WOMEN AND SUCCESSFUL TOBACCO CESSATION STRATEGIES

by

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PROJECT SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTERS IN EDUCATION
IN
MULTIDISCIPLINARY LEADERSHIP

UNIVERSITY OF NORTHERN BRITISH COLUMBIA

March 2013

Abstract

Tobacco rates throughout Canada continue to fall, but use is still alarmingly high in northwestern BC. The purpose of this study was to explore how some women have been successful in abstaining from tobacco products. I conducted qualitative, semi-structured interviews with women who have quit smoking successfully for more than six months. In my analysis, I looked for commonalities and differences in their decision and ability to quit and I compared participant responses to the tobacco cessation strategies in the literature. Strategies for successful tobacco cessation for women expressed by participants may be emulated by those who wish to quit smoking, and contribute to their success. The findings of this study may also be of interest to health care workers encouraging clients to make this healthy lifestyle change.

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Acknowledgements

I am privileged to have had the opportunity to carry out this project and work with the women involved. I would like to thank all the women who participated in the process, sharing their stories and insights. I would also like to thank my Supervisor, Dr. Linda O'Neill, Associate Professor, Counselling, School of Education, University of Northern British Columbia and Committee Members, Dr. Tina Fraser, Associate Professor, School of Education, University of Northern British Columbia and Dr. Theresa Healy, Adjunct Professor, School of Environmental Planning and School of Gender Studies, University of Northern British Columbia. I am deeply appreciative of their support, feedback and guidance. Special thanks to Nancy Viney, Nicotine Intervention Counselling Centre Coordinator for Northern Health for assisting with locating and sharing resources.

Chapter One: Introduction

"When calling attention to public health problems, we must not misuse the word 'epidemic.' But there is no better word to describe the 600-percent increase since 1950 in women's death rates for lung cancer, a disease primarily caused by cigarette smoking. Clearly, smoking-related disease among women is a full-blown epidemic."
David Satcher, M.D., Ph.D., Surgeon General (2001)

Significance

Tobacco use rates have been steadily decreasing over the years and knowledge about the harmful effects from using this product have grown, yet tobacco is still being used at alarming rates in northwestern British Columbia (B.C.), resulting in detrimental effects on people's health and the health care system. A September 2011 news release from the BC Ministry of Health stated the cost to the BC economy is approximately $2.3 billion annually, including more than $605 million for direct health-care costs. During the past 12 years (1999-2010), the Canadian Tobacco Use Monitoring Survey (CTUMS) reported a decline in the overall current smoking rate among Canadians aged fifteen years and older from 25% in 1999 to 17% in 2010. However, the tobacco use rate across northwest B.C. is estimated at 24%, substantially higher than our provincial rate of 17% (Health Canada, 2011).

The reasons why tobacco rates are higher in the northwest are a source of frequent speculation but there does not appear to be research to explore or explain these higher rates. Research has confirmed that some populations in other parts of the country tend to have higher rates of tobacco use. These populations may include Aboriginal people, people with mental health and addiction issues, lower socioeconomic status and Lesbian, Gay, Bisexual, and Transgendered (LGBT) population members. Yet the reasons behind these populations having higher tobacco rates do not appear to be adequately researched or explained. Bottorff, Haines-Saah, Oliffe, and Sarbit (2012) noted that differences in smoking patterns that reflect gender influences are also evident in subpopulations, for example, significant

higher smoking prevalence rates among LGBT people compared with their heterosexual counterparts.

The Ontario Research Unit (2010) declared there is an extreme paucity of research and availability of evaluated local/regional public health interventions on effective cessation strategies for special populations and populations with high rates of smoking. While there is emerging research on strategies for youth, pregnant women and mental health and addiction populations, evidence is especially lacking for Aboriginal, lesbian, gay, bisexual and transgendered (LGBT) and socio-economically deprived populations, blue collar workers and young adults. Bottorff et al, (2012) asserted that the higher smoking rates among LGBT is a health inequity that, along with higher rates of other types of substance use, is undoubtedly linked to systematic discrimination and homophobia experienced by persons who are positioned as gender and sexual minorities.

There appears to be research to how to effectively provide smoking cessation to these special populations but qualitative research is lacking as to why these populations experience higher smoking rates than the overall population. Acknowledging and understanding why these populations experience higher tobacco rates could help to improve the development and success of tobacco cessation programs.

One vulnerable population that has been researched regarding higher tobacco use rates is the Aboriginal population. One explanation offered for the higher tobacco use rates among Aboriginal people is the availability of lower cost tobacco on reserve. I will explore later in this project how taxation of tobacco products may be an effective means for decreasing tobacco use. Wardman and Khan (2005) stated that taxation of tobacco is a widely-used strategy that prompts smoking cessation among adults and reduces cigarette

consumption among continuing smokers; however, registered Aboriginal communities rarely utilize taxation.

It is well known that it is a struggle to quit using tobacco and I am fascinated by people who have faced this addiction and quit. Gonzales, Jorenby, Grandon, Arteaga and Lee (2010) maintained that while effective smoking cessation treatments, including counselling, social support and pharmacotherapy, are widely available, quitting success rates can vary significantly. Even among those who receive evidence-based treatments, adherence to recommendations is often poor, with negative implications for treatment outcomes. To gain a better understanding of how and why some people are able to successfully quit smoking, it is critical to talk with people who have successfully quit and learn from their experiences of which cessation strategies have worked for them and how an analysis of their experiences can contribute to enhanced efficacy of tobacco cessation practice.

In this study, I examined the experiences of women who have recovered successfully from tobacco addiction using a qualitative approach. In keeping with current practice in health education, I refer to the addicted use of tobacco as the *misuse* of tobacco. Ceremonial and cultural uses of tobacco do not fit into the misuse category and were not addressed because in Ceremonial use, tobacco is not normally habitual and tends to be used for connecting with the Creator, honouring, blessings and respect which are unique and separate from the reasons someone who is addicted to tobacco may use.

The focus of this study was women who have self-identified as addicted to tobacco and who have successfully quit. I focused on women because men and women tend to use the health care system differently and they often respond to services and therapeutic

interventions in diverse ways (Bottorff et al., 2012). This difference may have had the potential to influence the findings in various ways in terms of specific cessation strategies.

Demographics on these women were not collected. Socio-economic status, sexual orientation, race and culture not were not explored in this research because of the focus on an in depth exploration of successful strategies. While these demographics may affect tobacco use rates and cessation success, the complexity of these factors requires a similar focused examination in relation to use and quitting beyond the scope of this research.

Tobacco use and the health effects from its use is a significant concern for our province's population. Thus, tobacco cessation continues to be an important Public Health goal. The Northwest health and service delivery area has trained professionals to conduct tobacco cessation initiatives. In September of 2011, the BC government began providing tobacco cessation initiatives and access to Nicotine Replacement Therapy through Health Link BC. The collision of ongoing high rates, local expertise and provincial supports provides an ideal laboratory to explore how tobacco use can be impacted if gender is successfully understood as a variable in success in cessation practice.

Research Question

In order to better understand effective tobacco cessation strategies for women, my research question was: *What elements or strategies do women believe have contributed to their success in quitting smoking?*

Personal Location

In September of 2009, I began working for Northern Health as a Tobacco Reduction Coordinator. Part of my role was to work with people who accessed our program for cessation services. A mandate of my work was to be a resource and provide education to

help people make informed choices about their health. Our program focused on research-based initiatives such as group counselling, individual counselling, providing nicotine replacement therapy (patches, gum and/or inhalers) and combination therapy, which consisted of counselling and the use of nicotine replacement therapy. I found it fascinating to work with people who had quit and then encounter them months down the road to learn if they had continued with their abstinence or if they had encountered a relapse. I always wondered how some people were able to maintain abstinence from tobacco while others relapsed or did not move past cutting back on their use.

Prior to my position of Regional Tobacco Reduction Coordinator, I worked as an Addiction Clinician for over thirteen years. In those years, I noticed a proportionally high rate of people with addiction issues who also used tobacco products. In conversations with clients, we often discussed their tobacco use and there were varying opinions on whether they thought it best to cease all substance use, including tobacco, at once or to continue to smoke while addressing other substance misuse issues.

My interest in tobacco use and cessation stems from several years of working and socializing with people who use tobacco products and hearing them share their feelings toward their tobacco use and often their desires to quit. It appeared that their relationship with tobacco was conflicted, they would share that they enjoyed smoking but wanted to quit. The purpose of this study is also professional in nature in that I want to understand more about a tobacco user's relationship with smoking, why they started, why they continue to use, what motivates them to quit and how are they able to maintain their abstinence. This research will benefit other practitioners in their approaches.

Overview of the Study

I undertook my research using qualitative methods. There appears to be considerable quantitative data related to tobacco use but limited qualitative data. Through quantitative research I can find out who is using tobacco, their age, gender, and other demographics as well as the success rates of quitting for people who have used abstinence, nicotine replacement therapy, counseling, and combination therapy. However there is only limited qualitative data on how people are able to successfully quit and the factors supporting success. I recruited and interviewed women, over the age of thirty, who have quit smoking for at least six months, in order to gain a better understanding of the elements and strategies that they believe contributed to their success. I suggest that if more detailed knowledge is gathered and shared about people's lived experience with quitting smoking, a greater proportion of people be able to quit successfully with greater self-efficacy, and less self-deprecating thoughts.

For my research, I followed a similar format to the one outlined by Puskar (1995) in "Smoking Cessation in Women: Findings from Qualitative Research". I appreciated that she utilized qualitative methods in her research, addressed gender issues, and used a semi-structured interview process. The methodology in Puskar's study consisted of a convenience sampling of ten women, ages twenty-five to forty-two who quit smoking for at least six months but not longer than one year.

