Health Attitudes and Socioeconomic Status
A Qualitative Study

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Abstract

To enhance our understanding of why lower SES people are less likely to engage in various recommended health behaviours, this qualitative exploratory study investigated attitudes towards health and smoking in fifteen upper SES and fifteen lower SES smokers. A structured open-ended interview explored dimensions of the Health Belief Model (Rosenstock, 1975) within a theoretical context informed by the social structure and personality perspective (House, 1981). Transcribed interviews were analyzed for regularities and themes. Three general attitudes or reasons emerged from the investigation which appear to underlie why lower SES people are less likely to engage in the recommended health behaviour of "not smoking". These are acceptance of lower levels of health, a perceived low effectiveness of engaging in the recommended health behaviour in preserving health and greater situational pressure to engage in the negative health behaviour. Both cultural factors and material circumstances appear to underlie these SES differences in health orientation and the implications for this are discussed.

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Social Class and Health Inequalities

Social Science research demonstrates a consistent, across time and space, inverse relationship between health outcomes and socioeconomic status (SES) (Williams, 1990; Smith, 1990). People of higher SES can expect to live longer and to experience healthier lives than their lower SES counterparts. Large differentials in mortality and morbidity rates, favouring those in higher classes, have been demonstrated in **all** countries that have collected the relevant data (Smith, 1990). Lower SES people die earlier and are sicker more often and more severely.

House (1981) uses the term "socioeconomic status" to describe the hierarchy and inequality of ranking that occurs in our society. Education, income and occupation are considered to be key dimensions of this socioeconomic stratification. The higher the SES a person has, the more privileged he/she is thought to be; having greater social power, access to knowledge and access to resources. For Illsley (1980) "social class" is a preferred notion and this is based on the recognition that occupation is a sensitive indicator not only of working conditions, but also of income, education, housing conditions, diet and a variety of cultural characteristics, often loosely described as "lifestyle". Different occupations can be pragmatically classified together through the sharing of living conditions and lifestyle. Throughout this study "SES" and "social class" will be used interchangeably since both refer to relative positioning within our socioeconomic hierarchy.

The relationship of SES to mortality has been a subject of intensive study during the latter part of this century. Stockwell's (1961) review of the literature demonstrated that the overall evidence supported an inverse relationship between SES and mortality. Antonovsky (1967), in a comprehensive review of more than thirty studies, dealing with a diverse range of people and methodology, concluded too that there was a consistent inverse relationship between SES and mortality. He found that up to and throughout the

1940s this differential between upper and lower SES had been narrowing, but this progression had then halted.

More recent research documents the persistence of this inverse relationship between SES and mortality. In a detailed and comprehensive study of mortality differentials in the United States, Kitagawa and Hauger (1973) found that lower SES groups had higher death rates, relative to age, than their higher SES counterparts. This was so whether income, education or occupation was used as an SES indicator. Williams (1990), in an international review of the literature, discusses SES differences in health status as being "a fairly universal phenomenon" (p. 84). Significant social class differences in mortality have been shown to exist in Norway, Sweden, Denmark, Finland, Germany, The Netherlands, Australia, New Zealand (or Aotearoa), Canada, Japan, and several third world countries. Smith (1990), adds Hungary, France, England and Wales to this list, confidently stating that such "Health inequalities have been shown in all countries that collect the relevant data" (p. 373).

This "fairly universal" phenomenon is persistent over time. Behm and Vallin (1982) reviewed the archival mortality data for England, France and the United States, and concluded that the excess mortality in the lower socioeconomic groups has not changed since World War 2. This supports Antonovsky's point, that the narrowing of the social classes has not progressed since the 1940s. Before the 1940s, these differences were even larger (Antonovsky, 1967). Social class differences in mortality are thus a relatively stable or persistent phenomenon. They are near-universal, spanning time and geography. This is also the case for morbidity. Social class differences in mortality are preceded by social class health inequalities during life. The shorter life span associated with less privileged groups is accompanied by greater periods and degrees of poor health.

Rates of chronic illness are higher among the less prosperous groups. This finding has been reported in early studies (Jaco, 1958) and in more recent reports (Haan & Kaplan, 1986). National surveys consistently reveal that morbidity, impairments and disability are more prevalent among poorer social groups (Illsley, 1980; Lerner, 1975; Newacheck et al., 1980; Williams, 1990). This SES gradient in morbidity is evident for a broad

range of diseases, in the young, the middle-aged and the elderly (Haan & Kaplan, 1986).

In Britain, for example, upper SES people can expect to live over seven years longer than lower SES people (Illsley, 1980) and this gap is widening. In 1971, for men aged 15 to 64, the standardized mortality ratio in social class V (lower) was 1.8 times that of social class I (upper). In 1981 the V:I ratio was 2.4 (Smith, 1990). Documented studies show that lower SES people in Britain, during their lives, experience higher levels of longstanding illness, pain, tiredness, sleep disturbance and emotional distress. Lower SES people experience twice the rates of angina, respiratory problems, digestive system problems, eye complaints, ear complaints, musculoskeletal problems, and disability (Slurge, 1992; Smith, 1990). Blood pressure is 6mm higher in social class V than it is in social class I (Smith, 1990). Archival data reveals sharp and persistent social class differences in lung cancer, chronic bronchitis and heart disease (Townsend, 1978).

As Smith (1990) points out, "the social class differences in mortality and morbidity found in Britain are present in other countries with similar social structures" (p. 374). Smith is aware that every country that has systematically explored the health status of it's populace has discovered these class based health inequalities. He is thus making the assertion that any society with an unequal social structure will have inequalities in health. Aotearoa (New Zealand) is no exception to this rule. We too have a socioeconomic hierarchy and we too demonstrate this associated inverse health relationship.

Pearce et al.'s (1983a, 1983b, 1984, 1991) publications on New Zealand social class differences in mortality demonstrate this phenomenon clearly. Far from showing any evidence of "the devotion to equality for which New Zealand is famous" (Oliver, 1960, p. 277), the findings give a startling view of the extent to which inequalities are inherent in our society. Such health differentials indicate that Aotearoa is not as egalitarian as we might like to think it is. We do have a socioeconomic hierarchy and, as with other countries, this is reflected in our health statistics.

Pearce et al. (1983a, 1991) examined male mortality in Aotearoa, from ages 15-64 years, using death certificate and census data. SES was determined from the available occupational data, using both the British Registrar-General's classification of social classes and the New Zealand Elley-Irving Socio-economic Index. In each case it was found that the lower social classes had mortality rates significantly higher than upper social classes, with the mortality rate of the lowest SES group being approximately twice that of the highest on a six point socioeconomic scale. In the period 1975-1977, the standardized mortality ratio of social class 6 (the lowest SES group) to social class 1 (the highest SES group), was 1.9. For the period 1985-1987, the mortality ratio was 2.0. Women were not included in these studies because death certificate occupational data for women in this country is inadequate for social class classification.

Pearce et al. (1983b) additionally investigated social class differences in New Zealand men for each major disease grouping. It was found that for every major cause of death, lower SES groupings suffered significantly higher mortality rates. The strongest social class mortality gradients were found for deaths related to accidents; poisonings and violence; diseases of the respiratory system; endocrine, nutritional and metabolic disease; diseases of the genito-urinary system; and diseases of the digestive system. Gradients for coronary heart disease and neoplasms were weaker, but in the same direction. A follow up study eight years later (Pearce et al., 1991) demonstrated that little had changed over the years, indicating that social class disease differentials of Aotearoa are relatively stable over time.

Social class health inequalities have thus been shown to exist. This is so in New Zealand and in most places abroad. As Pearce (1983a) points out, the point of such an analysis is that it has identified groups in the community which are dying earlier and living sicker lives than they might be. These groups have a potentially preventable excessive mortality. The key to utilizing this potential however, is in understanding the causes of such inequalities, by no means a simple and straight forward task as Blaxter (1978) has noted:

> "A great deal of effort has gone into the task of proving again and again that socially associated differences in health status...do exist, almost as if this is something society did not wish to believe, and had to rediscover at regular intervals. To continue to prove however that...health differs according to social class makes little impact on the task of explaining why this should be so."
>
> (Blaxter, 1980; cited in Illsley, 1980; p. 44).

Here in Aotearoa, Paul (1985) expresses the same concern.

> "There is still a leap between understanding mechanisms and taking action to change the situation. The bridge depends on interpreting correctly why people of the lowest status act in or are acted on in health damaging ways."
>
> (Paul, 1985; p. 100).

Although there seems to be no one complete explanation accounting for social class differentials in health, there are several ideas which provide partial explanations, offering different insights into different levels of causality. These have developed over time.

Early explanations of the link between SES and health focused on the lifestyles and living conditions of the poor. Overcrowding, poor housing, and malnutrition were some of the factors identified as being responsible for the excessive mortality and morbidity in lower SES groups (Jaco, 1958). Noting the growing prosperity of the lower SES groups and the continuing decline of the impact of infectious diseases on health status, Mechanic (1978) predicted that it would become more difficult over time to characterize health risks through SES indicators. It was expected that the SES differentials would disappear as public health measures, such as mass immunizations and improved sanitation, became more widespread. When these optimistic expectations didn't realize other explanations developed.

Another early explanation is the "artifact" hypothesis, a theory which explains social class variations in morbidity as being merely artifacts of the data. Kadushin (1964, in Marmot et al., 1987) for example, argues that there are differential reactions to illness dependent upon SES; that members of lower SES groups "feel" sicker and thus report more illness. According to this perspective, cultural and structural factors combine to make the poor more concerned about illness and more likely to give undue attention to their symptoms. Mortality statistics and reviews of the evidence offered by Kadushin however, show that this position is not valid (Conover, 1973; Mechanic, 1968). Similarly the Black report on social class inequalities in health in Britain, concluded that none of the artifact explanations are likely to contribute significantly toward the understanding of SES health differentials (Department of Health and Social Security, 1980).

The drift hypothesis, another explanation, posits that health status is inversely associated with SES because chronic illness prevents some individuals from obtaining or keeping higher income jobs. Thus illness, disease, disability etc, cause people to drift down the socioeconomic hierarchy. Early studies that provided evidence in support of the drift hypothesis were plagued by methodological problems (Mechanic, 1968). Recent and more careful attempts to assess the drift hypothesis have concluded that although health related downward mobility does occur, it is not sufficiently widespread to have any major impact upon the SES mortality gradient (Fox, Goldblatt & Jones, 1985; Wilkinson, 1986).

Similarly, it is frequently assumed that equalizing the availability of medical care will have a significant impact upon eliminating class health disparities (Paul, 1985). Studies show that small financial barriers do deter use of medical services in lower income groups (Brook et al., 1983). The available evidence however, suggests that the attention given to medical care is disproportionate to its importance as a determinant of health status. Improvements in health status in the last 150 years, in both the U.K. and the U.S., have been due more to improvements in the standard of living and the environment than to personal medical care (McKeown, 1979; McKinlay & Mckinlay, 1977; Preston, 1977). According to the U.S. Department of Health, Education and Welfare (1979), medical care explains only 10% of the variation in social class health

outcomes. Hadley (1982) notes, for example, that a reduction in cigarette consumption would do more to improve health than would an increase in medical expenditure. Similarly, medical economicists state that greater reductions in morbidity and mortality are more likely to eventuate through additional expenditures in formal education rather than through increases in medical care (Auster, Levenson, & Saracheck, 1969; Fuchs, 1979). The persistence of SES health differentials in Western European countries where inequalities of access have been virtually eliminated (Williams, 1990), is further testimony to the limited contribution of medical care to class differentials in health status.

The Black report on health inequalities in Britain (Department of Health and Social Security, 1980) provides a valuable overview of the various levels of causal explanation. It is recognized as being a most significant document in terms of enhancing our understanding of class based health inequalities (Smith, 1990). The report downplays the significance of those causal factors discussed above. Its primary focus was to explain the class based health inequalities in Britain for the British government. After investigating different hypotheses and potential explanations for this phenomena, material circumstance and behavioural lifestyles were considered to be the prime determinants. This independent research commission emphasized that lifestyles were not spread randomly throughout society but were in fact deeply rooted in material circumstance. It offers a behaviour-in-context perspective, thus emphasizing a materialist explanation for class-based health inequalities. The Black report was not welcomed by the government of the day (Smith, 1990). It was radical in the sense that it proposed by implication that the only way to achieve health equality, was to distribute material circumstances equally throughout society; that is to demolish the class structure.

As Illsley (1980) points out, it is not social class in itself which determines health outcomes. Social class is an intellectual construct rather than a cause of death or illness. It does however place individuals in a broad structural position with distinct environments, experiences and opportunities. These are the mediating variables between groups and their respective and distinct mortality and morbidity rates. This explanation for social class differentials in health, supported by Black et al., and backed up by a large body of research, is that the higher morbidity and mortality rates for lower SES

people reflect the environments they live in and the way they live their lives (Calnan & Johnson, 1985; Department of Health and Social Security, 1980; Feurestein, 1985; Knowles, 1977; Smith, 1990; U.S. Department of Health, Education and Welfare, 1977; Williams, 1990). The U.S. Departments of Health, Education and Welfare (1977) for example, conclude that health status variations can be explained predominantly by reference to behavioural lifestyle (a 50% determinacy in health outcomes) and environmental conditions (20%). Only 10% of variations can be explained by reference to medical inequalities, and 20% by reference to genetics.

This relatively recent paradigm shift, focuses upon environmental conditions and lifestyle as being the key determinants of health outcomes. As will be shown, this explanation goes a long way towards explaining class based health inequalities. It is well summed up by Knowles (1977):

> "Over 90% of us are born healthy and suffer premature death and disability only as a result of personal misbehaviour and environmental conditions."
>
> (Knowles, J.A. Science 1977; 198, p 1104).

Environmentally, lower SES people **are** (situationally) more vulnerable to death and disease. The less favourable living and working conditions of manual workers and lower SES people in general expose them to greater physical hazards, such as air and water pollutants, accidents, hazardous wastes, pesticides and industrial chemicals (Calnan & Johnson, 1985). This along with poor quality and damp housing (Department of Health and Social Security, 1980) lends toward a disproportional prevalence of accidents and diseases, such as respiratory infections, in lower SES groups (Townsend & Davidson, 1982). In addition, the stress generated by poorer socio-ecological environments can have harmful effects on the health status of area residents (Harburg et al., 1973). Stressful features of lower SES environments include high rates of crime, unemployment, residential mobility, violent offending, marital instability, and housing problems. Stresses generated by financial problems, of which there may be several at any one instance, contribute directly to higher rates of illness (Calnan & Johnson, 1985). Research has demonstrated that blood pressure is inversely related to SES (Eyer &

Sterling, 1977; Pearce, 1983; Smith, 1990).

Thus the environment plays a major role in determining SES health status variations. In the next chapter behaviour, debatably the most powerful influence of all upon health status, will be explored in a class-based context. Such a perspective, as will be demonstrated, is of fundamental importance as we seek to heighten our understanding of class based health differentials.

This chapter has presented the basis for this research. Social class inequalities in health outcomes have been demonstrated and various theories explaining them have been presented. The most recent paradigm explaining these findings focuses upon behaviour and links it to the material context from which it has emerged. Different social classes live in different material contexts, and this is thought to give rise to differences in behaviour. The following section discusses the significance of health behaviour in determining health outcomes and explores the extent to which social classes differ in this respect. This paradigm is developed further and a specific explanation for class based health inequalities is developed.

Social Class and Health Behaviour

There is a general finding in health psychology that morbidity and mortality rates are primarily related to behaviour. This factor is thought to impact upon health status more than any other immediate factor (U.S. Department of Health, Education and Welfare, 1977). Powell (1987), for instance, argues that lifestyle, our day to day life habits, account for over 50% of the years lost before age 65.

"Most of the leading causes of death are behavioural in nature." (Feurestein et al., 1986, p. 237). This is so for America and the Western world in general. Feurestein lists seven of the ten leading causes of death in America and demonstrates how they are all associated with the absence of health behaviours. For example, coronary heart disease (CHD) is causally related to; diet, exercise, smoking, stress and weight. CHD is the largest killer not only in America but also in New Zealand and Australia. Similarly, stroke, the third to largest killer, after cancer, is causally related to stress, diet, oral contraceptive use and smoking. Cancer of the digestive system, to take a single cancer, is related to alcohol use, smoking and stress (Russel & Wilson, 1991). The ten leading causes of death in America are virtually identical with those here in Australasia (Russel & Wilson, 1991) and presumably are found in similar proportions throughout the Western world. Most of the causal agents are behavioural in nature or involve some behavioural response on the part of the individual.

Biomedical research suggests that major breakthroughs in science have contributed significantly toward reducing the prevalence of infectious diseases in the twentieth century. Diseases such as influenza, rubella, whooping cough, and polio are no longer a major concern of health professionals. Matarazzo (1983) points out that such contagious and infectious diseases now contribute minimally to death and illness, and that other illnesses have emerged which are of a different nature. Today deaths are predominantly caused by heart disease, cancer and stroke. Recent epidemiological

evidence suggests that these modern illnesses are the by-products of changes in twentieth century industrial practices and personal lifestyles (Feurestein et al., 1985). Health care professionals are beginning to recognize and are providing empirical evidence that "behavioural pathogens" or personal habits and lifestyles are the major causes of death today, in contrast to the "external pathogens" such as infectious agents and nutritional deficits which characterized earlier times (Feurestein et al., 1985).

Belloc and Breslow (1972) examined the relationship between several common health practices such as hours of sleep, regularity of meals, physical activity, smoking and drinking alcohol, and people's physical health status. A probability sample involving 7000 adult residents, aged 20 and over, in Alameda County, California in 1965, completed a comprehensive questionnaire on health status and health behaviour. The results showed that those persons who engaged in all recommended health practices had better health than people who did not. The results of the study showed that those individuals who practised health behaviours tended to have more positive health and that the effects were cumulative. In other words, those who practised more or all good health behaviours were in better health, regardless of age, than those who failed to do so or did less. Since this representative study, other investigations have supported the conclusion that certain behaviours are associated with better health (Feurestein et al., 1986).

A further study in Alameda county by the same researcher 11 years later (Breslow & Berkman 1983) found strong evidence linking five habits of daily living (not smoking, drinking moderately if at all, maintaining normal weight, physical exercise and getting 7-8 hours sleep) with a self report index of good health and that these were predictive of lower mortality. The U.S. Surgeon General's Report (U.S. Department of Health, Education and Welfare, 1979), similarly found personal habits to be closely connected to today's leading causes of death. Numerous other studies testify to this general finding; the Framington Heart Study, the Tecumesah Community Health Study, and the Duke Longitudinal Study of Aging, all provide similar evidence providing direct links of health habits to morbidity and mortality rates (Williams, 1991).

