behaviour would appear to concur with dominate medical understanding of inter-generational smoking behaviour; that it is learnt behaviour and children who smoke are simply copying their parents (see for example WHO 2001). Yet Alison also anticipated a time when her daughters will have to reconcile the knowledge that smoking is dangerous with the observation that she smokes.

Parents with school-aged children were very aware of the difficulties that children faced in reconciling what they learnt about smoking in school with the fact that one, or both, of their parents smoked. After starting school children become more aware of health risks associated with smoking. Kate described how her son (Jordan aged 10) had started to report back what he is learning in school about smoking:

And Miss said Mums and Dads who smoke are going to get very sick so he's doing this now, like, beforehand he didn't really understand about smoking but now I think he's educated a bit more.

She went on to describe a recent encounter at her son's school when a child challenged her (and her teacher) about Kate's smoking:

Yeah, and then I was sitting outside his school the other day, while my Mum had ran into pick him up and I had a ciggie in the car, out the window, baby not in the car and I'm out the window smoking, it was a lovely sunny day and the kids are all coming out of church because it's like a church of the school and one of the communion classes were coming out, he'd been the day before, and as the teacher stands in the road, because it's like a dead quiet road but she stood in the road to let the kids pass, and I was like this, and this kids went "Miss, tell that lady she's going to die, she's having a ciggy" and I went "oh, I'm like a leper, Miss tell that lady" and the teacher just looked all embarrassed. Sorry. So yeah, it bothers me when I hear things like that.

Kate's observation of both her own and the teacher's embarrassment about this encounter suggests how teachers themselves might be hesitant about school's moral authority to tell parents how to behave, and that children find it difficult to comprehend why adults should participate in a behaviour that at school they are taught is so dangerous and wrong. Yet in not dealing with the polarisation between school and home, neither parents nor teachers are able to provide the support that children need to make sense of these contrasting and confusing behaviours. Instead parents described how their school-age children become frightened and angry about parental smoking and wanted their parents to quit:

Erm, as I say, I'd love to pack in because of the kids. The kids hate seeing me smoking. *Dawn*

he says doesn't he, he worries you're gonna die, you're gonna die of cancer. Peter's [son] always been way ahead, even since he was a baby like. *Tanya*

Jordan [son] hates me smoking, only because he's just done it in school. *Kate*

Susan's [daughter] very anti-smoking, she's always on at us to give up. *Pauline*

In contrast to Department of Health (no date) claims that parents are not aware of their 'loved ones' fears about smoking, all the parents of older children were very aware of what their children felt about parental smoking. Yet neither parents nor children were able to deal with children's emotive response to parental smoking. While parents acknowledged that their children (as well as partners and parents) wanted them to give up, responding to this was far harder. Thus the tension between parents and children was not resolved, as Lorna described:

Erm, as I say, I'd love to pack in because of the kids. The kids hate seeing me smoking. You know, which I tried to explain and I did try and pack in for two weeks. You know cos, you know, every night these adverts come on and me son's like, you know, 'that's going to be you, that's going to be you'. You know, an I'd go to my three year old after a ciggy and he's like 'you stink mum, go away and brush your teeth'.

In our small sample while parents wanted to give up smoking for their children and some had attempted to do so, none had been able to sustain this over a long period of time. At her first interview Tanya described that she had recently given up smoking because of her children, yet at the second interview had started smoking again due she described to 'being really stressed out'. Her oldest boy in particular had not taken this well:

Peter is the oldest, he, the others didn't really, Jack made a few comments, he is 3 and he was like, why have you got ciggies, you don't have ciggies, my dad has ciggies, they are my dad's and stuff like that. But because like Peter pressured me into packing it in the first place, he used to always go on to me about cancer and stuff, so erm, I got a bit of grief off him and he still says to me now, when are you going to Fag Ends⁴, when are you going to pack in?

The issue in these homes is not therefore one of ignorance, either of the health impacts of smoking or of the fears and anxieties that children have about parental smoking, but of the impossibility of reconciling opposing behaviours. Not surprisingly for this group of parents, campaigns that played on these fears were not liked, though parents did acknowledge that recent initiatives accurately reflected their lives. Pauline for example 'hated' herself for being a smoker, described her smoking as 'stupid' and did not want her daughter Susan (aged 12) to start smoking. Yet commenting on a recent campaign that targeted parental smoking she described how it was too real and could potentially frighten her daughter:

that advert about that Mum and she took her little girl to pick her headstone because she's not got long left. I can Susan watching it and I know she can relate to the advert because the little girl has got the same bed and the same bedding and I can't help thinking if she's thinking that could be my Mum one day. That's a bit too real that advert, it's very real.