Similar to Puskar (1995), I used a semi-structured interview process with seven women ages thirty and above who have quit for at least six months. I employed the semi-structured interview process because it allows for open-ended questions and freedom to go with the flow of the conversation. I chose questions that would provide the most insight into the research question. I recruited women over the ages of thirty and younger than sixty who

have used different methods for quitting including, but not limited to, nicotine replacement therapy, group sessions, and one-to-one sessions. The women had a variety of quit time behind them, ranging from one year to thirteen years.

My purpose for interviewing only women and not both men and women was to narrow the focus of my project and pay particular attention to the needs of women during tobacco cessation. It has become increasingly recognized that gender plays a role in health. A gender relations approach recognizes the importance of gender dynamics and the circumstances under which they interact to influence health opportunities and constraints (Bottorff, Oliffe, Robinson, & Carey, 2011). I anticipated that while interviewing women for my project, themes relevant to gender would arise. Bottorff et al. (2012) suggested that there is a relationship between women's smoking and social disadvantage, and there is a need to consider how gender and socioeconomic inequalities contribute to smoking among women.

The findings were documented in a case report format and were compared to the findings from Puskar's (1995) research. I chose a case study format because I wanted to draw attention to my research question and what could be learned about my participant population. Stakes (2005) affirmed that the term "case study" is emphasized by some of us because it draws attention to the question of what specifically can be learned about the single case. In my research, the single case is my group of seven participants who are currently successful in not smoking. A case study approach was an appropriate choice in this research as a case study concentrates on the experiential knowledge that can be explored in depth through the close attention to the influence of its social, political, and other contexts (Stakes, 2005). My research includes and highlights the social, political, and contextual aspects involved in tobacco cessation. While conducting my research, I was looking for common

themes found in existing research as well as being open to experiencing and exploring unique occurrences emerging in my own study. This approach is shaped by Stakes (2005) who noted that case researchers seek out both what is common and what is particular about the case. I will further explore some of the key concepts of case studies in Chapter 3.

Definition of Terms

In this section, a definition of the terms used throughout the study provides a shared understanding of the important concepts explored.

Case study. Stake (2005) stated that a case study concentrates on experiential knowledge of the case and close attention to the influence of its social, political, and other context.

Coding. Coding is the process of reviewing transcribed interviews and analyzing significant words or phrases. Saldana (2009) described coding as most often a word or short phrase that symbolically assigns a summative, salient, essence capturing and evocative attribute for a portion of language-based or visual data.

Convenience sampling. For this project, convenience sampling describes a plan to choose research participants who are easily accessible, for example, participants I have worked with in the past and/or participants who hear about the study through word of mouth and agreed to be interviewed.

Gender. The women who I interviewed were self-described women. When seeking participants for my project I made my intent clear that I was seeking female participants. For the purpose of this project I will adopt the definition of gender as outlined by Bottorff et al. (2011): Gender is defined as the socially prescribed and experienced dimensions of femininity and masculinity in society.

Misuse. For project purposes, the term misuse refers to the non-cultural and non-spiritual use of tobacco products.

Northwest BC. Research participants were drawn from the northwest area of BC which has a population of just under 12,000 (Statistic Canada, 2012 Census).

Nicotine Replacement Therapy (NRT). Nicotine Replacement Therapy is the practice of using nicotine to manage withdrawal from tobacco. Nicotine is the addictive ingredient in tobacco and NRT is sometimes used to alleviate the unpleasant withdrawal systems from tobacco abstinence. NRT usually takes the form of nicotine patches, nicotine gum, or a nicotine inhaler.

Tobacco products. Tobacco products may include, but are not limited to, cigarettes, cigars and chewing tobacco.

Trustworthiness. In order to maintain high trustworthiness in a qualitative study, Krefting (1991) suggested four criteria to ensure valid interpretation of data: truth value, applicability, consistency, and neutrality.

Summary

In this chapter I have presented an overview of the intentions of my study to contribute qualitative, gender-based information on tobacco cessation. This information will be of use to community health educators and health professionals who support those who wish to adopt a healthier lifestyle. I have described my professional and personal connection with the topic and made a case for the significance of the study. I also defined terms that I use throughout this project proposal and provided an overview of my intended project proposal.

The method for my study was modeled after Puskar (1995) research, a similar study of women's tobacco cessation strategies. However, my study contributes information that is relevant to northwestern BC, where tobacco misuse is more prevalent than in other parts of Canada. Upon completion of this project, I have a deeper understanding of how some women were able to quit smoking tobacco by exploring their words and their interpretations of their experiences with quitting. I found unexpected lessons while interviewing my participants, creating the space for them to share their experience and finding the emerging themes to be shared with health professionals and individuals wanting to quit smoking.

Chapter Two: Literature Review

Introduction

There appears to be an abundance of research on the effects of tobacco use on human health. A range of quantitative research data on the demographics of tobacco use is readily available including: which provinces have the highest tobacco use rates, which gender has higher use rates, who the at-risk populations for high tobacco use rates are, the average age of first use, and the methods of quitting that yield the best and worst success rates. There appears to be only limited qualitative data pertaining to personal stories of *how* people have been able to quit misusing tobacco. Another question that appears to be unaddressed but is beginning to emerge is how gender, tobacco use, and health are intertwined.

The literature review for this study provides insight from the few previous studies on how women describe their successful cessation and what strategies may have been particularly effective. The literature review creates a context to better understand what has been done in the area of tobacco cessation, issues surrounding the process, and how these apply to women. The main themes uncovered were: (a) tobacco use; (b) tobacco use and women; (c) cessation strategies; (d) cessation strategies and women; (e) tobacco use in the northwest; and (f) women and tobacco use in the Northwest.

Tobacco Use

The effects of tobacco use on our health are well researched and documented. Tobacco use still remains the number one preventable cause of death and disability (Parker, 2010). More than 6 million people have died from tobacco use and exposure and 22% of the world's population are smokers (WHO, 2011). Researchers have studied quit attempt rates and Cepa-Benito, Reynoso, and Erath, (2004) shared that over 70% of smokers have made at

least one quit attempt. In 1988, the US Surgeon General's report concluded that cigarettes and other forms of tobacco are addictive, and that nicotine is the drug that causes this addiction. The pharmacological and behavioural processes that determine tobacco addiction are similar to those that determine addiction to drugs such as heroin and cocaine (Hatsukamo, Stead & Gupta, 2008).

Further evidence of the potential addictive nature of tobacco may be people's relapse rates. Cepa-Benito et al. (2004) reported that of the 17 million adult smokers who attempted to quit in 1991, only 7% were still abstinent one year later.

People do not need to be tobacco users to experience the ill effects of tobacco. Any exposure to tobacco can cause harm, including exposure to second hand smoke and third hand smoke. Second hand smoke is the smoke that is expelled from the smoker while exhaling and is the smoke that wafts off the end of the cigarette. Winickoff, Friebely, Tanski, Sherrod, Matt, Hovell & McMillen (2008) described third-hand smoke as the smoke contamination that remains after the cigarette is extinguished. Third-hand smoke residue and particulates will settle into the furniture, flooring ceilings and walls. Both of these sources are known to contain constituents that may cause harm. Ŏberg, Jaakkola, Woodward, Peruga and Prüss-Ustün (2010) declared that lower respiratory infections, asthma, lung cancer and heart disease were all possible health outcomes for non smokers who experience exposure to second hand smoke. Winickoff (2008) asserted that children are uniquely susceptible to third hand smoke exposure. Possibly due to the nature of children's play as children may crawl on contaminated surface and they tend to touch items then put their fingers in their mouths, therefore, ingesting the toxins.

Tobacco Use and Women

Tobacco continues to be the leading cause of preventable death for both men and women but the difference lies in the fact that the worldwide rates of tobacco use among men is declining whereas the tobacco use rates for women are on the rise (Bottorff et al., 2012). In reviewing literature, it appears that strategies for tobacco reduction initiatives fail to address gender specific content. Amos, Greaves, Nichter and Bloch (2011) declared that tobacco control has remained relatively gender blind with little importance of understanding the context and challenges of women's smoking and second-hand exposure. Amos et al. (2011) reported that exploring gender and diversity analyses in tobacco control to reflect and identify intersecting factors affecting women's tobacco use will help reduce the impact of tobacco on women.

As suggested earlier, men and women use tobacco products for different reasons, quit for different reasons, and their health is affected differently. Bottorff et al. (2012) expressed gender inequality, and the gendered roles and responsibilities assigned to women and men, influence when tobacco is used, why it is used , how it is used, and how often it is used. Literature shows that women use tobacco for different reason. Men tend to use because they are addicted to the nicotine whereas women tend to use for social and emotional reasons. Cepa-Benito et al. (2004) declared that when compared to men, women are more craving-reactive to smoking, have great expectation that smoking will enhance or facilitate social interactions, reduce negative mood and prevent weight gain. These researchers also stated that nicotine's physiological effects may play a larger role in motivating smoking in men than women (Cepa-Benito et al., 2004).

In regards to second hand smoke exposure, women tend to bear the burden on increased risk to their health. (Ŏberg et al. 2011). They also went on to maintain that in non-smokers, there are clear inequalities in the burden of disease from second-hand smoke according to sex and age and women have the greatest burden of deaths of the total attributable to second-hand smoke (Ŏberg et al. 2011).

Cessation Strategies

There is a variety of research-based and non-research-based methods for quitting smoking. Some of the most commonly known strategies consist of behaviour therapy, pharmacotherapy, combination therapy (behaviour and pharmacotherapy), hypnosis, acupuncture and "cold turkey".

