Occupational Transition of Smoking Cessation in Women: More than Just Butting Out

by

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Dedication Page

This thesis is dedicated to all those individuals who are trying to transition from smoker to non-smoker. It is my hope these insights will support, encourage and/or ignite the occupational transition process. Don't give up, celebrate your successes and build on each learning experience.

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Abstract

This qualitative study used interpretative phenomenological analysis to explore the question*, How do women cigarette smokers experience and perceive their occupational transition from smoker to non-smoker?* The sample consisted of seven women, aged 35-55, living in New Brunswick, Canada, who quit smoking for at least twelve months, but no longer than 24 months. Data were collected through in-depth, face-to-face interviews. The occupation of smoking was shown to be a valued and meaningful occupation with both positive and negative aspects that influenced the occupational transition process. The occupational transition of smoking cessation was described as a cyclical journey that required building skills and occupational competence, not only to support occupational adaptation and engagement in meaningful occupations, but also to overcome barriers and occupational losses throughout the transition process. This also fostered the occupational identity of non-smoker, by allowing the women to become and express the self they wanted to be.

List of Abbreviations Used

ASAM	American Society of Addiction Medicine
CAOT	Canadian Association of Occupational Therapists
FGS	Faculty of Graduate Studies
IPA	Interpretative Phenomenological Analysis
WFOT	World Federation of Occupational Therapists
WHO	World Health Organization

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Chapter 1: Introduction

Smoking is a leading health issue in our society. Twenty-two percent of all deaths in Canada are attributable to smoking, costing our healthcare system almost 17 billion dollars per year (Health Canada, 2009; Makomaski Illing & Kaiserman, 2004). The 2009 Canadian tobacco use monitoring survey reported that 17% of adult Canadians age 25 and older smoke. 70 percent of these individuals, who smoke, want to quit (Center for Disease Control and Prevention, 2002). Most smokers will attempt to quit at least once, but the majority will relapse (Collins, Maguire, & O'dell, 2002; Hajek, Stead, West, Jarvis, & Lancaster, 2009; Health Canada, 2009; Lennox, 1992; Schiffman, 1986; Song, Huttunen-Lenz, & Holland, 2009; Stapleton, 1998). Relapse contributes to a plateau seen in Canadian smoking rates since 2005 (Health Canada, 2009).

Presently there is no evidence to support any of the current approaches used for smoking cessation to address or prevent relapse (Hajek et al., 2009). Many studies published on smoking cessation conclude that the effectiveness of interventions is limited (Hajek et al., 2009; Song et al., 2009). Peer and parental relationships, personality/temperament, reduction in withdrawal symptoms, expectancies, and stress reduction are just some of the many diverse factors that influence one's ability to reach readiness to quit and prevent relapse; however, it is unclear how these factors work collectively (Baker, Brandon, & Chassin, 2004). Baker et al. (2004) call for more research to comprehensively examine how all these factors are integrated in the development and continuation of smoking. Exploring smoking cessation through an

occupational lens can provide a comprehensive view into how these numerous factors interact and affect relapse rates, yet there are no published studies using this approach.

Employing an *occupational lens* means using occupation as the foundation to facilitate our understanding and exploration of how we "give shape to our daily lives" (Hasselkus, 2006, p. 627). References to occupation, as in occupational transition, refer to the broad view that occupation means meaningful activities and tasks:

> Groups of activities and tasks of everyday life, named, organized, and given value and meaning by individuals and a culture. Occupation is everything people do to occupy themselves, including looking after themselves (self-care), enjoying life (leisure), and contributing to the social and economic fabric of their communities (productivity) (Townsend, 2002, p. 34).

Hammell (2004) reminds us that "expression through occupation (time, energy, interest)" (p. 297), such as belonging and sharing of oneself should also be considered when examining occupation.

The purpose of this study is to gain a greater understanding of the occupational transition from smoker to non-smoker, in particular how it relates to occupational loss, occupational adaptation, identity and meaning creation. An occupational transition occurs when there is a shift from one occupation to another. An occupational transition can happen because of a life event, a developmental process or it can be self-initiated (Townsend & Polatajko, 2007). Schwartzman, Atler, Borg, and Schwartzman (2006) remind us that transitions are part of all our life experiences and not just in the temporal aspect of aging. Transitions have been examined from many different perspectives such

as psychology, sociology, and stages of development; however, few studies have looked at the complexity of transitions from an occupational perspective (Blair, 2000; Wiseman, & Whiteford, 2009; Schwartzman et al., 2006). Exploring this transition through an occupational lens will identify what smoking cessation means in daily life routines and occupations that give life meaning with and without smoking. The occupational science literature has explored transitions related to disease and disability, but it is limited in the area of prevention and wellness from a population health view point (Blair, 2000; Hammell, 2004; Schwartzman et al., 2006; Wilcock, 2006; Wiseman, & Whiteford, 2009).

