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Experiences of Relapse in Smoking Cessation

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Experiences of Relapse in Smoking Cessation

By Natalie Kay D'Abrew

**A Report Submitted in Partial Fulfilment of the Requirements for the Award of Bachelor
of Arts (Psychology) Honours
Faculty of Community Studies, Education and Social Sciences
Edith Cowan University**

October, 2001

DECLARATION

"I declare that this written assignment is my own work and does not include;

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Experiences of Relapse in Smoking Cessation

Abstract

Relapse is regarded as a common occurrence, and it is known that smokers make an average of three to four attempts to cease smoking before maintaining smoking cessation. Thus, relapse continues to be a problem for interventions for smoking cessation. This qualitative study explored the experiences of relapse in smoking cessation. Fourteen participants, seven maintainers and seven relapsers aged between 21-80 participated in the study, which was facilitated by a semi-structured interview format. Several themes and sub-themes were generated under the categories of strategies, reasons for relapse, and reasons for cessation. The themes highlighted that there were differences between the maintainers and relapsers. All participants reported relapse episodes. Maintainers, utilised both cognitive and behavioural processes indicated by the Transtheoretical Model of Change and relapsers focused more on the behavioural processes. Maintainers seemed to have more personalised reasons to cease smoking than relapsers, by having more incentive to quit, also they illustrated a high sense of self efficacy. Maintainers also experienced more internal and external negative health events. This qualitative study promotes further research in specific populations in regards to smoking relapse. Specifically with smoking cessation during pregnancy.

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Paul Chang
Submitted: October, 2001

Declaration

I certify that this thesis does not incorporate, without acknowledgment, any material previously submitted for a degree or diploma in any institution of higher education and that, to the best of my knowledge and belief, it does not contain any material previously published or written by any other person except where due reference is made in the text.

Signature: Andrew.

Date: October 2001

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Introduction

Smoking

In 1997 approximately 80% of all drug related deaths were attributable to tobacco use (Australian Institute of Health and Welfare, 1998). In a review of health effects of active smoking, 32 medical conditions with evidence of a relationship with smoking were identified which included, oesophageal cancer, stomach cancer, lung cancer, heart failure and laryngeal cancer (English et al., 1995, cited in Australian Institute of Health and Welfare (AIHW), 1996). The use of tobacco is estimated to have cost Australian society \$853 million in direct health care costs in 1992 (Collins & Lapsley, 1996, cited in AIHW, 1998). In 1998, Australia was ranked 17th in the world for per capita consumption of cigarettes (AIHW, 1998).

Cigarette smoke contains thousands of different substances which cause damage to a persons health (Healy, 1997). These include carbon monoxide, nicotine, and tars, as well as other chemicals including cyanide, arsenic and ammonia (Healy, 1997). These chemicals may be toxic, carcinogenic, or require chemical or hormonal modification to be harmful (AIHW, 1996).

Smoking Control

Prevention of smoking has been an important strategy in the efforts to reduce the use of tobacco (Brandon, Lazev & Juliano, 1998). Attempts to control smoking have included taxation, health warnings on cigarette packets, advertisement restrictions, bans and partial bans in the workplace and public places. These attempts have helped to slow consumption but smoking remains a great risk to public health.

As prevention of smoking is an important public health measure, it is also important not to over look individuals who are at later points in their experiences with smoking. These include, those who need help quitting, as well as those who may remain at risk (Brandon et al., 1998).

Smoking cessation is a major modifiable risk factor for cardiovascular disease (AIHW, 1996), and decreases the risk of cardiac arrests, coronary disease, strokes, cancer and respiratory disease (US Department of Health and Human Services (USDHHS) cited in AIHW, 1996). Within one year of cessation, the risk of coronary heart disease reduces to about half and after approximately 15 years is similar to that of never smoking (USDHHS, cited in AIHW, 1996). The National Tobacco Campaign was launched in 1997 in Australia and aimed to assist smokers along the road to quitting. Despite the campaigns success there are signs of the key indicators slowing down on it's impact on smoking behaviour (Commonwealth Department of Health and Aged care (CDHA), 2000).

Over time there has been a steady decrease in the prevalence of smoking in Western Australia, as illustrated in Table 1, between 1984 and 1997 the prevalence of smoking dropped from 31% to 25% (Health Department of Western Australia, 1998).

Table 1

Western Australian Changes in Prevalence of Smoking 1984-1997

1984	1985	1987	1991	1994	1997
32%	31%	30%	25%	25%	25%

Note. Adapted from "Smoking and health in Western Australia: 1998 Resource Book," by Health Department of Western Australia.

In Australia in 1998, 43% of males and 36% of females were considered ex-smokers (AIHW, 1998). In Western Australia, 30.2% of the population were ex-smokers and 25.1% were smokers, illustrating that there are more ex-smokers than smokers in the adult population (HDWA, 1998).

Even though the proportion of smokers in the Australian population has declined, this decrease is due to people giving up smoking rather than not taking up smoking in the first place (Healy, 1997). For instance in 1989 to 1990 approximately three quarters of all smokers reported that they had attempted to give up smoking (Healy, 1997).

The Transtheoretical Model of Behaviour Change (TTM)

The Transtheoretical Model of behaviour change was developed out of research on smoking cessation with and without treatment and integrates six stages and ten processes of change (Prochaska & Velicer, 1997). The resulting model is an integrative outlook of the stages and processes of how people intentionally change behaviours (Prochaska, DiClemente, & Norcross, 1992). In a study comparing self change to therapy change, it was found that both self changers and therapy changers identified five common stages of change through which they progressed while quitting smoking (DiClemente & Prochaska, 1982). More recently the TTM views change as a process in which an individual progresses through six stages of change (Prochaska & Velicer, 1997). These six stages are; precontemplation, contemplation, preparation, action, maintenance, and termination.

Precontemplation is the earliest stage where the individual has no intention to take action in the foreseeable future (Prochaska et al., 1992). The contemplation stage is when the individual is intending to implement change within the next 6 months (Prochaska &

Velicer, 1997), but there is no commitment to action (Prochaska et al., 1992). The individual weighs up the pros and cons of change (Prochaska & DiClemente, 1992), which can produce ambivalence and can keep a person stuck in this stage over a long period of time (Prochaska & Velicer, 1997).

The preparation stage combines intent and behavioural change. Those in this stage are intending to take action in the next month or immediate future and have often unsuccessfully implemented action in the past year (Prochaska, et al., 1992). DiClemente et al. (1991) reported that some individuals implement some small behavioural changes such as reducing the number of cigarettes smoked per day. The action stage is when individuals make overt modifications of their environment, behaviour and experiences to overcome their problem (Prochaska et al., 1992). However, it is important not to overlook the work that prepares changers for this stage and also the work needed to maintain the changers following action (Prochaska & Velicer, 1997; Prochaska et al., 1992).

Individuals in the maintenance stage work to prevent relapse (Prochaska & Velicer, 1997). It is estimated that this stage lasts from six months to five years, as research suggests that after twelve months of cessation the percentage of people returning to regular smoking was 43%, whereas by five years the risk of relapse dropped to 7% (General Surgeons Report, cited in Prochaska & Velicer, 1997). However, the fear of relapse can last years or even a life-time as some smokers find that they struggle with temptations for the duration of their lives (Prochaska & DiClemente, 1984). The Termination stage is when people have zero temptation (Prochaska & Velicer, 1997). Lifetime maintenance may be a more realistic goal for the majority of people and there

has been little attention to the termination stage in the existing literature. Therefore, it has not been a focus within this present study.

The Processes of Change

The processes of change are overt and covert activities used to progress through the stages of change. Ten processes have received the most empirical support (Prochaska & Velicer, 1997). The stages are *when* shifts in behaviour and attitudes occur and the processes describe *how* these shifts happen (Prochaska et al., 1992). Each process is viewed as a broad category of techniques or methods that can be used with and without therapy (Prochaska et al., 1992). Research has found that self changers, psychotherapy clients and mental health patients utilised the same processes regardless of the theoretical basis of the therapeutic system (DiClemente & Prochaska, 1982; Prochaska & DiClemente, 1984). Thus, the change processes are perceived to encapsulate basic change activities (Prochaska et al., 1992).

A common set of change processes has been identified across problem areas such as smoking, obesity and psychological distress (Prochaska & DiClemente, 1985). These processes represent both experiential/cognitive and behavioural coping activities (Kristeller, Rossi, Ockene, Goldberg & Prochaska, 1992). The experiential or cognitive processes include internal experiences and the behavioural processes include more overt activities (Prochaska & Velicer, 1997). The ten processes are listed in Table 2.

DiClemente, 1984). Healthy role models are techniques that can assist in self re-evaluation (Prochaska & Velicer, 1997).

Environmental re-evaluation includes cognitive and affective assessments of the impact a problem has on one's own social environment, such as the effect of one's smoking on others. Community values can be perceived to be in conflict with the problem behaviour. There is also an awareness that one can serve as a positive or negative role model to others (Prochaska & DiClemente, 1984; Prochaska & Velicer, 1997).

Social liberation, also represents an increase in choices but at the environmental level (Prochaska & DiClemente, 1984). It involves making changes in the environment, to enable more choice. Smoke free zones, empowerment procedures and appropriate policies can increase opportunities for an individual to make choices for change (Prochaska & Velicer, 1997).

Self liberation, is the belief that one can make choices for change and is also known as willpower (Prochaska et al., 1992). The commitment to act upon the belief that one can change increases the client's ability to choose at the level of the person's own experiences. Motivation research illustrates that a person has more commitment when they have more choices than fewer and that multiple choices rather than one choice enhance self liberation (Prochaska & DiClemente, 1984; Prochaska & Velicer, 1997). For example with smokers, action choices may be nicotine gum, cold turkey or nicotine patches.

Counter-conditioning, involves adopting healthier behaviours to substitute for problem behaviours (Prochaska & Velicer, 1997). An example of this is relaxation.

Therefore, the person eventually experiences the stimulus as positive or neutral rather than as threatening (Prochaska & DiClemente, 1984; Prochaska & Velicer, 1997).

Stimulus control, includes restructuring one's environment by removing cues to smoke or adding prompts for alternatives (Prochaska & Velicer, 1997). Some examples are removing alcohol or cigarettes from the house avoiding high risk situations (Prochaska et al., 1992).

Contingency (or reinforcement) management, includes establishing consequences such as punishments or rewards for particular actions (Prochaska & Velicer, 1997). It was found that self changers relied more on rewards than punishments (Prochaska & Velicer, 1997). Contingency management includes overt or covert reinforcements such as positive self statements, rewarding oneself or being rewarded by others for the actions taken (Prochaska et al., 1992).

Helping relationships includes being open about the problem behaviour with a person who cares. Helping relationships combine caring, trust, acceptance and support for the health behaviour change. Such examples are therapeutic alliances, social support and self help groups (Prochaska & Velicer, 1997; Prochaska et al., 1992).

Integration of the Stages and Processes of Change

Cross sectional research involving self changers for smoking cessation and weight loss suggest a relationship between the stages and processes of change (DiClemente et al., 1991; Prochaska & DiClemente, 1983, 1984). Systematic relationships were identified between the stages people were in and the processes they were using (Prochaska & Velicer, 1997). People more frequently applied cognitive/experiential processes through

the early stages and in the later stages, relied more on the behavioural processes as they progress through the stages (Prochaska & Velicer, 1997).

Processes of change are also related to outcome. Recent research has focused on the two higher order factors and how these act with the different stages. For instance, experiential processes peaking in the contemplation stage and the behavioural processes are used most in the action and maintenance stages (Perz, DiClemente & Cabonari, 1991, cited in Scotts, DiClemente, Cabonari & Mullan, 1996). However, the integration of the processes and stages has not been consistent and may be due to the greater complexity of integrating 10 processes across the stages (Prochaska & Velicer, 1997).

Relapse

Relapse continues to be a problem for interventions for smoking cessation programs. The majority of smokers who attempt to cease smoking, eventually return to it (Brandon et al., 1998). Many smokers require multiple attempts before long term success is achieved (Cohen et al., 1989). It is known that smokers make an average of three to four attempts before maintaining their smoking cessation (Schachter, 1982). Therefore, relapse is a common occurrence in smoking cessation.

There has been an array of conflicting research looking into the situational determinants of relapse with ex-smokers. For instance, Lichtenstein, Antenuccio and Rainwater (1977, cited in Shiffman, Read, Maltese, Rapkin, & Jarvick, 1985), studied relapse episodes of 84 unaided quitters and found that urges and temptations accounted for 18% of relapses, and social pressure 48%. Urges, temptations and social pressure were more prevalent than negative emotional states. However, Cummings, Gordon, and Marlatt (1980, cited in Shiffman et al., 1985) found with persons relapsing who had

undergone outpatient treatment, that negative emotional states accounted for 37% of relapses and interpersonal conflicts 15%. More than one third of relapses also occurred when alcohol was involved and nearly two thirds when other smokers were present (Lichtenstein et al., 1977, cited in Shiffman et al., 1985).

Shiffman's (1982) study of relapse processes in ex-smokers collected data from 183 ex-smokers who rang a relapse counselling hot-line. Relapse crises were found to be associated with negative affect, including anger, depression and anxiety. One third were also associated with positive feeling states and precipitated by other smokers, eating and alcohol consumption. Withdrawal symptoms seemed to play a lesser role. Ex-smokers who put into action any coping response were more successful in delaying relapse than those who did not, and a combination of cognitive and behavioural responses were most effective. In all, these studies illustrate that negative and positive affects and social pressure can contribute to relapse.

The TTM views relapse not as a separate stage of change but a return or recycling from action or maintenance to an earlier stage (Prochaska & Velicer 1997). When relapse is incorporated the TTM views change as a spiral pattern rather than a linear pattern. This spiral pattern demonstrates how individuals move through the stages of change, when relapse occurs individuals recycle back to an earlier stage (Prochaska et al., 1992). For example, an individual may start at the precontemplation stage move through the stages to action or maintenance and then relapse. However, they may return to the contemplation stage and progress through the stages again. This may happen many times until the individual achieves successful change (Prochaska et al., 1992).

Research on self change with smokers found that 15% recycled back to the precontemplation stage and 85% back to the contemplation and preparation stages (Prochaska & DiClemente 1984; Prochaska & DiClemente, 1983). Each time an individual relapses they can recycle through the stages again and potentially learn from their mistakes and try something different the next time around (DiClemente et al., 1991).

Within a clinical setting, reports of relapse are often attributed to an inability to cope with high risk situations (Marlatt & Gordon, 1985), rather than acknowledging that a decision is made to engage in the behaviour that is both pleasant and problematic. Allsop (1990) argues that to understand relapse in an entire context a person's decision making is most important. That is, the role of relapse precipitants and coping skills in high risk situations have been over emphasised and decision making under emphasised. Therefore, to fully understand relapse the process of making the decision to change needs to be understood (Allsop, 1990).

