AnthropologicalForum.net

'Doing Things Little by Little': Smoking and Vaping While Being Pharmaceutically Treated for Schizophrenia

Julia E H Brown

Department of Anthropology, Australian National University

Abstract: This paper explores the experiences of smoking and 'vaping' while being pharmaceutically treated for schizophrenia, as well as what the experiences of breathing smoke and vapour in and out can reveal about health 'care', toward the self and others. Drawing on ethnographic data collected over 2015-2016 in Australia and the UK, and particularly on patient experiences in the UK where electronic cigarettes had become an endorsed Nicotine Replacement Therapy, I argue that inhaling nicotine via e-cigarettes can, like tobacco cigarettes, be experienced in terms of temporal opportunities for self-reclamation and experiences of health. When patients opted to vape instead of smoke, their sense of self-reclamation allowed for shifted attention toward the movement and materiality of exhalations, and toward how second-hand vapour (compared to smoke) is socially received. Experiences of vaping were, however, contingent on the clinical endorsement of e-cigarettes, and were inconsistent inside and outside of clinical spaces. Further consideration should be given to vaping as a harm minimisation tool in Western societies dealing with widening disparities in health. Ultimately, clozapine-treated schizophrenia patients continue to smoke or vape for reasons that speak to the desire to make 'time'; to find connections to life rather than focusing on death.

Keywords: smoking, vaping, phenomenological health, schizophrenia, self-reclamation

Australian chronic schizophrenia patient Charlie's last attempt at taking his own life a year ago resulted in a hospital discharge contingent on him taking the antipsychotic drug clozapine.[1] Charlie, 35, told me, however, that choosing death prior to this had been a "strategic decision". In the lead up to his suicide attempt, he had committed a crime. Charlie's previous experiences of jail involved his family sending him money to buy cigarettes. On this last occasion, "my family told me that, if I went back to jail, they weren't gonna' support my cigarettes anymore". He continued,

> I was basically confronted with this idea that I was gonna' go to jail and not have cigarettes for a year, which is so horrible to me, and unthinkably bad, that I decided to commit suicide. And then, once I failed my suicide attempt, they put me in an adult mental health unit. I wasn't allowed to smoke anymore, and that's when I discovered I didn't need to smoke cigarettes all the time, and I was really happy!
>
> JB: but you still want to smoke cigarettes?
>
> Charlie: Yeah, I still want to smoke cigarettes, but I don't *need* to smoke cigarettes.

Charlie used Nicotine Replacement Therapies (NRTs) provided by the mental health unit during his in-patient treatment, but returned to smoking cigarettes upon discharge due to newfound feelings of choice rather than '*need*'. Charlie added that he used to be 'constantly tormented by this idea that somehow I was gonna' die - and I didn't wanna' die'. The voices he heard had provoked these ideas (and the crimes he had committed). Since taking clozapine, Charlie reclaimed the experience on his own terms. He felt he had simply 'stopped listening to 'em'. He laughed, dismissively, 'now I wouldn't care if I died'. 'You wouldn't care if you died?' I queried. 'Nup'. We sat in a moment of stillness, the cluttered clinic room and the strong cigarette odour from Charlie's body no longer noticeable to me. I proceeded, delicately, 'what do you live for?' Another pause. 'Maybe smoking cigarettes … that's probably one of my favourite things to do'. 'Tell me about why you enjoy them so much'. 'It's just relaxing, and, I dunno', maybe it's something about you can *see* your breath or something? … You focus on your breathing'.

The temporal plenitude and visual appreciation of one's breathing existence through smoking cigarettes is a complex cultural phenomenon. The embracing of present time through smoking can elicit a sense of agency that engages an open-ended future (Keane 2002; Dennis 2006). As Merleau-Ponty (1962) argued, this kind of openness is utterly critical to being a body, as opposed to simply having a body that things might happen to. Klein's (1993) unrepentant ode to the cigarette can be appreciated insofar as 'the temporal productivity of smoking, the alluring repetition and brevity of the act' applies to lived experiences (Keane 2002, 120). Smokers can experience 'perfection' in the 'unsatisfied promise of fulfilment', otherwise pathologised as addiction (Keane 2002, 133). For Charlie, smoking constituted something he lived for but not in a clearly resolute way ('I wouldn't care if I died').

