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Is Smoking Queer? Implications of California Tobacco Denormalization Strategies for Queer Current and Former Smokers

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Abstract

This article is concerned with normative conceptions of health structuring tobacco control strategies designed to “denormalize” tobacco use. Analysis of 201 interviews with non-heterosexual and/or non-cisgender adults in California revealed that participants implicated tobacco use in exacerbating health inequities and perpetuating harmful narratives of queer suffering, but also regarded smoking as a critical tool for self-care and symbol of resistance. Participant narratives suggest that using stigma in health promotion efforts which reinforce normative conceptions of health may be harmful to queer people whose social identities exist within ongoing legacies of pathology, health stigma, and deviance from hegemonic structural norms.

Introduction

In 1989 California’s Department of Public Health began its tobacco control program with an explicit denormalization approach that seeks “to create an environment in which tobacco use becomes less desirable, less acceptable, and less accessible” (CA DHS 1998). This approach, designed to “reinforce the fact that tobacco use is not a mainstream or normal activity in our society,” emphasizes norm change - that is, shifting meanings of tobacco use from normal and acceptable to abnormal and deviant - as a way to reduce cigarette use in the general population (CA DHS 1998; Lavack 1999:82; Roeseler and Burns 2010). Denormalization strategies include often high-shock-value advertising campaigns about smoking prevention and cessation, the dangers of environmental tobacco smoke, and the predatory practices of the tobacco industry. Denormalization efforts also include regulatory controls on the sale, marketing, and use of tobacco products that are enacted through taxes, smoke-free laws, and age of purchase restrictions (Lavack 1999).¹ While in other areas such as mental health, HIV/AIDS, and substance use, public health efforts and policy making

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¹Notably, industry denormalization strategies are distinct from social denormalization strategies in that they target the tobacco industry instead of the individuals who smoke (Voigt 2013). This article is primarily concerned with social denormalization.

have explicitly focused on reducing the stigma associated with illness, addiction, or specific substances (Ahern, Stuber, and Galea 2007; Corrigan, Druss, and Perlick 2014; USDHHS 1999, 2003; Valdiserri 2002), tobacco denormalization is unique in that it diverges from these movements by *endorsing* and *promoting* stigma rather than working to mitigate it for the sake of better health outcomes (Bell et al. 2010a; Stuber, Galea, and Link 2008).

While California indeed maintains low overall smoking rates compared to the rest of the United States and has long been considered a leader in tobacco control (Roeseler and Burns 2010), a growing number of critics contend that smoking and its negative health consequences now remain concentrated among historically marginalized groups (Bell et al. 2010b; CDC 2018; Graham 2009; Voigt 2010). For example, the prevalence of tobacco use remains disproportionately high among sexual and gender minorities (SGMs) in California (as well as the US in general) (Blosnich, Lee, and Horn 2013; Bye et al. 2005; Cochran, Bandiera, and Mays 2013; Gruskin et al. 2007). Trend data on the prevalence of SGM smoking is limited by failures of measurement and disclosure issues (Rath et al. 2013; Stepleman et al. 2017); however, the available data in California suggest that SGM smoking prevalence has not decreased over the past decade. A 2004 statewide household survey conducted by the Tobacco Control Section of the California Department of Health Services found that the prevalence of SGM smoking was nearly double that of the general population (Bye et al. 2005), and more recent data from 2013 imply that this striking disparity persists (CA CTCP 2013). As the social gradient in smoking worsens, the privileged become healthier and historically marginalized people are once again overlooked while their inequalities intensify. Perhaps even more troubling than growing inequities in smoking is the coinciding intensification of social marginalization arguably resulting from the increasing stigmatization of people who smoke (Greaves and Hemsing 2009; Riley et al. 2017; Voigt 2010, 2013).

Roberts and Weeks discuss smoking stigma - and the social denormalization policies which foster it - as a form of “healthism” in which the association of smoking with poor health makes it such that smokers are socially and structurally “devalued” because they are “deemed unhealthy” (2017:484). Increases in the stigmatization of smoking have been documented, and negative social meanings and stereotypes have become attached to smoking bodies, including “weak-willed,” “outcasts” and “lepers,” “selfish and thoughtless,” “unattractive,” “undesirable housemates,” “addicts,” and/or “a social underclass” of abusers of public services who “are blamed if they” or those around them “experience poor health” (Bell, et al. 2010b:797; Chapman and Freeman 2008:27; Farrimond and Joffe 2006:468; Goldstein 1991:172; Ritchie, Amos, and Martin 2010:625; Roberts and Weeks 2017:486). In light of these “deeply discrediting” and devaluing characteristics now associated with individual smokers (Goffman 1963:3), as well as research documenting the negative influence of stigma on people’s health (Blacksher 2018; Hatzenbuehler, Phelan, and Link 2013; Major, Dovidio, and Link 2017; Metzl and Hansen 2014), what are the implications of social denormalization strategies for people who historically have been stigmatized as unhealthy or pathological for reasons other than smoking?