Cognitive Determinants of Change

Cognitive factors that also lend importance in the understanding of relapse, include decision making (Janis & Mann, 1977) and self efficacy (Bandura, 1982). Decision-making is a critical process in changing health related behaviours like smoking. Decisional balance within the TTM reflects the weighing of the advantages and disadvantages of changing a behaviour (Velicer, DiClemente, Prochaska & Brandenburg, 1985). The TTM utilises the Decision making model (Janis & Mann, 1977) to understand how motivational considerations are related to the stages of change (Prochaska & DiClemente, 1992). The balance of the pros and cons alters as individuals progress through the early stages (Prochaska & DiClemente, 1992). However, during the

action and maintenance stage considerations for decisional balance are less important predictors of success (Prochaska, DiClemente, Velicer, Ginpil & Norcross, 1985).

Janis and Mann (1977) identified five different types of decision making. These are:

1. Unconflicted adherence, which is when a person perceives no risk from their current course of action, and continues what they are doing based on limited evaluation. This is seen as the best option.
2. Unconflicted change, is when with little evaluation the person adopts a new course of action, which is perceived as more attractive than the old one.
3. Defensive- avoidance, is when a person views a serious risk from the current course of action, but they also view a serious risk from the new course of action and take the least worst option.
4. Hypervigilance, occurs in a time of stress when there is a need for urgent action. The person hastily pursues options and selects one with little or no evaluation;
5. Vigilance, is when a person carefully examines all available options and chooses an option based on that evaluation. A vigilant decision is more likely to lead to a robust resolution to change.

Vigilant decision making is not commonly associated with addictive behaviours (Allsop, 1990). A central feature of addictive behaviours is ambivalence, which is the conflict of restraint and inclination to use. Orford (1985) states that an addictive behaviour is characterised by conflict and can not be fully understood until the importance of the balance struck between inclination and restraint is understood. This conflict between restrain and inclination is created by the inclination towards use

(smoking) and the restraint from use (Orford, 1985). Thus, these two tendencies increase in strength the nearer the person gets to consumption, as the inclination becomes stronger and the restraint becomes harder to maintain (Orford, 1985). This produces a high level of stress and dissonance or ambivalence characterised by 'I must not ...but I want to'. Under these conditions poor decisions will be made (Allsop, 1990). Therefore, in regards to relapsing the chance of relapse will be minimised by a more robust decision to change (Allsop, 1990).

Self-efficacy theory (Bandura, 1982) views an individual's perceived ability (efficacy expectation) to perform a task as a mediator for future task performance. So, an increased self-efficacy can predict increased performance and vice-versa (Bandura, 1982). Efficacy expectations determine whether coping behaviour will be used when faced with obstacles (DiClemente, 1981). Self-efficacy reflects beliefs about being able to deal with demands by means of adaptive action, builds one's capacity to deal with stress and results in a difference of how one feels, thinks and acts (Schwarzer & Fuchs, 1996). Efficacy expectations in respect to a particular set of behaviours are relevant for coping efforts only for those specific behaviours. Therefore, efficacy for non-smoking must be sustained for long term success for smoking cessation (DiClemente, 1981).

The predictiveness of self-efficacy in smoking cessation has been demonstrated in a number of studies. Condiotte and Lichtentsein (1981) studied 78 smokers entering smoking cessation programs to estimate their ability to maintain abstinence pre and post treatment. The participants' self-efficacy rose as a result of treatment and post treatment self-efficacy scores predicted who would relapse (Condiotte & Lichtenstein, 1981)

DiClemente (1981) used a measure of self-efficacy for avoiding smoking and applied it to relapse and maintenance in smoking cessation. It was found that two thirds of those who successfully maintained cessation illustrated higher self efficacy scores than those who relapsed. In a study predicting change in smoking status for self changers it was found that self-efficacy was one variable which had predictive power in regards to smoking cessation (Prochaska et al., 1985).

A model that incorporates self efficacy, beliefs and attitudes is the Health Belief Model (Nutbeam & Harris, 1999). The Health Belief Model views that the chance of a person taking action to a health problem is dependent upon the interactions between four different beliefs (Nutbeam & Harris, 1999). A person will take action to protect or promote health if:

1. They perceive themselves to be susceptible to a condition or problem.
2. They believe it will have potential serious consequences (perceived threat).
3. They believe a course of action is available which will reduce their susceptibility or reduce their consequences.
4. The benefits of taking action outweigh the costs or barriers.

The perceived vulnerability to negative consequences is a critical factor in the decision to retain health promoting or health harming behaviours, such as smoking and smoking cessation (Gibbons, Eggleston & Benthin, 1997). Risk perceptions of current smokers are positively associated with the intention to cease smoking (Prochaska et al., 1985). The greater the perceived benefits the greater the intention to quit (Velicer, DiClemente, & Prochaska, 1985). The health belief model also integrates self efficacy, which is the belief in ones ability to take appropriate action. The Health Belief Model is

used to account for the variance in an individual's health behaviour by different attitudes and beliefs, however, other forces also influence action, such as social, financial, and environmental factors (Nutbeam & Harris, 1999).

The Processes as Predictors for Change

The processes of change have been predictors of change for both therapy changers and self changers, and are predictive of successful smoking cessation (DiClemente & Prochaska, 1982; Rossi et al., 1988; DiClemente et al., 1985). There is some empirical evidence demonstrating that different processes are used by successful and unsuccessful self changers.

Perri, Richards and Schulthers (1977, cited in Prochaska, Crimi, Lapanski, Martel & Reid, 1982) interviewed students who were successful and unsuccessful in quitting smoking. It was found that maintainers utilised self reinforcement procedures more than those who relapsed. However, this study is limited as it only focused on four processes of change (cited in Prochaska et al., 1982).

Prochaska et al., (1982) compared maintainers and relapsers who had ceased smoking on their own on measures of processes of change, self-efficacy and self concept. Successful changers were found to have relied on experiential/cognitive processes of change and relied more on self-liberation during the maintenance stage, whereas the relapsers utilised environmental change processes more across the stages. Self efficacy was also higher for successful changers. Relapsers reported being less confident in coping with situations which elicited negative emotions such as anger, anxiety and frustration. It was suggested that greater reliance on an experiential/cognitive process may lead to

successful change rather than relying on environmental processes of change (Prochaska et al., 1982).

A study on the change processes utilised by 872 self changers over five different stages of quitting smoking reported that participants in the maintenance stage used less reinforcement management but continued to use counter conditioning and stimulus control processes for dealing with temptations to smoke (Prochaska & DiClemente, 1983). Relapsers used processes such as self re-evaluation and consciousness raising commonly used by those in the contemplation and action stages. It was suggested that relapsers might be preparing themselves to quit smoking again or attempting to prevent a total relapse by also utilising action or maintenance processes, such as helping relationships and stimulus control to control their current levels of smoking (Prochaska & DiClemente, 1983).

Prochaska et al. (1985) in a longitudinal study investigated the processes of decisional balance and self efficacy in self changers to predict which participants would progress through the stages or recycle and which would remain the same in their attempt at smoking cessation. It was found that those relapsers who became precontemplators relied more on processes focused on environmental events such as stimulus control, dramatic relief and social liberation. Those relapsers who became contemplators and actioners relied more on experiential events such as self re-evaluation, counter conditioning, helping relationships and self liberation. These relapsers were more open with others (helping relationships), believed in their ability not to smoke (self liberation), changed the way they responded to smoking situations (counter conditioning), and

appraised the way they felt about themselves as smokers (self re-evaluation) (Prochaska et al., 1985).

Rossi et al. (1988) compared a group of light and heavy smokers on ten processes of change. Light smokers were found to outperform heavy smokers on four of the ten processes, especially the behaviourally orientated ones, such as reinforcement management, self-liberation, counter-conditioning and environmental re-evaluation. It was concluded that heavy and light smokers can be differentiated by the use of the processes of change, the results also being consistent with why light smokers are more successful in quitting than heavy smokers (Rossi et al., 1988). For instance, data from 10 long term studies relating to key issues of self quitting of smokers found that light smokers were twice as likely to quit than heavy smokers (Cohen et al., 1989). Additionally, a study of heavy smoking found that heavy smokers were more dependant on cigarettes, experience greater difficulty in quitting and experience stronger urges, cravings and withdrawals (Killen, Fortmann, Telch, & Newman, 1988)

DiClemente and Prochaska (1985) conducted a longitudinal study of smokers/ex-smokers comparing maintainers and relapsers. Long term quitters who had quit smoking on their own and had been abstinent for at least six months saw the disadvantages of smoking as greater than the advantages. Temptations to smoke were low and efficacy to abstain was high. These maintainers continued to use counter-conditioning and stimulus control to maintain their cessation, and utilised social support or reinforcement management. They also engaged in some internal counter-conditioning and external stimulus control to avoid relapse. On the other hand, relapsers resembled contemplators in regards to their assessment of the pros and cons of smoking, temptation levels and

confidence about not smoking. They were similar to contemplators in regard to the processes of change, and recent quitters and long term quitters in other ways. These relapsers continued to use consciousness raising, self liberation, self re-evaluation, social liberation, stimulus control and reinforcement management procedures. Approximately 85% of relapsers were seriously thinking about quitting again and continued to seek information and re-evaluate themselves and their environment. They kept active with self liberation and behavioural processes in attempts to control the habit and to keep from relapsing completely or to ensure their next attempt would be more successful. On cognitive measures such as self efficacy and decisional balance they seemed to be unsure of themselves but continued to engage in processes that may help them deal with the relapse experience and future attempts to quit (DiClemente & Prochaska, 1985). It was concluded that relapse may not be as much of a negative consequence as thought. Interestingly, these relapsers were a very active group because at the end of the two year study 27% of the relapsers were not smoking again, whereas only 11.5% of the contemplators who had also entered the study were not smoking (DiClemente & Prochaska, 1985).

Scotts et al. (1996) examined the processes of change in pregnancy smoking cessation and compared women who had stopped smoking during pregnancy and those quitters who were not pregnant. It was found that women who had stopped smoking during pregnancy used different change processes from non-pregnant women who had recently quit smoking. Experiential/cognitive and behavioural change processes were lower for the pregnant women than the non-pregnant women in the action stage. Low levels of process of change use and high self-efficacy indicated an external motivation for

stopping rather than an internal, intentional process of change which may account for high relapse rates post partum (Bottorff, Johnson, Irwin, & Ratner, 2000; Scotts et al., 1996).

The Scotts et al. (1996) concluded that quitting smoking in pregnancy is embedded in a context of other life changes at that time. The decision to stop seems to be made without resolving their ambivalence (Scotts et al., 1996). This is argued to pose challenges for the TTM, as it explains intentional behaviour change. However, the results indicate that these pregnant women are experiencing cessation of smoking as an externally motivated or imposed challenge. This has implications in relation to perceived health risks and understanding of externally motivated or imposed cessation is needed (Scotts et al., 1996).

Davidson (1998) also comments on the TTM and argues that the model views successful change as progressing through the stages and using the right processes at the right time. However, there is some evidence indicating successful unconflicted change among heavy drinkers (Orford, Somers & Daniels, 1992, cited in Davidson, 1998). So, for those drug users who seem to stop abruptly as a result of a sudden and significant life event (Tuchfield, 1976, cited in Davidson, 1998) there seems to be no progression through the stages. It is premature to conclude that quality change happens only if one proceeds through each of the stages. However, there are models which have primarily been used to explain health behaviour decisions and emphasise cognitive processes as critical determinants in the adoption of beneficial health behaviour, such as the Health Belief Model (Nutbeam & Harris, 1999) mentioned earlier.

Overall, the TTM is a useful model in describing when and how an individual may change. The processes of change offer a means of identifying active coping activities. The stages of change enable sub division of individuals in a manner meaningful for intervention. The TTM has focused less on a clear explanation of causal account. That is why people change. However, it does seem compatible with a broad range of perspectives regarding determinants of change (Miller & Heather, 1998).

The Present Study

This study is a qualitative study about the experiences of relapse in smoking cessation. Relapse is regarded as common, it has been suggested that relapsers recycle back through the stages and potentially learn from their mistakes attempting different processes the next time around (DiClemente et al., 1992; Prochaska & Velicer, 1997). However, there has been little recent research in regards to the processes used by individuals before and after having relapsed with smoking cessation. Thus, more research is needed on those who relapse to test this suggestion (Prochaska et al., 1992). Much of the past research has been quantitative especially regarding which processes have been used by unsuccessful or successful changers. In addition, there is existing literature about when people may relapse, such as in high risk situations. So, a major focus of relapse prevention and management of relapse has been on the precipitants of relapse which are attributed to the inability of the individual to cope in these high risk situations. This misses the importance of the decision that is made to cease smoking or to relapse. So, the reason people change is also important in understanding why people relapse. To understand relapse as a whole research must include investigation of the decisional

aspects of relapse (Allsop, 1990). It is suggested that qualitative methods are the most appropriate for this type of research.

This present study aims to explore the personal experiences of individuals who have attempted to cease smoking. Specifically, the interest is to explore what strategies are used and why some people change a health behaviour like smoking and why some relapse. Individuals who have relapsed and those who have maintained smoking cessation will be interviewed about their experiences of smoking cessation. This study will result in rich descriptions of the personal experiences of those who cease smoking but relapse and those who maintain smoking cessation by entering into their psychological and social world (Smith, 1995).

1994). Therefore, the researcher can gain an understanding of the participant's perspective (Smith, 1995). Examples of the questions are as follows; questions (1) and (2) are for the relapsers and questions (3) and (4) are for the maintainers (Appendix A).

Probe questions were also asked as and when it was necessary.

- (1) *How long have you been smoking for?*
- (2) *Can you tell me the reasons why you started smoking again?*
- (3) *What are the strategies you use to help you maintain smoking cessation?*
- (4) *How do you feel about smoking now?*

Interviews

Interviews were conducted during the period of 4 July to 17 September, 2001. All interviews were conducted face to face, audio taped and lasted from 20 minutes to 45 minutes. The semi-structured interview format was followed and probing was added as and when needed. Twelve interviews were conducted in the homes of the participants, one interview was conducted in the home of the researcher (requested by the participant), and one interview was carried out in a participant's workplace (office setting). None of the participants were interviewed more than once for this study.

Procedure

The basic approach of snowball sampling was utilised in obtaining participants, having informants introduce the researcher to others (Taylor & Bogdan, 1998). Participants were obtained by approaching people in public places such as Edith Cowan University. However, the majority of participants were obtained through another participant, or the researcher talking and approaching people with a standard script (Appendix B) and being referred on to others. Phone numbers were obtained and then

participants were contacted to arrange a convenient time for an interview. Before each interview took place, participants were verbally informed of the nature of the study and were handed a written information sheet on the study (Appendix C). Signed consent was also obtained from all participants (Appendix D).