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[1] Schizophrenia is a severe and 'sublime' category of human disorder involving profound disruptions in cognition, emotion and social functioning (Woods 2011). Clozapine is the 'gold standard' antipsychotic treatment for chronic schizophrenia in the UK and Australia (Dold and Leucht 2014).

Clinically, smoking is understood to alleviate, temporally, flatness of emotion in schizophrenia (Lawn and Pols 2005), and smoking was indeed one of Charlie's 'favourite things to do'; what he could 'care' for to keep living. As Keane has said of any smoker aware of the potential harms, 'the desire for a long and disease-free life can, and often does, conflict with practices that make us feel like we are doing more than merely existing' (2002,133). Understanding how smoking can make patients like Charlie feel actively alive, rather than tempting death, is critical to understanding his experiences of 'health'.

Charlie later asked me what 'advice' I might give to clinical staff about how to 'engage' schizophrenia patients with their 'health'. As I had tried to explain throughout my fieldwork, my role as an anthropologist was to understand experiences then and there, rather than to provide future directives as such. I would try to explain how smoking, for instance, could contribute to his wellbeing. As my fieldwork had encompassed two clozapine clinics in Australia and the UK, though, my analysis was 'comparative' insofar as similarities and differences in experiences arose. On this occasion with Charlie, my attention first turned to how the process of smoking (to 'focus on your breathing') could be experienced as a form of livelihood rather than a provocation of death in ways that were neither unique to Australian patient experiences nor to those of people with mental illness (Keane 2002; Dennis 2006). Second, in the wake of smoking bans in hospital psychiatric wards, previous research had suggested that longer-term smoking cessation was contingent on patients feeling part of an 'equitable consultation' process (Lawn and Pols 2005, 882). For anybody, feelings of self-efficacy can play a role in decisions to smoke or to quit (Nezami, Sussman and Pentz 2003). As Mol (2008, 92) described in the case of diabetes treatment clinics, when healthcare strategies waver, 'the crucial question is not whose fault it was, but what to try next'. My ethnographic research suggests this also applies to clozapine-treated schizophrenia patients in the making and remaking of one's 'health' (Brown and Dennis 2017).

In terms of 'what to try next' for patients who smoked primarily for agentic pleasures, by the end of 18 months of fieldwork over 2015-2016, a notable difference in clinical influences between the UK and Australian clozapine clinics was that electronic cigarettes[2] had been clinically endorsed as an NRT in the UK but not in Australia. Among the general Australian population, however, 'vaping' e-cigarettes had been increasingly 'associated with the notion of health as an individual project of self-improvement and a personal responsibility' (Keane *et al.* 2017, 473). This paper asks how the experiences of smoking and vaping by patients, who are being pharmaceutically treated for schizophrenia compares to experiences amongst general population groups. To date, there has been little ethnographic research on vaping amongst socially marginalised groups (Thirlway 2016), especially not as an NRT option for schizophrenia patients. In exploring the reception of smoke and vapour into the shared atmosphere, I continue Dennis' (2016a, 167) theoretical 'attendance to [the] travel' of smoke moving in and out of bodies, asking what it means for vapour to do the same in the context of clozapine-treated schizophrenia.

The experiences of breathing smoke and vapour in and out illuminates experiences of health

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[2] Electronic cigarettes, hereafter referred to as 'e-cigarettes', were first made available in 2004. E-cigarettes are battery-powered cigarette shaped devices that heat flavoured nicotine liquid into an aerosol, to be inhaled and exhaled by the user (Pisinger & Døssing 2014).

