‘If you smoke, you stink.’ Denormalisation strategies for the improvement of health-related behaviours: the case of tobacco[1]

Kristin Voigt

Department of Philosophy & Institute for Health and Social Policy, McGill University, Montreal, Canada

Abstract Denormalisation has emerged as a possible strategy to influence health-related behaviours, particularly in the context of anti-smoking initiatives. Denormalisation strategies aim to influence social norms surrounding the behaviour in question, by making the behaviour less visible and reducing its social acceptability, so as to motivate individuals to change behaviours and to strengthen public support for other public health measures and interventions. Focusing on anti-smoking efforts, this chapter assesses denormalisation strategies with respect to two concerns. First, denormalisation strategies may contribute to the stigmatisation of smokers. Second, denormalisation strategies may add to existing burdens among disadvantaged groups. These concerns point to highly problematic and potentially counterproductive effects of denormalisation strategies. However, two approaches – social norms marketing and tobacco industry denormalisation – could provide more constructive and less problematic applications of the denormalisation strategy and may therefore have a role to play in the pursuit of public health.

Introduction

Denormalisation has emerged as a possible – if controversial – strategy to influence health-related behaviours, particularly in the context of anti-smoking initiatives. Denormalisation strategies aim to influence social norms surrounding the behaviour in question, by making the behaviour less visible and reducing its social acceptability. The rationale for this strategy is that our behaviour is influenced by (our perception of) prevailing social norms. Making a behaviour less socially acceptable could provide a motivation for individuals to change behaviours and may also strengthen public support for other public health measures and interventions.

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However, denormalisation strategies raise ethical issues. The smoking context, where denormalisation has become particularly prominent, highlights two concerns. First, denormalisation strategies may contribute to the stigmatisation of smokers. Second, smoking – like other behaviours that might be singled out for denormalisation – is particularly prevalent among disadvantaged groups, particularly low income groups. Denormalisation strategies may therefore exacerbate already existing burdens, raising concerns about inequalities resulting from the adoption of this strategy.

This chapter assesses the use of denormalisation strategies for the improvement of population health, with particular reference to the two concerns noted above. The chapter begins by discussing the emergence of denormalisation as a strategy in the anti-smoking context. I then address the two concerns just outlined: stigmatisation (and its negative effects) and equality. I suggest that these concerns point to highly problematic and potentially counterproductive effects of denormalisation strategies. I then consider two approaches – social norms marketing and tobacco industry denormalisation – that could provide more constructive and less problematic applications of the denormalisation strategy and that may therefore have a role to play in public health.

Denormalisation as a strategy for the improvement of public health: the case of anti-smoking initiatives

Policies may have unintended effects on social norms that, in turn, affect health behaviours. Health warnings on cigarette packs, for example, may not just provide information about the consequences of smoking but also signal that tobacco is different from other consumer products – it is not 'normal' (Chapman and Freeman 2008). In some contexts, efforts to portray a particular product in a negative light are an intentional response to marketing efforts of companies to present their products as desirable and glamorous; for example, denormalising and 'deglamorizing' smoking through particular campaigns can help counteract such marketing messages (Koh et al. 2007).

In the smoking context, the contribution such mechanisms could make to the reduction of tobacco use has been recognised and they are now explicitly adopted in a number of tobacco control strategies, often under the label 'denormalisation'. Anne Lavack defines denormalisation as 'all the programs and actions undertaken to reinforce the fact that tobacco use is not (and should not be) a mainstream or normal activity in our society … urging current smokers to quit, and thereby conform with the smoke-free majority' (Lavack 2001). Similarly, a policy document by the California Department of Health Services describes the idea of what they call 'social norm change' as an attempt 'to indirectly influence current and potential future tobacco users by creating a social milieu and legal climate in which to-

bacco becomes less desirable, less acceptable, and less accessible' (California Department of Health Services 1998).[2]

Denormalisation has been integrated as a goal in a number of broader anti-smoking strategies. It is central to various campaigns in North America (see, for example, California Department of Health Services 1998; Steering Committee of the National Strategy to Reduce Tobacco Use in Canada 1999) and Europe (e.g. Russell et al. 2009). At the global level, the World Health Organization, whose Framework Convention on Tobacco Control has become a central example of global tobacco control efforts, has similarly endorsed the denormalisation of tobacco as a central aim in anti-smoking efforts (World Health Organization 2008a).