Nicotine Replacement Therapy (NRT) is a method people access to assist with their tobacco cessation strategies. Cepa-Benito et al., (2004) acknowledged that Nicotine Replacement Therapy was introduced over 20 years ago and is the most commonly used pharmacotherapy for smoking cessation. NRT is a harm reduction method that provides the body with the nicotine it craves without the harmful effects from smoking, alleviating the withdrawal symptoms typically experienced when one quits smoking.

Cessation Strategies and Women

More research is exploring the concepts of gender, health, and smoking and early findings have indicated that gender influences have been observed in relation to reducing and stopping smoking. Along with exploring gender and health, research is starting to look at the importance of gender- specific and gender-sensitive cessation programming. Research on gender related smoking cessation interventions increasing. Bottorff et al. (2012) found that women often experience less success on initial smoking cessation than men, greater negative

affective response during withdrawal, and less successful cessation in relation to nicotine replacement therapy (NRT). Thus, there is a need for cessation interventions to be not only gender-sensitive but also gender specific (Bottorff et al., 2012).

Investigation of women specific cessation interventions revealed that overall outcomes of different interventions were inconsistent but did reveal that women tend to prefer "women only" cessation treatment (Bottorff et al, 2012). Bottorff et al. (2012) revealed that recommendations for creating women-centered approaches to support tobacco reduction have been created and the best-practice guidelines include: (a) tailoring; (b) reducing stigma; (c) harm reduction; (d) social support; and (e) social issues integration.

Tailoring. Interventions must be tailored to a woman's unique circumstances and needs. A tailored program would increase engagement as the information provided is more specific and relevant to the needs of those involved with the approach. Those who lead the interventions would need to have the skills and resources to tailor interventions for the participants. Moving from being a tobacco user to a non-smoker involves changing behavior. Behaviour change can be a challenge and Fox and Khan (2010) maintained that a systematic assessment of possible barriers to change can help in devising a tailored strategy and can improve patient's outcomes toward desired behaviour change.

Reducing stigma. Bottorff eta l. (2012) asserted that tobacco cessation interventions need to be designed to provide women with positive and non-judging mental support to increase women's engagement and success with quitting.

Harm reduction. Harm reduction includes addressing the needs of the women who smoke "where they're at" and developing strategies that are flexible and non-judgmental.

Social support. To increase a woman's success with quitting, it is important to consider a women's pattern of smoking within her social network, assess the relationship and be mindful of power dynamics.

Social issues integration. Bottorff et al. (2012) highlighted the importance of recognizing that smoking occurs alongside other complex and intersecting social issues and to be successful, these issues cannot be avoided or ignored during tobacco cessation interventions. These components are discussed further and related to statements made by participants in Chapter 4.

With best practice for women's cessation strategies being identified, strategists need to also be aware of the strategies of tobacco companies to combat their efforts to expand the use of their tobacco products. It appears that tobacco companies are well aware of the gender differences with tobacco use and have increased their marketing towards women. Gender is often taken into account to develop tobacco product marketing by rarely taken into account when guiding tobacco reduction and cessation strategies (Bottorff et al. 2012).

Research has investigated cessation strategies and found some compelling differences between not only why men and women use tobacco products but also their approaches to quitting. Research has shown that women may be more likely to access cessation services but it is men who tend to have more success with quitting. Amos, Greaves and Nichter (2011) revealed that with cessation services including counselling and pharmacotherapy, women are more likely to use these services but have lower success rates than men. They went on to state that quit rates are lowest in women who are younger, live in deprived areas, and/or are from ethnic minorities.

Research has also investigated tobacco relapse rates and has shown that there are also differences between men and women in regards to relapse. Research focused on smoking relapse indicates that women relapse in situations involving negative emotions (eg. conflict or stress), whereas men tend to relapse in positive situations (eg. social events) (Bottorff et al. 2012). This finding touches on the issue of a women's sense of self worth and that negative social complexities can make it a challenge to address or maintain tobacco cessation. It also speaks to the importance of including relational issues in gender specific cessation programs. These issues will be addressed in more detail further in this project.

In Puskar's (1995) work with women and smoking cessation, she noted that four major themes depicted women's experience with tobacco cessation. These themes were: evolving commitment to health and personal growth, being stigmatized, changing conceptualization of smoking, and smoking cessation as a relational phenomenon. I compared my findings to these themes in the Discussion section, paying attention to similarities and contrasts.

Tobacco Use in the Northwest

When comparing smoking rates in the northwest BC to the rest of the province, smoking rates are significantly higher in the Northwest for both men and women. In June 2012 Statistics Canada reported that the Northwest Health Service Delivery area had a smoking prevalence of 20.9 % for both men and women. The total percentage of current smokers for British Columbia (B.C.) is 16.7%.

Women and Tobacco Use in the Northwest

The use of tobacco by women in the northwest is alarming. The June 2012 Statistics Canada Health Profile indicated that 20.6% of females and 21.2% of males in the northwest are current tobacco users. The percentage of female smokers for BC is 14.3 while the percentage for men in BC is 19.3. These statistics speak to the importance of addressing tobacco usage rates in the northwest and not only focusing on the problem but taking a positive approach by investigating how some women have been able to overcome their addiction and are no longer a negative statistic when it comes to tobacco use rates.

Current Cessation Strategies

I have reviewed some of the most relevant current tobacco cessation strategies I non-gender specific strategies and then address some of the gender specific strategies for women. This is not a comprehensive list of the existing programs but a summary of some the more noteworthy and utilized programs available.

BC Smoking Cessation Program. The BC Smoking Cessation Program was implemented to support the high costs of smoking cessation pharmacology or NRT and is eligible to BC residents who want to quit smoking. People who access this program have two options for cessation support. The patient can choose to use prescription tobacco cessation medication or non-prescription medication (NRT). When choosing the NRT option, the patient needs to register with Health Link BC at 8-1-1. Further information on this program can be found at http://www.health.gov.bc.ca/pharmacare/stop-smoking/.

This program was implemented in September of 2011 and will require an evaluation as to its effectiveness with helping people to quit smoking and decreasing health costs.

Brief Intervention. Brief Intervention is when a clinician, physician or other professional address tobacco use with their client. This approach was developed to address tobacco use with brevity, ease and with little training required in places where a smoker was likely to encounter someone they trusted and respected. For a tobacco intervention to be implemented routinely in most health care settings—especially fast-paced settings like a hospital emergency department or a busy primary care clinic—it must be brief, convenient, and require little specialized training (Boudreaux et al. 2012).

Stop Smoking Before Surgery (SSBS). The Stop Smoking Before Surgery initiative is a partnership between BC Cancer Agency and Health Services to support patients to quit smoking eight weeks prior to surgery. Research has indicated that stopping smoking before surgery can reduce the risk for infection and help patients to heal in a timely manner. Li (2010) stated that it is established that smoking is a risk factor for surgical wound complication, with complication rates being more than two to three times higher in smoking patients then in non-smoking patients undergoing various procedures.

The SSBS initiative aims to work with partners and stakeholders to provide resources and referrals to patients on the surgical waitlist. Further information on this strategy can be found at http://www.bccancer.bc.ca/NR/rdonlyres/5704E7EF-4BA9-4A9D-8D34-7D5213AFB1D1/55275/SSBSfactsheet2012.pdf.

Tobacco Legislation. As discussed throughout this project, tobacco legislation is an effective means for decreasing tobacco use. Increasing tobacco taxes, restricting tobacco advertising and limiting smoking in public places have all proven to increase tobacco cessation. Tobacco legislation also serves to denormalize tobacco use.

Start Thinking About Reducing Second Hand Smoke (STARRS). STARRS was developed in 2000 in Canada and developed for low-income women who are also single parents with children younger than six years old (Bottorff et al. 2012). This program also aims to reduce the children's exposure to second hand smoke. This is one of the few cessation programs that incorporates harm reduction principles. Many cessation programs will recognize harm reduction as a strategy but often stress abstinence. This program offers non-judgemental support for women who may "tune out" messages about second hand smoke that evoke guilt and blame (Bottorff et al. 2012). This program appears to incorporate best practice guidelines and the components to best support tobacco cessation and gender in that it utilizes harm reduction strategies, reduces stigma, and is focused on women.

Smokefree Women. Bottorff et al. (2012) shared that Smokefree Women is a comprehensive gender-specific and gender sensitive program that has been created to support the immediate and long term needs of women who are trying to quit smoking. Free, evidence-based information and professional assistance is provided through a skilfully designed website at http://www.women.smokefree.gov. This website recognizes that the quitting process is different for every woman, and that everyone has a story to share based on their own experiences and their own reasons for quitting (Bottorff et al, 2012).

Summary

In this chapter I presented current literature related to tobacco addiction, cessation strategies and tobacco use rates with a particular focus on how these topics relate to women. I also provided literature to support the importance of addressing women's and men's tobacco use from a gender specific perspective. I have addressed the importance of using qualitative research when exploring women and tobacco cessation and stated that qualitative

research and gender specific research is expanding. I also briefly outlined current cessation strategies and resources for improving tobacco cessation programming for women.

Tobacco addiction has been a health and societal concern for several decades and will continue to be a concern for years to come. Both qualitative and quantitative research will continue to highlight the benefits of quitting and best practices for cessation initiatives. With this research our population can move closer to obtaining better overall wellbeing as we begin to see a decline in tobacco use rates.