Such studies, linking health habits with health outcomes, either through studying groups

of people over time or through hypothesizing the etiological determinants of specific diseases, indicate that behaviour is indeed of major significance in determining health outcomes. Lifestyles thus have a tremendous impact upon health and thus it is not too surprising to find that there is a large body of research which links different health lifestyles with different social classes. Lifestyles associated with good health are reported more frequently higher up the socioeconomic scale. This goes a long way towards explaining health differentials between the social classes.

In the Alameda County Study discussed above (Berkman & Breslow, 1983), SES was explored as a relevant dimension or variable involved in health behaviour. It was found that persons in the lower SES were three to four times more likely to report negative health behaviours than their upper SES peers. Lower SES people were significantly over-represented in each of the negative health behaviours of smoking, drinking, over eating, lack of exercise and not getting enough regular sleep.

Furthermore Mechanic and Cleary (1980) report a positive association between education levels and good health practices. They found that taking risks, drinking more, engaging in less preventative care, smoking, lack of exercise, and not wearing seatbelts, were moderately inter-correlated and that education levels "contributed significantly to explaining differences" in such health behaviour (p. 809).

Langlie (1977) found that upper SES people were significantly more likely to engage in both "direct" and "indirect" risk preventative health behaviour. Lower SES people were thus more likely to walk and drive recklessly, to smoke, and to have poor hygiene (direct risk behaviour). They were also more likely to avoid immunizations, dental care and medical checkups. They were less likely to use seatbelts, exercise regularly or eat nutritionally (indirect risk behaviour). Similarly Schoenborn (1986) in a recent American national study found a positive relationship between SES and the health enhancing habits of the Alameda county study.

Makela (1981) reports that alcohol use is associated positively with SES, but that heavy consumption of alcohol is associated inversely. Gochman (1988) reports studies indicating that lower SES people make less use of preventative health measures such

as preventative care, vaccinations against threatening diseases such as polio, and using seat belts. Illsley (1980) observes that upper SES people behave more healthily in terms of smoking, exercise, nutrition and dental care and concludes that such behaviour reflects the fact that disease prevention and health maintenance in general is more prevalent in the middle and upper classes.

In terms of food, Stunkard (1975) reported a strong inverse relationship between SES and obesity. Wilkinson (1986) found strong differences in nutritional behaviour between the classes. Lower SES people were more likely to consume excessive amounts of sugar and refined foods. Marmot (1978) found sugar and fibre differences in diet between upper and lower SES with lower SES groups being less healthy. Calnan and Johnson (1986) support the notion that sugar is over-represented in lower SES diets.

In Aotearoa, lower SES people report eating a higher fat and a lower fibre diet. Lower SES men eat more high cholesterol foods such as milk puddings, hamburgers, eggs, particularly fried eggs, and cream cakes. Upper SES people eat more rice, muesli/porridge and wholemeal breads. Lower SES people eat white bread and eat meat pies more often. Higher SES men and women are more likely to reduce fat intake, eat more fruit, cut down on sugar, eat more vegetables and fish and to stop adding salt to food. Higher SES men are more likely to want to eat foods rich in vitamins and minerals, to avoid foods with additives and to eat more wholemeal foods. Higher SES groups are more likely to perceive butter, wholemilk, cheese and processed meats as sources of fat (Russel & Wilson, 1991).

Smoking is considered to be the most damaging health behaviour of all (Feurestein et al., 1986; Mann et al., 1991; N.Z. Health Department, 1988; Sobal et al., 1985; U.S. Public Health Service, 1975). It is the largest cause of preventable death in the people of Aotearoa (N.Z. Health Department, 1988) and the United States (U.S. Public Health Service, 1975). Given the accumulation of research studies on the effects of smoking, a strong statement can be made regarding the negative effects of smoking on health, particularly with regard to heart disease, cancer, emphysema, peptic ulcers and chronic bronchitis (U.S. Public Health Service, 1975). In a recent survey of 1040 primary health care physicians' beliefs about the importance of 25 health care behaviours, elimination

of smoking stood out as being consistently recommended as the most important (Sobal et al., 1985). In New Zealand 4000 people a year die from fatal diseases due to smoking (N.Z. Health Department, 1988) and ten million Americans suffer from ongoing chronic diseases due to smoking (McGinnis et al, 1987). As will be discussed, most of these people are from the lower SES.

Lower SES people have qualitatively and quantitatively different smoking habits to those of the upper socioeconomic groups. They smoke more often, thus having more cigarettes per day (Calnan & Johnson, 1986; Guttmacher, 1979; Hay & Foster, 1981; Marmot et al, 1978; Pierce et al, 1989) and they smoke brands higher in tar and nicotine (National Centre for Health Statistics, 1981; Townsend, 1978; Williams, 1991). Thus lower SES people are heavily over-represented in smoking related diseases such as lung cancer, coronary heart disease and chronic bronchitis (Pearce et al., 1983b; Townsend, 1978). In New Zealand 31% of men and women in lower SES groups smoke tobacco, where as only 17% of upper SES groups do (Mann et al., 1991).

As discussed above coronary heart disease, traditionally the disease of the affluent, is, despite considerable advances in medical research and practice over the past thirty years, still the primary cause of premature death in the Western world. The overall decline in incidence however is thought to be due to reductions in smoking and cholesterol intake more than any other factor (Cook, 1984; N.Z. Health Department, 1989). This decline however, has been so for upper SES groups only and for lower SES people an increase in incidence has actually been the case (Marmot et al., 1978). This reversal in the SES prevalence of CHD is thought to reflect the changes in standards of living and lifestyles that have occurred in the latter part of this century (Illsley, 1980). Marmot et al. observed that growing CHD mortality rates in lower social classes have been parallelled by increases in smoking, higher consumption of sugar, and a lower consumption of fibre, whilst the upper SES have reduced cigarette and cholesterol intake and have increased fibre consumption.

In Aotearoa, the major cause of premature death is CHD (32%). It is concentrated disproportionately in lower SES groups (Pearce, 1983b) as is smoking and other causally related negative health behaviours, (Mann et al., 1991; Russel & Wilson, 1991).

Lower SES people are more likely to die earlier and to live sicker lives than upper SES groups and possibly the most significant reason for this is the way in which they live their lives. Lower SES people clearly behave in less health enhancing ways, if not more health damaging, than their upper SES counterparts. Such an observation may lead people to blame lower SES people for their predicament, claiming that they bring it on themselves. But such "blaming the victim" is misleading and racist (Inkles, in Merton et al., 1959), if not classist and may also be an example of the fundamental attribution error. What is important, according to Williams (1991) and the sociological social psychology approach in general (Inkles, 1959; House, 1981), is that we understand such behaviour within the context of such people's lives. These lives are typically more stressful, having less opportunity, with fewer resources to cope, and are culturally different with different norms and values, such as having greater concern with daily survival over abstract health needs (Calnan & Johnson, 1986).

The association between social stratification and health behaviour is viewed as a classic problem in the study of "social structure and personality" (Williams, 1990). This major paradigm in sociological social psychology provides a theoretical and analytical framework from which to understand the relationship of macro social structures, such as class, to individual personality characteristics, such as values, attitudes and behaviour (House, 1981; Inkles, 1951; Williams, 1990). This approach holds that the individual's behaviour is very strongly influenced by his or her sociocultural and structural environment. The approach thus has the potential to explain group tendencies in behaviour, such as class differences in health behaviour.

The sociological social psychology perspective has developed out of classic sociological studies of behaviour such as Durkheim's "Suicide" (1897) and Shaw's "Delinquency Areas" (1931). The approach observes that the individual's behaviour reflects group tendencies and that different groups in society behave differently, i.e. have different tendencies. Differences in tendencies are thought to reflect different structural and sociocultural conditions of life.

Durkheim observed, for example, that suicide rates vary from country to country but that within each country the number of occurrences are stable over time. This means

that each year roughly the same number of suicides take place in any given country. Such regularities lead him to believe that forces beyond the individual were at play; structural and sociocultural forces such as religion, that vary over countries, but are relatively stable within any given country. His point was to show that even the most seemingly individual and psychologically based behaviours are determined to a large extent by the social and structural attributes of situations. "The social suicide rate can be explained only sociologically." (Durkheim 1897, in Merton et al., 1959, p. 249). Similarly Shaw's "Delinquency Areas" (1931) observed that delinquency and "crime in general" is more predominant in certain parts of cities and that these areas are characterized by certain objective conditions; these being poor housing, physical decay, a heavy representation of ethnic and racial minorities, lower SES, marital instability, high unemployment and high rates of alcoholism.

Not all people living under the same conditions behave in the group stereotyped ways, but there is a significant tendency for personal behaviour to correlate with the social pattern of the group to which the person belongs. Thus not all higher SES people will live healthier lifestyles and live longer than lower SES people, but most of them will. Group tendencies are clear and robust and according to the social structure and personality perspective we can attribute these differences to differences in the cultural and structural environments of the groups, which lead to distinct experiences and opportunities and thus different values and behaviours.

The social structure and personality perspective provides a powerful explanation as to why people of different social classes engage in different health behaviours. The perspective posits two distinct yet complementary mechanisms to be regulating group behaviour (House, 1981). Differences in group behavioural tendencies can be explained in terms of cultural and/or structural factors. The cultural approach emphasizes the importance of shared values and beliefs in determining socially patterned behaviour, whereas the structural approach emphasizes the influence of common objective situations and the adaptive response required to sustain life within the limitations of opportunity imposed by the structural situation. These two are complementary to the extent that specific adaption to objective circumstance can be shared both between and within generations and can be learnt from others as well as being self discovered

(House, 1981).

The Subcultural Thesis (Lewis, 1967) provides a useful framework for demonstrating the cultural dimension to the sociological social psychological explanation of class differences in health behaviour. The subcultural thesis posits that different groups, differing in their position in the social structure, develop different cultures in response to their situation. They develop distinct values, attitudes and behaviours. Differences in health behaviours from this perspective are thought to reflect the existence of culturally transmitted beliefs. Each successive generation is thought to acquire it's cultural perspective through socialization and in turn passes this acquired way of life on to the next.

The upper class - working class distinction is one of the most frequently used distinctions in research into social differences in Britain. It is employed in such disparate fields as political attitudes, leisure, education, achievement, sexuality etc. The distinction derives from various sociological traditions which view non-manual occupations as enjoying fundamental advantages over manual occupations with regards to power, opportunity, status and income. Differences in rewards and experiences both in and out of the workplace parallel two sharply distinctive lifestyles and sets of attitudes characteristic of the two communities. A working assumption of the research, more often than not validated, is that there are two broadly different lifestyles and sets of values and attitudes (Fitzpatrick et al., 1984).

The Culture of Poverty Thesis (Rosenstock, 1975) can be understood as an extreme form of this notion. Here, communities that experience extreme poverty and low status have been observed to develop, in response to their situation, a culture central to which is a sense of powerlessness, passivity and fatalism. Subcultures, with distinctive behaviours, values and attitudes, emerge and exist over generations. They are internally consistent designs for living, which are functionally adaptive within the context of such people's lives. Relevant features of the culture of poverty include; acceptance of low levels of health, low life expectancy, mistrust in modern medicine, "...a strong present time orientation, with relatively little ability to deter gratification and plan for the future, (and) a sense of resignation and fatalism based on the realities of their difficult life

situation." (Lewis, 1967, pp. xxvi-xxvii). The culture of poverty is thus particularly incompatible with a future orientated preventative view of health which may be a pre-requisite for simple preventative health behaviours.

House (1981) believes however, that there has been an undue overemphasis on cultural factors to explain differences in class behaviours within sociological social psychology. He suggests this may be due to our tendency to attribute causality to actors, that is to consider the causes of their behaviours as residing in their beliefs and attitudes, whilst underemphasizing situational constraints on behaviour. Culture and social structure are two distinct entities which influence the individual in different ways. A "culture" is a set of cognitive and evaluative beliefs, about what is and what ought to be, that are shared by members of a social system and are transmitted to new members. A social structure on the other hand, is a persisting and bounded set of social relationships among units (people) in a social system; a system which has inherent in its nature, an unequal distribution of opportunities, income and experiences amongst its units.

This alternative explanation of group differences in behaviour emphasizes the influence of contemporary situational or structural contingencies and constraints in guiding behaviour. Situational constraints, such as time, energy and income, limit the extent to which disadvantaged groups can use services or practice the (health) behaviours they might otherwise choose.

Cole-Hamilton and Lang (1986) in a report on the impact on food, for example, discuss how meaningless it is to consider diet as being purely a matter of choice and not constrained by income levels. Brook et al. (1983) reports that financial barriers do deter use of the preventative health services, which results in measurably worse health for many lower SES people who don't have access to free care compared with those that do. Similarly, health education does not reduce smoking in lower SES groups at least in part because of the different structural constraints and truncated options facing them. Cigarettes are used widely to alleviate stress and tension (Guttmacher, 1979) and lower SES people face more stress and have fewer resources to cope with it than do their upper SES peers (Williams & House, cited in Williams, 1991).

Thus health behaviours are constrained by their material context. After a long days manual work, energy constraints may not allow for exercise or nutritional pursuits. Risk factors for distant health outcomes may be basic survival strategies of day to day existence for lower SES people (Williams 1991). McKinlay (1975) thus warns that efforts to improve the health status of lower SES people by changing their lifestyle, without also altering the social structure and their life chances, not only may be ineffective, but also may do more harm than good.

The structural versus cultural distinction is important because it reminds us that "...any macro-social phenomenon has multiple components; some cultural, some structural." (House, 1981, p. 547). Both cultural and structural variables mediate between the social structure and the individual personality (i.e. behaviour attitudes and values). Each new generation confronts similar structural constraints as the previous one, adopts a similar mode of adaptive response and is reinforced by the relative effectiveness of the mode of response in that they survive as best as possible. Differences in values and attitudes may reflect both culturally acquired orientations and/or inferences and internalizations made by the individual as a consequence from his or her culturally inherited and structurally constrained behaviour. The psychological literature on dissonance and self perception (Bem, 1972) and generalizations (Beck, 1976) provide explanations for any inferences of attitudes and values from that may emerge from one's behaviour. This perspective may be used exclusively by some pure structuralists to account for any group differences in attitudes, but the "social structure and personality" perspective holds that both structural and cultural factors impact upon the individual's personality (values, attitudes and behaviour).

Culture is seen as an adaptive response both inter-generationally (passed on designs for living) and individually (learnt and/or reinforced from experience within the social structure). Social structure determines the objective conditions of life to which people must adapt. These objective conditions vary throughout society. Thus the social structure and personality perspective explains why different social classes exhibit different health behaviours and consequently different morbidity and mortality rates; different conditions require different adaptive responses. Different positions in the social structure offer different resources, with the lower classes having fewer options than the upper classes.

Groups, over generations, in similar conditions, adapt in similar ways. Designs for living vary over structural circumstance and are passed down over generations. Health behaviours, from this perspective, reflect structural contingencies and adaptive attitudinal and value orientations.

Social class health inequalities, from a sociological social psychological perspective thus become more understandable. Different cultural and situational contingencies give rise to differences in health behaviour and different health behaviours lead to different health outcomes.

Health Beliefs and Health Behaviour

The domain of Health Psychology has sought to explain variations in health behaviour on a more distinctly psychological level. One such explanation has been particularly successful: The Health Belief Model (HBM) (Rosenstock, 1975). Although this model is individualistic, having evolved out of concern for explaining individual variations in health behaviour, it may prove to be a most appropriate and useful tool for exploring and understanding group differences in health behaviour, such as social class.

The Health Belief Model was developed in an effort to explain and account for variations in preventative health behaviour. It has been presented as a conceptual formulation for understanding why individuals do or do not engage in a wide variety of health behaviours. It is one of the few models available that attempts to explain health behaviour and is by far the most researched and empirically validated model. It has been found to be highly successful in explaining and predicting health behaviour. In a review of 46 HBM investigations, "substantial empirical support" for the model's effectiveness was found, in both prospective and retrospective studies, including preventative health behaviour (Janz & Becker, 1984). A working assumption of the model is that certain health beliefs and attitudes underlie health behaviour.

The basic components of the HBM are derived from a well established body of psychological and behavioural theory whose various models hypothesize that behaviour depends to a large extent upon two variables; the value placed by an individual on a particular goal (the desire to have good health), and the individual's estimate of the likelihood that a given action will achieve that goal (the efficacy of health behaviour) (Janz & Becker, 1984).

The HBM proposes that an individual's subjective state of readiness to take action and engage in health related behaviours is a function of the following health beliefs:

1) Perceived Susceptibility: Individuals vary widely in their feelings of personal vulnerability to a condition of ill-health. This dimension refers to the subjective perception of the risk of contracting a specific condition or ill-health in general.

2) Perceived Severity: Feelings concerning the seriousness of contracting an illness also vary from person to person. This dimension refers to the seriousness of both clinical (death, pain, disability) and social consequences (effects on work, family life, social ties).

3) Perceived Benefits: Whilst acceptance of personal susceptibility to a condition also believed to be serious is held to produce a force leading to behaviour, it does not define the particular course of action likely to be taken. This was hypothesized to depend upon beliefs regarding the effectiveness of the various health actions available. This dimension refers to subjective opinions of behavioural efficacy.

4) Perceived Costs: The potential negative aspects of any health action may act as an impediment to undertaking a recommended behaviour. A kind of cost-benefit analysis is thought to occur where-in the individual weighs the action's effectiveness and the extent of the risk involved, against perceptions that it might be dangerous, unpleasant, distressing, expensive, time consuming, a hassle, etc.

5) General Health Motivation: In a revision of the HBM (Becker et al., 1977) the individual's motivation for, or desire to have, good health was emphasized as a further important variable. The value factor was thought to be important because a person might score high on perceptions of vulnerability and severity, but unless he or she is concerned about their health to begin with, health behaviour will not take place.

To summarize, the model suggests that the individual's beliefs or perceptions of his or her likelihood of contracting an illness condition, along with perceptions of severity of that condition, and the extent to which the person cares about such consequences, provides the impetus to act; whilst conceptions of the effectiveness or benefits of specific actions less the cost of such actions, determine the preferred path of action and thus the health behaviour. The HBM has been demonstrated empirically over a number of studies (Janz and Becker review 46) to be highly effective in explaining (1) preventative health behaviours (actions taken to avoid illness or injury; such as breast self examination, smoking, diet, exercise etc); (2) sick-role behaviours (actions taken after diagnosis of a medical problem in order to restore good health or to prevent further disease progress, such as compliancy to medication); and (3) clinic visits (clinic utilization for a variety of reasons) (Janz & Becker, 1984). "Significance ratios" were constructed for each HBM dimension by dividing the number of positive, statistically significant findings for each dimension by the total number of studies exploring that dimension. Examination of these ratios reveal that the best results are obtained by the "costs" dimension (91%), followed by "benefits" (81%), "susceptibility (77%), and "severity" (59%). "General health motivation" was not explored in this context, presumably because it is a relatively recent addition to the model. The health belief model is thus a rather comprehensive theory with much explanatory power, as indicated by its "substantial empirical support".