The general idea underlying denormalisation strategies is that social norms influence behaviour, through direct and indirect channels. At the most direct level, the social unacceptability of smoking can motivate smokers to quit, or reduce their tobacco use, to evade the social consequences of being seen as a smoker:

> unfavorable public sentiment toward smoking may have been functioning as an informal social control device that enforces behavioral conformity among smokers. In this sense, quitting smoking (or not starting smoking) can be understood as an effort not only to avoid hazardous health consequences or legal sanctions…, but also to escape from such psychological punishments as social isolation or embarrassment. (Kim and Shanahan 2003)

Further, social norms may influence what kinds of policies are adopted, which then influence individuals' behaviours (Hammond et al. 2006; Kim and Shanahan 2003). For example, the presence of strong anti-smoking norms may facilitate the introduction of higher taxes on cigarettes, which then constrain individuals' smoking behaviour.

Different policies can contribute to denormalisation efforts. Smoking restrictions, in addition to protecting non-smokers from the harms of environmental tobacco smoke, can contribute to denormalisation because they reduce the acceptability of smoking (Albers et al. 2004; Department of Health and Human Services 1991); in fact, some commentators regard smoking restrictions as the most effective way of denormalising tobacco use (Bell et al. 2010a; Brown et al. 2009). Many countries have now adopted legislation that bans smoking in workplaces, restaurants and bars (Mackay et al. 2006) and, more recently, bans in outdoor

[2] This strategy has been discussed primarily in the smoking context. However, similar goals may be pursued with respect to other health-related behaviours. For example, a policy document published by the UK Department of Health calls for a 'cultural shift in public attitudes towards the type and amount of food eaten and the importance of regular physical activity' (Department of Health 2004, p. x). The focus of this chapter will be on denormalisation in the context of tobacco use; however, many of the concerns raised in this paper may also apply to denormalisation strategies used with respect to other health-related behaviours.

spaces have also been considered (Chapman 2000; Bloch and Shopland 2000; Thomson et al. 2008; Colgrove et al. 2011).

One mechanisms through which smoking bans can contribute to denormalisation is by reducing the general visibility of smoking. One study finds an association between the frequency with which youth observe smoking in different locations and the perception that smoking is socially acceptable; the authors conclude by recommending smoking bans specifically as a means of reducing the social acceptability of smoking (Alesci et al. 2003). Smoking bans in bars and restaurants also help undermine the association between smoking and exciting lifestyles promoted by tobacco marketers (Hammond et al. 2006). Thus, smoking bans help establish non-smoking environments as the 'norm' (Brown et al. 2009).

In addition, introducing smoking bans can in itself express and promote a negative attitude towards smoking and contribute to its denormalisation. As Glantz suggests, 'clean indoor air legislation reduces smoking because it undercuts the social support network for smoking by *implicitly defining smoking as an antisocial act*' (Glantz 1987, my emphasis). The ways in which such bans are communicated can contribute further to these effects. For example, Chapman and Freeman emphasise that smoking bans on flights are announced in a way that emphasises that smokers are addicts:

> At the start of every airline flight to, from and within Australia passengers are warned via onboard announcements that smoking is banned in-flight and, evoking memories of warnings given to schoolchildren about toilet-block smoking, an added warning is given that they must not smoke in aircraft toilets … When each flight ends, it is then seen as necessary to remind smokers that they cannot light up until they get outside the airport buildings. Again, the subtext of the message is plain: here are desperate addicts counting the seconds until they can smoke. (Chapman and Freeman 2008)

The aim of denormalisation is perhaps seen most clearly in connection with media campaigns that aim to change social norms around smoking. For example, a recent anti-smoking campaign by the UK's National Health Service included a video advert that depicts a young woman in a bar with a couple of female friends. After exchanging glances with a man across the room, he approaches her. As he leans in closer to speak to her, his smile disappears and he looks disgusted. He points to his (half-full) pint glass to make his excuses and leaves. In the final shot, we see the woman, now by herself, smoking a cigarette and looking puzzled, with the caption, 'If you smoke, you stink', as well as information identifying the campaign and link to a website (entitled www.uglysmoking.info) for advice on quitting. Unlike many anti-smoking ads, this advert provides no information about the health effects of tobacco use. Instead, the idea conveyed is that smoking is unattractive ('ugly', as the URL suggests) and will lead to 'romantic rejection' (a common theme in anti-smoking campaigns; see Goldman and Glantz 1998).