Queer² bodies, desires, and forms of life have been and continue to be marginalized within the health establishment and broader society due to the pathologization and stigmatization of non-heterosexual practices and non-heteronormative sex and gender variance which have been and largely continue to be regarded as moral perversions, physiological malfunctions, and mental illnesses (De Block and Adriaens 2013; Drescher 2010; Eckhart 2016; Fausto-Sterling 2000; Valdiserri et al. 2018). For example, homosexuality was defined as a psychiatric disorder until 1973 (Drescher 2010), men who actively have sex with men are still banned from donating blood in the US (Caplan 2010; Cohen, Feigenbaum, and Adashi 2014), sex education curricula in US public schools more often than not address only heterosexual and cisgender bodies and practices (Kosciw and Gay 2014; Pound, Langford, and Campbell 2016), homosexuality and gender norm transgression have been explicitly criminalised (Dennis 2014; Mogul, Ritchie, and Whitlock 2011), and the discrimination of queer people in housing and employment is widespread (Badgett et al. 2007; Friedman et al. 2013; Sears and Mallory 2011). In light of this pervasive structural, political, and social stigmatization and marginalization, “queer” has become one way to talk about “non-normative” sexualities and genders - about bodies and desires that deviate from proscribed, hegemonic norms. Thus, “queer” can be used to underscore the powerful historical construction of normativity in separating out some forms of sexual and gender expression from others, and devaluing, erasing, or punishing those that are deemed deviant. In this way, queerness is - at least partially - defined in contradistinction to what is considered “normative” within the broader society.

Scientific and biomedical research, practice, and policy concerned with notions of health are influential in defining what is *natural* and *normal* for humans, thus shaping normative health ideologies (Gordon 1988; Illich 1975; Lupton 1995; Metzl and Kirkland 2010). Tobacco denormalization strategies, in socially and structurally stigmatizing tobacco use on the basis of its perceived threats to individual and population health, explicitly mobilize the power of normative health ideology to position smoking as deviant. If queerness has historically been made socially and legally consequential through authoritative claims of immorality and deviance that were first religious and then medical,³ and now denormalization as a health policy uses scientific medical authority to govern smoking as morally, statistically, structurally, and socially deviant: is smoking queer? If queer people smoke at higher rates than their heterosexual and cisgender peers within this policy environment, is smoking queer? Though these questions are ultimately unanswerable,⁴ they nevertheless serve as our rhetorical entrance into critically considering the potential unintended consequences of a policy environment designed to denormalize tobacco use, paying special attention to the experiences of queer adults who smoke and live in California.

²We are using the term “queer” here instead of either LGBT or SGM to emphasise the problematics of representational identity category labels - as this was an issue that came up consistently throughout our study - and to underscore the axis of normativity around which tobacco control policy, contemporary identity politics, and hegemonic biomedical health discourse all pivot. “Queer” holds space for this complexity, and gestures towards the many different forms of sexuality and gender that are made socially consequential primarily through their discursive positioning as deviating from social and structural norms. This is discussed in more detail in the following paragraphs.

³Interestingly, tobacco has a sometimes-similar historical trajectory - see Hughes (2003).

⁴For more on the impossibilities of fixing either ‘queer’ as a concept or tobacco as a substance to a single or stable meaning, see for example, respectively, the works of Jagose (1996) and Hughes (2003) or Klein (1995).

Methods

This analysis is based on the narratives of 201 adults between the ages of 19-65 living in California who participated in in-depth qualitative interviews for a study investigating their attitudes, perceptions, and experiences surrounding tobacco, stigma, and identity. We conducted 2.5 hour open-ended interviews with both current and former smokers who qualify as what the National Institutes of Health call “sexual and gender minorities” or “SGMs,” based on participants’ self-identification of their gender or sexuality as anything other than straight and cisgender, including lesbian, gay, bisexual, transgender, queer, intersex, asexual, transsexual, non-binary, genderqueer, genderfluid, pansexual, demisexual, and others. Participants were recruited on the street, through community-based organizations, Craigslist and Facebook advertisements, and by referral. Before being interviewed, participants were screened online, via phone, or in person to determine eligibility and once eligible completed a close-ended survey designed to collect basic demographic information, tobacco use frequencies and quantities, and perceptions of multiple forms of stigma. Interviews included open-ended questions about topics such as smoking and other tobacco use behaviors, perceptions of tobacco laws and policies, background information about participants’ core intersectional identities, and experiences with stigma and discrimination. To thank participants for their time, they received a \$55 honorarium. All interviews were professionally transcribed and scrubbed of any information compromising confidentiality. Participants were asked to create their own pseudonyms to be used for publication, and these are included in the identifiers attached to each quotation. All study procedures were approved by the Institutional Review Board of the Pacific Institute for Research and Evaluation.