Given that different social classes behave differently in terms of health behaviours, and that there is a large body of empirical support for the health belief model indicating that such health beliefs and behaviours are related, we might infer that different social classes have different health beliefs.

Whilst the correlational relationship between structural factors and health behaviour has been well substantiated, the mediating variable of health beliefs, proposed as being of significant importance by the Health Belief Model, where they fit into this relationship, has not. Both structural and cultural approaches have neglected a detailed examination of the nature of the beliefs about health and health behaviour held by different social groups (Calnan & Johnson, 1986). Those offering a purely structural explanation assume that beliefs are of limited importance given the constraints on behaviour produced by

material circumstances. On the other hand, those that emphasize the difference in beliefs between the social classes make apriori assumptions about the nature of beliefs without recourse to any empirical examination (Dingwall, 1976).

The social structure and personality perspective emphasizes both structural and attitudinal differences as being the primary determinants of the differences in the health behaviours of upper and lower SES people, but it does not specify to what extent each contributes to this phenomenon. There has been little research from this perspective to look at the relationship between the social structure and the different dimensions of health beliefs. Such an exploration is necessary to further our knowledge of the social structure and it's implications for behaviour, which at this time is far from complete (Illsley, 1980).

Blaxter and Patterson (1982) in a 3 generational study of working class women, found that for the majority of respondents (both for mothers and daughters) "health" was defined or understood in a functional way, in terms of the ability to carry on normal roles such as working. Calnan and Johnson (1986) too found that working class women more frequently use a "uni-dimensional" definition of health, which they describe as being more functional (e.g. getting through the day), whereas their professional counterparts more frequently operate with a "multi-dimensional" definition, which incorporated a wider range of elements such as being fit, being active, and the absence of illness. This is consistent with a French study (Herzlich, 1973) which also found middle class groups tending to have a wider multi-dimensional definition of health consisting of the absence of illness, the reserve of health (physical strength and a potential resistance to illness), and a third dimension, which is the full realization of the individual's reserve of health. A more recent French study also found such uni-dimensional and multi-dimensional distinctions in social class conceptions of health (d'Houtard & Field, 1984), further indicating, along with the Blaxter and Patterson study, that such conceptions are stable over time and possibly generations.

This small cluster of findings, reflecting the limited research into this area, suggests that there are indeed social class differences in conceptions of "health". Lower SES people tend to be more functional in their outlook whilst the upper SES tend to be more

positive and are not limited to a single (physical) dimension. This presumably reflects social and material circumstances. It has been argued that the use of a positive conception of health, such as physical fitness and the capacity for resistance, is an important variable in the decision to carry out preventative health behaviour (Blaxter & Patterson, 1982).

Another dimension of health beliefs, considered to be central to the activation of health behaviours, is the notion of personal control or "locus of health control". This refers to the degree of control one perceives oneself as having over one's health. Hallal (1982) reports there is evidence that an internal locus of control has predictive value for the following health behaviours; information seeking, taking prescribed medications, making and keeping physician appointments, maintaining a prescribed diet, giving up smoking, using contraception and other preventative and compliance behaviours.

In a review of the evidence surrounding locus of control and SES, Mirowsky and Ross (1986) conclude that because lower SES people are exposed disproportionately to experiences that lead to a sense of powerlessness, they have a lower sense of personal control. A sense of personal control is thought to be shaped by experience; i.e. from the conditions under which one lives and works. Not surprisingly then, income, occupational status, education, high status jobs and subjective ratings of social class, are all associated positively with a heightened sense of personal control (Gurin and Gurin, 1976).

Kohn (1972) argues that an important source of the heightened vulnerability to sickness among the lower classes, involves conceptions of one's personal control over the world in general and one's health specifically. He affirms that such conceptions are products of the disempowering conditions of life to which lower SES people are subject to. Their characteristic conception of social reality includes "a fatalistic belief that one is at the mercy of forces beyond one's control, often beyond one's understanding" (p 300). Thus Kohn makes the point that feelings of low personal control can lead to a sense of fatalism, which in terms of health may lead to a sense of passivity and thus a lack of preventative measures and other positive health behaviours.

Blaxter and Patterson (1978; cited in Illsley, 1980), found that lower SES people do indeed have a more fatalistic conception of health. "If they're going to be ill, they'll be ill.", was a typical response from the lower class sample.

Langlie (1977) found "perceived internal locus of control" to correlate with direct risk preventative health behaviours. From a systematic random sample of 383 american adults, Langlie found a significant relationship between locus of control and health behaviours such as driving behaviour (e.g. speeding and indicating), pedestrian care, smoking and personal hygiene (e.g. avoids sick people and washes hands after going to the toilet). This serves to indicate that notions of personal control may be an important variable over and above the dimensions of the health belief model for determining health behaviour. From a social class perspective this is a most significant issue. Langlie's research, though not directly addressing the issue of whether or not different social classes have different health loci of control, indicates that they do. "Person's who consistently and appropriately engage in (preventative health behaviour) tend to have high SES...and tend to be...internal" (p. 257).

Thus two beliefs relevant to health behaviour have been explored in the social class health literature, indicating that differences in health attitudes do exist, and that these may in part explain the class differences in health behaviour, such as lack of preventative care. The HBM variables however, have not been explored in this context, and given the empirical validity of the model in terms of explaining health behaviours, it may be prove to be a useful and most logical step as we seek to heighten our understanding of how SES impacts upon health.

The Present Study

The aim of the present study is to explore the relationship between one aspect of the social structure (SES) and several dimensions of health beliefs. It is hoped that through engaging in such an investigation our understanding of why lower SES people are over-represented in excessive morbidity and mortality will be enhanced. Because prior research into this area is limited to a handful of studies, and because there have been no studies exploring the Health Belief Model from a class perspective, this study is significant. More specifically, it is hoped that this study will contribute towards an explanation of why lower SES people typically engage in less healthy behaviour than upper SES people.

The exploratory study undertaken here involves a comparison of the health beliefs of New Zealand men and women who come from upper SES backgrounds with those from lower SES backgrounds. Six dimensions of health beliefs will be explored, incorporating all dimensions discussed previously. The Health Belief Model will provide the basic tools for the investigation and this will be operating in the theoretical context informed by the social structure and personality perspective. All five dimensions proposed by the model will be used in this exploration of class differences in attitudes towards health.

The health locus of control construct is the only non HBM dimension to be used in this study and this constitutes the sixth dimension to the investigation. "Concept of health", discussed in the previous chapter, is subsumed under the HBM's "general health motivation" because the valuing of health implicitly implies a conception of it. Thus conceptions of health will be explored also in this study, within the context of general health motivation.

Health locus of control has been incorporated into this study along with the HBM dimensions because it is recognized as being an important pre-requisite to health

behaviour and because it is thought to vary between social classes. Lower SES groups are thought to have a greater sense of fatalism and a lesser sense of personal control over the world, including their health, because of their less empowering experiences in the world. As discussed in the last chapter, there is some evidence which suggests that this general finding extends to, and may underlie, much health behaviour. The essential idea and relevance of this construct is that persons who view themselves as having some control over what happens to them are more likely to perceive actions as efficacious and are thus more likely to perceive and process information relevant to engaging in specific actions such as health behaviour (Langlie, 1977).

To provide a defined focus, these beliefs, where relevant, will be explored within the context of a single health behaviour. Because smoking is considered to be a most hazardous health behaviour and because it is most prevalent in lower SES groups, it is an ideal health behaviour to be explored given the theoretical context of this research. Thus crucial health beliefs surrounding the health behaviour of smoking will be explored. In this way we may be able to enhance our understanding of why different social classes engage in different smoking habits and this may be generalizable to other health behaviours.

Of the six health perceptions to be explored in this study (general health motivation, health locus of control, benefits of not smoking, severity, susceptibility and costs of not smoking), five were straight forward in their applications to this specific research context (smoking behaviour). Appendix 1 lists each of these health beliefs and demonstrates the process by which these beliefs are to be explored. In this appendix operational definitions are provided for each of these health beliefs and these are followed by the respective questions developed to facilitate their exploration.

The third health belief variable however proved to be less directly applicable. This was the "benefits of not smoking" dimension; operationally defined as the perceived effectiveness of not smoking in reducing the health risks associated with smoking. This health belief was less straight forward in its applicability because the nature of the construct involved more than one dimension. The rationale for the questions employed to explore this construct is as follows.

The health risks associated with smoking may be subjective and objective in nature. Research indicates that smoking is causally related to lung cancer, other cancers, cardiovascular disease, pulmonary disease, emphysema, peptic ulcers and chronic bronchitis (U.S. Public Health Service, 1983; Feurestein et al., 1986). This relationship, statistically proven, refers to the "objective" risks of smoking. Perceptions of this "objective relationship" is an important variable for exploration here. For example, do people think that lung cancer and smoking are related? and to what extent? The subjective dimension to perceptions of the ill-effects of smoking, refers to how the person thinks smoking impacts upon health. This may be entirely different from perceptions of the "objective" dimension. Both subjective and objective dimensions constitute valid and important areas of exploration and thus both will be explored in this study.

In exploring the perceived benefits of not smoking we are looking into perceptions of the ill-effects of smoking. This notion is implicit to the perceived effectiveness of not smoking. This positive definition, looking into perceptions of what smoking causes, is a preferable option for exploration because of it's specific and concise nature; it isolates perceptions of causal relationships. The perceived health benefits of not smoking depend upon the subjective opinion of whether or not and to what extent smoking causes ill health.

These relevant variables for exploration in this study, isolated here under the "benefits of not smoking" dimension but ultimately having much wider implications for the other health belief variables, are the beliefs the person has concerning the relationship between smoking and ill-health. Subjective dimensions will be explored openly and perceptions of an objective outcome will be explored by way of reference to one particular smoking related disease; lung cancer. Lung cancer was chosen rather arbitrarily from the two mostusal relationships. Qualitative research, in contrast, gathers verbal information based on empathy with other people, and reports this information in context, without requiring that it fit into a linear causal framework. Whereas psychological research in the received view tends to look at what is observable (behaviour counts as data), qualitative research additionally uses the researcher's understandings of people's inner experience. Because human experience cannot be

reduced to numbers, data gathering and analysis rely upon empathy. Qualitative research thus encompasses the study and sharing of meanings, including the purposes and significance that people attach to what they do (Stiles, 1990). Data is thus linguistic rather than numeric, is empathically understood by the researcher, and is reported in its meaningful non-linear context.

Qualitative research then is distinctively different from traditional quantitative research. Miles and Huberman (1984) argue that quantitative and qualitative approaches form an epistemological continuum, not a dichotomy, and that many of the best studies employ a combination of methods. Like other opponents of the either-or distinction, Morgan and Smircich (1980), emphasise that qualitative research stands for an approach rather than a particular set of techniques, and its appropriateness, like that of quantitative research, depends upon the nature of the phenomenon being studied.

By emphasizing the need for empathy in order to gain understanding, qualitative approaches generate rich and context embedded data that has the potential to yield fresh perspectives on the phenomenon being studied. The aim is exploration, identification and description of potentially important variables relating to the phenomenon being studied, for subsequent explanatory or predictive research. Because qualitative methodologies are exploratory rather than confirmatory, they are more likely to lead to unexpected findings and thus help generate fresh theoretical formulations.

For the present study, a qualitative approach was selected as being the most appropriate method of investigation. This is because this study is exploratory in nature, exploring attitudes towards health in general and smoking specifically, over different socioeconomic contexts. As discussed above, and in particular noted by Marshall and Rossman (1989), qualitative methodologies are particularly appropriate for exploratory research in the social sciences.

The various health belief dimensions discussed above will serve to guide this exploration, providing a focus for peoples' stories. The questions pertaining to these health beliefs will form the basis of the structured interview, although the ordering of the questions will differ from that listed in appendix 1. These questions are placed

together into a coherent whole so that the interview can progress smoothly and comfortably. This structured guide will be flexible however, so individual variation, when appropriate, can occur.

Issues of Validity in Qualitative Research

When practising interview based or exploratory based qualitative research, some interesting and important issues arise which are idiosyncratic to this research process. Validity and reliability issues are important issues which need to be addressed in order for the research to have "scientific" credibility. Because of the methodological and epistemological differences between the two research approaches, constructs reflecting the assumptions of the positivist, quantitative paradigm are inappropriate for assessing the reliability and validity of qualitative research (Addison, 1989). Some criterion is necessary however, for ensuring the general "trustworthiness" of the research (Stiles, 1990), so we can be confident that interpretations do in fact reflect the phenomenon being studied. Qualitative research has thus generated its own methods and criteria for dealing with these issues, reflecting its distinctiveness and validity as a paradigm in its own right in contemporary psychological research.

A diverse range of criteria for assessing credibility has evolved out of the qualitative research paradigm. No single one of these conditions can be considered to be an adequate test on its own and no one combination can necessarily ensure that the interpretation says how things really are (Stiles, 1990). An appropriate combination however, can give a piece of research a sense of trustworthiness; in that its findings are shown to be reliable and valid.

Stiles (1990) proposes the following guidelines, among others, as being an appropriate means for establishing the trustworthiness of the material gathered and of interpretations made in some cases of qualitative research. Each of these criteria is addressed in this research.

1) Testimonial validity: Testimonial validity, or face validity as it been called (Lather, 1986), involves checking with the participant that you have understood what he or she has said. Such "participant confirmation" ensures that the interpretation is valid simply

by asking the participant whose experience it purports to represent. Participant confirmation can also provide a useful reliability check, whenever such reflections are delayed for a significant period of time. It can check whether or not participants speak the same truth on different occasions.

2) Triangulation: Triangulation involves seeking information from multiple data sources, methods and theoretical schemes; seeking patterns and convergences. Multiple case research, as described by Rosenwald (1988), seeks to illuminate cultural forces by triangulation from the experience of numerous individuals who have been subject to them. Relevant questions involved in the process of triangulation include: Do different participants say the same thing on different occasions? Is there a pattern to their responses?

3) Coherence: A triangulation of themes into one "story" is frequently an important feature of qualitative research, especially when one is attempting to illuminate the impact of cultural forces upon people. The degree of coherence found in this shared story is important for determining its validity as a whole. Coherence refers to the quality of the whole interpretation. If this convergent story is comprehensive enough to account for much of the phenomenon being studied and this is internally consistent, then the quality of the interpretation is greatly enhanced. If the data "hangs together" and makes sense, then the interpretation has coherence.

4) Consensus among researchers: Consensus amongst researchers is a pragmatic criterion, which may determine which interpretations are explored further. On its own consensus does not necessarily ensure validity but interpretations from people other than the researcher(s) can greatly enhance the trustworthiness of the research. If observations are value-laden (Stiles, 1990), a check for alternative interpretations and possible omission of themes by observers outside the research team, can enhance the quality and credibility of the research considerably.

5) Catalytic validity: In contrast to the positivist tenet of researcher neutrality, this principle acknowledges that the research process can help participants to know their reality better in order to transform it. Catalytic validity refers to "the degree to which

the research process re-orients, focuses and energises participants" (Stiles, p. 33). It thus addresses the empowerment of the people involved in the study. The research process is catalytically valid "if it sparks a change in its participants" (Stiles, p. 33).

Method

Participants:

Thirty adult smokers, ranging in age from 21-55, were interviewed in this study; 15 were lower SES people (7 men and 8 women) and 15 were higher SES people (8 men and 7 women). The Elley-Irving scale for men (Elley & Irving, 1985) and the Irving-Elley scale for women (Johnston, 1983) provided the means by which SES levels were determined. The ages of participants ranged from the early twenties to the early fifties for both groups. The average for the lower SES group was 38 with the average age of the higher SES group being 32.

Smokers were defined as being those who smoke ten cigarettes a day or more. This criteria is based upon the observation that such smokers are more stable in their smoking behaviour over time than those who smoke less (Weinberger et al., 1981). Thus these people are, due to the greater quantities and stability of their smoking behaviour, particularly susceptible to the ill-effects of smoking.

Adults aged 21-55 only were selected for participation in this study. This criteria was employed because it was considered essential that personally mature participants engage in a study such as this, which necessitates life experience, disclosure and honesty. The lower age limit of 21 was adopted because this age has long been recognized in our culture as being a significant milestone in terms of personal maturity. The upper age limit of 55 was chosen rather arbitrarily, but was based upon the observation that people over this age smoke considerably less than those beneath it (N.Z. Health Department, 1989) and the desire to avoid people who may be suffering from, and therefore preoccupied with, ill-health. As we get older we are more likely to suffer from the ill-effects of degeneration and thus are more likely to become more vulnerable to ill-health in general. This upper age limit of 55 was chosen as a cut-off point to avoid the possible bias of health preoccupations that may occur in later life.

A further criteria used in this study was that participants needed to be both willing and able to talk about their perceptions and beliefs. Willingness to disclose was indicated by choosing to participate in the study, having read the study information sheet and knowing what was to be expected of them as participants. Articulateness was subjectively determined at the outset of the first meeting, when the nature of the research was being discussed and a sense of rapport being established.

Measures:

The question list used to guide the structured interview can be found in the appendix of this report (Appendix 2). A pilot study of five people was initially carried out to test and develop the interview structure before it was finally implemented. All interviews were recorded on a small portable tape deck.

The Elley-Irving and Irving-Elley scales, were considered to be the most appropriate measures for identifying people from differing socioeconomic backgrounds. The scales are based upon relatively recent New Zealand normative data, the 1981 census, and have been devised specifically for this purpose within the context of Aotearoa. Occupations are ranked on this six point scale via a combination of typically associated educational and income levels. Lower SES people were defined as such through being employed within occupational levels 5 and 6 (typically semi-skilled or unskilled occupations) and upper SES people through by being employed in levels 1 and 2 (typically professional occupations).

Procedure:

Participants were recruited by word of mouth. The researcher sought information on people who fitted the above-mentioned criteria from collegues and friends. Participants also were asked about other smokers they knew who might be willing to participate. Potential subjects were given a "study information sheet" either by the researcher or by an intermediate person who knew them. They were contacted soon after, any queries were addressed and, if they agreed to take part, an interview time and place was established. In this way 30 people who fitted the criteria were recruited for participation in this study. Interviews took place during April and May of 1992.