As Wakefield et al. suggest, media campaigns can influence individual behaviour through a number of different mechanisms. Media campaigns can elicit emotional or cognitive responses in individuals exposed to them, affecting individual choices directly. In addition, there may be a number of indirect mechanisms. Campaigns may encourage discussions about a particular issue within social groups, affecting the behaviour of individuals within them. If media campaigns lead to norm change within particular networks, this may also influence individual behaviour, even among those who have not been exposed to the media campaign. Finally, campaigns can encourage public discussion and lead to policy changes, resulting in constraints on individual behaviour, thus achieving behaviour change indirectly (Wakefield et al. 2010).

How effective are denormalisation strategies in reducing smoking rates? Even if, as many commentators suggest, denormalisation motivates smokers to quit, motivation in itself is not sufficient for cessation: the majority of cessation attempts are unsuccessful, and relapse is common (Fiore et al. 2008). In a study with smokers from Canada, the UK, the US and Australia, Hammond et al. (2006) find that quit intentions were greater for smokers who perceive high or medium levels of denormalisation of smoking, and that such smokers were also more likely to have quit smoking at follow-up eight months later.

Macro-level data have also been used to assess the importance of social norms around smoking. Kim and Shanahan use polling data from different US states to estimate public attitudes towards smoking. They find that smoking rates are lower in states where public sentiment towards smoking is more negative (Kim and Shanahan 2003). They acknowledge, however, that such associations do not necessarily indicate a particular causal connection. Perhaps more importantly, this kind of analysis cannot confirm to what extent policies that *increase* negative attitudes towards smoking help *reduce* smoking rates, particularly in the short run as smokers may not be able to respond to changes in social norms by quitting. The effects of policies that affect the social acceptability of smoking are estimated in a different study, which draws on indices of the social unacceptability of smoking in different US states. The authors of this study conclude that 'increasing the social unacceptability of smoking is a highly effective policy tool in reducing consumption' (Alamar and Glantz 2006). They estimate that if anti-tobacco campaigns could increase social unacceptability of smoking across the country to the levels seen in California (where social unacceptability was highest), this would lead to a 15% decrease in tobacco consumption – similar to the effects that would be expected from a $1.17 increase in the price of a pack of cigarettes.

Denormalisation and stigma

Perhaps the most important concern about denormalisation strategies is that they can contribute to the stigmatization of those who engage in targeted behaviours. Many commentators have voiced concerns about the possible stigmatisation

of smokers that may result, intentionally or unintentionally, from the pursuit of anti-tobacco strategies (e.g. Kim and Shanahan 2003; Bell et al. 2010a).

The classical treatment of stigma is Erving Goffman's 1963 work *Stigma: Notes on the Management of Spoiled Identity*. Goffman describes stigma as (evidence of) an attribute that marks an individual out as different from, and less than, others; the person bearing such an attribute 'is thus reduced in our minds from a whole and usual person to a tainted, discounted one' (Goffman 1963). While in fields such as psychology and sociology, stigma has been an important research topic (e.g. West and Hardy 2007; Major and O'Brien 2005; Link and Phelan 2001), it has received less attention from philosophers. The most notable exception in this context is Martha Nussbaum's *Hiding from Humanity*, which considers the concepts of shame, stigma and disgust to assess the use of shaming penalties. On Nussbaum's conceptualisation, stigma can be understood as an attribute that is perceived as not 'normal', where 'not normal' can refer both to the idea that an attribute is uncommon and the sense that it is deviant or not 'proper': 'whoever does not do what most people do is treated as disgraceful or bad' (see Nussbaum 2004, pp. 217-8).

How close is the conceptual link between denormalisation and stigmatisation? Burris argues that denormalisation strategies are very different from the dehumanising approach that is central to stigmatisation:

> We can make smoking seem undesirable, unglamorous, uncool. I do not advocate an effete sensitivity in which even the least whiff of social disapproval of a behavior is seen as coercive or stigmatizing. Fear of smoking … may contribute to stigma, but it is not itself stigma, and there is no reason not to promote it if we think it will reduce smoking rates. (Burris 2008)

Burgess et al. support Burris' approach, arguing that the goal of denormalisation is merely to depict smoking in a negative light, which does not amount to the 'highly visceral form of social control' that is characteristic of stigmatisation (Burgess et al. 2009).