After signed consent was obtained, the interview commenced. At the end of each interview the participant was thanked. The researcher also had available material on smoking cessation and referral contacts, should any of the participants require them (Appendix E).

Data Analysis

Data was analysed by a process adapted to suit the researcher, as it is suggested that researchers can develop their own ways of analysing qualitative data (Taylor & Bogdan, 1998). The analysis process was adapted from various sources such as Taylor and Bogdan (1998), Coffey and Atkinson (1996), Morse (1994) and Miles and Huberman (1994). Firstly, all interviews were transcribed verbatim with participant responses being numbered for easy reference. Random interviews were reviewed by an independent person to verify that they were verbatim.

Secondly, starting with those participants who were maintainers, the transcripts were subjected to content analysis and categories were constructed comprising of strategies; reasons for relapse; and reasons for cessation. Themes and sub-themes were generated under these categories. Over 450 quotes were collated under the themes and sub-themes [Abbreviated quotes used in the Results section can be identified by numbers to correspond to quotes in Appendix F]. The coded data was analysed for patterns, similarities and contrasts between each group (Coffee & Atkinson, 1990). Additionally,

the stages of change were identified for those participants who had relapsed. An audit trail consisting of transcripts with notes, data reduction notes and data reconstruction was also established as a measure of reliability and validity (Morse, 1994).

Results

Stages of Change

Of those participants who were relapsers, two indicated they were in the precontemplation stage with one of the two not referring to quitting again at all. For example:

no...probably not...no not at the moment anyway Relapser (454).

Four relapsers comments illustrated they were in the contemplation stage, they acknowledged that they may quit in the future but had made no commitment yet. Such as:

yes, but I am not really ready yet...I know eventually I will give up

Relapser (455).

Only one relapser indicated to be in the preparation stage by setting a quit date. For instance:

I have chosen the 1st of October - and I will have another go at it

Relapser (463).

Of all maintainers and relapsers, all had attempted to cease smoking at least once or more times. Three broad categories were produced during data analysis of strategies; reasons for relapse; and reasons for cessation. Under each category, several themes and sub-themes were generated. Table 3 illustrates the list of categories, themes and sub-themes.

Table 3

List of Categories, Themes and Sub-themes which Emerged from Analysis.

STRATEGIES CESSATION	REASONS FOR RELAPSE	REASONS FOR
COGNITIVE/EXPERIENTIAL PROCESSES	INTERNAL FACTORS	INTERNAL FACTORS
Consciousness raising	Stress	Negative health events
Environmental re-evaluation	Physical Aspects	General health / well-being
Social liberation	Enjoyment	Self
Self re-evaluation	No perceived benefits/Not doing it for self	Self Efficacy
Dramatic relief	Self Efficacy	
BEHAVIOURAL PROCESSES	EXTERNAL FACTORS	EXTERNAL FACTORS
Stimulus control	Environment	Negative health events
Counter-conditioning	Alcohol	Money
Self liberation		Pregnancy
Contingency management		Environment
Helping relationships		
OTHER STRATEGIES		
Reducing smokes/milligrams		
Light /heavy smoker		

Strategies

Examination for the category strategies produced three themes: cognitive/experiential processes with sub-themes of consciousness raising; environmental re-evaluation; social liberation; self re-evaluation; and dramatic relief. Behavioural processes with sub-themes of stimulus control; counter-conditioning; self liberation; contingency management; and helping relationships Other responses for processes were under the theme other strategies which contained sub-themes of light/heavy smoker/reducing cigarettes/milligrams. Table 4 illustrates the number of participants in either group who utilised these specific strategies.

Table 4

Number of Maintainers and Relapsers Indicating use of the Cognitive and Behavioural Processes and Other Strategies.

STRATEGIES	Maintainers	Relapsers
COGNITIVE PROCESSES		
Consciousness raising	5	3
Environmental re-evaluation	4	1
Social liberation	1	3
Self re-evaluation	5	6
Dramatic relief	3	0
BEHAVIOURAL PROCESSES		
Stimulus control	5	5
Counter-conditioning	4	7
Self liberation	6	5
Contingency management	4	1
Helping relationships	1	1
OTHER STRATEGIES		
Reducing smokes/milligrams	3	3
Light /heavy smoker	1	1

Cognitive Processes

Consciousness Raising

Five of the maintainers and only three relapsers referred to the process of consciousness raising with increasing awareness of the negative aspects of their smoking behaviour.

...it was the risk on your body, smoking and with all these extra hormones the risk of having a deep vein thrombosis was a lot higher and this baby is an extremely wanted baby and I can't do anything to take that away. There are too many risks involved with smoking and hormone treatment and it is just not worth it. Maintainer (1).

I think that it seems undeniable that it will kill you eventually and anyway have side effects on your health. Relapser (16).

Environmental Re-evaluation

Four of the maintainers, but only one relapser indicated the use of environmental re-evaluation, reflecting concerns about the impact of their smoking on the environment.

You have to think of it - healthwise it is not the best thing being in the health profession and all have a responsibility. It is not a good role model being a nurse and being a smoking nurse. It is not accepted in our practice to be breathing on patients. Maintainer (28).

I am conscious if I smoke in an enclosed space the smoke I produce is encroaching on other peoples freedom as well. Relapser (31).

Social Liberation

Only one relapser and three maintainers referred to social liberation, where their environment enabled them to have some choice in their cessation efforts.

...and I actually work in an operating room and getting out to have a smoke at lunch was too hard so that was when I tried to give it up then because access was not there to get out. Maintainer (33).

....because I was working in a place where I could not smoke during the day and because I went to the gym...I did not have the opportunity ..I guess Relapser (41).

Self Re-evaluation

The majority of maintainers and relapsers utilised the process of self re-evaluation. They indicated some sort of conflict with their smoking behaviour and that it would be resolved without smoking.

...I had started lifting weights while I was still smoking but was getting out of breath and to me at that time at my age...I mean crazy. Maintainer (44).

.....Well I am getting older and of course I can feel my breathing and I can feel that there are health problems coming on if I do not stop. Relapser (58).

Dramatic Relief

No relapsers and only maintainers referred to the use of this process. For example:

...I lost my brother when he was 46, he was married and had 6 kids all over the age of 12, and that had a profound effect at the time....mentally....physically..... Maintainer (67).

Behavioural Processes

Stimulus Control

The majority of maintainers and relapsers illustrated use of the process of stimulus control, by restructuring their environments or avoidance.

...I tried not to socialise on weekends where it entailed that I would be wanting to have a cigarette. Maintainer (74).

I did not go out that much when I was not smoking so I took myself away from my environment.... Relapser (86).

However, two maintainers used a form of stimulus control that was opposite to avoidance. For instance:

I found the thing that really worked for me was that I allowed myself to have a packet of cigarettes in the house and they were in a drawer and I thought if it gets to the stage if I really can't stand it they are there and I can have one. Maintainer (77).

Counter-conditioning

All relapsers and four maintainers indicated used of counter-conditioning, by substituting smoking for healthier alternatives.

...I would pick up a pen or a pencil and just hold it in my hand, I found that got me over the cravings of wanting to pick up a cigarette. Momentarily that action just putting something in your fingers which is a pen or a pencil which really feels like a cigarette - yes it can help you over the craving Maintainer (101).

...and trying to substitute it with good things like physical activity and keeping myself busy. Relapser (119).

Self Liberation

The majority of maintainers and relapsers indicated a use of self liberation, the belief that they could change.

But I feel good about myself not smoking...I mean I can do it... Maintainer (145).

I wanted to smoke, but I kept on deciding against it because I thought I could do it and I'd stop... Relapser (166).

Contingency Management

Four maintainers and only one relapser referred to using rewards or punishments.

...and I find it does work as really you are seeing what money you are putting away each week and at the end of the week instead of buying the cigarettes put the money into an envelope and count it each week.

Maintainer (182).

But by the time night came I had not had a cigarette I would say 'oh, I made it I will do this again' and I did. Relapser (191).

However, only one maintainer referred to a negative reinforcement, which was chemotherapy, for example:

....and smoking is associated with cancer uh...I won't like to go through that same treatment again no never again. Maintainer (177).

Helping Relationships

Only one maintainer and one relapser referred to helping relationships in their cessation efforts.

Yes - my friends and family understood what I was trying to say and respected my feelings and decision to do it that way...so it was really good. Maintainer (193).

The second time it actually helped more because she was quite encouraging by saying if you just get through those first couple of weeks the withdrawals are not so bad...it gets easier. That enabled me to carry on longer as her advice was relevant to me as she was a smoker going through it herself. That helped especially when I was feeling down and wanting a smoke. Relapser (198).

Other Strategies

Reducing Cigarettes/Milligrams

Three maintainers and three relapsers referred to cutting down in milligrams of tar and nicotine content or in the number of cigarettes smoked per day to aid them on the road to quit.

This time it was much easier for me - I had cut down in nicotine content and also cut down in the number of cigarettes thereby also enhancing the progress that you will have when giving up cigarettes so that you don't give in to that urge of wanting to pick up the cigarette. All those things I feel did play a very big part. Maintainer (200).

I am slowly eliminating it from parts of my life to make the transition easier when I actually kick the habit. I suppose the stage I am at now...I keep justifying it as it may be better that I am smoking 4 milligrams

instead of 12 and smoke outside instead of inside and only have 10-12 instead of more per day. I did smoke more earlier on. Relapser (219).

Light/Heavy Smoker

One maintainer and one relapser referred to being able to quit because they considered themselves to be a light smoker. For example:

...I think I was not a heavy smoker so that made it easier for me."

Maintainer (205).

..it was far easier (first attempt) than it was the most recent time because the first time I tried I had not been such a heavy smoker for so long so I guess the cravings were not as strong then so I managed to suppress them and not smoke where as now, having smoked more heavily for a longer period of time, I find it difficult to resist the craving Relapser (206).

Reasons for Relapse

Examination of the data for the category reasons for relapse produced two themes: Internal factors with sub-themes of stress; physical aspects; enjoyment; no perceived benefits/not doing it for self; and self efficacy. Other responses came under the theme of external factors with sub-themes of environment and alcohol . Table 5 illustrates the number of participants in either group who referred to internal and external reasons for relapse.

Table 5
Number of Maintainers and Relapsers Indicating External and Internal Reasons for Relapse.

REASONS FOR RELAPSE	Maintainers	Relapsers
INTERNAL FACTORS		
Stress	4	6
Physical Aspects	3	6
Enjoyment	3	5
No perceived benefits/Not doing it for self	4	3
Self Efficacy	1	4
EXTERNAL FACTORS		
Environment	4	6
Alcohol	3	3

Internal Factors

Stress

Four maintainers and six relapsers referred to stress being a factor in their reasons for relapsing, such as:

... it is just like a crutch really - things are not going the way they should.....stress related definitely really makes you want to go back
Maintainer (227).

...but if I had better control of the stress factor I don't think I would be smoking now. Relapser (231).

Physical Aspects

Three maintainers and six relapsers referred to physical aspects as another reason for relapsing. A difference between the two groups here was that the relapsers referred to cravings or withdrawal symptoms, whereas two out of the three maintainers also referred to weight and eating too much such as:

...You are eating more, putting on weight so you go back to smoking
Maintainer (244).

I just remember getting up in the morning and wanting a cigarette and
actually coughing more because I'd quit... Relapser (257).

Enjoyment

Three maintainers and five relapsers referred to enjoying cigarettes as another reason for relapse, for instance;

I have tried to give up numerous times, but as I said, I really enjoyed
smoking Maintainer (266).

...Also part of me still liked it... Relapser (274).

No Perceived Benefits/Not Doing it for Self

Four maintainers and three relapsers referred to no perceived benefits/ not doing it for self. However, a difference was that all of the relapsers made reference only to not having any benefits to cessation, whereas within the maintainers the majority referred to relapsing because they were not doing it for themselves. Following are two quotes that reflect the difference:

..and it was the fact that I didn't really want to give up, but I was giving
up as a support thing but it wasn't really what I wanted to do Maintainer
(293).

So in a way I never really found a real incentive or substitute to quit
Relapser (306).

Self Efficacy

Self Efficacy was another sub-theme that emerged where four relapsers' comments indicated low efficacy. This was also evident in one maintainer on their relapse experiences.

..You sometimes lack confidence Maintainer (309).

I hate it, I felt embarrassed. I'm a big boy I should be able to stop and do something when I want to Relapser (319).

External Factors

Environment

The majority of all participants' comments reflected issues about their environment as a factor in their relapse experiences. Six of the seven relapsers and four maintainers referred to their environment.

My first time I went back because of friends smoking around me.. Maintainer (331).

all of a sudden everyone is smoking around you, it tends to lead you to want to go back to smoking. So that is probably what made me do it Relapser (336).

Alcohol

Another sub-theme that emerged was alcohol, in which participants referred to it as a factor that they associated with smoking and a reason for relapse. Three relapsers and three maintainers commented on the association of drinking and smoking.

I would be wanting to have a cigarette because I am having a drink with somebody Maintainer (354).

I think if you have been a smoker you tend to associate drinking with smoking together and I think if you have a drink you just acquire the urge to smoke a cigarette Relapser (361).

Reasons for Cessation

Examination of the data for the category of reasons for cessation produced two themes: internal factors with sub-themes of negative health events; general health/well-being; self; and self efficacy. Other responses came under the theme external factors with sub-themes of negative health events; money; pregnancy; and environment. Table 6 illustrates the number of participants in either group who have referred to external and internal reasons for cessation.

Table 6

Number of Maintainers and Relapsers Indicating External and Internal Reasons for Cessation

REASONS FOR CESSATION	Maintainers	Relapsers
INTERNAL FACTORS		
Negative health events	2	0
General health/wellbeing		6
Self	2	2
Self Efficacy	4	0
EXTERNAL FACTORS		
Negative health events	2	1
Money	3	2
Pregnancy	3	2
Environment	1	4

Internal Factors

Negative Health Events

Only two maintainers indicated negative health events they had experienced as a reason for their cessation. Whereas no relapsers experienced any such events. Following is an example quote:

Because in December 1999 I got sick (cancer). Due to my sickness I gave up smoking Maintainer (363).

General Health/Well-being

Interestingly, only one maintainer referred to general health/well-being as a reason for cessation such as:

I was getting into weights and things like that and I needed the lung power as well in order to lift weights and keep up with it Maintainer (364).

However, with six of the seven relapsers the sub-theme general health/well-being was reflected in their reasons for cessation attempts. For instance:

Just not being fit, getting out of breath all the time Relapser (376).