The study information sheet (see Appendix 3) explained the nature of the research and what was to be expected of participants; they would be asked "a series of questions designed to explore your beliefs and understandings about health in general, and of how health may be effected by smoking". Additionally, they were assured that their responses would be treated with confidentiality and respect. They also had the opportunity to discuss and clarify anything before the interview began. Once satisfied and willing to participate, participants were asked to indicate their informed consent to taking part in the study by filling out a participation sheet (Appendix 4).

In the interview the interviewer had two paramount concerns. Firstly, collecting useful data on people's perceptions and beliefs concerning health, and secondly, ensuring that the participant was comfortable discussing the pertaining issues. It was emphasised prior to the interview, both verbally and in writing, that the participant did not have to answer any questions he or she did not feel comfortable with and could terminate the interview at any time. This relaxed attitude was apparent throughout the entire interview. People were treated with respect and given room to answer as they would like to, without any demands being made which might cause discomfort to the person.

Interviews took place in an informal atmosphere with attention being paid to achieving rapport. Once relaxed and ready to begin, the tape recorder was switched on, and the part of the interview focusing on data collection took place. Interview questions were open ended and typically followed the structured format as laid out in Appendix 2. Occasionally participants would spontaneously make reference to other dimensions of the model being explored and the researcher would follow their lead, listening and asking the relevant questions there and then. Sometimes further probes were required, beyond the questionnaire, to ensure that the underlying dimensions of health beliefs were being adequately explored. Because the interviewer had constructed the questionnaire, he was well equipped to be aware of any discrepancies between participant responses and the dimensions at which questions were addressed. More often than not however, nods, reflections and simple statements such as "go on" and "anything else?" were adequate to ensure sufficient elaboration.

Interviews typically lasted for an average of 30 minutes with the shortest interview

being 18 minutes and the longest being 45 minutes in duration. The recorder was then switched off, and the interview completed with attention being paid to the participant's satisfaction with the process. Participants were asked for permission to be quoted and if they agreed, as did all participants, they were asked to fill out a permission to be quoted form (see Appendix 5). The interviewer then thanked the person for their participation and told them that they would be contacted again later in the year with the results of the study.

It was not made explicit to participants the class based nature of the research. This was because the investigator felt uncomfortable using labels such as "lower SES" and "working class" etc to categorize people. I felt these words were patronizing and depowering, especially for those people in the "lower" SES. When people enquired about the specific goals of the research I replied that I was exploring perceptions of health over a wide range of people in society; that I was exploring attitudes of a diverse a range of occupations as possible; from teachers to cleaners, from accountants to electricians, to see if there were differences in attitudes, which is true and avoids stigmatic labelling.

Data analysis process:

The 30 taped interviews were transcribed in full by a research assistant. These transcripts were read over by the researcher before being subject to individual scrutiny and summarisation. These summaries reduced the data to a more manageable level which facilitated the extraction of meaning. The process of summarisation also facilitated "immersion" (Stiles, 1990) in the data.

Because qualitative data analysis involves a search for general statements about relationships among categories of data, the first task involved noting regularities in the data in order to identify recurring concepts, ideas, attitudes and patterns of beliefs. These phenomena were then grouped into significant categories or themes. This process was carried out for one socioeconomic group at a time. Themes common to both groups and themes unique to each group became apparent.

A list of common ideas or themes were drawn together by the researcher and these were

illustrated by quotations from participants. These observations were checked by an independent person for omissions (had the researcher overlooked any information of relevance?) and for alternative interpretations (could statements and themes be interpreted any differently?). Minor adjustments were made as a result of this "consensus" validity check with one new theme being added and another being reconceptualised.

A letter was then sent to over a third of the participants (six from each group). Because of the large number of participants and the diversity of interest expressed by them, only the most interested and enthused received the letter. The letter contained a summary of the interview and asked for an assessment of its accuracy. Participants were also invited to add or change anything and to comment on the experience of the interview itself. The point of the letter was threefold; to check the accuracy of the researcher's interpretation of people's stories (a testimonial validity check); to involve further the people who were wanting to be involved in the study; and to explore the impact of the interview on the person (a catalytic validity check). This letter, the follow-up questionnaire and two example interview summaries, from one person in each SES group, can be located in the appendix of this report (Appendix 6).

Upon completion of the interpretive part to this investigation, a second letter summarising the results of the study was sent to all thirty participants. This second letter can also be viewed in the appendix to this report (Appendix 7). The letter fulfilled a researcher obligation to inform participants of the findings to the investigation. This was a formal commitment made by the researcher, both verbally and in writing (see the study information sheet), to all those who participated in and thus contributed to this research.

Results

A large number of regularly expressed ideas emerged from the interview data. These themes were highly diverse in nature; varying widely in content, prevalence (or magnitude) and exclusiveness (or the extent to which they are common to both groups). The six constructs explored in this study are presented here in the same chronological order as presented earlier. This provides an orderly structure in which themes can be clearly and simply presented, whilst retaining their original complexity.

The running dialogue found throughout this section communicates this complexity in a simple as possible manner, expressing the content of each theme, its degree of prevalence and the extent to which it is common to both groups. Quotations from participants' stories, usually one or two, are used to support and demonstrate each theme's content. The names given in such instances are not the participant's real names. The number of quotations has little to do with prevalence. It has more to do with capturing and expressing the essential quality or essence of the theme. Prevalence is expressed by reference to a continuum of magnitude, ranging from "strong" or "major" themes (ideas discussed by the majority of people in a group) through to "moderate" or "mild" ones (a large minority of a group) to "minor" or "weak" tendencies (a pattern expressed by a few people in a group). The magnitude of each theme is made explicit for each group (upper and lower SES). "SEI" numbers refer to occupational ranking in the socioeconomic index described earlier. A brief summary of themes can be located towards the end of this chapter.

Construct 1: General Health Motivation

This variable essentially consisted of two parts; conceptions of what health means and its relative importance to the person. Three themes concerning the meaning of "good health" became apparent. The first was shared by both groups and demonstrated a strong conviction that good health had much to do with functionality; having the ability

and the energy to do things.

> "Being able to do what you want to do. Being able to work as you should. Having enough energy to get through the day."
>
> (Anna, a cleaner; SEI 6).

> "It means having a body that feels good, functions well, and doesn't tire very easily. Feeling that I have the energy to do what I want to do, like I won't pike out in a game of squash or bike riding."
>
> (Bart, an author; SEI 2).

A second theme that emerged was the idea that good health entails feeling good, alive and happy. This was more apparent in the upper SES group (a major theme), though by no means was this confined to this group. It was a minor theme amongst the lower SES group.

> "Being able to accomplish all we are capable of. Ease as opposed to disease, the greatest joy of all. Joy comes from health and the reversal too." (Susan, an educator; SEI 1).

> "You feel your whole state of mind and body is feeling alive. Holistic well-being. Feeling good."
>
> (Kathy, a teacher, SEI 1).

> "Waking up in the morning and feeling bright."
>
> (Donna, a cleaner, SEI 6).

The third theme was expressed strongly by the upper SES group but was not really expressed by the lower SES group. It concerned the holistic nature of health. The idea expressed by several members of the upper SES group was that health encompassed several dimensions of well-being (e.g physical, mental, emotional, and spiritual) and thus their conceptions extended beyond the physical. The lower SES in contrast, tended to be concerned almost exclusively with physical aspects of health.

"I have this really wide notion of what health is. I think your mind and body are related and that they effect each other."

(Gretchen, a tutor; SEI 1).

"It means being healthy in the holistic sense. Physically, mentally, emotionally, spiritually. Being balanced in all these areas."

(Joan, a nurse, SEI 2).

"The way I am now. I am on no pills or nothing . I feel healthy. I'm not on tablets and I don't have to go to the doctor."

(Molly, a cleaner; SEI 6).

For the value dimension of this construct both groups perceived good health to be of central importance in their lives. This general high value placed on health reflected different reasons for the different groups, although similarities exist. Functionality was a key reason for both groups, but the goals of such means, or the reasons behind being able to do things, differed. Lower SES people tended to see their health as being essential for gaining their livelihood. Without their health, they could not work and thus gain an income. The upper SES group however, tended to view their health as being an essential means for more leisurely pursuits. They rarely mentioned work.

"It's very important because I like to do certain things, like go mountain bike riding, and I don't want any illness or injury to get in the way."

(Jason, a technical editor; SEI 2)

"To me its pretty important. I don't know why, it just is. I need to be to go swimming, do Tai Chi and stuff like that."

(John, a sales rep; SEI 2).

"Yes, it's important. Otherwise I can't work."

(Molly, a cleaner; SEI 6).

"Health is very important to me as it provides an income."

(Jack, a caretaker; SEI 5).

A second theme in the reasoning behind valuing health was to avoid negative feelings or, more positively, to feel good. This was a strong theme for the upper SES, equal with the need for functionality. It was a minor one for the lower SES, and was not as often expressed as their need to be able to work.

"I think it's the most important thing in my life ideally...Because it touches on so many dimensions of your life. If you're not healthy you may as well be dead, cause you can't enjoy it."

(Joan, a nurse; SEI 2).

"I feel better when I'm healthy. I don't feel as good physically or mentally when I'm unhealthy."

(Bart, an author; SEI 2).

"If you don't have your health, you get very depressed."

(Mike, a labourer; SEI 6).

Construct 2: Health Locus of Control

Both upper and lower SES groups, when asked specifically how much control they perceived themselves as having over their health, stated that they perceived themselves as having a reasonably high sense of control. In the discussion that followed however the upper SES group indicated a (mildly) stronger sense of control and this is reflected in the themes expressed by each group. Several themes surrounding this sense of control emerged from the interview data; some were common to both groups whilst others were distinct to one.

Both groups exhibited a strong tendency to consider exercise and diet as being basic to their attainment of good health. Most people mentioned both of these.

"I think most people have got control over (their health)...You can have a well balanced diet, plenty of exercise and fresh air, things like that."

(Jackie, a cleaner; SEI 6).

"Yep, there's heaps you can do (to look after your health). Eating well, exercising, not doing silly things or taking silly risks...In general, if you look after yourself right you can be healthy for a long time."

(Paul, a counsellor; SEI 2).

Both groups, to a lesser extent, considered moderation in living habits to be additionally basic to maintaining good health.

"The old moderation principle is really important. If you don't go overboard, like drink or eat to much, you can't be doing too much wrong."

(Jenny, a town planner; SEI 1).

"Just moderation I suppose. If you are happy and are doing everything in moderation, then you are actually a healthy person."

(Moana, a canvasser; SEI 5).

Similarly, a lesser theme expressed by each group was the idea that money can further help to preserve good health. This theme was slightly stronger for the lower SES group.

"I think its up to me to have one hundred percent control over my health. Obviously there will be lots of other things that will control it; like wanting to go to the dentist but not being able to afford it. Money."

(Jackie, a cleaner; SEI 6).

"A lot depends on your circumstances. I think if you've got the means, you won't skimp on food and things".

(Mike, a labourer; SEI 6).

"I've never had to worry about where my next meal comes from and that sort of thing. I think money worries are the worst for health".

(Joan, a nurse; SEI 2).

Upper SES people had a tendency to consider hygiene as being additionally fundamental to good health. This was a mild theme which was not apparent in the lower SES group.

"Yep, there's lots you can do; eating, exercising, thinking positively about your body...also hygiene, living in a clean environment."

(Kathy, a teacher; SEI 1).

"It starts off with nutrition, hygiene and cleanliness, positive thinking, a healthy mind...a healthy mind is important for a healthy body."

(Susan, an educator; SEI 1).

These extracts demonstrate another moderate theme unique to the upper SES group; that the mind has much power over the health status of the body. One can control one's physical health to an extent through one's mind. Susan continues...

"Once we've got them (diseases), our minds can influence them. Lots of cancers can be cured by meditation and visualisation, seeing the cancer disappear and it works."

"I subscribe to a philosophy where a lot of illness is associated with the psychological state."

(Nigel, a psychologist; SEI 1).

Another mild theme unique to the upper SES group is the idea that "awareness", in the abstract, can foster good health.

"Awareness is important. There are certain guidelines for healthy living you just have to read about. Drinking water is good for you. Natural medicines are good to read about."

(Joan, a nurse; SEI 2).

"A lot of diseases are caused by things we are not aware of. For example aluminium and alzheimer disease. Not many people are aware of that. Awareness is important."

(Kathy, a teacher; SEI 1).

"Understanding is health giving. Reading is important for opening your mind to other ideas. A healthy mind."

(Susan, an educator; SEI 1).

Themes unique to the lower SES group tended to be of a more vulnerable or less controlling nature. They were much more likely, for example, to consider germs and diseases as being beyond control. This was a moderate theme found in the lower SES only.

"If you're born healthy, you have got almost total control disregarding contact with various diseases and viruses."

(Jack, a caretaker; SEI 5).

"Diseases like cancer and that eh, you can't control them."

(Donna, a cleaner; SEI 6).

"A fair bit of control (over health). Bugs that float around and things like that. Germs. That sort of stuff (is beyond control).

(Bob, a labouring mechanic SEI 5).

Lower SES people also talked about smoking as being out of control. This was a spontaneous expression as the interviewer had not discussed smoking at this stage. Upper SES people did not discuss smoking as being out of control at this stage in the

interview. It was a mild theme found in the lower SES group only.

> "I haven't really got much control over smoking. I really do try to give up smoking periodically and then I go back to it...I can't have any control over my health if I continue smoking can I, but I can do all the other things but it's not really that total control."
>
> (Moana, a canvasser; SEI 5).

> "There's a lot you can do if you really want to (to look after your health). It's motivation and will power really. I have the will power for just about everything healthy, except for one thing, smoking."
>
> (John, a farmhand; SEI 5).

Lower SES people indicated a mild to strong sense of fatalism. They saw events such as accidents and ill-health as being out of control and a sense of destiny surrounded this issue.

> "You've probably got quite a bit of control I feel, but I don't worry about it. If something is going to happen it's going to happen isn't it."
>
> (Donna, a cleaner; SEI 6).

> "Some things just happen and there is not any control. You've done your best yet it still happens."
>
> (Jackie, a cleaner; SEI 6).

> "It's (health) a lot of my responsibility. But when your numbers dialled you have to answer the phone. I try not to worry about the future, haven't got much say in it."
>
> (Doug, a labourer, SEI 6).

This fatalistic theme sometimes manifested itself in a conclusion of living day by day and enjoying what you can when you can; thus implicitly justifying smoking.

"An accident, if that was going to happen to me it would just happen...I enjoy smoking...I just take each day as it comes."

(Moana, a canvasser; SEI 5).

"If you enjoy it, why not do it...you're going to go one way or another. You may as well enjoy it. You could die crossing the road. If you enjoy it, do it. That is really my philosophy."

(John, a farmhand, SEI 5).

Construct 3: Benefits of not smoking

This dimension explored people's perceptions of causal relationships between smoking and health. As discussed previously this notion is implicit to any perceived benefits of not smoking. Perceptions involved the most likely outcome of their own smoking, the worst possible outcome of anyone's smoking, and the extent to which lung cancer and smoking are causally related. Because of the obvious overlap, perceptions of the most likely health outcome are reported under the susceptibility dimension (construct 5). Every participant thought that smoking impacts upon health in some way.

Both the upper and lower SES groups considered the worst health consequences of smoking to be heart disease, emphysema, cancer in general, and lung cancer specifically. These four responses predominated in both groups, sometimes on their own, sometimes in conjunction with another.

"I guess they develop a terminal illness that can be directly traced back to smoking, irreparable damage to the heart. Cancer."

(Toni, a labourer; SEI 6).

"I should imagine it would be lung cancer."

(Moana, a canvasser; SEI 5).

"For a person who is in their 30s or 40s, a heart attack when they are normally expected to be active and so on. Getting through that, emphysema in the later years, in the 50s and 60s and so on."

(Jack, a caretaker; SEI 5).

"I don't know. Whether they get heart disease or lung cancer I suppose."

(Rebekah, a social worker; SEI 2).

"Lung cancer or emphysema."

(Nigel, a psychologist; SEI 1).

Both upper and lower SES groups believed the smoking/lung cancer relationship to be a moderately high causal relationship. Both groups perceived smoking as being the major cause of lung cancer, although neither saw this as being the only cause.

"I believe that, purely and simply, smoking has a big content towards lung cancer."

(Jack, a caretaker; SEI 5).

"I think (smoking) has a big impact (on lung cancer). It's pretty intensive stuff to be doing to your body."

(Paul, a counsellor; SEI 2).

Both groups commonly cited counter examples of the smoking/lung cancer relationship as evidence for rejecting absolute or exclusive causality.

"I have had relations, 18 and 19 year olds who have died of cancer who never smoked or drunk. Smoking is not the only cause of cancer. You never know what is going to bring it out."

(Molly, a cleaner; SEI 6).

"I know if you smoke for a long time you aren't bound to get it. I know people who have smoked until they died at 80 and they didn't get it."

(Nigel, a psychologist; SEI 1).

"Research shows it's pretty major. About an eight (out of ten). Some people smoke all their lives and don't get it. There's no absolutes."

(Joan, a nurse; SEI 2).

Both groups identified other causal factors that might impact upon lung cancer. A strong theme for both upper and lower SES was genetical predisposition.

"A lot of people get cancer without smoking. It can be genetically based."

(Simon, a technician; SEI 2).

"It can be an hereditary type. It's just in you. The cancer is already there."

(John, a farmhand; SEI 5).

"I think smoking definitely plays a part, but then it depends too. I think a lot of it is hereditary. If it's in the family you will find people tend to get it and then of course if they are smokers it will rush the process a bit more."

(Jackie, a cleaner; SEI 6).

Similarly the environment, with particular reference to pollution, was frequently mentioned as being a further cause of lung cancer. Jackie continues...

"...There are lots of other factors too...Pollution. The environment and all the bombs they let off and things like that. They all play a part too. You only have to look out at the weather and I'm sure that something has happened to the weather so it must have something to do with our health."

"I know people who have died from lung cancer who have never smoked, so it must be something else. Probably top dressing sprays and that, paint smells and things."

(Donna, a cleaner, SEI 6).

"Statistics say that smoking is definitely a cause, but there are other causes as well, like pollution and chemicals."

(Rebekah, a social worker; SEI 2).

"Genetics plays a part and so does stress, how stressful your environment is. Also pollution, like a smoggy city might have an effect."

(Joan, a nurse; SEI 2).

This last quote (Joan's) identifies stress as being a further cause in the development of lung cancer. This was a moderate theme for the upper SES group. It was not discussed by people from the lower SES group.

"Some people are not prone to illness. Stress does make you more prone to things."

(Simon, a technician; SEI 2).