However, the line between denormalisation and stigmatisation may be harder to draw than Burris and Burgess et al. suggest. What is striking is that Lavack's definition of denormalisation (quoted above) picks out both senses of a behaviour being 'not normal' that Nussbaum describes as typical of social stigma: as Lavack explains, the denormalisation of smoking reinforces the idea of a 'smoke-free majority' and that tobacco use is not 'a mainstream or normal activity in our society' (i.e. it is not the 'usual' thing to do) and also the idea that smoking 'should not be' a normal activity (i.e. it is wrong) (see Lavack 2001).

Furthermore, empirical evidence supports the idea that smokers feel stigmatised by many of the denormalisation strategies discussed above. For example, in one study, smokers reported that smoking bans made them feel like 'lepers' (Ritchie et al. 2010). Smokers have also reported feeling ashamed about being

smokers, and that they feel that others regard them as lacking strength of character due to their smoking (Kim and Shanahan 2003). In a different study, smokers talked about feelings of stigma when they smoked publicly, and the importance of creating an acceptable social identity as a 'considerate' smoker (Phillips et al. 2007). In a study by Stuber et al., 38% of current smokers who participated in the study agreed somewhat or strongly with the statement 'Most people think less of a person who smokes' (Stuber et al. 2009). Explicitly linking smoking restrictions and the stigmatisation of smokers, the authors of a US study conclude,

> Cigarette smoking is not simply an unhealthy behavior. Smoking is now arguably considered a deviant behavior. The stereotypical image of a smoker who greedily … smokes at the front of public buildings dramatically symbolizes the status of smokers in this country. Smokers are in some sense disqualified from full social acceptance. In other words, they are 'stigmatized'. (Kim and Shanahan 2003)

The denormalisation and stigmatisation of smoking may have severe negative effects on individuals and their health. For example, smokers may be more likely to keep their smoking secret and less likely to seek help with cessation (Stuber and Galea 2009; Stuber et al. 2009). Further, it has been suggested that the experience of stigmatisation can affect individuals directly, for example by increasing blood pressure (Major and O'Brien 2005; possible causal pathways between stigma and disease in the context of obesity are explored in Muennig 2008).

An additional, related concern about denormalisation strategies is that they often involve campaigns with moral overtones, leading to feelings of shame and guilt in those engaging in the targeted behaviour. By focusing on individual behaviour and describing it as morally problematic, denormalisation campaigns may also implicitly blame those who engage in a certain behaviour for any subsequent ill health.

In the smoking context, it is in campaigns that emphasise the harms of smoking on others that the moral overtones are felt most prominently. Such harms include the health effects of environmental tobacco smoke but also the emotional effects of a smoker's tobacco-related disability or premature death on their children. For example, a recent anti-smoking campaign in Australia shows a young boy entering a busy train station with what appears to be his mother, who subsequently disappears from view. Much of the spot depicts the child becoming increasingly distressed, ending with the voiceover, 'If this is how your child feels after losing you for a minute, just imagine if they lost you for life.' Such campaigns help denormalise smoking by portraying its harmful effects on others (Ling and Glantz 2002; Goldman and Glantz 1998).

The emphasis on blame and guilt in anti-smoking initiatives and the values and judgements implicit in campaign messages may have significant effects on individuals and their behaviours. Presenting smokers as morally culpable makes it difficult to acknowledge the difficulties individuals face in changing health-related

behaviours. This could contribute to a sense of personal failure and feelings of frustration and self-blame when individuals cannot adopt healthier behaviours (Guttman and Salmon 2004; Guttman and Ressler 2001). Such feelings can make behaviour change even harder (Guttman and Ressler 2001; Burgess et al. 2009) and may actually deter individuals from seeking treatment or support (Richards et al. 2003).