'care', toward the self and others. Drawing on patient experiences in the UK clozapine clinic where e-cigarettes had become part of the clinical tool kit, I argue that inhaling nicotine via e-cigarettes can, like tobacco cigarettes, be experienced in terms of temporal opportunities for self-reclamation. Resonating with qualitative findings about decisions to vape amongst the general population in the UK (Farimond 2017, 82), clozapine-treated schizophrenia patients in my ethnographic study vaped with harm minimisation in mind. When patients felt better about themselves and their health, my research indicated that they became more active in a wider sphere of social knowledge exchanges. While socialities in and through vaping differed from general population experiences insofar as knowledge exchange did not pertain to wider social or online communities (Bevan 2016; Keane *et al.* 2017), knowledge exchange pertained to clinical supports. Expressions of support for e-cigarettes inside the clozapine clinic were taken on board by individuals to not only build on self-efficacy but begin to expand concerns from the self to the shared atmosphere, as indeed intended by wider public health norms.

Nicotine & Schizophrenia

The practice of vaping e-cigarettes highlights the socially symbolic, rather than biomedical, components of public health efforts to curb smoking. E-cigarettes may be described as a 'disruptive innovation' for tobacco control (Stimson *et al.* cited in Farimond 2017, 88). Inhaling second-hand vapour from e-cigarettes is not the same as inhaling second-hand cigarette smoke or, as one of Dennis' ethnographic participants in Australia put it, a matter of 'catching cancer' from 'selfish idiots' who smoke in close proximity to others (2016a, 126). Until e-cigarettes were introduced, NRTs were distinguishable from tobacco cigarettes – 'to retain legitimacy as a 'medicine' – but the way e-cigarette vapour imitates smoke 'invokes both the memory of public smoking culture and its possible resurgence' (Bell and Keane 2012, 245). Now that e-cigarettes have been endorsed as a medicinal alternative to cigarettes in the UK, though, they no longer quite cause public health trepidations in regard to the 'pleasure' of smoking cigarettes (Bell & Keane 2012).

In the UK, nicotine delivery via e-cigarettes invites a clinical compromise. The UK Royal College of Physicians suggest e-cigarettes to be '95% safer' than tobacco cigarettes, thus approving of them as an effective NRT (McNeil *et al.* 2016; Mendelsohn 2016). E-cigarettes are not currently restricted under UK Smokefree laws but have been progressively regulated under UK tobacco product laws.[3] Meanwhile, smoking status and socioeconomic status are, irrefutably, 'inversely related' across Western societies (Greenhalgh *et al.* 2015). For people diagnosed with schizophrenia, this relationship is more pronounced. The smoking prevalence is at least triple that of the general population (Lourey *et al.* 2012). There is a growing body of biomedical evidence that nicotine eases 'psychotic symptoms' at a neuro-chemical level (Koukouli *et al.* 2017), as well as the 'negative symptoms' of apparent nihilism (Lawn and Pols 2005), as suggested by Australian patient Charlie. Further, ethnographic evidence

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[3] E-cigarettes are intended to be tobacco-free, although the precise chemical content of e-cigarettes is not standardised and therefore safety largely comes down to 'subjective interpretations' of inconclusive evidence (Pissinger & Døssing 2014).

suggests that smokers with chronic schizophrenia can reanimate the relationship between nicotine and the anti-psychotic drug clozapine[4] to infer nicotine's 'anti-psychotic properties' (Brown and Dennis 2017, 377). Moreover, self-constitutions may be tenuous for people with schizophrenia (Fuchs 2007, 2015; Laing 1960; Sass and Parnas 2003), while people who smoke increasingly embody social abjectness (Dennis 2016a; Douglas 1966).

Self-security felt by 'being' in the present may be particularly pertinent for people living with schizophrenia. Phenomenologically, schizophrenia is understood to involve a disruption to the dynamic Merlean-Pontian 'flesh' between self, other and world (Fuchs 2015; Laing 1960; Sass and Parnas 2003). Like the premise of clozapine treatment, which buys 12-24 hours of psychiatric stability between orally consumed doses, the past and future were often not as relevant for my participants as present-time self-assurance was. As one participant described his condition after commencing clozapine, 'it's all about eking out an existence' – a process of 'constantly touching base' by asking oneself, 'what should I take today, what should I do?' Linear time configurations can be disrupted in experiences of schizophrenia (Fuchs 2007). I found, however, that these disturbances can be at least *ephemerally* resolvable via the embodied experiences of "taking" clozapine and engaging in consumption practices like smoking.