Interviewers completed fieldnotes immediately following each interview to provide contextual and descriptive information not captured in audio recordings, and to record preliminary analytical ideas emerging from the data. The project manager and two research assistants coded transcripts using ATLAS.ti, a qualitative data management software, to process and organise the data into manageable, analytically meaningful segments (Frieze 2013). The substantial code list included codes such as agency, health, stress, identity, reasons for smoking, cigarettes, perceptions of policies, and structural stigma. The research team used analytical memos attached to relevant sections of the transcripts during the coding process to record and refine preliminary analytical ideas about the data, as part of an iterative analytical approach (Birks, Chapman, and Francis 2008). Once transcripts were coded, the lead author used a pattern-level analytical approach to explore the multiple ways in which the data may contain patterns, including: (1) declaration from a participant that a pattern exists, (2) omission of an expected pattern, (3) frequency of a particular pattern in the data, (4) congruence of a pattern with prior research and theory, and (5) co-occurrence of ideas suggestive of a pattern (LeCompte and Schensul 1999). The research team also conducted searches for disconfirming evidence, divergent patterns between interviews, and contradictory or conflicting data within interviews to refine and refute our interpretations of the narratives (Antin, Constantine, and Hunt 2015).

Sample

Like most qualitative work, our study and its sample were not designed to be representative of California's SGM populations. Instead we sought inclusivity to identify a range of perspectives from California queer adults from which we could ultimately analyze in the aggregate to produce analytically generalizable theory (Bernard and Ryan 2010; Kvale 1996). For this project, inclusivity may be defined by gender identity, sexual identity, ethnicity, age, and social class variation, differences in smoking trajectories, various perceptions of smoking-related stigma, and diversity in beliefs related to main topics of interest for the study.

Descriptive analysis of the brief closed-ended survey illustrates the basic demographic characteristics of the sample, and provides some contextualisation of participants' narratives by highlighting the range of experiences within this sample of participants. Seventy percent of participants indicated that they were a sexual minority only, 7% indicated being only a gender minority, and 23% indicated both sexual and gender minority status.⁵ Approximately 34% of participants reported that "others assume [they] are LGBTQ" most or all of the time, a measure we included to assess participants' perceptions about the visibility to others of their SGM identities. Participants varied in age from 19 to 65 years old, with an average age of 38.5, and 35% were under 30 years old. A narrow majority (n=62) of participants identified as "White," 55 participants identified as "Black or African American," 21 participants reported other ethnicities (i.e. Asian, Latinx, Native Hawaiian/Pacific Islander, and American Indian/Alaskan Native), and 32 participants reported more than one racial or ethnic identity. Thirty-one participants chose not to provide a response. Economic disadvantage was prominent in our sample, with nearly 57% (n=114) of participants reporting yearly household incomes below \$20,000 and only 9% (n=18) making \$75,000 or more, which in the San Francisco Bay Area may suggest widespread economic disadvantage across the sample due to the high cost of living. Over 57% of participants were unemployed at the time of the study. Twenty-four percent of participants reported experiencing housing instability in the past-30 days, and notably, narrative data suggests that many more had experienced periods of homelessness at some point in their lives. These closed-ended survey results, corroborated by the narrative data, suggest how the experiences and life conditions of the participants in this sample are also shaped by social and material disadvantages resulting from interlocking systems of oppression such as classism, racism, sexism, and heterosexism (Collins 1991; Crenshaw 1991).

⁵The themes of this analysis are drawn from the entire study sample, but the specific quotations selected for dissemination here focus on participants who explicitly used the term "queer" in their narratives to discuss their lives, identities, and/or communities, especially in relation to tobacco use. Providing a concise count (e.g. n=x) of "self-identified queer participants" in the study is complicated by the diverse meanings and uses of "queer" that were present. For instance, many participants who identified as queer also identified themselves using other labels, such as lesbian, gay, bisexual, or pansexual, depending on the person and the context in which the label was being used. Not all of the participants who use the term "queer" in their narratives self-identified as queer. Many other participants were either not familiar or comfortable with the term, yet highlighted similar themes using different language such as "gay" or "LGBT/LGBTQ/LGBTQIA/+" or "the community" when discussing marginalization and issues of normativity.