The stress this campaign caused for Pauline could also potentially be counter-effective, given that the one of the most widely acknowledged benefits of smoking is that it reduces stress and tension (Holdsworth and Robinson, 2008).

If parents struggle to give up smoking for their children, what does this mean for their children's future smoking, and will children's hatred of parental smoking deter them from smoking as adults? In our sample parents were not optimistic about their children choosing not to smoke. It should be stressed that parents did not want their children to smoke and were certainly not encouraging this behaviour. Yet parents felt that they had no moral authority to influence their children's behaviour. As Lorna recounted, even though her

⁴Fag ends is a community based stop smoking service based in Liverpool that provides support for smokers wanting to quit.

children hated smoking when younger, as they grew older this changed, but she herself could say nothing to stop this:

Erm I say me oldest son he come in a while ago and he smelt of smoke and I thought he'd been smoking. He denied it, but, you know, he said to me why should I be telling him off when I do it. *Lorna*

Some respondents had themselves experienced the shift from being anti-smoking as a child, to smoking as an adult. For example Natalie explained how she had grown up in a smoking home and hated smoking, yet this did not prevent her from starting smoking as she grew older, something that she still regretted:

Natalie: I just wish I never ever tried one in the first place. I wish I stayed in my own mind the way I was, dead against it because my parents smoked, I hated it, I really hated it.

INT: What did you hate about them smoking?

Natalie: Well I think it was like the way me son is, I was thinking about their health and I was thinking ... not about me so much because passive smoking then wasn't as important as it is now, it wasn't like you focused on .... But I was just thinking about their health and I used to worry that they were going to die young and do you know, may be that was a bit selfish because I'd lose them do you know what I mean, but it wasn't like the passive smoking stuff, I didn't really think about my health. Where me son does he says I want to be a footballer but you're going to ruin it for me and I'm like but I don't smoke in the house or round you or ... do you know what I mean. So I sort of convinced myself that I'm not stopping him being a footballer and I'm not making Rose's [daughter] health any worse, do you know what I mean. I don't know, it's just ... it really is hard, its hard ... it is.

Natalie's account of both her attitude to parental smoking, and that of her children to her own smoking recasts accepted medical discourse about the parental role models and the inheritance of smoking behaviour. Despite hating her parents' smoking this was not sufficient to prevent her from starting smoking, but rather the pervasiveness of smoking in her family and community led to her starting, and despite hating it, she has not been able to stop. While Natalie worried about her parents' health and that they would die young because of their smoking, her son was more concerned about his own exposure to second-hand smoke and that his mother was 'ruining' his aspirations to be a footballer. Her solution was to 'convince herself' that by not smoking around her children she was not damaging her children's health, and as such she could justify the contradictory position of being an 'anti-smoking' smoker.

Conclusion

The aim of this paper is not to challenge the legitimacy of health education, smoking is an acknowledged contributory agent of inequalities in health and a significant causal factor of avoidable deaths; thus reducing children's exposure to both tobacco smoke and smoking is an unequivocal health promotion target. Yet the ways in which smoking cessation campaigns target specific groups, such as parents, and the assumptions that underlie these interventions