Self

Two maintainers directly referred their cessation efforts being for themselves.

I guess I had really made up my mind to quit and this time it is for myself not anyone else Maintainer (383).

However, one of the two relapsers comments reflected not wanting to quit, but both these relapsers commented on cessation efforts being a test to see if they could quit. Such as:

No..... probably not really (to wanting to quit) ...Just to see whether I could or not...basically Relapser (387).

Self Efficacy

No relapsers and only four maintainers' comments reflected a sense of self-efficacy that seemed high in regard to their attempts to quit.

...but I was determined and I am determined and if I do set my mind on something I do it irrespective of the physical thing, if I want to do it I will.....I don't want to smoke...so I won't smoke Maintainer (392).

External Factors

Negative Health Events

Two maintainers and one relapser referred to external negative health events that had occurred in their lives. However, the two maintainers tended to elaborate more on the issues in regard to it being a reason for cessation.

....but some people need something in their life and in my case it was tragic and maybe that was the trigger and the spur to get me to do what I have done Maintainer (401).

...but my father had emphysema when he died, so that's a hereditary thing and that's why I've got to stop Relapser (405).

Money

Three maintainers and two relapsers referred to money as an incentive for cessation. However, two out of the three maintainers comments indicated strong views of money being the reason for their cessation, whereas the relapsers tended to refer to it as one of the reasons to their cessation efforts.

I decided this time because it was burning a lot of money and one can save a lot of money if you are a smoker these days.....So over a 12 month

period it is a lot of money which would enable me to have a holiday somewhere Maintainer (406).

...Um also financially I was strapped for cash as I was not working at the time and that also benefited me Relapser (418).

Pregnancy

The sub-theme of pregnancy was generated with two relapsers and three maintainers as a reason to cease smoking. However, two out of the three maintainers ceased smoking due to a pregnancy, whereas one maintainer quit in the past when having her two children, but then reverted back to smoking.

Each time I was pregnant (past) - I went cold turkey. I suppose I felt it was not just me it was then dealing with my children and I could make that decision as I did not want to put their health at risk, maybe that was the very good reason for giving up smoking during that time Maintainer (423).

I fell pregnant and that was the real motivation for me Maintainer (424).

In regards to the two relapsers, they had not experienced a pregnancy, but both referred to it as an important reason for cessation.

...Maybe having a child or doing something like that...I would because of a child's life.... Relapser (440).

Environment

Only one maintainer but four relapsers referred to factors in their environment, which seemed to encourage them to cease smoking.

Just a build up of people telling you that I should..... Maintainer (441).

...living with a girlfriend and she quit smoking previously for 2 weeks before I tried...because I was living with her I found it an easy situation to give it a go Relapser (446).

Summary of Results

Overall, the data indicated that all participants had relapsed at least one time before in their cessation efforts. Of those relapsers, all indicated recycling back to a previous stage of change. Under the category of strategies, the maintainers illustrated more use of both cognitive and behavioural processes. Whereas the relapsers made more use of behavioural processes rather than both cognitive and behavioural. The relevance of being a light or heavy smoker or cutting down in number of cigarettes or in nicotine content was evident in both groups.

The category reasons for relapse illustrated that relapsers reported more on stress, physical aspects, enjoyment and illustrated a lower self efficacy than maintainers. The relapsers indicated no benefits for cessation as a reason for their relapse, where the majority of maintainers indicated it was for themselves. However, both groups reflected factors in the environment for a reason for their relapse.

The category reasons for cessation reflected that only maintainers experienced internal negative health events and comments from the maintainers also reflected a high self efficacy. Relapsers indicated general health and well-being as a reason for cessation. External negative health events were elaborated on more with the maintainers than relapsers. In addition to money being an incentive relapsers referred to it as one of the benefits and the maintainers were strong in their views of money being a great incentive. Both groups expressed pregnancy as a reason for cessation. However, some relapsers had not experienced a pregnancy but referred to it as an incentive not to smoke. Also majority of the relapsers referred to environmental factors in their reasons for cessation.

In all, there seemed to be more differences between the two groups under the category reasons for cessation. Each individual had differing experiences and different combinations of factors for their relapse, cessation reasons and processes used. However, of those who maintained smoking cessation their experiences reflected use of both cognitive and behavioural processes, they had more incentive to cease smoking and were clear in why they had quit. These maintainers also experienced both internal and external negative health events and illustrated a high self efficacy. On the other hand, relapser's experiences reflected more use of the behavioural processes than both cognitive and behavioural. Relapsers experienced more stress, physical aspects and enjoyment that led them to relapse as well as having no benefits for cessation. Relapsers' reasons for cessation were less personalised with general health reasons and environment influencing their reasons for cessation. The results will be discussed in the following section.

Discussion

The aim of the present study was to explore the personal experiences of individuals who had attempted to cease smoking. In particular, to investigate what strategies are used in smoking cessation and why some people change a health behaviour like smoking and why some relapse. Using qualitative methodology, individuals who relapsed or maintained smoking cessation were interviewed. Utilising a semi-structured interview format facilitated the exploration of cessation experiences with these individuals.

Past research has consisted largely of a quantitative nature. As well as little recent research in regards to the processes used by individuals who have relapsed have been conducted in a qualitative way. Additionally, for relapse to be understood as a whole the decisional aspects of relapse are just an important factor. Much relapse research has focused on relapse participants. Therefore, this present study elicited personal experiences of smoking relapse and cessation maintenance. This provides a detailed experience through which the psychological and social world of the participants were explored (Smith, 1995).

The findings of this study suggest that in attempting to cease smoking relapse is a common occurrence. Successful change tended to incorporate use of both cognitive and behavioural processes. Also stress, physical aspects like cravings, enjoyment and environment were more salient with the relapsers than maintainers as relapse precipitants. However, relapsers indicated no benefits or incentives as a reason for their relapse and maintainers acknowledges that they relapsed because they were not quitting for themselves.

An individual's reasons for cessation are also an important factor for successful change. The data suggests that relapsers experienced less personalised and more general reasons for their cessation. Interestingly, pregnancy was a factor for reasons to quit and was evident in both groups. Also, self-efficacy played an important part, with a low self-efficacy being evident with those who relapsed and a high self-efficacy being evident with those who maintained smoking cessation.

Stages

The majority of relapsers indicated that they were in the contemplation stage. This is consistent with previous research. Prochaska and DiClemente (1984) found that 85% of the smokers in their study who had relapsed were in the contemplation stage. As only two relapsers in this study indicated they were in the precontemplation stage and one in the preparation stage, indicates the majority of relapsers do not recycle endlessly to where they begin from (Prochaska et al., 1992).

Strategies

Shiffman (1982) found that a combination of cognitive and behavioural coping responses were more useful in preventing relapse. As relying on behavioural coping responses related to situational influences and cognitive factors are less affected by situational variables (Shiffman, 1982). Data from the present study indicated that maintainers used cognitive and behavioural processes more. Relapsers referred more to the use of the behavioural processes, especially counter-conditioning. This is consistent with Prochaska et al. (1982) and Prochaska et al. (1985) where cognitive or experientially oriented processes predicted progress. Relying on behaviourally orientated processes may leave the individual dependant upon their environment, which is open to change.

Changing internally how they may feel, think and act on their smoking cessation has an advantage of being in control of themselves. Therefore, even if the environment ceases to help them sustain non-smoking, the cognitive processes used helps to continue the non-smoking behaviour, in situations where an individual's environment changes (Prochaska et al., 1982: Prochaska et al., 1985). Certainly, the present findings suggest that having a combination of both cognitive and behavioural processes is an important factor in successful change in smoking cessation, and an internal causal attribution for change is important (Prochaska et al., 1982), as the cognitive processes of change are also associated with the process of decision making (Kristeller et al., 1988).

An interesting finding is that majority of the relapsers seemed to indicate use of self-liberation. Self-liberation is the belief that one can make choices for change and is also known as willpower (Prochaska et al., 1992). However, these participants relapsed, suggesting the notion of a false sense of confidence. The relapsers may not have fully engaged in the cessation process and may have been overly confident. This may be similar to the findings of Scotts et al. (1996), even though the study is with pregnant women. These women were exposed to external factors to support their cessation. Thus, leading to a false sense of control in their ability to remain abstinent. This may be the same for these relapsers as they referred to the use of self-liberation and they also focused more on the behaviourally orientated processes like counter-conditioning.

Participants also indicated other strategies in their cessation experiences. These were being a heavy or light smoker and cutting down in milligrams of nicotine and tar in reference to making their cessation efforts easier. Rossi et al. (1988) found that light smokers out performed heavy smokers on the processes of change. Light smokers have

also been found to quit smoking twice as much than the heavy smokers (Cohen et al., 1989). Linked to this notion is the factor of chemical dependence. Heavy smokers have been found to be more dependant on cigarettes, have stronger urges, cravings and withdrawals and in general experienced a harder time quitting (Killen et al., 1988). The present findings illustrate that generally both maintainers and relapsers acknowledged these strategies. Physical dependence is an important factor. Cutting down in the number of cigarettes smoked per day or in milligrams of nicotine and tar content may certainly play a role in reducing their dependence to make the cessation process easier. However, the issue of dependence may not imply that light smokers will be more successful than heavy smokers. Schachter (1982) found that heavy smokers found giving up to be more difficult but light smokers were no more successful than the heavy smokers. So, in light of Rossi et al. (1988) results, as light smokers may find it easier they in turn may attempt to quit more. This, though does not solely imply successful cessation of smoking.

Reasons for Relapse

Schachter (1982) argued that most people who relapse will try again and again until they succeed at cessation. Many people recycle back and forth from smoking to non-smoking (Cohen et al., 1989). All participants within this study had experienced a relapse at least once. This implies that relapse certainly does occur commonly in attempting to cease smoking. However, as both groups experienced more than one relapse episode, the current findings are not indicative to the notion that multiple attempts at quitting leads to success. For instance, a maintainer in the present study referred to two previous attempts before achieving successful smoking cessation; whereas one relapser had attempted to cease smoking more than three times and is still unsuccessful. This illustrates that each

individual differs in their cessation process and experiences and other factors are certainly involved. As Cohen et al. (1989), states that the process of smoking cessation and relapse is very complex in nature.

Shiffman (1985) suggests that relapse occurs when a triggering situation happens combined with deficient coping responses. An ex-smoker's coping responses are critical in regards to the notion of relapse (Shiffman, 1985). All but one relapser indicated stress to be a factor in their relapse experiences. The majority of maintainers also referred to stress. Participants seemed to be using smoking as a crutch when factors in their lives were not going right for them.

Shiffman (1982) and Shiffman et al. (1985) found that ex-smokers were tempted to smoke when they were depressed, angry or anxious in hope that smoking would reduce these negative feelings. In other words, smoking was used to reduce the feeling of stress, but the stress is caused by other factors within a person's life (Shiffman, 1982; Shiffman et al., 1985). Therefore, using smoking to cope with stress increases the chance of relapse in stressful situations. This is also consistent with Bottorff et al. (2000) where women smoked not because of the lack of skills to resist smoking, but as a strategy to deal with stress and emotions. Cummings et al. (1980, cited in Shiffman et al., 1985) also found that negative emotional states accounted for 37% of all relapses. However, Liechtenstein et al. (1977, cited in Shiffman et al., 1985) found social pressure, urges and temptations were more prevalent for relapse than negative emotional states. Also alcohol was involved in more than a third of relapses.

The findings of the present study lend support to both these studies as six out of the seven relapsers clearly indicated that their environment, stress, physical aspects and

the environment were a reason for their relapses. To a lesser degree, alcohol was also referred to as a reason for relapse and was evident in nearly half of all the participants. However, alcohol was not as prevalent as stress, physical aspects, enjoyment and the environment. Shiffman's (1982) study found that one third of all relapse crises were associated with positive feeling states, which were precipitated by alcohol consumption, eating and other smokers. DiClemente (1981) also found that relapsers referred to relapse precipitants such as missing and desiring to smoke, over confidence in control of the habit and stress. This is also consistent with Prochaska et al. (1985) and Condiotte and Lichtenstein (1981). This may be illustrated through the relapsers acknowledging that they still enjoyed smoking cigarettes, in relation to alcohol and their environment. As the relapsers referred to enjoyment and their environment more than the maintainers as a reason for relapse. Certainly, some of these factors may be interrelated.

The participants who were relapsers in this study also alluded to having no benefits for their cessation or no incentives and pay-offs. The maintainers differed by realising they had not really given up for the right reasons and were not quitting for themselves. The maintainers realised it was not really what they wanted to do at the time. The relapsers expressed difficulty in seeing a pay-off for non-smoking in particular, one relapser talked about having general surgery and being told that she was really fit for a smoker and acknowledged that this reinforced her to smoke. Thus, she found it hard to find a personal incentive. This also indicates support towards an internal property to cease smoking (Prochaska et al., 1982).

In seeing a personal pay-off and quitting for oneself, the individual has more of a chance in dealing with situational precipitants mentioned beforehand. The process of

decision making whereby a person does not really see many pros to quitting but decided to try anyway implies that a robust decision is not really made. As the balance of the pros and cons alters an individual's progress through the stages of change (Prochaska & DiClemente, 1992). Therefore, not only are relapse precipitants and coping skills in high risk situations important, these findings in relation to one's reasons for relapse are also illustrating the importance of the decision to quit. Quitting smoking for the right personal incentive has a strong internal attribution rather than solely external reasons. Utilising both cognitive and behavioural processes in addition to making a personal decision to quit affects how individuals may cope in high risk situations. Thus, they are less likely to relapse. In the present study there was a difference in relation to these factors between the maintainers and relapsers.

Bandura (1982) argues that high self-efficacy predicts an increased performance and low self-efficacy predicts low performance. So the concept of self-efficacy is an important factor in understanding relapse. Those who relapsed and one maintainer in referring to his past relapse episodes, indicated low self-efficacy. Interestingly, this maintainer had attempted to quit more than five times which was higher than any other participant. The findings of the present research are consistent with DiClemente (1981), Condonette and Lichtenstein (1981) and Prochaska et al. (1985) where relapsers indicated low self-efficacy, as this is regarded to be one predictor of smoking cessation.

Reasons for Cessation

There were more differences between the relapsers and maintainers in regards to their reasons for cessation. This was evident especially under the sub-themes of general health/well being and environment. In particular, relapsers seemed to attribute their

cessation efforts to general health/well being and to factors in their environment. These relapsers wanted to improve their health in general and had factors in their environment to influence their reasons to quit. For instance, one relapser quit because her flatmate also quit. Thus, she seized a situation to make it easier. Whereas the maintainers seemed to experience external and internal negative health events. For instance, one maintainer was diagnosed with cancer and another maintainer's mother was diagnosed with tuberculosis, which influenced his decision.