Chapter Three: Project Plan of Inquiry

Introduction

I chose a qualitative research approach because these methods allow greater understanding of human experience and qualitative research has advanced the collective understanding of the human health experience (Whittemore et al. 2011). Qualitative researchers are well positioned to examine gender influences in the context of women's and men's health practices (Bottorff et al., 2012). We tend to be a society that seeks medical diagnosis (find out what the problem is) and then seek treatment. Having more access to qualitative data may provide insight into health concerns and provide more opportunities for education and prevention rather than diagnosis and treatment.

Case Study

This research used a case study structure. This format best supports the investigation of why and how women are able to be successful with quitting smoking. Case study research requires an intense interest in personal views and circumstances (Stakes, 2005). It was my intent, through interviewing women who have had success with quitting smoking, to find common themes in their success and by the end of the study have a greater understanding of the elements required for success. In the midst of looking for common themes I also listened for uniqueness in each of the women's stories and experiences. These commonalities and differences are explored in Chapter four.

Stakes (2005) described this type of investigative work as multiple case study or collective case study. This occurs when a study is extended to several cases. Individual cases in the collection may or may not be known to manifest some common characteristics but are chosen because it is believed that understanding them as a collective data set will lead

to better understanding and perhaps better theorizing about a larger collection of cases. It is not my intent to generalize my findings to the larger population, but rather to encourage further qualitative research in the field of gender and tobacco issues.

Stakes (2005) stated that qualitative researchers sometimes are orientated toward casual explanation of events but more often perceive events. I began my research with a similar motivation. I was genuinely curious to how some women are able to quit smoking and maintain their abstinence where others could not. My interview questions were developed to encourage my participants to explore and explain their own stories which would allow me to gain an understanding of the event. During the interview process I become more receptive to what was being shared.

I also began to realize that there were many complexities emerging within my study. I anticipated that the coding and theme development process would open a realm of concepts on cessation to be interpreted and reflected upon. However, the women involved brought up issues that at first seemed external to their tobacco use and cessation. One women talked about realizing and having to admit she has depression while another talked about her past financial situation and lack of access to money and basic needs. Stakes (2005) maintained that there are cases within the cases – embedded cases or mini-cases. I believe each of these mini-cases had effects on each of the women's tobacco use and ability to quit. It appeared that there had to be some acknowledgement of these situations or mini-cases in order for them to move toward successful cessation.

Stakes (2005) asserted that the bulk of case study work is done by people who have intrinsic interest in the case. The intrinsic case study design draws researchers toward understandings of what is important information about that case within its own world. This

research approach has allowed me to gain more understanding into the motivating factors for quitting smoking and how gender plays a critical role in both tobacco use and cessation. I theorized that tobacco use is not a singular phenomenon but is deeply intertwined with varying psycho, social, emotional and societal complexities and that research would validate this theory.

It is important for readers of this project to interpret my findings with their own sense of reflexivity and draw their own conclusions. Stakes (2005) declared that in terms of intrinsic case study, researchers expect their readers to comprehend their interpretations but to arrive as well, at their own. Thus, this project includes my interpretations but allows freedom for readers to interpret for themselves the quotes and statements made by my participants.

Research Process

Stakes (2005) described that casework regularly begins with cases already identified and are of interest before formal study begins. This is true of this project as I have been puzzled by the success of some women I have worked with in the past who were able to cease tobacco use. Since the researcher examines various interests in the phenomenon, selecting cases that seem to offer opportunity to learn (Stakes, 2005), I openly recruited women who could offer the most insight into my research question and from whom there was the best opportunity to learn from regarding tobacco cessation success.

I employed a convenience sampling that consisted of seven women over the age of thirty who have been tobacco free for at least six months. I found participants through open recruitment including e-mail, telephone, information posters, and word of mouth. The majority of my participants were acquired through word of mouth, not an uncommon

occurrence in small communities. Interviews occurred at my office at work because it is in a public, convenient, safe location and is accessible to people with mobility issues. Using my work space also allowed me to store my data securely.

My intent was to interview women who have used varying methods to quit, such as, the use of nicotine replacement therapy, one-to-one sessions, group support and combination therapy. I was also open to interviewing women who have used methods that have been less frequently reported in the research, such as laser therapy, hypnotherapy, and acupuncture.

Interview Questions

My first step was to develop a semi-structured interview format to research what factors the interviewee attributed to personal success with quitting smoking. I developed my interview questions to reflect the skills I learned about coaching strategies. My questions were open-ended and provoked deeper thinking from my participants. Hunt and Weintraub (2002) acknowledged that coaches use good questions to encourage others to reflect on the situation and assess themselves. After asking each question I created the time and space to allow participant to think about their answers and respond without interruption. Listening requires that the coach have a certain tolerance for silence and if you ask a tough question you have to give the person the time to think and respond (Hunt & Weintraub, 2002).

Interview questions encouraged open dialogue between myself and the interviewee and consisted of the following:

- *How long have you been tobacco free?*
- *How long did you use tobacco products?*
- *What led you to start using tobacco products?*
- *How were you able to quit?*

- *What factors lead to your decision to quit?*
- *How many times have you tried to quit?*
- *Why do you think you were successful this time?*
- *What aspect of quitting did you find most difficult?*
- *Were there any surprises for you along the way?*
- *How have you been able to remain tobacco free?*
- *Now that have quit, do you have any recommendations for others trying to quit?*
- *Is there anything you would like others to know?*

The rationale was to encourage participants to examine what they understood to be the factors contributing to their success. These questions assisted participants to explore how they were able to be successful with quitting and provide the space for participants to reflect and analyse their own experiences.

I anticipated the interviews to be around one hour in length and most were between 30 to 60 minutes in length. Some of the women simply responded to the questions asked while others elaborated on the questions. Since sessions were audio taped, I did not take notes during the interview so I could pay full attention to my participants. I recorded my impressions in a reflexive journal after each interview. The sessions were transcribed and then the transcripts were coded. The codes were then reviewed to look for themes. The themes helped me to draw conclusions from the study. After reading and signing the Information Letter and Consent Form, participants were reminded that they could receive a copy of their interview transcript for a chance to review and make correction and that they could receive a copy of the completed study. Two participants indicated that they would like to receive a copy of the completed study and will be provided with a copy upon completion.

Data Analysis

Interviews were audio recorded so they could be transcribed and then coded and reviewed for emerging themes. I used thematic analysis which identified emerging patterns and meaningful structures from the participant's stories. Thematic analysis is a method that works both to reflect reality and to unpick or unravel the surface of 'reality' (Braun & Clarke, 2006). This methodology draws on the power of themes, where the most meaningful and common elements from all the data collected surrounding the phenomenon come together. These themes provided insight into how women were able to successfully quit smoking through their own words, stories, experience and interpretation. I coded my data by assigning descriptive words to sections of the data and then organized these codes and sections into themes. While working with my data, I paid attention to commonalities but also listened for uniqueness in the interviews and experiences shared.

Boyatzis (1998) explained that thematic analysis gives a comprehensive summary of the use, application, and validity of this methodology. Thematic analysis enables scholars, observers, or practitioners to use a wide variety of types of information in a systematic manner that increases their accuracy or sensitivity in understanding and interpreting observations about people, events, situations, and organizations.

The themes were generated from the information provided by my participants and compiled as codes in a codebook. I added codes every two to three sentences and used these codes to develop my themes. Saldana (2009) described that a code is most often a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based data. In this case, the data consists of interview transcripts from participants. I coded the data that was relevant to my research

question. Saldana (2009) shared that most qualitative researchers feel that only the most salient portions of the document or transcription merit examination.

Issues and complexities continued to develop and arise throughout the planning phase, interview process and evaluation of the data. Stakes (2005) maintained that in many studies, there are no clear strategies: issue development continues to the end of the study, and write-up begins with preliminary observations. I was surprised by the variety in cessation strategies used and the complexities that have been shared by the women who participated. I was moved that two of the women cried during their interviews as they talked about how tobacco has negatively affected their lives and decision making, and when one woman shared being in unhealthy partnerships, realizing as she talked that she was living with depression. More than anything, I was honoured that the women were willing to share personal stories with me, having met me only briefly

Evaluative Criteria

One concern among qualitative research is establishing validity. Whittemore, Chase and Mandal (2001) stated that qualitative research seeks depth over breath and attempts to learn subtle nuances of life experiences. I used my interview findings to learn more about the experiences of the participants and how they achieved success with quitting smoking. Validity is established based on the process of the women authentically and candidly sharing their lived experience and stories. I strove to be authentic in my research and to proceed with integrity.

During the data analysis process I chose which interview statements to include in my findings. I selected statements that I believe are most relevant to my research question. This process makes my research very personal and subjective. Stakes (2005) asserted that even

when empathetic and respectful of each person's realities, the researcher decides what the case's "own story" is, or at least what will be included in the report. This bias may unintentionally omit critical information. However, I worked to interpret my findings with no ulterior motive for representing them inaccurately.

Ethical Considerations

I was aware of the impact my questioning and interviewing may have on my research participants just as Clark (2006) reminded that researchers must be mindful of the impact their questioning can have on vulnerable subjects. I intended to interview participants that I may have had previous contact with in order to build on a pre-existing relationship that might enhance rapport. Clark (2006) declared that rapport is frequently mentioned as an important part of the qualitative interview process.

A most critical component of the ethical process was the development of a consent form for participants to review with me and then sign to indicate understanding and agreement (See Appendix B). To ensure my participant were comfortable with the process I gave them the time to read the consent form then reiterated important points with them. I gave each participant the opportunity to decline the interview. I was nonjudgmental in my approach and consciously and purposely used effective communication skills during the process. The approach utilized allowed participants to reflect on their own lives and experiences and share personal aspects of their journey that were critical to my research.