The knowledge and insights gained will not only add to the understanding of how some smokers manage this occupational transition successfully, but may also illuminate areas to improve and support the 95% of recent non-smokers who, contrary to their own wishes, will relapse within one year of quitting (Hughes, Keely & Naud, 2004). A better understanding of this occupational transition could improve smoking cessation strategies and reduce associated health care costs. Research, policy and programs in smoking cessation are predominately "gender blind" (p. 263) and recognition of the importance in understanding the experiences of smoking in women is limited (Amos,Greaves, Nichter &Bloch, 2012). As well, "research in the area of smoking has to a large extent overlooked middle-aged women" (Treloar &Gunn, 2012, p. 52). This study will explore how women cigarette smokers experience and perceive their occupational transition from smoker to non-smoker using Interpretative Phenomenological Analysis.

Chapter 2: Literature Review

In June 2011 the Canadian Association of Occupational Therapists published a new joint statement on the role of health professionals in tobacco cessation. This position statement advocates that occupational therapists, among other health professionals, have a role to play in helping people quit smoking and preventing relapse (CAOT, 2011). Smoking cessation has been defined as the process of discontinuing the practice of inhaling a smoked substance (American Cancer Society, 2011). Relapse is generally understood to mean when an individual starts smoking again after quitting smoking (Hajek et al., 2009). In order for occupational therapists and other health care providers to best help these individuals, an understanding of this transition from an occupational perspective is needed.

Occupational Transitions

The occupational transition of smoking cessation can occur for a number of reasons; it can be self-initiated due to personal reasons, such as the drive to alleviate the social stigma of smoking, pressure from a loved one, or a desire for a healthier life style. It can also be in response to a medical condition, such as heart attack or cancer, which triggers the desire to quit (Salive, Cornoni-Huntley, LaCroix, Ostfeld, Wallace, & Hennekens, 1992). When one decides to quit smoking the changes experienced are "dynamic and transitional" (Blair, 2000, p. 231). This point marks the beginning of the transition process.

To effectively manage any occupational transition requires personal awareness, recognition of the event and new behaviors to deal with the discontinuity in occupational

performance that may occur (Blair, 2000). The well being of a person going through a transition may be at risk if an individual is not adequately equipped to cope with the changes (Schwartzman et al., 2006). Hence, the transition from being a smoker to being a non-smoker entails numerous occupational changes. The non-smoker may no longer engage in occupations associated with smoking, such as smoke breaks with colleagues or casual interactions with other smokers. The literature suggests relapse rates are high when an individual does not change their social circles to include more non-smokers (Collins, Maguire, & O'dell, 2002; Lennox, 1992; Schiffman, 1986). A focus on occupational performance is critical during a transition as continued engagement in occupation contributes to one's well-being (Clark et al., 1997).

The most prominent transition model used in smoking cessation is based on the work of Prochaska and DiClemente (Collins et al., 2002; Kelly, 2008; Prochaska & DiClemente, 1983). This transtheoretical model proposes that cessation of unhealthy behaviors and the acquisition of alternative healthier behaviors requires progression through five stages of change: precontemplation, contemplation, preparation, action and maintenance (Prochaska & DiClemente, 1983). Precontemplation is the stage when an individual is not thinking about making a behavior change. For example, some smokers do not think about quitting, they enjoy smoking or don't believe they can quit. Contemplation is when an individual has started to think about a behavior change within the next six months. Many smokers think about quitting, but are not quite ready; they hope to quit in the near future. The preparation stage is when an individual plans to change their behavior within the next month. A smoker in the preparation stage may start going to a smoking cessation program, start reading information on how to quit or may

take up new occupations or cease old ones to facilitate change. The action stage is defined as the first six months after an individual has started to change their behavior. In this stage, a smoker has quit smoking. The maintenance stage is the final stage, when a smoker has quit smoking and the new behaviors are fully integrated into their daily life. Movement between stages occurs when the benefits of a new behavior outweigh the cons of a behavior.