Inhalations and 'Dwelling' Smoke

UK patient Peter, 54-years-old, rarely left the house and felt able to approach each day only after consuming his morning clozapine dose, tea, and cigarette. While clozapine fuelled him for the duration of half a day (before the next dose), Peter said, smoking 'makes me feel that I'm *doing* something' in between. Fragments from the past and an unpromising future were suspended. Peter became psychotic during a period of intensive work but also lives with guilt about various criminal offences committed while he was unwell, while there were minimal prospects of forgiveness from his family, insecure housing arrangements and lifelong dependence on medication. The idea of discontinuing smoking might seem too finite in contrast to the momentum granted by the temporal replenishment. Another participant reflected, 'it gives me something… motivation and that… but I should stop soon.' However, to 'stop' might be to take away the 'something' allowing 'motivation'. Quitting smoking may jeopardise a reliable way of 'being-in-the-world' and feelings of embodiment (Heidegger 1962 [1927]; Merleau-Ponty 1962 [1945]).

Public health campaigns against smoking aim to provoke awareness of the future consequences of smoke residing inside bodies. The temporal risks of inhaled smoke are emphasised in order to disrupt the involuntary experience of breathing in air, and images of smoke 'dwelling' in the air and in bodies can be thought of in terms of Heideggerian temporality framework (Dennis 2016a, 110). Heidegger (1962 [1927]) posited that we exist and 'dwell' *in* and *with* hybrid contexts and interactions. Our 'being' (*Dasein*) is about improvising and 'being *there*'. The future is unknowable but possibilities for it continually

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[4] Clozapine acts on the same receptors in the brain such that abrupt cessation of smoking (the most effective method for quitting) is potentially fatal (Prior and Baker 2003)

open up. Patients told me how smoking gave them 'something to do' and enabled them to 'focus' their thoughts, on their breath or otherwise, which provided distraction from aspects of their illness or drug side effects. Charlie's experience demonstrates how the process of smoking grounded him in the present experience of his breathing and the evidence of it ('you can *see* your breath'). Yet, contrary to public health provocations of smoke as *perniciously* dwelling inside the body (Dennis 2016a, 99), other reasons patients gave for smoking remedially often concerned the experiential qualities of inhaling and tasting the smoke.

When one participant spoke of the 'satisfaction' smoking granted him and I asked him how, he said, 'cause I feel like one so I have one – *satisfied*'. Further, this satiation was self-directed and enacted. This could be interpreted as a way of investing 'care' toward present desires via the use of physical 'equipment' (the cigarette) - as a 'something in-order-to' project experiences with (Heidegger (1962 [1927], 97;H68). Arguably, when smoking becomes habitual, possibilities for self-world continuity can be opened up without imposing past or future speculations. Repetition of embodied acts can grant what Carel (2006, 91) described as a 'unity of temporality'. Carel (2006, 92) saw this as, 'a moment of individuation, but not as alienation from the world or from being-with-others, rather as opening the factitial possibilities of Dasein's concrete existence'. In other words, the embodied experience of smoking repetitively may serve to reinforce a sense of self-reclamation that outweighs perceived inconveniences, such as experiences of "chest pains" or intense coughing.

Feelings of self-reclamation from smoking could also be facilitated by the way its effects travel through the body. UK patient Trevor, 55, who spoke of nicotine's 'antipsychotic properties' (see Brown and Dennis 2017, 377), said that smoking 'stimulates my mind and helps me to think about various things … maybe slowing things down a little' He said that smoking enabled him 'to focus'. Similarly, UK patient Nathanial, 36, reported that he smoked to 'combat' and 'overcome' a 'feeling of weakness' – concerning his 'consciousness' and 'physical body' – when taking clozapine:

> If I'm taking the medication, I might have two or three cigarettes within half an hour, 45 mins, to *lower* that stuff out of my blood stream … I feel more coherent, I'm able to think, I'm able to then plan in my mind what I'm doing, I'm able to just *function* better. And then I'll survive on that – the smoke's gone – and then I'm all of a sudden rushing around to remember what I was doing when I was smoking, like always being *active* ... then if I can't get to what I'm doing or I can't remember, the thoughts just *gone,* I'll have another smoke and then think, 'ah that's what it was, I was doing *that'*.