"Stress wears the body down...What these people have shown, if you remove the cancer, but what about the problem that causes the cancer, the stress or whatever will manifest itself in another form."

(Steve, a teacher; SEI 1).

A strong theme, found only in the lower SES sample, was the assertion that the work environment contributes towards lung cancer.

"There are other things which can cause lung cancer though. Asbestos factories, working in mills, working where there is a chemical environment."

(Moana, a canvasser; SEI 5).

"Other people say it may be the work environment."

(Anna, a cleaner; SEI 6).

"I worked as a chippie and you get all this fine dust you take into your lungs which aggravates it, but if you are a smoker you have got more chance of getting it."

(Mike, a labourer; SEI 6).

Sometimes people of the lower SES group talked about chance as playing a role in the formation of lung cancer. This was a moderate theme, also unique to this group.

"Lots of smokers don't get it so you are in with a chance."

(John, a farmhand; SEI 5).

"You might get it. You might not. It's hit and miss."

(Doug, a labourer; SEI 6).

Construct 4: Severity

This dimension explored the perceived severity of the various health outcomes associated with smoking. Heart disease, lung cancer and emphysema were all perceived as being high in severity by both upper and lower SES groups. The reasons given varied, but tended to be shared and expressed by both groups. Death, for example, was a common reason; a major theme for both groups.

"It'd be horrible I reckon. I'd die. It'd be a bitch because there's so much I've got to do."

(Hanna, a canvasser; SEI 5).

"It would kill me. I think about that. Death."

(Kathy, a teacher; SEI 1).

Pain was another often cited reason.

> "It's a very painful experience apparently. It takes a while for the person to die and you go through a period of six months of intense medication and pain."
>
> (Jason, a technical editor; SEI 2).

> "The pain and agony you go through as you wither away and die. A major downer for grand-dad when it happened to him. You just wished he'd die and be free of it. Better than going on like he was."
>
> (John, a farm-hand; SEI 5).

Psychological distress, including depression, excessive stress and other negative psychological responses, was another commonly cited reason.

> "Pretty horrible, pretty painful. I met a guy who had lung cancer and he was a sad case...you'd be pretty bummed out...I think I'd have psychological problems."
>
> (Henry, a labourer; SEI 6).

> "With emphysema you can't talk very easily because you run out of breath every minute. That would frustrate me no end. I'd go mad. That would hurt me terribly."
>
> (Susan, an educator; SEI 2).

> "If I got it, especially at the moment, I'd be cut up about it for myself."
>
> (Peter, a scientist; SEI 1).

Loss of functional ability and restrictions in lifestyle describe the fourth theme that emerged from people's stories. People from both groups rated these diseases as high in severity at least partly because of the restricting impact it would have on their current lifestyle.

"Not being able to breathe, not being able to walk, having an oxygen tank following you. It would be terrible."

(Jackie, a cleaner; SEI 6).

"You're very limited. Gasping for breath. Your intake of breath is so limited. Basically you suffocate. You can't climb stairs, walk distances. On cold days you're fucked. On hot days you're fucked. It would be very bad."

(Nigel, a psychologist; SEI 1).

"Once you got it (lung cancer), you can't do much about it. It slows you down right up to the end."

(Bob, a labouring mechanic; SEI 5).

A slightly more abstract theme, best summed up as a reduction in quality of life, was expressed by many upper SES participants. It was a strong theme, unique to this group.

"It degrades the quality of life. The way I see it, if you have troubles with your health, it detracts from the rest of your life."

(Peter, a scientist; SEI 1).

"It's not that you are going to live a fulfilled life and then die early, you can't even live a fulfilled life."

(Gretchen, a tutor; SEI 1).

There was a minor theme in the upper and lower SES groups where lung cancer and the "worst possible health consequence" was considered to be relatively low in severity. For these people, there was a general sense of acceptance and "OK-ness".

"If I get lung cancer, I get lung cancer. I'd be disappointed in myself if I got it, but if I got it, it would be OK."

(Steve, a teacher; SEI 2).

"Cancer isn't a threatening thing to me. People talk about cancer but I think you are either going to die one way or another...If I die I want to know I am dying and I don't mind suffering for three or four or even six months if I can get all my house in order."

(Moana, a canvasser; SEI 5).

There was an important SES group difference in this respect however. Whilst some upper SES members did not fear health outcomes normally considered severe, they did not consider themselves susceptible to them either. Such lower SES people, in contrast, did. Moana for example continues:

"I think I will probably end up on a breathing machine and I hope to goodness they take me off and let me die peacefully."

Construct 5: Susceptibility

This dimension explored peoples' perceptions of the risk of contracting the perceived health consequences of smoking personally. For high severity outcomes, the dominant theme was one of low susceptibility. This theme however was stronger in the upper SES group. The majority of participants considered themselves unlikely to develop heart disease, lung cancer or emphysema. Of the reasons given, some were shared by both groups and some were distinct to one group. The reasoning presented here typically reflect moderate themes. "Mind-blocks" was one such response common to both groups. Here people in every day life blocked themselves from thinking about the possibility of severe health outcomes.

"You don't like to think nothing's going to happen to you...You kind of block it out of your mind don't you."

(Donna, a cleaner; SEI 6).

"I don't know, I don't think so...I haven't really thought about it (lung cancer). I don't really think about things like that...I just don't think about things like that at all."

(John, a sales rep,; SEI 2).

A further cited reason for low susceptibility was the idea that the person would be giving up smoking in the near future, and thus would be exempt from any ill-health effects. This was a fairly common expression.

"I'm planning on giving up in a month's time so no, I don't expect any effects."

(Nigel, a psychologist; SEI 1).

"I've already cut down and I'll stop completely in the next year or two. These days I'm virtually only a social smoker anyway. There's no reason to expect any long term damage in the future."

(Aroha, a waitress; SEI 5).

Upper SES people spoke of lung rejuvenation occurring if and when they gave up. This reaffirmed and strengthened their confidence in their low susceptibility.

"I've heard that your lungs can get back to their original state once you stop smoking, even though it takes a long time."

(Gretchen, a tutor; SEI 1).

"I will have damaged tissues beyond repair if I don't knock it on the head now. It's repairable now. I've read that your lungs have a chance to regenerate in the right environment if it's not too late. I know people who quit after thirty years and who feel wonderful later."

(Joan, a nurse; SEI 2).

Upper SES people additionally stated hereditary reasons for their lack of susceptibility.

They often considered themselves to be genetically safe. Lower SES people didn't mention this. They were much more likely however, in general terms throughout the interview, to make reference to family members who had developed severe conditions.

> "I don't think I'll get it (lung cancer)...Cancer can be hereditary and no-one's had it in my family."
>
> (Kathy, a teacher; SEI 1).

> "I don't think so (get lung cancer). If in a family a mother and a father die of cancer it's probable that their children will get cancer as well...No-one in my family has had it."
>
> (Kate, a technical artist; SEI 2).

> "I watched my father go through it (emphysema). It was awful."
>
> (Molly, a cleaner; SEI 6).

The lower SES group sometimes expressed an "it won't happen to me" philosophy. This form of reasoning was not apparent in the upper SES group and was a minor theme only for the lower SES group.

> "It won't happen to me (laughs)."
>
> (Henry, a labourer; SEI 6).

> "Not very likely I don't think. Yeah, but nobody thinks I better stop this or I will get lung cancer. They always think this will never happen to me."
>
> (Janine, a waitress; SEI 5).

This latter comment reflects a further theme that emerged from the interviews; an awareness of the possibility of rationalizing. This was predominantly an upper SES group occurrence, where it was a moderate theme.

"Smokers all have this problem; on the one hand they know smoking is bad, on the other hand they smoke. So they reconcile it with "I don't really smoke","I'm going to give up" or "It's not that bad for me". The one I do is say I'm going to give up, otherwise I'd be irrational."

(Gretchen, a tutor; SEI 1).

"I suppose we all sort of think it won't happen to us."

(Rebekah, a social worker; SEI 2).

Although members of both groups tended to consider themselves unlikely to develop high severity outcomes, there was a moderate theme amongst the lower SES group in which a perceived likelihood of severe health repercussions was apparent. In general the lower SES people considered themselves to be more vulnerable to serious health consequences than their upper SES counterparts. These people were distressed at the thought that they would be suffering in later life. They would not be changing their behaviour however, because smoking was considered to be an important part of their life.

"If I'm silly enough to carry on the way I'm going I probably will (get lung cancer). I'm not kidding myself. Nobody wants to go like that...I wish I had another way of dealing with stress...I think I have a harder job than most. I'm a woman for one and a black, two...It would be a bitch."

(Hanna, a labourer; SEI 5).

"Nine (likelihood out of ten). I lost both my parents through lung cancer and it wasn't very nice. Not that I'd probably change my life...It's a companion in my situation."

(Mike, a labourer; SEI 6).

"I'm dreading it. It's going to be horrible."

(Donna, a cleaner; SEI 6).

Also there was a further related theme amongst the lower SES group, in which death, due to smoking, was accepted as being a most likely (if not inevitable) outcome, but was not feared as being severe. This was a minor-to-moderate theme.

> "I will probably end up like both my parents and develop emphysema...If I got lung cancer and died in a fortnight it would not worry me."
>
> (Jackie, a cleaner; SEI 6).

> "If someone told me I was going to die tomorrow I would not worry about it."
>
> (Moana, a canvasser; SEI 5).

What people typically did perceive to be the **most likely** health outcome, of their smoking for them personally, was typically low in severity. This was particularly so for the upper SES group where the theme was paramount, in contrast to it being a moderate theme for the lower SES group. The reasonings presented above contribute to these conclusions. Some people, more strongly so in the upper SES group, expected no ill-effects from their smoking.

> "I don't expect any effects. I'm 24 now and recovery, if I give up now, will be complete."
>
> (Nigel, a psychologist; SEI 1).

> "I'd like to think it wouldn't have an impact upon my life."
>
> (Henry, a labourer; SEI 6).

Loss of vitality and fitness was another likely outcome expected by a large minority of both groups.

"I'd say, when I get older, if I am still smoking, it will slow me down a lot. My grandfather (who smokes), he is eighty and he is still working. A lot of people that smoke are a lot more decrepid, slow down and find it hard to get up in the morning. I don't want to be that way...I can't envisage it being that bad."

(Doug, a labourer; SEI 6).

"How it has already affected me...losing energy and being less active. I used to be much more active and play sports when I was younger."

(Aroha, a waitress; SEI 5).

"You are probably not quite as fit as you should be. Breathing isn't as good. I'm thinking of myself tramping although it hasn't affected me until now."

(Rebekah, a social worker; SEI 2).

The upper SES group, when they did speak about long-term physical damage, had a tendency to predict, at worst, low-mildly severe outcomes only.

"Sore lungs. It's a pain because they will get sore like they do and sometimes I won't be able to do the things that I want to do. It would be a hassle and maybe discomforting at times, but other than that it wouldn't be that big a problem."

(Kathy, a teacher; SEI 1).

"My most likely outcome is an increased vulnerability to sickness."

(Bart, an author; SEI 2).

"I can feel it in my chest...It also effects my skin, it ages a lot quicker. Those are the most likely effects."

(Kate, a technical artist; SEI 2).

Construct 6: Costs of not smoking

This dimension involved an exploration of why participants smoked. A wide variety of rather strong themes emerged in response to this question, with most people offering several reasons. Most were shared by both upper and lower SES groups. Helping to cope with stress was one such reason.

> "If I feel uptight and stressed I usually have a smoke. It does seem to have a relaxing effect."
>
> (Rebekah, a social worker; SEI 2).

> "Because of stressful situations. It calms me down and makes me feel good. It seems to relax you when you are feeling uptight."
>
> (Molly, a cleaner; SEI 6).

Physical addiction and psychological habit were two reasons discussed together as often as they were given separately. People of both groups tended to distinguish between them.

> "It is something you get used to. It's just a habit basically and it tastes good afterwards. The rest of the time it's like you need it."
>
> (Jason, a technical editor; SEI 2).

> "For the same reasons as a heroin addict, a total addiction. I'd get the shakes if I stopped and psychologically I'd be a bitch."
>
> (Susan, an educator; SEI 1).

> "I do it out of habit and addiction. It's both physical and psychological."
>
> (Toni, a labourer; SEI 6).

"...the biggest thing of all, it's a habit. If the phone rings I will automatically light up a smoke, as soon as I have a cup of coffee I light a smoke. Sometimes I wonder myself why I am doing it...a lot of it is just a pattern in my life...and I can't survive without smoking otherwise I get really bad tempered."

(Jackie, a cleaner; SEI 6).

Similarly both groups said smoking was something to do, especially with one's hands, in uncomfortable social situations.

"It's something to do with your hands, relaxing in social situations."

(Gretchen, a tutor; SEI 1).

"It's more something to do socially. I'm normally quite fidgety, so it helps." (Henry, a labourer; SEI 6).

People from both groups also reported that smoking was a good thing to do when on their own. They found it comforting, either as a companion, a ritual or as a time fuller.

"I like the company of it too because I spend a lot of time on my own."

(Joan, a nurse; SEI 2).

"If I'm bored, like after finishing the housework, I think "What can I do a cigarette and have a smoke."

(Janine, a waitress; SEI 5).

Similarly when one is feeling depressed and/or lonely, people thought smoking helped alleviate this negativity.

"Smoking is a way to let off steam. When I have been really depressed I smoke more."

(Anna, a cleaner SEI 6).

"When I'm feeling depressed it's easier to smoke. You don't want to deny yourself anything. What's good for you or not doesn't matter when you're depressed."

(Bart, an author; SEI 2).

Smoking is reportedly important to both groups in their social relationships. There was a subtle difference however, in the flavour of this for the different groups. The upper SES group spoke more along the lines of smoking being a joining ritual; that somehow sharing a cigarette brought people closer together. The lower SES group however spoke more along the lines of smoking being embedded in their already existing social relationships and that these relationships necessitated them to be smoking.

"I like the social interactiveness of sharing a smoke with people. It's a form of communication."

(Joan, a nurse; SEI 2).

"I enjoy it. It's social. There's nothing better than a room full of smokers. I love it. I don't care about what people say, that it's anti-social. There is a culture involved with smoking, a special bond."

(Nigel, a psychologist; SEI 1).

"Giving up smoking means getting probably a whole new set of friends, a whole new family and job away. Haven't been able to do that yet."

(Hanna, a labourer; SEI 5).

"You'd have to be strong to give up. You'd have to change your whole social life."

(John, a farmhand; SEI 5).

These extracts reflect another theme. The upper SES group seemed to appreciate their smoking more. Enjoyment was a common theme, found in both the upper and lower SES groups, but it was more consistently so in the upper SES group. The upper SES group often expressed a love of smoking. Lower SES people however, whilst sometimes

expressing this, as often as not claimed that they didn't enjoy it. Thus there was a tendency for upper SES people to enjoy smoking more.

> "It's as satisfying as eating. Just as enjoyable. A reliable basic pleasure."
>
> (Kathy, a teacher; SEI 1).

> "I don't know if I enjoy it. I only enjoy it part of the time. That's whe even if it isn't enjoyable you have a cigarette."
>
> (Mike, a labourer; SEI 6).

Another related theme was how people started smoking. Although there was no question which addressed this specifically, the notion of peer pressure as an initial foundation for the act of smoking was spontaneously mentioned several times, mostly so by the lower SES, in which it was a moderate theme.

> "At first it was peer pressure at school when I was 12 or 13."
>
> (Aroha, a waitress; SEI 5).

> "When I was nine, it was more peer pressure than anything."
>
> (Janine, a waitress; SEI 5).

> "I started when I was 15 at school, peer pressure."
>
> (Peter, a scientist; SEI 1).

Upper SES people however, were just as likely to say that rebellion provided the beginnings as they would peer pressure. This was a minor-to-moderate theme found amongst the upper SES only.

> "When I started it was something to do with being different from my family. I didn't smoke with my peers. I liked being unique.
>
> (Nigel, a psychologist; SEI 1).

"I started late, about 16, it wasn't peer pressure. I wanted to rebel, I was tired of being a good girl. I wanted to feel grown up and independent."

(Gretchen, a tutor; SEI 1).

A minor-moderate theme that emerged only for women, was the idea that smoking reduces one's appetite, and thus keeps one's weight down.

"I don't put on much weight when I'm smoking. When I stopped for a few months once there was this big girl in the mirror looking back at me. I know her, she's my height. I realised that's me and I started again."

(Donna, a cleaner; SEI 6).

"A side effect is weight loss".

(Jenny, a town planner; SEI 1).

Summary of Themes

The upper SES people typically expressed a strong conviction that to have good health is to be functional and to feel good. For these reasons they typically perceived their health as being of great importance to them. Uniquely, they frequently expressed a holistic notion of health which encompassed more levels than the physical. The lower SES group shared the strong theme of health being functional and this was why they too typically considered it as being of a great importance; so that they can function properly, usually so that they can work and thus survive. Feeling good, in contrast, was a minor theme for this group.

Both groups exhibited a reasonably high sense of personal control over their health, with the upper SES group's sense of control being mildly stronger. Both groups considered exercise, diet, and moderation in all things to a lesser extent, to be fundamental to maintaining good health. The upper SES additionally cited hygiene, awareness and a healthy mind, although to a lesser extent, as being further basic to ensuring good health. Lower SES people were more likely to consider germs and diseases as being beyond control, as they did smoking. Additionally, they frequently expressed a sense of fatalism. Both groups considered money to be helpful in preserving their health.

People of both groups typically reported that smoking is a prime determinant of lung cancer. They didn't however consider it to be an exclusive or necessary cause. Both groups offered counter examples to the contrary, and cited the environment, for example pollution, and genetics as being additional determinants. The lower SES group also talked about the work environment as being conducive to the formation of lung cancer. They also discussed chance as playing a part in its development whilst the upper SES participants were more likely to consider stress as playing a role.

Heart disease, lung cancer and emphysema were all typically perceived by both groups as being both high in severity and as constituting the worst possible health consequence due to smoking. Fears of pain, death, psychological distress and lifestyle restriction, emerged as dominant themes in the reasonings behind such convictions. Additionally,

the upper SES group spoke of a reduction in the quality of one's life. A minority of each group considered such outcomes to be low in severity.

There were clear differences in terms of susceptibility to negative health outcomes between the groups. Both gave accounts expressing low susceptibility, with this being a dominant theme for the upper SES group and a mild theme for the lower SES group. Mind-blocks and stopping smoking in the near future were shared reasons for this lack of susceptibility. Upper SES people additionally spoke of complete lung rejuvenation and being genetically safe. They were also more likely to speak of the role of rationalizations in considering oneself safe. A minority of lower SES people thought that such tragic events couldn't or wouldn't possibly happen to them. Lower SES people were much more likely to consider themselves to be susceptible to high severity outcomes. This was distressing for them. Some upper and lower SES people considered themselves to be susceptible to mildly severe outcomes. Lower SES people sometimes talked of death as being an inevitable health consequence of their smoking, yet they considered this to be low in severity.