These findings suggest that majority of relapsers did not have a serious perception that they were susceptible to serious health problems from their smoking. Even though the majority of relapsers were aware of the health risks of smoking, they did not seem to perceive these risks as a great consequence. This may be due to not having experienced any internal or external negative health events yet. Only one relapser indicated an external negative health event in which his father had died of emphysema.

The perceived vulnerability to negative consequences is a critical factor in smoking and smoking cessation (Gibbons et al., 1997). It has been found that risk perception also declines with smoking relapses indicating a dissonance reduction takes place (Gibbons et al., 1997). So with the maintainers experiencing more internal and external negative health events and having more personal internal reasons to quit they have higher risk perceptions of smoking and more benefits of non-smoking, which are related to being able to maintain (Gibbons et al., 1997). Therefore, it seems that the relapsers relapsed because their initial decision to quit was less personalised and they perceived less risks of smoking, which may have influenced them to relapse. Relapsers may need to realistically assess of the risks of smoking or experience a negative health

event to arouse this dissonance. This also lends support to the notion of decision making. That a more robust decision to quit from the onset may decrease the chance of relapse. Change is about making a decision to stop (Saunders & Allsop, 1987). For instance, Prochaska and DiClemente (1983) indicated that change from the contemplation stage to the action stage was often characterised by a personal and painful situation or life event. Thus, making the decision to smoke harder to maintain. This can be illustrated by one maintainer's comment '...but some people need something in their life and in my case it was tragic and maybe that was the trigger and the spur to get me to do what I have done' (402).

Risk perceptions are seen to be related to the intention to cease smoking (Prochaska et al., 1985). These maintainers and relapsers in the present study offered reasons for cessation that reflected the Health Belief Model. The Health Belief Model states that a person will take action to change a health behaviour like smoking if:

1. They perceive themselves to be susceptible to a condition or problem.
2. They believe it will have potential serious consequences (perceived threat).
3. They believe a course of action is available which will reduce their susceptibility or reduce their consequences.
4. Their benefits of taking action outweigh the costs or barriers (Nutbeam & Harris, 1999).

To apply this to one relapser in this study, for example, she:

1. had not experienced any problems with smoking, thus, has a low belief of being susceptible to a problem caused by smoking;

2. had a low belief that smoking will have any serious consequences, as she was told by a physician that she was remarkably fit for a smoker;
3. as she has a low belief of problems and consequences from smoking there is no reason to really find a course of action;
4. her benefits of ceasing smoking do not outweigh the costs. Thus, this relapser finds it hard to quit, whereas a maintainer who experiences a negative health may be more motivated to take action to stop, especially if it has personal costs. For instance, maintainers also referred to quitting this time for themselves and relapsers not really wanting to quit.

The resolution and commitment to change will occur if an individual believes that negative consequences will happen if they continue use, in addition to being able to use internal and external resources to facilitate change (Allsop, 1990). The theme of money that was elicited in the present study can also be linked into this. Even though only a small amount of maintainers referred to money as an external incentive, these maintainers did in fact refer to it more strongly in their reasons to cease smoking, where the relapsers referred to it only as an added benefit. Money was more of an incentive to help these maintainers where the relapsers did not perceive it as a major incentive. One relapser illustrated this in particular who indicated he would go without other things before going without cigarettes.

Self-efficacy was also an important factor in reasons for cessation and is a concept that is also taken into account by the Health Belief Model. The maintainers in this study indicated to have a high sense of self-efficacy, whereas none of the relapsers indicated

this. DiClemente (1981) and Condonette and Lichtenstein (1981) found that maintainers had a high sense of self-efficacy and also had less difficulty in maintaining non-smoking.

Pregnancy was a sub-theme elicited by maintainers and relapsers for a reason for cessation. However, the relapsers only referred to it as a reason to stop smoking whereas the maintainers actually experienced a pregnancy and ceased to smoke. Scotts et al.(1996) suggests that the decision to stop smoking by pregnant women seems to be made without resolving their ambivalence. Pregnant women illustrated less process use and a high self-efficacy. Thus, indicating that the change process is different for this group of women and an external mechanism for stopping rather than an internal process of change is evident. Additionally, women who stop smoking during pregnancy may not engage in all the stages of change (Prochaska et al., 1992). Moreover, their motivation is driven and facilitated by symptoms associated with their pregnancy such as hormonal changes and nausea (Bottorff et al., 2000). The present data illustrated this. In particular, one maintainer clearly indicated that 'if I hadn't been pregnant I wouldn't of succeeded' (425). This maintainer acknowledged that she did not know whether it was the hormones with a combination of other factors. This may also suggest why the relapsers would quit if they did have children, as the relapsers in this study focused more on environmental and behavioural factors to quit. Pregnancy is an external factor, and they would be quitting for the health of the baby. The focus on an external factor like pregnancy in turn leads to an unrealistic sense of self-efficacy to remaining abstinent after the birth of their child. Thus, relapse is likely to occur (Scotts et al., 1996). In fact, one maintainer had quit during two pregnancies and resumed smoking again after. The two different scenarios had

quit during pregnancies, however, why do some maintain and some relapse after the birth of the child?

Additionally, the perceived health risk to their baby from smoking may be a very big consequence to these individuals. So, by increasing the costs of smoking can make the decision to quit easier. These findings pose challenges for the TTM, for instance, are pregnant women intentionally changing?, as they are clearly changing because of an externally motivated reason. Thus, cessation is imposed on them. These women are experiencing unconflicted change, and this implies that these women may not be going through an intentional process of change. Certainly, this is not how successful change is described within the TTM.

The finding that some pregnant women successfully maintain after giving birth and some do not illustrates another difference. The TTM views successful change as doing the right processes at the right times. Davidson (1998) argues that it is premature to think that quality change only happens if you use the right processes at the right times. There has been other evidence that indicated successful unconflicted change among heavy drinkers (Orford et al., 1992, cited in Davidson, 1998). This also has implications for the TTM in regards to planning interventions that are appropriate. For example, pregnant women can not be viewed as typical non-pregnant woman in the action or maintenance stage (Scotts et al., 1996).

These findings have implications on a wider scale for interventions and strategies to reduce smoking prevalence and to prevent relapse. Interventions need to consider a wide number of factors in regards to relapse and smoking cessation. Limiting interventions to only one model would not be useful. For instance the TTM is useful in

matching interventions and identifying what processes are needed. However, why people cease smoking should not be looked at lightly. In addition, there are populations which are different and individuals need different strategies and interventions.

In sum, individuals' intentions and reasons to cease smoking differ. Some of this difference can be attributed to why people relapse. Some intentions or reasons may be external such as a pregnancy or some may be influenced by significant life events or negative health events. However, solely external and less personalised reasons seem to mediate the weighting in decision making with the costs and benefits for cessation and smoking. Not all emphasis can be placed on coping skills and high risk situations. The belief in the ability to cease smoking is also important. For instance one may resolve to act but does not put it into action. The nature of relapse and smoking cessation is very complex which seems to include external and internal processes, robust decisions to cease smoking where there are salient consequences to the person, and in turn that may affect how people cope in situations or whether they relapse or not.

Future research into smoking cessation during pregnancy is needed. What are the differences in those pregnant women who succeed at cessation and those who relapse? In relation to reducing the number of cigarettes smoked or nicotine content, it would be interesting to explore if that has a psychological impact as well as a physical impact. Additionally, more research into unconflicted smoking cessation on a single life event would also be interesting.

Strengths and Limitations of the Study

This present study focused on the experiences of smoking cessation. A strength of this study is the methodology. Much of the past research has been quantitative in nature.

In addition, some qualitative research has been conducted, however, they are older studies. Using a semi-structured format to interviews provided rich data of the personal experiences on smoking cessation. Thus, the narratives elicited enabled exploration of the personal experiences of those who had ceased smoking and those who had relapsed, which aided an understanding of these participants from their own frames of reference (Taylor & Bogdan, 1998).

Unfortunately, this present study was dependent upon a time frame, in which a limited amount of data was obtained. Even so, as an exploratory study it produced a rich data set of findings of the experiences in smoking cessation for maintainers and relapsers. The data highlighted the complex nature of the process of cessation and relapse, and that maintainers and relapsers differed on a number of factors, and paying attention to all these factors is of great importance.

People can exaggerate success and downplay failures, and this may have occurred in the present study. The issue of truth in qualitative research is a complicated one and it is perspectives that qualitative researchers are interested in. However, any inconsistencies that were salient to the researcher were asked to be clarified. As the best way to deal with inconsistencies is gently and directly, as they are often misunderstandings (Taylor & Bogdan, 1996). In relation to this, the stories of the participants may change over time, depending upon who they are offered to and in different settings. The present study tried to deal with this by conducting all interviews in an environment in which all participants were comfortable. Additionally, improvement on the present study might be to qualitatively explore each relapse episode in more detail, by conducting more than one interview.

The influence of smoking cessation stories being shaped by characteristics of the interviewer, interviewee and social context is important. For instance, Perth is a place where knowledge of smoking and its harmful effects is increasing and, for example, has developed regulations and policies in regards to restricting smoking in public places for example. In contrast, places that have fewer restrictions, smoking cessation stories and relapse experiences may differ to the current results.

Future qualitative studies on smaller scales may also have benefits two fold as; (1) being able to gain a more detailed insight and; (2) as Bottorff et al. (2000) found that through narrative research on women who relapsed postpartum, some were gaining insight into their own behaviour and began to imagining possibilities of life without smoking. Through the act of story telling a person can also learn to think differently. They learn by hearing themselves (Bortoff et al., 2000). Therefore, a strength of this qualitative study may be that it has had some benefit to some of the relapsers who had a chance to talk about it. As one of the relapsers in the present study commented at the end of the interview;

...and talking about it is quite good actually because you don't get a chance to talk about it as to why.

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Appendix A: Semi-structured interviews for maintainers and relapsers

RELAPSERS:

1. How long have you been smoking? How much on average?
2. Over this time, how many times have you attempted to quit smoking?
3. How long was each attempt?
4. Can you tell me why you decided to quit smoking?
5. Can you tell me about how you attempted to quit smoking?
6. What did you find the hardest about quitting?
7. Can you tell me the reasons why you started to smoke again?
8. How do you feel about returning to smoking?
9. How did you cope with high risk situations when you quit? What did you do?

MAINTAINERS:

1. How long had you been smoking, before you quit? How much on average?
2. Over this time, how many times have you attempted to quit smoking?
3. How long was each attempt?
4. Can you tell me why you decided to quit smoking?
5. Can you tell me about how you attempted to quit smoking?
6. What did you find the hardest about quitting?
7. What are the strategies you use now to help you maintain your smoking cessation?
8. How do you feel about smoking now?
9. How did you cope with high risk situations when you quit? What did you do?

Appendix B: Script

Script

"Hi, My name is Natalie and I am conducting a study on smoking cessation and relapse. This study is for my Thesis project at Edith Cowan University. I am interested in peoples personal experiences to do with how they quit smoking. Would you mind if I ask you a few questions?"

(IF YES)

"Are you a current or an ex-smoker?"

A: (IF current) "Have you ever attempted to quit smoking?"

B: (IF ex-smoker) "How long have you quit for?"

(IF YES to A/ and B if over 6 months)

A: (IF current) " How long did you quit smoking for?"

(If answers are ranging 24 hours to more, ask for interview)

B: (IF ex-smoker) " How often did you smoke before quitting?"

(If answers are ranging from daily to less frequently than daily, ask for interview)

"Would you mind being interviewed on your experiences of how you attempted to quit smoking?"

(IF YES)

"Great, All I need is your name and a contact number so a convenient time can be arranged for the interview. I also require you to read and sign a consent form if possible (Give them information sheet and consent form). The interviews will be taped and transcribed on paper. Participation is totally voluntary. The interviews will take approximately one hour. However, contact maybe made at a later date after the interview to verify that my interpretation of the information you supply is correct. No names will be used with the reporting of the data."

"Thank you for your time"

Appendix C: Letter of information/consent

Consent

This interview is about exploring the personal experiences of how individuals attempt to quit smoking. This research is being conducted for my Thesis for my fourth year Bachelor of Arts Honours (Psychology) at Edith Cowan University.

The interviews will be taped and then transcribed onto paper. The interviews will take approximately 1 hour. However, contact may be made at a later date for the purpose of verifying the information obtained.

Participation in this study is totally voluntary and you may refuse to answer any questions. You are free to withdraw at anytime during the interview without penalty, and remove any data that you may have contributed.

Please be assured that any information which you provide will be held in confidence. At no time will names be reported along with your responses. Therefore, responses will be anonymous in regards to the publication of my Thesis. At the conclusion of this study a report of the results will be available upon request.

Any questions concerning this study can be directed to myself Natalie D'Abrew on 94045474 or my supervisors Alison Salmon 9400 5466 and Paul Chang 9400 5745.

Appendix D: Signed consent

Consent

I _____ have read the above information and any questions I have asked have been answered to my satisfaction. I agree to participate in this taped interview realising that I may withdraw at any time. I agree that the data gathered for this study maybe published provided I am not identifiable.

Participant

Date

Investigator

Date

(Researcher copy)

I _____ have read the above information and any questions I have asked have been answered to my satisfaction. I agree to participate in this taped interview realising that I may withdraw at any time. I agree that the data gathered for this study maybe published provided I am not identifiable.

Participant

Date

Investigator

Date

Appendix E: Referral contacts

Alcohol and Drug Information
Service (ADIS) line.

Ph: (08) 9442 5000

Quit Line

Ph: 131 848

The Seventh Day Adventist Church
(Quit Now)
92 Mills Road
Gosnells 6110

Ph: (08) 9309 9440

Derbarl Yerrigan Health Service
156 Wittenoom Street
East Perth 6004

Ph: (08) 9421 3888

Appendix F: Qualitative data from transcripts

STRATEGIES

COGNITIVE PROCESSES

CONSCIOUSNESS RAISING

(Maintainers)

1. ...it was the risk on your body, smoking and with all these extra hormones the risk of having a deep vein thrombosis was a lot higher and this baby is an extremely wanted baby and I can't do anything to take that away. There are too many risks involved with smoking and hormone treatment and it is just not worth it.
2. Seeing it from a health point of view, I think they have to do something to deter it. I think that there was a study in the paper the other day when they actually said that it was like 86 million dollars worth - cigarette company and it cost 46 million to look after the people with smoking related illness.
3. ...He was my oldest brother and at 46 and me being at that stage 30...yeah it was a big effect on me.
4. I did go for one session to an acupuncturist which lasted for about an hour and immediately after that I stopped...but I think it was more being in tuned in to I was going to stop because as he explained to me as well it is up to you really at the end of the day.
5. ...The medical fright of what the consequences were.
6. ...He asked me the question about smoking and I said yes I smoke and he said I want you to give up straight away and I said why and he (ontologist) said I am not going to treat you for cancer on one side and where you can develop it on the other side...and that was it.
7. ...Even in my 20's I noticed that...you know if I'd been standing on my feet for a while in the shower or something I'd look at my feet and they'd have a bluish tinge.
8. ...a lot of talk about it and they were having little campaigns to try and stop smoking.
9. The Seven Day Adventists were having stop smoking campaigns in Perth at the time.
10. ...And there was more public awareness to stop smoking that it was coming out more frequently and being publicised and so forth to stop smoking and the popular thing was to try and stop.
11. ...As they would be nagging me to death so you just try and extend this as long as you could for whatever reason....
12. the longer you live yourself and you go into hospitals visiting your own, you see other people in hospital suffering from problems over a period of years through smoking, emphysema is very common if you are lucky enough to make it into your 60's. Emphysema is very common and ...weak hearts, everyone who smokes is going to get a weak heart - that is certain of it. You may be lucky enough that your lungs hold out but your heart definitely will not.