Denormalisation, stigma and equality

In the tobacco context, denormalisation strategies have also been criticised for exacerbating existing inequalities. Given that smoking prevalence tends to be greater in low-income groups, many have worried that the increasing denormalisation of smoking (and stigmatisation of smokers) will lead to further burdens for groups that are already significantly disadvantaged. In fact, it has been suggested that denormalisation has become a viable strategy in the anti-smoking context only since smoking became increasingly concentrated among lower socioeconomic groups (Bayer and Colgrove 2002). Thompson et al. caution that smokers are increasingly subject to the 'dual stigmatisation' of being both smokers and poor (Thompson et al. 2007). Similarly, Kim and Shanahan express concern that

> those who fail to comply with health behavioral prescriptions are punished through guilt, rejection, isolation, and special taxation. Because the punished behaviors are often more common among minorities, the poor, and the educationally disadvantaged, such punishments can seem like a regressive social tax. (Kim and Shanahan 2003)

An important challenge for denormalisation strategies is that social norms may vary across subgroups. Thus, smoking may become increasingly unacceptable in some groups but remain perfectly 'normal' in others. Some of these effects can be seen in the smoking context. A recent analysis of data from the Framingham Study suggests that there is an increasing tendency for smokers to be connected primarily to other smokers. The study also found that 'the network became progressively more polarized with respect to smokers and non-smokers over the period from 1971 to 2003, with relatively fewer social ties between these groups' (Christakis and Fowler 2008). Further, we know that in disadvantaged communities smoking is often still the norm and deeply embedded in people's daily lives and interactions (Wiltshire et al. 2003). Thus, smokers are often segregated from non-smokers in 'smoking islands' (Thompson et al. 2007).

This means that disadvantaged smokers may, in fact, perceive *less* stigmatisation than smokers in more affluent groups, as in their immediate social group smoking is more common than in the population as a whole. The empirical evidence on this is inconclusive. One study finds greater perceived stigmatisation of smokers and internalisation of such stigma by smokers among lower socioeco-

nomic status groups (Farrimond and Joffe 2006); other studies, however, find *less* denormalisation of smoking among lower socioeconomic status relative to higher socioeconomic status smokers (Hammond et al. 2006) and lower levels of stigmatisation of smoking and internalisation of such stigma among groups with lower levels of education and among ethnic minority respondents (Stuber et al. 2008).

What does this imply for denormalisation strategies, in particular with respect to their effects on smokers in smoking 'islands'? On the one hand, smokers from disadvantaged backgrounds may be more susceptible to the burdens associated with denormalisation; however, this might also contribute to improved health behaviours in these groups. As Bayer explains, such effects

> may be inequitable in the near term. But if they work, they may represent a significant contribution to the well-being of the very people they burden and on those who might be dissuaded from engaging in behaviors that have profound implications for health on a population level. (Bayer 2008)

On the other hand, if denormalisation and the experience of stigmatisation are less severe among disadvantaged relative to more affluent groups, this may also make it less likely that individuals in disadvantaged groups change their behaviours. In fact, some research suggests that smokers in disadvantaged communities may regard smoking as a form of 'resistance' against broader social norms, making them less receptive to anti-smoking messages and information about the health consequences of tobacco use (Thompson et al. 2007). The empirical evidence does not allow any definite conclusions about this question. As Schroeder emphasises, it is not clear whether it is just a matter of time before broader anti-smoking norms spread to the 'last bastions of smokers', or whether the continuing 'normality' of smoking in their immediate social environment will, in fact, make it harder for these smokers to quit (Schroeder 2008).

However these considerations work out in practice, what also matters from the perspective of equality is that even if disadvantaged smokers are protected from stigmatisation within their immediate social networks, broader social norms can influence their opportunities outside these communities. Anti-smoking norms can be conducive to forms of discrimination and unequal treatment in various contexts. For example, Bell et al. argue that denormalisation strategies are 'likely to exacerbate [class-based health inequalities] because they enable a political environment in which healthcare is increasingly seen as a privilege that smokers have negated the "right" to access' (Bell et al. 2010b). Similarly, a number of employers, particularly in the US, have now adopted non-smoker hiring policies: those who are found to have used tobacco (or to have been exposed to second-hand smoke or are using nicotine replacement therapy) can be barred from employment (Voigt forthcoming). In the US, a number of companies and hospitals have put such policies in place (Houle and Siegel 2009), and it has also been adopted by the World Health Organization, specifically because it can help denormalise tobacco

use (World Health Organization 2008b). Such policies can, of course, significantly reduce opportunities available to smokers and decrease the quality of care they receive in the health care system. If denormalisation helps to provide the normative grounds on which such policies can be regarded as legitimate, it actively contributes to poorer outcomes – including poorer health outcomes – for those in disadvantaged groups.