Habit, addiction and stress were frequently cited as reasons as to why people smoked by both groups. Upper SES people were more likely to enjoy their smoking. Both groups found it a good thing to do on their own. It helped with boredom, depression or feeling lonesome. Lower SES people tended to start their smoking out of peer pressure and saw it as being cemented in their present relationships. Upper SES people were more positive about their social experiences, often reporting it to be a pleasant joining or sharing ritual. Both upper and lower SES people discussed smoking as a means of reducing social anxiety.

Convergence: Themes into Stories

An appropriate validity check for this study is an assessment of the extent to which each group's themes converge upon a story of their own (Stiles, 1990). Do they converge upon a story? (triangulation validity); and if so, is it comprehensive and internally consistent? (coherency validity). Such questions address the validity of the research findings as being a true reflection of the experience of the groups to which they purport to represent. In essence, can a seemingly valid and sensible prototypical experience be extracted for each group from the research data?

The results of this study demonstrate that differences and similarities in attitudes towards health exist for the different socioeconomic groups explored in this study. Whilst much overlap exists in their perceptions, the various themes that emerge for each group do converge upon distinctive stories. These stories are internally consistent and comprehensive, and they do make sense.

Beginning with the upper SES group, a prototypical story representative of their experience, might be as follows:

> Good health means to feel good on a multiple of levels. Not just physically, but also emotionally and mentally, if not spiritually. In this way one can achieve all sorts of things in life and enjoy doing them. You can live life to the full and can thus be happy and fulfilled. Good health is basic, if not equivalent, to personal well-being. One can preserve one's health simply by looking after yourself. Diet, exercise, hygiene, and positive thinking are all basic to this. If you do things in moderation and know what you are doing, you should be OK. Having money helps. If you do get sick you can easily see a doctor. I know smoking isn't very good for your health but I enjoy it. That's why I smoke. I like smoking by myself because it gives me a space to think. I like smoking with others too. Its a nice sharing ritual. It helps when I'm feeling stressed and when I feel nervous socially. I guess a lot of

my smoking is habit; maybe addiction too, but mostly its because I enjoy it.

Smoking causes lung cancer for sure. Its not the only cause though. The environment can be dangerous too and it can be hereditary. Mental stress doesn't help either. Emphysema, lung cancer and heart disease are all as bad as each other; horrible. You die sooner or later, you feel awful, and you can't do much while you're alive. Your life wouldn't be worth living because you could no longer realise your true potential. It's unlikely I'll get any of these anyway, because they don't run in my family and I plan to give up soon. I know this sounds like a rationalization but I will. At worst I'll end up with reduced fitness and maybe a soar throat for a while. I don't really expect any long term effects from my smoking.

A prototypical lower SES story might best be represented as follows:

To have good health is to be able to function as you should. To have the physical ability and energy to get through the day. There are certain tasks that must be completed each day and you have to be able to do them, otherwise you get behind. You need to be able to work in order to make a living and you need your health to be able to do this. This is why health is so important. Without your health you feel gross. There's quite a lot you can do to look after your health though. Eat properly, exercise now and then. There's some things you can't control though. Like germs and diseases or accidents even. Sometimes its like they're waiting for you. I sometimes think that having more money would make looking after your health a bit easier. I mean you could go to a doctor or a dentist whenever you wanted.

Heart disease, lung cancer and emphysema would all be awful to get. I don't think about it really. I guess I could get one of them. My dad died of lung cancer. It was horrible. He was suffering right up till the day he died. I hope

that if I get one of them I die quickly. I don't mind dying, you have to die one way or another, but going out slowly and miserably would be unbearable. I think lots of things can cause lung cancer. The environment for one. Dad used to work in a mill and it was the asbestos which killed him in the end I'm sure. He used to come home coughing and then would have a cigarette. I don't want to end up like him, but its possible I guess.

I smoke because all my friends smoke and I like to smoke with them, even though I don't even like it half the time. I guess its just habit. I started smoking with my friends when I was young and I guess I never stopped. Most of my friends smoke. I think that's probably one of the things that stops me giving up. Its a habit with my friends and workmates. Its a terrible habit though. I think I might be addicted to it too. I find it to be calming sometimes when things aren't going right. It's good to be able to have a cigarette and distance yourself from things for a while.

These convergent stories, reflecting the shared experience of members in each group, do make sense and do appear to "hang together" (Stiles, 1990) in a coherent way. There appear to be no contradictions in what's being said, and there is strong evidence for consistency and coherency in both groups. For example, the upper SES group's holistic conception of health theme appears throughout their story; If you think positively you are more likely to be healthy as a result (emotionally and physically). Lung cancer can result from physical (cigarettes, the environment) and mental (stress) causes. Your life essence and quality of being is seriously flawed when you become ill.

The lower SES group's convergent experience also demonstrates a strong sense of coherency and consistency. This group, for example, expressed a lesser sense of control over their health and this is reflected throughout their story; For example their unique idea that the work environment can play a role in the formation of lung cancer. Also their greater experience with (smoking related) illnesses running in their family is consistent with their expressions of a sense of fatalism and this in turn explicitly reflects their lesser sense of control.

Comprehensiveness of these stories, as a further condition to convergent validity (Stiles, 1991) is necessarily implied in the format of this study. These stories are comprehensive to the extent to which the Health Belief Model is complete in its account of health behaviour. All the variables or constructs described by the model are present in the above stories and thus these stories, according to this criteria, are comprehesive. Subjectively speaking, as a general outlook upon health and of the health behaviour of smoking, there seems to be a strong sense of comprehensiveness in these stories .

These validity checks, triangulation and coherency, used to assess the extent and quality of theme convergence in this study, build upon the inter-rater reliability measure discussed earlier to empower and strengthen the general trustworthiness of the results presented here. Two further strategies which further empower the validity of this research are discussed below.

Follow-up Questionairre

Of the twelve people who were sent the follow-up questionnaire and interview summary, four people from the lower SES group and five from the upper SES group replied. Each person indicated that they perceived the summary to be accurate. Two people made additional comments and thereby expanded their interview summaries with new information. These were not significant in terms of altering the results however, because these additions reflected themes already apparent to the researcher. One person commented that smoking helped relieve stress whilst another emphasised the difficulty of giving up. Both of these people were from the lower SES group.

These responses indicate that the researcher's interpretation of what was discussed in the interviews was consistent with participants' perceptions. Thus a shared understanding of the interview content is apparent. These responses provide support for the overall validity of this research. Perceptions have been checked with nine participants and these have been affirmed as being accurate representations of their experience. Such responses demonstrate testimonial validity.

A second validity issue addressed through the follow-up questionnaire is catalytic validity. Catalytic validity addresses issues such as: Did the research do anything for participants? Did it spark a change in them? In assessing catalytic validity, it is useful for the purposes of this research to distinguish between three levels of possible "change". The first is on a personal level. A relevant question is: Was it a positive experience for participants to participate in this research? Each participant indicated that they had enjoyed the research process. Simon (a technician; SEI 2), gives a typical response:

> "I felt relaxed and interested by the whole thing...I liked it when you sat on the floor. It took me back to when I was younger and so did our conversation about the environment...I found it enjoyable being a participant.".

A second level of change concerns the specific attitudes and behaviours which surround

smoking. Most of the people (6) who responded to the letter indicated that the interview had been a catalyst to increasing their awareness and thinking about the issues of smoking and health. No-one however, had stopped engaging in the negative health behaviour. A typical response was that of Marilyn (a cleaner; SEI 6).

> "It did make me think of the harm smoking can do to me, although I still have not given up.".

Evidence of catalytic validity at this level frequently emerged spontaneously during the course of the actual interviews. For example Susan (an educator; SEI 1) commented:

> "I hadn't thought of that before. Thank you my dear. Now that's a good reason to stop smoking. If I got emphysema, I'd lose my voice and I couldn't hold conversations with people.".

Given the various themes which have emerged from this study, especially under the "costs to not smoking" dimension, this lack of change in behaviour is understandable. As will be demonstrated in the discussion, there are numerous factors which impact upon the perpetuation of smoking behaviour. It is unlikely that a single interview will change this. Never-the-less it is significant in itself that the study has stimulated greater thought over the issues of health and smoking. It is possible that this could manifest itself in a behaviour change at a later date.

A third level of change is the most politically significant. This level however was not addressed in this research. Relevant "changes" could have been addressed by the following questions: Did the lower SES people gain a greater understanding of their ill-health predicament as a group? Does this awareness enhance their ability to preserve and protect their health? As discussed earlier in this report, the researcher did not feel comfortable labelling people with "upper" and "lower" SES categories and thus this issue was not addressed.

Catalytic validity then, was achieved to a reasonable extent in this research. The research process was enjoyable for participants and it did stimulate further thinking

about the pertaining issues. It did not however generate change either at a personal behavioral level (smoking) or at a group empowerment level (identity and politics).

In summary, receiving the follow-up questionnaire information from participants was useful. Testimonial validity and some degree of catalytic validity was established. These build upon the general trustworthiness of the research that has been established by the validity related measures discussed previously. Along with triangulation, coherency and the inter-rater reliability check, the testimonial validity check and the catalytic validity measure, to a lesser degree, provide support for recognizing the findings of this study to possess a general sense of "trustworthiness".

Discussion

When the health belief dimensions explored in this study are compared and contrasted between the two SES groups, four of the six constructs emerge as being significantly different. "Conceptions of health", "health locus of control", "susceptibility", and "costs of not smoking" all offer rich and meaningful data in terms of demonstrating differences in SES group attitudes towards health. The "benefits of not smoking" dimension, in contrast, is essentially identical in content for each group, yet the implications of these ideas may be profoundly different for each group. The "severity" dimension is also very similar for each group, demonstrating minor differences only. The attitudinal differences found in this study appear to significantly contribute towards explaining the differences in health behaviour for the two social classes. If we accept that, as the health belief model proposes, such ideas influence behaviour, then these differences in attitudes towards health are important for their explanatory power in this respect.

The following discussion focuses upon these differences and attempts to highlight their significance as precursors to health behaviour. In general each health construct is discussed, in light of theory and past research, in the same chronological order that has been retained throughout this research report. Where relevant, their connections to the other health beliefs will be explicated. Because of the intimate and meaningful connections that have emerged between some of the health beliefs, the fourth construct (Severity) will be presented second, following "conceptions of health". The remaining four health beliefs (locus of control, susceptibility, costs of not smoking, and benefits of not smoking) are highly interconnected and this meaningful relational whole is best demonstrated through discussing these variables together.

In terms of conceptions and values surrounding health (construct 1) strong group differences were apparent and these are consistent with the findings from previous research. This study indicated that the upper SES people's conception of what it means

to have good health was more multi-dimensional, holistic and positive than that of the lower SES group. The lower SES group tended to be uni-dimensional or physical and negative in the sense that good health implied the absence of physical illness. These differences were reflected in the reasonings behind their valuing of health. Upper SES people valued health highly so that they could feel good and do things. In contrast being able to function so that one could work was the dominant reasoning for the lower SES group.

Previous research along this dimension has indicated that a uni-dimensional conception of health is more apparent in lower SES groups (Blaxter & Patterson, 1982; Herzlich, 1973; d'Houtard & Field, 1984). It has been argued that socially disadvantaged groups are more likely to define health in a negative sense and in terms of the absence of illness which seriously disrupts practical and necessary activities. This lack of a positive and holistic conception of health is thought to be influenced by the high prevalence of physical ill-health amongst this group (Calnan & Johnson, 1985). It has been further argued that the use of a "positive" definition of health may be an important influence on the decision to carry out preventative health behaviour (Blaxter & Patterson, 1982; Williams, 1983).

The findings presented here for this construct concerning conceptions of health support the ideas and tentative conclusions that have emerged from previous research. It would seem that the different socioeconomic groups develop different ideas of what health is as a result of their experience. These different ideas offer a different criteria for good health and it would seem that this criteria reflects a general acceptance of lower levels of health in the lower SES group. Subjective well-being on a multiplicity of levels, for example the mental, physical and emotional realms, is a different and somewhat higher standard of health than a functional criteria.

Lewis's (1967) culture of poverty thesis reflects this finding. The thesis posits that people from communities existing in deprived material conditions tend to develop an acceptance of markedly lower levels of health. Given the experiences of such groups with quantitatively and qualitatively higher rates of ongoing illness, such an attitude within the lower SES as a whole is not unexpected. The findings of this research thus

support the assertion that adverse social and material circumstances may lead people to operate predominantly within functional definitions of health (Blaxter & Patterson, 1982; Calnan & Johnson, 1985).

In terms of severity (construct 4), more similarity than difference in attitudes was obviously the case. Lung cancer, emphysema and heart disease were all typically considered by both groups to be highly severe outcomes. The reasons given were shared by the groups and included pain, death, debilitation and psychological distress. Because of this strong overlap in attitudes, this variable (severity) offers little insight into the nature of class based differences in health behaviour. One small theme stands out however that may have some significance in the overall scheme of things and clearly relates to Lewis's observations mentioned above.

A small minority in the lower SES group only, reported feeling vulnerable to such outcomes **and** considered them to be relatively low in severity. The rationale being that you have to die one way or another, sooner or later. Because there is an absence of research in this area, there is little to compare these results to in order to maximise the sense that can be made from it. Lewis's (1967) culture of poverty thesis however, provides some rationale in respect to this small theme. The relatively deprived material circumstances of the lower SES group could feed into a greater acceptance of such illness. As Lewis observed, people from the culture of poverty not only have an acceptance of lower levels of health but they also demonstrate a markedly lower life expectancy. Thus they have a greater acceptance of "pre-mature" death. The fact that illness and pre-mature death is disproportionately distributed into lower SES social groups would presumably effect such expectations. This is a minor theme only for this research and this could reflect that lower social classes in Aotearoa do not suffer the extent of material deprivation and hardship that the subcultures of which Lewis is describing do. However, in light of the conceptions of health dimension, some degree of a culture of poverty in the lower SES group is apparent.

Health locus of control, the second construct explored, demonstrates strong SES group differences in attitudes which may contribute towards differences in health behaviour. Whilst both groups perceived themselves as having a relatively large degree of control

over their health, the lower SES group indicated a more moderate position. This was backed up in a series of themes unique to each group which were strongly indicative of a greater sense of powerlessness in the lower SES group. Whilst both groups considered measures such as nutrition and exercise to be basic to looking after their health, it was the lower SES group only which expressed an explicit sense of fatalism. This group typically saw things such as germs and diseases as being out of control. The upper SES group in contrast, talked about awareness and hygiene as playing important preventative roles. Both groups considered money to be empowering in terms of looking after their health, a resource obviously more accessible to upper SES people.

A greater sense of personal control over health for the upper SES group was an expected result and is consistent with previous research and literature on this subject. The control literature suggests that lower SES people are exposed disproportionately to experiences which lead to a sense of powerlessness, resulting in different social classes perceiving different degrees of personal control (Gurin & Gurin, 1976; Illsley, 1980; Kohn, 1972; Mirowsky & Ross, 1986). Because of their less empowering experiences in the world, lower SES people are thought to develop a generalized expectancy of reinforcement being greatly influenced by outside uncontrollable forces. This leads to a sense of fatalism, an idea commonly and explicitly expressed by the lower SES group in this study. It is thought that this sense of low personal control or fatalism in the lower SES underlies much behaviour, including health behaviour, and thus it permeates the more specific construct of health locus of control. Health locus of control is additionally shaped by specific experiences in the arena of health, an area which again disadvantages or undermines lower SES groups' sense of control. In terms of health experiences specifically, lower SES people are disproportionately over-exposed to negative health events through being structurally over-exposed to health risk factors (Calnan & Johnson, 1985; Williams, 1991). Thus they observe in those around them, and experience personally, significantly higher rates of illness, injury and pre-mature death than the population as a whole.

The health locus of control variable is an important construct for understanding the implementation of health behaviour. If people see themselves as having control over their health, they are more likely to perceive preventative health actions as being

efficacious (Langlie, 1977). If they perceive themselves as having little or no control, they are less likely to engage in prescribed health behaviours because they are less likely to perceive such behaviours as being effective in preserving their health. Langlie (1977) offers empirical evidence to support this theoretical link between SES, health locus of control and health behaviour.

The observation in this study, of a lesser sense of control among the lower SES group, sheds light upon the issue of why lower SES people are less likely to engage in preventative health behaviour. To some extent recommended health behaviours are perceived as being less efficacious because other variables beyond control are more likely to be perceived as impacting upon health outcomes. The third health belief explored in this study (benefits) explicates this idea in the arena of lung cancer and smoking specifically.

In terms of the "benefits of not smoking", or the extent to which smoking causes ill-health, both groups considered smoking to be detrimental to one's health and a major contributor of lung cancer specifically. Other causal agents such as environmental pollution and genetics were frequently cited by both groups as being additional determinants of lung cancer. Thus both groups appear similar in attitudes concerning causality. As will be discussed below however, under the susceptibility dimension, these additional determinants of such ill-health are more predominant in the lives of lower SES people. So whilst these groups appear identical in their appreciation of the causality of lung cancer, they may not be so similar in their perceptions of the "benefits" of not smoking in reducing the likelihood of developing such a condition.

The fifth health belief explored in this study was that of susceptibility and this variable provides some important insights into class differences in perceptions concerning health. Lower SES people were much more likely to feel vulnerable to severe ill-effects from smoking. They were thus much more likely to consider themselves to be highly susceptible to developing lung cancer, emphysema and heart disease. This perception, as a reflection of prevalence rates in the wider society, is realistic. This was a distressing thought for most of these people yet they are not likely, as a class, to stop their smoking behaviour. An important issue of relevance here is why, in the face of

heightened vulnerability, do these people, predominantly lower SES, continue to smoke.

According to the health belief model, perceived vulnerability to and the perceived severity of the consequences of incurring a disease heighten the "psychological state of readiness to take specific action" (Rosenstock, 1966, pp. 98-99). As discussed above, both groups consider health outcomes associated with smoking to be high in severity. Given such a high state of "readiness" or motivation, the specific direction action takes is thought to depend upon the individual's beliefs about the relative effectiveness (benefits) and costs of alternative actions known to the individual. If this is so, we would expect to find differences in perceived costs and benefits between the two SES groups.