To respect my participant's privacy, even in the cases where participants indicated and signed that they were agreeable to their names being used in my research, I chose to exclude their names and refer to the individual women as "participant". Stakes (2005)

acknowledged that researchers should go above and beyond the rules to protect human subjects.

Summary

I have a lot of passion toward this topic and hope that my work helped my participants feel proud about their accomplishment of quitting; offering some insight for health professionals, and answered some burning questions I had about addiction to tobacco and behavioural changes.

This project took the form of qualitative research using a case study approach. Rational for choosing qualitative research and case study were addressed. I theorize that the findings from qualitative research in the area of addiction can help restructure health promotion initiatives and build more successful programming if gender-specific and gender sensitive issues are fully recognized and addressed.

Research participants were selected using convenience sampling that evolved into snowball sampling, and interviewed using a semi-structured format. The findings were arrived at through thematic analysis. The intent of the research was to obtain some lived experience data from the participants and present a foundation for future research on women and successful tobacco cessation. I created a safe space to allow women to share their stories on how they were able to quit smoking and share these interpretations with health professionals, researchers and women interested in quitting tobacco use.

Chapter 4: Findings

Introduction

Dialogue during the interviews was very rich and the women appeared open and willing to provide well thought out, personal answers to the questions. Participants answered each question thoughtfully and were encouraged at the beginning of the session to elaborate and share what they deemed as most important. The women all expressed that they were happy to participate in this project and seemed at ease and comfortable during the session. When receiving expressions of gratitude after the interview, each participant expressed her comfort with the process and all participants were happy to provide further clarification if needed. Participants focused on tobacco use, motivation to quit and cessation strategies.

Some women were emotional during the session as they talked about their motivation for quitting and many expressed feeling proud of their accomplishment. One woman stated, "*I am proud of myself, I'm certainly proud of myself. I don't think it's anything to brag about but I am proud of myself and that's all that matters*". Another woman stated, "*Who knew this would work, but it was a matter of thoughts and believing in myself. It's been very good for my self-confidence; feeling like I was worth it was a unique feeling for me. I am very proud of myself for not going back to smoking*".

I was very struck by this comment that feeling "*worth it*" was a unique feeling for her. This participant's comment made me ponder her level of self-worth and I wondered if her apparent lack of self worth not only contributed to her tobacco use but also affected her ability and confidence in herself to quit smoking. I wondered that if she had experienced a greater sense of self worth, would she have been able to successfully quit earlier in life.

All women stated that they would not return to smoking and had conviction in their voices as they spoke these words. One woman talked about how she enjoyed smoking but will not start again. She stated, "*I loved it [smoking], I really loved it even though it was killing me. I miss smoking but I won't do it again*". I appreciated this woman's comment that she enjoyed smoking and was impressed that although she enjoyed smoking she was able to reject the pleasure and choose to quit. This participant shared that she had felt great sadness in her life and this sadness motivated and compelled her to quit smoking. She was emotional and very candid during the interview session. She shared that she felt that the sadness she was feeling was attributed to smoking and if she quit, the sadness would go away. I was intrigued that her sadness overrode her love for smoking and she was able to quit.

Another participant stated, "*I try not to think about it anymore. I am done, I'm not worried about starting anymore. I can joke about smoking now*". In this comment, I heard confidence and a strong sense that she was well in her maintenance phase of being a non smoker and relapsing was not a concern for her.

There was quite a difference in quit attempts among my participants. One woman stated she was successful on her second attempt whereas other stated it took several quit attempts to be successful. One participant shared that she had several quit attempts in the past and spoke with strong conviction that she would never return to smoking.

"*I've never had one puff because I know if I have one, I'll know I blew it, and start again, punishing myself. So I've never had one puff and I never will*", were the words from another participant. What I found intriguing in this statement was not only her confidence in

her ability to maintain her abstinence but also her statement about punishing herself. This raised the question of how much smoking could be linked to low self esteem.

Many shared that they had made several attempts to quit and using a variety of methods. "*I tried several times before, you know they say it takes seven times [to quit] but honestly, three or four times I honestly tried. I tried Zyban, lonzenges, patches and Champix*" stated one participant. Another participant laughed when she shared that she had tried to quit fifteen to twenty times.

When asked if she had tried quitting before, one participant stated, "*For the last ten years, I had always said, this birthday I will quit, this summer I will quit, this trip I will quit but I only managed a few hours, few days or week. I once quit for almost three months but I went back to school and smoking was the only way for me to cope with the stress*". Another stated, "*I tried hypnosis, the patch, gum and nothing seemed to work for me.*"

It appeared that making more than one attempt to quit was almost normalized. This circular pattern needs to be seen as part of the quitting process. Some women appeared to not have any thoughts or feelings toward how many times they had tried to quit while others appeared to be intrigued at how many times they had tried to quit. I wondered if unsuccessful quit attempts negatively affected self esteem and the willingness to try to quit again.

Presentation and Analysis Themes

As stated previously, I compared my findings to those of Puskar (1995). In her work with women and smoking cessation, she noted four major themes that I use to compare and contrast my findings. Puskar's (1995) themes were: evolving commitment to health and personal growth; being stigmatized; changing conceptualization of smoking; and smoking

cessation as a relational phenomenon. I also found money and the cost associated with smoking to be a significant theme.

I have inserted a table after each theme that shows which interview question was related to each theme and the participant's response to the interview question.

Evolving commitment to health and personal growth. Each of the participants mentioned health as a motivator to quit. Puskar (1995) described this theme as quitting smoking being part of a larger commitment to health and personal growth. One participant shared that health was her number one motivator for quitting as she struggled with being chronically ill. She proudly boasted that she has not been sick once since quitting over a year ago. Another woman spoke of being told by her surgeon that her recovery time would double since she is a smoker. She said, "*... a light bulb went off and I thought, Good God, I'm not going to be held up for 12 weeks because I smoke.*"

Each of the women had their different health reasons for quitting. Some stated that they knew if they continued that it would kill them, others stated that they felt contradictory for smoking when they were healthy in other areas of their lives, i.e. exercising and eating healthy. One participant stated, "*Even though I was doing boot camps, hiking, up the ski hill, going to the gym at 5:00am, I would smoke two cigarettes going to the gym, then two after the gym. I was healthy in other aspects of my life*". This woman appeared to incorporate physical activity into her life and smoking was a contradiction on her perspective of being healthy. Puskar (1995) found that for many of her subjects, smoking was viewed as a self-defeating behaviour that had become incongruent with a lifestyle that was increasingly health focused.

Table 1

Theme		Interview Question
Evolving commitment to health and personal growth		What factors lead to your decision to quit?
Subject	**Response**	
1	Becoming pregnant and realizing it affects more than me.	
2	I want to be a healthy grandma. I wanted to be there for my parents and grandkids and just live life.	
3	My health was number one. I have been chronically ill for a very big part of my life.	
4	There may have been some motivation to quit because of my health and difficulty breathing. It made me want to slow down.	
5	I always wanted to quit. We all know it's bad for us. When I went to see a surgeon for knee surgery I asked how long it would take to heal. He said about six weeks then went, wait, you smoke, double that.	
6	I had quit because I was pregnant and I knew it was better for the child to quit. I didn't like the health effects.	
7	I finally noticed my voice had changed. I love singing and I can't sing anymore. I realized that if I didn't quit right away then I would die from it.	

The table clearly illustrates that health was on each of the women's mind and a motivating factor for quitting. Some women clearly connected smoking with death while others acknowledged that their health was affected or going to be affected. These women not only connected smoking with ill health but also made the connection that not smoking would improve health and was already, or would soon, negatively impact thing in their lives.

Being stigmatized. Puskar (1995) findings indicated that some of her participants were motivated by feelings of being outcasts. Some of the women I interviewed spoke of the changes that have occurred with society's acceptance of smoking and how smoking is no longer as acceptable as it once was. One participant shared that she wanted to quit in order to make a good impression at her new job. I interpreted this statement as her feeling that her new colleagues and/or employer would think negatively of her for smoking which may or may not have been true but was her perception. In this statement I believe she is expressing concern of being stigmatized for smoking.

Another participant stated, "*I think it might be easier to quit now because it is more taboo now.*" This statement speaks to awareness and belief that smoking has become more socially unacceptable. Not long ago, smoking was acceptable in bars, restaurants, airplanes and malls. Now tobacco use has been banned from these areas and the bans on public smoking is considered an effective strategy for decreasing tobacco use.

Most women indicated that they felt tobacco use was becoming less socially acceptable but it did not appear that being stigmatized was a main motivating factor to quit for the women interviewed while some spoke directly to feeling stigmatized. One participant stated, "*I used to hide around a corner when I smoked, I was so embarrassed*". One participant stated, "*Smoking has become stigmatized and looked down at*". And another stated that she felt that she was judged because she was judging herself.

Table 2

Theme	**Interview Question**
Being Stigmatized	What factors lead to your decision to quit?
Subject	**Response**
1	I didn't want to smoke again so she [daughter] didn't have the constant second hand smoke, smell and to be a role model to her.
2	Let me be a positive role model to me first then others.
3	I did not want to let my father or husband down and my kids for that matter.
4	It's better now not smoking. I want to do stuff and I don't sneak around. I think it pathetic, I feel judged because I judge myself with how pathetic I was.
5	I started at my new work and wanted to make an impression.
6	I think it might be easier to quit now because it is more taboo now. I used to hide around a corner when I smoked. I was so embarrassed.
7	I kept it a secret from my co-workers and friends. Smoking has become stigmatized and looked down at.

