# The Quest to Quit:
# an exploration of the
# cessation—relapse cycle of cigarette smoking

by

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## Abstract

The smoker's perspective is seldom sought in cessation research. Consequently, cessation approaches may be less effective because they are not based on assumptions and interpretations shared by those who smoke. Understanding how chronic relapsing smokers interpret their predicament could enhance cessation approaches, improving the chances for complete, permanent cessation.

To generate such an understanding, five participants were recruited who had attempted to quit smoking several times. Aiming for depth rather than breadth, multiple interviews were conducted with each participant, who also kept an event diary, recording current smoking, nicotine withdrawal, lapsing and relapsing. Narratology, a biographical method of symbolic interactionism drawing on thematic, structural, and dialogic analysis, was used to elicit the participants' points of view from interview and diary data. The findings show that participants make sense of their chronic relapsing through a master narrative of 'willpower versus weakness'. Meanwhile, the tobacco control domain is largely driven by 'cost', and subsidised treatments are driven by the 'addiction' master narrative. This gap between ways of making sense of smoking and relapse can cause self-stigma, reducing the likelihood that quitting will be attempted and that quit attempts will succeed.

Changes are proposed to mitigate the negative effects on self-efficacy brought about through the present approach to tobacco control. Ways to improve the effectiveness of existing treatments are suggested. Finally, the value of the narrative method is highlighted, with suggestions for its use in research where elucidating the insider point of view may improve treatment outcomes.

## Acknowledgements

Enrolling fulltime at university in early mid-life was a big step for me, after several hit-and-miss attempts to study part time. For all that, it would have been impossible without favourable circumstances soothing the way. Principal in this respect is my husband, Terry Friel, who has every right to feel somewhat mislead, as my intended 'one semester, full time' stretched to five and half years, with another three beckoning. I am aware that I have dented the financial goodwill. Thank goodness it hasn't reached beyond the pocket. Thank you.

I offer a big thank you to my undergraduate and graduate lecturers, and especially my thesis supervisors, Chamsy el-Ojeili and Jenny Neale, for their encouragement as I navigated my thesis year. Thank you also to my class mates, especially Marilyn and Shadiya, and also my office buddy, Tess. Congeniality certainly makes life easier, and conviviality keeps it lively.

Narratology is a powerful means of bringing experiences to life, delivering a degree of verisimilitude that I sought but scarcely dared to hope I could achieve. For all the method and the process, what I have achieved in this thesis would not have been possible without the generosity, goodwill and trust of those who shared their stories.

Kia kaha to you all.

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## Introduction

One hundred years ago tobacco use was largely split along class lines. Some had the uncouth and stigmatized practice of chewing and spitting their tobacco, while others slowly smoked it in a pipe (Brandt, 1998; Doll, 1998). The accelerating pace of life, especially moving to indoor workspaces, removed this class distinction by promoting the pre-rolled cigarette. Cigarettes eliminated the need to spit and they were quickly consumed. By the 1950s smoking was ubiquitous, and "signalled attractiveness, glamour and sexual allure," (Brandt, 1998, p. 165). Concurrently, doctors noticed the previously rare disease of lung cancer was being diagnosed more frequently. They suspected this had something to do with tar, that is, the tar used to seal the expanding road network that had developed since late in the 19th century (Doll, 1998, p. 133).

But roading tar was not to blame. Between 1950 and 2000, and including data just from 'developed' nations, about 63.4 million people died from smoking-related illnesses, with almost 39 million dying before the age of 70 (Peto, Lopez, Boreham, & Thun, 2006, p. 8). Such large numbers can be difficult to grasp, but for context, the current population of France is about 64 million. As a consequence of the mounting death toll, tobacco use has again become increasingly stigmatised, with smokers seen as deviant and weak-willed for continuing to indulge in an offensive and dangerous activity (Brandt, 1998, pp. 176-177) despite extensive anti-smoking campaigns and cessation assistance.

By 2003 the New Zealand government was spending about half its $26m annual tobacco control budget on cessation treatment subsidies (World Health Organization, 2003), and about 65% of New Zealanders who smoke claimed they have attempted to quit in the five years to 2006 (Ministry of Health, 2007b, p. 50). Nevertheless, only about 5% of quit attempts result in the person

becoming a life-long ex-smoker (Glover, 2006; Stead, Rafael, Bullen, Mant, & Lancaster, 2008) and, on average, people try to quit 14 times before they succeed (Zhu, 2007).

Despite this high relapse rate, research has not focused on the experiences of chronic relapsing smokers, people who repeatedly try to quit. Instead, studies have demonstrated links between smoking and health problems, tested possible cessation treatments, and reported treatment service utilisation. Very few studies have focused on the perspectives of would-be ex-smokers.

Because of this gap in the research, the tobacco control domain is not informed by the interpretations of those most impacted by smoking. Often programmes that intend to assist people with personal troubles do not work as well as they might, because they are based on assumptions that differ from those they intend to serve (Denzin, 2001, p. 3). It is my contention that the needs of would-be ex-smokers will be better met when services are based on an empathetic understanding of chronic relapsing.

My research question asks:
"How do smokers make sense of their repeated attempts to quit?"
I aim to give a voice to smokers experiencing the cessation—relapse cycle, in contrast to perspectives from within the New Zealand tobacco control domain.

The Background and Literature Review introduces three master narratives that shape how New Zealand society understands smoking. I contextualise the tobacco control domain, from the earliest causal link between tobacco and lung cancer to the array of organisations striving for a smoke-free[i] New Zealand. I review tobacco control strategies, which largely draw on the 'cost' master narrative, then explore the advancing knowledge about addiction, which is the second master narrative. Finally, I review academic research articles

from the last ten years where the central focus is the point of view of the would-be ex-smoker, showing the prevalence of the 'willpower versus weakness' master narrative.

My research design is detailed in the Research Methodology chapter. I explain how I operationalised the biographical method of narratology to analyse the interview and diary narratives collected from five participants. I show the method to be embedded in social constructionist epistemology and idealist ontology, which underscore and focus on culture and language.

The Research Findings are presented in four parts, aligned with the aspects of chronic relapsing of most relevance to the participants: smoking, deciding to quit, quitting, and relapsing. Interview and diary exerts illustrate the findings.

The Conclusion suggests possible extensions to this study and makes recommendations based on my research that will improve the chances of would-be ex-smokers achieving a smoke-free future. Finally, I suggest ways the narrative method could be fruitfully used to explore other issues where the point of view of the people most affected has been overlooked and should be taken into account.

# Background and Literature Review

My review of the literature has shown that attitudes to smoking cessation are influenced by three master narratives relating to cost, addiction, and willpower. Briefly, people should stop smoking because it is costly in multiple ways; nicotine addiction makes it more difficult for some people to stop smoking; and people who smoke do not really want to quit. Literature associated with each master narrative is reviewed, building an overview of the resulting social environment and understandings about smoking and cessation in which would-be ex-smokers attempt to make sense of repeated attempts to quit.

## *Cost: a cultural-historical overview*

In New Zealand the Ministry of Health is the major institutional influencer of attitudes to smoking and enabler of approaches to smoking cessation treatments. Appendix A shows the flow of funds and services within the New Zealand tobacco control domain, with the Ministry of Health being central. Consequently the Ministry of Health and its agencies are a major focus of this section.

### Background

British researchers first identified a causal link between cigarette smoking and lung cancer in 1947 (Doll, 1998). The New Zealand National Cancer Registry was established the following year, and began accumulating data that highlighted the link between tobacco use and cancer (Cancer Control Council of New Zealand, 2008). New Zealand was one of the first nations to establish such a Register, and was an original contributor, in 1966, to the World Health Organisation research comparing international cancer prevalence rates (Parkin, Whelan, Ferlay, Raymond, & Young, 1997, p. 3).

In the 1960s the Royal College of Physicians of London (1962) issued their report on the dangers of smoking, and the link between tobacco

and some cancers became accepted medical knowledge. Two years later came the landmark report *Smoking and Health: Report of the Advisory Committee to the Surgeon General of the Public Health Service (U.S. Department of Health and Human Services, 1964).* The report was direct: the more one smokes, the worse the health effects; those who start younger have more severe health effects; and the likelihood of experiencing these effects is greatly reduced by quitting (U.S. Department of Health and Human Services, 1964, p. 29).

In 1972 the U.S. Surgeon General's Report tentatively recognised the risks of second-hand-smoke, concluding that a room filled with tobacco smoke contained carbon monoxide levels that *may* be sufficient to cause harm to people, whether or not they were personally smoking (U.S. Department of Health and Human Services, 1972, p. 7 emphasis added). From this time the credo of the tobacco industry, that smoking was a personal choice impacting no one but the person smoking, was turned on its head. 'Personal choice' changed to 'personally irresponsible behaviour' (Brandt, 1998, pp. 166, 177). In New Zealand the second-hand-smoke issue drove interventions to restrict tobacco use, leading to the Smoke-free Environments Act (1990) and its 2003 amendment.

Also in the 1970s, research showed smoking prevalence differed between socio-economic groups. In colonial contexts such as New Zealand, socio-economic disparities generally translate to ethnic minorities having the highest smoking prevalence rates, the lowest quit rates, and the highest mortality rates from smoking-related illnesses. The local literature of greatest significance in this regard is that of Christchurch cardiologist, David Hay (1972), who drew attention to the disparity in cancer rates between Māori and Non-Māori. Hay was the sole New Zealand delegate at the World Conference on Smoking and Health in September 1971, where an address by Sir Richard Doll noted "the high lung cancer incidence among New Zealand Māori women … [who] now have the highest

lung cancer incidence among females in the world" (Hay, 1971).[ii] It was not until 1980 that the Department of Health Advisory Committee on Smoking and Health recognised its tobacco control efforts were less effective for Māori than for non-Māori. Subsequent campaigns were designed to appeal to a Māori audience (Cancer Control Council of New Zealand, 2008).

In 1962 the London Physicians Report noted that "smokers may be addicted to nicotine" and that cigarettes appeared to be more habit-forming than alcohol (The Royal College of Physicians of London, 1962, pp. S6, 42). Nevertheless it was the late 1980s before nicotine became more generally acknowledged as an addictive substance (U.S. Department of Health and Human Services, 1988, p. 9; Waxman, 2003). This created increasing awareness that for some smokers, stopping smoking is more complex than making the decision and sticking to it, bringing about an increase in both medical and non-medical cessation treatments, (discussed in the Biological and Physiological Overview).

A milestone event for tobacco control occurred in the 1990s, when the State of Minnesota and the Minnesota Blue Cross Blue Shield sued seven tobacco manufacturers to recover smoking-related medical costs. The 1998 settlement found they had proved the industry knew the addictive properties of tobacco and the health risks of smoking, but nevertheless marketed cigarettes as safe and appealing, particularly targeting youth (British American Tobacco Documents Archive, 2004).

Despite the culpability of the tobacco industry, some researchers now report smokers' feelings of stigmatisation (Laurier, McKie, & Goodwin, 2000; McKie, Laurier, Taylor, & Lennox, 2003; Thompson, Pearce, & Barnett, 2007). Brandt (1998) drew attention to the difficulties faced by smokers:

> If the smoker is pariah and criminal, we may well forget that it is truly the smoker who is the victim, inevitably suffering the double jeopardy of inhaling both active and passive smoke. The cigarette, we might remind ourselves, is a formidable enemy (Brandt, 1998, p. 177).

Ten years later, in 2008, Mark Peck, Director of the New Zealand Smokefree Coalition, finds it necessary to remind people:

> We have to be very careful not to blame the smoker. The smoker is not the problem. The industry is the problem and always has been, ("More teens reject smoking," 2008).

Most recently, tobacco control has attained a global influence through the World Health Organisation's *Framework Convention on Tobacco Control (FCTC)*. This was ratified by New Zealand in 2004 and came into effect in 2005 (Framework Convention Alliance for Tobacco Control, 2008). While New Zealand has already addressed the core obligations of the FCTC, initiatives beyond this minimum are now emerging on the local tobacco control agenda. For example members are expected to raise public awareness of the tactics used by the tobacco industry to work around the tobacco control policies, and the Smokefree Coalition is at the forefront of delivering on this obligation in New Zealand. Director of the Smokefree Coalition, Mark Peck, urged retailers to spurn a promotion whereby a cigarette tin was offered as a "free gift" with the purchase of alcohol, as shown in Figure 1. Peck considered this a thinly-veiled attempt by the tobacco industry to circumvent changes to tobacco packaging health warnings, which threatened to make the appearance of cigarettes less attractive to youth (NZPA, 2008).


**Figure 1: Poster offering a free cigarette tin with alcohol purchase.**

## Pragmatic medicalisation

In the United States the Harrison Narcotic Act (1914) transformed drug addicts from patients to criminals, following the logic that drug use is immoral and wicked: a vice. Addiction was viewed as a form of deviance: "a kind of neurosis arising from personality defects" (Durrant & Thakker, 2003, p. 200). While tobacco is not an illegal substance, since the mid-1960s the fundamental meaning of the cigarette has been recast, "from an object of pleasure, consumption, autonomy and attraction to a symbol of personal disregard for health, addiction, and weakness" (Brandt, 1998, p. 165).

More recently and from the medical point of view, the *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-RT* (2000) has recognised both nicotine dependency disorder and nicotine withdrawal disorder. Nicotine dependence is diagnosed when at least three of the following symptoms are present:

- Needs to smoke more to get the desired effect;
- Smokes more than intended;

- Unsuccessful attempts to quit;
- Expends effort to obtain tobacco;
- Daily life patterns revolve around timing of next cigarette;
- Withdraws from activities where smoking is not permitted;
- Suffers withdrawal when nicotine levels decline.

Nicotine withdrawal is diagnosed when nicotine is withheld and at least four to the following symptoms are experienced:

- Depressed mood;
- Insomnia;
- Irritability;
- Frustration or anger;
- Anxiety;
- Difficulty concentrating;
- Restlessness or impatience;
- Decreased heart-rate;
- Increased appetite or weight gain,
  (American Psychiatric Association, 2000, pp. 193, 265).

In parallel with this medical view of nicotine disorders, the New Zealand government approach to cessation substantially changed in the new millennium, with the introduction of heavily subsidised nicotine replacement therapy (NRT) as an additional service to the already established Quitline, a telephone-based behavioural support service (The Quit Group, 2005).

Some commentators suggest that institutional approaches to cessation do not stem entirely from an altruistic concern to save citizens from the effects of smoking-related illnesses. Instead, governments are interested in reducing the burden of smoking-related illnesses on the health system (Chapman, 2007, p. 20).

Chapman's assertion is evident in New Zealand through a Ministry of Health report *Reasons for Investing in Tobacco Control* (Wilson, 2003). Wilson's reasons include "harm to the workforce and the economy" and the "cost burden on the health sector". With a quarter of those who die from smoking related illnesses being aged 35 to 69 years, adverse health outcomes are costly in terms of lost productivity as well as medical costs, (Bloomfield, 2008). Policies to reduce smoking prevalence are motivated by pragmatic concerns to minimise the economic impacts, and these policies fit into three broad strategies: demand reduction; regulation of supply; and treatment programmes (Durrant & Thakker, 2003, p. 216). An overview of these strategies contextualises the approach of the New Zealand tobacco control domain to cessation.

### Strategy 1: demand reduction

Social marketing campaigns are often used as a demand reduction strategy, attempting to discourage uptake and encourage cessation. McKie et al. have suggested this strategy draws on Foucault's idea of governmentality, by influencing everyday understandings about smoking, people choose not to smoke, and encourage others to act similarly, for the good of society in general (2003, p. 84; also see Thompson et al., 2007, p. 512). The campaign *Smoking: Not Our Future* exemplifies this strategy. This initiative of the Health Sponsorship Council, an agency established and funded through the Ministry of Health to promote healthy lifestyles through social marketing (Health Sponsorship Council, 2008), presents youthful celebrities declaring smoking to be abnormal and socially irresponsible (Smokefree Coalition - te ohu auahi kore, 2008).

A smoke-free future is encouraged through advertising using "'threat appeal' themes [which] focus on the adverse health consequences of smoking" (Wilson, Grigg, Graham, & Cameron, 2005, p. 284). A problem with threat appeals is that they do not take into account that nicotine addiction makes it extremely difficult to carry through

the choice not to smoke. A research project at the University of Missouri (2008) has cast a light on the phenomenon reported by some smokers and ex-smokers, that they experience nicotine cravings in response to threat appeals. The Missouri study found that health messages need to separate content meant to scare from content meant to disturb or disgust. The physiological responses of people exposed to messages combining scare and disgust content suggest these backfire: viewers switch off, rejecting the message. While this does not fully explain the frequently reported desire to smoke when confronted with threat appeal messages, it goes some way to recognising that the impact of threat appeal messages is not always what was intended.

### Strategy 2: tobacco supply regulation

Regulations cover tobacco content, the sale and purchase of tobacco, and how it is advertised, displayed and packaged. For example 30% of the front and 90% of the back of tobacco packaging must be covered with government-supplied pictorial and written warnings of the threat appeal kind ("Smoke-free environments regulations 2007," 2007). In another initiative tobacco control groups have lobbied to ban tobacco displays, arguing that these promote uptake and relapse. Their efforts have prompted a public consultation process, led by the Ministry of Health, which has reported strong support for the removal of tobacco displays, or 'power walls' as these have been termed (Ministry of Health, 2008d). Tobacco taxation is another important element of the regulating strategy, and Wilson (2007) has shown that smokers are sensitive to tobacco pricing. A 10% price increase leads to a 5% to 8% reduction in tobacco sales (pp. 15, 40).

### Strategy 3: treatment provision

The Ministry of Health has a two-pronged approach to treatment provision: funding public-facing cessation assistance services, which

are addressed in the next section; and funding or part-funding research into treatment options.

### *Research*

Three organisations at the fore of New Zealand research into treatment options, all university-based, are the Auckland Tobacco Control Research Centre (ATCRC), the Clinical Trials Research Unit (CTRU) and the National Addiction Centre (NAC). Two research studies underway at NAC are testing hypotheses relating to the use of NRT. One uses NRT in parallel with *ad libitum* smoking prior to the quit date, to see if quit rates are improved by easing the nicotine replacement process. This study builds on an earlier pilot, conducted by the CTRU and reported in 2006 (Bullen, Whittaker, Walker, & Wallace-Bell, 2006). Another study assesses NRT as a long-term nicotine delivery system. Removing the cigarette as the nicotine delivery system is seen as a priority ahead of remission from nicotine addiction (National Addiction Centre, 2008).

Meanwhile at the CTRU, trials are focusing on innovative NRT delivery mechanisms, which deliver nicotine faster, thereby reducing nicotine cravings more quickly. Acute forms of NRT are also being used in conjunction with slow-release forms as a means of managing cravings and therefore reducing the incidence of relapse. The CRTU is also testing new ways of assessing and validating tobacco abstinence, and assessing the effectiveness of delivering behavioural support through the use of mobile telephones (Clinical Trials Research Unit, 2008). The research projects at CTRU and NAC build on emerging theories about treatment practices, such as that of Renee Bittoun (2006), a leader in the cessation field in Australia, who advocates creative approaches for hard-to-treat chronic relapsing smokers.

At the ATCRC there is considerable focus on ethnic and socio-economic smoking prevalence disparities, and 'at-risk' groups, such as expectant mothers and youth. Other research seeks the attitudes

and awareness of treatment options amongst health professionals (Auckland Tobacco Control Research Centre, 2006).

The research projects at NAC, ATCRC, and CTRU foreshadow the cessation service enhancements that may become available in New Zealand. To summarize, for the most part, as the historical overview showed, the direction of tobacco control in New Zealand is led by international trends, with local research initiatives sharpening New Zealand tobacco control and particularly cessation services.

### *Services*

Complementary therapies such as hypnotherapy and acupuncture are regarded as unproven, possibly no better than making an unassisted attempt - going 'cold turkey' (Abbot, Stead, White, & Barnes, 1998; The Cochrane Library, 2008; White, Rampes, & Campbell, 2006). This is partly because these therapies are seldom tested with the rigor required the Cochrane Tobacco Addiction Review Group, which favours randomised, controlled, before-and-after testing (Abbot et al., 1998; Lancaster et al., 2009; White et al., 2006). The Ministry of Health selectively funds cessation services on the basis of empirical evidence-based research, and the Cochrane Reviews are frequently cited to support claims of treatment effectiveness. (See Appendix B.)

The Ministry of Health has four channels for cessation treatment services: The Quit Group, Aukati Kaipaipai, Pacific Islands Heartbeat, and District Health Boards (DHB). Until recently DHB's have mostly focused on helping in-patients manage their stay in the smoke-free hospital environment by providing NRT. Since late 2007 all health care workers have been expected to follow the 'ABC' protocol laid out in the *New Zealand Smoking Cessation Guidelines* developed through the CTRU (Ministry of Health, 2007a). Health care workers must:

- **A**sk about and document smoking status for all people;

- **B**riefly advise that stopping smoking is in their best interests;
- And refer all would-be-ex-smokers for evidence-based **C**essation treatment and support.

Further, DHB's are developing smoke-free policies in relation to their mental health facilities (Beverley, 2008), where co-morbidities commonly include nicotine addiction. This is a significant challenge because cigarettes have historically been a form of currency in mental health institutions, both between patients and also between caregivers and patients (Wallace-Bell, 2008).

Pacific Islands Heartbeat Programme (PIH) is part of the National Heart Foundation, and the development of a Pacific tobacco control strategy is one of its functions. The underlying principal of having a distinct strategy is that Pacific people know best how to address and deliver tobacco control to other Pacific peoples, thus their mantra 'By PI, for PI'. In his address to the National Tobacco Control Hui in June 2008, PIH director Haikiu Baiabe noted the inadequacy of the ABC protocol for Pacific Islanders: "We don't visit the doctor until we're nearly dead; and (even) then we pray for a miracle". For Baiabe, "talking briefly is a contradiction in terms": communication is nuanced and nothing can be dealt with "briefly". Further, Baiabe claims, the ABC protocol assumes an egocentric gaze which is not appropriate amongst Pacific peoples. Particularly, the "best interests" of the individual are not necessarily the shared priority of the social group. Consequently, quitting smoking may not have the priority it might (ideally) hold for one whose main concern is for oneself. The PIH provides cessation services to individuals, and also works closely with the church, which is a major influence amongst people from the Pacific (Baiabe, 2008).

Aukati Kaipaipai (AKP) provides cessation support 'by Māori, for Māori' through face-to-face counselling coupled with NRT at no charge. This service arose after a trial in 1999, which delivered NRT and also behavioural cessation support to Māori women (Ministry of

Health, 2003). In its expanded form, the service is available to Māori women and their families, with treatment expected to last about eight months. AKP also supports and assists marae to become smoke-free.

The Quit Group is a charitable trust which aspires "to be a national leader in smoking cessation for Aotearoa/New Zealand, with effective help available for people to successfully quit smoking" (The Quit Group, 2008). It assumes that people can achieve full and permanent cessation through "the right attitude and support" (Glasgow, 2008). In real terms, this amounts to the desire to quit, supported by an eight-week supply of a nicotine replacement therapy and three follow-up telephone calls from the Quitline.

As well as running Quitline, The Quit Group operates a cessation service website and a text-message service. It also contributes to the demand reduction strategy through anti-smoking campaigns, including threat appeals designed to prompt calls to the Quitline. Quitline data analysis demonstrates that depictions of novel forms of smoking related illness, such as blindness, stroke, and oral cancer generate more calls than other advertising campaigns (Wilson, 2004). Call volumes are a significant indicator of success for the service, and are a focus of their evaluation reports to their major funding provider, the Ministry of Health (for example, see The Quit Group, 2005).

Of the four cessation treatment delivery agencies, only The Quit Group has an internal research unit. However, most of its research outputs are quantitative, interrogating the Quitline database, focusing on service use by demographic and ethnicity indicators. For example the *Evaluation of the Quitline NRT Programme* (The Quit Group, 2005), gives a demographic breakdown of callers and highlights the Quitline telephone operators as outstanding, friendly and supportive. Quantitative reports use the language of mathematics and logic, using statistics to convince the audience of effectiveness. A major limitation of this approach is that "we cannot

understand the inner lives of people and the meaning they attach to their lives, actions and existence" (Gustavsson, 2007, p. 7). A subjective leap is required to measure motivation to quit, or reaction to relapse.