Denormalisation and public health

While denormalisation strategies are used to encourage the adoption of healthier behaviours, the preceding sections explored possible negative effects of denormalisation, particularly through the stigmatisation of those who engage in the behaviours targeted by such strategies. Is it still acceptable to use denormalisation strategies?

Ronald Bayer has recently suggested that, if stigmatisation of tobacco use can contribute to the improvement of health-related behaviours, then it could, in principle, be part of public health practitioners' armoury (Bayer 2008). This, as he explains, involves a view on the relationship between stigma and public health that is very different from the one that has been characteristic of public health, where stigma has generally been seen as a major obstacle, rather than a possible tool, in the pursuit of population health.

However, even if there is no principled objection to policies that, advertently or inadvertently, lead to stigmatisation, it is not clear how we should decide when the use of such policies would be permissible. Bayer and Stuber emphasise the importance of assessing the quality and scope of particular instances of stigmatisation:

> Much will depend on the nature and the extent of stigma-associated burdens and on how the antitobacco movement deploys stigmatization as an instrument of social control. For example, policies and cultural standards that result in isolation and severe embarrassment are different from those that cause discomfort. Those that provoke a sense of social disease are not the same as those that mortify. Acts that seek to limit the contexts in which smoking is permitted are different from those that restrict the right to work, to access health or life insurance, or to reside in communities of one's choice. (Bayer and Stuber 2006)

Since stigmatisation can take many forms, some being less severe, long-lasting and far-reaching than others, we need to get a better sense of the stigmatising effects of particular policies. At the same time, it is not clear how any such harmful effects should be weighed against possible benefits of such policies. Against the possible positive effects of denormalisation strategies, primarily in terms of health outcomes, we must weigh the possible harms of denormalisation and stigmatisa-

tion, which may include negative health effects, the inducement of feelings of shame and blame, and exacerbating existing inequalities. It certainly is not obvious how these different considerations could be made commensurable. Thus, a 'utilitarian calculus' is not just insufficient for answering this question (Bayer and Stuber 2006); it is not clear how such a calculus would even get off the ground, given the disparate values and considerations at stake.

Social norms marketing and tobacco industry denormalisation: promising (and less problematic) applications of the denormalisation strategy?

Given the concerns about the denormalisation of particular health-related behaviours, could there be ways of integrating denormalisation strategies into broader public health strategies that avoid some of the most important pitfalls? Two possibilities will be considered here: social norms marketing and tobacco industry denormalisation.

Social norms marketing, like the denormalisation strategy, is based on the idea that our behaviour is influenced by perceived social norms and expectations of how others behave. However, a person's understanding of social norms is shaped by her perception of the prevalence of a certain behaviour.[3] Such perceptions can, however, be wrong. This is problematic from a public health perspective when individuals perceive an unhealthy behaviour to be more common than it actually is. Social norms marketers seek to correct such misperceptions. Studies suggest that students overestimate the alcohol consumption of their peers; letting them know their fellow students' actual drinking patterns can reduce drinking in this group (DeJong et al. 2006; Perkins and Craig 2006).

It may be possible to harness this mechanism to address health inequalities. People living in deprived communities appear to have misconceptions about the prevalence of particular unhealthy behaviours, such as smoking (MacAskill et al. 2002; Thompson et al. 2007). If this contributes to smoking behaviours in those groups, correcting such misperceptions by presenting correct information about the prevalence of the behaviour could be an important strategy for achieving behaviour change (Voigt 2010). It corrects what is, in effect, an unfair inequality in the choices they face: people whose reference group has greater prevalence of certain unhealthy behaviours is going to perceive norms in a way that makes them more likely to engage in that behaviour.

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[3] This approach is also part of the idea of 'libertarian paternalism', which has received much attention over the past few years. Sunstein and Thaler suggest that this insight can be exploited to reduce energy consumption: informing customers on their utilities bills that their neighbours are using less energy than them can motivate them to reduce their energy usage (Sunstein and Thaler 2008).