The movement of inhaled smoke helped Nathanial to not only lessen the impact from clozapine, it also helped him to '*function* better', and to keep on 'being *active*'. Further, he could temporally 'survive' on the effects of the smoke inside his body to trigger his memory for what he was 'doing', thus expediting experiences of self-momentum. These means of 'being' and 'doing' vis-a-vis inhalation of nicotine into the body are relevant to perceptions of what is later exhaled into the shared atmosphere.

Exhalations: 'Travelling' Smoke and Vanishing Vapour

What would an analysis of cigarette smoking look like, if it were to be theorized through an attendance to travel? This is the critical point: it would look rich, full, unconstrained, unpolarized. It would look productive. – Dennis (2016a, 167).

Exhaled cigarette smoke and e-cigarette vapour travel through bodies and air. The carcinogenic danger of tobacco warrants utilitarian public health goals to eliminate tobacco smoke in shared spaces. The potential reach of smoke as it 'travels' (Dennis 2016a) also brings to attention the symbolic danger at play in the sharing of smoke. Tobacco smoke is experienced as shared because the smells of it are emitted from one body and inhaled into another, thus making it a form of social contamination as well a transmission of disease (Dennis 2016a; Douglas 1966). As Dennis (2016a, 98) asserted, 'the air is explicated as the harbinger of illness, even death, to smokers and non-smokers', and in this way becomes something more definable. Tobacco smoke is inherently temporal but substantive enough to distract those around it.

Just like temporal 'dwelling' of smoke inside the body can invoke reflections about one's own health, the way in which smoke travels can invite wider realms of Heideggerian 'care'. As outlined in the above section, investing 'care' toward the self and world via repetitive use of cigarettes can invite temporal unities (Carel 2006, 91-92). Included here also can be 'care' toward the movement of cigarette smoke. UK patient Trevor commented to me one day,

> I know it isn't good to be in a room full of smoke, really, because you're smoking and then you breathe in the smoke again, and it's not good, but if I do smoke it'll be in my flat and I put the extractor fan on. Um, because otherwise it'll go down the corridors and hit the fire alarms!

Trevor's concern about second-hand smoke inhalation being 'not good' was less about biomedical health imagery, as I might have first assumed, and instead more about the potential to disturb his neighbours. Moreover, the way e-cigarette vapour travels can bring into focus potentialities that concern the 'health' of self and others. Take, for instance, the following account of 43-years-old UK patient, Alan.

Alan had been on clozapine for 16 years to treat his schizophrenia, and had subsequently developed type II diabetes mellitus. When we first met, he smoked 20 hand-rolled cigarettes per day in order to 'prep' himself for various activities – before getting in the bath to wash his hair, before getting on the bus, before attending his theatre group. However, he was concerned about his breathing difficulties, and he did exhibit a raspy, short breath. He said to me, 'as an eventuality you do have to consider your health… so, come the new year, I'll be on a nicotine vapour pipe rather than all that carbon dioxide and monoxide from tobacco'. By

August, he had asked his mother for the vapour pipe (or electronic cigarette) for Christmas and alleged, with a big smile, 'if she does that I'll have the ball rolling' and 'stop rolling cigarettes'. Over the next few months he became increasingly confident about this upcoming change, despite identifying as 'anxious' and 'depressed' when it came to other prospects in his life.

Having not seen Alan in 10 months by the time I returned for the second leg of my UK fieldwork, we greeted each other cheerfully in the entrance to the clozapine clinic. Before we could exchange more than mutual hellos, he interjected intercepted excitably, 'I've been walking up the hill to Tescos *without* getting out of breath!' He had been vaping rather than smoking since the first week of January.