Regarding treatment effectiveness, The Quit Group is required to carry out its research in a timeframe too short to demonstrate full remission. Short-term research is suited to treatments that effect rapid change, but is unsuitable for addiction treatments, because of the frequent and repeated relapse experiences known to beset behavioural change associated with addiction (Orford, 2007, pp. 876-877). Further, The Quit Group assesses the success of its treatments through point prevalence abstinence: "self-reported quit (not smoked for previous two days)" (The Quit Group, 2005, p. 4). The claim made in the *Evaluation* (2005b) that almost 20% of callers who receive the full intervention are not smoking twelve months later, is not claiming a period of twelve months sustained abstinence. Rather, respondents have made a non-verified self-report of not smoking in the previous two days. This highlights a shortcoming in the cessation treatments effectiveness literature, not just in New Zealand but world-wide. There is no standard definition of how long one needs to have abstained in order to count as an ex-smoker.

### Assessing effectiveness

Within the tobacco control domain there is increasing awareness of inconsistencies in the use and definition of key terms. This makes it difficult to compare data from nations with similar tobacco control environments. The Quit Group has attempted internal consistency and external transparency vis-à-vis becoming an ex-smoker through its document *Defining Quit* (Woodward, 2004). Further, a Ministry of Health (2008b) technical report highlights the variations in terms and definitions relating to 'smoker status' used by three major data gathering surveys (the Census, the New Zealand Tobacco Use Survey (NZTUS) and the New Zealand Health Survey). Such surveys are

interested in how many people smoke and how many have stopped. Their definitions are compared with those from comparable surveys in Australia, Canada, the United Kingdom and the United States of America. None of these nations qualifies the ex-smoker status through a defined period of tobacco abstinence. For survey purposes, one shifts from smoker to ex-smoker simply by declaration.

As well as the difficulties deciding who counts as an ex-smoker, there are inconsistencies in who counts as a current smoker, with the New Zealand surveys and their international counterparts using different parameters:

- New Zealand includes those aged 15 to 65 years who smoke at least once a month;
- Australia and the USA include those 18 years and over who smoke at least weekly;
- The UK includes those 16 years and over who smoke every day; and
- Canada includes those 12 years and over who smoke daily or occasionally
  (Ministry of Health, 2008b).

The DMS-IV-TR (American Psychiatric Association, 2000) offers a solution to this confusion, but for reasons that have not emerged through this research, the DMS definition of progressing from dependence to sustained remission over a twelve-month period, illustrated below in Figure 2, has not been adopted by the tobacco control domain.

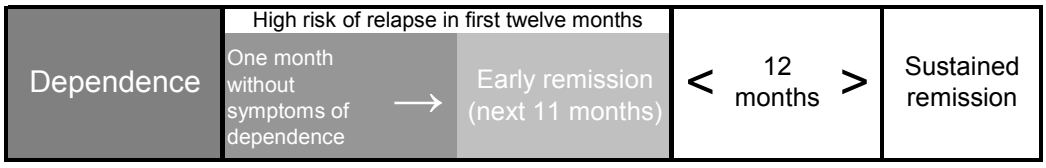



**Figure 2: The path from dependence to sustained remission (American Psychiatric Association, 2000, p. 195)**

To return to the problem of defining the smoker status of ex-smoker, considered in terms of the definition used by the New Zealand government, the use of point-prevalence rates by The Quit Group is problematic. In publishing its technical report the Ministry of Health has brought attention to the need to carefully consider such data, keeping in mind the limitations that background its production, and the potential for confused readings of seemingly straightforward data.

## Approach effectiveness

Despite the broad application of three strategies to reduce smoking prevalence – demand reduction, supply regulation, and treatment provision – it is not clear that the overall approach is effective. A decline in smoking prevalence requires either a significant reduction in uptake and/or a significant increase in the number of life-long ex-smokers. Regarding smoking uptake, The Quit Group cite a Health Sponsorship Council estimate that 19,000 New Zealanders, 90% of whom are children and young people, take up smoking each year (Health Sponsorship Council 2002 Smoking in New Zealand - Tobacco Facts and Figures, in The Quit Group, 2004, p. 2). More recently the Cancer Society has claimed that 8,000 New Zealanders under the age of 16 start smoking each year, with the average age at uptake being 14 years (Kelly, 2008, p. 1). If both statistics are correct,[iii] about 11,000 people aged 16 to 19 take up smoking each year. On the basis of published data (see Appendix C), I have calculated that each year about 6,250 New Zealanders become life-long ex-smokers and about 4,700 smokers die each year from a smoking-related illness (Ministerial Committee on Drug Policy, 2007, p. 25). On these bases, uptake continues to exceed the quit rate plus mortality rate even when under-age smokers are excluded from the equation. This raises questions about the claim that smoking prevalence has dropped below 20% (Ministry of Health, 2008c).

The New Zealand definition of current smokers includes those aged 15 to 65 years – despite the average age at uptake being approximately 14 years (Ministry of Health, 2007b). Further, the Ministry of Health claim that a relatively small proportion of the smoker population is over 65 years (2008b, p. 9). However, this is at odds with mortality rates. As Figure 3 illustrates, half the life-long smoker population die from smoking-related illnesses, and the age at death is evenly split between those 69 and under and those 70 years plus (Bloomfield, 2008; Ministry of Health, 2008a; Peto et al., 2006).

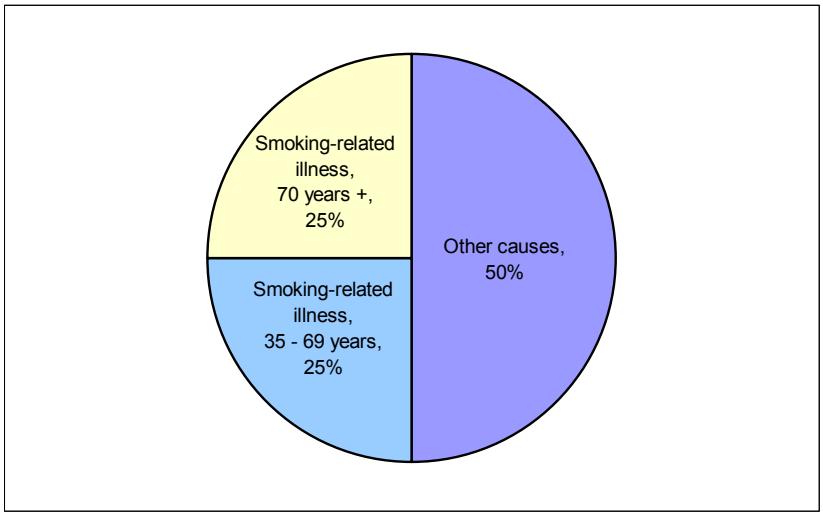



**Figure 3: Life-long smokers: how they die, by age**

A World Health Organisation breakdown of the cause of death data for New Zealand in 2000, presented by Peto et.al (2006, pp. 350-361), includes the proportion of New Zealanders who die from smoking-related illnesses. Peto et al. found:

- Only a very small proportion of New Zealanders die aged less than 35, and the proportion of these who die from a smoking related illness is too small to reliably estimate.
- About 20% of those who die in mid-life (35 – 69 years) die from a smoking-related illness.
- Almost 80% of New Zealanders live until at least age 70, and then about 20% of males and 13% of females die from a smoking-related illness (Peto et al., 2006).

Those who die in mid-life differ from older people who die from smoking-related illnesses in that the estimated mean years lost through premature death is 23 years compared to eight years for those aged 70. There is no clear reason for including the 70+ age group in the smoking-related death statistics yet excluding them from the smoking prevalence statistics. However, public health advocate Simon Chapman points out that "governments, having an interest in the relationship of health to *economic development*, will want to reduce smoking to reduce the costs [to society] of smoking" (2007, p. 20 emphasis added). With this in mind, it is noteworthy that for the mid-life demographic group, the bulk of the 23 years 'lost' might otherwise have been economically productive, while those over 70 are more likely to have retired. Taking a pragmatic view, it is not economically logical to consider the smoking behaviours of those aged 70+ as part of the problem of smoking, if the problem is that premature death negatively impacts economic development and productivity. With an average of eight economically unproductive years left to them, older smokers offer little return on investment in comparison to potential workforce participants. This may explain the choice to exclude those over 65 years of age from the definition of current smokers, which has the effect of reducing the size of the official current-smoker population.

### Nicotine replacement therapy effectiveness

The Ministry of Health claims NRT to be twice as effective as unassisted or cold turkey quitting, but the Cochrane Nicotine Addiction Review Group is less generous, finding NRT to increase the quit rate by 50% to 70% (Ministry of Health, 2007a, p. 12; Stead et al., 2008). NRT aims to reduce nicotine withdrawal symptoms by delivering small quantities of 'clean' nicotine – without the carcinogenic properties of tobacco-delivery. By alleviating withdrawal symptoms, the transition to a smoke-free future is expected to be less traumatic (Lancaster, Stead, Silagy, & Sowden, 2000; Stead et al.,

2008). The New Zealand government has heavily subsidized some forms of NRT since November 2000, but less than 25% of people prescribed NRT through Quitline complete the eight-week treatment. Of those who did complete the treatment, point-prevalence reporting at twelve months showed that 18% had not smoked in the previous two days (The Quit Group, 2005). By applying these figures, the effectiveness of the treatment becomes clear. Of 100 Quitline callers, 25 people used the treatment as prescribed, and about five were smoke-free for the two days prior to being interviewed approximately one year later. Thus, the lived experience of New Zealanders using the Quitline is in accord with the Cochrane Nicotine Review Group findings: NRT improves the chances of quitting by about 50% to 70%, or in real terms, from 3% for unassisted quitting, to 4% to 5% for NRT assisted quitting.

NRT is not very effective, even when it is used as directed. Anecdotally, it appears even less effective because only a quarter of users complete the treatment. Transdermal NRT patches provide slow-release nicotine, while other forms provide acute nicotine delivery, giving a 'nicotine hit'. In practice, the nicotine hit is much slower than that received from cigarette inhalation. Cigarettes deliver nicotine to the brain in about ten seconds, (Gwinnell & Adamec, 2006, p. 175; The Quit Group, 2004, p. 1), while NRT gum takes about fifteen minutes to provide its full effect and patches take eight to ten hours to be delivering at their peak (Bittoun, 2008). NRT also delivers a considerably milder dose of nicotine than a cigarette, providing 10% of the nicotine a deep-inhaling smoker is accustomed to, resulting in very low levels of nicotine (Bittoun, 2008). A reasonable comparison would be an espresso made with a single coffee bean.

The 'low and slow' delivery of NRT makes it difficult for many would-be ex-smokers to use the products to their best effect, because people must anticipate their needs, preventing the craving from taking hold

rather than attempting to dull it in full flight. When needs are not anticipated, cravings are interpreted as the product not working and it is consequently abandoned. At the other end of the spectrum, would-be ex-smokers who use the products effectively often interpret the lack of intense cravings as evidence that quitting is easy and NRT is not necessary – followed by relapse, usually within a fortnight. These scenarios explain why three-quarters of those supplied with NRT do not complete the eight-week course. Such instances are very common amongst would-be ex-smokers and arose repeatedly at the National Tobacco Control Hui, prompting international cessation experts Saul Shiffman and Renee Bittoun to reiterate that NRT products are not an instant cure, but they do no good at all if left in the box (Bittoun, 2008; Shiffman, 2008). To return to the earlier example, if the 100 Quitline callers all used the full eight week course, it is possible that four times as many people would self-report as smoke-free twelve months after their quit-date. This is significantly better than the present figures suggest.

### *Addiction: a biological and physiological overview*

A second master narrative apparent in the literature relates to the biological and physiological aspect of smoking and cessation: nicotine addiction. Nicotine is highly addictive and is responsible for the addictive nature of cigarette smoking (Gwinnell & Adamec, 2006, p. 175; U.S. Department of Health and Human Services, 1988, p. 9). Nicotine is more addictive than alcohol, cocaine or heroin. About 15% to 20% of people who try these substances become addicted. However, over 30% of those who try tobacco become addicted to nicotine (Glover, 2006, p. 8). Further, anecdotal reports from people with co-dependencies suggest that giving up nicotine is more difficult than giving up other addictive substances (Glover, 2006, p. 8).

Scientific knowledge about the physiology of addiction is relatively new and adds a further layer of complexity to the understanding of

cigarette smoking: “Until 15-20 years ago, the concept of nicotine receptor sites in the brain was a relatively unknown phenomenon” (Glover, 2006, p. 8). Nicotine addiction occurs when neural receptors respond to nicotine in maladaptive ways. First, they multiply, and those who smoke can have 100 to 300 times more nicotine receptors than non-smokers (Glover, 2006, p. 8). Second, they stimulate the production of noradrenaline and dopamine, “the master addiction molecule” (Glover, 2006, p. 9). Moderate, stable levels of dopamine are necessary for experiencing pleasure, pain, elation and reward; while an oversupply can lead to addiction and behavioural disorders (Glover, 2006, p. 9). Noradrenaline is necessary for alertness, concentration, and memory. Consequently, when a person dramatically reduces their nicotine intake, the accustomed heightened level of noradrenaline decreases to its unstimulated level, leaving them drowsy, lacking concentration, and forgetful – some of the symptoms of nicotine withdrawal identified in the DSM. By stimulating an overproduction of dopamine and noradrenaline, nicotine negatively impacts the structure and function of the brain, and has been described as “a leading mental disorder of our age” (Sellman, 2005, p. 848). The consequence of nicotine addiction is that despite *knowing* one wants to quit, transforming this desire into practice requires more than making a conscious decision to act in a different way. Improved assistance with quitting may be on the horizon. Researchers have demonstrated that blocking the nicotine receptors dramatically reduces the motivation to smoke (Hollander, Lu, Cameron, Kamenecka, & Kenny, 2008, p. 19483).

### Addiction and stress

Many smokers claim that smoking relieves stress. However, Gwinnell and Adamec (2006, p. 175) claim that anxiety and stress impact how the body reacts to nicotine and, as a result, more nicotine is needed to achieve the accustomed effects of elevated levels of dopamine and noradrenaline. In support of this, the Behavioural Neuroscience

Branch at Maryland (Wang et al., 2005) found that rats in remission from addictive substances "return to, and press selectively, a lever that had been previously (but not recently) associated with rewarding … [addictive substance] injections" (Wang et al., 2005, p. 5393). Post-mortem analysis showed elevated levels of dopamine in comparison to the control group. The report concludes: "Our most important finding is that [addictive substances] cause a long-lasting neuroadaptation … that predisposes stressed animals to relapse" (Wang et al., 2005, p. 5394). The findings are applicable to numerous addictive substances including nicotine and demonstrate "that stress can interact with the dopamine system … [suggesting] a link between stress mechanisms and drug reward mechanisms that has long been suspected but not, until now, identified" (Wang et al., 2005, p. 5395). This explains how people experience comfort as a consequence of smoking, and provides a physiological explanation for why would-be ex-smokers crave nicotine when they become distressed. It links strongly to Glover's explanation of the role of dopamine in nicotine addiction (Glover, 2006).

## Priming

An adage amongst chronic relapsing smokers and ex-smokers is that it takes just one cigarette to return to smoking. This experience has now been explained through physiology. For 80% to 97% of people who have quit or are quitting, the effect of a single cigarette is that they will return to regular smoking within a week (Juliano, Donny, Houtsmuller, & Stitzer, 2006). The brain is 'primed' by the lapsing cigarette, resulting in a return of nicotine seeking cravings, virtually returning the would-be ex-smoker to the earliest days of their quit attempt. The priming effect is evident with nicotine and other addictive substances, and has been demonstrated in human testing (Juliano et al., 2006, pp. 166-167). In their study, which included a controlled lapse after four days of abstinence for two-thirds of the participants, Juliano et al. (2006) supplied half of the 'lapsing' subset

with nicotine-free cigarettes. There was little difference in the likelihood of relapse between those who lapsed with nicotine and those whose lapse was of the nicotine-free variant. Juliano et al. conclude that the addictive substance is not the only thing at work in bringing about relapse after a lapse incident. Reinforcing conditioned expectations also plays an important part in bringing about relapse, especially early in the quit attempt.

The literature about biological and physiological influences on the quest to quit has shown that these factors can play an important part in the cessation—relapse cycle for people who are addicted to nicotine. Advancing knowledge about how addiction comes about and operates in a physiological sense is beginning to influence treatments, and may eventually allow would-be ex-smokers to better manage the disturbing effects of withdrawal. Folk wisdoms such as the impacts of stress and the lapsing cigarette are now being scientifically explored and influencing treatment approaches.

### *Willpower and weakness: self-efficacy*

A third master narrative is apparent in qualitative research which seeks the smokers' point of view: willpower versus weakness (for example, see Lennon, Gallois, Owen, & McDermott, 2005, p. 1352; Wood, France, Hunt, Eades, & Slack-Smith, 2008, p. 2384). The willpower master narrative posits that smokers could quit if they *really* wanted to; consequently chronic relapsing smokers see themselves and are seen by others as not *really* wanting to quit.

Willpower is associated with self-efficacy. According to Bandura (1998) 'self-efficacy' refers to "*beliefs in one's capabilities* to organize and execute the courses of action required to produce given levels of attainments" (p. 624 emphasis added). My emphasis highlights the key phrase linking this quotation to 'willpower', and the following quotation reinforces this.

> Efficacy belief is a major basis of action. Unless people believe they can produce desired effects by their actions, they have little incentive to act. … Belief in the power to produce effects determines how long people will persevere in the face of obstacles and failure experiences, their resilience to adversity, whether their thought patterns are self-hindering or self-aiding, and how much stress and depression they experience in coping with taxing environmental demands (Bandura, 1998, p. 624).

Self-efficacy develops through mastery, positive vicarious experiences, supportive others, and maintaining a positive emotional stance toward the goal. Self-efficacy diminishes through despondency, discouragement, negative vicarious experiences, and the failure to meet goal-related objectives (Bandura, 1998, pp. 624-626). Addiction recovery complicates self-efficacy, because one of the "obstacles" is a maladaptive physiology. Gwinnell and Adamec (2006) have recognised that self-efficacy is different when the desired effect is recovery from an addiction. Addiction recovery requires self-efficacy enhanced by an acknowledgement of the destructiveness of the addictive behaviour; a strong desire to change that behaviour; and a willingness to act in order to achieve the goal (Gwinnell & Adamec, 2006, pp. xix-xx).

Even armed with an enhanced self-efficacy, the quitting period can also be extensive because physiological maladaptations prompt a return to substance seeking, or cravings, when particular stress conditions arise, as demonstrated by Wang, et al. (2005). Further, the ability to attain and maintain sufficient enhanced self-efficacy to achieve a permanently smoke-free future can be seriously undermined by stigmatization, especially if stigma is internalised, impacting self-identity (Corrigan & Calabrese, 2005, p. 239).

Room (2005) has argued that stigma contributes to adverse outcomes experienced by members of stigmatized groups where stigma relates to what he calls "heavily moralised" problems, including tobacco, alcohol and illicit drugs. In western societies users of psychoactive substances are generally regarded as personally accountable for their

vice or moral weakness and thus undeserving of sympathy and support. Room concurs with Durrant and Thakker (2003), that addiction is considered deviant and associated with weakness of character. He cites Olsen et al. (2003), who reviewed six studies from Britain, the United States, and Australia which asked about prioritising health care services on bases such as social role, lifestyle choices, and embodied characteristics. Being a smoker is the characteristic most likely to warrant lower priority for health care. In an Australian study (Nord, Richardson, Street, Kuhse, & Singer, 1995) 65% of participants favoured prioritising non-smoker health-service users ahead of smokers (Olsen et al., 2003, p. 1165). Luoma et al. (2007, p. 1332) have shown that individuals who apply stigmatizing attitudes to themselves are likely to assess themselves as less-worthy of treatment compared to those who deflect stigma. This decreases the likelihood that they will access services which may assist them to overcome the stigmatising condition. People who are blamed for their condition have lower self-esteem and therefore less self-efficacy than people who attribute their situation to circumstances beyond their control (Amato & Crocker (1995), cited in Watson & River, 2005, p. 152). Therefore, messages about smokers and smoking have implications for the self-esteem of those who smoke, because of the impact on self-efficacy.

There is a growing pool of literature about stigma in relation to mental illness and the concurrent use of illicit substances (for example, Corrigan & Calabrese, 2005; Luoma et al., 2007; Peterson, Barnes, & Duncan, 2008). However, despite studies such as Olsen et al. (2003) and Nord et al. (1995) demonstrating the stigmatization of those who smoke, the idea that smokers are stigmatized is not widespread in the tobacco control domain. Those who have addressed it preface their concerns in somewhat apologetic terms. A British study points out that the shared project of biomedicine and public health "rightly intends [to] … rid the body (both individual and

social) of disease, … [but the approach results in the] stigmatisation of marginalised groups who are considered to be 'unhealthy' or 'risk takers'," (Laurier et al., 2000, p. 153). Locally, a New Zealand research report notes that:

> While we are broadly sympathetic with anti-smoking strategies, we are concerned that the tendency to stigmatise smokers will … produce either active resistance or a sense of helplessness, (Thompson et al., 2007, p. 514).

As these examples show, when stigmatising effects are recognised, they are uncomfortably juxtaposed against the established and over-riding goal of creating smoke-free people and places.

The literature shows self-esteem to be important to smoking cessation, especially if stigmatizing beliefs have been internalised, causing a loss of self-efficacy. While willpower seems like a matter of personal inner resource, it is significantly influenced by factors beyond the control of the individual.

### Qualitative studies of smoking and cessation

According to Bott, Cobb, Scheibmeir and O'Connell (1997), "despite the vast literature on smoking cessation, no study actually describes this experience from the perspective of the subject," (p. 258). My search for more recent literature focusing on the point of view of the would-be ex-smoker located some studies, but the proportion remains extremely small. The paucity of literature extends to New Zealand, as was evident in a search of the National Library database, Te Puna. Various search field combinations were used, (abstract, keyword, subject, and title) to locate literature published in 2000 or later, including the terms 'New Zealand', 'cessation', 'quit?', 'smok?', 'tobacco', 'nicotine'. Twenty-five unique titles were returned.

- Twelve focus on ethnic minorities, usually Māori;
- Nine report on cessation treatment trials or services;

- Six are clinically-based, focussing on smoking prevalence as well as the biological effects of smoking and cessation;
- Four focus on policy or politicians;
- Three are concerned with mental health co-morbidities;
- Three focus on the tobacco industry;
- Three profile tobacco control personalities;
- Two look especially at female smokers; and
- One is historical.

New Zealanders who smoke were the focus of just one article: *Moralising Geographies: Stigma, Smoking Islands and Responsible Subjects* (Thompson et al., 2007). Smokers living in socio-economically deprived areas are argued to be doubly stigmatised by being both poor and a smoker. Anti-smoking messages are sometimes interpreted as stigmatizing, and when addiction prevents compliance with the social expectation to quit, smokers become increasingly resistant to such messages. The same resistance was found in Aberdeen by McKie et al. (2003), where participants represented a cross-section of socio-economic groups. Resistance was explained in terms of the self:

> Pressure to change incurs resistance, which is about more than behaviour, it is about habits as a key mechanism of self-continuity. Requests from others to remove an important part of the sovereign self are thus dismissed as beyond their jurisdiction (McKie et al., p. 91).

Internationally, most of the literature presenting the smoker's point of view focuses on at-risk groups, such as ethnic minorities, adolescent smokers, pregnant women or their partners, or people experiencing a particular smoking-related illness. Five studies were located that did not focus on an at-risk group. One addressed

smoking (Laurier et al., 2000 and also McKie et al., 2003), three addressed quitting (Bott et al., 1997; Cobb et al., 1997; Vogt, Hall, & Marteau, 2008), and one addressed being quit (Hänninen & Koski-Jännes, 1999). The paucity of literature from qualitative studies where the participant characteristics matched those in my study caused me to broaden the review. Also included is literature from sites contemporaneous with New Zealand where an at-risk group is the focus and the methods of data collection or analysis were similar to my research.