While social norms marketing shares assumptions about individual behaviour with denormalisation, it seems to attempt to detach the idea of how *common* a behaviour is from questions about how *acceptable* it is. For example, one intervention used messages such as 'The majority (66%) of [this school's] student-athletes drink alcohol once per week or less often or do not drink at all' and 'The majority of athletes (71%) do not use alcohol to relieve academic pressures' to challenge overestimates of alcohol consumption (Perkins and Craig 2006). Referring back to Nussbaum's conceptualization of stigma as an attribute that is 'not normal' in both statistical and normative senses, we can think about social norms marketing as an attempt to challenge false beliefs about how 'normal' a particular behaviour is, while decoupling the statistical sense of the term from its normative connotations. It is not clear, however, to what extent it is feasible to portray a behaviour as uncommon without also implying a negative judgement of that behaviour. If social norms marketing is successful in achieving this separation, then it could be a helpful strategy in public health contexts.

A second approach that is often discussed in relation to tobacco denormalisation and that shares many of its ideas is tobacco *industry* denormalisation, which has been adopted as part of several anti-smoking strategies (Lavack 2001; Hersey et al. 2005; Thrasher and Jackson 2006; Thrasher et al. 2006). Instead of trying to denormalise tobacco use and thus risking negative perceptions of smokers, such campaigns aim to change public perceptions of the tobacco industry, by depicting it as deceitful, reckless or manipulative, and by connecting the industry to the ill health and mortality linked to tobacco use. Perhaps the most prominent example in this area is the US 'Truth' campaign, which aimed to inform audiences of the problematic nature of tobacco industry business practices and the effects of such practices on individuals. For example, in one advert aired as part of this campaign, 12,000 body bags are placed around the headquarter building of a major tobacco company; in another, the marketing director of a tobacco company is approached with a lie detector (see Healton 2001 for illustration).

Tobacco industry denormalisation appears to have some desirable effects in common with denormalisation strategies that target tobacco use. Like tobacco use denormalisation campaigns, anti-industry strategies have been found to be associated with intentions to quit and smoking initiation (Hammond et al. 2006; Farrelly et al. 2002); effects on smoking *cessation*, however, were not found (Hammond et al. 2006). It has also been suggested that such policies could strengthen public support for restrictions on the tobacco industry (Hammond et al. 2006).

An important advantage of this approach over denormalisation strategies that focus on individuals' tobacco use is that they shift blame for smoking away from smokers and towards industry. For example, the Californian strategy notes that, through its anti-industry marketing, '[b]lame was shifted onto the tobacco industry, where it belongs, and smokers were cast as the victims of the industry rather than villains' (California Department of Health Services 1998). Instead of making feel smokers feel guilty about smoking, such campaigns help them redirect feelings of guilt towards anger (Goldman and Glantz 1998). Thus, such an approach

can avoid some of the concerns about denormalisation that have been raised above.

Is it problematic for governments to single out the tobacco industry in this way? It might be argued that manipulating perceptions of an industry that provides a product that, although unhealthy, is perfectly legal goes beyond the scope of market interference that is legitimate for liberal governments. Exploring the appropriate scope for markets and the circumstances under which interference is permitted or even required is beyond the scope of this paper. With respect to the tobacco context, however, it should be noted that, given the health concerns about smoking, many countries already interfere with the 'demand' for tobacco in a number of ways. For example, taxation of tobacco, restrictions on tobacco advertising and mandatory health warnings on cigarette packs are common across the developed world. As far as interference with the market goes, it is not clear that tobacco industry denormalisation goes any further than other policies we find acceptable in the tobacco context.

Conclusion

Denormalisation, which aims to undermine the social acceptability of tobacco use, has emerged as an important aspect of anti-smoking strategies. However, while a few studies suggest that denormalisation could reduce tobacco use, the approach raises distinct problems that cast doubt on the role it should play in public health contexts. Denormalisation strategies can be linked, conceptually and empirically, to the stigmatisation of smokers. Moralised discourses around health-related behaviours, which can further denormalisation aims, may create feelings of guilt and shame among those who are unable to adopt particular health advice. Denormalisation strategies can also exacerbate the burdens experienced by socially disadvantaged groups. These concerns cast doubt on the use of tobacco denormalisation strategies. Tobacco industry denormalisation and social norms marketing may be examples of norms-related strategies that can help achieve changes in health-related behaviours while avoiding some of the concerns about stigmatisation and inequality.

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