Shame-based appeals in a tobacco control public health campaign: potential harms and benefits

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Smoking is the leading preventable cause of death worldwide, responsible for 1 in 10 deaths globally (>5 million a year). Tobacco use adversely impacts not just smokers, but also those around them through secondhand smoke exposure. Given the significant personal and societal costs of tobacco use, any strategy to reduce smoking should be considered.

In this issue, Amonini *et al*[1] report on development and evaluation of a shame-based public health campaign in Perth, Australia. Public health media campaigns in Australia, in particular, have raised awareness and instigated behaviour change via approaches ranging from direct and forceful (eg, 'Belt Up or Suffer the Pain' seatbelt campaign[2]) to humorous and memorable (eg, 'Slip! Slop! Slap!' for skin cancer prevention[3]).

In developing their tobacco control ad campaign, Amonini *et al* conducted focus groups with smokers and interviewed former smokers, identifying salient themes of social isolation (eg, "you feel like a 'leper'"). Next, they created and piloted an ad prototype in an experimental setting, which demonstrated believability/relevance and perceived efficacy in stopping smokers from smoking. Finally, they created the shame-based ad, evaluating it in a publicly launched campaign where a majority of respondents self-reported in the first several weeks that they reduced cigarette consumption (36%), attempted cessation (16%) or quit (2%).

While suggestive as a promising public health approach, the potential for harm associated with an emphasis on shame also bears consideration, particularly when in relation to a behaviour sustained through addiction and increasingly concentrated among marginalised groups. Today, smokers in Australia and other industrialised countries are largely characterised by lower income and education, ethnic minority status and co-occurring mental and physical health disorders.[4] Capitalisation on shame-based public health campaigns will, in effect, target these groups.

In contrast, the tobacco industry's campaigns have emphasised themes of freedom, affluence and excitement, creating the perception that smoking is a choice of free will.[5] In this context, when smokers fail to quit, they often blame themselves.[6]

SMOKING-RELATED SHAME AND STIGMA

Stigma is a concept derived from classic sociology, whereby negative differential treatment is experienced by groups with socially 'discredited' identities.[7] Stigma related to smoking is experienced as shame, self-judgement and outright discrimination in the form of denial of goods, opportunities and services.[8] Shame is a central focus of research on lung cancer stigma (where smokers blame themselves for the disease),[9] and an emergent area of interest with respect to tobacco use more generally.[10]

Research indicates about 40% of smokers and ex-smokers perceive substantial smoking stigma,[11] with a 'deep divide' existing between smokers and non-smokers.[12] While a minority of smokers report experiencing outright discrimination (eg, denial of work or housing), smokers may withstand many tiny insults (eg, purposeful coughing in their presence, glaring looks from non-smokers).[12] Smokers speak of 'smoking islands', the few remaining areas, largely isolated, where one can smoke without judgment.[13] While cessation is a positive possible response to smoking stigma, of concern is smokers' reported hiding of their use from potential supports, such as family, friends and healthcare providers.[11]

Shame-based antitobacco public health campaigns may lead smokers to attempt cessation in isolation, unassisted. Only 3–5% of unaided quit attempts are successful, and defeated efforts may negatively impact smokers by decreasing self-efficacy and increasing stigmatisation on relapse. To counteract this potential, shame-based appeals ought to at minimum include explicit instructions to contact a clinician or quit-line for help with quitting smoking.

RISKS OF A SHAME-BASED ANTITOBACCO MEDIA APPROACH

As with medications, side effects must be considered in terms of likelihood as well as magnitude. Of concern, in their three-part study Amonini *et al* did not test for increases in experienced shame among viewers.

Prior to dissemination, assessment of message impact on shame and stigma should be examined, particularly among disadvantaged groups. Broad-based communication interventions will reach those diagnosed with lung cancer and chronic obstructive pulmonary disease, who, smoker or not, may internalise the stigma of negative societal impressions. Lung cancer stigma is associated with poorer psychosocial outcomes[14] and morbidity[15] among smokers and non-smokers equally.[16] As such, shame-based public messages may contribute to stress and increased symptom burden. With regard to smokers with mental illness, imagery suggestive of individuals as lepers or isolates may compound stereotypes with adverse effects. Explicit fore-fronting of diversity and gender analyses is a strategy within tobacco control for protecting such vulnerable groups.[17]

MESSAGE ALTERNATIVES WORTH EXPLORING

In the current study, all messages except the shame-based ad had previously been used in public campaigns, and Amonini *et al* acknowledged a potential novelty confound effect. Future investigation should compare multiple novel message themes; worth considering as an alternative are shame-free guilt appeals, which explicitly do not elicit shame.

Though Amonini *et al* did not find guilt to be as effective as shame, shame-free guilt messaging has been a powerful motivator in other contexts. A recent study promoting STD screening found that shame-free guilt appeals focusing on behavior (eg, "forgetful behavior") and the consequence of actions on others (eg, to elicit empathy) that identified specific coping strategies outperformed shame appeals that focused on intrinsic features of identity (eg, "an irresponsible person").[18] Since Amonini *et al* did not formally assess the impact of the ads on feelings of shame and guilt, we do not know whether the guilt ad utilised was 'shame-free.' Future messages assessed for elicitation of shame and guilt individually will be better equipped to help determine

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the risks and benefits of shame and/or guilt messaging.

In exploring novel public health approaches, studies such as Amonini *et al*'s may move the field forward on the path to 100% smoke-free. Consistent with the Hippocratic oath of ethical practice in medicine, however, public health efforts above all must do no damage or harm. In particular, we should consider the effects on members of society under-represented in research efforts who are already socially isolated by socioeconomic circumstances or association with tobacco-stigmatised disorders. As tobacco use increasingly becomes denormalized, public health campaigns must not only attend to positive results, but also guard against harm in vulnerable groups. In particular, interventions that risk stigmatizing could backfire by exacerbating health disparities rather than reducing them.

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