Ten people who were trying to quit participated in a pilot study which thematically analysed interview transcripts to "identify the language people who are attempting to quit use to describe their coping strategies when faced with the urge to smoke" (Bott et al., 1997, p. 258). Participants "emphasised the importance of mental preparation for success" (Bott et al., 1997, p. 267). Smoking cessation advocates and health professionals who hold the view that "people who smoke do not have the willpower or are too weak to quit" (Bott et al., 1997, p. 265) were considered unhelpful. Instead, Bott et al. assert, health professionals need to acknowledge that quitting is difficult and reassure would-be ex-smokers that positive aspects of an unsuccessful quit attempt can be carried forward, making the next attempt more successful (Bott et al., 1997, p. 265).

The above pilot study was followed by an attempt to capture the lived experience of the early days of a quit attempt. Participants were given a hand-held audio device to record "their thoughts feelings and actions every time they had a coping episode" (Cobb et al., 1997, p. 703) for three consecutive days within the first ten days of their quit attempt. Taxonomies of coping strategies were created by thematically analysing the transcribed entries. People used both cognitive and active coping strategies to attempt to prevent cravings from arising, to manage a craving once it took hold, and to get back on track when they lapsed. The study concluded without considering

the success or otherwise of the quit attempts, and did not compare the strategies of people who were quitting unassisted and those who used a cessation service or treatment.

Ex-smokers from Finland wrote about their experiences of quitting. Stories were written in the third-person by people who had attained at least three years abstinence. These narratives told of enhanced self-respect, with willpower being the major reason for success. Mastery stories were "almost exclusively used by ex-smokers" (Hänninen & Koski-Jännes, 1999, p. 1845), suggesting this narrative form has particular features that allow the narrator to express their story in a way that is personally satisfying. Nicotine was cast in the role of protagonist, and victory resulted in glory and self-respect.

Late in the 1990s, researchers at the University of Aberdeen sought the perspectives of ex-smokers and smokers on smoking and quitting (Laurier et al., 2000; McKie et al., 2003). Semi-structured interviews were held with 54 participants, aged from 18 to 44 years, who were recruited on a mixed-gender basis across the spectrum of socio-economic groups. The findings show that quit attempts often relate to the purposes fulfilled by smoking, such as cementing a group – fitting in, for example, and caring for oneself – such as stress relief. Willpower explains a lot, with success demonstrating its presence, and failure demonstrating its absence. In addition to having the requisite willpower, timing of a quit attempt was also important. Quit attempts often coincided with positive life-changes, while relapses often occurred in periods of distress. However, for each there is an accompanying opposite, with a deep sense of loss usually accompanying the quit attempt, while relapse was often marked by relief (McKie et al., 2003, p. 89). Participants' smoking histories showed uptake to be associated with asserting independence, signifying being in control rather than being under the control of others. Realising one has become addicted turns this about-face. That which signified being in control has now taken control.

Completing the circle, achieving complete sustained remission from nicotine addiction returns the feeling of control (Laurier et al., 2000; McKie et al., 2003), and this ties in well with the third-person narratives analysed by Hänninen & Koski-Jännes (1999).

In Australia 25 men aged 20 to 53 years were interviewed after participating in a self-help smoking cessation programme as part of their partner's ante-natal care. The research sought predictive patterns to successful cessation. Three indicators were identified, including the level of reflexive awareness of their smoking behaviour, the optimism or expectation of success, and the level of addiction. The study concluded that about one third of participants had quit smoking. However, the period of abstinence is not specified and one person is noted as having quit on the day of the interview (Moffatt & Whip, 2004, p. 104). This illustrates the problem of variable criteria for attaining a smoking status of 'ex-smoker'. Applying the status of ex-smoker on the first day of a quit attempt is optimistic given that 50% of spontaneous quitters relapse in the first week (Bittoun, 2006). This example illustrates the problems arising from the diverse definitions of smoker status used within the tobacco control domain.

Female smokers and ex-smokers aged 16 to 28 years living in Queensland, Australia, were interviewed to gather smoking histories – including uptake, the perceived benefits of smoking, and quit attempts and eventual cessation (where applicable) (Lennon et al., 2005). Willpower was considered the most important factor when trying to quit: "only people who really wanted to quit could do so" (Lennon et al., 2005, p. 1352). Quitting was so difficult that it was almost "insurmountable" (Lennon et al., 2005, p. 1352). Previous failed attempts and an increasing awareness of being addicted led to "the too hard basket" (Lennon et al., 2005, p. 1352 (quoting a participant)). These findings relate well to self-efficacy, with willpower as an aspect of belief, and the "too hard basket" being a strong

indicator of reduced self-efficacy, with despondency being a reaction to previous failures.

Interviews were carried out with 22 current and former smokers, aged approximately 70 years, who have a diagnosis of chronic obstructive pulmonary disease (Schofield, Kerr, & Tolson, 2007). Reasons for continuing to smoke included a belief that smoking helped breathing. A productive cough was preferable to hard-to-shift phlegm, an argument supported by assertions that friends who had given up were now all dead. Further, they "did not have the necessary willpower," (Schofield et al., 2007, p. 1732), despite many having repeatedly tried to quit using NRT and other cessation treatments. The researchers concluded that health professionals need to be better acquainted with the beliefs of older smokers regarding smoking so that behavioural change can be initiated.

The perspectives of Aboriginal women to smoking during pregnancy were sought through in-depth interviews and focus groups in a study by Wood et al. (2008). Some women found it easy to stop smoking whilst pregnant, but for most this was not a priority. The women considered smoking reduced their stress by providing opportunities for relaxation and camaraderie. Wood et al. noted "a reoccurring sentiment … that giving up smoking is hard, and for a person to quit, they had to have determination and willpower" (2008, p. 2384).

Most recently, social cognitive theory has been used to make sense of why smokers resist using nicotine dependence medications when they are trying to quit (Vogt et al., 2008). This multiple-method research commenced with semi-structured interviews of 27 Londoners. The second phase surveyed 212 smokers from various English cities, with the sample being representative of smokers in terms of age, gender and social class. The questionnaire was based on three themes that emerged through the interviews: access to

treatment; side-effects; and effectiveness at reducing or preferably eliminating cravings, which was

> judged in relation to willpower to stop smoking. Smokers thought that willpower to stop smoking was a crucial determinant of resisting temptations and becoming a non-smoker (Vogt et al., 2008, p. 1407).

Self-efficacy was higher amongst people who held a high expectation that the cessation treatment would successfully control their cravings. However, some smokers have "unrealistically optimistic expectations" (Vogt et al., 2008, p. 1411) of medical cessation treatments, leading to disenchantment and despondency.

The literature that considers smoking and cessation from the point of view of the smoker consistently highlights the perceived need for willpower in order to permanently stop smoking. Not all smokers are would-be ex-smokers, but those who seek to quit are often underwhelmed by the cessation support available, both through health professionals and through pharmaceuticals.

### *Summary*

From the cost narrative, a pragmatic, medicalised basis for tobacco control has emerged. Smoking-related illnesses are costly to society in terms of treatment and care, and also through lost opportunity costs, when the workforce is reduced through smoking related illnesses and premature death. Therefore smokers should quit for the benefit of society. The cost to society is projected back onto the smoker, attempting to make smoking unattractive through taxation and through threat appeals, which reinforce the potential for missing out on the joys of later life through premature death. From the biological point of view, the literature connects nicotine addiction with physiological maladaptations, and this acknowledges the difficulty addicted smokers experience when attempting to quit. Smoking uptake is consequently dissuaded, and cessation treatments are emerging. Nevertheless, youth continue to take up

smoking and smokers often reject pharmaceutical cessation treatments, illustrating the third narrative which suggests that smokers do not *really* want to quit. From this point of view, the literature shows that smokers consider willpower is most important to quitting, and this is matched by a corresponding view of smoking as a vice, with smokers lacking strength of character.

# Research Methodology

This thesis contributes to a limited pool of literature, because it explores how would-be ex-smokers make sense of their experiences within the cessation—relapse cycle. From my point of view the ideal way to carry out such an exploration is to interact directly with people who are in the midst of the experience. The interactionist approach I favour is based on a distinct trail of ontological and epistemological assumptions, and opens the way to a variety of data gathering and analysis methods. Together, these form the research design. In this chapter, I explain the logic behind my choices and how I enacted these assumptions and methods.

## *Ontology and social science*

Ontologies make claims about the nature of reality, defining the scope of "what kinds of things do or can exist, the conditions of their existence, and the way they are related" (Blaikie, 2007b). From a social science perspective, ontological claims are considered for what they say about the nature of *social* reality. Two opposing positions, each with multiple variations, dominate ontological theories about the nature of reality: materialism and idealism. One important difference between these ontologies is the conflicting understandings about culture. From a materialist point of view, culture exists independently of a need for human recognition, working as a social constraint on human action (Blaikie, 2007b). Materialism also claims that natural phenomena behave in much the same way. Thus, the same logic or strategies used for non-human phenomena are appropriate for the study of human social reality (Blaikie, 2007a, p. 32, 2007b; Polkinghorne, 1988, p. 159).

On the other hand, from the idealist perspective, culture constitutes an insurmountable difference between human societies and non-human life-forms or phenomena. Culture is especially relevant to the social science perspective of idealist ontology because this is the

mechanism for transmitting shared meanings and knowledge between individuals and across generations. Cultural transfer is significantly achieved through language. Further, we use language to construct plans in the imagination, allowing us to interpret without doing, using conscious intention and reflexive thought to ask "What if …" (Johnson, Dandeker, & Ashworth, 1984, p. 76). Our capacity for intentionality and reflexivity distinguishes human beings from non-human entities, and thus "when social scientists come to the systematic study of social life, they encounter a subject-matter which already has an understanding of itself" (Benton & Craib, 2001, p. 29).

Selecting idealism to ground the philosophical assumptions supporting this research is significant in two related ways. First, idealist ontologies support the stance that multiple social realities can exist within a single social context, and this is my contention. With this in mind, it makes sense to conduct social science research by listening to what people have to say, as their point of view is grounded in their social reality. As Blaikie (2007a) asks: "how else *can* we find out about the socially constructed world they inhabit?" (p. 45 emphasis added). Second, my perspective on the importance of culture and its transmission is aligned with the idealist view of culture. To overlook the way in which humans make meaning ignores the complex intelligence necessary to generate and sustain culture on the scale that exists in human societies, and this is what shapes social realities. This supports my assertion that knowledge about the issues of smoking cessation will be more productively advanced when the research framework assumes that people in the midst of the experience have a valuable contribution to make to the discussion.

### *Epistemology and social science*

Empiricism and rationalism are the epistemologies that dominated scientific thought from the 16$^{th}$ century (Benton & Craib, 2001; Blaikie, 2007a). A core assumption of empiricism is that knowledge is

produced through use of the human senses, particularly observation and experience (Blaikie, 2007a, pp. 19, 20). In contrast, rationalism was influenced by mathematics, which, through formal reasoning, provided indisputable answers (Benton & Craib, 2001, p. 3). The common physical structure of the human brain was considered to demonstrate that humans share formal reasoning processes, therefore producing consistent knowledge, or in the case of human society, common social laws. Both empiricism and rationalism claim to produce absolute knowledge, and this sets up an important contrast with a third epistemology: social constructionism. In social sciences, epistemological assumptions address the matter of how to best acquire knowledge of social reality, and social constructionism claims to produce knowledge that is relevant to its social context (Blaikie, 2007a, p. 24).

Social constructionism considers human life as "a life of meaning, of language and reflective thought and communication" (Benton & Craib, 2001, p. 75). People apply socially and culturally contextual rationale to their reflexive thought. Therefore it is not so much *the experience* that matters (empiricism) as what we *make of* the experience: the reasoning that we apply to make sense of what is about to happen, is happening, or has happened.

The term 'social constructionism' was not used until 1966 when Berger and Luckmann coined the phrase (Benton & Craib, 2001; Berger & Luckmann, 1966). However, the idea that concepts are socially constructed appeared in 1904, in Weber's "*'Objectivity' in Social Science and Social Policy"*. Weber argued against the use of natural science methods for human inquiry on the basis that "there are no concepts free of human subjectivities … and consequently [the idea of] social laws have no 'scientific justification in the cultural sciences'" (Williams, 2005, p. 101).

Social constructionism encompasses approaches to inquiry underscored by conventional cultural relativism, a Boasian imperative that shaped cultural anthropology. Cultural relativism claims concepts and what counts as knowledge to be socially constructed and therefore variable according to the society doing that constructing. Different societies and cultures have different rules of social life: "There is no overarching form of life or language which is neutral and into which other languages can be translated" (Benton & Craib, 2001, p. 96). Cross-cultural variations are incommensurable. In my view, they cannot be treated as superior or inferior to one another as they are relative to their particular cultural context.

Social constructionists acquire knowledge of social reality by exploring the constructed and shared interpretations within the social context,

> [because] the extent to which a given form of understanding prevails … is not fundamentally dependent on the empirical validity of the perspective in question but rather on the vicissitudes of social process (e.g. communication, negotiation, communal conflict, rhetoric) (Gergen, 2007, p. 1).

The literature review has shown there to have been a change in the rhetoric about smoking. In order to acquire knowledge about the impacts of that changed rhetoric, this project reveals the constructed social reality as interpreted by people in the midst of renegotiating their understandings of smoking as they attempt to come to claim a new identity label: ex-smoker.

## *Research paradigms*

Interpretivism differs from the major classical research paradigms of positivism and hermeneutics in its insistence that qualitative differences between the entities being studied in natural science and those of social science require different methodological approaches.

> For Interpretivism, social reality is the product of its inhabitants; it is a world that is already interpreted by the meanings that participants produce and reproduce as a necessary part of their everyday activities together. Hence, because of this fundamental difference in the subject matters of the natural and the social sciences, different methods are required (Blaikie, 2007a, p. 131).

In contrast, the positivist paradigm insists both natural and social sciences must use empirical methods to explain phenomena. While empiricism is suited to investigating the natural world, interpretivism argues that the mental realm of human existence, which generates meaning, language and culture, is best studied by focusing on the lived and interpreted experiences of people. As Polkinghorne has pointed out, "much of the philosophical confusion about the realm of meaning has been related to the attempt to identify it as a substance," (1988, p. 4). Meaning, or interpretation, of course, is not a substance and not, therefore open to empirical explanation. Consequently, different philosophies for the natural and social sciences are necessary because the subjective interpretation of experience requires meaningful reflective consciousness, and produces abstract understandings which are not evident in the natural world.

Meanwhile, the hermeneutics paradigm has a more ambivalent attitude to empiricism: sometimes it is useful; sometimes it is not. Interpretivism and hermeneutics share the tenet that 'explanation' is the rightful role of natural science; however, the subject of social science is people, and people already have explanations for phenomena they consider significant. What is required of social science is not explanation but interpretation (Benton & Craib, 2001, p. 95; Blaikie, 2007a, p. 124).

The interpretation required of interpretivism is the discovery of "what a social actor means by his or her action in contrast to the meaning that this action has for other social actors in the situation or for the

outside observer" (Blaikie, 2007a, p. 129). Thus, it is not the interpretation of the researcher that is in focus, but the meanings of the research participant(s). Weber decreed the rightful interest of sociology to be *verstehen:* interpretive understanding: "understanding what is going on in the actor's head" (Benton & Craib, 2001, p. 79). As such, research conducted through interpretivism presents an opportunity to explore the point of view of the would-be ex-smoker.

### *Research strategy*

There are four research strategies frequently used in social science research: inductive, deductive, retroductive, and abductive (Blaikie, 2007a). Inductive research starts with the descriptive and moves toward generalising, but it stops at generalising, claiming not to present a particular point of view, positioning the researcher as 'neutral' (Thomas, 2006, p. 238). However, research is not value-free (see Quality Controls later in this chapter). Further, Denzin insists that the interpretive researcher "must take the standpoint of those studied" (1974, p. 269). Consequently, the inductive strategy is unsuited to my research. The deductive strategy works in the opposite direction, eliminating false theories or tentatively corroborating theories, heading towards 'truth' all the while knowing that absolute truth is unobtainable, as espoused by Karl Popper in his epistemology of falsification (Blaikie, 2007a, pp. 23, 70). This is not a productive approach for my study, because it stays within the bounds of theory rather than plunging into the murky pool of lived experience and social action, where social science truly becomes 'applied'. Retroductive research has a strong alignment with structuralism, hunting beneath the regularities that support prediction to find the structures or powers necessary for the regularity to exist (Blaikie, 2007c). This strategy offers insight to structural forces of power and ideology. If participants in my study represented an at-risk group, then structural considerations raised through a retroductive strategy would have been useful.

On the other hand, abductive research strategies construct theories derived from language, meanings, and interpretations of experiences as related by research participants, resulting in an 'insider' view of the research problem:

> The aim is to discover why people do what they do by uncovering the largely tacit, mutual knowledge, the symbolic meanings, intentions and rules, which provide the orientations for their actions (Blaikie, 2007a, p. 90).

There are three stages to an abductive research strategy:

- Discovering the everyday concepts and meanings attributed to the phenomenon by the participants;
- Interpreting the material provided by participants to generate concepts and descriptions that use the language of the group in focus, such that participants recognise their personal situations within those concepts and descriptions; and
- Producing a technical description of the social reality experienced by those inside that reality. This may be theory-producing, or it may contribute to existing understandings through a relationship with an existing social theory (Blaikie, 2007a, pp. 90-91).

In my research, the first stage was met through close and frequent contact with participants, who shared their historical quitting and relapsing experiences in informal recorded interviews. Experiences in the present were collected through an event diary. These techniques bring together the concepts and meanings that participants draw upon to make sense of their smoking and attempts to quit.

The second stage connects with the intention to ensure would-be ex-smokers and those who have quit can identify with the thesis findings. Rather than producing a generalising theory, the aim is to attain verisimilitude, "[producing] in the reader the same perceptual and experiential state sensed by the original observer" (Denzin, 1974,

p. 276), who, in this instance, is the participant. I achieve this through vignettes and the inclusion of extensive narrative extracts.

The third stage applies the study findings to the social context in which they occur, and in my study, the Conclusion chapter considers how the tobacco control domain can most effectively respond to the ways would-be ex-smokers make sense of chronic relapsing.

The abductive research strategy has a strong association with social constructionism and idealism. It is "advocated as *the* appropriate method of theory construction in interpretive social science" (Blaikie, 2007a, pp. 88-89 emphasis added). This strategy provides the means to smoothly flow from the philosophical concerns of epistemology and ontology to the social reality that encompasses the research problem central to this thesis.

To summarize the methodological journey thus far, ontological idealism has been coupled with epistemological social constructionism, as befitting an interpretive research paradigm, which is supported by an abductive research strategy. What remains to be addressed are the choices of method and technique used for data gathering and analysis.

## *Research approach*

Symbolic interactionism is tightly aligned with social constructionism and interpretivism. It arose through a melding of emergent sociological and psychology theories at the University of Chicago (Chicago School) during the first half of the 20th century (Bornat, 2008, p. 346). The shift in focus to theorising from fieldwork, in contrast to the abstract theorising of earlier sociologists, contributed to the development of research methods such as participant observation and the social science case study (Marshall, 1998, p. 67).

Denzin (1974) notes three main assumptions of symbolic interactionism. The ontological nature of reality is assumed to be

socially produced. Reality is a collection of social constructions whose meanings "arise out of the behaviours persons direct towards them" (p. 269). Second, symbolic interactionism assumes that people have "the capacity to engage in minded, self-reflexive behaviour" (p. 269), which strengthens the claim for the need for interpretation rather than explanation. Third, people interact symbolically, by manipulating symbols, words and meanings. The symbols, words, and meanings people use to interact are a consequence of minded, self-reflexivity, which is the feature that sets humans aside from other species. Symbols are neither consistent nor constant, but vary between groups and over time. These assumptions operate in a matrix of possibilities where each influences and is influenced by the others (Denzin, 1974, p. 269). A symbolic interactionist approach is well suited to studies where social reality and the issues of people within that reality are dynamic and complex.

Participant observation is the investigative method usually associated with symbolic interactionism. However, I was reluctant to use this method for accessing the everyday, lived experience of smoking because persistent exposure to second-hand smoke would negatively impact my health and tempt relapse.

The biographical method is another form of symbolic interactionism. It gained momentum in the latter twentieth century, and fits well with my research framework. There are multiple forms of biographical method and since the mid-1990s these have innovatively expanded across academic disciplines, creating "a constantly changing and expanding ferment of creative work," (Bornat, 2008, p. 344; also see Stanley & Temple, 2008). The fluidity within the method supports creative research designs, deploying data gathering and analysis techniques that are best suited to achieving the research aims. Four features are usually present in works using the biographical method:

- There is *direct social interaction* between the biographee and biographer, often through interviews;
- Analysis focuses on the *feelings and emotions* of the biographee, providing insight to their perceptions and understandings of situations and experiences;
- There is usually a predictable *structure* to both biographee accounts (start, middle and end) and biographer interpretation, which is usually informed by prior theory; and
- There is attention to *context*, both of the account and its telling (Bornat, 2008, pp. 345-346 emphasis added).

### Recruiting participants

I recruited participants through snowball sampling (Atkinson & Flint, 2003), where contacts are invited to refer colleagues who fit the participant criteria: smokers or ex-smokers who have made at least two quit attempts. Three women and two men agreed to take part, each having received the Information Sheet (see Appendix D) explaining my research and the participant characteristics I sought. Nevertheless, one person realised during the interview that despite many attempts to cut down, and other times of 'social' smoking, when cigarettes are provided by others rather than being purchased, there had never been a conscious attempt to permanently quit. By chance, I only interviewed this person once, due to other commitments on their part. I drew on the data arising from this interview for perspectives on current smoking and on returning to *ad libitum* smoking after periods of limited smoking.

### Data gathering

Face-to-face dialogue is the major data-gathering technique of the biographical method, and semi-structured in-depth interviews are advocated (Bornat, 2008, p. 345; Denzin, 2001, p. 66; Patton, 1990, pp. 283-284; Riessman, 2008, p. 21). The method favours depth

rather than breadth and so researchers tend to reduce the number of participants in favour of interviewing each participant several times. Meeting with a participant on multiple occasions creates greater rapport, and stories flow more easily, openly, and thoroughly (Laurier et al., 2000, p. 293; Riessman, 2008, pp. 22, 26). I met with four participants at least twice, and with the fifth on just one occasion. In the first interview I asked about their smoking history – from their earliest experimental smokes to becoming a daily smoker, their parents finding out, and then deciding to stop smoking and their experiences of quitting. Subsequent interviews sometimes more deeply explored events raised previously, and sometimes, especially for those who were attempting to quit, subsequent meetings focused on current smoking/not smoking attitudes and behaviours.

While in-depth interviewing is useful for reflecting on past experiences, a different technique was needed to access the real-time experiences of current smokers and those attempting to quit. This is where participant observation might have been fruitful, but having rejected this method on ethical bases, I asked participants to keep a diary. Diaries "are well adapted to getting contextualized, detailed … information, and …minimize the problems of bias in retrospective recall," (Coxon, 2003). Coxon notes that diaries have been used extensively in researching substance use and abuse, adding further confidence to this choice of method. Diary entries recorded smoking/not-smoking activities, noting the context, emotions, and anything they wanted to tell me about that particular encounter. These were emailed to me, accumulating throughout the fieldwork phase. Some diaries were straight-forward chronicles of smoking events, while others were descriptive and reflective.

## Analysis plan

The process of transcribing and preparing the data for analysis resulted in complete familiarity with the data, paving the way for a simple mental thematic analysis. Four aspects of the cessation—

relapse cycle were salient for the participant-narrators: current smoking, deciding to quit, trying to quit, and relapsing. In order to see how they made sense of their experiences I needed to associate the data with the relevant aspect and analyse it with questions in mind pertaining to that aspect.