As discussed earlier, under the benefits of not smoking dimension, both groups considered smoking and lung cancer to be highly related. This is to say that both groups considered smoking to be a major determinant of lung cancer and thus the perceived benefits of not smoking would appear to be high. It seems that it would make sense to simply stop smoking as a means of reducing this vulnerability, as people from both groups advocated. There is however a rather subtle yet important difference in the benefits dimension for these groups. Both groups considered the environment and genetics to be additional causes of lung cancer. This perception leaves lower SES people in a much more vulnerable position and thus in part explains their feelings of greater susceptibility. In terms of "genetics" they would appear to be more vulnerable and in terms of the environment, especially the work environment, they are much less well placed. It is much more likely that lower SES people will have family members from a number of generations who suffer(ed) from lung cancer and other ill-effects commonly associated with smoking. This was a specific theme which emerged from the susceptibility data. Thus lower SES people are more likely to feel genetically vulnerable, whilst their upper SES counterparts are more likely to feel genetically safe. It is also more likely that lower SES people live and work in environments which contain air and water pollutants, hazardous wastes, pesticides and industrial chemicals (Calnan & Johnson, 1985).

Thus the perceived efficacy of not smoking for the lower SES in preventing lung cancer

and ill health in general is lower compared with the upper SES group, although each group may appreciate the extent of the causal relationship to be about the same. The benefits of not smoking in this sense are not so well shared between the two SES groups because the other identified causes of lung cancer are more present in the lives of the lower SES. The lower SES feel situationally more vulnerable to other causes of lung cancer.

This intimate and meaningful connection between the content of the benefits of not smoking dimension and the heightened vulnerability of the lower SES reported in the susceptibility dimension is supported by the work of Kohn (1972) and the control literature in general. Kohn has argued that an important source of the greater vulnerability in the lower classes is the feeling that one is "at the mercy of forces beyond one's control" (Kohn, 1972, p. 300). The benefits dimension has exposed forces beyond control which are more prevalent in the lives of lower SES people. According to the locus of control literature, this leads to behavioural passivity and thus in the face of perceived high vulnerability, a reduced likelihood of engaging in the "beneficial" health behaviour of not smoking.

Further understanding as to why lower SES people continue to smoke in the midst of high vulnerability and high severity can be gained through exploring the "costs of not smoking". This dimension explored the reasons why people smoke. In general the perceived costs of not smoking were similar for the two groups. There was at least one important difference however. They did differ in the extent to which they felt smoking was embedded in their social relationships. Whilst the upper SES group may have enjoyed smoking with others, the lower SES frequently perceived their social relationships to necessitate their smoking. As one lower SES person commented in this report; "Giving up smoking means getting probably a whole new set of friends, a whole new family and job away". When one considers the fact that smoking is much more prevalent in lower SES groups in New Zealand and the world in general, this becomes understandable. In terms of social norms, smoking is more acceptable and normal in the lower SES, and thus expectations and pressures to smoke may be stronger. Perhaps this is why lower SES people spontaneously spoke of peer pressure as being the reason why they started smoking in the first place.

Most people from both groups discussed smoking as a means to relieving stress. Thus stress reduction may be a further "cost" to not smoking, and this may have profoundly important implications for the lower SES. Past research has shown that lower SES people experience more stress than upper SES people (Harburg et al., 1973; Eyer & Sterling, 1977), this being because stressful life events are associated inversely with SES (Dohrenwend & Dohrenwend, 1970; Kessler, 1979). If smoking does decrease stress psychologically, as the people of this study indicated, and lower SES people as a group are more vulnerable situationally to stress, then this too in part explains why lower SES people are more inclined to smoke. Additionally lower SES people may not have the resources, such as time, energy and money, to deal with stress in alternative healthy ways. Smoking may be a most accessible means to cope with immediate or ongoing stress. As another lower SES person said; "I wish I had another way to deal with stress in my life".

The "costs of not smoking" dimension, along with perceived benefits of not smoking dimension, thus offers some interesting insights into why it might be that lower SES people are more likely to continue smoking whilst feeling vulnerable to the ill-effects of smoking. Socially it is more encouraged and stress levels may pre-dispose people to be more likely to take up and continue such a habit. This would explain why lower SES people reported enjoying their smoking less than the upper SES group did. Additionally this could explain why the lower SES group reported feeling out of control of their smoking. Upper SES people may have less pressure and more choices when deciding to smoke. Enjoying it would presumably be a more influential reason for this group.

Related to these ideas are the attitudes which emerged from the first variables discussed, which involved conceptions and expectations of health. If lower SES people are more likely to accept a shorter lifespan and lower levels of health then the threat of any one specific illness may not be so great. Also the lower SES group's lesser sense of control would presumably further pre-dispose such people to feeling vulnerable to ill-health in general. As Lewis (1967) observes, there is a strong present-time orientation in materially deprived groups and a lack of planning for the future. In this study a moderate theme for the lower SES group was the idea of living for the moment, enjoying what you can while you can. The lower SES seemed to feel more vulnerable

in general to "anything happening", this again may be a further reason as to why they are more likely to smoke.

This research exercise in exploring key attitudes towards health has thus been successful in discovering differences between the two socioeconomic groups. These differences are clear and cohesive to the extent that a tentative hypothesis can be suggested which may account for the differences in health behaviour that the two classes typically demonstrate. This hypothesis is tentative yet tenable because of its contextual grounding in theory and previous research.

It would appear that the lower SES group are more inclined to engage in the negative health behaviour of smoking for a number of reasons. Firstly, they have a lower life expectancy and a general acceptance of lower levels of health and well-being. Secondly, they live in more volatile environments, in which their health and those around them are greatly threatened. They perceive themselves as having less control over their own health. In terms of lung cancer, and possibly other "severe" illnesses that may or may not be the result of smoking, perceived other significant causes are predominant in their lives and are beyond control. "Not smoking" is not likely to be as effective in ensuring good health as it could be for upper SES people. Thirdly, there are more external pressures on lower SES people to smoke, such as social norms and stress.

One other significant and interesting theme emerged from the interview data gathered from this study, although this is not, at least explicitly, related to the class analysis being carried out here. A few women from each SES group discussed body weight as being an additional reason for their ongoing smoking behaviour. The perceived "cost" of not smoking being a gain in body size and body weight. It is generally recognised and is well documented that tobacco use is inversely related to body weight and that many people, particularly women, report that they smoke to keep body weight down (Grunberg, 1990; U.S. Department of Health and Human Services, 1988). In light of the emphasis in Western society on low body weight, especially among women (Grunberg et al., 1991), it is of little wonder that body weight control emerges as a significant reason of why some women from each SES group choose to continue their smoking. The average weight gain after smoking cessation is reported to be around five pounds

(U.S. Department of Health and Human Services, 1990).

This gender effect in smoking is indicative of the diversity of societal pressures that induce people to take up and retain such a negative health habit. The interview data that has emerged from this study indicates, as will be discussed further in the following section, that the lower SES experience more pressures from more sources to take up and retain smoking than do their upper SES peers.

Issues and Implications

Three general attitudes or reasons appear to underlie why lower SES people engage in smoking whilst feeling vulnerable to the ill-effects commonly associated with it. These are acceptance of lower levels of health, a perceived low effectiveness of engaging in the recommended health behaviour, and greater situational pressure to engage in the negative health behaviour. These may be generalizable to other negative health behaviours commonly found in lower SES groups, such as lack of adequate nutrition and exercise. Research exploring these three ideas in other specific behavioural-health contexts may thus prove to be a fruitful area of research that could be explored in the future. We might expect to find similar differences (and similarities) in perceived costs, benefits, perceptions of severity, control, susceptibility and standards of health, which presumably underlie such behaviour.

Its important to note however, that the findings from this research cannot be taken as fact. Only fifteen people from each social class participated as representatives of their group and this is an immediate limitation to this research. A further limitation is the six year age difference that exists between the average age of the two groups. Although this is not a large difference, it is a difference which could have influenced these results, especially when one considers that it was the upper SES group who were the younger. It is possible that this age difference had a significant impact upon the results. None the less, this research was designed to be exploratory rather than confirmatory in nature, and to this end it has been fruitful.

Future research could address these issues by exploring the attitudes of more people from each group who are of the same age. A quantitative and confirmatory approach would be well suited to such an exercise. Given the three hypothetical reasons or cluster of attitudes that have emerged from this research, specific hypotheses could be generated to test these ideas. For example, a Likert scale with different "causes" of ill-

health could be used to assess attributions of causality in hypothetical situations in which the participant had contracted a serious condition. Variables such as genetics, the work environment, smoking, emotional wellbeing, the home environment, nutrition, etc could be incorporated into the study to assess the extent to which attributions might differ. Similarly, a Likert scale assessing the extent to which different reasons, such as stress or feelings of low effectiveness, contribute towards one not engaging in a specific recommended health behaviour, such as not smoking or exercising, may be further fruitful in developing our understanding of class differences in such behaviours.

More specifically related to smoking, research exploring attitudes towards dealing with stress could prove to be highly beneficial also. Do lower SES people have the knowledge and means to cope with stress effectively, other than through smoking? According to Williams and House (cited in Williams, 1991) lower SES people have fewer resources to cope with stress. Effective and accessible means for dealing with stress then are needed in this group so that viable behavioural alternatives to smoking can be implemented.

In general, it seems that the differences in attitudes between the two social classes presented here reflect differences in both cultural orientation and material circumstances. By "cultural orientation" I am referring to differences in health beliefs which appear to be based upon knowledges discrete to each group, operating relatively independently of material circumstance. As the culture of poverty thesis (Lewis, 1967) and the social structure and personality perspective (House, 1981) observes however, class differences in attitudes can rarely be separated from their material context. What might appear to be relatively independent is more likely to be a matter of degree. Both can be viewed as distinctive forces that impact upon group behaviour however, and the pragmatic implications of such a distinction necessitate this to a degree. If we can decipher different levels of causation for social class differences in health behaviours and attitudes, then we can work at different levels to bring about change.

The observation that lower SES people feel "genetically" more susceptible to illnesses such as lung cancer is one such attitude. In light of the higher prevalence of such illness in lower class families and also the general literature on attribution errors, such an

inference is understandable. It is a false one however because, although many cancers do tend to run in families, lung cancer is primarily induced through external and behavioural contingencies (N.Z. Health Dept, 1989). Although people have a tendency to infer internal or dispositional causes to events (Myers, 1988), it is more likely that it is the common behaviours and environments that family members share, both within and between generations, that determine such regularities.

Such an attitude, prevalent in the lower SES group, is not only misleading but would appear to be unnecessarily debilitating. Genetic attributions appear to incorrectly inform the extent of control one has over one's health. This myth distorts lower SES people's sense of personal effectiveness in reducing the likelihood of contracting illnesses such as lung cancer. The perceived "benefits of not smoking" are reduced in light of this misconception.

This cultural misconception is likely to be linked to the lack of empowering experiences that are associated with lower SES circumstances in general. This "uncontrollable" cause of ill-health would thus appear to have its roots grounded in the class differences in material circumstance. Such an idea is also likely to exist relatively independently however, surviving as a self-fulfilling prophecy of sorts. Such an attribution may well be generalizable, and thus would influence behavioural passivity in other health behaviour contexts as well. This would lead to an unnecessarily higher prevalence of general ill-health in this group, which in turn would directly perpetuate such an attitude. An unnecessary vicious cycle may be in operation which exaggerates lower SES people's lesser sense of health control and feelings of low effectiveness.

Research exploring the extent to which genetic attributions predominate in the perceived etiology of other common diseases and illnesses which are inversely associated with the lower SES, would seem to be a most logical progression for research in this area. If the lower SES are more likely to perceive themselves as being genetically vulnerable to such conditions, then such attributions need to be directly and specifically counteracted and disqualified. As Feurestein et al. (1986) has observed, most of the leading causes of premature death are behavioural in nature. Behaviours must be changed and attitudes such as misinformed genetic attributions which presumably underlie negative health

behaviours, must therefore be corrected if we are to reduce class-based health inequalities. Education about the real causes of lung cancer and other illnesses more prevalent in the lower SES, which explicitly remove the myth of genetic determinism, is in order.

In general however, health education campaigns typically achieve only limited success and are typically more effective in bringing about the recommended health behaviour changes in upper SES groups (Pursall et al., 1978; Townsend, 1978; Wilkinson, 1986). This general failure on the part of education, to bring about health behaviour changes in the group which needs it most, reflects both structural and cultural constraints. In terms of cultural differences, the genetic attributions which underlie behavioural passivity in the face of high vulnerability, may be so widespread that any one specific recommended health behaviour may be perceived as being relatively ineffective in preserving health, because lower SES people feel more vulnerable genetically to other diseases and illnesses anyway. An implication of this possible reason is to counteract such misconceptions through a holistic educational and life skills programme that encompasses a wide variety of illnesses, etiology and recommended health behaviours all at once. The idea that genetics are not significantly involved in any of these must be explicated. A danger of such a widespread campaign or intervention however, is that it assumes causes of such attitudes and behaviours to be exclusively "cultural". This study suggests that material circumstances also impact upon such attitudes and behaviour, both directly through structural constraints and indirectly through shaping these cultural realities. Such a level of intervention then, although seemingly comprehensive, fails to take this into account and in effect may do more harm than good. As Lewis (1967) observes, cultural lifestyles are extremely well adapted to material circumstance and thus attempts to change behaviours, especially more than one, amounts to an attempted change to a whole functional way of being which could be highly dangerous (McKinlay, 1975).

Another cultural constraint reducing any positive effects of education would be the power of social norms in inhibiting social change in any of the recommended health behaviours. Group norms and expectations have powerful effects upon an individual's behaviour (Myers, 1988). Furthermore in the arena of smoking, social norms would

greatly contribute toward lower SES peoples' perceived low efficacy of not smoking in reducing lung cancer because such individuals would still be subject to passive smoking. Thus the "cultural" norm of smoking may have an impact in more than one way in the perpetuation of smoking. A further possible cultural constraint is the observation that lower SES people are more sceptical and less accepting of the claims and recommendations of science and health professionals than upper SES people (Williams, 1991).

The reasons for a cultural norm such as smoking however, cannot be sufficiently understood purely in terms of cultural perpetuation. The data gathered from the interviews in this study strongly suggest that material circumstances play a significant role in the development of these health beliefs and thus to a large extent underlie the negative health behaviour of smoking. The fact that smoking in the lower classes is a near universal phenomenon supports this assertion. A further reason then, quite possibly the most significant, of why education seems to be relatively ineffective in inducing behavioural change in the lower SES, is because of the different material constraints faced by the lower SES. Explanation for the greater cultural norm of smoking in the lower SES can thus be further enhanced by reference to situational constraints.

The differences in attitudes between the social classes presented in this study indicate that, to large extent, material circumstances underlie these perceptions. Recommended health behaviours may be more applicable and "beneficial" in terms of preserving health to upper SES people and this might reflect an upper SES cultural bias in health campaigns which do not address the problem holistically enough. It seems that upper SES people may have more choice and reason to engage in recommended health behaviours because of their different material circumstances.

Situational constraints can be shown to be influential for the three significant attitudes distinct to the lower SES discussed above. The lesser sense of control over one's health, is linked in this research to the less empowering experiences of lower SES people in general (locus of control), and to more noxious environments specifically. Doll and Peto (1981) report that in a number of occupations, predominantly lower SES, workplace hazards increase the likelihood of developing lung cancer. Additionally lower SES

people are exposed to other health risk factors in their everyday environments which increase the chances of contracting diseases such as respiratory infections (Townsend & Davidson, 1982). Such real life structural constraints reduce the perceived "benefits of not smoking" for lower SES people in two ways; (1) recommended health behaviours such as not smoking are realistically, although this may be exaggerated culturally, less effective in reducing the likelihood of developing specific illnesses such as lung cancer and (2) volatile living and working conditions leave lower SES people in a more vulnerable position to disease and accidents in general, so that the anything in "anything could happen" is situationally more likely.

It is not surprising then, given that lower SES people are structurally over-exposed to health risk factors (Calnan & Johnson, 1985) that these people develop and express markedly lower expectations and standards of health. Although this acceptance of lower levels of health is likely to be partly due to cultural considerations, such as in the perpetuation of negative health behaviours, these expectations are significantly determined by structural factors too and if such expectations are further precursors to health behaviour, as Blaxter and Patterson (1982) suggest, then this is another way in which structural constraints impact upon health attitudes and thus health behaviour. Additionally, pressures to engage in the negative health behaviour, such as stress, are materially situational and are more prevalent in the lives of the lower SES (Calnan & Johnson, 1985; Eyer & Sterling, 1977).

This observation enriches and adds to the ideas of many "structuralist" who claim that differences in health behaviour reflect differences in material circumstance because material circumstances induce and constrain health behaviour (Coburn & Pope, 1974; Kelman, 1975; McKinlay, 1975; Williams, 1991). Many of the health beliefs explored in this study appear to reflect the realities of these structural conditions and thus they appear to be deeply rooted in material circumstance. A sub-culture may be present, for example aspects of Lewis's (1967) culture of poverty, but this is not redundant knowledge blindly passed on over generations. Most of these beliefs appear to be highly realistic given the context from which they have emerged.

Given that real life structural circumstances predispose lower SES people to be more

likely to smoke, then trying to change this health habit without altering aspects of the social structure and life chances, will be relatively fruitless and possibly harmful (Williams, 1991). This may also be the case for other negative health behaviours more prevalent in the lower classes. Education, judging its general lack of effectiveness to bring about change with this group and the realities of lower SES structural contingencies, is clearly not an adequate measure to resolve the health inequalities which emerge from lower SES peoples engaging in smoking. A more holistic approach would seem to be in order. Education could be useful, particularly in the arena of challenging misconceptions, but on its own it is not likely to be of any great significance for improving the health status of lower SES people. Cultural **and** material differences need to be seriously addressed.

A more holistic implication of this research would be to additionally counteract the structural causes underlying the differences in health behaviours and perceptions. It seems that class differentiating negative health behaviours may be induced directly through the social structure, as in the case of financial constraints when needing to visit a doctor, and indirectly through health beliefs, for example in the perceived lack of benefits of not smoking. Thus the social structure is to a large extent responsible for class-based health inequalities.

The range of interventions which are implied by this finding vary from radical to superficial. The more holistic or deep rooted the intervention, the more radical it appears to be. For example, one level of intervention, aimed at reducing smoking in the lower SES, might be to reduce stress levels in this group. If lower SES people experience more stress (Williams, 1991) and cigarettes are commonly used to alleviate such tension (Guttmacher, 1979), then such an intervention would seem highly pragmatic. Education, in terms of trying to reduce smoking in the lower SES, could be used more effectively if it additionally was to focus on the imparting of stress management skills, rather than its usual approach of advertising the health hazards of smoking.