Although this model is widely used in many clinical settings, the usefulness and vigor has been challenged by others in the social science community. West (2005) states that, "boundaries between so-called "stages" are therefore simply arbitrary lines in the sand", and using these stages to categorize people has little "useful meaning" " (p. 1037). He also suggests this model makes the assumption that people's intentions are clearly formulated; however, many smokers quit smoking with no planning or preparation. This model also neglects the role of reward and punishment, as well as habit formation (West, 2005). While this model has created awareness that progress can be made by slowly moving smokers towards behavior change, there has been "no convincing evidence that moving an individual closer to action actually results in sustained change in behavior at a later date" (West, 2005, p. 1037). This is supported by the vast literature on relapse rates (Collins et al., 2002; Hajek et al.2009; Health Canada, 2009; Lennox, 1992; Schiffman, 1986; Song et al., 2009; Stapleton, 1998). From an occupational perspective, it lacks full awareness of occupations associated with smoking that create meaning, identity and purpose in one's life. It also lacks appreciation for the loss of occupations associated with smoking and the adaptation involved in this occupational change. To ensure successful

cessation during this occupational transition, these intricacies need to be better understood.

Occupational Loss

Occupational loss is a dimension of occupational transition that occurs when an individual can no longer participate in the occupations and routines that make up the context of their life (Townsend & Polatajko, 2007). Each individual's experience of occupational loss will be unique depending on the level of importance and meaning the occupation held (Townsend, 2002). For example, some smokers may feel a sense of occupational loss if they do not participate in their daily visits to the staff smoke room, while other smokers may not. These feelings of loss can create additional challenges when trying to quit smoking. Full appreciation of the differences between the types of losses is needed in order to understand the impact on occupational performance and engagement (Townsend & Polatajko, 2007).

Many smokers underestimate the loss they may experience when quitting smoking (Schiffman, 1986). During this transition an individual may experience a loss of coping mechanisms as well as the support network of other smokers. If a non-smoker can no longer engage in many familiar occupations that are associated with smoking or interact with other smokers, these losses may affect identity and self-esteem, and could also contribute to emotional distress (Blair, 2000; Townsend & Polatajko, 2007). When an individual decides to quit smoking they not only have to stop the occupations associated with smoking and overcome the cravings and withdrawal, but will also be required to find a new balance of performing valued occupations as a non-smoker (Blair, 2000; Townsend & Polatajko, 2007). As demonstrated by Schiffman (1986), when an

individual quits smoking they may potentially need to build new social connections, as well as engage in new/other occupations to support their quitting.

Collins et al. (2002) have shown that individuals smoke for many different reasons in different circumstances. Despite the negative physiological consequences on health, "smokers derive many benefits from smoking and use it to fulfill various functions" (Collins et al., 2002, p. 642). Smoking has been used to help enhance performance in unfamiliar social situations, build affiliation with others, create an identity, improve cognitive states, ease social integration, increase pleasure, manage weight control, create pauses in a busy day, as well as regulate internal states such as boredom (Collins et al., 2002). All of these can be part of the experience of loss, for example, many teens smoke to "fit in" with the crowd or to be seen as "cool". Blair (2000) proposes that to understand a transition, one must understand the meaning, form and function that occupation plays in an individual's life during the transition. Alongside physiological health implications, smoking has valued meanings and functions:

> Smoking is a behavior fraught with contradictions; it fulfills important functions for the smoker, yet has serious detrimental health consequences; it is disapproved of by society at large, though it may be approved of in certain social groups and situations. (Collins et al., 2002, p. 643)

Occupational Adaptation

Occupational adaptation is described by Klinger (2005) as the changes in doing which enable a person to respond to their environment in order to maintain occupational participation. Throughout life, individuals will experience events or transitions that may challenge their ability to engage in occupations they value and hold meaningful

(Townsend & Polatajko, 2007; Vrkljan, & Polgar, 2007). Smoking cessation is one such transition. Many smoking related occupations such as gathering with friends in the smoking area, reaching for a cigarette when stressed or having a cigarette after a meal will need to be changed when quitting smoking. During the occupational transition to a non-smoker, individuals may find it difficult to give up such occupations they once participated in as a smoker. Effectively adapting to the changes in occupation "may be critical in preventing individuals from moving from a state of occupational disruption to occupational deprivation" (Vrkljan & Polgar, 2007, p. 36). The occupational therapy literature demonstrates that adaptation is essential to maximize occupational performance (Law, Cooper, Strong, Stewart, Rigby & Letts, 1996; Townsend & Polatajko, 2007; Vrkljan & Polgar, 2007; Wilcock, 2006). Wiseman and Whiteford (2009) advocate that slowly changing occupations while maintaining relationships are strategies for occupational adaptation that can help during a transition. For example, a smoker may not go to the smoking room with friends, but will socialize with them in non-smoking environments.