Most women appeared to take a positive approach to the concept of stigmatization, that is, instead of stating they felt judged or ashamed, they focused their attention on the benefits of being tobacco free and being a role model. Their focus appeared to more on their success of quitting rather than shame of using. This is a beneficial mindset that may have

contributed to their success with quitting. However, it is well known that stigmatizing people is not a useful strategy for motivating people to change behavior. Bottorff et al. (2012) stated the experiences of punishment, and blame attached to social interactions around tobacco use can be detrimental to motivation for cessation.

Changing conceptualization of smoking. Puskar (1995) described the changing conceptualization of smoking as developing a negative attitude toward smoking. A few of the women interviewed expressed a strong discontent toward smoking and stated that this attitude toward smoking helped them in their quitting process. One participant described talking down to the cigarettes during her quit process and while she was cutting back, and she would tell the cigarette , "*I don't need you*", "*I'm not going to be chained to you*", and "*I'm losing an enemy, not a friend*". This participant also stated that she became disgusted with the smoking habit. The process of talking down to her cigarette was a means for her to change her attitude and thoughts towards smoking.

Another participant describes hitting a very low point in her life and stated she "*didn't want to do this [smoking] anymore*". She shares that something inside of her broke and that she hit a rock bottom. She explained, "*Something just broke, it's the only way I can describe it. It was a horrible time, horrible. That month was just brutal; I've never felt like that again. I knew something was wrong and I knew it had to do with smoking.*" This statement is from the same woman who shared that she enjoyed smoking. She shared that she felt an intense sadness and attributed that feeling to her tobacco use. She shared that she did not know why she attributed the sadness with her smoking but she just knew it did. Having this switch in mindset toward smoking was incredible and prompted her toward successful

tobacco cessation. I think that her method for quitting was secondary to her motivation for quitting.

A third participant did not necessarily have a negative attitude toward smoking but stated that when she was smoking, things in her life were difficult and when she quit, her life appeared to become better. She associated not smoking with positive factors that occurred after she quit. "*To get over the addiction, I had to let it go and I did. I was a very spiritual moment and all of a sudden all this positive stuff started happening. I had a home, things came together and a bunch of other good things that occurred after*".

Table 3

Theme	**Interview Question**
Changing conceptualization of smoking	How have you been able to remain tobacco free?

Subject	**Response**
1	The key for me was seeing it wasn't for me
2	I kept telling myself that I wasn't born with a cigarette in my mouth and that it wasn't natural. All that self talk I did really helped and I changed my thinking of smoking
3	Everyone around me had quit, that [quitting] was now the thing to do
4	I knew something was wrong and it had to do with smoking
5	I started smoking at age 15 and quit 6 years ago, from 15 to 33, that's a long time. Gross, I've never actually said that out loud.
6	I started up briefly after having her but thought this was stupid and quit again. When I started up again, I thought this is just stupid.
7	Cigarettes don't have to define who we are

Changing conceptualization of smoking was apparent in the woman's motivation to quit although it was often a secondary motivation for quitting. The concept was present but did not appear to be at the forefront. It is a logical assertion that in order to quit smoking and maintain abstinence, one would have to change their conceptualization of smoking.

Smoking cessation as a relational phenomenon. Puskar (1995) describes relational phenomena as the relational features of the process of smoking cessation. Of the seven women interviewed, only one participant shared how her quitting was affected by others.

She talked about how difficult it was to quit when her partner was still smoking. She states, *"[he] would smoke and there were times he would open the front door and I just knew what he was doing*". Although she did not expressed that his smoking affected her, she implied it in her mannerism and tone during the interview. Most of the women spoke of their own internal thoughts and feelings toward their smoking and quitting. The participants did not discuss their feelings toward others in their lives who continued to smoke. Their focus appeared to remain internal and shared feelings of guilt, stupidity, sadness, and/or stress. External feelings of anger, disgust, and empathy toward others, specifically people who smoke, were not mentioned during the interviews.

Puskar (1995) shares that the women she interviewed expressed feelings they had toward those people who continued to smoke and their interactions. Similar to Puskar (1995) findings, the women I interviewed appeared reluctant to judge and respected other's rights to smoke or not. Interactions with smokers were tempered by a reluctance to judge, a respect for others' feelings and rights, or an acceptance of the compromised necessary for living in a world in which smoking still exists (Puskar, 1995). One participant shares, "*We went on a holiday to see my daughter. Her and her boyfriend both smoked and that was tough. They were out in the balcony and it was wafting into the apartment and I was grossed out*".

Table 4

Theme	**Interview Question**
Smoking cessation as a relational phenomena	Now that you have quit, do you have any recommendations for others trying to quit?
Subject	**Response**
1	(no comments made)
2	I used to avoid people who were smoking, even outside. I wouldn't take a breath until far away.
3	Everyone around me had quit, that was now the thing to do
4	(no comments made)
5	(no comments made)
6	My ex would smoke and there were times he would open the front door and I just knew what he was doing.

7	It's hard for me to not say anything to young smokers. I think everyone is on their own path, just follow your own path.

I am unsure whether smoking as a relational phenomena is a significant motivating factor for my participants or if my questioning during the interview process did not address this theme in the same manner that Puskar's (1995) research addressed it.

Cost associated. The cost associated with smoking arose in a few of the interview sessions as either a primary or secondary motivator for quitting or was merely as a comment. One participant asserted, "*It's hard to justify the cost of smoking versus a college savings account. I bet if you take the cost of smokes over 18 years, you could put a kid through college.*" Another woman declared, "*I honestly had a plan to gain back the money if I didn't quit. I had a plan and money was a factor*".

Puskar (1995) did not mention the costs associated with smoking in her research. This may be because tobacco products were much cheaper when her research was conducted. Tobacco taxes have drastically increased over the years as a means to decrease tobacco use. Tobacco taxation, passed on to consumers in the form of higher cigarette prices, has been recognized as one of the most effective population-based strategies for decreasing smoking and its adverse health consequences (WHO, 2009).

Table 5

Theme	**Interview Question**
Cost associated	What factors lead to your decision to quit?
Subject	**Response**
1	It's hard to justify the cost of smoking versus a college savings account
2	Money was a factor. Money was second to my quitting. I listed the positives of quitting, health and money saved
3	(no comment made)
4	I bought an expensive bike and I didn't feel bad spending that kind of money because of how much money I saved.
5	It was half the price when I started smoking. Maybe $3 or $4, now it's around $10
6	The cost of a pack of smokes has gone up a lot.
7	(no comment made)

With many of the participants mentioning the increasing costs of tobacco products, the effectiveness of tobacco taxation for reducing tobacco use is highlighted. Increasing the cost of cigarettes has the potential to be an effective means for decreasing tobacco use. When compared to Nicotine Replacement Therapy, anti-smoking interventions and bans on tobacco advertising and dissemination of health consequences, one study found that a price increase on tobacco cost would be the most effective and cost-effective intervention (Ranson, Jha, Chaloupka, & Nguyen, 2002).

Components for Successful Cessation Programming

As indicated previously, the women interviewed tended to express concerns for their health as a motivator for quitting smoking. It then makes sense for tobacco cessation intervention to focus on the health of the woman. Bottorff et al., (2012) acknowledged best-practice guidelines that adopt a women-centred approach emphasize a woman's health as her central motivation for quitting, and in recognizing that woman's smoking is a response to personal challenges, place a woman's needs in the context of her life circumstances. Bottorff et al. (2012) then affirmed that best practices should also include the following components: tailoring, reducing stigma, harm reduction, social support and social issues integration. To provide further clarity and evidence of the importance of these components, I will address each of these components further in relation to statements made by my participants.

Tailoring. The women who participated in the interviews each had their own unique way to stop smoking. Some used pharmacology, one used laser treatment and others prayed to their God. Each of their experiences and interventions were unique and they each had a plan that worked specifically for them. One had two weeks off work and secured herself in her residence, allowing herself to sleep in, and decreasing as much external stress as she

could. She declared, "*What helped is my work was closed for two weeks so I could stay home, sleep in, surround myself with friends, lots of feed, beer and sleep when I wanted to. I could just kick back and relax; otherwise I don't think I could have managed.*" This participant shared that stress was a trigger for her to smoke for her so being in a relaxing; no stress environment was a specific strategy that worked for her. Another woman shared that keeping busy helped her. This contrast in methods used addresses the need for a tailored intervention.

Another participant talked about going for long walks during the times she normally smoked. She explained, "*I would make sure I was away from the home during those times. I would take my husband and go for long walks, hours at a time. It was stupid but it worked.*"

Bottorff et al., (2012) shared that smoking interventions should be tailored to a woman's unique circumstances that affect her affect her ability to quit and tailored to the needs of specific subpopulations and to women's social and economic circumstances.

Reducing Stigma. Bottorff et al. (2012) addressed how the experiences of stigma, punishment, and blame attached to social interactions around tobacco use may be detrimental to motivation for cessation and provide women with positive and non-judgmental support are strategies for reducing stigma.

One of my participants used the term "stupid" throughout our conversation. She talked about feeling stupid for smoking and stupid for starting again. Some of her comments included, "*I started up briefly after having her but thought this was stupid and quit again. All I could think was that I could smoke again, so I did, then thought that was stupid.*" She also expressed, "*I'd be freezing and thinking about how stupid this is to suck poison into my face. Stupidity.*" She concluded her interview by saying, "*I used to hide around a corner*

when I smoked. I was so embarrassed." Her comments about feeling stupid and embarrassed lead me to believe that she was experiencing negative social responses to tobacco use and these feelings could have been detrimental to motivating her to quit. I wonder if she would have a more positive attitude toward her quitting success if she had received support in reducing the stigma that she was attaching to her tobacco use.