Alan elaborated that, since swapping to vaping, he no longer woke up in the night 'with a hacking cough … I gave up just in the nick of time for my health'. Of cigarettes, he now said, 'the other day somebody lit one near me and I thought (*imitates gag-cough*) it's like a P-Super! Quite strong those cigarettes. It was close to me and I thought oh *dear;* I didn't realize it was as ah… as *foggy* as that, the heaviness of the smoke.' The act of vaping, he contrasted, was 'cleaner, it's not a fire hazard, it's cheaper, and it's not so bad for your health'.

Having been told by other research participants as well as Alan that smoking rewards came mostly from inhalations rather than the exhalations, I clarified how e-cigarettes fared in terms of the inhalation experience. He said they felt similar enough; it was rather his perception of what was *exhaled* and his breathing experiences in between the activity that had changed. While he could not compare the frequency of his vaping to smoking, he imagined that overall he consumes less, adding 'I shall bring the vaping down and phase it out, when I'm ready, but the thing is I quite like it'. He reflected that, while smoking helped him to get through periods of psychosis and then a minimum number of daily tasks, with vaping, 'it's not *more* time so much as *not squandering* my time'. With a newfound momentum, he was now 'doing things little by little, adding more routines as I go', and felt he had 'more to look forward to in the day-to-day sense'.

The following week, I went along to a 'presence of mind' theatre group performance he had invited me to (a 15-minute segment of Samuel Beckett's *Waiting for Godot*). It was a sweltering summer's afternoon and, while waiting in the air-conditioned foyer, I observed him sitting outside, sweating profusely and vaping very intensively - prepping himself. The vapour did not seem to bother his non-vaping-nor-smoking fellow actor (and mental health patient) sitting in close proximity beside him. Alan vaped rapidly. The vapour was thin and vanished quickly. When he returned inside to perform, the intense vaping state I had observed Alan to be in had also dissipated, as he steadily and impressively acted out his role as Vladimir. After I'd congratulated him on his performance, Alan said to me, invigorated, 'I feel like I'm just getting started!'

For Alan, the decision to vape instead of smoke opened up his present-focused momentum further toward the future. For other patients, however, the process of smoking granted a sense of security and familiarity, prolonging present time such that they wished to 'just leave things as they are' – as one UK patient said when I asked him about cessation or switching to e-cigarettes. If the first experience of vaping did not go smoothly, like it had for Alan, patients

might quickly retreat back to smoking. For instance, another UK patient who said he kept smoking because it 'feels nice, tastes nice', because 'you breath it in, breath it out', had tried e-cigarettes upon the clozapine nurses' recommendation. He explained that he 'used it 3 times then it wouldn't work again, so I was stitched up' (the refilling of the nicotine 'cartridges' may be quite confusing without further social guidance). This patient was also 'surprised' to find that the inhaled vapour felt 'very harsh', such that he 'nearly choked'. The flavour was too strong, compared with the hand-rolled tobacco cigarettes he was used to. Therefore, the 'pleasure' and 'play' with nicotine flavours (Bevan 2016; Thirlway 2016; Keane *et al.* 2017) did not constitute my participants' agentic experiences with vaping so much as finding a reliable substitute that was distinguishable enough in terms of representing 'good' rather than 'bad' nicotine delivery (Bell and Keane 2014, 50), but familiar enough to build feelings of self-reclamation with.

To Alan, his decision to vape instead of smoke was doubly proactive. Firstly, vaping allowed Alan to build on the self-assurance and momentum he gained from smoking (prepping him throughout the day), giving him a means to imagine and work towards new goals, however gradually. He could also 'bundle' it freely with other activities insofar as e-cigarettes do not have the same 'temporal' and 'spatial' limitations as tobacco cigarettes (Keane *et al.* 2017). Consequently, potential feelings of disempowerment via the 'social defeat' often attached to having schizophrenia in Western societies (Luhrmann 2007), and the anti-social stigmas attached to smokers more generally (Bell, Salmon and McNaughton 2011) were perhaps lessened. Additionally, notions of 'irrationality' otherwise attached to schizophrenia and smoking may have been overridden by Alan's contextual 'rationality' in his 'healthier' and 'pro-social' preferences.