I devised a four-layered plan for analysis, drawing extensively on Catherine Kohler Riessman's *Narrative Methods for the Human Sciences* (2008), and to a lesser extent on Yiannis Gabriel (2000) and Corvellec (2007). See Appendix E for a diagram of the plan.

In the first layer, thematic analysis considers WHAT is said. The text is interrogated as a whole, at stanza, clause and expression level, searching for concepts of interest, ambiguities, and consistencies.

The second layer focuses on WHAT and HOW the story is told. Structural analysis considers the story across six structural elements, drawing attention to how people present their case in order to make it believable to their audience. According to Riessman (2008), "they must convince a listener, who wasn't there, that certain events *really* happened" (p. 86 emphasis in original).

The third layer is dialogical/performance analysis, and this adds the WHEN, WHY and TO WHOM aspects of the narrative. It draws on the back-story, it is conscious of the interviewer, and it asks how this story came to be told. Dialogical analysis considers the relationship of the storyteller to other characters and to the unfolding events, highlighting the impression of the self that the biographee wishes to create for the audience. This is important to the idea of the 'self' which supports the self-stigma literature. Cooley ([1902] 1964) and Mead (1934) have argued that individuals form their self-identity through conscious reflection upon personal experiences and also the relationship between these experiences and the shared cultural interpretation of such phenomena. Thus, my self-identity incorporates my life experiences as well as my understanding of how

my experiences are interpreted, or read, by others within my social milieu. The self, therefore, "is formed in the context of social interaction" (Woodward, 2002, p. 7). In sharing our stories, we open ourselves to being measured by others, and so we perform them in ways that we hope will present us in a positive light.

Dialogical/performance analysis also considers the reader to be part of the interpretive process, "bringing their positioned identities and cultural filters to interpretation," (Riessman, 2008, p. 111). This highlights the unfinished nature of interpretation: others may make different interpretations of the work. To counter arguments that all potential interpretations are equally plausible, Riessman advocates tightly linking interpretation to what the participant has said within the text of the narrative (2008, p. 111).

Dialogic/performative analysis calls for particular attention to five aspects of the narrative, where these are relevant:

- Language, which extends beyond the terminological choices of the narrator to include overt discussion about 'cleaning up' and presentation choices of the interpreter;
- The investigator as co-producer of interview texts;
- Micro contextual issues, such as the setting, and the relationship between the investigator and narrator;
- Macro context such as the historical, political and cultural background that encapsulates the narrative;
- Genre, and in this respect I draw on the poetic trope categories espoused by Gabriel (2000) shown in Table 1 (Riessman, 2008, p. 139).

The fourth layer of my analysis plan draws on Gabriel (2000), to consider the narratives by genre. The relevance of this layer relates to a study by Hänninen and Koski-Jännes (1999) which used written narratives to gain an insider point of view of addiction, including

nicotine dependence. The narratives by ex-smokers were almost exclusively epic tales with the hero gaining mastery – and this genre was seldom used for stories relating to other addictions (Hänninen & Koski-Jännes, 1999, p. 1845). I wanted to see if there was a similar pattern in the narratives about cessation and relapse. Table 1 crosses four genre with four characteristics, producing a matrix of anticipated features within different types of narratives. I adapted Gabriel's matrix to include 'black comedy' to reflect some of the relapse narratives, which unfolded with the inevitability and irony of the colloquial slow-motion train-wreck, with only the narrator seemingly unable to see what was ahead.

**Table 1: Characteristics of narrative genre**

| Genre | Epic | Romance | Comedy/ Black Comedy | Tragedy |
|---|---|---|---|---|
| **Protagonist** | hero | love interest | victim: deserved | victim: undeserved |
| **Plot focus** | achievement<br>noble victory<br>success | tenderness<br>gratitude<br>appreciation | deserved misfortune<br>chastisement | underserved misfortune<br>trauma |
| **Typical tropes: (style, theme, motif)** | alternating success and failure | nostalgia<br>sentimental | conversion of misfortune into deserved punishment for character flaw | blame supernatural/ fate/ benevolent forces/agent |
| **Emotions** | pride<br>admiration<br>nostalgia | love<br>care<br>kindness<br>thankfulness | mirth<br>scorn<br>aggression | sorrow<br>pity<br>anger<br>revenge |

### *Working with transcripts*

Taking a structured approach to transcription significantly aids analysis. I transcribed verbatim, with gestures and non-verbal communication noted in square brackets. I included interviewer input and, following the advice of Waldegrave (1999, p. 142), I commenced each clause on a fresh line. This step was said to aid stanza-level and clause-level analysis. In practise, the effect was even

better, because the nuanced way participants speak about their experiences became visible through the presentation style. Reading the extracts, one can *see* the narrator reflecting, thinking about what they are saying and going to say next.

Transcripts averaged 5500 words – thankfully, mostly those of participants, although there was more of my input in initial interviews with participants I did not already know. Each took about six hours to transcribe and review, and were transcribed within two days of the interview. The content became very familiar; having participated in the dialogue, created a verbatim transcript, and finally reviewed the transcript whilst listening to the recording. Patterns were emerging and coding beckoned in an exciting rather than daunting way.

Transcripts were stored on a secure file server, sorted by participant, with header and footer information applied to ensure printed copies were marked 'confidential' and labelled with the interview date. Copies were imported to NVivo 7 and coded at stanza level by smoking history phase. I also coded situations that Denzin (2001, p. 37) calls 'epiphanies': the turning points that stay strong in the memory of the narrator precisely because these moments hold some deeper meaning, even though this meaning might not be consciously interpreted at the time, and may be reinterpreted over time.

The choice to use narrative analysis was made after the data collection phase, when the transcripts seemed to offer more than was forthcoming from thematic analysis alone. Greater attention would have been given to non-verbal communication during the interviews if this decision had been made earlier. As it happened, some people were particularly demonstrative in the ways they related their experiences, and such instances had often been noted in the transcript. Other instances have been overlooked and their inclusion

would have amplified the performative aspects of dialogic/performance analysis.

I considered the narratives using Labov's analytical model of structural elements, as described by Riessman (2008, p. 84), coding on a clause-by-clause basis according to their structural role:

- Abstract (summarizing the point);
- Orientation (time, place, situation);
- Complicating actions (events, turning points, crises);
- Evaluation (narrators commentary on complicating actions);
- Resolution (resolves the plot); or
- Coda (concludes, returning to the present), (Riessman, 2008, p. 92).

Most stories were narrated with these structural components thoroughly mixed up, so the first task was to un-jumble them. This was simplified by the earlier choice to present each clause on a fresh line. Narratives gained clarity when the clauses were regrouped by structural element and arranged temporally. Better still, the narrator's interpretation was highlighted by collectively considering the evaluative comments.

### *Working with diaries*

Diary entries were emailed to me, resulting in a lot of emails. To simplify reviewing, I created a separate document for each participant. I transferred the email content, including the date and time, into the appropriate document as each entry arrived. As with the interview transcripts, I placed each clause on a separate line.

Extracts selected for in-depth analysis were copied into a Microsoft Excel workbook, with each extract having its own spreadsheet, and each clause commencing on a separate row. I numbered the stanzas and clauses so that I could sort the spreadsheet in creative ways and

then return the narrative to the order of its telling. I coded and made notes in the columns to the right of the relevant stanza or clause, making it simple to sort the narrative using the 'data/sort' command.

I analysed diaries in a different way to the structural approach used for the stories extracted from the interview transcripts, because while stories are put together in hindsight, diaries report and reflect while the story is in production.

To devise an analysis approach suited to diary manuscripts I drew on Riessman's description of Maria Tamboukou's work, thematically analysing historical letters and diaries (2008, p. 63). Based on her background understanding of the core concepts of her domain, Tamboukou reviewed the material noting words and phrases associated with known core concepts, and then looked for patterns. To apply this process to my data I reviewed each diary entry according to its location within the cessation—relapse cycle, and the relevant aspect of my research question pertaining to that phase. Considering the quit attempt diaries, I looked for clues indicating how the diarist made sense of the quitting experience, and the diarist's language use suggested self-efficacy to be the core concept.

To test my method, I selected a diary with entries from the first smoke-free day through to relapse.

- Drawing on Bandura's (1998) idea of thought patterns as either self-aiding or self-hindering, I reviewed the diary at stanza level, coding indications of rising or declining self-efficacy, and threats to the quit attempt.
- In the process, I noticed and then coded three types of threat:
    - General threats were apparent in reflective entries, whereas 'habit' and 'cognitive' threats arose in detailed, descriptive entries.

    - Habit threats arose in situations where the diarist usually smoked, and entries stood out due to the high level of cravings angst.
    - Cognitive threats were characterised by internal monologues attempting to justify smoking.

- I then reviewed at clause level within stanza, noting words or phrases that indicated the assigned self-efficacy code.
- In the midst of clause-level analysis I was struck by the apparent changes in language used by the diarist as the quit attempt progressed. To find out if there was a relationship to self-efficacy, I considered each clause on an emotional level. That is, my interpretation of the emotional state suggested by the diarist through word or syntax choices.
    - First I noted the specific emotion that was sensed as I read the diary.
    - Then I coded these as either pleasant or difficult/unpleasant feelings.

A parallel process was used to analyse the diaries of participants not actively trying to quit. Instead of looking for self-efficacy, of most interest to me in the diaries of current smokers was how the person made sense of the smoking event.

### *Quality controls*

An assertion of triangulation requires a demonstrated awareness of weaknesses in data collection techniques (Fielding & Fielding, 2008). However, the concept is achieved differently across various branches of science because these use different research paradigms and data collection techniques. I am interested in what 'triangulation' means in the sense of within-method methodological triangulation, where more than one data gathering technique is used as a way of addressing the characteristic weaknesses of a particular technique

(Denzin, 1970 in Bryman (2003); Fielding & Fielding, 2008). In this sense, the techniques are complementary as opposed to a combination of qualitative and quantitative techniques, or being drawn from different research methods (Bryman, 2003).

I used two techniques suited to the biographical narrative method to gather data in different ways, with one technique focusing on recollections while the other focused on real-time events. The two techniques were selected to cover both ethical concerns and the characteristic shortfalls of the other. I considered the interview method to be reflective, providing valuable information about previous experiences, but that it would not provide access to the immediate experiences of smoking and not smoking. To cover this shortcoming of the interview method, I used the semi-structured diary method (Coxon, 2003) to access the everyday experience of the would-be ex-smoker. In this way, the research design has attended to the triangulation concerns as these apply to social science using qualitative methods to explore the insider point-of-view of the cessation—relapse cycle.

### Veracity and verisimilitude

The qualities of veracity and verisimilitude assess the matter of believability: "How believable is this?" Empirical research addresses this concern through the notion of validity, but empirical criteria for assessing validity are not appropriate for assessing social constructionist, interpretive works (Lincoln & Guba, 1985, pp. 289-331). Just as narrators use literary means to overcome "the teller's problem" of ensuring their audience accept their point of view (Riessman, 2008, pp. 86-87), social scientists must convince their readers that their claims are valid by producing "sufficient evidence and/or reasons to reasonably believe it is so," (Polkinghorne, 2007, p. 474). The abstract ideas of 'sufficiency' and 'reasonableness' raise three related problems.

First, there are two distinct forms of social science research, each making different sorts of knowledge claims: quantitative research makes claims about relationships between variables, while qualitative research makes claims about understanding human experience (Polkinghorne, 2007, p. 475). This difference gives rise to the problem of subjectivity in assessing "sufficiency" and "reasonableness" of the claim. The philosophical assumptions of those making the validity assessment will influence their interpretation of what counts as valid, and in this way 'validity' is itself a social construction (Polkinghorne, 2007, p. 475). As a qualitative method, biographical narrative analysis makes scientific claims about the meanings of life events, and narratologists must present sufficient evidence and argument to facilitate an assessment of scientific merit and the reader must decide the extent to which these claims are justified.

The third complication is that narratives are open to interpretation. Riessman has pointed out that "readers are inherently part of the interpretive process, bringing their positioned identities and cultural filters to interpretation," (2008, p. 111). There *are* multiple ways of making sense of a scenario, and the interpretation of the narratologist is one way of making sense, rather than a definitive interpretation. Paying attention to structural and thematic components as well as the contextualizing elements of dialogical/performative analysis tightens the argument for the veracity of a certain interpretation, without voiding the possibility for other interpretations.

Polkinghorne notes four limitations to validity in narrative research, which cannot be eliminated and so need to be managed throughout the production of narrative research:

- Life experience is more intricate than can be expressed in language;

- It takes reflection to access layers of meaning: these are not apparent at surface level;
- Narrators protect their self-image; and
- Texts are interactive creations,
  (Polkinghorne, 2007, pp. 480-481).

The narrative method of dialogic/performative analysis, advocated by Riessman (2008, pp. 105-140), addresses these limitations. By paying attention to the way the narrative is 'preformed', through movements, gestures, expressions and non-verbal utterances, the researcher looks beyond the words of the narrator and recognises other ways of expressing meaning. Riessman and Polkinghorne both advocate interviewing each participant on multiple occasions in order to build rapport and encourage reflection (Polkinghorne, 2007, p. 481; Riessman, 2008). Multiple interviews also help address the tendency of participants to guard their self-image, because trust increases as researcher and participant establish rapport, increasing the likelihood that the participant-narrator will allow the researcher a more intimate view of their self-concept. Finally, dialogical/performative analysis is premised on the basis of texts as co-productions:

> It interrogates how talk among speakers is interactively (dialogically) produced and performed as narrative. … [It] requires a close reading of contexts including the influence of the investigator, setting, and social circumstances on the production and interpretation of narrative, (Riessman, 2008, p. 105).

By adding a dialogical/performative layer of analysis to the thematic and structural analyses used for interpretation of diary and interview narratives, the limitations of narrative research are brought into focus and 'worked-with' rather than 'mitigated-against', becoming a feature instead of a deficit.

## Ethics and quality

Yvonna Lincoln has produced multiple publications since the 1980s focusing on interpretive research and especially the matter of ensuring quality or trustworthiness of research findings (for example, see Denzin & Lincoln, 1998; Lincoln, 2002; Lincoln & Guba, 1985). She has critiqued ways of assessing validity and reliability which are appropriate to empirical research, finding these inappropriate for assessing the veracity of qualitative research (Lincoln & Guba, 1985, pp. 289-331). Instead, Lincoln sees a parallel between matters of ethics and of quality, noting that "many of the proposed and emerging standards for quality in interpretive social science are also standards of ethics," (Lincoln, 2002, p. 342). Lincoln highlights five ethical concerns specific to interpretive research:

- The problems of face-to-face encounters: building trust and rapport;
- The impossibility of guaranteeing anonymity or confidentiality in all circumstances;
- Recognizing the importance of researcher standpoint;
- The need for transparency in data collection methods; and
- The importance of honesty in analysis and presentation.

### *Trust and rapport*

The snowball sampling technique I used for participant recruitment has implications for trust and rapport. I knew two of the five participants very well and used them as my initial contacts. Of the other three, I knew one by sight but did not know the other two at all. Establishing rapport was simple for those I already knew, but I consciously worked at establishing a sense of trust and empathy with the other participants, perhaps most importantly by sharing my own experience of spending about twenty years quitting and relapsing. By coincidence, I am of similar age and have similar social roles to those

I interviewed, which may also have eased the establishment of rapport. Snowball sampling ensured each participant and I had a common acquaintance, and this required some care on my part, for instance when one person wanted to know how the quit attempt of an acquaintance was progressing.

The Participant Information Sheet (see Appendix D) stated that people were not expected to make a quit attempt, but if they did I would give them my full support. Two participants were several weeks into a quit attempt when they joined the research, and one in particular sought my support when her cravings returned. This required some balancing. First, I wanted to encourage the attempt, but not in ways that would discourage her from telling me if she relapsed. I did not want her to feel that relapsing would be 'letting me down', and stories of past experiences of returning to smoking show relapse to be associated with strong feelings of guilt and personal failure and a sense of disappointment on the part of family, friends and colleagues, (for example, see Bott et al., 1997, pp. 260-261; Laurier et al., 2000, p. 281). Second, the opportunity to closely observe the process of relapsing was not something that I could be sure to encounter within my fieldwork. It was possible that I would be limited to recollections of relapsing as opposed to witnessing the process. However, the relapse phase is an extremely important phase of the cycle. So while I did not want anyone's quit attempt to fail, if it did, I wanted to capture the experience as the process was navigated.

Sometimes my advice was sought about the value of cessation treatments, which I provided, but soon realised the extent to which I was being swayed by empirical, evidence-based research. Some participants sought my opinion on the nature of nicotine addiction, generally by expressing their own understanding and asking if this was 'correct'. This is an expression of 'trust' and also of 'power'. The researcher is commonly seen as being in a position of holding more knowledge, and I measured my responses to avoid expanding this

gulf, bearing in mind that for my research, it was the participants who were the experts. I provided explanations based on the background reading for this research and offered material that I had found useful.

In selecting narrative extracts for in-depth analysis and presentation, I have provided contextual information without disclosing sensitive information. Some participants shared highly sensitive experiences that contributed to relapsing. To ensure their privacy, these experiences have been paraphrased and generalised.

### *Confidentiality*

Recruiting through snowball sampling also has implications for confidentiality, because, theoretically, every participant knows at least one other participant. This raises the question of just how 'confidential' the research can be. In addition to using pseudonyms, the need to respect the privacy and confidentiality of other participants was included in the Information Sheet, (see Appendix D) and the Consent Form (see Appendix F).

Early in the data collection phase just one participant was male, and unless at least one other male was recruited, every extract or reference to experiences which were in any way gendered with a male perspective would be automatically attributed to him. After several unsuccessful attempts to recruit another male, I considered using gender-neutral pseudonyms and making a conscious attempt to keep gender out of the findings. However, I was reluctant to do this because I wanted participant's experiences to come alive to the reader, and de-gendering seemed counterproductive to this aim. The problem was resolved when a second male was eventually recruited.

I explored the use of web-blogging for diaries, which had novelty appeal and offered the possibility for inter-participant interaction. I rejected the idea because confidentiality would be significantly

jeopardised. With email being a lot more secure than the internet, I opted for rudimentary email-based recording and delivery. Entries were securely stored in the email system of the university until they were transferred to the secure file server for analysis.

### *Researcher standpoint*

Research is not value-free. From the research design to presenting the research findings, this project has been shaped by the values and perceptions that I, as researcher, bring to it. Concerning inquiries where personal issues intersect with public concerns, Denzin is adamant that researchers must be overt about their values and assumptions (Denzin, 2001, pp. 6-7). Likewise, Lincoln (2002, pp. 333-334) asserts that researchers must 'come clean' about their stance. In additional to an overt adherence to this philosophy within this thesis, 'coming clean' was also important for establishing rapport with participants.

### *Transparency*

Throughout the research approach section I have described the processes and techniques used to gather and analyse the narratives collected through interviews and diaries. The intent is for methodological transparency, allowing a critique of my processes, so the reader can see how I arrived at such conclusions, despite these not being the only possible interpretations.

I consciously avoided using participant observation despite this method being commonly associated with symbolic interactionism. For example, to research the experience of alcoholism, Denzin integrated himself into a chapter of Alcoholics Anonymous (2001, p. 72). In the past, participant observation may have been used in my research. Indeed, early in my planning it was suggested I 'join' the smokers by taking up herbal cigarettes and regularly visiting areas where smoking is permitted. This overlooked two ethical concerns. I am not prepared to risk relapse by repeatedly locating myself in an

environment where smoking is normal and expected. From the point of view of the Human Ethics Committee, this would jeopardise researcher safety, first through exposure to second-hand smoke, and second, by enticing relapse. This was an important personal consideration: I have been smoke-free since August 2000 but I relapsed more times than I can reliably recall in the previous twenty years. I wish to remain smoke-free for the rest of my life – which is *not* to say that I never, ever, think about having a cigarette: the threat of relapse remains, although it is thankfully no longer constant. Consequently, I used snowball sampling for participant recruitment, instead of frequenting smoking environments, and a creative solution was used to tap into the real-time experiences of smoking, with the diary technique proving a successful alternative.

### *Honesty in analysis and presentation*

Participants checked the direct quotations I planned to include in this thesis. For one participant, it was "quite emotional" seeing and reading her own story, as told by her, now made permanent through my pursuit of academic mastery. The extensive use of direct quotation coupled with contextual information that comes about through dialogical analysis goes some way to ensuring honesty in analysis and presentation. However, this overlooks the stories that have not been included, and this is a limitation of interpretive analysis, and it is mitigated by the preface that this research does not intend to generalize.

The most important measure of an 'honest' telling of the troubles of attempting to quit will be evident if would-be ex-smokers and those who have quit can sense themselves and their own experiences in the research findings.

## Research Findings

My research findings illustrate the four points in the cessation—relapse cycle which stood out in both interviews and diaries as significant times for the would-be ex-smoker:

smoking → deciding to quit → attempting to quit → relapsing

Figure 4 shows these aspects as well as the entry and exit points of the cessation—relapse cycle, and names the main narratives that I draw upon. These illustrative narratives are not claimed to be general or typical of the experiences of would-be ex-smokers. Rather, they show a range of interpretations and meanings that would-be ex-smokers have attributed to their experiences. I start with 'smoking' and then follow the progress of the cycle. Relapsing is the crucial aspect: it keeps would-be ex-smokers within the cycle, and consequently I have devoted more space to relapse experiences.

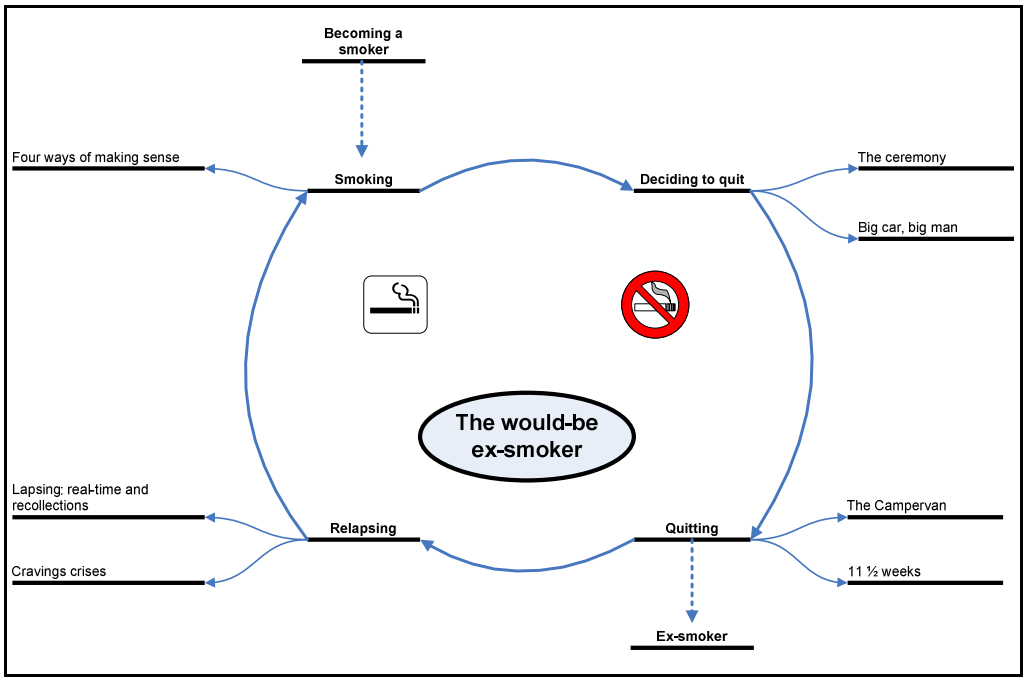



**Figure 4: Four aspects of the cessation—relapse cycle**

Interwoven with this chapter is a vignette providing an indicative natural history of smoking, which is presented in three parts:

becoming a smoker; being a smoker; and the would-be ex-smoker. This illustrative narrative is composed entirely from participants' experiences. Thus, the material is not fiction, but my telling of it is *fictional*. My intention is to provide verisimilitude to the context of being a would-be ex-smoker, so that never-smokers get an enhanced degree of empathy for the participants.