about who smokes and why are more contested. The model of individual self-regulation and reliance on individual action to reduce exposure has been challenged in recent years with the result that adult's exposure to tobacco smoke is increasingly regulated by spatial control. The capacity for individuals to negotiate 'considerate' smoking behaviours and thus reduce others' exposure to tobacco smoke, is being replaced by regulation of where individuals can smoke. Yet this approach has had less direct impact on children's exposure. In response health promotion campaigns have assumed that the solution is education and that parents smoke out of ignorance of the health risks and anxieties and fears experienced by their children. The premise of campaigns targeting families is that for parents to adopt appropriate technologies of the self and take responsibility for their children's health, they need to be educated about these risks and modify their behaviour accordingly. This assertion of parental ignorance makes some important assumptions about family relations in smoking homes, that parents are at best unaware, or at worse insensitive to children's needs. Moreover it fails to recognise that many parents (though not all) enjoy smoking and do not smoke just out of ignorance but as a way of reliving stresses they face at home and in their communities (see Holdsworth and Robinson, 2008). Yet qualitative research with smokers demonstrates that lack of awareness of health risks can no longer be regarded as the main 'missing link' in explaining the persistence of risky behaviours such as smoking (Thompson et al, 2007; Coxhead and Rhodes, 2006). The findings from this study with parents illustrate the same is true for understanding children's exposure to tobacco smoke; parents are acutely aware of children's fear and anxieties, and while parents might try and deny or play down the health risks to their children (as for example Natalie appears to do), they cannot ignore what their children feel about their smoking. The Department of Health in supporting campaigns such as the Halloween advertisement, also appears to have failed to consider the impact on children, and the ethics of both creating and mobilising their fears.

Yet what appears to be lacking is a response to Halstead's observation that moral education needs to incorporate the rights of schools, parents and children, and that children need to be able to articulate their own views and concerns about smoking through, and not in spite of, the connectivities that children have with significant others, particularly family and places including schools and communities. For health education this right might be considered of less importance, that in the case of smoking, children need to learn to make one decision only, that is not to smoke. Yet while younger children do appear to acquiesce with this as a result of health education they receive at school, this makes it particularly difficult for children to make sense of their parents' choices. Thus what is lacking is support for children in coming to terms with the moral inconsistencies between behaviour observed at home and that learnt at school. As our research illustrates, many smoking parents are not able to respond to children's uncertainties, and, in this community, there does not appear to be much support from schools. As such many children from smoking households have to negotiate contradicting moral positions; the official anti-smoking messages learnt at school and reinforced by smoking bans in public spaces (such as schools and shopping centres) with the daily reality of living in a smoking home and in a community where the majority of adults smoke.

The inconsistency between the normative moral view of smoking as expressed at school and adult behaviours encountered at home and in children's local communities is potentially

challenging for the delivery of effective health education at all ages. Delivering consistent messages within the context of the school environment maybe relatively straightforward, but children need to be able to articulate these messages outside of school. Yet as the interview data with mothers reveals, children struggle to make sense of the behaviours they encounter at home and their communities, and though children challenge parental smoking, there appears to be little support, both from families as well as from service providers, for children in reconciling this contradiction between smoking homes/community and non-smoking public space. Furthermore children might also recognise that smoking might be pleasurable, in opposition to how it is approached in smoking-cessation and health education campaigns yet are given little guidance in how to reconcile these contradictory positions. However the most telling evidence is that this 'hatred' of parental smoking is not recognised as a reason for rejection of smoking as an adult. Among the parents interviewed the possibility that dislike might turn to acquiescence as their children grew up was openly discussed. This is the behaviour that smoking cessation and health campaigns need to target, ensuring that children maintain their younger resistance to smoking through their teenage years, and one that is potentially missed by not recognising and responding to children's anxieties. From this perspective current policy based on stigma and shame as the most effective way of breaking the pattern of inter-generational inheritance of smoking behaviours is found wanting as children are not given an opportunity to explore contradictory positions at a younger age. Echoing Rich et al (2010: 13) we need to be 'more attuned to the contexts within which young people find themselves when affective responses to particular bodies might be troubling, transgressive or confusing' and recognise that children will not maintain consistent responses to smoking as they move through different spaces and times.

This paper also reveals the importance of a critical geographic perspective, that recognition of spatial unevenness of smoking behaviours is essential in understanding how children and parents respond to smoking cessation and health education. For the majority of children who live in smoke-free homes, there is relatively seamless transition between smoke-free public and private spaces, and as such anti-smoking message are unequivocal and straightforward: smoking is bad for you. These children will have relatively few occasions on which this moral conviction has to be challenged. For children from smoking homes, this challenge is made on a daily basis. Moreover the bifurcation of smoking/smoke-frees spaces can intensify children's unease and uncertainty about smoking. The ultimate goal of effective health education should not be to scare or frighten children, but to enable children to make sensible health choices, and this can only be achieved through understanding how children experience the spatial and social unevenness of health and health-related behaviours.

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