Occupational adaptation is a framework relevant to understanding occupational transitions (Wiseman & Whiteford, 2009). For one to effectively manage a transition requires awareness and recognition of the transition and the ability to develop behaviors and occupations to deal with the discontinuity (Blair, 2000). Wiseman and Whiteford (2009) support that an essential element of occupational adaptation in relation to transitions involves the "capacity to support continuity in terms of a sense of competence in meaningful occupations, lifelong connections and valued occupational identity" (p.108). Developing occupational competence involves moving along a continuum from

novice to mastery, dependent on factors such as ability, demands of the occupation and supports available to foster improvement (Townsend & Polatajko, 2007). Once an individual has a basic understanding of the occupation they are trying to master, repetition and trial and error are the keys to developing the skills and abilities to enhance occupational competence. Being able to construct skills needed to identify and adapt to the changes encountered when quitting smoking, such as having other meaningful occupations to engage in, instead of smoking, will assist in the transition to a non-smoker. For example, an individual may decide to go for a walk instead of having a cigarette to manage their stress. Smoking cessation interventions focus primarily on the adjustments and adaptations that need to be made once a person has decided to quit, not on the preparation and forethought for the transition (Hajek et al., 2009). Perhaps if more preparation and planning were put into the transition prior to quitting, this could aid in occupational adaptation. When smokers don't foresee the adaptations needed and plan for these during the transition to a non-smoker, it can impact their success.

Occupational Identity

Changes in one's ability to participate in meaningful occupations during a transition have the potential to impact a person's self-identity, particularly if the changes are numerous, unexpected, or involuntary (Blair, 2000; Klinger, 2005; Laliberte-Rudman, 2002; Liddle, Carlson, & Mckenna, 2004; Townsend & Polatajko, 2007; Vrkljan, & Polgar, 2007). During the transition to becoming a non-smoker, an individual's identity can be challenged because occupation is a means through which individuals express who they are to themselves and to others (Laliberte-Rudman, 2002). There is an interdependent relationship between the occupations one participates in and identity

(Banaji, 1994; Klinger, 2005; Liddle et al., 2004; Vrkljan, & Polgar, 2007). Laliberte-Rudman argues that the influence between occupation and identity is reciprocal: "On one hand occupation influences one's sense of personal and social identity, on the other hand, an individual's sense of personal identity and his or her preferences regarding social identity influences his or her occupations" (Laliberte-Rudman, 2002, p. 17).

Smoking is an important part of socializing for many smokers and provides a mutual occupation that can be the basis for a social network (Collins et al., 2002). Many social connections are formed during 'smoke breaks' at work, for example. Smoking-related occupations are often organized around social companionship, as well as a means to express one's identity and improve performance in unfamiliar social situations (Collins et al., 2002). Studies demonstrate the identity of being a smoker is positively valued, especially among young people (Baker et al., 2004; Lucas & Lloyd, 1999). As social policy becomes more restrictive to smokers, such as separate smoking areas or smoke free buildings, this serves to strengthen bonds among smokers and to build group identity (Schiffman, 1986). These individuals may regard themselves as an extension of the smoking group to which they belong (Bochner, 1994; Echebarria-Echabe, Fernandez-Guede & GonzaLez-Castro, 1994).

In a study by Collins et al. (2002), smokers reported they smoke to "protect, project and maintain identity and to facilitate socialization" (p. 649). Adjusting to changes in occupations during a transition can redefine one's sense of who they are (Vrkljan, & Polgar, 2007). When transitioning to become a non-smoker, there will be occupations an individual will no longer participate in, for example, a non-smoker may not meet in specified smoking locations to socialize with friends (Blair, 2000; Lennox,

1992). If an individual is limited in occupations this can impact how they perceive themselves, and how they manage their social identities (Vrkljan, & Polgar, 2007). Individuals need to find new ways to express themselves when occupations are disrupted due to a transition, if not, it can lead to an occupational identity crisis (Vrkljan, & Polgar, 2007). A transition may reveal the need of an individual to re-engage in familiar routines and occupations as a way to protect and postpone changes in their roles and occupations (Blair, 2000). This need to engage in familiar occupations such as accompanying friends on a "smoke break" may present a challenge to an individual trying to quit smoking.