This level of intervention, although positive and reasonably holistic in that it addresses underlying structural causes as well as challenging cultural misconceptions, may also be considered to be relatively superficial. The fact that lower SES people experience

more stress in the first place is an issue which needs to be addressed. A more holistic approach would seek to remove such stressors.

The Black report on health inequalities in England (Department of Health and Social Security, 1980) concluded that the only way to achieve true equality in health outcomes for the different social classes is to distribute material circumstances more equally throughout society. Its behaviour-in-material-context approach is supported by the findings of this study, which indicate that deeper or more structural causes underlie many of the differences in health perceptions between the social classes.

To equally distribute material circumstances in society means in effect to redistribute empowering experiences (e.g. having more choices), stress factors (e.g. lack of financial resources and security), and risk factors (e.g. volatile work and home environments) on a more equitable and/or improved basis. Such an intervention addresses these deep structural and material causes of class differences in health perceptions, behaviours and outcomes. This is the most radical implication of this research and at its most extreme basically amounts to a social revolution; i.e. a removal of the class structure and an improvement in living and working conditions for the present lower SES. If we are serious about removing class based health inequalities then this idea warrants serious consideration.

Such an implication for intervention however, may be holistic in that it addresses underlying causes of class health inequalities which undoubtedly contribute towards the perpetuation of cultural factors, but it is not realistic in our society at present. Whilst governments may be interested in serving the interests of the populace it represents, it is unlikely that they will be interested in redistributing resources in society on a more equitable basis. Perhaps this is why the Black report was not appreciated by the very government which had commissioned its enquiry (Smith et al., 1990). Our society's foundation is based on a class structure with class divisions and it is in the governments and rulers interests to preserve this structure (Giddens, 1989). Less radical and thus ultimately less holistic interventions are therefore more realistic in terms of their likelihood of being applied by the state to the problem of lower SES health inequalities.

Such a level of intervention is clearly visible within the context of Aotearoa. Educational campaigns advertising the ill-effects of smoking are one such example. The Community Services Health Card, implemented by the New Zealand Health Department in 1991, is another good example. This card gives discounts in medical expenses for lower SES people who as a group desperately need such discounts because (A) they cannot afford these expenses like upper SES people can, and (B) they experience greater levels of sickness and illness and thus have a greater need for health professionals and the medical services and treatment they offer. Whilst such an intervention does not meet the needs of lower SES people to an adequate or sufficient extent, it does provide some relief and some degree of justice, given the political and economic context of such policies.

This level of treatment however is relatively superficial. The reasons why lower SES people smoke and possibly engage in other negative health behaviours are deeper and more structurally induced than these remedies would indicate. In essence they are band-aid responses which do not address the issues holistically enough. Such a level of intervention is unlikely to remove the class based health inequalities here in Aotearoa or abroad, and is in fact more likely to lead to a "blaming of the victim" scenario, as in the case of stop smoking campaigns. In essence this lack of holism in the intervention strategies chosen by our government is neither fair nor just to the lower classes and will not lead to health equality, though they do "alleviate the symptom" to a degree.

It is an issue of significance then for future research to explore the extent to which these health beliefs are found in other behavioural-health contexts thought to be both damaging and disproportionately prevalent in lower SES groups. These include many negative health behaviours such as lack of exercise, nutrition, wearing seatbelts, getting medical check-ups, hygiene, receiving immunizations etc. Confirmatory research, exploring the health attitudes to smoking exposed in this study, is also needed. Such investigations can ascertain the extent to which the above mentioned conclusions and implications, drawn from this exploratory research, are to be taken seriously.

Conclusion

The attitudes and beliefs explored in this study, considered to be important precursors to health behaviour, indicate that significant and meaningful social class differences exist. These in part explain differences in health behaviour between the two SES groups, which ultimately contribute towards an explanation of class based health inequalities.

The data gathered from the interviews indicate that these differences in health beliefs are due to a complex interplay of both structural contingencies and cultural orientation. In essence, it appears that both cultural factors and material circumstances (A) induce an acceptance of lower levels of health in the lower SES, (B) exert greater pressure on the lower SES to engage in the negative health behaviour of smoking, and (C) induce in the lower SES a perception of lower efficacy in the recommended health behaviour in preserving health.

Such attitudes, more prevalent in the lower SES, appear to approximate, though to a milder degree, attitudinal features of Lewis's (1967) culture of poverty. Such attitudes appear to be internally consistent, highly adaptive to the circumstances and on the whole realistic, although at least one significant and seemingly self damaging cultural misconception became evident. Lewis claims that such attitudinal orientations are present in cultures which experience adverse material conditions and so we might infer that the differences in cultural orientation are at least partly reducible to material circumstance, although there is evidence of some degree of autonomy.

The implications of these findings suggest that in order to improve the class based health inequalities which prevail in our society, holistic programmes intervening at a number of levels are required. The deeper or more holistic the intervention, the more effective it will be in reducing not only these class disparities in health attitudes, but also in health behaviours and health outcomes.

Many contemporary preventative health programmes, including those advocated by the New Zealand Government, can thus be accused of "treating the symptom" with superficial remedies which do not truly address the problem of excessive morbidity and mortality in the lower SES. The more radical and more deeply holistic implications for intervention however do not appear to be realistic given the political and economic context of our society today. A mid-ground for intervention would thus seem to be in order.

Holistic programmes, which address both structural causes which are amenable to intervention within the limits of our social system, whilst also addressing debilitating cultural realities, would seem to be the most appropriate response for our government in addressing these concerns. Examples of such programmes might include educational programmes which attempt to discredit cultural myths that may be depowering for the lower SES. They might also include educational programmes which teach life skills such as effective stress management. Additionally, attempts to change the volatile nature of lower SES environments, as in the case of asbestos being outlawed several years ago, may be feasible. Financial constraints could be reduced by "taxing the rich" and distributing it more fairly throughout society. Perhaps an increase in revenue from this source could be used to provide cheaper and subsidized health foods for everyone. Exercise in the workplace could be institutionalized. Assertiveness training courses for those in the lower SES who want to stop smoking could be made more available and accessible for these people, so that they can be more effective in coping with peer pressure or keeping their homes "smoke-free". The list could go on, its limits being confined only by a lack of resources and commitment from people and Government. Asking people from the lower SES what they think about all this and what ideas they have would be essential for any rehabilitation package considering itself to be seriously holistic. Awareness and sensitivity to the complexity of the issues involved is essential.

Whilst the conclusions are tentative, the implications drawn from this research are of great significance. This exploratory study has yielded many fruitful ideas which are consistent with the research and theory in the field of health and social science today. It has, in the author's opinion, contributed towards understanding social class health inequalities.

Appendix 1

Construct Operationalization and Exploration

Construct 1: General Health Motivation:

Operational definition:

The extent to which one desires or values good health and the nature of this goal.

Set probing questions:

What does "being healthy" mean to you?
How important is that to you?

Potential questions (to be used in the face of ambiguity or lack of elaboration):

How come (or Why's that do you think)?
On a scale of 1-10; if (1) was "I don't care about my health" and (10) is "My health is the most important thing there is to me", where would you stand?

Construct 2: Health Locus of Control:

Operational definition:

"The degree to which an individual perceives (health and illness) as being due to his/her own actions versus the degree to which s/he feels it is controlled by external and uncontrollable forces." (Rotter, 1966).

Set probing questions:

Do you think there's much you can do to preserve your health? If so, what sorts of things?
How much control over your health do you think you have - as opposed to factors which are out of your control?
What factors that might impact upon health are out of our control?

Potential question:

On a scale of 1-10, how much of an impact do you think you can have on your health? How much control have you got?

Construct 3: Benefits of not smoking:

Operational definition:

The perceived effectiveness of "not smoking" in reducing the health risks associated with smoking.

Set probing questions:

Do you think that smoking impacts upon your health? If so, how?

In terms of your health in the future, what do you think the most likely outcome will be? (probe for a specific a medical response as possible = "Y").

What is the worst health consequence that can happen to people due to their smoking? (probe for specific a medical response as possible = "X").

What do you think causes lung cancer? Any other causes?

To what extent do you think smoking causes lung cancer?

Potential question:

On a scale of 1-10, how causally related is smoking and lung cancer?

Construct 4: Severity:

Operational definition:

The perceived seriousness of contracting the (objective and subjective) health risks associated with smoking.

Set probing questions:

How bad would it be to get this condition and why? (for each of; lung cancer, the most likely outcome ("Y"), and the worst possible outcome ("X"), due to smoking.

Potential questions:

On a scale of 1-10, if (1) was "not a problem" and (10) "a major catastrophe", where would you stand? (for each of lung cancer, "X", and "Y").

Any other reasons why it would be so bad?

Construct 5: Susceptibility:

Operational definition:

The subjective opinion of the risk of contracting the perceived health consequences of smoking personally.

Set probing questions:

Do you think that you could get this (develop this condition)? (for each of lung cancer, "X", and "Y")

How likely is it do you think, that you could develop this condition within the next 5-10 years? (for each health consequence).

Potential question:

On a scale of 1-10, how likely is it that you could contract this condition, if (1) was "no chance at all" and (10) was "definitely" ? (for each health consequence).

Construct 6: Costs of not smoking:

Operational definition:

The perceived loss involved in not smoking.

Probing question:

Why do you smoke? Tell me the good things about it; the reasons why you do it.

Appendix 2

The Structured Interview

What does "being healthy" mean to you?

How important is that to you?

potentially: -How come/ Why's that?
-On a scale of 1-10; if (1) was "I don't care about my health" and (10) is "My health is the most important thing there is to me", Where would you stand?

Do you think there's much you can do to preserve your health?
If so; What sorts of things?

How much control over your health do you think you have, as opposed to factors which are out of your control?

What factors, that can impact upon our health, are out of our control?

potentially: -On a scale of 1-10, how much of an impact do you think you can have on your health? How much control have you got?

Do you think smoking impacts upon your health?

In terms of your health in the future, what's the most likely consequence of your smoking?

How bad would that be and why?
potentially: -On a scale of 1-10, if (1) was "not a problem" and (10) "a major catastrophe", Where would you stand?
-any other reasons why it would be so bad?

What's the worst health consequence that can happen to people because of their smoking? (probe for a specific a medical consequence as possible: "X").

Why do you consider this condition (X) to be so bad?

How bad would it be?
potentially: -On a scale of 1-10, if (1) was "not a problem" and (10) "a major catastrophe", Where would you stand?

Do you think YOU could get this condition (X)?

How likely is it do you think, that within the next 5-10 years you could develop this condition?
potentially: -on a scale of 1-10, if (1) was "no chance at all", and (10) was "definitely", how likely?

What do you think causes lung cancer? Any other causes?

To what extent do you think smoking causes lung cancer?
potentially: -scale 1-10

How bad would it be to get and why?
potentially: -scale 1-10 (1= "no problem", 10= "major catastrophe")
-any other reasons?

Do you think YOU could get lung cancer?

How likely do you think it is that you could develop this condition within the next 5-10 years?
potentially rate on 1-10 scale; (1= "no chance at all", 10= "definitely")

This is the last question, so please answer it as fully as you can.

Why do you smoke? Tell me the good things about it: the reasons why you do it.

Kia ora.

Appendix 3

Study Information Sheet

The aim of this study is to explore people's attitudes towards health. The study involves an interview which takes approximately 40 minutes. The interview consists of a series of questions designed to explore your beliefs and understandings about health in general, and of how health may be affected by smoking.

The researcher in this study is Damian O'Neill (me), working in conjunction with the Massey University psychology department. If you wish to contact me at any point, for whatever reason, you can write via the psychology department, Massey University or phone me on 3258831.

To participate in this study you must;

-be between the ages of 21 and 55 years old,
-smoke at least ten cigarettes a day, and
-be willing to be interviewed.

All participants have the right to refuse to answer any particular questions and to stop the interview at any time.

All information and ideas that you share will be kept confidential. Tapes used to record the interview will be coded and these codings will be kept separate from any recordings or transcriptions. It will not be possible for any individuals to be identified from any published reports this study might bring about.

At the completion of this study, if you choose to participate, I will get in contact with you again and let you know what we find. Your participation will be appreciated and I look forward to interviewing you if you choose to do so.

Thank you,
Damian

Appendix 4

Participation Sheet

I have read the information sheet describing the conditions and objectives of this study and I understand what is expected of me as a participant. I am willing to participate and hereby give my consent to be interviewed.

name .....

date .....

signature .....

Appendix 5

Permission to be Quoted

I give my permission to being quoted in the final report of this research study, on the understanding that my identity will be kept confidential.

name .....

date .....

signature .....

Appendix 6

Follow-up

Example letter to participants

[redacted]

Dear David,

Earlier this year I interviewed you, exploring your ideas and attitudes towards health and smoking. I thank you once again for your participation in the interview. It was greatly appreciated.

You will find enclosed with this letter a summary of that interview. I would like to check with you that this is how you remember it. Also enclosed is a small questionnaire of which I would greatly appreciate you filling out and sending back to me. This invites you to comment on your experience of the interview and to tell me whether or not my summary is sufficiently accurate. A self addressed envelope has been provided to make this easier for you. I encourage you to respond as soon as is convenient for you, hopefully some time within the next couple of weeks.

Once again, thank you for your participation. It was a pleasure interviewing such cooperative and interesting persons such as yourself. Thank you.

Your's sincerely

Damian O'Neill

SMOKING AND HEALTH

Follow-up Questionnaire

Please tick the appropriate spaces and answer the following questions. Feel free to use more paper if required.

1) Do you consider the summary of the interview to be accurate? Is this how you remember it?

Yes .... No ....

If no, what would you like to add or subtract?
If yes, is there anything else you would like to add further?

2) Did you get anything out of participating in this study? (e.g. did you learn anything? did you enjoy it? etc). How did you find it, being a participant?

3) Would you like to hear back about the results of this study?

Yes .... not really ....

Example interview summary 1: (Anna, a cleaner; SEI 6)

I found our interview discussion to be along the following lines:

> You defined health as having energy and being physically capable of doing the things that you want to do, without getting run down. You said health was highly important to you, mainly because you hate not being able to do things. It's important for you to get things done. You feel horrible when you are run down and are incapacitated. You like to wake up and feel alive.
>
> You said that you have a lot of control over your health. That there was a lot of basic things you could do to look after yourself. Things such as eating well, exercising, getting plenty of fresh air, doing things in moderation, etc.
>
> You thought that a breathing impairment of some sort was a likely outcome of your smoking, and that you could possibly end up on a machine. You hoped that if this did happen that you could be left to die peacefully. As long as you got your house in order this would not be a problem. You'd hate it if you were kept alive artificially and had to have chemotherapy. Being stuck on a breathing machine with no energy would be horrible.
>
> The worst health outcome for you would be lung cancer (if you were stuck on a machine). Otherwise maybe its not so bad given that we all have to die one way or another. This isn't that likely however. Lots of other things cause lung cancer besides smoking. Things like asbestos, the work environment, genetics, etc all contribute to it.
>
> You smoke because you enjoy it, because its a habit, and because it gives you something to do with your hands socially. You also find it relaxing. Whilst you don't need it as such, you might be grumpy if you had to go without.

Example interview summary 2: (Simon, a technician; SEI 2)

I found our interview discussion to be along the following lines:

> You had a holistic notion of what health is. A balance of wellbeing in many areas; physically, mentally, emotionally, spiritually. To be healthy is to be able to survive and enjoy life. You said that your health was very important to you and that you make an effort to look after yourself.
>
> You thought that there were many basic things you could do to preserve your health - some basic laws for living. Sleeping properly, relaxing, eating a good diet, drinking water, exercising etc, were all considered to be basic to looking after yourself. You thought you had quite a lot of control over your health, but this was by no means total. Though we do make choices which determine our destinies, there are some things which we can't control (e.g. natural disasters and genetical causes of ill health). You also mentioned capitalism as an evil influence on our health. Capitalism can dupe us in to making bad choices.
>
> You considered smoking to be detrimental to your health. You also thought that you would not suffer from any major ill-effects because you plan to give up soon. The reasoning being that if you did give up in the near future your lungs would completely rejuvenate. Because your smoking has not been too full on for too long, you consider your body to be in a reasonably healthy condition. You plan to stop smoking soon (before any irreparable damage is done).
>
> You thought that lung cancer would be one of the worst things someone could get as a result of smoking. You thought that smoking and lung cancer were significantly related but that other variables too played a part in the formation of lung cancer. Whilst smoking is a major contributor, other things such as genetics and pollution also play a part. You think its unlikely you'll be getting lung cancer because you plan to give up soon and believe in a philosophy of moderation in the meantime. You consider lung cancer to be horrible, mainly because of knowing death was just around the corner and that ones life force would be lost. One's life force is the most important thing there is, and to lose that would make life virtually not worth living.
>
> You smoke because you like the interactiveness of sharing with other people and the companionship of it when alone. Sometimes you enjoy it. You find it helps when you are stressed or depressed.

Appendix 7

Letter Sharing Results with Participants

[redacted]

Dear Hamish,

You may recall earlier this year being interviewed by me about your attitudes towards health and smoking. I'd like to thank you once again for your participation in the study. It was greatly appreciated. As promised, here is a summary of the findings to this study.

The study explored attitudes towards health and smoking of a wide variety of people in our society. This included men and women from a diverse range of occupations. There were many similarities in the health attitudes of these people. Most of the people interviewed considered smoking to be a significant cause of lung cancer. Most of the people interviewed smoke because it helps with stress, anxiety and depression, because they are addicted to it and/or because it is a sharing thing socially and can be nice sometimes alone. Most people feared the negative health outcomes that they associated with smoking. These were typically lung cancer, heart disease and emphysema. The reasons people feared these were because of consequences such as pain, death, psychological distress and restrictions in life style.

Some differences existed between groupings of participants too. For example, women sometimes continued their smoking to keep their weight down. Men never mentioned this as a reason for why they smoked. When attitudes were compared over various occupations it was found that those with better paid and more educated occupations (e.g. lawyers and teachers) tended to have higher standards of health. They were more likely to consider themselves healthy only when they felt good mentally and emotionally as well as physically. They also expected to live longer. People from less educated and less well paid occupations (e.g. unskilled labourers) tended to think that although smoking was damaging to their health, there were also many more damaging things around which they could not control, which also effected their health negatively; for example their work environments.

Thus these people were less likely to consider stopping smoking to be an effective means to preserving health. People from such occupations were also more likely to emphasise social pressures as a reason for their smoking and were less likely to mention pleasure or enjoyment. These expressed attitudes provide some understanding of why people from "professional" occupations are much less likely to smoke than "unskilled workers".

Once again, thank you for your participation in this research. I enjoyed meeting you and interviewing you. If you'd like to know more about this research please write to me at the above address.

Your's sincerely

Damian O'Neill

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