Harm Reduction. One of the participants talked about cutting back on her tobacco use during her cessation method. She shared, "*I went on Champix and didn't do it the way it said. I think I smoked for about three weeks, not the two weeks that are recommended. I did it my own way*". Permitting herself to smoke until she didn't want to smoke anymore aided her in her ability to quit successfully. Harm reduction does not require immediate, total abstinence from tobacco but starts with addressing the needs of the smokers where they are at (Bottorff et al., 2012).

Social Support. Bottorff et al, (2012) affirmed that the presence of smokers in women's lives has a direct influence on a woman's cessation outcome and her overall health, therefore, it is important to consider patterns of smoking within a woman's social network. Many of my participants addressed the social aspect of tobacco use. One stated, "*I used to avoid people who were smoking.*" another stated, "*my husband and I quit together*".

One participant talked with her family members, husband and children, to ask for support and set rules for how they were able to support her. She stated, "*I told him this time is different and this is what I need from you. I need you to be supportive and this is how. I set the parameters for him.*" She also stated, "*Then I told the kids they had permission to ask me if I was going outside, she had permission to follow me, she had permission to say, I don't believe you and then could hold me accountable*".

Six of the seven participants shared that they had support for quitting from either family members and/or friends. One participant talked about the challenges of quitting while being with a partner who continued to smoke.

Social Issues Integration. This approach recognizes that smoking occurs alongside other complex and intersecting social issues within women's lives, and how alcohol use and illicit substance use, experiences of violence and trauma, mental health issues, poverty, and social marginalization influence smoking an create substantial barriers to cessation and to a woman's overall health (Bottorff et al. 2012).

It is beneficial to increase access to a variety of cessation methods. There is not one approach that will work for everyone and the approach taken should be guided by the person's preference as suggested by my participants. Puskar's (1995) declared that there remains a need for health professionals to continue to campaign for restriction on smoking in public areas and to promote smoking deterrents such as increased cost of cigarettes, the latter which aligns with this study's findings.

It appears that gender specific interventions with tobacco cessation have been sparse as most interventions tend to be general. Bottorff et al (2012) asserted that the cessation experiences of men and women have been sporadically taken into account in smoking cessation, but interventions have tended to be generic, individually focused, and delinked from the many social and contextual influences that affect tobacco. With this being said, it appears that for tobacco cessation strategies to be more successful, they should be tailored for the individual, be gender specific and gender sensitive and include components on the societal influences and impacts of tobacco use and cessation. Bottorff et al (2012) also acknowledged that research has identified LGBT populations as one of the several priority

groups for whom interventions targeting the general population of smokers may not be effective, and for whom specific interventions are required.

Successful Cessation Strategies

I had decided the choice of smoking cessation strategies would not be a limiting factor in selecting participants. I wanted to interview women who had used any method for quitting, including cessation strategies that are research based and those that are not as evidence based. My intent for this approach stemmed from my belief that the cessation method used was a secondary phenomena for predicting a women's success. The primary predictor of success, I believe is more internally motivated and less contingent on the actual cessation method used. It was not my intent to reveal which tobacco cessation method promotes the most success but to share my participant's experiences with successful tobacco cessation.

Of the seven women interviewed, there were some similarities in cessation methods used. Two participants quit cold turkey, without the aid of any Nicotine Replacement Therapy when they learned they were pregnant and another two women quit using the pharmaceutical Champix. Others used quit strategies that included connecting with their spirituality and asking God for support and praying. The two women who used spirituality as a means for quitting also augmented their quit success with a Nicotine patch or gum. One participant attributed part of her success to laser treatment.

When asked if they had any recommendations for others how are exploring quitting, each participant, in her own words, expressed that it is an individual decision and that nothing anyone says can make you quit. They expressed that the decision was personal and had to come from an internal desire to quit and a commitment to follow through with their

quit plan. One woman remarked, "*I really believe it's got to be a different approach to helping people quit. People really need to explore their internal motivations*". Another woman pointed out, "*I really can't give people advice on how to quit smoking. No one could have told me to quit. You are just the preachy ex-smoker*".

When asked if there is anything she would like others to know when trying to quit smoking, a participant declared, "*Never quit quitting*". She shared that this statement helped her to continue with her quit attempts and was a statement she had read on a quitting pamphlet. Another women stated, "*For people who want to quit, I would say the main thing is that the craving is just a thought and it comes and it goes away*".

Summary

During the interviews, it appeared that the women truly believed that there needed to be strong internal motivating factors to be successful with quitting smoking. Many of the women had tried to quit on more than one occasion and spoke quite passionately about having a change in thinking and determination to quit.

I believe these finding and statements demonstrate that further research in the area of gender and tobacco cessation is warranted. The physical effects of smoking is one factor in the importance of quitting but from the participants' stories I suggest that just as critical or more critical is the tobacco user's value that she places on herself and her tobacco use. From the interviews with these women, I identified the importance of a supportive approach to tobacco cessation is needed with less focus on scare tactic strategies. My analysis suggests the participants see that scare tactics place shame and blame on the user and make it more difficult for effective internal motivations to surface.

I believe that programs and approaches to tobacco cessation are making a shift. Scare tactics are diminishing and cessations strategies are beginning to include more supportive elements and the acknowledgment of self-efficacy. One of the many tactics used are the visual effects of cigarettes on packages. With this model, I believe we will continue to see a decline in tobacco use but there are vulnerable populations that are still not being adequately addressed. There are potentially huge benefits for prevention work to be done in this area through recognizing the determinants of health such as gender that may exist. The health of our whole population is vital and tobacco use as a threat to that health status needs a more nuanced up stream stance.

Chapter 5: Conclusions and Further Thoughts

It was an honour to be able to experience these women's stories and then compare findings from these interviews to those of Puskar's (1995) study. The similarities and differences are intriguing. When comparing my finding to those of Puskar (1995), there did not appear to be a trend or commonalities in cessation strategies. Success with smoking cessation appeared to be more contingent on the women's motivation to quit. Common themes during the interviews were found in the desire and drive to quit. Success with quitting began with the motivation and determination to quit and the actual strategy for quitting was secondary and served to augment the drive to quit.

There were many significant similarities between my findings and Puskar's (1995) study from 18 years ago. The constant between the two projects was that success was usually determined by each woman's determination, internal motivation, and desire for health. It appeared that once the women made the decision to quit smoking, they then chose a method or strategy for quitting. Having options and choice in cessation strategy appeared to add to the women's confidence in quitting. One women stated, "*All those years and smoking and seeing the stuff on packages, seeing advertisement and knowing that there was a way out, definitely had an impact on me. It was always in my mind that I could do this and that other people quit and there are programs available when I'm ready*". Availability of a method to assist with quitting smoking had a significant impact on making the decision to quit smoking as indicated in the older research study (Puskar, 1995).

Although the sample sizes in Puskar's (1995) research and my project are small (10) and (7) this is consistent with qualitative research expectations. These are compelling findings that speak to the importance of continuing with qualitative research in the area of

women and tobacco cessation. When exploring women and tobacco cessation success I also believe it is critical to address Bottorff's et al. (2012) findings that highlighted the importance of recognizing that smoking occurs alongside other complex, intersecting social issues and to be successful, these issues cannot be avoided or ignored during tobacco cessation interventions.

My theory at the beginning of this project, and the reason I chose to explore this topic was that cessation strategy choice is a secondary factor in quitting and that there has to be a change in perception of self-worth about smoking to increase success. This was evident in the women's stories and their expression that they experienced a change in thought or internal motivation that propelled them to success. Another compounding variable was that chosen cessation strategies were diverse.

Future research

The results from this research have implications for further research. It is unclear if my findings and Puskar's findings are unique to women; therefore, further research specific on health and gender is warranted. Puskar (1995) expressed that additional research also needs to be done on gender differences in smoking cessation. Puskar (1995) indicated that a similar study to the one she conducted but with male participants would form the basis for a comparison of how men and women experience smoking cessation. These findings could also support the identification of and implementation of tobacco cessation strategies that would be most beneficial for men.

Similar to Puskar's (1995) findings, this project identified that quitting smoking was part of a larger commitment to health and could be a basis to increasing motivation for quitting. Further research into the health benefits of quitting smoking may assist women with

finding the motivation to quit smoking. I suspect that healthy community initiatives could also prompt women to address their tobacco use. For example, the SunRun is an initiative to encourage communities to participate in healthy living and physical activity.

Similar to Puskar's (1995), this study implied that social influences like tobacco denormalization strategies, restrictions on smoking areas and health promotion messaging are encouraging some women to quit. At this point, it may be important to continue with and increase tobacco denormalization strategies including increased taxation on tobacco products, knowledge dissemination about the health effects of smoking along with the benefits of quitting and affordable access to a variety of cessation strategies.

Further qualitative research into how women were able to be successful quitting smoking may also spark knowledge toward other healthy behaviour changes, like achieving and maintaining a healthy weight, decreasing sedentary behaviour and making healthier food choices. Puskar (1995) stated that the themes identified in her investigation could be applied to the study of other health behaviour such as diet, exercise and compliance with health-screening recommendations.

As stated in a previous chapter, there are mini-cases within the case study. I suspect it would be prudent to further investigate these mini-cases. For example, in the case of my participants, it would be beneficial to have explored women's tobacco use and depression, and women's tobacco use and low socio-economic status, and women's tobacco use and sense of self-worth. Each of these complexities, depression, low SES and self-worth, were touch upon or expressed during the interview. To help a person to health, I believe it to be critical to not only take a biophysical approach to health but also a social, emotional, and spiritual approach as well.