Appendix F:2

13.And there has been a few documentaries on TV over recent times from the health department of a medical university and he was saying that if you paired your lungs down to micro thickness your lungs could cover a tennis court and after 10-15 years of smoking, your lungs would be clogged up that you only have one service court left to breath with effective and your heart has to pump so much harder to get the blood through that it puts strain on your heart and other extended periods where you would find particles in people who smoked, micro-particles they get into your lungs and attach themselves to a molecule of your lung tissue and then you get lung cancer starting otherwise it gets taken into the blood stream. That is why we hear of people who have no circulation in heir hands and feet. They have to have a foot off or leg off because they were cigarette smokers and it has a bad effect on their circulation.
14. The more you think of it you say, gee it's not doing me any good, every cigarette is doing you harm.

(Relapsers)

15. I am fully aware of the negative consequences about smoking....maybe not so much when I was younger.
16. I think that it seems undeniable that it will kill you eventually and anyway have side effects on your health
17. you do it (quit) because everyone else tells you should because it will kill you.
18. In light of the evidence that we have, we tend to feel that sooner or later you should stop.
19. There is nothing worse than going into a room, you know when a smoker walks in and the smell is appalling, washing of the hair, keeping the clothes clean.
20. We talked about it, only yesterday.

ENVIRONMENTAL RE-EVALUATION

(Maintainers)

21.and now you walk into a smoking pub or something like that and it's horrible I hate it.
22. ..But it was over in Ireland and everyone smokes there and it's the same in England and Scotland, they smoke in pubs and restaurants....just nothing has changed over there and I think it was a big let down...to see people smoking in Macdonald's where there is food being consumed and kids around.
23. I did used to smoke in bed you know, which I think is shocking.
24. On reflection (of smoking in bed) that is weak, that is shocking, and that was terrible. That was putting other people under pressure that you live with...that a thing like that...you never get over. I still think about the position that I put other people in due to my ignorance. I always regret that part of it really.....just didn't think enough.....I was selfish really. I just didn't think of the others around me.

Appendix F: 3

25. It is a dirty habit and if we want to start living in an environment as clean we have to start looking at all these little things that make up the environment and if everybody did their bit by cutting down or giving up it will help the environment in the long run and the people too.
26.The end picture is also that you are doing something for people around you - which is good when you look back.
27. This is also coming from a nurse who should know better.
28. You have to think of it - health-wise it is not the best thing being in the health profession and we all have a responsibility. It is not a good role model being a nurse and being a smoking nurse. It is not accepted in our practice to be breathing on patients.
29.And what shits me off...I don't think I ever did it was the amount of butts getting thrown out of car windows...I have seen it is the pollution it is not a good thing. I have seen smokers empty ashtrays at traffic lights....
30. you may be a smoker but then you are putting how many people at risk in a confined space, especially pubs and bars.

(Relapsers)

31. I am conscious if I smoke in an enclosed space the smoke I produce is encroaching on other peoples freedom as well.
32. In theory it makes a lot of sense to have a non-smoking environment and perhaps it is right that restaurants should be non-smoking environment.

SOCIAL LIBERATION

(Maintainers)

33.and I actually work in an operating room and getting out to have a smoke at lunch was too hard so that was when I tried to give up then because access was not there to get out.
34. ...I think that it is good that restaurants are cutting it out there is nothing worse than having a meal and having someone behind you smoking.
35. We had a group of 14 of us and 12 out of the 14 are smokers so we never smoked while we ate. Now you look at the same group of 12 or 14, 12 are non-smokers and 2 are smokers. So we have done pretty well...you can see that the trend had definitely changed.
36. The younger ones (nurses) these days are not tending to smoke, but that generation when you went out to the nurses quarters they all smoked and they are still in the work force.
37. Ban all intra building smoking don't even have smoking allowed in a building.
38. Going outside in the freezing cold to have a cigarette, you would probably find that a lot of people will give it up. I have seen this amongst my friends who are still smokers that they can actually go through the whole length of dinner and not go out for a cigarette outside - it's too cold.
39. ...It was becoming socially unacceptable even back then um.....

Appendix F: 4

40.it was very antisocial as we used to go dancing at the time and the girls did not smoke and they did not like the smell of cigarettes on you. That was a big thing. I did not know any girls that smoked. They complained that your breath was close to terrible and things like that.

(Relapsers)

41. ...because I was working in a place where I could not smoke during the day and because I went to the gym...I did not have the opportunity I guess.

SELF RE-EVALUATION

(Maintainers)

42. I can't no longer think of myself, I have someone else to think about.
43.And then on reflection, having a family looking back saying I really don't want to be like that and I associated that as part of his (brother) untimely death at 46 which is relatively young.
44. ...I had started lifting weights while I was still smoking but was getting out of breath and to me at that time at my age....I mean crazy.
45. Things like that...I said these white guys can't stand in your way they have to go.
46. I have a family and things I want to do so they were in my way and that was it...they had to go.
47.And then I said I was being foolish to myself and to everyone else and that's it, since January this year I haven't had a cigarette at all.
48. Tell myself I'd be a bloody fool if I carry on smoking because when I what I went through of 2 weeks of treatment....I wouldn't wish that on anyone....with chemotherapy...yes it was.
49.And I knew it wasn't good for me and yeah I did want to give it away.
50. I thoughtI'm in my thirties, I'm pregnant and it's...the time has come...I really have to give it up now.
51. I just thought...you know your getting on a bit now and the time has come you have smoked for 13 years um....
52.she offered me a puff of her cigarette and I said yes I'll take a puff and I hated it. I could not stand the feel of the smoke going down into your lungs and I thought I can't believe I did this for so long and I never....that was it for me....
53. my circulation was getting quite...and I'd look at me feet and I'd have a bluish tinge to my feet. I mean it was affecting my circulation...it really was.. I mean I don't have any of that now...
54. ...and I used to paly a fair bit of sport at the time and it was not doing us any good so we thought we should not be smoking....

(Relapsers)

55. I felt a lot fitter and healthier when I was not smoking - taste was different, wake up in the morning feeling better.
56. Just did not feel right.

Appendix F: 5

57. ...Not feeling fit I can still do stuff but not to the full extent.
58. ...Well I am getting older and of course I can feel my breathing and I can feel that there are health problems coming on if I do not stop.
59. That's how bad I think it is. I think about it everyday. Very conscious, and at my age it's not healthy.....
60. You try and re-evaluate your life as to what is important, as you get older when you start having grandchildren and you want to be fit...and you are looking at your time there is no point having superannuation if you are not going to enjoy it...so that's it.
61. We went to the zoo with our grandson and energy wise he is full on and you have to be able to keep up.... so you have to be fit.....
62. Part of me does not like it....
63. I am important too and I am damaging my own body which is important too....
64. I feel that it is far better not to smoke than to smoke and if you can get yourself off it its a great thing.
65. I think that in a way I would prefer to be a non-smoker and I hope to be a non-smoker eventually.
66. So you kind of think that the years that I smoked are never going to be a positive thing for my health but perhaps they wont actually kill me if I stop at a stage in my life where I still have enough time to make a recovery.

DRAMATIC RELIEF

(Maintainers)

67. ..I lost my brother when he was 46, he was married and had 6 kids all over the age of 12, and that had a profound effect at the time...mentally....physically....everything.
68. ...and I started to think about my brother and I said no I am not going to end up like that.....
69. ...but what helped me was that around that time my mother was diagnosed as having tuberculosis....that was an incentive and lung disease was not going to be helped with smoking...So it was a really ever present thing.
70. It's sort of tricky...you know...being pregnant too. I was really emotional and I used to cry a lot um....I did cry at a drop of a hat and I don't really know if it was all of that tied up or just the hormones.

BEHAVIOURAL PROCESSES

STIMULUS CONTROL

(Maintainers)

71. we did not go to night clubs because they were smoky environments because if someone offers you one you will take it. You just don't go.

Appendix F: 6

72. ...And there has been a major difference to the last with the socialising and thereby I suppose because my husband doesn't smoke and with him being in Perth now.....
73. ...in the first 6 weeks I literally withdrew from society....
...I tried not to socialise on weekends where it entailed that I would be wanting to have a cigarette.
74. By not socialising the first 6-8 weeks helped me get over the hardest part of giving up.
75. As when we do go out and there's a lot of smokers around I have to buzz off like and go to a non-smokers area. As having people on either side of you smoking makes it a lot harder.
76. I found the thing that really worked for me was that I allowed myself to have a packet of cigarettes in the house and they were in a drawer and I thought if it gets to the stage if I really can't stand it they are there and I can have one.
77. So it was gone from the house.
78.And then the fact that he (husband) wasn't smoking when I gave up certainly helped....
79.being pregnant I was not drinking either so instead of having a glass of wine with dinner. I wasn't even having that....
80. I still got a big Cuban cigar in the bar that I smell now and again. I reflect and that satisfies me.

(Relapsers)

82. ...my smoking environment at home was changing and it was easier so there was no smoker in the house....
83. There were no smokes in the house.....
84. ...just not having any smokes around or any temptation.....
85. ...eliminating smokes from my house and environment.
86. I did not go out that much when I was not smoking so I took my self away from my environment....
87. However, over a period of time I used to smoke inside of my house and now I do not. (presently)
88. ...Trying to keep away from the smokers.
89. ...But if I am with people who do smoke I smoke more...if it is sitting there I use it...if I put it away in the room and make a concerted effort than I can control it.
(Presently)
90. I found I had stopped drinking....
91. when I go out I just don't take them with me. They are at work or in a place in the shed. (Presently)
92. Yes I have, but I have to stop it's got to be none that's it... (to eliminating it from home environment)
93.go do something else where no one was smoking....
....worked in a place where I could not smoke.

Appendix F: 7

- 94. I could not smoke at work where I was, it was not all that easy.
- 95. I did not have much of a social life back then, and so I did not go out that often and did not find myself in pubs or places like that with friends that were smoking.
- 96. I stayed at home a lot more.
- 97. I did not go out that much when I was younger.

COUNTER-CONDITIONING

(Maintainers)

- 99. The more you allow yourself to be occupied and do things that you have never done before really helps to get over that initial period of craving for a cigarette...
- 100. ...where you are able to do something else while drinking.
- 101. ...I would pick up a pen or pencil and just hold it in my hand, I found that got me over the cravings of wanting to pick up a cigarette. Momentarily that action just putting something in your fingers which is a pen or pencil which really feels like a cigarette - yeah it can help you over the craving.
- 102. ...And if you find different things to divert yourself whenever you feel the craving coming on you will succeed.
- 103. ...Where as now in a stressful situation I remove myself from the room and yes it does help.
- 104. ...I did not go outside, pour myself a drink, watch TV or go for a walk.....
- 105. I tend to take my dog out a lot more now.....
- 106. ...but now I carry around a lot of minties with me and just keep popping minties.
- 107. I still do even now. Even some places we go to where there is a lot of smoke I do get the craving for it and I pop a mintie to more or less get my mind off it and then for the physical craving. I think it's more for the mental than physical.
- 108. No...just lollies, lifesavers...um I was never a big one on chewing gum...mainly lollies...I used as a replacement.
- 109.I mean I would go around with a pencil in my hand all day, and I would play with the pencil and I associated a lot of times and why a lot of people would smoke I would think it was to do with having something in their fingers and doing something with their fingers.
- 110. ...And uh...got that down to using a pencil and having something in your hand.
- 111. ...And uh just to keep occupied.
- 112. ...90% of people were smoking and I was surrounded by it and I didn't like it but it was part of my work...I needed the money... so I had to be there. But at all times it was in my mind physically the proverbial glass of tar sitting on the table instead of a drink and I'd say well why would I sit down and drink a glass of tar? You know...its like a slow arsenic poisoning over a year in small doses.

(Relapsers)

- 113. ...the physical side of things and health-wise. I thought it was a good substitute...

Appendix F: 8

114. yeah also I tried then too..to get into the physical side of things, because I had access to a gym where I was living and pools, and I was trying to get my physical fitness up as well.
115. ...Basically substituted it with going to the gym I was working full-time so I was busy which was easy.
116. I would go to the gym in the morning....
117. So my life was busy. That enabled me to quit...
118. ...and I found raspberry liquorice helpful.
119. ...And trying to substitute it with good things like physical activity and keeping myself busy.
120. ...But I would be doing some physical activity which my environment enabled me to do so that made it easier.
121. ...Basically substitution.
122. Um... doing other activities like knitting or whatever to occupy my hands.
123. ...In the mornings I might be able to put it off for 2 hours. I get to work, get straight on the computer. (present)
124. So now I go in there (work) and I start straight on and try not to leave the desk and that's really really hard, incredibly hard. (Present)
125. I normally have milk or milk coffee or something like that and I found milk is much like beer I cry for a cigarette. So now I have orange juice with lunch. (Present)
126. ...the citrus acid type of thing doesn't go well with a cigarette...
127. ...just maybe did something else or have a drink or ate something. Just tried to get on with something else.
128. ...I tried chewing gum and doing something else I also used pot as a substitute for a while.
129. Chewing gum.
130. Just kept myself busy.
131. Chewing gum, yes.
132. Yes every-time I wanted a cigarette I had a chewy.
133. I would find something else to do and keep busy.
134. I just kept myself busy.
135. ..Have a drink, glass of water, eat chewys.
136. ...And went to the gym...
137. I went to the gym in the evenings pretty often.
138. Go for a walk.

SELF LIBERATION

(Maintainers).