As a general context for the five people whose experiences are discussed below, and in addition to the vignette, the participants shared several characteristics aside from those which were participation requirements (see Appendix D):

- They started smoking as teenagers and are now in their 40s;
- They are current smokers who smoke lightly: no one smokes within half an hour of waking, and they consume approximately ten cigarettes each day;
- None have been diagnosed with a smoking-related illness;
- They are in committed relationships which include children;
- They live and work in the greater Wellington area; and
- They are ethnically New Zealand European/Pakeha or more recent immigrants from Great Britain.

As such, they belong to a group which is not a focus for the New Zealand tobacco control domain. These people mirror my own circumstances, with one exception: I have not smoked for eight years.

### *A natural history of smoking: Part 1: Becoming a smoker*

*Life begins in a smoky home. If just one parent smokes, the other is likely to be strongly anti-smoking. When both smoke, one smokes significantly more, with the lighter smoker frequently trying to quit.*

*The first experimental smokes occur immediately prior to secondary school, with tobacco filched from home or scabbed from peers and older siblings. These occasions are shared with friends, hiding in a sheltered outdoor public area, often a nature reserve.*

*By age fourteen they are buying their own cigarettes, because the urge to smoke is now so frequent that it is not possible to sneak or scab enough smokes without being noticed. Leaving home and starting work both increase the quantity smoked, and from this time they recognise themselves as a 'real' smoker, but smoking is still usually concealed from their parents.*

*When their parents do find out, some respond by negotiating acceptable boundaries to smoking behaviours – limiting smoking to away from the family home, or conversely, forbidding smoking on the street. Parental concerns are centred on how smoking looks to others, and that "Smoking will stunt your growth!" The advice is ignored: a choice justified as an act of rebellion.*

*Smoking soon becomes associated with other enjoyable activities, particularly alcohol, coffee, and driving – all relatively new experiences associated with approaching adulthood. They typically set off for a night out with twice their usual supply: popular singer Gary Clail had a strong point when he sang "Like alcohol and nicotine, the sweetest lovers there's ever been." And that is true not just for themselves: after a couple of drinks, the 'social smokers' start bumming cigarettes.*

**Figure 5: Vignette: Becoming a smoker (see Clail, 1991)**

## *Smoking*

> *From the first beginning of our knowledge of man, we find him consuming substances of no nutritive value, but taken for the sole purpose of producing for a certain time a feeling of contentment, ease and comfort (Lewin, 1924).*

My objective when analysing the smoking behaviours of current smokers was to understand what smoking means to them. I started by noting different ways of naming the cigarette (smoke, fag, nicotine blast, quickie); then found the different smoking environments (car, skip bins, deck, street, doorway, car park); and then language and syntax indicating the emotional impact of the smoking event (pleasure, joy, anger, frustration). I considered individual smoking events and whole days; I compared weekends with work days; and I related the emerging patterns back to stories told within interviews. I moved to a dialogic approach to include the performative aspects of the telling, which highlights the self-image of the narrator, who relates the event in a way that attempts to persuade the audience to adopt the narrator's point of view (Riessman, 2008, p. 108).

### Holly's diary

Holly's highly descriptive diary provided generous access to how she interprets the smoking events that punctuate her day. My analysis highlighted four meaning categories for Holly's smoking: pleasure, procrastination, stress management, and antagonism.

#### *Pleasure*

Holly's pleasurable smokes are always when she is alone, always associated with additional sensory stimuli, such as warmth, sunshine, or a pleasant outlook, and just about always associated with a cup of tea or coffee, or a glass of wine. They often occur immediately prior to making the evening meal. This extract is typical.

FRIDAY 18 APRIL, 18:45
[Husband's] gone to walk the dog,
so home alone.
Out onto deck,
*sitting quietly*
*just watching the view*
*and enjoying a glass of wine*.
Perfect time for a smoke.
Really enjoyed this one.

Pleasure smokes seem to provide Holly with more than just nicotine. Examples elsewhere in her diary include "cup of tea *in hand*", "A final smoke *whilst* I finish off my wine seems *a good way to end the day*", "Just finished weeding the garden, *nice clean hands* – smoking on the front door step *enjoying the view*," "A smoke and *a sip of wine* … out on the balcony." Her language choices, also italicised in the above extract, suggest serenity and elegance. Although Holly did not overtly note any attachment to this smoke, her language and syntax choices suggest it is significant for mental and emotional re-centring.

In contrast, when Holly smokes in places where smoking is tolerated rather than accepted, and when she is not alone, indications of pleasure are diluted or absent.

THURSDAY 8 MAY, 14:55
Getting that 3 o'clock feeling,
Need a break.
Coffee and a smoke with the skip bins.
Not glamorous but needed.

Holly's diary does not indicate that she is aware of this subtle difference, but by choosing not to smoke "with the skip bins", for instance, she could achieve a natural reduction in her smoking. Holly's pleasurable smokes are typically followed by a 111 minute interval before the next cigarette (see Figure 6), while less pleasurable smokes are typically followed by another cigarette within 60 minutes.

The tactic of 'cut down, then quit' is salient for many would-be ex-smokers and ex-smokers, and it is used in Great Britain as a harm-minimisation tool (Shiffman & Bloomfield, 2008). Saul Shiffman drew

attention to this option at the 2008 National Tobacco Control Hui, discussing the merits of reduced consumption amongst people with a distal rather than proximal desire to quit. Conscious attempts to reduce consumption seem to lead some people toward making a quit attempt, because, it is thought, they gain a sense of mastery through their reduction successes. For many smokers, contemplating the withdrawal symptoms associated with abrupt quitting is extremely distressing. This makes the idea of reducing consumption prior to trying to quit an attractive alternative because it does not invoke the fear and tension associated with anticipated nicotine withdrawal (Shiffman & Bloomfield, 2008). If Holly limited her smoking to opportunities that provide genuine pleasure, not only would she smoke less, but she may more readily attain what she calls "the right head-space" for making another quit attempt.

### *Procrastination*

Procrastination cigarettes are purposefully used by Holly at home and at work. These are not in themselves pleasurable, but by deliberately delaying a boring task, Holly derives a degree of satisfaction.

> FRIDAY 18 APRIL, 11:00
> 3rd smoke of the day.
> Just about to start writing my report for [client].
> This is a procrastination fag, so I can postpone the start of report writing (yawn).
> Silently smug on return to desk
> as I've delayed a painful task.
>
> FRIDAY 25 APRIL (ANZAC DAY), 10:00
> I don't feel like doing the washing:
> "get out of the kitchen" excuse smoke.
> Back to start the washing. Yay - not!

In these two extracts Holly is overt about her procrastination and boredom, which is also signified colloquially: "(yawn)", "Yay – not!"

Holly often cites “procrastination” as a reason to smoke when she has not had a cigarette for about two hours. Permitted to smoke at will, Holly spaces her cigarettes about two hours apart (see Figure 6). The timing aligns with the half-life of nicotine, which is about two to four hours. Nicotine has nine and half half-lives, so the body is not free of nicotine for 36 to 48 hours after it was last ingested (Glover, 2006, p. 9). Shiffman et al. (2006) have shown that declining levels of nicotine result in the feeling of reduced concentration, or attention deficit, and Holly interprets this as boredom. From Holly’s point of view, she goes for a smoke because she is bored.

On the other hand, physiologically, the urge to smoke is due to Holly’s brain signalling a decline in dopamine brought about by reduced levels of nicotine, which she has unconsciously learned can be quickly remedied by having a smoke. From this perspective, Holly is bored because she *needs* a smoke. Should she be unable to smoke, her nicotine and dopamine levels will continue to decline, making her increasingly lethargic. Her diary shows that as soon is she is free to do so she will smoke several unsatisfying cigarettes in about two hours – or one pleasurable cigarette. This pattern is evident in Figure 7, where Holly’s ability to smoke was limited through most of the day, making it necessary to space her cigarettes by three hours and then two and half hours. Consciously or unconsciously, she recovers from her depleted dopamine state by topping up her nicotine levels with four cigarettes in less than two hours – cigarettes 6, 7, 8 and 9 in Figure 7.

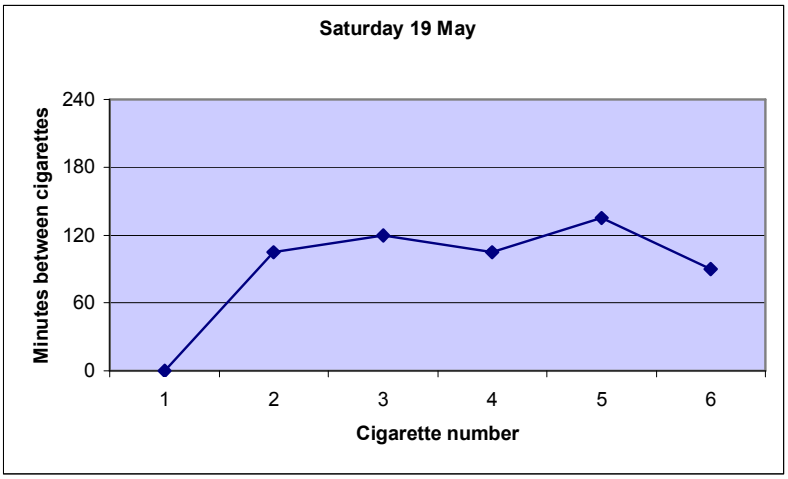



**Figure 6: *Ad libitum* smoking: an average of 111 minutes between cigarettes**

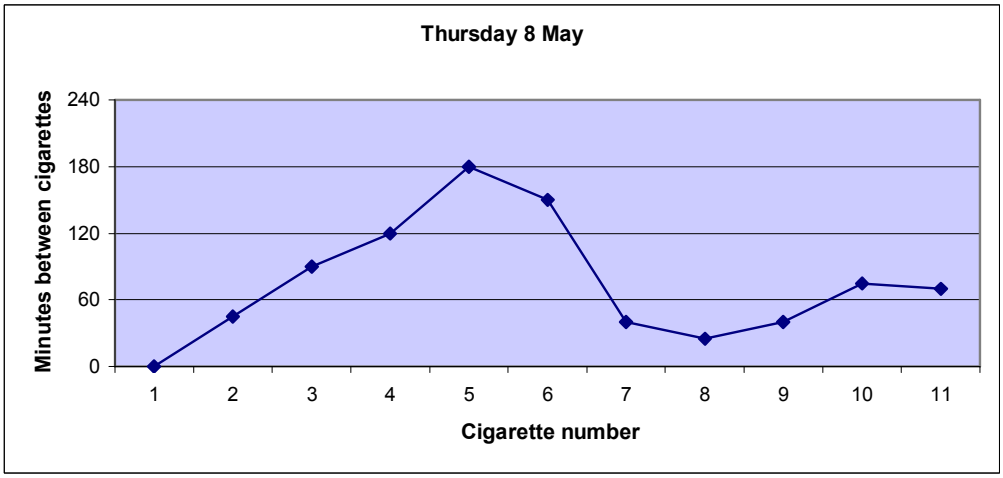



**Figure 7: Limited smoking: an average of 84 minutes between cigarettes**

So while Holly understands many of her cigarettes as "procrastination smokes", which speak of boredom, these cigarettes may be about a physiological need for nicotine, which is made sense of in terms that are meaningful to Holly. She cannot fully concentrate, so her activity is interpreted as boring. While procrastination smokes are about Holly feeling bored, her stress smokes are about feeling threatened.

### *Stress management*

Holly smokes both proactively and reactively to manage stress, and she typically smokes significantly more on a stressful day than on a day when she is relaxed. This is evident in Figures 6 and 7, where

Holly consumes six cigarettes on a relaxed *ad libitum* smoking day compared to eleven on a busy workday when opportunities to smoke were limited. Her diary shows that when she feels unsatisfied with the potential of an obligation, Holly interprets this feeling as stress. Mother's Day provides a good example, with three cigarettes smoked in just over an hour.

> SUNDAY 11 MAY (MOTHER'S DAY), 10:55
> A quickie post breakfast
> and before we head off to (mother-in-law's).
>
> + 50 MINUTES = 11:45
> Heading through [township]
> so need nicotine before getting to (mother-in-law's).
>
> + 20 MINUTES = 12:05
> Heard that all (husband's) sisters are at his Mum's
> so another blast of nicotine to cope with the expected stress levels.

Three different terms are used to name the cigarettes, starting with "a quickie", then "nicotine" and finally a "blast of nicotine", creating a sense of escalating stress. In the third part, Holly overtly anticipates forthcoming stress, but seems unaware she is already displaying its effects. Despite her proactive measures designed to manage the non-smoking environment and her sisters-in-law, the diary suggests increasing agitation throughout the day, even after the visit concludes. By bedtime Holly had consumed 50% more cigarettes than usual, some of which were smoked in places where smoking is not permitted, and she gave no indication that any of the smoking events provided her with pleasure.

### *Antagonism*

Holly has used cigarettes to antagonise others since she started smoking as a very young teenager. At our second interview she related the basis for the troubled relationship with her mother, "a harsh disciplinarian" whose "mental torture" prompted Holly to learn to be "extremely sneaky". On the other hand, she told me, she adored

her father, who smoked – much to the chagrin of his wife. Looking back, Holly considers she took up smoking to align herself with her father against her mother, and the ubiquitous presence of smoke in the house meant her smoking went undetected. Thirty years later, when she becomes defensive she responds by lighting a cigarette with the conscious intent of subtly antagonising her foe. This gives Holly the impression she is in control, but rather than being assertive, her antagonistic smoking is consciously passive-aggressive, as signified in the terms italicised in the following extracts.

> FRIDAY 18 APRIL, 19:30
> Hanging out the sliding door as its getting cold.
> I hate smoking outside when the weather's not fantastic.
> I feel like a complete prat
> having to hang half in and half out the door
> and *feel rebellious*
> *and want to smoke inside*
> *just to incur [husband's] wrath.*
> Next smoke: + 65 minutes = 20:35
>
> THURSDAY 24 APRIL, 10:43
> Fitting in a quickie
> just before [work colleague's] monthly catch-up.
> This guy can talk for Africa
> so I feel I need some fortification.
> *Just 5 minutes outside*
> *and I can sit and breathe smoky breath over him for an hour.*
> Next smoke: + 195 minutes = 14:00 (prevented from smoking)
>
> SATURDAY 26 APRIL, 20:25
> [Unwelcome visitors are] still here.
> *Perhaps they'll get the hint to go if I keep smoking.*
> [Visitor] hates it as she's an ex nurse.
> Next smoke: + 10 minutes = 20:35, then + 45 minutes = 21:17

In these extracts Holly consciously smokes to antagonise others, just as she did to subtly assert one-upmanship over her mother. These extracts and other like them show no signs of pleasure and unless it is not possible to smoke, they are followed by another cigarette within about an hour.

### *Summary*

Holly usually smokes alone, because her smoking is about self-care rather than socialising. When she smokes for pleasure, she smokes less than when her smoking is motivated by external circumstances. If Holly planned her pleasure smokes and avoided the unsatisfying smokes relating to stress and antagonism, she would smoke less whilst retaining the effects of raised dopamine levels. When circumstances limit or prohibit smoking, Holly boosts her nicotine levels by smoking several cigarettes in close succession to delay the onset of withdrawal symptoms. Afterwards, she restores her depleted nicotine levels by repeating this process. Smoking to relieve stress does not seem to have the desired effect and may even have the opposite effect, as the downward spiral of Mothers Day showed. Stress smokes are followed by another smoke much more quickly than pleasure smokes. Similarly, the antagonistic smokes are not seeking nicotine, nor are the desired effects achieved by raising her nicotine level, and Holly has another cigarette quite soon, still seeking the elusive effect.

Finally, Holly's diary rarely addresses her desire to quit, and few entries indicate anxiety about smoking. One comment stood out:

> MONDAY 21 APRIL, 21:23
> Just thinking this would be a really good opportunity to stop again,
> but not really in the right head space.

This is interesting for two reasons; the idea of "head space", and a subsequent occurrence that was not diarized. The following morning, Holly was too sick to go to work and she then spent several days in bed. Her most recent and most successful quit attempt came about when she was sick and realised that smoking may be contributing to her ill-health, possibly even killing her (see 'The ceremony' in the following section). In the above diary entry, Holly dismisses the idea of trying to quit on the basis of being in the wrong "head space", and

her subsequent illness does not prompt her to revisit her earlier epiphany. This suggests that being ill was not the sole trigger for her earlier quit attempt. Her comment, above, relating to head space, draws on the common understanding that the essential element needed to quit is willpower: one has to *really* want to quit. This notion is explored further in the next section, *Deciding to quit*.

## Other participants

Two features of current smoking stood out in diaries and interviews: the favourite smoke of the day, and household rules about smoking.

### *Household rules about smoking*

Household rules are likely to be mandated by the non-smoker rather than jointly negotiated. Holly's diary voiced her desire to smoke inside, and on Mother's Day she defiantly had a smoke in the bedroom, leaning out the window. For some participants, the rules extend beyond smoking outside, to concealing their smoking.

> I have gone and sat out the back and had a cigarette
> And [wife] just does not like it.
>
> So when I come in she says:
> "You make sure you wash your hands before you touch the children!"
> (Peter)
>
> It gets a bit irritating and annoying
> when you're just three of four drags into a cigarette
> and then you get caught
> and you have to throw it out.
> (John)

Their language choices suggest deviance. The dialogue attributed to Peter's wife infers dirtiness, and for John, getting "caught" and then discarding the cigarette suggests he accepts that he is 'misbehaving'.

### *Favourite smoke of the day*

Hope's favourite smoke signifies the end of her day in the role of manager and supervisor, and is enjoyed prior to the resumption of

her role as wife and mother, as she drives home. The 15 minute journey is the only time she can reliably consider her own. It is “just me”, with neither work colleagues nor family commanding her attention. Similarly, Montana’s favourite smoke is when her mothering role is over for the day. The language choices and imagery presented by Montana, relaxing with her “coffee, book and fag”; and Hope, driving with the stereo blazing and the window open, “sucking down on a cigarette”, the breeze having its inevitable effect on her carefully coiffured hair, suggest this favourite smoke is enjoyed in a liminal zone. There is a major break in activities and responsibilities, where normally unacceptable behaviours are permitted. For each of them, this pleasure smoke signifies something integral to their selfhood. For all the participants in my research, there is considerable routine to their favourite smoke of the day, and it is always a solitary experience.

### *A natural history of smoking: Part 2: Being a smoker*

*By their early twenties they have realised that lighting a smoke has become a regular response to stress: it calms their nerves. They also start to use smoking like a series of punctuation marks, breaking up their day: they have a smoke 'before' doing something; as a break in the middle; or at the conclusion of tasks.*

*Even before they marry, their non-smoking partner wants them to quit, but everyone knows there is no point trying unless you're in the right frame of mind, and although nobody knows, precisely, what 'the right frame of mind' is, they confidently predict they will know it when they feel it.*

*The arrival of children puts new limits on their smoking. Those who previously smoked inside now find themselves smoking outdoors, away from the house, and out of sight of the children. As they come back inside after a smoke, their non-smoking partners provide less than subtle feedback: "Wash your hands before you pick up the baby!" Smoking in the bedroom and car are also banned.*

*From primary-school age, their children recite jingles and provide graphic descriptions of the damage smoking causes. They admire this, rationalising that their children won't smoke. However, as secondary school approaches, cigarette packets are closely guarded: they were about this age when they started smoking. By the middle teenage years, some of the children have started smoking, bringing anxiety and guilt to their smoking parent, coupled with extra pressure from their non-smoking spouse.*

*At work, they take smoke-breaks, holing up in a sheltered spot – often a dock-way or a doorway, where they chat with friends and strangers: smokers are friendly; always ready to share a light or lend a smoke, and always up with the gossip. They see other smokers making quit attempts, and they try to be supportive but know their colleague will be back outside in a few weeks. Hardly anyone ever completely quits.*

**Figure 8: Vignette: Being a smoker**

## *Deciding to quit*

*Quitting smoking is easy. I've done it hundreds of times - Mark Twain*

'Deciding to quit' is a phase of the cessation—relapse cycle that relates to a specific quit attempt, rather than a general inclination to quit sometime in the future. All the participants in my study mentioned the same distal, high-level general reason for wanting to quit: the possibility of a smoking-related illness prematurely ending their life. For most participants, premature death means missing the pleasures of grandparenthood. Becoming a grandparent is a warmly anticipated rite of passage, but with their children mostly being pre-teens, this is a future possibility, providing little motivation for the quit attempts presently being made. Instead, quit attempts made in the present are motivated by circumstances in the present.

The deciding to quit stage of the cessation—relapse cycle presents an opportunity to unravel the idea that Holly touched on in her reflective diary entry, when she rejected the possibility of trying to quit because she was in the wrong "head space". Narratives about deciding to quit which relate to a quit attempt that the narrator considered successful seemed to be a good place to search for indications of high self-efficacy about quitting, some elements of which relate to head-space. Two narratives stood out, because the participants achieved the longest period of full abstinence from tobacco they have ever experienced. Holly remained smoke-free for six months, altering her self-identity to ex-smoker, while Peter was smoke-free for 20 months, and came to self-identify as "a smoker who is currently not smoking".

### Holly: The ceremony

Holly invited me to her home for our second interview. I had been there once before, about six years earlier when we worked together. I sensed she wanted to share stories that needed more time and a greater degree of privacy. Over a pot of tea, and looking out to the

stunning views beyond the balcony, which I later realised was the setting for her most pleasurable smokes, she related detailed accounts of different aspects of her smoking history, including this occasion when she decided to quit. (The full transcript is included as an example of structural analysis coding. See Appendix G.)

Holly drew me into the story with a theatrical performance. She moved back and forward between structural elements, keeping me involved in the progression of the story which she simultaneously told, contextualised, and evaluated. As well as voicing her internal monologues, she included dialogue, giving speaking parts to her father, doctor, and husband. The pivot of the narrative is the 'ceremony of the final cigarette'. Of the four types of smoking event in Holly's diary, this was a pleasure experience. She purchased a "really nice bottle of wine, which I drank myself," and just before bed she went outside and had her final cigarette, saying to herself "This is my final cigarette, and I'm really happy that this is my last one." Then she screwed up the packet, destroying the remaining cigarettes (when performing the narrative she acted this out, as if wringing water from a cloth), and then she put it in the bin: "It was calm; it was a final send-off, a final goodbye … and it was consciously done."

It seems to me that this is a very private event in Holly's smoking history. It was not easy to share. She prefaced the story with an evaluation, telling me "It sounds a bit stupid." Holly's telling of it, jumping from element to element, suggests she has not told the story very often. She seemed to be contextualising the story for herself as much as for her audience. Telling the story was emotional for Holly. It seemed to me that she was reminded of the power and determination she had felt, and this was uncomfortably juxtaposed with her disappointment when she relapsed six months later.

By reconstructing the story into temporal order, where the abstract is followed by orienting background, leading to the action and thence to

her evaluation and finally the coda, a two-part evaluation becomes clear. The first part is medical. Holly is sick, which she compares to her father's smoking-related illness which ended his life. She visits her doctor, not in relation to her present illness, but to get a prescription for NRT. In order not to follow the path of her father, she opts to quit smoking so that it does not kill her. This is significant because her distal motivation relating to premature death has become proximal through her illness. In the second part of her evaluation, Holly takes control, which she explains as "powerful". Proving to herself that this is a decision of her own making, she devises a celebration to farewell her reliance on cigarettes. She smokes her final cigarette on her own terms, consciously, assertively, and decisively enjoying her final smoke before destroying the remaining cigarettes in a ritual-like fashion.

There is a lot of power in this story, even in my re-telling, which only draws on her evaluative comments. In Holly's telling, the evaluation is interspersed with other elements. Orienting background detail injects an emotionality that is not easily overlooked, such as her father's death-bed wish that she quit smoking. Complicating actions give space to introduce drama, with Holly describing the extent of her sickness, ("on my hands and knees, out the door, just staring at the deck"), dialogue moments, presented as verbatim, with her doctor – where timeframes are established, and also with her husband, who is dubious about her claim of quitting. The story ends with a satisfying coda: "I didn't smoke for over six months." This closes the account with the narrator in a positive light, and the audience, myself, delighting in her creativity and fortitude.