Meaning Creation during Occupational Transitions

Townsend and Polatajko (2007) argue that, "Meaning is a significant piece of our thinking, our cognitive state, and our reality" (p. 61). The link between meaning and occupation is interwoven into who we are, what we believe, and how we portray ourselves to others through occupation (Townsend & Polatajko, 2007). Engaging in everyday occupations that are culturally and personally meaningful can create a sense of purpose (Townsend, 2002; Mee, & Sumsion, 2001; Hannam, 1997). The occupations that an individual engages in and the amount of time they spend doing a particular occupation are determined by a complex interaction of internal and external components, such as ability, social, cultural, institutional and physical factors (Townsend, 2002; Townsend & Polatajko, 2007). For example, an individual may choose to spend time volunteering because it gives meaning and purpose to their life as well as being highly regarded in their culture.

Hammell (2004) proposes that some of the most meaningful occupations may not fit into the three categories normally looked at in the occupational therapy literature, self-

care, productivity and leisure. She uses examples of being with special people, physically expressing love, or caring for one's children, parents, or pets. She notes these examples do not fit into the three traditional categories used to describe occupation, but rather are "an expression through occupation (time, energy, interest) of something much more important; of a connectedness and of a sharing of oneself" (Hammell, 2004, p. 297). "Belonging" within a group of smokers, can support both the ability to engage in occupation as well as the pleasure and meaningfulness of the occupation (Hammell, 2004, p.302). Hammell (2004) suggests that occupation may be better understood by looking at the dimensions of meaning and how they meet intrinsic needs.

Occupations are "neither inherently healthy or unhealthy" but rather engagement in occupations can be associated with both positive and negative consequences (Kiepek & Magalhaes, 2011, p. 266). Engaging in the occupation of smoking is an example that can be associated with consequences that are both positive and negative. Smoking is a known physiological health hazard, a negative consequence, yet one cannot discount the positive consequences such as interactions with friends or being part of a group that create meaning in a smoker's life (Hammell, 2004; Hannam, 1997; Townsend & Polatajko, 2007). Graham (1994) reported although smokers were aware of the negative physiological health consequences of smoking, it provided them with highly valued "down time". Kiepek and Magalhaes (2011) recommend considering the variety of ways, both positive and negative, occupation and health are interconnected.

To understand the relationship between occupational engagement, health and well-being, the meaning of occupation is an important factor to consider (Townsend & Polatajko, 2007). As mentioned, the occupation of smoking is not only associated with

negative consequences (Kiepek & Magalhaes, 2011). For example, social time with friends, a common ground in unfamiliar situations or "down time" to relax are positive consequences that create meaning, and may contribute to one's well-being and health. Hammell supports that "engagement in personally meaningful occupations contributes, not solely to perceptions of competence, capability and value, but to the quality of life itself" (2004, p.303). Thus smoking may be physiologically harmful, while nonetheless improving quality of life. Wilcock (2006) reminds us "for people to flourish, they not only need to meet the prerequisites of health, but also an apparent need for meaning, purpose and self-actualization" (p. 182). In order for an individual to maintain their occupational well-being during smoking cessation they will need to engage in a balance of meaningful occupations, as this can change how the significance and consequences of this transition are perceived (Hannam, 1997; Hammell, 2004; Wiseman & Whiteford, 2009).

The Role of Addiction in the Occupational Transition to Non-smoker

Nicotine addiction is one of many factors for consideration in the successful occupational transition from smoker to non-smoker (Baker et al., 2004; Benowitz, 2008; Cappmetto & Polosa, 2008; Choliat-Traquet, 1992; Dawson, Cargo, Stewart, Chong & Daniel, 2012). The American Society of Addiction Medicine (2013) defines addiction as:

> A primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors (p.1).

This impetus for reward, or relief, may challenge the success of one's occupational transitioning to become a non-smoker. This is reinforced in the statistics on relapse; only 3-5% of smokers will still be abstinent one year after they try to quit smoking (Caponnetto, Keller, Bruno & Polosa; 2012; Hughes et al., 2004).

Nicotine addiction has been likened to a chronic disease, where the majority of those trying to quit will need ongoing treatment, not just a one-time intervention (Batra, Patkar, Weibel, Leone, 2002; Caponnetto et al., 2012). Neurophysiological changes in the brain of a cigarette smoker and the effects of nicotine addiction, such as withdrawal symptoms and cravings, have been shown to contribute to chronic relapses, hence the multiple quit attempts seen during an occupational transition to a non-smoker (Batra et al., 2002; Benowitz, 2008; Caponnetto et al., 2012; Caponnetto & Polosa, 2008; Hajek et al., 2009; Perkins, 2001; Song et al., 2009). Benowitz (2008) suggest the most basic evidence of this addiction is that most smokers have the desire and motivation to quit smoking but are still unable to successfully become non-smokers. Recovery from addiction is best achieved through a combination of professional care, self-management and mutual support; however, similar to other chronic diseases, addiction needs to be monitored over time to decrease the frequency and intensity of relapses and to increase the length of remissions (ASAM, 2013). The cyclical nature of relapse suggests occupations that are oriented to new roles, meaningful use of time and opportunities for self-discovery will support the transition process (Helbig & Mckay, 2003).