139. So that was the thing I just had to achieve and I done it.

Appendix F: 9

140. ...But I was determined and I am determined and if I do set my mind on something I do it irrespective of the physical thing. If I want to do it I will and uh...that's is the same with diet or anything....I choose with smoking as well. I don't want to smoke. So I wont smoke.
141. ...It was in my head and that was it...I wasn't smoking and said I'll never smoke again and I didn't.
142. ...It was a thing I had to do and I done it...
143. ...I just felt good about myself that I could actually do that, that I could cut that part of my life gone and um...I was big enough to do it.
144. So yeah I am happy with the decision I made very very happy I stuck with it and I'm very very happy now.
145. But I feel good about myself not smoking...I mean I can do it....
I was determined and it was going to happen...thank god you know...
146.and wanting to go back but I said to myself no....I'm giving up that's it.
147. But I had decided I couldn't afford it and that was it.
148. Kept telling myself...no that is it...
149. I just made up my mind to give it away and that's it.
150. Actually, I did end up lighting one and I thought...I am not going to do this...I'm not giving in and I put it out.....
151. ...but I was so determined that I wasn't going to give in....
152. ...but I was so stubborn I wasn't going to give in.
153. ...It just passes (thought of cigarette) cause I don't ever want to go back to it.
154. Its very unhealthy...I'm really glad that I don't smoke....
155.but I am glad that I gave it up.
156. ...I can really see that there has been many a time where I have encountered really stressful situations and was really very very close to picking up the cigarettes again and it is just trying to be a bit stronger and see if I can work through a little bit longer at a time taking it each day. It does get closer and closer to achieving your goal.
157. ...I guess I had really made up my mind to quit...
158. ...and I am determined that I will do it this time.
159. ...Its a big hurdle and it feels good.
160. So I decided I would try a bit harder.
161. Yes, I don't have any interest in smoking at all not the slightest.
162. I really enjoy having a cigarette but for the first time in my life I have not had that wanting to enjoy...
163. I don't know, hopefully I can stay off them this time.
164. ...That I did want to have a cigarette but I am determined not to have it.

(Relapsers)

166. I wanted to smoke, but I kept on deciding against it because I thought I could do it and I'd stop....
...so I'll just have to keep at it...I have to.

Appendix F: 10

- 167. ...I have chosen the first of October...and I will have another go at it.
- 168. Just talked to myself saying ...you don't really need this....
- 169. ...it is difficult to quit...I'm sure if I made a concerted effort...I have set goals in my life before and I have achieved them.... I will persevere and one day I will get there.
- 170. I basically tried to tell myself that I don't need it....
- 171. Just talked to myself...saying you don't really need this.
- 172. well its like that I choose to do to my own body and has a negative side effects as many things do.....

CONTINGENCY MANAGEMENT

(Maintainers)

- 174. ...imagine that the money that is wasted there lying on the ground...it's crazy...it could go towards other things instead of filthy things and keep saying that to yourself.
- 175. I now realise that a lot of money was spent on that for no reason really.
- 176. ...And the treatment that I did go through I wouldn't want to go through the same thing again. (Negative)
- 177. ...and smoking is associated with cancer uh...I wont like to go through that same treatment again no never again. (Negative)
- 178. ...because I used to be sick as a dog...you don't know what chemo is until you have been through it. (Negative)
- 179. I think it has to be the point is more emphasised if there is a scare...medical scare than anything else...
- 180. ...\$100 a month so over a 12 month period it is a lot of money which would enable me to have a holiday somewhere. Put that money aside which is very beneficial if someone gives up smoking to actually put that money into an envelope each week and each time you put that money away you are able to see what you have in that envelope and that alone is quite an incentive to keep going as you want to reward yourself substantially at the end of the year to see when you have saved so much. You can look at it and say 'I did it' and now even better still I can have something worthwhile which you can really enjoy and have some enjoyment out of spending it rather than having enjoyment out of a cigarette...
- 181. ...seeing the money one can save each week - is worth giving up.
- 182.And I find it does work as really you are seeing what money you are putting away each week and at the end of the week instead of buying the cigarettes put the money into an envelope and count it each week.
- 183. Because of saving money (referring to using no replacement therapy) - you definitely save a lot of money these days compared to 5-10 years ago.
- 184. I want to save the money and be proud of buying nice things at the end of it.

Appendix F: 11

185.That little bank balance that increases and as it increases your confidence increases absolutely and its one thing physical you can see and each week that goes past I remind myself at the end of each week 'ah, that's another week I have gone through' and look back and acknowledge that I did feel the urge a few times to have a cigarette but I did not...
186. ...but still acknowledging the fact that I still felt like a cigarette during the week but I did not have it.
187. Reward yourself.
188. You really feel good when you look back and say 'at that point it would of been easy to pick up a cigarette - but I did not'....
189. ...money-wise you will see your rewards - you can have a lovely holiday or buy yourself something really fabulous and also its an achievement.

(Relapsers)

190. at first I though I was doing good.
191. But by the time night came I had not had a cigarette I would say 'oh, I made it I will do this again' and I did.

HELPING RELATIONSHIPS

(Maintainers)

192.and thereby I suppose because my husband does not smoke and with him being in Perth now made it easier to give up that the last few times when he was working away from home.
193. Yes - my friends and family understood what I was trying to say and respected my feelings and decision t do it that way....so it was really good.
194.Maybe having my husband home was another major thing in not wanting to pick up a cigarette whereby he is not a smoker so it did help me this time with my husband being at home.
195. ...But the support of my husband at home I think has helped me to go as far as I have this time.

(Relapsers)

196. She (friend) encouraged me to give it a go and because she has successfully gone through 2 weeks...
197. when I quit I did find that the people I did live with and because they quit as well that support did actually help.
198. The 2nd time it actually helped more because she was quite encouraging by saying if you just get through those first couple of weeks the withdrawals are not so bad...it gets easier. That enabled me to carry on longer as her advice was relevant to me as she was a smoker going through it herself. That helped especially when I was feeling down and wanting a smoke.
199. ...Um..back then...he (boyfriend) also encouraged me to keep it up.

Appendix F: 12

OTHER STRATEGIES

REDUCING CIGARETTES/MILLIGRAMS

(Maintainers)

200. This time it was much easier for me - I had cut down in the nicotine content and also cut down in the number of cigarettes thereby also enhancing the progress that you will have when giving up cigarettes so that you don't give in to that urge of wanting to pick up the cigarette. All those things I feel did play a very big part.
201.But I have not bought a packet for about three years. In a way it has been a lead up to not smoking.
202. ..I used to smoke 12 milligrams and then um... and for the 1st few years I was down to the low milligrams...4 milligrams. So I came down from 12 to 8 to 4 milligrams.
203.I mean I really made a conscious effort to cut down to about 3 a day.....
204. but I certainly made a conscious effort to cut down.

(Relapsers)

205. ...And there has been quite a few times where I have just tried to cut down in cigarettes.
206. Up to now - trying to cut right down.
207. In smokes per day.
208. I take everyday as it comes, slowly cutting down and just try.
209. Trying to cut down...trying to cut out.
210. ...But I have cut down considerably.
211. ..But now I have stopped all the after dinner ones virtually from about 5 o'clock onwards. I won't even...I'll have one or two more today and that'll be it and I have only had 1 today so far.
212. Oh...hugely yeah. (Of taking note of how many he's smoking)
213. Yeah yeah (to cutting the milligrams over the years)...they say it doesn't make a difference. Between 2 and 4 milligrams
214. sometimes...I start the morning by putting a stroke on the packet...or say I will not go over this quota...sometimes I do sometimes I don't...
215. however, I started on 12 milligrams and then cut down over the years to 8 and now I am on 4's.
216. So I am trying to do it gradually. So going from 12 milligrams to 8 to 4 and I try and count how many I have per day.
217. I am slowly eliminating it from parts of my life to make the transition easier when I actually kick the habit. I suppose the stage I am at now...I keep justifying it as it may be better than I am smoking 4 milligrams instead of 12's and smoke outside instead of inside and only having 10-12 instead of more per day. I did smoke more earlier on.

Appendix F: 13

LIGHT/HEAVY SMOKER

(Maintainer)

218.I think I was not a heavy smoker so that made it easier for me. I never exceeded a pack a day if not less than...a pack was 10 cigarettes.....

(Relapser)

219. it was far easier (first attempt to quit) than it was in the most recent time because the first time I tried I had not been such a heavy smoker for so long so I guess the cravings were not as strong then so I managed to suppress them and not smoke where as now, having smoked more heavily for a longer period of time, I find it difficult to resist the craving.

REASONS FOR RELAPSE

INTERNAL FACTORS

STRESS

(Maintainers)

220.but the transition from high school to uni was hard and I just could not be bothered and no one was going to force me to give up....
221. when you get to uni, the stress of uni you can't give up because, one you have the pub, you have high stress....
222. you find you can't because you need that level because you stress is so high so you need to be doing something.
223. ...You get very nervous and you could not do your job properly.
224. Growing up stress, establishing yourself certain groups stress.
225. I was bored or over worked or over tired....
226. I think basically also it was very stress related in the sense that it is just a psychological thing - you felt stressed out so you picked up the cigarette and psychologically it helped you to cope with whatever the situation is at that point in time.
227. It is just like a crutch really - things are not going the way they should - you feel secure when you revert back to taking up the cigarettes again...stress related definitely really makes you want to go back.

(Relapsers)

228. ...and that was way back when I started my degree. So maybe it wasn't a good time for me to start it. Cause I was... you know...I t was quite stressful....way back in 91 I did that and....that didn't work at all...for me.
229. I think I actually went through a stressful period...personally.
230. ...and stress on top at the time I was breaking up with my girlfriend - gee I need a cigarette.
231. ..But if I had better control of the stress factor I don't think I would be smoking now.

Appendix F: 14

- 232. ..The added pressure of what happened at that particular time
- 233. No it was the stress factor that made me go back.
- 234. ...It was something you got angry or emotional about...you'd light up a smoke.
- 235. I'd say stress...
- 236. there has been some stress....
- 237. you trigger very quickly on any stress related thing and I don't really feel stress but when I'm giving up smoking I feel everything and there is no where else to go
- 238. Yes. (to stress relief)
- 239. ...it relieves the stress
- 240. Pretty much...yeah. (to reason of relapse)
- 241. ..and the stress which was what led me back to smoking.

PHYSICAL ASPECTS

(Maintainers)

- 242. Its more craving a cigarette mainly.
- 243. ...But from 80kgs which used to be my standard weight...I went up to 98 kgs and it was more uncomfortable and more tiring for me to move around and do everything at 98kgs..which made me say what is the point so I took up smoking again and gradually got my weight back to 80kgs and I am 80kgs today.
- 244. ..You are eating more, putting on weight so you go back to smoking.
- 245. You sort of missed it, a bit of a craving for it.
- 246. It was hard I was eating too much.

(Relapsers)

- 247. ...and I was just dying for a cigarette and that was probably what brought me back to it.
- 248. Yes. (to cravings)
- 249. ..obviously it is an addiction as well, and not allowing your body to really free itself..
- 250. it is just this want, this urge, this need for no particular reason.
- 251. Yeah..I was physically sick for the whole 10 days, that's why I started up again.
- 252. Yeah and the withdrawals and feeling sick from not smoking....
- 253. I'm addicted to it basically.
- 254. Something that I'm addicted to...
- 255. ..but I am still addicted to it. So I still take it.
- 256. ..I need a cigarette to get me through the day.
- 257. ...I just remember getting up in the morning and wanting a cigarette and actually coughing more because I'd quit. I was coughing up a lot of phlegm and just didn't really feel right without having a cigarette in the morning...it was like a fix...basically.
- 258. the 2nd time it was the physical withdrawal..
- 259. I feel addicted to it.

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- 260. ...The cravings..
- 261. ..it is more addictive than heroin.
- 262. It's just the physical desire....

ENJOYMENT

(Maintainers)

- 263. ...I used to savour those 3 cigarettes.
- 264. Um.. but so I used to look forward to them and I really enjoyed them.
- 265. Because...I did really enjoy them...
- 266. I have tried to give up numerous times but as I said, I really enjoyed smoking.
- 267. ..So it came to the point that when I felt like a one I would have one and that is in the last 2 years - if I felt like one I would not deprive myself and had a cigarette. I think that the bottom line was that I did not want to, you know, I enjoyed it too much.
- 268. No, nothing like that (withdrawals), just because I enjoyed it.
- 269. It was just the feeling of having a cigarette, that relaxed feeling.
- 270. I enjoyed the feeling of having a cigarette in my hand and just having that drag.
- 271. I could give it up any time I wanted to but I enjoyed it.

(Relapsers)

- 273. I actually like smoking.
- 274. ..Also part of me still liked it...
- 275. I still like it.
- 276. ...I like smoking and that part of me does want to quit but not yet.
- 277. Just enjoyed it.
- 278. ..But I enjoy it too much.
- 279. ...But I think that there are not that many pleasures in life so you know, I am hesitant to deny myself one of them...
- 280. basically I enjoy smoking.
- 281. I do it because I enjoy it.
- 282. I still do enjoy having a cigarette.
- 283.Something that I do enjoy to do.
- 284. ...And the amount of enjoyment.

NO PERCEIVED BENEFITS/NOT FOR SELF

(Maintainers)

- 285. ...not serious attempts. I didn't really want to stop.
- 286. I really didn't want to though.
- 287. ...But underneath it wasn't really happening.
- 288. So there was no sincere attempts on my part to stop it....
- 289. half-hearted attempts which were not really attempts at all...the idea of buying for failure.
- ...Where before on the previous attempts they were half-hearted.....

Appendix F: 16

- 290. yeah maybe perhaps I didn't really want to give them away.
- 291. ...And at the time I was giving up because he was giving up not because I wanted to.
- 292. ...And it was the fact that I didn't really want to give up, but I was giving up as a support thing but it wasn't really what I wanted to do.
- 293. There is no urge to give up...
- 294. ...I think the bottom line was that I did not want to....
- 295. No, it didn't benefit me at all. (attempt at quitting)
- 296. I went up to 98kgs and it was more uncomfortable and more tiring for me to move around and do everything like that at 98kgs...which made me say what is the point so I took up smoking again.....
- 297. I lost a grandparent to smoking when I was smoking - that is another thing you have to think of. That was directly related and I have seen mouth and tongue cancers taken off and they are not pretty sights. It still does not deter you - if you are going to do it you are going to do it regardless.

(Relapsers)

- 299. I had some surgery and the Anaesthetist said for somebody who smokes you are remarkably fit, so that is a reinforcer
- 300. I had all my tests done and the doctor said you are perfect...
- 301. ...to date because I have gone unscathed.
- 302. I feel that I have to have a reason to live to quit smoking.
- 303. If I felt that I had a reason to want to live to an old age - I think that would help.
- 304. It is pretty hard to see the pay-off when you are a smoker to not to smoke.
- 305. It is hard to see the pay-off of the non-smoking.
- 306. So in a way I really never found a real incentive or substitute to quit.
- 307. I haven't really found a substitute to replace what I really enjoy about smoking.
- 308. Yes it is.....what would probably do it for me is a scare of some sort you know.....