Findings

Analysis of these participants' narratives suggests contradictory meanings of smoking which are shaped by the social structures enacted upon and the agency exhibited by participants. On the one hand, cigarette smoking was perceived as reinforcing the status quo of intersecting systems of oppression that participants experience as consequential to their lives and identities. On the other hand, smoking was also simultaneously understood as a way to resist and cope with the conditions of stigmatization within these same systems of oppression. Complex tensions between health, normativity, identity, and resistance emerge when the meaning and role of smoking is considered from the perspectives of the participants themselves. Though participants implicated tobacco use in exacerbating health inequities and perpetuating harmful narratives of queer suffering, smoking was also regarded as a critical tool for self-care and an important symbol of resistance in an oppressive and unjust society. Understanding these roles and meanings of smoking – and especially their relation to health, harm, and care – from participants' perspectives provides crucial context for their evaluations of denormalization strategies discussed in the final section of these findings. Given existing tobacco inequities, the perceptions of people belonging to populations for whom denormalization has proven less effective offer insights into this policy's possible shortcomings. Even more critically, however, an examination of these shortcomings in the case of tobacco denormalization demonstrates the extent to which dominant public health priorities and perspectives are incommensurate with some participants' approaches to health and well-being.

Smoking as Reinforcing the Status Quo: Health Inequities, Deviance and Self-Destruction

Many participants worried about smoking's negative health consequences exacerbating existing inequities facing queer people (Valdiserri et al. 2018). Like other participants, Janet, a 25 year-old former smoker who identifies as a queer cisgender woman, was especially concerned about the health consequences of smoking in light of structural inequities that disenfranchise queer people:

I would like to see our community as happy and healthy as possible, and especially with a lack of financial security and lack of access to like, competent healthcare, and the amount that smoking contributes to having to access those services, I worry for folks not being able to actually get the help that they need if smoking does have a really negative impact on their health.

Elaborating further, SB, a 24-year-old polyamorous queer cisgender woman and former smoker, agrees with other participants that quitting smoking for queer people is:

[V]ery important [...] especially for trans folks who are so targeted medically, and are so overwhelmingly invalidated with their medical concerns. [...] another physical ailment to be addressed in the medical world is, it's dangerous. And queer folks in general, I think the same thing. I think it's important to stay healthy, because those resources aren't super readily available for us. At the same time, I totally understand why they do [smoke]."

Notably, for these participants, the idea that smoking is unhealthy is not just about its negative physiological effects. Rather, these narratives underscore the ‘dangerous’ significance of an unhealthy status within medical institutions (Lupton 1999; Roberts and Weeks 2017). Queerness has historically been defined and treated as pathological in dominant health discourse (De Block and Adriaens 2013; Drescher 2010; Eckhert 2016), a fact not lost on these participants, whose narratives frame the health establishment as potentially dangerous to queer lives due to structural incompetence, inaccessibility, and widespread heterosexism operating within (Enson 2015; Fish 2006; Heyes, Dean, and Goldberg 2016; Utamsingh et al. 2016). Many participants worried that smoking would increase reliance on (already inadequate) health resources, thus increasing this danger and exacerbating their existing marginalization.

Participants’ narratives emphasized not only structural consequences but also important social consequences related to the negative health effects of smoking (not that the two can be fully disentangled). For instance, some participants discussed the pervasiveness of smoking among queer people as potentially playing into stigmatizing narratives of tragic queer self-destruction, suffering, and doomed unviability (Ahmed 2006; Butler 1993; Hansen 1991). A 24-year-old former smoker who is cisgender and identifies as a lesbian, Jackie expressed her concerns about queer people smoking:

I really do not want queerness and smoking associated, because it’s like we’re killing ourselves, [...] I think queers should not have this like pattern of [...] self-destruction. But I think unfortunately, it’s just like the stress and lack of acceptance, you know, can lead to that.