Occupational choice and control is built on the assumption that an individual has the power to exert their own preferences, derived from likes, needs and values, to enhance occupational engagement (Townsend & Polatajko, 2007). When choice and

control are experienced, this can lead to empowerment and self-determination (Rodin & Langer, 1977, cited in Christiansen and Townsend, 2004); however, the opposite can be seen when choice and control are restricted, such as decreased independence and motivation for occupational participation (Gage & Polatajko, 1996, cited in Christiansen and Townsend, 2004). Although smokers may choose to have a cigarette, "it is important to appreciate that addiction is not solely a function of choice" and more than a behavioral disorder; it encompasses behavior, cognition, emotions and internal and external interactions with the environment (ASAM, 2012, p.1). It can be characterized by the absence of control, such as the lack of impulse control or the dysfunctional need to use the addictive substance to resolve withdrawal symptoms or a dysphoric emotional state. This preoccupation and avolitional aspect of addiction can lead to feelings of powerlessness. The absence of occupational choice and control related to nicotine addiction may have detrimental effects on one's occupational performance throughout the transition to a non-smoker.

Helbig and Mckay (2003) believe addiction is occupational in nature suggesting there is a "complex relationship between addiction and occupation" (p. 144). Occupational factors shown to be related to the cycle of addiction include occupational risk, environmental influences, the nature of occupation, flow and boredom (Helbig & Mckay, 2003). For example, how a smoker organizes their day and their use of time may revolve around securing their nicotine intake; planning ahead to ensure time is allocated to have a cigarette before work, or prior to an occupation like going to the movies (when access will be limited to cigarettes). Using occupation to understand individuals with addiction allows for an alternative perspective to maximize health and human abilities

(Helbig & Mckay, 2003). A consequence to engaging in addictive behaviors is dysfunctional occupational performance that my lead to ill health and social problems (Helbig & Mckay, 2003). Despite the vast literature on smoking cessation, no studies have explored smoking cessation specifically as an occupational transition.

Chapter 3: Methods

This study used interpretive phenomenology to gather and analyze data from seven women, who recently became non-smokers, to examine how they experienced and perceived their occupational transition from smoker to non-smoker. Through this study, I wanted to explore the transition from smoker to non-smoker, using an occupational lens, to better understand the role occupation played. This chapter will discuss and provide justification for the research design and methods used to conduct this study.

Research Design

Research question.

The goal of this study was to gain a greater understanding of the experiences and perceptions of the occupational transition for women from smoker to non-smoker. The research question explored was: *How do women cigarette smokers experience and perceive their occupational transition from smoker to non-smoker*? As noted earlier, the study was conducted with a small group of women in New Brunswick, on Canada's East coast.

Methodology.

This study is a qualitative exploration of the experiences and perceptions of seven women who self-reported they had quit smoking at least twelve months, and no longer than 24 months earlier. Data were collected through seven in-depth, face-to-face, audio-recorded interviews that lasted between 60-90 minutes each.

The methodology that guided this study was interpretative phenomenological analysis (IPA), a qualitative methodology centered in psychology that examines how people make sense of their life experiences (Smith, Flowers & Larkin, 2009). The theoretical foundation of interpretative phenomenological analysis draws from a range of ideas in philosophy, namely Phenomenology, Hermeneutics and Idiography. This approach focuses on the detailed exploration of human lived experience (Smith et al., 2009, p. 32).

Interpretative phenomenological analysis is based on the belief that human beings make sense of their own experiences; however, it also recognizes that access to the experience is dependent on what an individual tells the researcher about their experience. Hermeneutics is the theory of interpretation (Smith et al., 2009). During interpretative phenomenological analysis, the researcher engages in a double hermeneutic approach, "The researcher is making sense of the participant, who is making sense of x" (Smith et al., 2009, p. 35). The researcher then needs to interpret the experience in order to understand it. This higher-order interpretation is recognition that the researcher has an implicit role in the analytical process (Cronin-Davis, Butler, & Mayers, 2009).