Considered against Gabriel's narrative genre model (Gabriel, 2000), this is an epic story, with Holly as the hero protagonist. This is fully aligned with the findings of Hänninen & Koski-Jännes (1999), where narratives in the third person by people who had quit smoking at least three years previously all used epic mastery narratives to

convey their victory over a powerful foe. The plot of Holly's story focuses on the pivotal moment of her enactment of the decision to quit: the ceremony. In presenting her story, she alternates between her determination to quit and the roadblocks in her way, such as her husband's less-than-encouraging reaction. The emotional impact is one of pride and admiration, both for herself and from her audience.

The structural analysis suggests the story is salutary. Despite her eventual relapse, the six months of mastery has a special meaning for Holly. It tells her that she *can* quit. Elsewhere in our interview, when I asked how she felt about future quit attempts in light of her past quitting experiences, she confirmed this:

> I'd tried so many times,
> but I'd never felt I'd been successful at it.
> Like I may have stopped for a few weeks or a few days or whatever,
> but never felt that it was really successful.
> Whereas this time,
> I think because I *did* feel so powerful about it,
> …
> and I know I can do it,
> and it was easy,
> so I think that I could do it again.
> In fact I *know* I can do it again.
> Um, but I just have to make the decision at the right time.

Holly injects a degree of tentativeness as she pulls back from her assertion, at the end of this statement. This again links to the idea she referred to earlier as being in the right head-space, but here the notion of "the right time" takes over from "head-space". This seems to be two ways of referring to the same thing.

To make some comparisons, I now consider Peter's story about deciding to quit, which arose under very different circumstances.

### Peter: Big car, big man?

While Holly seemed to be assembling the story as she told it, Peter's story was clearly laid out, with all the structural elements presented in a smooth, linear form, suggesting this story has been told before.

When I asked Peter if he was currently smoking, he leaned deliberately over my audio recorder, telling me:

> I tried to give up about four weeks ago
> and I lasted about two weeks and I'm now smoking again.
> Don't tell my wife: she doesn't know yet.
> …
> [I feel] very deceitful.
> But I tell myself that I am in the *process* of giving up
> …
> I'm at a crossroads at the moment, as in,
> I've really got to make a call: [inner dialogue]
> "You keep smoking, you tell [wife], and you carry on,
> or are you just going to stop again?"

This shows Peter's state of mind vis-à-vis quitting, and it acknowledges my existing relationship with Peter and his wife. Peter revealed things over our caffeine-fuelled chats that were new to me, despite having known him for about ten years. I was very conscious that he was sharing private information, outside of that shared even in friendship. This reinforced to me the need to respect the privileged information that arises through fieldwork.

The story about deciding to quit that is the focus of this section does not relate to Peter's most recent quit attempt, but to one he made several years ago. Peter was having a smoke outside a shop while his pregnant wife was inside. An impressive vehicle parks alongside, and a well-dressed man alights in a cloud of cigarette smoke. Peter approvingly assesses him as a like-minded individual. The man walks around the vehicle, opens the back door and lifts out a toddler, causing Peter's reaction:

> I thought:
> "That's the most disgusting thing I've ever seen in my life!
> I can't believe the guy could be that stupid to do it.
> That's me; I smoke in our car, I smoke everywhere;
> it's got to stop.
> I don't ever want that to happen with my children!"

Peter's story is also an epic. The plot focuses on his success over smoking, brought about by the pivotal realisation that his smoking threatens his self-image. To consider himself a good father, he needs to quit. The narrative oscillates between establishing a point, then rejecting it, establishing another, and then modifying it again. This builds toward the resolution: as hero of the epic, Peter stubs out his half-smoked cigarette and immediately buys a cessation treatment. The coda leaves Peter proud and the audience filled with admiration.

Peter and Holly's accounts are similar in four ways. First, there is a sudden disruption to the status quo. This signals to Holly that she is in the right head-space, or that the time is right, as her high-level motivation suddenly becomes salient in the present. For Peter, there is the dramatic reassessment of how he wishes to present himself in his forthcoming fatherhood role. Second, they were each compelled to take immediate action, which in these instances involved obtaining a cessation treatment. Third, both Holly and Peter regard this quit attempt as emanating from within themselves, rather than being at the behest of someone else. Finally, for each of them, this occasion was "different". This aligns well with the experiences reported by Bott et al. (1997, p. 265), where their participants perceived some quit attempts to be in some way "different" from previous attempts.

> They asserted a belief in having the will or discipline to quit 'this time'. They described it as having the commitment or determination to be successful, which they felt they had not had in previous quit attempts, (Bott et al., 1997, p. 265).

In my study, Holly attributed this difference, which she made sense of in terms feeling "powerful", to the success of the quit attempt.

Peter sees this as the first and only time he has felt the personal compunction to "STOP!!" as he put it, rather than simply cut down.

These four similarities are closely aligned to the aspects necessary for successfully overcoming addiction, elucidated by Gwinnell and Adamec (2006), suggesting Holly and Peter were highly self-efficacious when the status-quo was suddenly destabilised. They acknowledge the seriousness of the problem, with Peter shocked to recognise himself ("that's me") in the man who acted in a way that was "disgusting"; and Holly's dawning realisation: "Oh my God! I'm actually killing myself!" The desire to change is evident in Peter's internal monologue: "It's got to stop," and in Holly's assertion to her husband, who was less than convinced at the veracity of her claim to be quitting: "You can say what you like, but this is my decision, for me". Their willingness to act is evident from their immediately arranging cessation treatments. Finally, the sense of this attempt being "different" suggests a belief they *can* quit and that they *really* do want to quit, and this is the "head-space" aspect that Holly referred to. It seems to me that heightened self-efficacy enhanced by the elements necessary for addiction recovery led to extended periods of total abstinence from tobacco.

## *Quitting*

Narratives about quitting were gathered through interviews and diaries. Participants who were attempting to quit were asked to keep a diary detailing their handling of nicotine withdrawal and nicotine cravings. In contrast, the stories told in interviews were shaped by subsequent reflection and the dialogic narrative process. I took a thematic approach to the diaries and a structural approach to the stories told in interviews. In both situations, I looked for language use that indicated the meaning of the situation for the person amidst the experience, and assessed this for its impact on self-efficacy.

### Montana: 11½ weeks

Montana was five weeks into a quit attempt when she agreed to participate in my research. She and her best friend were "quitting buddies", providing mutual support as they both attempted to quit. Montana has an internet blog for close friends and family, and she gave me access to this, allowing me to see how she had reported the first weeks of her quit attempt to those closest to her. In the following weeks she emailed me her blog, occasionally supplementing the content. Thus, Montana's diary is a mix of what she wanted to tell me, and what she wanted to share with her friends and family.

To assess Montana's level of self-efficacy, I examined the diary for phrases and intonations indicating her interpretation of her experiences. Table 2 includes an extract with my coding notes, and is provided as an example. The extract is Montana's blog posting from the first day of her quit attempt, modified by me to highlight language I coded as indicating positive or increasing self-efficacy (underlined), while phrases I coded as indicating negative or declining self-efficacy are in SMALL CAPITALS.

**Table 2: Example of coding for self-efficacy**

| |
|---|
| **Quit Day:**<br>Well today was the beginning of the new me …<br>I didn't have a smoke all day! PHEW!<br>The day for me still isn't quite over<br>and I HAVE BEEN STRUGGLING ALL NIGHT since I put the kids to bed<br>which is usually when I relax with a coffee and a fag,<br>but I have resisted! |
| **My interpretation:**<br>The first line is optimistic (positive/increasing);<br>she hasn't had a smoke (positive/increasing);<br>"Phew" signifies relief rather than celebration (negative/declining).<br>As she writes this blog, she accepts there is a chance her resistance may crumble ("the day … still isn't quite over"), suggesting that she is less than sure that this quit attempt will be successful (negative/declining);<br>she has been struggling (negative/declining):<br>but has resisted (positive/rising). |

The changing descriptive language Montana uses through her ten blog entries highlight the overall pattern of this quit attempt. She starts tentatively, as the Quit Day extract shows, then quickly becomes anxious as nicotine withdrawal develops: "hard"; "stressful"; "urges"; "so bad"; [internal] "arguing". From the fourth week her vocabulary expresses more confidence, to the extent that Montana adjusts her self-identity: "still a non-smoker", "less and less", "got over it", "all good". This continues until her major motivation for this quit attempt is seriously threatened when her quitting buddy relapses. Montana panics. Her language changes, expressing intense anxiety as she begins to envisage the quit attempt ending in relapse: "copy her", "on my mind", "irrational", "nut-house", "addiction", "but! … but! … but!!", "Oh! I don't know!" Finally, as she relapses, her

language choices show the return of counterintuitive thinking: “stupid”, “snuck”, “obsessed”, “deny”, “enjoy”, “kill”, [smoking as] “something I like”.

Montana’s language choices suggest that her self-efficacy was relatively balanced when she was experiencing nicotine withdrawal. She counterbalanced negative expressions with positive ones. After three weeks the level of negativity had significantly reduced, resulting in an overall positive and climbing self-efficacy, which continued until she experienced a landslide of self-doubt.

For the six weeks between withdrawal and lapsing, Montana experienced a lot less threats to her self-efficacy, and those that occurred were mostly non-specific general threats with some habit threats that she confidently dismissed, suggesting improving rather than weakening self-efficacy. Montana was feeling so positive and confident that she stopped using the NRT patches, telling me: “the patch only gave me my daily dose whilst I got used to not wanting to reach for a smoke instead.” She did not anticipate the return of the cravings after successfully navigating the nicotine withdrawal stage. Within a week her quitting buddy revealed she had smoked several cigarettes, and Montana’s cravings and cognitive threats to her self-efficacy returned.

Montana’s diary alerted me to the changing ways that some would-be ex-smokers talk about smoking. When she was experiencing nicotine withdrawal, and again when she was nearing relapse, cigarettes and smoking were addressed in positive and affectionate terms. She “likes to smoke”, she “enjoys” it, it is “pleasurable”, or as the above extract shows, she liked to “relax with a coffee and fag”. Not smoking was “hard”, it made her grumpy “for God’s sake”, and she felt like “a head-case”. Between the withdrawal and lapsing stages, when self-efficacy was high, cigarettes and smoking were described in negative terms: it is “smelly”, it “surrounds” her, it is “expensive”, and when

she thought about having a smoke she “got over it real quick”. This switch in the way terms are used was confusing as I attempted to pinpoint the sentiment within the diary entry, because the way Montana describes smoking when she is craving is counterintuitive to her goal of quitting. As the internal voice of the addiction quietens, language use realigns with her objective. To conclude, what it means to smoke, and what it means *not* to smoke, depends significantly on the phase of the quit attempt Montana is experiencing. This is intricately tied to her self-efficacy, which is not entirely within her control, as was evident by her major tumble in self-efficacy when her friend relapsed.

### Holly: The camper van

In our second interview, at her home over a cup of tea with Lemon Madeira cake, Holly related the story of her attempt to quit whilst holidaying with her husband-to-be. They were accompanied by his young children, whom she had not previously met. Holly and her partner had been living together in Europe for several years when this holiday was planned, and he suggested they quit smoking since he did not like to smoke around his children and none of his immediate family smoked. Holly was surprised by the suggestion, but agreed. She remembers the holiday as “horrible”, from the flight out to the flight home, rubbing the patch on her arm, “willing the nicotine to enter my blood stream”. Her memories of the camper van tour are dominated by attempts to deal with nicotine withdrawal on top of the expectations and evaluations of strangers who were very significant to her partner, and the strains of life in a camper van with two young children. Te Anau seems to be permanently associated with a harrowing evening of relentless cravings and a feeling of total powerlessness. She endured, and then relapsed within days of returning to Europe. On the other hand, her husband has remained smoke-free ever since.

Holly relates this as an epic saga, with herself as the central heroic character. She endures through the progressing plot: from the long flight, to meeting people, to being with the children in the camper van, then flying home to Europe. In hindsight, Holly makes sense of this experience by assessing it as “doomed to failure” because she never believed that it would result in her becoming a life-time ex-smoker. From her point of view, she will only be able to finally quit when she is quitting entirely for herself. Her interpretation suggests the quit attempt was based on a level of self-efficacy that lacked an essential element, having no confidence that the goal of a smoke-free future could be achieved through this quit attempt.

### *A natural history of smoking: Part 3: The would-be ex-smoker*

*The most important thing for quitting smoking is willpower: without enough willpower, there is no point in trying. Further, quitting treatments are expensive; and everyone knows someone who has tried everything and nothing worked.*

*Cravings are evidence of a lack of willpower and are not fought for long: smoking resumes fairly quickly, usually over a drink or after a row. Some women remain smoke-free throughout their pregnancies, but within days of giving birth the cravings start and smoking resumes. Some tell themselves that they have given up, but continue mixing tobacco with marijuana – only to notice they are getting through a lot of spliff's! Cold turkey quitting seldom results in total tobacco abstinence for more than a week, and alcohol cops the blame for weakening the willpower. Within a few days of bumming a smoke at the pub they buy a packet, promising that this time they will limit their smoking to certain times and places. It sometimes takes weeks before they tell their spouse that they are smoking again, during which time they feel guilty and deceitful, blaming other smokers for their smoky hair and clothing.*

*After a few cold turkey attempts they get some help, but stop the treatment about half way through, when the cravings seem to be gone and they are feeling great: like a teenager! Within two or three weeks most start smoking again. The lucky few who don't slip-up in the first few months confidently claim the status of 'ex-smoker', remaining smoke-free for extended periods.*

*The eventual relapse results in an acute sense of failure, often compared with childhood memories of disappointed and angry parents. This relapse is often pre-empted by major stress, such as bereavement, a changed social role, or a legal matter. This time their spouse is among the first to know. Again, they resolve to keep control of their smoking; and they also have a new awareness: they <u>can</u> do it! But there is still a strongly-held notion that there is no point in attempting to quit until they are in the right frame of mind.*

**Figure 9: Vignette: The would-be ex-smoker**

## *Relapsing*

*Only about 6% of people trying to quit smoking at any given time are successful for more than one month (U.S. Department of Health and Human Services, 2000).*

The relapse signals a return to current smoking after a period of abstinence, keeping the would-be ex-smoker within the cessation—relapse cycle. The only alternative to relapse is to become a life-time ex-smoker. The interviews yielded many relapse stories, and in addition, one diary provided an intimate window to the craving-by-craving experience of relapsing. I have drawn extensively on this example because its immediacy provided an opportunity to see how the participant made sense of her experiences as they unfolded rather than in hindsight.

### Montana: Lapsing

Relapsing is often preceded by a period where the would-be ex-smoker has the occasional cigarette, referred to as a slip-up, or lapse. Montana emailed me at 12:32am after a late-night slip-up, eight weeks into her quit attempt, and two weeks after stopping NRT:

> I just smoked half a smoke!
> What's up with that?
> I am really pi**ed at myself [her language presentation]
> but it was nice!
> …
> I think I wanted to taste it
> to remind myself I didn't want it …
> but I am not sure it's worked!
> AARRGGGHHHHH!!!!!

The diary entry contains themes of anger and confusion. The biggest challenge for Montana is that despite being angry at herself for having smoking it, she liked it. She draws on the idea of self-deception to make sense of what has occurred. The notion that having a smoke would remind her that she did not want it made sense before the smoke, but immediately afterwards she realises the

flaw in her thinking, and she is “not sure it’s worked”. Our first interview and her diary entries suggest that Montana enjoys smoking. Wanting to quit has nothing to do with smoking *per se*, but is prompted by the threat of an early death through a smoking-related illness. I am not sure that Montana had made this distinction prior to this slip-up, but the narrated scream that ends the email suggests she may be moving closer to that understanding.

Our second interview was already organised for later that week and, over coffee, Montana told me about that night. In the extract below my contribution is included, and italicised, to demonstrate the dialogic, conversational nature of narrative story telling. I was consciously using body language such as nodding, keeping eye contact, and maintaining an attentive, alert posture to engage with Montana and encourage her to elaborate in telling her story. My brief verbal contributions had the same intention, and I was consciously avoiding expressing anything that might cut off or redirect the story. Montana started by telling me she was avoiding talking about “the incident”, which I said was ok: what she shared with me was up to her. Perhaps it was this reassurance that prompted her mode of delivery, but without delay she told me a tremendously detailed story – about 1700 words with under 50 being my own – of an afternoon and evening of frustrating events which eventually led to her having a cigarette. The opening “So” of the following extract closes the prolonged sequence of orienting and complicating actions, and marks the moment Montana decided to have a smoke.

> So I’ve got these cigarettes in the pantry.
> Two? Three? Two!
> And I’ve also got these other ones that I had in Australia
> …
> They are in a different packet that opens right up
> and they look gorgeous: they are the coloured ones.
> …
> There’s three of them now but there were four of them:
> There were two pink and two purple ones left in the packet.
> …

And I didn't want to smoke the two real ones [from the pantry],
so I had half of one of those:
they are actually very long, so I had half of one of those.
[long pause]
And I had the other half last night.

*Did ya?*

Yeah. Because I knew that the other half was sitting there.
Pathetic ay?
Especially when you're standing outside freezing your arse off
[laughing] doing it.
Anyway, and now it's gone.
It's gone now.
I was thinking to myself:
"Now it's gone, Montana!
You can't go back to it.
It can't be calling you, coz it's gone."

*Was it calling you?*

Well, I did feel that it was, yeah.
Could you not hear it? [laughing]
Or was that something just in my head?
I'm sure it was audible.

Montana commenced by drawing on the tropes of an epic narrative. She detailed each drama the day had presented and how she had overcome it without resorting to smoking. Her detailed explanations suspend the action. For example, in the extract she focuses on the quantity of cigarettes and their brands, right down to their colours. This helps set the scene and also allows Montana to present a self-image of sophistication and control. She has "gorgeous" cigarettes as well as "real" cigarettes, and she has refrained from smoking these "hidden" cigarettes for over eight weeks.

As the narrative moves on, she does not reflect on the act of smoking the cigarette: she simply "had" half of a cigarette, and from this pivotal moment the narrative turns from an epic struggle to a black comedy. As she told the story there was a dramatic pause and something in her manner changed: she seemed to realise that the image she was presenting was not sustainable. It came undone as

the pause ended and she revealed she had smoked the other half of the cigarette the following night. Montana then presents a new image of herself and the sophisticated woman skilfully navigating her busy life as wife, mother, friend, and workplace manager are replaced with a comedic “pathetic” woman standing in the cold sneaking a few puffs on a colourful cigarette. Her self-appraisal as “pathetic” possibly also relates to the increasingly strong urges to smoke. Montana gives a theatrical performance here, as if pleading for an empathetic hearing, by scripting the imagined dialogue with the half-smoked cigarette, injecting humour to downplay the threat to her quit attempt.

Late in the narrative, the coda uses repetition, with four instances within 30 words: “now it’s gone”; “It’s gone now”; “Now it’s gone”; and “coz it’s gone”. This suggests that for Montana, the epic tale turned black comedy has now become a tragedy. Montana seems to be experiencing a sense of loss, which may be about her desire to smoke or it may be her realisation that what is “gone” is her quit attempt. This coda pulls the narrator and audience back to the present, and for much of the rest of the interview Montana talked about ways she might shore up her quit attempt.

To conclude, the anger and confusion evident in the email are missing from the narrative 30 hours later. These are replaced with a sense of loss and weakness, despite her initial attempts to project a valiant front. The prolonged narrative, relating the multiple stresses of the afternoon and evening fit the description of a stress spike, and this phenomenon, which typically builds over a period of five to six hours, putting the person into an increasingly bad mood, is a common precursor to relapse (Shiffman, 2008). It seems that Montana’s quit attempt was so seriously jeopardised by the lapse that unless she took deliberate and determined steps to reinvigorate the attempt, she was heading for relapse from her first puff. As empirical studies have shown, despite eight weeks of total

abstinence, within ten seconds of inhaling on her "gorgeous" cigarette, nicotine was racing through the familiar pathways of Montana's brain, producing a rewarding burst of dopamine, priming her to seek the satisfactions of another nicotine hit (Gwinnell & Adamec, 2006; Juliano et al., 2006; Laviolette, Lauzon, Bishop, Sun, & Tan, 2008; Wang et al., 2005).

### Montana: Craving crises

A few weeks later Montana was experiencing waves of intense cravings which she attempted to placate with the occasional cigarette. The striking difference between her real-time email and her later recollections about her initial lapse prompted me to ask Montana to keep a one-day log, noting each craving and smoking-related event as it occurred. The outcome is an unsettling account of a day of cravings, which arrived by email the following day. Her honesty leaves her bare, and I am very grateful that she indulged my request. What follows is not a glorious account of epic heroism, but something more akin to a slow-motion train-wreck.

I analysed the log thematically, looking for clues to what each event meant for Montana on an emotional level. Then I considered each entry from a structural analysis perspective, before looking at the day as a whole and considering the log in the context of our earlier interviews and Montana's blog entries. The log was kept on the one day of the week when Montana works from home.

> 10.18AM
> Random, I want one now.
>
> I actually went and bought some yesterday
> cos I was pinching my husband's and hate menthol
> but smoked it anyway.
>
> So now I know I have some, I want one.
>
> I haven't actually eaten yet today
> so might opt for some toast instead.

> Up until now I have only ever had one at night,
> so it is weird that I want one now, in the morning,
> which is actually the time I would have had my first smoke of the day 13 weeks ago when I was still smoking.

This "random" craving is made sense of in two ways. The availability of cigarettes has created a temptation, and the timing coincides with her first smoke of the day when she is smoking *ad libitum*.

Montana justifies purchasing cigarettes by revealing that she had been "pinching" from her husband's packet and does not like his brand. This background information perhaps unwittingly reveals that the six "hidden" cigarettes referred to earlier are no longer available. Also, her justification takes the revelation a little further: "pinching" cigarettes suggests this was underhand. Montana might not like menthol, but the feeling of deceit may be even more distasteful.

> 12.45PM
> Next big craving…
>
> I am working from home today
> and think that this is why I suddenly want to smoke
> as opposed to if I was in the office in Wellington.
>
> I have however mentally abused everyone who sent me dumb emails and requests.
> Actually I have made someone in [department] apologise to me which is funny… [Name] speaks like that to everyone, but I got on my high horse and took offence.
>
> I actually have decided that people are taking stupid-pills and are just out to get me today
> and it is nothing to do with the fact that I am being unreasonable!
>
> I have eaten, cleaned the kitchen, swept the floors and tried other ways to take my mind of running outside to smoke.
>
> Right now I have a watery mouth like a hunger…
> but it's for a smoke!!!
> Grrrr! HELP ME!!!

Again, Montana makes sense of her predicament in two ways. Instead of being at her office, she is at home, where her regular diary

has noted occasional lapsing cigarettes. Secondly, she attributes her distress to the incompetence of colleagues and clients. Over half of this entry addresses the shortcomings of others, illustrating the claim that narrators give lengthy accounts in order to persuade their audience that actions are justified, "especially if they go against the grain," (Riessman, 2008, p. 86). This subtly strengthens Montana's attempt to shore up the claim that her colleagues are the cause of her stress and therefore responsible for her cravings.

Counterbalancing this, Montana recognises that she is being unreasonable and lists ways she has tried to manage the cravings. Yet despite her cognitive recognition of what is happening she is unable to satisfactorily resolve her predicament and fears she is losing control: the entry ends in a frustrated panic.

> 1.05PM
> Just got off the phone from the Quit Group
> and they are going to send me out some vouchers for gum.
> We discussed patches vs gum
> and she thinks at this stage that gum could be a good alternative.
> Then I can pop one in my mouth or chew on the one already in there, as a craving takes over.
>
> She was really nice and praised me for my efforts so far and didn't tell me off for smoking the ones I have smoked to date, but instead said that of the 15 I could have smoked, it was good I have only had 3!
>
> Which is true!
>
> Just got to wait till the voucher gets here
> and hope I am not smoking anymore than that before then!
> Ha ha!!