Here, Jackie highlights the ways smoking is considered a form of self-destruction because of the threats it poses to physical health and longevity; threats that are perceived to be wholly avoidable by individual choice (Crawford 1980; Lupton 1999; Roberts and Weeks 2017). As such, smoking in the face of these known threats was perceived by some participants as constituting a form of pathology that risks perpetuating the social marginalization experienced by many queer people. The marginalising impact of this pathologising discourse of the smoker arguably is reinforced by tobacco control approaches that intentionally position smoking as socially unacceptable and morally deviant (Bell 2011; Bell, Salmon, et al. 2010; Bell and Dennis 2013; Dennis 2016; Keane 2014). Notably, this positioning of smokers also mirrors the modern historical construction of queerness as risky, deviant, and culpable for the conditions of suffering with which it has become associated (e.g. Ahmed 2006; Watney 1987). Thus, normative conceptions of health that define both smoking and queer lives as risky only serve to threaten queer well-being, situating the health of queer smokers in a liminal space not easily recognizable in a mainstream public health agenda that serves to “constitute and regulate... ‘normality’, ‘risk’, and ‘health’” (Lupton 1995:4).

As Neil, a 24 year old genderqueer and queer participant who is a current smoker put it, queer smokers are viewed as “trashy” because smoking “is like part of a narrative of deviant behavior” that is especially relevant for queer people whose sexual and gender (and often also class, race, and immigration-related) identities have been constructed as deviant. While tobacco denormalization efforts clearly aim to (re)construct tobacco use as deviant, participants saw this mobilization of stigma as not only ineffective, but potentially iatrogenic

- a theme that will be explored in more depth within the final subsection of these findings. Addressing concerns similar to the ‘pattern of self-destruction’ that Jackie framed in relation to ‘stress’ and ‘the lack of acceptance,’ Guttersnipe brought up what he called an “expectation” that queer lives may be doomed insofar as they are perceived as unworthy of care. When asked about the high prevalence of smoking in queer communities, this 30-year-old queer and genderqueer participant said:

I feel like I know a lot more straight people who are like, *no way* [about smoking]. And a lot more queer people, who are like, *I don’t care...* one thing I’ve heard people say is like, we’re all going to die. I’m probably going to get cancer anyway. [...] Maybe it’s like people hate queers, and so what do we care? I mean, we don’t want to do anything that society wants us to do anyway. ...It’s like this expectation that our lives are going to be short, because somehow society doesn’t care about us.

Explaining his perception that more queer people than straight people he knows express ambivalent rather than negative attitudes about the physiological and social consequences of tobacco use, Guttersnipe suggests that mortality, nihilism, resistance, and marginalization may all be relevant factors. Furthermore, the ‘expectation’ that queer lives are less worthy of the care necessary to survive may position the health risks and social stigma of smoking – upon which the efficacy of denormalization in changing smoking behaviors depends, by the way – as relatively inconsequential in the lives of many queer people. Guttersnipe’s narrative indicates that this is even more relevant for queer people who may already be receiving the message that their lives do not matter and that neither their health nor the care it requires can be taken for granted.

Smoking as Resisting Conditions of Oppression: Self-care, Coping and Resistance

Importantly, participants’ narratives did not only frame smoking as a form of self-destruction; they also emphasized the role of smoking in self-care. This brings us to the other side of the contradictory meanings of smoking mentioned earlier, where many participants discussed smoking as a way to cope with and resist identity-based stigma. A 20-year-old current smoker who identifies as a queer non-binary femme person and as bisexual, Ana shares their belief that:

[W]orking class people, folks of color and queers and god forbid if you are all three of those things, you are going to be smoking. You are stressed out. There are not a lot of things that are accessible for you in terms of relief. Like, who can afford to get a massage every week? I can’t. Who can afford to get mental health care? Sometimes smoking a cigarette is the difference between – I don’t know, at least for me, it’s the difference between cutting myself or not. [...] So sometimes I think it is a coping mechanism. Sometimes it’s the only one and it’s the best one that people have.

Ana’s narrative emphasizes how limited access to self-care and health care resources positions smoking as an accessible and effective coping strategy for people who experience social and structural marginalization. For Ana and others, smoking is understood as a self-care practice and self-harm reduction strategy, running counter to mainstream public health discourse that situates smoking only in relation to its physiological risks to health. Within

dominant ideologies that position both smokers and queers as unworthy of care because of their moral culpability for their health status (De Block and Adriaens 2013; Lupton 1995; Roberts and Weeks 2017; Watney 1987), smoking for self-care not only serves a practical harm-reduction function, offering well-being through relief from certain forms of suffering, but may also be an act of resistance that challenges the narrow definitions of health that have come to differentiate healthy subjects from risky Others.