Gender and Tobacco Cessation

Literature has explored how gender influences tobacco cessation and describes the most successful and least successful cessation initiatives for men and women. Bottorff et al (2012) declared that in relation to cessation, women often experience less success on initial smoking cessation than men, greater negative affective response during withdrawal and less successful cessation in relation to nicotine replacement therapy. As stated earlier, men and women also tend to relapse for different reasons. It appears that life situations have differing effects on men's and women's cessation success.

A commonly heard concern when quitting smoking is weight gain. There has been much dialogue and research in regards to how much weight a person may gain when they quit along with strategies for preventing weight gain. Research in this area has ranged from stating that weight gain is an unhealthy effect from quitting to gaining weight after quitting is less harmful than continuing to smoke. Some researchers have cautioned that the gendered issue of postcessation weight gain needs to be carefully reconsidered, as ongoing study in this domain contributes to feminine stereotypes and may work to perpetuate the myth, as originally propagated to women by the tobacco industry, that smoking "keeps you thin" (Bottorff et al., 2012).

When exploring women-centred smoking cessation interventions, there appears to be many resources for women who are pregnant and quitting. Research outside of this subject area has been limited until recent years. The emphasis on pregnant women's smoking behaviour has diverted attention from examining the effect of the partner's smoking patterns and fail to address structural factors that influence smoking behaviour (ie, poverty, class, age, gender, education, microsocial factors (ie, the influence of family and intimate social

networks), and the effect of power inequities in the home and in workplace (Bottorff et al, 2012).

Implications for Practice

It is critical to address gender in cessation strategies. As mentioned earlier, tobacco companies have capitalized on advertising based on gender and it makes sense that prevention and cessation strategies would benefit from a gender specific approach. Bottorff (2011) asserted that a gender relations approach recognizes the importance of gender dynamics and the circumstances under which they interact to influence health opportunities and constraints. Understanding gender differences and the aspects that surround tobacco use will help to develop effective smoking cessation initiatives. It is also important to factor in personal issues that may be present. Bottorff et al. (2012) declared that subgroups of women seem to prefer "women-only" cessation treatment (eg, women who are mothers, lesbians, or women who have a history of trauma).

Along with continuing taxation to reduce tobacco use, another strategy may be to continue to restrict smoking in public areas. This strategy will at least decrease harm caused by second hand smoke on non-smokers, which are usually vulnerable population including children and seniors. Öberg et al. (2011) acknowledged that there are well documented and effective interventions to reduce exposure to second-hand smoke in public and private places. Öberg et al. (2011) also maintained that smoke-free policies reduce cigarette consumption among continuing smokers and leads to increased successful cessation in smokers. These policies contribute decisively to denormalize smoking, and help with the approval and implementation of other policies that reduce tobacco demand, such as increased tobacco

taxes and a comprehensive ban of tobacco advertising, promotion and sponsorship (Ŏberg et al., 2011).

Northern Health has been taking a proactive gendered approach when it comes to health and has developed a Men's Health program which recognizes men's health challenges and encourages men to talk about their health and become better informed. Recent studies of men's health behaviours indicate distinct patterns including poor self-health and risk taking, and reluctance to take up professional health care series (Bottorff et al., 2012). Bottorff et al. (2012) also explained that researchers have begun to take a gendered approach to the examination of tobacco use and tobacco policy, and the focus of much of the initial "gender and smoking" research was predominantly on women.

Summary

These women's stories and experiences provide justification that further qualitative research in the area of gender and tobacco cessation is required. This research has the potential to assist with developing programming, cessation strategies and prevention initiatives in the area of tobacco reduction and denormalization that will aid to decrease tobacco use and prevent onset.

As an outsider, being a non-smoker, I found it moving how emotional, passionate and driven these women were when they spoke about their experience and their relationship with smoking, the quit process and the days, weeks, and months that followed during their recovery. The participants expressed how proud they are of themselves and how determined they are to never smoke again.

I look forward to reviewing further qualitative research that puts gender at the forefront of successful cessation experiences. I also hope that new cessation programming will include the importance of addressing gender, exploring motivational factors and providing choice in cessation strategies. Our health care system needs to continue to research best practices and implement upstream initiatives such as those found in the participants' stories. Research such as this illustrates the personal lessons and insights that can be gathered qualitatively and contribute to improved and more effective cessation strategies. Given the increasing cost of the health care system, the design and efficacy of tobacco cessation strategies must be of paramount importance in order to maximize results that reduce ill health and disease.

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Appendix A

Women and Successful Tobacco Cessation Strategies:

An M.Ed. Research Project by Trenna Johnson
UNBC Master's of Education Student

Information Letter and Consent Form

What is the Purpose of This Study?

Tobacco rates throughout Canada continue to fall but use is still alarmingly high in northwestern BC. The purpose of this proposed study is to explore how some women have been successful in abstaining from tobacco products.

How Were You Chosen to Participate in This Study?

I am interviewing a small number of women over the age of 30 who have successfully abstained from tobacco products for at least 6 months. Availability and interest in this topic are two reasons you were chosen to participate.

What am I Asking You to Do?

Please read this information letter carefully. If you are willing to be interviewed about your success with quitting smoking and to have the interview audiotaped, you can contact me, Ms. Trenna Johnson by email at tjohnson2@unbc.ca to let me know that you will participate. We will arrange a time and place for your interview that is convenient for you. The interview will take up to one hour. When you are interviewed, I will record your responses so that I can transcribe and review them for analysis. If you are interested in the questions I will ask, they are at the end of this form.

There will be no other use made of the audiotapes and they will be destroyed upon completion of my Master's project along with all other raw data, by June 30, 2013.

Who Will Have Access to Your Data?

No one except me, Trenna Johnson, will have access to the information from your interview with your name attached. My university supervisor Dr. O'Neill may have access to your anonymous information to help me with my analysis. I will be recording and transcribing your interview myself, and so there will be no one else who reads your information.

Participation in this Study is Voluntary

You may decline my invitation to participate in this study by simply ignoring this written invitation. If you choose to participate, you may withdraw from the study at any time. If you withdraw, none of the information that you contributed will be included in the study.

Potential Benefits and Risks

It is my hope that we will both benefit from this study. I would like to create the time and space for you to share your success story and the information you provide may support others to find success in tobacco cessation as well. I do not believe there are any risks to participating in the study, but if for any reason you become distressed during any part of the interview and research process, I will provide you with a list of counselling services found in your home community once I know what community each participant is from.

Anonymity and Confidentiality

Your anonymity will be protected because only I will have access to the information in your interview with your name attached. You or I will choose a pseudonym to identify you in my research project - individual names will not be used in any future presentations, reports, or journal articles. Confidentiality is important to me because I will learn the most from your open responses.

Information Storage

All information from this study will be stored in a locked filing cabinet at my office at work and on my password-protected computer. All data will be deleted or shredded by June 30, 2013. The only remaining material after this time will be my completed project, presentations and/or papers that relate to the study but do not contain identifying information.

Questions or Concerns about this Study

If you have questions about this study, please contact me or you may contact my Master's supervisor Dr. Linda O'Neill at loneill@unbc.ca 250- 960-6414. If you have concerns or complaints, you are encouraged to contact the UNBC Office of Research at reb@unbc.ca or phone 250 960-6735.

How Do I Get a Copy of the Results?

I will give each participant a copy of their own interview transcription to check for accuracy. At the end of the study I will provide each participant with an executive summary of the entire study in the form of my completed project. .

What Questions Will I Ask?

Here is a sample of the interview questions that I will be asking:

- *How long have you been tobacco free?*
- *How long did you use tobacco products?*

- *What led you to start using tobacco products?*
- *How were you able to quit?*
- *What factors lead to your decision to quit?*
- *How many times have you tried to quit?*
- *Why do you think you were successful this time?*
- *What aspect of quitting did you find most difficult?*
- *Were there any surprises for you along the way?*
- *How have you been able to remain tobacco free?*
- *Now that have quit, do you have any recommendations for others trying to quit?*
- *Is there anything you would like others to know?*

Consent Form

I agree to participate in the *Women and Successful Tobacco Cessation Strategies* study as described on this Information Letter. I am agreeing to an audio-taped interview of not more than one hour, with questions about my success with quitting smoking.

Pseudonym:_____ Name used:_____

Signature:_____ Printed Name: _____ Date: _____

Appendix B

School of Education, University of Northern British Columbia

VOLUNTEERS NEEDED FOR RESEARCH ON:

WOMEN & SUCCESSFUL TOBACCO CESSATION STRATEGIES

Looking for female volunteers who have been tobacco free for at least 6 months to complete an interview centred on your tobacco cessation strategies.

As a participant in this study, you would be asked to: share your experience with quitting smoking. The interview will take under one hour. In appreciation of your time, you will receive a $10 gift card.

If you are interested or would like more information, please contact me at: tjohnson2@unbc.ca

Thank you!

Trenna Johnson, UNBC student

Dr. Linda O"Neill, PhD., CCC, Supervisor

250 960-6414

loneill@unbc.ca

This study has been reviewed by the Research Ethics Board at the University of Northern British Columbia

Appendix C

Here is a sample of the interview questions that I asked:

- *How long have you been tobacco free?*
- *How long did you use tobacco products?*
- *What led you to start using tobacco products?*
- *How were you able to quit?*
- *What factors lead to your decision to quit?*
- *How many times have you tried to quit?*
- *Why do you think you were successful this time?*
- *What aspect of quitting did you find most difficult?*
- *Were there any surprises for you along the way?*
- *How have you been able to remain tobacco free?*
- *Now that have quit, do you have any recommendations for others trying to quit?*
- *Is there anything you would like others to know?*