Notably, the vessel emitting the vapour itself was also critical for Alan. Just as vaping may have become 'a specific practice in its own right', so too, models of e-cigarettes have evolved to be less 'cigalike' and instead loftier and more variable in shape and size (Keane *et al.* 2017, 466). When I had first sat in with Alan during a 'physical' health check in 2015, before his transition to vaping, the nurse asked him if he had tried e-cigarettes before. Alan explained that he had, 'and it worked', however he was concerned that he needed a device that looked more like a 'pipe' so that it would 'look different' and not evoke quite the same hand-held image of smoking a cigarette. Further, Alan's perceptions of how second-hand smoke and vapour travels had come to align more with wider social receptions.

Social Reception of Smoke and Vapour

The second way in which Alan's decision to vape instead of smoke can be seen as proactive is that he himself categorised the behaviour in a (comparatively) culturally conscientious way: his perception of cigarette smoke changed, discerning his own (and medically abiding) position in a greater public health conscience. In de-normalising smoking *for himself,* Alan moved to include himself among the more distinguishable 'others' who experience second-hand smoke as experientially offensive. Vaping allowed a new perception of cigarette smoke as 'quite strong' and 'heav[y]' enough in the air to make him want to cough or gag. He had described the vapour, by contrast, as not only 'cheaper' and healthier but 'cleaner' and 'not a

fire hazard'. Symbolically, vaping (and vapour) was experienced and perceived in terms of its comparative 'purity', compared with the 'pollution' carried by cigarette smoke upon leaving the body (Douglas 1966). Moreover, in subscribing to socio-medical advice available, to vape instead of smoke, Alan's attention shifted beyond the e-cigarette inhalation experience (still satisfied by e-cigarettes) to the impact of the exhalation. Having taken command of his own behaviour, he became aware of what made smoking offensive to other bodies and the environment.

In the 'mental health' context, the reception of vapour is not necessarily consistent with the general public reception of it. One day when sitting in on a clinic consultation with Peter, he informed me that he had started to substitute some of his smoking with vaping when outside the comfort of his home. Peter now left the house wearing an e-cigarette encased in a pouch around his neck, which he felt comfortable accessing while in public (compared with retrieving a cigarette packet concealed within his backpack). Peter asked the nurse's permission to vape inside the clinic room during the consult. The nurse, busy going over his case notes, replied, without looking up, 'sure'. Peter thanked him and pulled out his e-cigarette from his necklace. He quietly started vaping away while the nurse asked him about other matters. The nurse did not appear to register the sweet smell, while I observed that it was not intrusive, and disappeared, along with the vapour, in between Peter's exhalations. When I asked Peter about the inhalation experience, he said that the e-cigarette was even 'sometimes better than a fag' (a British and Australian colloquialism for cigarette).

Critically, the circumstances in which I observed Alan's vaping and then Peter's vaping were not representative of typical interactions in public (or all clinical) spaces. A few weeks after the consultation with Peter, another UK patient told me that he had received disapproving looks and coughs while vaping on the street. He had found this confusing, as he had perceived himself to be posing comparatively little risk to bystanders (as per clinical advice). However, he resolved to avoid busy public areas from then on, just in case. The vast majority of patients, Peter included, spoke of feeling highly vulnerable when moving in public spaces anyway. For them to now have another reason to avoid public spaces despite having a newfound social resonance with goals to not smoke in shared spaces is, arguably, unfortunate. What is more, the option to retreat into vaping 'cafés' may be equally intimidating for patients who preferred to smoke alone in the first instance. While Bevan (2016, 238) suggested how for general population groups in France, vaping spaces and experiences were fundamentally social and occasions of mutual reinforcement, to be able to smoke and thus vape in one's own company seemed more important to patients in my study. Further, the switch to vaping appeared to be more bound up in opportunities for self-assertion within a medical context rather than factors such as 'the performance of age and gender' (Thirlway 2016, 111).