Similarly, K shares her own perspectives regarding mental health, self-care, and the relatively insignificant power of anti-smoking efforts in comparison to the important meanings of smoking in her life. A 27-year-old queer and gay woman, K is a current smoker, and at the time of our study was in an intensive outpatient mental health program. Smoking played a big role in K's life as a harm-reduction strategy for suicidality and self-harm and was also a tool for social bonding and stress reduction both while she was at school and during her program. K explains how her perceptions of anti-tobacco messages are related to these experiences, saying:

[W]e have so many, at least in the queer community, mental health issues, and those aren't being addressed, but we're going to try to address self-care, or stuff that's considered self-care, without addressing the underlying issues. Like, for me, I can see all the little anti-tobacco messages that I want. That, stacked against my own kind of internal pain, it's not going to mean anything. So, until the internal pain gets kind of helped, and some [...] issues get kind of resolved, that's not going to be effective, for me at least. You know? [...] So, if the point is to scare kids straight, I don't think that necessarily works. If the point is to kind of help people get to the point where they don't need to self-medicate as much, that would be money better spent, I think.

K illustrates how tobacco control efforts which focus on individual health behaviors - instead of the issues that contribute to a situation where smoking is perceived as an available, accessible form of self-care - may miss their mark for many queer smokers. Perhaps even more troubling, such efforts may be perceived to be more about making "straight" that which is deviant than about supporting well-being or fostering equity. K's choice of words suggests that straightness (which most directly indicates heterosexuality but also may refer to other normative or mainstream proscriptions for living), abstinence from tobacco and other substances, and health are collapsed into each other and implicitly equated, at least within some health promotion efforts such as 'anti-tobacco messages.' As long as this is the status quo of normative health policies that stigmatize difference as moral, social, and physiological failure, the health of smokers, users, queers, and other 'Others' is arguably compromised and foreclosed as a possibility within the dominant health establishment.

Other narratives from participants, exemplified by SB's quote below, emphasize that smoking is not just a replacement for a lack of services but also a way to exert control over the experiences of stigmatization that queer people face for their identities. She explains that an important reason queer people might smoke is:

Stress relief. Being queer in a heterosexist society is very stressful. [... A] lot of substance abuse within the queer community is directly tied to that stress, to that sense of comfort and support that is difficult to find outside [in] the big brawn scary world. [... A] lot of it's addressing I think stresses and anxieties and self-loathing that we're socialised to accept in ourselves. [...] I found it was -- I can't change the society around me, but I can change the way I feel [... and] really take control over how I felt in that society that seemed unwelcome of me.

Though some have argued that the mere act of coping in an oppressive environment “can signify a form of resistance” (Griffin 1993:125), it is not always clear that the person identifies their own coping in these terms. However, more conspicuous displays of smoking as resistance emerged among our participants in discussions of smoking as a purposeful response to an oppressive power structure. For example, Peachtree, a 40-year-old current smoker who is a cisgender woman and identifies as queer, expressed her belief that for many people who choose to smoke now as opposed to many years ago, smoking is “a way to say, ‘Fuck you’ to the world.” Indeed, the idea that smoking is a symbolic “fuck you” to the powers that be was perhaps one of the most consistent responses participants gave about the meanings of smoking within this study. On the relevance of smoking as a form of resistance for queer people in particular, Peachtree explains further:

I think a lot of the LGBTQ community has grown up with a disproportionate amount of baggage, like a lot of minority and oppressed groups. They may be more likely to pick that up either as a way of identifying themselves as outside of the norm or as a way of expressing they don't give a damn about society's rules or they don't give a damn about themselves.

From Peachtree's perspective, smoking now facilitates multiple forms of social resistance, including marking outsider status, expressing rejection of norms and rules, and asserting autonomy over one's body (Factor, Williams, and Kawachi 2013), a perspective that has been supported in other studies of socially disadvantaged groups and substance use more generally (Anderson 1990; Hunt and Joe-Laidler 2015). Though the tobacco industry has ruthlessly capitalised on similar meanings of smoking (Kulke 2015; Washington 2002), tobacco control strategies that traffic in stigma - as tobacco denormalization does - may make industry efforts more, not less, salient.

Taken together, the findings presented thus far suggest that within the context of tobacco denormalization, important meanings of smoking for these participants are caught up in complex tensions between health, deviance, and resistance that have been highly consequential in the structural positioning and formation of queer identities. These narratives demonstrate participants' critical awareness of their positionality within larger structures that they perceive as threatening to their well-being and influential in their tobacco use. In this section we have shared some of the meanings and roles of tobacco use that participants discussed as particularly relevant to queer smokers. In the following section we shift the focus onto participants' responses to tobacco policies themselves, to underscore this article's larger purpose of bringing the priorities and assumptions of the public health establishment under critical examination. Therefore, rather than understanding the findings thus far discussed as simply offering insights into how denormalization might more effectively target

queer people, we intend the current section to help contextualize the experiences and perspectives within which participants' evaluations of denormalization are situated. In light of these perspectives, we argue that the tobacco control (and arguably also larger public health) focus on manipulating individual health behaviors - rather than addressing structural inequities - can be understood as inappropriate, stigmatizing, and ineffective for queer health and well-being.