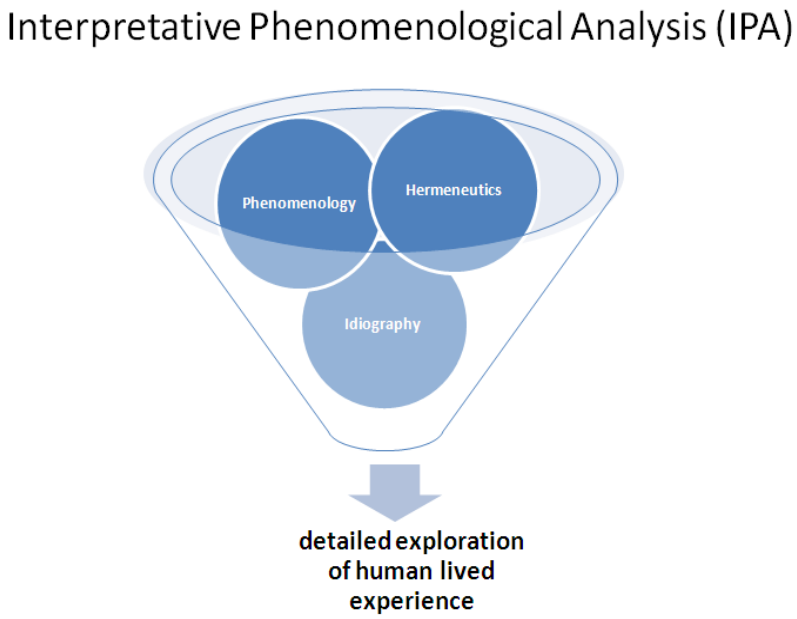
Idiography is "concerned with the particular" (Smith et al., 2009, p. 29). The idiographic aspect aims to reveal something from an individual's experience: "It wants to know in detail what the experience for *this* person is like, what sense *this* particular person is making of what is happening to them" (Smith et al., 2009, p. 3). The goal is not to generate large quantities of data but rather to gather quality information that will provide a deeper understanding of the participant's experiences as they emerge (Clarke, 2009).

I felt that conducting this study, using interpretive phenomenological analysis would ensure a detailed understanding of each women's unique lived experience of their occupational transition from smoker to non-smoker, as well as to support the researchers role in the interpretation of those experiences.

Interpretive phenomenological analysis.

The research methodology of interpretative phenomenological analysis was developed by Jonathan Smith in London, England in 1996. He preferred an approach that captured both experiential and qualitative aspects, but would still hold meaning with mainstream psychology. Since then, the use of this approach has expanded to human, health and social sciences (Clarke, 2009; Cronin-Davis et al., 2009; Dean, Smith & Payne, 2006; Seamark, Blake & Seamark, 2004). Clarke (2009) suggests interpretative phenomenological analysis is a useful methodology for occupational therapists to explore a deeper understanding of occupation and how it impacts health and well-being. Interpretative phenomenological analysis offers a person-centered framework to develop insights into unique experiences and perceptions of individuals (Clarke, 2009; Cronin-Davis et al., 2009).

Figure 1. Interpretative Phenomenological Analysis



Sample Selection and Recruitment

Sample.

The sample consisted of seven women, employed, fluent in English, aged 35 to 55, living in New Brunswick, Canada, who self-reported having quit smoking at least twelve months, but no longer than 24 months previously, and were still not smoking. Meeting the criteria of twelve months smoke-free was based solely on self-reports of the participants, if they reported being smoke-free for the minimum (and maximum) time required, they were considered for the study. I did not screen for whether the participants had smoked the occasional cigarette during that time; I accepted their self-identification as not having smoked for 12-24 months. Participants in this study were chosen through purposeful homogeneous sampling to offer insight into the experience being studied, the occupational transition from smoker to non-smoker in women. For interpretative

phenomenological analysis participants are selected on the "basis that they can grant us access to a particular perspective on the phenomena" (Smith et al., 2009, p. 49). Choosing a sample that is uniform based on obvious social and/or theoretical factors also assisted the analysis of patterns of divergence and convergence (Smith et al., 2009).