This event is the resolution to the entry from twenty minutes earlier, which ended with Montana in a panic. The entry starts very positively and I was initially delighted that Montana had taken a positive step toward shoring up her quit attempt. But this did not last. Montana's expressed hope that she will not have smoked more than three cigarettes before she gets the NRT gum is immediately rendered

meaningless by her laughter. There are two ways in which "Ha ha!!" makes sense: jest and irony. Jest, if Montana expects to smoke, and irony if she has already smoked more than three cigarettes, and this is possible. As she revealed in the second interview, Montana had six cigarettes available before resorting to her husband's packet. Her laughter seems to indicate that Montana is a step closer to accepting she has relapsed.

The email chain showed that the previous day Montana was considering resuming NRT. She had 14 patches available, having stopped the treatment after six weeks. I responded to her suggestion: *"Nice idea about banging on a patch – you could even ring up Quitline and get some more!"* The dialogical approach includes a focus on the dialogue between narrator and audience in interviews, maintaining that narrative recollections are composed through interaction. However, this was not expected or evident in the diaries. On the other hand, email correspondence opens a new opportunity for dialogical analysis, and this instance is clearly an example of my (the audience) impact on an unfolding story. Not only is the narrated recollection a story composed in interaction, so is the real-time journey.

Returning to the log, the next craving crisis entry reads:

> LATER: NOT SURE OF THE TIME …
> Work got even more stressful
> and so I called my boss and told him I quit!
> Then I vented about all the stupid people that kept calling me and making my life hell.
> He listened, and declined my resignation.
>
> I went and had a smoke
> and got back on with work
> and sorted out another crisis for another customer….
>
> Oh what fun! I really need a new job I think!

Montana makes two attempts to resolve this craving crisis, first venting her frustration at her boss, and when that fails to satisfy, she resorts to a smoke, the ultimate cravings satisfier. The dramatic

gesture of resigning demonstrates the extent of her frustration. Montana felt she no longer had any choice or control over her circumstances. The cigarette is the pivot of this story. Having a smoke has solved her crisis so that she can return to resolving other peoples' crises. For Montana, the cigarette signifies a return to a sense of control. Finally, the absence of a time suggests Montana wrote this some time after the event. It is likely to have occurred prior to 3pm, because once school was finished Montana could not smoke undetected until late in the evening.

> EVENING
> The kids wouldn't stop fighting and yelling at each other;
> it wasn't quiet yelling either.
>
> But I didn't smoke because
> I don't want the kids to know I am having sneaky smokes.
> So I just breathed through it and yelled some of my own!

Montana refrains from smoking to avoid detection, but from her point of view the squabbling children are accountable for her urge to smoke. She resolves her frustration by joining the fray.

> LATE EVENING
> BUT…when they went to bed,
> I got my book, made a coffee and enjoyed some quiet time with a fag in my hand!
>
> DOH! That's two today now!
> Come on voucher for the gum!

It is not certain that Montana started craving once the children had gone to bed. She possibly anticipated this smoking event, which was her favourite smoke of the day prior to her quit attempt, and the timing corresponds with other lapses reported in her diary. Alternatively, she may have rejected the battle with cravings, immediately attending to the desire for a cigarette. This is a satisfying cigarette for Montana. The combination of book, coffee, quiet time and cigarette, enable her to re-establish a sense of wellbeing that has been absent from the log throughout the day.

Montana attempts to close on notes of regret and hope, but misses the mark. There is a strong sense that the quit attempt is over through the use of Homer Simpson's "Doh!" This puts the diary into the genre of black comedy, where the actions of the protagonist result in a predictable outcome that somehow remains concealed from the main character until the situation has fully played out. Montana's "DOH!" strongly suggests she has realised the end of her quit attempt has arrived or is rapidly approaching.

Considering the log as a whole, there is a pattern to the timing of Montana's cravings, and it aligns with the cravings cycle of other participants who are current smokers, such as Holly. Montana made sense of each craving and smoking event in ways that she recognised as stress attributable to external factors, but these occurred in a cycle of about two and a half to three hours. Some of these times are approximations based on the contextual knowledge received through interviews, particularly the after school routine, and Montana's end-of-day cigarette:

10:18, 12:45, and ≈15:00, ≈17:30, ≈ 20.30/21:00.

One explanation is that the lapsing cigarettes have primed Montana to seek nicotine in the same way she did before successfully navigating withdrawal about 13 weeks ago. This supports clinical research which demonstrates that for people who have acquired a substance addiction and then withdrawn from that substance, a single use "will reinstate drug-seeking behaviour" (Juliano et al., 2006, p. 166). Thus, it may be significant that the first craving event coincided with the timing of her previously customary first smoke of the day. Additionally, the final entry corresponds exactly with Montana's favourite smoke of the day, and the one she missed the most whilst abstinent. Montana attributes events two, three and four to external stresses, but the time intervals between events suggest

that nicotine dependence has taken control, and she is effectively back at day one of her quit attempt.

As a post-script, Montana's regular diary noted that the "voucher for gum", or QuitCard, arrived two days later (Thursday). She planned to get it filled over the weekend and to start using the gum on Monday. But it was never redeemed. Three months later I met with Montana to thank her for contributing to my research. She described herself as "a smelly smoker," which is "very frustrating, but I will kick this habit one day!"

### Other experiences

Hope had not smoked for eight weeks when her partner's parents arrived from Europe for a one month visit. His mother smokes and has obsessive compulsive disorder, constantly cleaning and, most annoyingly for Hope, "she's one of these people that puts towels in with everything … I had to hide the [laundry] hamper in the wardrobe!"

> She'd be out there smoking.
> I think had she not been a smoker…
> And I didn't have access to them,
> then I wouldn't,
> I don't think I would have started again.
>
> But they were 'there'
> So yeah.
>
> And she'd go and buy them for me!
> So then I thought,
> "Well, I have to smoke them!" [laughing].
> …
> She probably felt guilty which is why she'd buy me cigarettes.

Hope's quit attempt was undermined by her partner's mother in several ways. The stress of a lengthy visit was compounded by her illness, and topped off by her purposefully purchasing Hope's preferred brand so that Hope would join her outside for a smoke. Hope nonetheless accepts responsibility for ending the quit attempt:

"I have to smoke them!" The laugh that follows this statement suggests resignation or defeat: she has given up trying to quit due to what has become an overwhelming burden. Not directly present in this extract but gleaned from the overall narrative is the sense that Hope needed to keep the peace in her temporarily crowded home. The temptation of cigarettes being on-hand was already stressing Hope, but her resolve dissolved when she was offered her preferred brand. When I asked her if the stress affected relationships within the house Hope closed down the narrative by telling me "I get on really well with them; she's lovely. We were all fine." Nevertheless, Hope's comment to her partner: "I can't NOT smoke while she's here, I'm sorry!" suggests that not everyone was fine.

Holly relapsed after six months of total abstinence when her uncle died just an hour after a family gathering celebrating his birthday. The family reassembled late at night, in the bar of the hotel where they were staying, and Holly despaired:

> "Just give me a cigarette!"
> And that was it:
> AGAIN!!!
> …
> I had been so proud of myself
> and feel really shit;
> and letting people … [trails off]
> Like the guys that work here were really proud of me
> for not smoking.
> And to see them,
> one by one,
> to recognise that I was smoking again
> and to realise the disappointment, from them:
> you just feel like ooooo [clutching stomach, like pain in gut]
> I feel so bad
> It's horrible, it's really horrible.
> But, but I will keep trying.

Despite the relapse occurring five months earlier, the impact on her self-esteem is clear through Holly's use of the present tense to describe her feelings. She makes an analogy with physical pain to ensure her interpretation is understood. She later compared this with

feelings she experienced as a child when she was punished by her mother for something she had not done. Despite her diary of current smoking showing little intention to quit, she asserts here that she "will keep trying", and it seems to me that this assertion is inspired directly by the impact of recalling and telling this story.

Peter had not smoked for about four months when he was seconded to a very important government agency where he "was struggling a wee bit." A well-meaning colleague referred him to a senior consultant with experience in both the subject and environment, but this backfired:

> [He] treated me like an absolute piece of shit.
> When I left his office I just absolutely could not believe that I could feel this way;
> that someone would treat me like that.
> I was young, I was naïve.
> I went back to my little area [of the office],
> I sat down and I looked out the window
> and I saw some people down there smoking
> and I went straight down there
> and said "Can I bum a cigarette off someone?"
> and they said "Yeah, sure mate"
> and BANG: smoking again.

On the surface, this story is about what prompted Peter to relapse, rather than how he feels about relapsing, which is a major contrast to Holly's story. But a deeper reading, focusing on the literary devices used to tell the story, gets beyond the cause to reveal how Peter feels about the relapse. One trope he uses is to suspend the plot through a descriptive account of his actions, frequently using "and" to add layers to the picture he is drawing in the mind's eye of his audience. The result is action presented in a slow-motion haze, creating a sense of Peter's confused state. By doing this he builds a scenario that invites the audience to lend a sympathetic ear, precisely because the outcome is contentious and he needs his audience to accept the veracity of his interpretation. He uses the epic trope of alternating success and failure, but with a significant difference. Where there

should be success (with the consultant), there is failure; and while some might interpret the return to smoking as a failure, for Peter this is a success. Peter self-deprecates throughout the story, positioning himself at first as young and naïve, then returning to his "little area", and finally "bumming" a cigarette. His language choices suggest a tragedy. Peter wants the sympathy of his audience, because this is an undeserved trauma inflicted by the antagonist. Finally the narrative turns to romance when the smokers treat Peter with kindness and call him "mate" despite his having abandoned the ranks of current smokers four months earlier. There is a similarity to the biblical story *The Parable of the Lost Son:* all is forgiven, even though you rejected us. In contrast, the consultant-antagonist, who was supposed to become a supportive mentor, left him feeling "like … shit". The smokers restore his disrupted sense of self, and he expresses his gratitude by scripting a speaking part for the unidentified smoker. Thus, for the narrator, this relapse story concludes happily, with Peter restored to the ranks of current smoker, and able to access some much-needed camaraderie, just outside the building.

Permanent cessation has never been a priority for John, who has instead sought to reduce or quit on a temporary basis, usually associated with a specific financial or sporting aim, and more recently due to pressure from his non-smoking partner. Consequently, when faced with the urge to smoke, he has never fought it: "when I've really wanted to have a cigarette, I've just had one". Rather than narrating specific stories, John talked more generally about relapsing.

> For me, that's been the invariable pattern:
> pubs, socialising, drinking.
> And other smokers.
> But even, invariably, there's been other smokers around and that's what's kicked me off as it were.
> Obviously I make the decision,
> but um,

> but even if there's no other smokers
> and I have a couple of drinks,
> [I'm soon thinking] "A cigarette would be nice to go with this".
> So, other smokers don't even have to necessarily be present.
> If they are present it makes it all the more likely.

Just as Montana, Holly, Hope and Peter noted, John associates his tendency to relapse with the presence and availability of tobacco. All five participants noted this in various ways, suggesting there is some salience to the argument for removing tobacco displays from retail outlets. While it might not be true that out of sight is out of mind, it does seem that the presence of cigarettes increases the frequency and intensity of nicotine cravings for all five participants.

Like Hope, who felt it would be impolite not to smoke the cigarettes specifically purchased for her, but that it was nonetheless her own choice, John considers returning to smoking a matter of personal choice. He had been limiting himself to one cigarette each day for about a year when he was to attend a wedding, bringing together friends, alcohol and cigarettes.

> I just decided not to kind of be unrealistic about it,
> because there was a lot of smokers there.
> So I just said,
> "Look, whatever I smoke tonight, I smoke tonight and that's not a problem. I'll just revert to my programme tomorrow."

John consciously gives himself a free pass, forgiving the likely excesses of the event prior to it occurring. From his point of view, it would be "unrealistic", and detract from the pleasures of the evening, to attempt to adhere to his "one per day" quota, so he makes what for him is the positive choice to smoke *ad libitum* for the evening.

If failing to quit indicates a lack of willpower, reframing the story as a conscious choice to smoke negates the willpower—weakness narrative. John and Hope attempt this with their assertions that they are "making a choice" to smoke, because choosing to smoke is not equated with failing to quit. If smoking is considered normal, such as

at the wedding, or when Hope is hosting her partner's mother, then not smoking is dangerous to that norm. For people who are cutting down or quitting, it may be easier to keep the peace – as Hope did – or accept that in some circumstances they will smoke – as John did – rather acting in a non-normative way.

The strong association of nicotine and alcohol noted by John was also noted by Peter, who avoids alcohol when he is trying to quit. Writing about her lapsing cigarette, Montana noted with pride that she had avoided having a smoke whilst out drinking with friends, only to lapse in secret, on her own, a few days later. There was a sense that having a cigarette whilst out socialising would have been more acceptable than what happened later in the week. Hope, who achieved extended periods of abstinence when she was having her children, also associated relapsing with the presence of alcohol combined with other smokers:

> It's usually when I'm drinking and when I'm around other smokers.
> And I just think,
> "What the hell. Only one! I'll just have one" [whispering].
> I really envy people that can only smoke when they drink.

Hope's coda effectively moved the dialogue away from her experiences of relapse to the potential joys of being a social smoker without addressing the missing aspect of the story: "just one" is not enough.

For John, the experiences that prompt a return to his usual pattern of smoking are very similar to those of other participants: other smokers and alcohol. He makes sense of this by rejecting the idea that he has ever *really* wanted to achieve total cessation. This is possibly easier to accept than having to assess oneself as lacking the willpower to succeed, but it is also possible that John has never attempted total cessation despite his distal desire to be smoke-free.

In summary, there are two characteristics that are highly evident in the relapse narratives: availability and distress. The availability of

cigarettes was always integral to the lapse or relapse. For Peter and Holly, tobacco availability accompanied by a sudden urge to smoke came as a surprise and it was not resisted. For others, there was a building sense of inevitability, such as occurred with Hope and Montana who both had access to tobacco but fought temptation for some time before relapsing. For John, there was a calculated decision to suspend his quota regime in favour of the social opportunities presented by not having to avoid people who were smoking.

Overwhelming distress is frequently at the core of relapse stories where the person has been smoke-free for six months or more. Just two of a possible six such stories gathered from four of the five participants have been analysed here, with Holly and Peter describing single incidents that provoked an immediate and unexpected return to smoking. In both cases relapse is attributed to being suddenly plummeted into despair. In their despair they drew on a familiar behaviour that seemed to have worked in the past: they reached for a cigarette. This demonstrates in human terms the study by Wang et al. (2005) which showed the long-lasting effects of neuroadaptation caused by addiction. People who have successfully navigated the withdrawal phase of nicotine addiction still have a long road ahead before the sudden and unwelcome pull toward nicotine fades away.

On the other hand, Montana described accumulating stresses that gradually wore away her resolve, and while Hope gave a similar description of building tension, she rejected the suggestion that stress contributed to her relapse, preferring to invoke the “personal choice” argument. Meanwhile John’s approach of permitting *ad libitum* smoking at certain times mitigated the probable distress of attending the wedding as a “one-per-day” smoker.

## Conclusion

The aim of this research was to elicit the point of view of would-be ex-smokers so that their ways of making sense of chronic relapsing will be available for enhancing cessation services. The research design and analytical method I deployed have not previously been used to explore this topic. I have demonstrated the value of this method for eliciting the insider point of view, showing that chronic relapsing smokers interpret their situation through a different master narrative than those deployed by the tobacco control domain.

Three master narratives impact the cessation—relapse cycle: cost, writ large; addiction; and willpower versus weakness. Although the tobacco control domain is largely driven by the cost narrative, cessation assistance is mostly centred on pharmacological treatments which attempt to alleviate withdrawal symptoms. However, NRT is not particularly effective (and appears even less so because treatment is usually truncated), because the master narrative of willpower versus weakness is more salient to those being treated than the addiction master narrative.

The willpower versus weakness master narrative is very closely associated with self-efficacy. High self-efficacy enhanced by the elements necessary for addiction recovery was evident in the experiences of people who stopped smoking for extended periods. Their efforts were ultimately undermined because they did not have alternative ways to cope with intense and unexpected urges to smoke when traumatic events interrupted their lives. This was evident even when full remission seemed to have been attained. People wanting to quit would be better served by programmes that include the tenets of addiction recovery as well as nicotine withdrawal assistance, and which extend their focus beyond early remission, including tactics for remaining smoke-free.

Self-efficacy is not entirely in the control of the self. Just as narratives are created through dialogue, so are the events that they depict. An unfortunate and unintended consequence of some approaches to demand reduction, such as threat appeal campaigns, is that some smokers interpret these as stigmatising. Negative vicarious experiences diminish self-efficacy, making it more difficult to imagine oneself as achieving lifelong recovery from the pressing desire to smoke. More quit attempts may be successful when would-be ex-smokers are supported and informed in ways that boost their self-efficacy.

These conclusions lead to several recommendations for the tobacco control domain:

- Actively direct blame and responsibility onto the tobacco industry.
- Review threat appeal campaigns for their potential to stigmatise those who smoke.
- Inform the public and health practitioners about addiction and the extent to which pharmacology can assist with quitting.
- Increase and strengthen offers of cessation assistance support.
- Encourage creative and flexible approaches to cessation treatments, such as the simultaneous use of NRT with concomitant smoking, the 'cut down, then quit' approach, and simultaneous use of both acute and slow-release forms of pharmacological cessation treatments.
- Increase the behavioural aspects of cessation treatments, focusing on skills that will support the decision to remain smoke-free even when confronted by extreme distress.

Through this thesis, a new view of smoking cessation has been achieved by the creative application of narrative methods, including two complementary forms of data collection. The overarching dialogical approach made the real-time experiences reported through diaries more informative than if thematic analysis had been used alone. Recollected narratives gathered at interviews were structurally analysed and became more informative with the attention to context brought by the dialogic approach. Consequently, the findings are rich in human experience, giving the participant-narrators a definite presence. If the research design had been limited to one technique or one method of analysis, the complexity of the insider point of view would have been over-simplified.

The method provided exceptional access to the experience of relapse, offering a vicarious encounter with the drama and trauma of diminishing self-efficacy. This raises questions such as how widespread counterintuitive thinking is amongst others actively attempting to quit; the role of counterintuitive thoughts in relapse; and whether this experience is also evident amongst people making other behavioural changes. My research suggests that monitoring the changing ways in which people make sense of their situation – such as through the counterintuitive thinking that characterised withdrawal and the lapsing phase – would provide identifiable opportunities for targeted bolstering of self-efficacy, possibly extending the duration of the recovery attempt and avoiding relapse.

Research about smoking cessation from the insider perspective could be further advanced by comparing groups of at-risk participants to find out if the willpower/weakness master narrative is generally prevalent, and to see if different groups have particular ways of making sense of smoking and trying to quit. A limitation, however, is that language and syntax patterns are not universal. For example, counterintuitive thinking may be regarded differently in some cultures. Nevertheless, this method holds considerable promise for

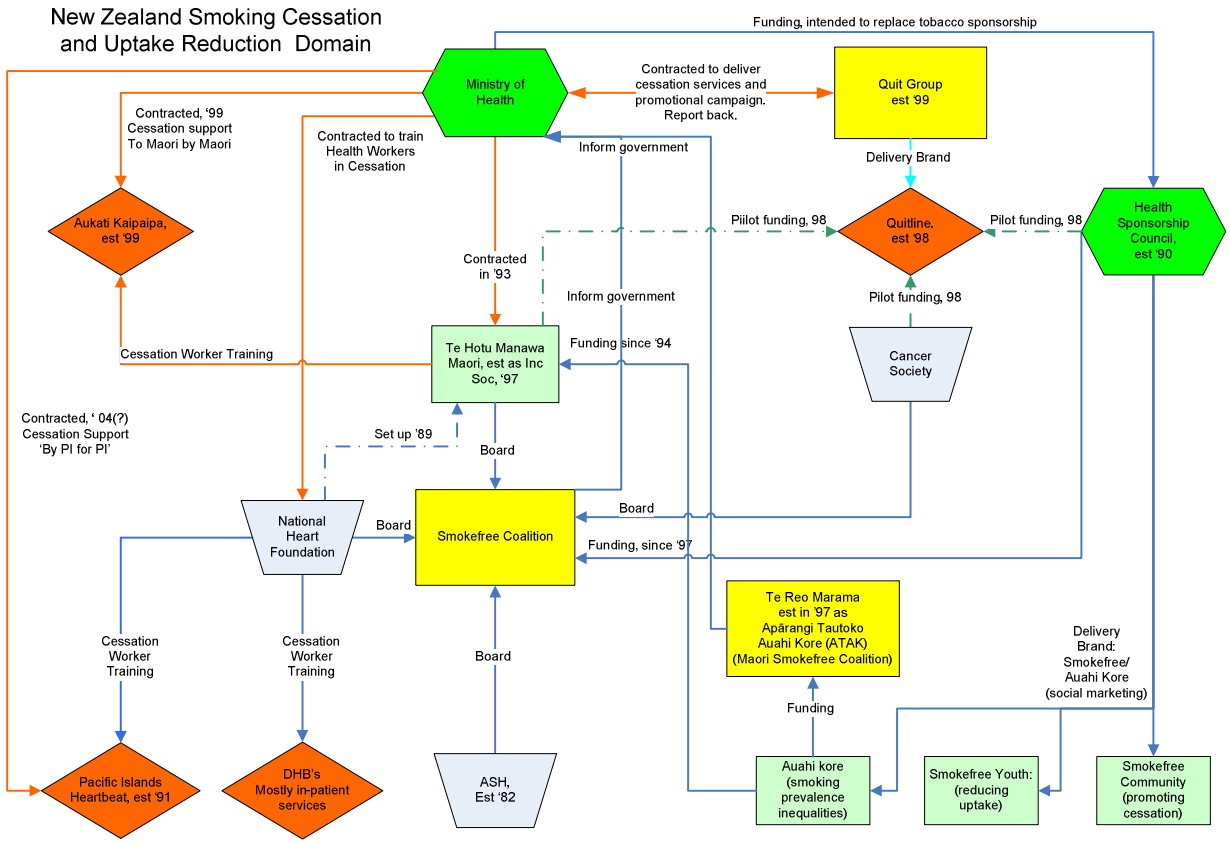
use with people for whom spoken language is substantially supplemented with physical attitude – an aspect that is elevated through the dialogical approach but often overlooked in thematic and structural analyses.

In this study the dialogical process extended beyond interviews to all aspects of direct communication between the researcher and the participant, particularly email. In future studies using narrative analysis, participants should be asked to approve use of all forms of communication, subject to their review of direct quotations. This will ensure analysis can extend to the dialogical process of narrative creation beyond the formal means of data gathering, into the lived space of researcher—narrator interaction.

A method of narrative analysis not used in this study is visual analysis. Visual analysis seems well suited to studies where the researcher seeks the point of view of the person in the midst of the experience. Incorporating an image-diary, where participant-narrators photograph aspects of their experience, is another way that the lived experience could become available for analysis without the researcher 'being there' in the ethnographic sense.

Narrative methods are well suited to studies which seek the insider perspective. Dialogic analysis greatly enhances the possibilities of reaching the inferred interpretations that are present in narrative accounts, because thematic and structural aspects are overlaid with attention to context writ large. The narrative is situated within the biographical context of the narrator, and the contexts of narrative creation and narrative performance are also crucial to the analysis. Patton (1990, p. 357) declared that "If participant observation means 'walk a mile in my shoes,' then depth interviewing means 'walk a mile in my head'", and the narrative method of dialogical analysis significantly enhanced my ability to achieve this promise.