Participant Evaluations of Denormalization: “Who thought that was a good idea?”

With the above findings in mind, participants' evaluations of denormalization as a tobacco control and health promotion strategy are particularly revealing. The participant responses introduced here shed light on potential understandings/explanations of denormalization's inequitable inefficacy for queer people, the harm such a strategy may cause (to people but also to its own purpose), and implicate a re-structuring of public health priorities and approaches as central to supporting the well-being of queer people, smokers, and other Others.

For instance, in light of the significance of smoking as a symbolic “fuck you” mentioned in the last section, Peachtree worries that denormalization efforts that:

[Put] pressure on people to stop smoking sometimes ha[ve] the opposite effect [and may provide] just another opportunity to say, ‘fuck you!’ And not quit. [...] With the queer community in specific, if they [...] are more likely to feel disenfranchised or rejected from their family or face feelings of alienation and smoking is a way to say, ‘fuck you,’ to all of that. And if they are aware that there is help, not only for quitting smoking, but for feeling more accepted and dealing with stress and anxiety and depression, those are all generally positive things that I think would have the side effect of people smoking less.

The vast majority of participants in this study not only thought queer people face health issues more pressing than quitting smoking – such as unaddressed mental health needs, violence, discrimination, social alienation, and homelessness – but also advocated that addressing these issues directly would reduce tobacco consumption and improve public health overall.

Ana, introduced earlier, was extremely explicit and impassioned in their rejection of tobacco denormalization, putting the issues of normativity, policy priorities, health, tobacco use, and structural sickness - with which this analysis is primarily concerned - into striking perspective:

That is so fucking stupid! I feel socially unacceptable for being queer. Like, I already feel socially unacceptable. I feel isolated. I feel fucked up and fucked over. [...] Denormalization – like, how much more ostracized do you think you want people to feel, right? *Denormalization* – literally, *you are not normal. You are a freak of nature*. Yesterday, I was basically called a fucking freak of nature in my doctor's office. He basically said, what you are is not natural. That is still ringing in my fucking ears. [...] But it's like, it's not normal to smoke? It's not normal to be hungry and jobless and houseless either, so why are we not confronting that? It's

not normal to walk around with this hyper vigilance due to being raped. And it's not normal to walk around with this hyper vigilance due to people who are supposed to keep you safe, fucking trying to kill you. Like, *that is not normal*. So why don't you do some denormalization strategies on fucking police brutality and then get back to me and tell me how that goes? Oh my God! Who thought that was a good idea? That's what I think about that. I think, gross. Gross, gross, gross. I'm going to have to smoke a big cigarette after this.

Ana is clearly critical of the way denormalization inequitably, harmfully, and non-reflexively invokes and mobilizes normativity in the name of health at the level of individual deviance rather than structural violence. While their suggestion of denormalising police brutality, sexual terror, and economic causes of suffering is quite compelling in its specificity, other participants voiced similarly critical perspectives in broader terms.

For instance, a queer 25-year-old current smoker, in discussing the health and health behaviors of individuals and communities, James shared his perception that the public health establishment could perhaps better serve its public by shifting the premise and priorities of its discourse to examine questions of structural circumstance as foundational to issues of behaviors and outcomes. He explains, "I think folks are trying to survive, and I think there needs to be more conversations around what that survival looks like, or like, why we're even in a position to survive in the first place, instead of thriving." James situates conversations about queer health and well-being within larger considerations of structural marginalization, a marked difference and implicit critique of the dominant public health focus on individual behaviors as unconstrained choices that are either good or bad, responsible or risky, healthy or unhealthy.

The issues taken up in this analysis are encapsulated in a quotation from one participant, Sarah, a queer-identified 30-year-old genderqueer former smoker who upon hearing the definition of tobacco denormalization responded, "That's gross. Fuck you." Addressing the inefficacy of denormalization for queer people, Sarah brings up the iatrogenic effects of a health policy paradoxically based in stigma - which they characterize as "shaming," "triggering," and exacerbating of the conditions in which people with queer identities are devalued as deviant. Sarah explains:

I think, internal ways that communities can organise to help each other is better than a way that like, *someone from here is shaming you*. Cause like, that's just very triggering [...] It just amplifies all the other ways that we have been either oppressed or marginalized, and it negates its efficacy in that way.