Returning to the experiences of Australian patient Charlie, the temporal pleasures explaining his decision to keep smoking, despite his experiences of mental health unit smoking bans resulting in a realisation that smoking was now a choice rather than addiction, might be better thought through in the context of vaping had it been clinically provisioned as an NRT. In Australia, some public health arguments support the use of e-cigarettes as an NRT

(Mendelsohn 2016), especially for vulnerable groups (RANZCP 2017). However, the safety unknowns of first and second-hand vapour are emphasised, along with possible, slippery social 'gateways' to smoking via vaping (McKee *et al.* 2016). As Bell and Keane (2014, 50) have cautioned, though, concerns about e-cigarettes constituting a 'gateway' to smoking largely hinge on '*predictive* model rather than an *empirically-driven* one' (original emphasis). Vaping in public spaces in Australia was quickly categorised under the same legislative restrictions as smoking. These bans were reinforced by the US Surgeon General's advice that e-cigarettes pose a particular threat to youth, and that the vapour 'can have harmful effects on the user, as well as those who inhale it second-hand' (Vivek *et al.* 2016, np).

Yet, as Kaufman and Harper (2013, 740) surmised, 'a scientific impropriety is not resolved by allowing less rigor for the proponents of opposing views'. Dennis' (2016b, 129) ethnographic findings that lived smoking logics in Australia are irreducible, conditional and incomplete, 'recombining elements of systems of knowledge into new combinations that help shape experience, and bend it to the needs and particularities of the moment'. My ethnographic findings highlight how for particularly vulnerable people, too, nicotine inhalations and exhalations involved different locuses and potentialities of being-in-the-world.

Conclusion

This paper has demonstrated how operations of health 'care' of self and others can be explored in and through experiences of breathing in and out cigarette smoke and e-cigarette vapour. Smoking and vaping is and is not different from general population experiences of smoking where harms are emphasised. For clozapine-treated schizophrenia patients in my ethnographic study, inhaling nicotine via both cigarettes and e-cigarettes provoked a temporal, not just neuro-chemical, reclamation of self and being-in-the-world. Drawing particularly on patient experiences from the UK clozapine clinic where e-cigarettes were offered as an NRT, I have argued that a switch from smoking to vaping can be seen as expanding temporal spheres of Heideggerian 'care' toward shared spaces and social norms around health. Further, 'rationality' around vaping can align with medically endorsed harm-minimisation and evoke social considerations for second-hand ingestions of smoke.

The way smoke 'travels' (Dennis 2016a, 167) in and out of people's bodies may be applied to vapour. As smoking did not necessarily embody risk during the temporal experience of inhalation for my participants, consideration for how exhaled vapour, compared to smoke, was actively imagined by my participants to implicate other people indicated more far-reaching (and hopeful) projections of self-world connection. Vaping indicated patients' self-efficacy and preference for biomedical and wider social notions of 'health', aligning with general population attitudes of vapers in the UK (Farimond 2017).

Although secondary and inequitable impacts of public health interventions like smoking denormalisation may be inevitable (Marmot *et al.* 2012), the anthropological concern that 'exclusionary behaviour validates itself' by being more prevalent amongst people that embody greater health and social risks deserves careful scrutiny (Douglas 1992, 36). For

Australian patients like Charlie, the option to vape instead of smoke may or may not have been welcomed, however the choice to do so may have opened up a space for 'engagement' – as Charlie had asked me about, and which I had observed in the UK clozapine clinic. Patients may then begin to experience themselves as 'crucial members of the care team' as they might be if they were non-mental health patients (Mol 2008, 26). Clinical supports of vaping furnished patients with a sense of social acceptability. Bystander ambivalence around vapour, however, problematised its status as 'good' nicotine (Bell and Keane 2014). Account should thus be taken of the implicit, nascent concerns for the self and others experienced by those who opt to vape rather than smoke. Further, clozapine-treated schizophrenia patients have self-efficacious reasons for continuing to smoke or vape, just like anybody else finding temporal freedoms and connections in experiences of living, not merely toward death.

Acknowledgements

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