SELF EFFICACY

(Maintainers)

- 309. You sometimes lack confidence.

(Relapsers)

- 310. I have not really coped at all this most recent time I tried.
- 311. You know...there was always an element of doubt of whether I will do it...so I doubt whether I could before I did it.
- 312. ...Because I don't think I have the strength to do it. I need help.
- 313. I have always set goals in life, and I have always obtained them, yet with smoking I am completely hopeless.
- 314. I get really cross with myself for being weak.
- 315. ..This one seems to beat me and I can't put my finger on as to why I am failing in this respect and not that respect.

Appendix F: 17

- 230. Disappointed in myself for going back.
- 231. The disappointment when I gave up - I gave up and went back to it, I was very disappointed in myself.
- 232. I am a very strong person but when it comes to the smoking...its really a weak point.
- 233. I hate it I felt embarrassed. I'm a big boy I should be able to stop and do something when I want to.

EXTERNAL FACTORS

ENVIRONMENT

(Maintainers)

- 320. with our friends I would buy a packet when we were out and then let it go when we were finished.
- 321. Yes, definitely. (to environmental factors)
- 322. Yes, if we were out with friends that smoked...yes I would definitely have one.... School environment, peer pressure....
- 323. Socialising - that is what I found brought me back to smoking at the early stages....
- 324. whereas, when out socially you are just sitting talking and drinking and while doing that you will want a cigarette.
- 325. I really thing your associated and you general circumstances, peer pressure and so forth play a big part.
- 326. I probably did not recognise it - it was a hopeless situation. Usually the people hand you a cigarette and they would smoke.
- 327. ...You are more likely to have a cigarette or drink just what the rest of the crowd was doing.
- 328. Yes, yes all my friends used to smoke.
- 329. Yes, that's right.
- 330. My first time I went back because of friends smoking around me....

(Relapsers)

- 332. Being in a TAFE situation when everyone is taking a break and everyone is smoking...
- 333. I had moved to England and a lot more people smoked there.
- 334. ...There was a lot of smokers where I was working.
- 335. ...And I went from a situation where I was constantly surrounded by non-smokers in Australia to when I was there I was constantly surrounded by smokers.
- 336. ...All of a sudden everyone is smoking around you it tends to lead you to want to go back to smoking. So that is probably what made me do it.
- 337. ...When I went to England was that there was a lot more people smoking than here in Australia. The place that I was working a lot of people smoked.

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- 338. ...Once you work in a place where everyone smokes and there are no real restrictions on smoking, you tend to smoke more and more and if you are with people that are smokers.
- 339. ...Everywhere was a high risk situation and when I went to Italy, even more so again...over there everyone smokes everywhere...
- 340. ...not being able to concentrate enough to keep it up in a normal work environment...that's the hardest... a lot of people around me that smoke.
- 341. ...Went out with some friends and just said 'oh I'll just have one...oh I'll just buy a packet for tonight'....but that did not work...and I found myself back on the smokes from then on.
- 342. ...The environment...
- 343. ...to me its a social thing.
- 344. Oh that's right, in the middle of the Zyban I went to Bali with 2 smokers and that was that.
- 345. Again you know I suppose weakness, environment...
- 346. ...and being in an environment that's conducive to helping. (to quit)
- 347. ...it is quite hard when there is a smoker in the house...when you are trying to stop.....
- 348. just having a cigarette when I was driving... I do a lot of driving...
- 349. ...to me its a social thing.

ALCOHOL

(Maintainers)

- 351. but it was the drinking, that was the hardest bit because there was a balance, you have a wine glass in your hand you have a cigarette in your hand
- 352. you have a glass of wine and enjoy a cigarette...
- 353. when out socially you are just sitting, talking and drinking and while doing that you will want a cigarette.
- 354. I would be wanting to have a cigarette because I am having a drink with somebody.

(Relapsers)

- 355. I associated smoking and drinking and I like to go out and have a drink and to have a smoke.
- 356. I like my beer and it goes together with my beer it's the taste.
- 357. The only thing I was thinking about while I was having a beer was to have a smoke....
- 358. we were often in the evenings go to the pub whatever.....
- 359. ..if you go out drinking with your friends, it is definitely a high risk situation.
- 360. As people tend to smoke in pubs...

Appendix F: 19

361. I think if you have been a smoker you tend to associate drinking with smoking together and I think if you have a drink you just acquire the urge to smoke a cigarette.

REASONS FOR CESSATION

INTERNAL FACTORS

NEGATIVE HEALTH EVENTS

(Maintainers)

362. I think I had the flu actually. I went for about 5 days when I could hardly breathe and so I thought that it was a good opportunity. So I did not smoke any more after that.
363. Because in December 1999 I got sick. Due to my sickness I gave up smoking.

GENERAL HEALTH/WELL BEING

(Maintainers)

364. I was getting into weights and things like that and I needed the lung power as well in order to lift weights and keep up with it.

(Relapsers)

365. ...but I think I just wanted to be healthier...
366. it's killing me...end of story. It's gonna kill me if I don't stop smoking.
367. That's it...only the health risks.
368. I can feel that there are health problems coming on if I do not stop.
369. ...You know the physical side of things and health-wise.
370. ...Tried then too to get into the physical side of things...
371. I was trying to get my physical fitness up as well.
372. Just did not feel right.
373. Health-wise as well...I would say I wanted to put on some weight.
374. Just the physical level, not feeling so fit.
375. Health reasons, health concerns...I went on a fitness thing.
376. Just not being fit, getting out of breath all the time.
377. ...And of course health as you get older..
378. we went to the zoo with our grandson and energy-wise...he is full on and you have to be able to keep up..so you have to be fit..
379. ...health primarily.
380. Health yeah.....

SELF

(Maintainers)

381. I just wanted to stop and that was it....
382. I think it has to come from well within the person.

Appendix F: 20

- 383. I guess I had really made up my mind to quit and this time it is for myself not for anyone else.
- 384. I am doing it for no-one else but myself.
- 385. Determination plays a big part on how much you really want to do it for yourself.
- 386. ...what you are going to do for your yourself what you are going to do for you life.

(Relapsers)

- 387. No... probably not really (wanting to quit)...just to see whether I could or not...basically.
- 388. I wanted to see if I could stop it...

SELF EFFICACY

(Maintainers)

- 389. ...but I was so stubborn I was not going to give in.
- 390. ...I don't ever want to go back to it.
- 391. I personally never experience stress where I let the stress rule me, I'll either do it or I won't stress out in being able to do it.
- 392. ...But I was determined and I am determined and if I do set my mind on something I do it irrespective of the physical thing, if I want to do it I will.....I don't want to smoke...so I won't smoke.
- 393.And said I'll never smoke again and I didn't...
- 394. I just felt good about myself that I could actually do that, that I could cut that part gone my life gone.....'
- 395. I was big enough to do it.
- 396. No, never...to me that is giving in...I don't do that...(to feeling like a smoke)
- 397. but I feel good about myself not smoking...I mean I can do it...
- 398. more confidence, more assured in what you are doing and saying...

EXTERNAL FACTORS

NEGATIVE HEALTH EVENTS

(Maintainers)

- 399. I lost my brother when he was 46, he was married and had 6 kids all over the age of 12 and that had a profound effect at the time - mentally...physically... everything, he was my oldest brother and at 46 and me being at that stage 30 um...yeah it was a big effect on me.
- 400. Maybe there is a factor...maybe something that should happen or has to happen in their life and maybe they need to see that maybe that's the trigger.
- 401. ...But some people need something in their life and in my case it was tragic and maybe that was the trigger and the spur to get me to do what I have done.

Appendix F: 21

402. But what helped me was that around that time my mother was diagnosed as having tuberculosis.
403. That was an incentive and lung disease was not going to be helped with smoking.
404. The length of time that she was in hospital, we see some people get discharged, some come back and some become deceased. So it was a really ever present thing....And one of the processes was when they worked on peoples lungs...they would cut the ribs away and then they would wait...there were all sorts of medical technologies been developed to try and over come it...new drugs...so everyone was quite aware of it, so when your talking about anything to do with lungs it was a pretty frequent subject in the family an din the social circle.

(Relapser)

405. ...but my father had emphysema when he died, so that's a hereditary thing and that's why I've got to stop

MONEY

(Maintainers)

406. I decided this time because it was burning a lot of money and one can save a lot of money if you are a smoker these days, as it is nearly \$9 for a packet of 30 cigarettes so.. it was 10 a day before I gave up and that's about 3 packets a week so it works to about \$25 a week - \$100 a month so over a 12 month period it is a lot of money which would enable me to have a holiday somewhere.
407. Because of the saving of the money - you definitely save a lot these days compared to 5/10 years ago...
408. I want to save the money and be proud of buying nice things at the end of it.
409. When I decided to quit it was mainly economic reasons.
410. I thought I could make better use of the money so... I had to start paying for a house, and I needed that little extra cash. So I said no.. I will give up smoking and it was that's it. I decided to give it up like straight away and never went back to it.
411. I had made up my mind...but I couldn't afford it and that was it.
412. ...But when it was done for a financial reason that was it.
413. I now realise that a lot of money was spent on that for no reason really.
414. Well that was the main reason..financial I felt I could use that money elsewhere. It wasn't so much health as I was younger back then.
415. Recently, its the cost factor when I started smoking you could buy a packet of cigarettes for \$1.30 and now they are about \$10 a packet. Not really affordable even duty free they are still \$25 - a carton or some crazy amount. The money factor.
416. Oh god yeah, I see it as a waste of money.
417. The most I ever paid for a packet of cigarettes was about \$3.80 and to pay 9-10 now is just crazy.

Appendix F: 22

(Relapsers)

- 418. ...um also financially I was strapped for cash as I was not working at the time and that also benefited me....
- 419. well I suppose primarily it was the cost, as the cost increases, so I thought you know....
- 420. and again we talked about all this money for superannuation..planning for our retirement what's the point if we will be spending all on medication....
- 421. ..the money factor again...well I'm not paying \$11 dollars now if I can get it for \$10 to tomorrow..then I will cut down....

PREGNANCY

(Maintainers)

- 422. When I had my 2 children and once I knew I was pregnant I never touched a cigarette.
- 423. Each time I knew I was pregnant - I went cold turkey. I suppose I felt it was not just me it was then dealing with my children and I could make this decision as I could not put their health at risk, maybe that was they very good reason for giving up smoking during that time.
- 424. I fell pregnant and that was the real motivation for me.
- 425. I thought..... I'm in my 30's, I'm pregnant and its.....the time has come..I really have to give it up now. But honestly I believe that if I hadn't been pregnant I wouldn't of succeeded.
- 426. Absolutely (about being pregnant), because I found it so difficult....I wouldn't of lasted.
- 427. The fact that I was pregnant.
- 428.But it was the fact that I was pregnant and I knew I was pregnant.
- 429. Its sort of tricky... you know..being pregnant I was not drinking either so instead of having a glass of wine with dinner I wasn't even having that.
- 430. Pregnancy I suppose, I don't know whether is is the hormone levels or just consciously thinking that this is a very precious baby and I just to want to but it has been the first time in many months that I have not had or felt like a cigarette and that is with friends smoking around me so I think it might be good for now, I hope so, I really hope so.
- 431. I cant no longer just think of myself I have someone else to think about.
- 432. I do not even want to influence my child because I was to get a healthy start and if they choose to smoke, you can only educate them in the right way.
- 433. As I said there is no way I would do anything to jeopardise this pregnancy and its too precious to me.

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434. Having tried to have a baby for 6 years and being on different hormones, stimulant drugs and knowing the risk and this is even when I was just still smoking, it was the risk on your body, smoking with all these extra hormones the risk of having a deep vein thrombosis was a lot higher and this baby was an extremely wanted baby and I can't do anything to take that away there are too many risks involved with smoking and hormone treatment and it is just not worth it.
435. Now, I don't know whether it is because of the pregnancy but the smoke does get to me...
436. I reckon if I did not have a baby I would be still having one when I felt like it.
437. I probably would not have it in front of him or her if I was it would be outside, nowhere near the baby...I would always put my baby's health in front of anyone's else or anything else.
438. I would never expose a child to smoke. What I do to my body is my business, but now my body is not mine so I can't do that.

(Relapsers)

439. I think a lot of people are quitting when they have children. I think they fear that now they have something - they want to protect their kids from second hand smoke and also you tend to think if you have kids you want to be in good health as they grow up and it's a kind of reason not to smoke...if you are by yourself...that motivation is not there...
440. Maybe having a child or doing something like that...I would because of a child's life.....

ENVIRONMENT

(Maintainers)

441. ...just a build up of people telling you that I should.
442. ..And then it became very popular to get off smoking.
443. They were having little campaigns to try and stop smoking etc. So I decided I would try a bit harder.

(Relapsers)

444. ...it was easier as my boyfriend quit at the time.
445. ..My smoking environment at home was changing and it was easier so there was no smoker in the house.
446. ...Living with a girlfriend and she quit smoking previously for 2 weeks before I tried..because I was living with her I found it an easy situation to give it a go...
447. ...and another good thing is that a lot of my good friends..there is only one who smokes now...they have all given up...(Present)
448. I did not know many people who smoked...

Appendix F: 24

- 449. ...I did not know many smokers and the person I did know was a non-smoker and it just seemed like an easier thin not to smoke...
- 450. ...and worked in a place where I could not smoke anyway...and just seemed relatively easier.
- 451. The whole environment was pretty conducive to non-smoking to make it easier.
- 452. When I was younger I was perhaps more susceptible to all this sort of negative press that smoking gets and everyone gives you a very negative...and I was very susceptible to that and feeling guilty about smoking...now I don't feel guilty.
- 453. ...Everyone said it was so hard and just to prove that I could.
- 454. Yeah...to prove everyone else wrong.

STAGES OF RELAPERS

PRECONTEMPLATION

- 455. No...probably not...no not at the moment anyway....

CONTEMPLATION

- 456. Yes, but I am not really ready yet...I know eventually I will give up.
- 457. Maybe I will the next attempt who knows?
- 458. Part of me does want to quit but not yet. Something in me that is not really ready.
- 459. I think that in a way I would prefer to be a non-smoker eventually.
- 460. It has crossed my mind but I have always considered it to be something I will have to do sooner or later, but I am not looking forward to it.
- 461. I see myself quitting in a couple of years.
- 462. I have to stop it's got to be none...thats it.
- 463. I might have some lapses, but the lapses wont be oh i'll try in a few months time, it will be straight away. How to monitor and change and keep maintaining it everyday.

PREPARATION

- 464. I have chosen the 1st of October - and I will have another go at it.
- 465. But I am thinking about it again and I am looking at the 1st of October.