Rather than questioning the place of tobacco in conversations about health, Sarah critiques the perspective from which denormalization operates, locating the 'shame' perceived in this stigmatizing policy not only as ineffective and potentially harmful, but also as originating outside of and forced upon 'communities' who Sarah suggests may be able to produce their own strategies to better 'help each other.'

Social denormalization is designed to change the population's smoking behavior by addressing an abstract public that is assumed to share and expected to adhere to the same health ethic that motivates and structures the public health establishment - one that is

objectifying, calculating, risk-averse, utilitarian, moralising, and normative (Lupton 1995). Kane Race describes other state efforts to govern health through the ideological regulation of consumption as forms of “exemplary power,” explaining how in this “abstract space of public address” where public health efforts such as tobacco denormalization operate, “any deviation from normative prescriptions around corporeal practice appears as a case of pathology [...] or else reckless intentionality and moral transgression” (2009:59, 162). Drawing on the works of Warner (2002) and Fraser (1990), Race proposes the concept of “counterpublic health” to discuss specific health, well-being, and care practices and discourses of people in a marginal position relative to the normative neoliberal subject implicitly addressed by the public health establishment (i.e. white, heterosexual, cisgender, often male and at least middle class) (Race 2009:157–63). Counterpublics - such as queers and arguably now smokers - which “maintain some awareness of their subordinate status in relation to the dominant public,” may conceptualise well-being, health priorities, and care practices quite differently than the public health establishment (Race 2009:159). In the case of denormalization as perceived by the queer smokers and former smokers we interviewed, there is an obvious mismatch between the assumptions and priorities structuring the strategy and those important or salient to the populations it excludes. These findings strongly suggest that the equation of health and normativity which structures tobacco denormalization is a fundamentally alienating and iatrogenic conception that reifies in tobacco control the marginalization of queer health more broadly.

Conclusion

The findings we have introduced through our framing of an exploration of ‘is smoking queer?’ raise an important cluster of related questions that can be elaborated with more nuance than our terse and somewhat insincere titular inquiry: Does the social unacceptability of smoking matter enough to get people to stop smoking if they’re already told they are abnormal, unhealthy, and immoral for other reasons? If being unhealthy is stigmatized, and you’re considered by powerful structures to be unhealthy whether you smoke or not, does smoking matter? If stigma is bad for health, but a health policy dependent on stigma is considered successful even despite glaring health inequities and ethical pitfalls, what does that reveal about dominant conceptions of what health is supposed to mean? Thus, rather than whether smoking is queer or not, this analysis and the participant perspectives it aims to communicate explore the nature of the relationships between smoking, health, and queer experience.

Denormalization positions smoking as an unhealthy moral failure, yet situated within the “concrete and relational contexts” of participants’ lives, the meanings and roles of tobacco use for queer smokers in this analysis emerge as complex, pragmatic, political, and personal in ways current tobacco control approaches fail to address (Race 2009:162). It is apparent that when concerned about the risks smoking poses to queer lives, participants are not simply focused on the quantifiable biomedical outcomes that often ostensibly motivate public health policies. These narratives, in light of the high prevalence of smoking among queer people and other marginalized groups, bring up important considerations of embodied well-being and structural ills that are often absent from mainstream public health approaches, including those focused on eradicating tobacco use. Narratives about smoking

as self-care, for instance, alongside critiques of normative, structurally-incompetent denormalization strategies indicate the importance to participants (and current policy-level neglect) of meanings and uses of tobacco that may be at odds with the utilitarian ethic structuring the public health establishment's priorities and tactics. While important theoretical and empirical research into the ethics of denormalization and its impact on health equity for other marginalized groups such as low-income women have developed in recent years - much of which has informed this analysis and the study upon which it is based: e.g. Graham (2012), Greaves (1996), Bell (2011), Bell et al. (2010), Bell and Dennis (2013), Dennis (2013), Nichter et al. (2007), Farrimond and Joffe (2006), Blacksher (2018), Hefler and Chapman (2015), Hefler and Carter (2017), and Hui Tan (2016) - little empirical work has thus far specifically explored the experiences of queer adults within this policy environment.

Race argues that developing a concept of counterpublic health and elaborating its possibilities for alternative care practices is "crucial in terms of enhancing the well-being and pleasure of subordinate and endangered populations, such as queers, women, and drug users" (Race 2009:162). By foregrounding the perspectives of participants themselves in contrast to those that dominate mainstream approaches to public health, it is our hope that this analysis contributes to the elaboration of counterpublic health ethics and care practices. Such elaboration can work towards critically expanding both the boundaries of the 'public' and narrow definitions of normative biomedical 'health' by which 'public health' efforts are currently limited.

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