# Appendix A: New Zealand Tobacco Control Domain (my own diagram)



# Appendix B: Cochrane Reviews

A summary of reviews conducted by the Cochrane Nicotine Addiction Review Group
for physiological and psychological treatments

To determine the effectiveness of the trials included in the Review,
all of these Reviews considered the smoking status of participants six months or more following the treatment.

| Year | Title and URL | Treatment claim | Conclusion |
|---|---|---|---|
| | **Physiological/Pharmacological Treatments** | | |
| 1998 | **Hypnotherapy** for smoking cessation http://www.cochrane.org/reviews/en/ab001008.html | Weakening the desire to smoke, strengthening the will to quit, or helping people concentrate on a quit programme. | Claimed effects not confirmed. Not shown to be any more effective than unassisted quitting. |
| 2005 | **Acupuncture** and related interventions for smoking cessation http://www.cochrane.org/reviews/en/ab000009.html | Reduces withdrawal symptoms, reducing the likelihood of relapse. | Inconsistent evidence due to methodological issues. Further research is warranted. |
| 2008 | **Nicotine replacement therapy** for smoking cessation http://www.cochrane.org/reviews/en/ab000146.html | Reduce withdrawal symptoms, reducing the likelihood of relapse. | Increases the quit-rate by 50 - 70%. Using slow-release in conjuction with accute delivery forms further increases the quit-rate, and starting using NRT with ad libitum smoking prior to the quit date improves the quit-rate even further. |
| | **Psychological/Behavioural Treatments** | | |
| 2001 | **Aversive smoking** for smoking cessation http://www.cochrane.org/reviews/en/ab000546.html | Rapid smoking: deep inhalation every few seconds to make smoking unpleasant. | Not conclusively effective, but it may be worth further research: there are indications of promise which warrant evaluation using modern rigorous methodology. |
| 2002 | **Community** interventions for reducing smoking among adults http://www.cochrane.org/reviews/en/ab001745.html | Community-wide, multiple channelled programmes reinforce and support norms for not smoking. E.g. anti-smoking campaigns, quit campaigns. | Little convincing evidence that community interventions reduce smoking among adults. Although intervention communities often showed substantial awareness of their programme, this rarely led to higher quit-rates. |
| 2004 | **Exercise** interventions for http://www.cochrane.org/reviews/en/ab002295.html | Exercise aids cessation | Insufficent evidence to claim that exercise alone helps prevent relapse in the longer term. |
| 2005 | **Competitions and incentives** for smoking cessation http://www.cochrane.org/reviews/en/ab004307.html | Material or financial incentives induce behavioural change. | Smokers may quit while they take part in the competition or receive rewards but do no better than unassisted quitters in the longer term. |
| 2005 | **Group behaviour therapy** programmes for smoking cessation http://www.cochrane.org/reviews/en/ab001007.html | Individuals learn behavioural techniques for smoking cessation and provide each other with mutual support. | Group programmes are twice as effective as just using self-help materials. |
| 2005 | **Individual behavioural counselling** for smoking cessation http://www.cochrane.org/reviews/en/ab001292.html | Face-to-face, one-on-one cessation counselling | This is beneficial, but not necessarily more so than group therapy. |
| 2005 | **Quit and Win contests** for smoking cessation http://www.cochrane.org/reviews/en/ab004986.html | Abstainence for a period earns 'entry' to a prize draw (cash, holidays, consumer goods) | Increases quit attempts but little impact on overall quit-rate. |
| 2005 | **Self-help** interventions for smoking cessation http://www.cochrane.org/reviews/en/ab001118.html | Cessation manuals and brochures to guide the quit attempt. | Materials tailored to the individual are more effective than generalised material, but even then the effect is very small. |

# Appendix C: Maintaining the status-quo

**Table 3: Applying the statistics to a real population**

| | |
|---|---|
| *Applying statistics from the New Zealand Tobacco Use Survey 2006 (Ministry of Health, 2007c) to the smoking population, and incorporating the cessation approach effectiveness statistics from authoritative sources within the international tobacco control domain, gives an indication of the number of attempts occurring each year, how successful these are.* | |
| The 2006/07 New Zealand Health Survey claims that just under 20% of New Zealand adults are current smokers – smoking at least monthly (Ministry of Health, 2008c, p. 61). This subset is the 'smoking population' of New Zealand. | 619,000 |
| About 65% of the smoking population tried to quit in the past five years, with almost 70% of them stopping for at least one week (Ministry of Health, 2007b, p. 51) | 401,370<br>278,000 |
| Of those who stopped for at least one week, about 64% tried to quit at least once in the past year (Ministry of Health, 2007b, p. 54). | 177,085 |
| About 75% of those who tried to quit in the past year used no assistance (Ministry of Health, 2007b, p. 61)<br>About 3% of unassisted quit attempts result in life-time quitting (Glover, 2006) | 130,160<br>3,900 |
| About 25% of the quit attempts that occurred in the past year used a cessation treatment – usually NRT (Ministry of Health, 2007b, p. 61)<br>NRT improves the chances of permanent quitting by 50% to 70% (Stead et al., 2008), so, optimistically, about 5% of those who used a cessation treatment will have permanently stopped smoking. | 46,930<br>2,350 |
| So the number of people who achieve full, sustained abstinence from smoking in a year, with or without assistance, is roughly …<br>And quit attempts that end in relapse number about … | 6,250<br>170,800 |
| The Quit Group (2004) estimates that annual smoking uptake as … | 19,000 |
| Meanwhile, the number of smokers who die each year from smoking-related illnesses is approximately …<br>(Another 300 die due to illnesses attributed to second-hand-smoke) (Ministerial Committee on Drug Policy, 2007, p. 25) | 4,700 |
| *Conclusion: The number of people who take up smoking each year (19,000) outnumbers those who stop smoking, either by quitting (6250) or by dying (4700).* | |

# Appendix D: Participant Information Sheet

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI
VICTORIA
UNIVERSITY OF WELLINGTON

## Participant Information Sheet: Ever tried to quit smoking?

Researcher: Carolyn Hooper: School of Social and Cultural Studies, Victoria University of Wellington, telephone 463 5222 ext 8444
Supervisor: Chamsy el-Ojeili: School of Social and Cultural Studies, Victoria University of Wellington, telephone 463 6740

I am studying toward a Masters (Applied) in Social Science Research. As part of this degree I am writing a thesis about trying to quit smoking. The experts I will refer to in my thesis are not health professionals, quit service providers, or academics; they are smokers and ex-smokers who have tried, repeatedly, to quit. The working title for the thesis is *"The Quest to Quit: an exploration of the cessation – relapse cycle of cigarette smoking"*.

The University requires ethics approval for all research involving human participants, and this was received on 28 March 2008.

### Participant characteristics

The group will include four to six people (smokers and ex-smokers) who have tried to quit at least twice. Anyone making a quit attempt during the study will have my full support, but it is not necessary to be planning to quit or to make an attempt during the study.

### What will participation involve?

Participants will keep an electronic journal for six months, focusing on aspects smoking, quitting, or staying quit. This will be in the form of an email, and each entry will take a few minutes. Ideally everyone will make at least one entry each week. Daily entries are welcome.

We will meet several times between April and September 2008.

- Set-up session: an hour for paper work and getting underway.
- One-on-one interview: about previous quit attempts:1-2 hours
- Coffee catch-up, for about 30 minutes, every few weeks: my shout, at your choice of cafe.
- Focus Group: All participants will get together one evening in June or July, to discuss attitudes to smoking and quitting. This will be a two to three hour session, including supper.

SCHOOL OF SOCIAL & CULTURAL STUDIES Te Kura Mahinga Tangata
PO Box 600, Wellington, New Zealand
Phone +64-4-463 5317 Fax +64-4-463 5064 Email sacs@vuw.ac.nz Website www.victoria.ac.nz/sacs

### Can I change my mind?

You can withdraw from the project at any time by notifying me. Data that has not yet been analysed can be removed from the study at your discretion, however it is not possible to withdraw analysed content or content provided in group contexts and so this needs to remain in the study despite your withdrawal.

### What about my privacy?

When I use quotes in my thesis I will use pseudonyms, and I will ask you to check the quotation and the context, to make sure I am accurately conveying the meaning you intended.
Participants also need to be aware of protecting each other's confidentially, especially where informal discussions include people who are not involved in the research.

### What happens to all the raw data?

There are two forms of raw data: digital audio files (interviews, discussions, etc), and emails of journal entries. All raw data will be destroyed at the end of the study, in accordance with the Victoria University Human Ethics Committee instructions.

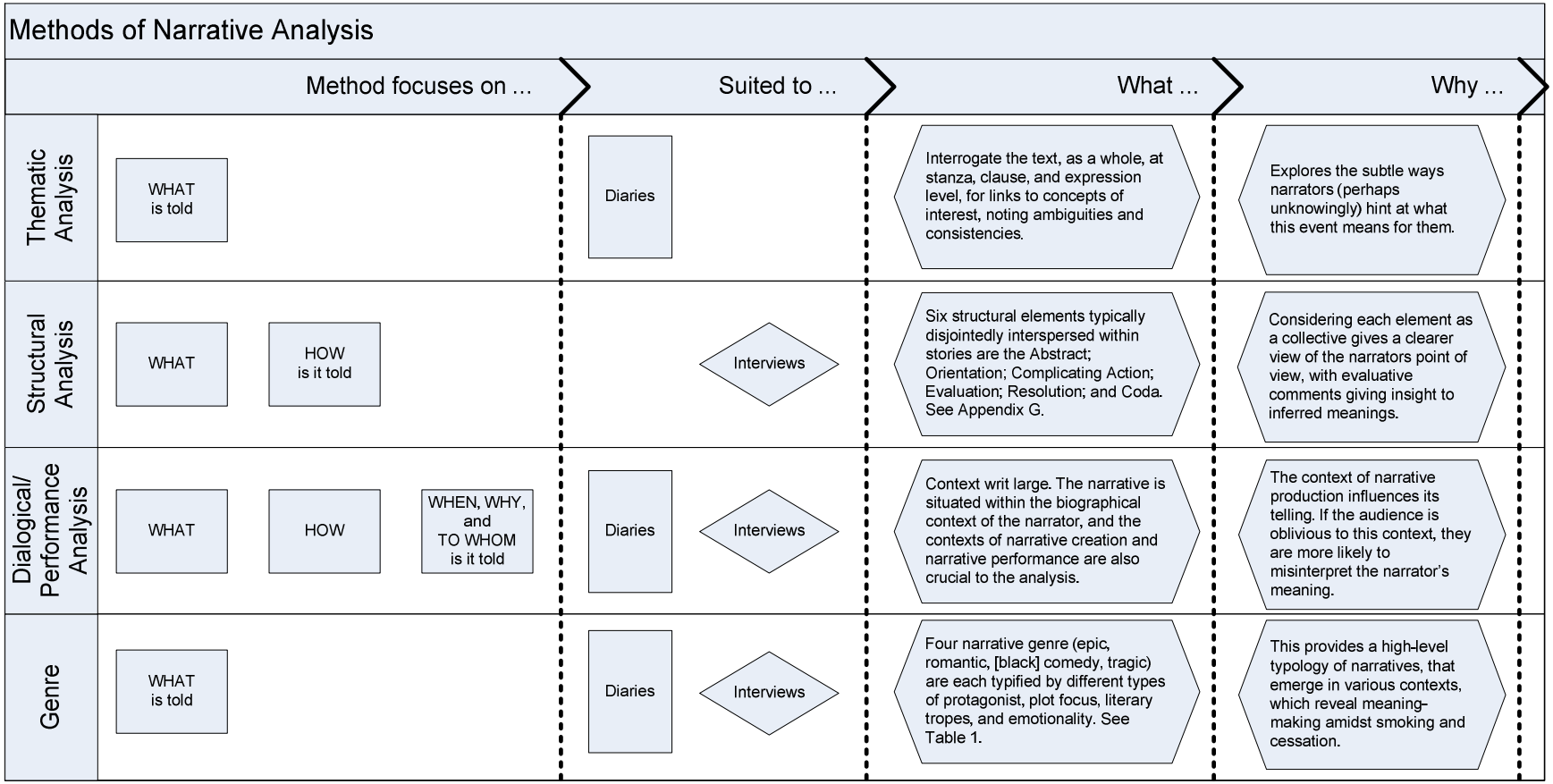
### What becomes of the research results?

My thesis will be lodged at the university library, and therefore accessible to library users.
It is possible that articles for academic journals or presentations might result from the research and thesis.
A concise overview of the research findings will be available on request to research participants, after the thesis has been submitted at the end of February 2009.

Thank you for considering taking part in my research. If you are interesting in finding out more, please contact me by 31 May 2008.

Carolyn Hooper
04 463 5233 ext 8444
027 430 0829
04 479 5459 (evenings)
carolyn.hooper@vuw.ac.nz

# Appendix E: Methods of narrative analysis



# Appendix F: Consent Form

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI
VICTORIA
UNIVERSITY OF WELLINGTON

CONSENT TO PARTICIPATE IN RESEARCH

Research Title: The Quest to Quit: An exploration of the cessation – relapse cycle of cigarette smoking.

Researcher: Carolyn Hooper, School of Social and Cultural Studies
Supervisor: Chamsy el-Ojeili, School of Social and Cultural Studies

- ☐ I have been given and have understood an explanation of this research project.
- ☐ I have had an opportunity to ask questions and have them answered to my satisfaction.
- ☐ I understand that the data I provide will be used for a research project toward a Masters (Applied) Degree in Social Science Research, which may lead to further academic writing, or academic presentations that draws upon the data I provide.
- ☐ I understand and support the need to respect the privacy of other participants, so I will not reveal any personal information shared by fellow research participants.
- ☐ I understand that the data I provide will be kept confidential to the researcher and the research supervisor; the results will not use my name; and no opinions will be attributed to me in any way that will identify me.
- ☐ I understand that the data generated during the project will be stored and disposed of in accordance with the directions of the Victoria University Human Ethics Committee.
- ☐ I understand that I may withdraw from this project by notifying the researcher. At my discretion, data that has not yet been analysed may be removed from the study.
- ☐ I agree to take part in this research.
- ☐ Please provide a copy of applicable audio files when the research ends.
- ☐ Please provide a summary statement when the research is completed.

***name:*** _____

***date:*** _____

***signature:*** _____

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# Appendix G: Example of structural analysis coding

**Table 4: Interview extract coded by structural elements with coding notes**

| ID | Transcript | Element |
|---|---|---|
| a<br><br>b<br>c<br>d | I've probably tried to commit to quit five or six times,<br>when I felt like I was seriously trying to quit,<br>but I can only say I've been successful once,<br>which was last year when I quit for six months. | AB (abstract) |
| e<br>f | And the reason I think I felt that was successful was because I got sick: a really bad chest infection. | EV (evaluation) |
| g<br>h<br>i<br>j<br>k<br>l<br>m<br>n<br>o<br>p | I was really sick. I couldn't breath:<br>I was hanging out my bedroom door [*onto the deck*] trying to get air into my lungs [gasping]:<br>I was really sick.<br>I was on my hands and knees,<br>out the door, just staring at the deck, thinking<br>"My God!"<br>You know?<br>"I'm (age) and I'm just going to end up dead,<br>before my time." | CA (complicating action) |
| q<br>r<br>s<br>t<br>u<br>v<br>w<br>x | I could really feel the impact of being a smoker.<br>I don't know if it was an age thing,<br>but my dad died when he was 52, and he was a smoker, and I'm (age).<br>I watched my dad for a week,<br>slowly die, after serious heart attacks,<br>and as he was dying he said to me | OR (orientation) |

| | | |
|---|---|---|
| y | “Please stop smoking.” | |
| z<br>aa<br><br>bb<br><br>cc<br><br>dd<br><br>ee<br>ff<br><br>gg<br>hh<br>ii<br><br>jj<br><br>kk | I promised my dad I would stop smoking.<br>And even that wasn’t powerful enough to make me want to stop.<br>It was like, that was somebody else’s opinion.<br><br>I’ve tried to give up before by being aware of health and trying to be healthy,<br>but I think it was more from other peoples’ input<br>rather than thinking<br>“Oh my God, I’m actually killing myself”.<br><br>I think probably just being that little bit older<br>and being aware.<br>I could really feel the impact of being a smoker.<br>Like I think I would just have had a really mild chest infection if I was a non-smoker,<br>and I really felt there was a difference in how sick I was because of being a smoker. | EV |
| ll<br>mm<br>nn<br><br>oo<br>pp | I went to the doctor the following day<br>and I said<br>“I need patches because I’m going to stop smoking,”<br>and she said “When are you going to stop?”<br>And I said “Tomorrow”. | CA |
| qq | That must have been Thursday. | OR |
| rr<br>ss<br>tt | I’d said to the doctor I was stopping,<br>and it was a real [trails off]<br>The decision making process seemed different. | EV |

| | | |
|---|---|---|
| uu<br>vv<br>ww<br><br><br>xx<br>yy<br>zz | I don't know why it was different<br>but it felt very different.<br>It felt like a really strong decision that I'd made for me.<br><br>Not cos I felt I should stop,<br>but it was cos I felt so sick.<br>And I actually felt quite powerful with that decision. | |
| aaa<br>bbb<br>ccc<br><br>ddd<br>eee | So I came home and said to [husband]<br>"I've made a decision that I'm stopping",<br>and he said<br>"Oh yeah, whatever!"<br>And I said<br>"You can make whatever comments you like,<br>but this is my decision, for me,<br>and I'm not interested in what you have to say, really." | CA |
| fff | The next evening I went and bought myself a really nice bottle of wine. | CA |
| ggg<br><br>hhh<br>iii<br>jjj | I felt I was going to celebrate stopping smoking<br>rather then it being, um, …<br>rather than loosing something.<br>Rather than being, giving something up,<br>I was celebrating it. | EV |
| kkk<br>lll<br>mmm<br>nnn<br>ooo<br>ppp | So I had a really nice bottle of wine,<br>which I drank myself [laughing].<br>And just before I went to bed,<br>I had a couple left in my packet<br>and so I went to the backdoor of my bedroom<br>and had my final cigarette | CA |

| | | |
|---|---|---|
| qqq<br>rrr<br><br><br>sss<br>ttt<br>uuu<br><br><br>vvv<br>www | and I was kind of saying:<br>“This is my final cigarette, and I’m really happy that this is my last one.”<br><br>And before I went to bed,<br>I screwed up the packet,<br>really screwed it up, [hand motions like wringing a facecloth] and got rid of it in the bin.<br>There was no way I could recover any cigarettes out of that packet! [laughing] | |
| xxx<br>yyy<br>zzz<br>aaaa | But it was calm,<br>it was a final send-off,<br>a final goodbye or whatever,<br>and it was consciously done. | EV |
| bbbb<br>cccc | On Saturday morning I got up and it was like “That’s it!” | RE |
| dddd | I didn’t smoke for over six months. | Coda |

Notes:

The dominant theme here is power: it is the perceived powerfulness of her decision to stop smoking that [name] interprets as the reason for remaining smoke-free for over six months. The powerful decision is attributed to her realisation, for the first time, that smoking seemed to be killing her (ff). She made a conscious decision to quit when she got a chest infection that she interpreted as being worse because of her smoking (jj-kk). The experience made her conclude that smoking was killing her, just as it had prematurely killed her father, whom she adored (external to extract). She felt this decision to quit was in some way different from previous occasions: it was a ‘very

different' and 'a really strong decision' (vv-xx) that she had made herself and for her personal benefit rather than at the suggestion or for the benefit of someone else (bb, tt-zz).

Her awareness of the forcefulness and significance of this decision, in comparison to previous decisions to quit, prompted her to plan a 'ceremony' (ggg-jjj) – something she had never done before (external to extract) – during which she enjoyed and celebrated her final cigarette accompanied by an especially selected bottle of wine; and concluded with the destruction of her remaining cigarettes (ttt-www).

This story is very dramatic – she sets scenes, from crawling about on the deck to selecting a 'really nice' bottle of wine; there is physical motion (crawling out the door; gasping for breathe; screwing up the remaining cigarettes); and speaking parts to herself, her doctor and her husband. She convinces her audience that *this* quit attempt *is* different, in part by recalling her father's death-bed wish that she should quit, which she had never been able to deliver because it was something that others wanted for her as opposed to something she wanted for herself.

Considered from a genre point of view…

This is an EPIC story:

- the main *protagonist*, the hero, is [name];
- the *plot* focuses on her achievement; her victory over her desire to smoke;
- the *poetic trope* shifts between [name]'s point of view and that of her husband (who is not convinced of her intentions);
- and *emotionally*, [name] is very proud and her audience filled with admiration.

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## Endnotes

[i] The terms ‘smokefree’ and ‘smoke-free’ are used in the literature. I have used ‘smoke-free’, in alignment with the Smoke-free Environments Act, 1990. Exceptions are for organisation names, such as the Smokefree Coalition.

[ii] The following extract shows the full extent of Hay’s comment in the New Zealand Medical Journal:

> According to Sir Richard Doll, Maori women have the highest female lung cancer rate in the world, a fact which is attributed to their longer history of heavy smoking. The Māori figures are presented in more detail in Table IV and Figure 4, but I think one should be cautious in drawing too many conclusions because of the small absolute numbers. According to Dr Ian Prior’s figures, 60 percent of Māori women smoke compared with 30 percent of European women; while 42 percent smoke more than 10 cigarettes a day in contrast to 23 percent of European New Zealand females (Prior, 1971) [the bibliographic entry for Prior notes this to be a personal communication] (Hay, 1972, p. 6).

The journal article goes on to show 1969 data in table and graph forms for deaths from five types of cancer, including lung cancer, amongst Māori women. The sample size is thirteen, hence Hay’s remark about “small absolute numbers”.

While Hay does not provide a citation for Doll in this journal article, I am confident that the information stems from Hay’s attendance at the 2nd World Conference on Smoking and Health, held in London during September 1971, where Hay represented the Department of Health as the sole New Zealand delegate. He reported back to the Department and also the National Heart Foundation and the Cancer Society, both of which financially supported his attendance. The report, *Smoking and Health: A Report* provides a précis of conference

presentations, including that of Sir Richard Doll. Of Doll's presentation, Hay reports:

> The high lung cancer incidence among New Zealand Māori women was quoted and ascribed to the fact that they have smoked pipes from the beginning of the 20th century and now smoke nearly as many cigarettes as New Zealand men. Māori women now have the highest lung cancer incidence among females in the world (Hay, 1971, p. 3 [Held at the Canterbury Medical Library, call number QV137 H412]).

The source of Doll's data is not revealed, but he was on the editorial team of *Cancer Incidence in Five Continents Vol. II* (Doll, Muir, & Waterhouse, 1970), which includes data supplied by the New Zealand National Cancer Registry, established in 1948. The New Zealand data covers 1962 to 1966, and each record includes an attribution of either 'Māori' or 'Non-Māori'. But there is a problem: of the 24 participating countries, only half appear to have national registers, with the remaining registers collecting data on a county, region, or state scale. Further, only six out of 47 participating registers (less than 8%) gathered data relating to 'racial' or ethnic characteristics. Thus, if *Cancer Incidents in Five Continents Vol. 2* is the source of Doll's claim, the high incidence of lung cancer among Māori women stands out due to the far-sighted design of the New Zealand National Cancer Registry. Other populations with similar levels of lung cancer incidence would most likely have been concealed by both the partial nature of less-than-national data, preventing any claim relating to the group as a whole; and the unlikelihood of an ethnic identifier. That New Zealand Māori women were able to be portrayed as having "the highest lung cancer incidence among females in the world" is an unfortunate and unintended consequence of rigour in the design and reporting of the National Cancer Registry.

A copy of Hay's report to the Department of Health is held at the Canterbury Medical Library, call number QV137 H412. Many thousands of premature deaths through smoking-related illness may have been prevented if Hay's recommendations had been implemented at the time: some of them are only now being considered, more than 35 years later. Interestingly, none of his recommendations specifically address the high prevalence of smoking or cancer amongst Māori.

Nevertheless, Hay is put forward contemporarily in the following terms:

> A major advance in understanding the harm caused by smoking came in 1972, with David Hay observing that Māori women had the highest female rate of lung cancer in the world (New Zealand Medical Journal 76, 4-12 in Cancer Control Council of New Zealand, 2008).

Hay did not make this 'observation' of Māori women at all; indeed he warned against such conclusions. It seems that recognition of a growing disparity in smoking prevalence came about despite Hay rather than because of him: it was not until 1980 that the Department of Health Advisory Committee on Smoking and Health recognised its tobacco control efforts were less effective for Māori than for non-Māori and consequently designed campaigns for a Māori audience (Cancer Control Council of New Zealand, 2008, p. 24).

[iii] The sources of smoking uptake statistics are not apparent. The Health Sponsorship Council document is out of print and unavailable, and the Cancer Society provides no citation.