The length of time quit, twelve to 24 months, was a time frame that allowed for the participants to experience life as a non-smoker, but also short enough to allow detailed reflection on a recent transition. At least a full year of smoke-free experiences added to the richness of the data collected. The age range was chosen based on the life stages of Erik Erikson (Harder, 2009). He identified different stages of adulthood based on normal life experiences. Restricting the sample to middle adult hood, age 35 to 55, allowed for a homogeneous sample with potentially similar life experiences. Women were chosen due to the fact that there is limited literature looking at smoking cessation experiences of women, more women than men report attempting to quit, and more women than men report being in the action and maintenance stages of change according to the 2010 Canadian tobacco use monitoring survey (Health Canada, 2010). It was also based on my personal perceptions that women tend to be more open than men, in sharing their lived personal experiences, which I felt would add to the richness of the data. Keeping the group as uniform as possible based on obvious social factors, such as being employed, supported the detailed examination of variability within a homogenous group (Smith et al., 2009).

A small sample size supported the idiographic approach suggested in interpretative phenomenological analysis as well as the focus on a detailed account of individual experiences: "The issue is quality, not quantity, and given the complexity of

most human phenomena, interpretative phenomenological analysis studies usually benefit from a concentrated focus on a small number of cases" (Smith et al., 2009, p. 51). I originally sought 6-8 participants, to allow me to conduct a detailed analysis of each case, as well as a micro-analysis of similarities and differences across cases.

I realized after many of the interviews were completed, that even though each woman met the inclusion criteria, I could have focused more on the amount of cigarettes previously smoked, and/or the degree of nicotine addiction experienced, in the inclusion criteria. The small sample allowed for an idiographic approach focused on obtaining a detailed account of the individual's experiences, but having a larger sample size, consisting of both casual smokers and heavy smokers, would have allowed for additional analysis of similarities and differences. This can be considered a limitation, but due to restrictions of resources and time, this was not possible. The sample of seven women consisted of five full-time smokers (before they quit) and two casual smokers.

Recruitment.

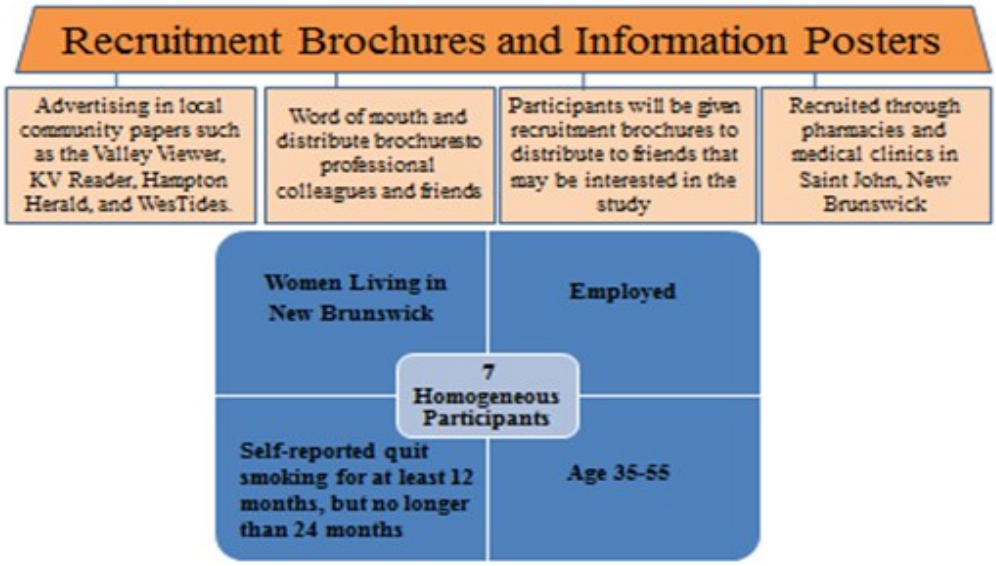
This study was approved by the Dalhousie University Health Sciences Research Ethics Board, in Halifax. Once approved, the participants were recruited through pharmacies and medical clinics in New Brunswick. The pharmacies and medical clinics used in the recruitment were locations that had an interest in smoking cessation and/or an established professional or personal relationship with the researcher. Each location was contacted by phone or in person and asked to assist with recruitment. A script was used (Appendix A) to make the request, each location was only asked once and was free to say "no". The final locations that agreed to participate consisted of five pharmacies and four doctor's offices. The recruitment materials included a brochure (Appendix B) and

information poster (Appendix C). Health care professionals at pharmacies were also asked to place a brochure in customer's bags and medical clinics were asked to distribute brochures to anyone they knew had quit smoking in the past; this was to increase awareness of the study. Although the posters were readily displayed, the distribution of brochures was random in some locations; brochures were left by the cash or on a desk for others to view, or take on their own.

All potential participants had to make contact with the researcher if they were interested in participating and met the inclusion criteria. Nine potential participants contacted the researcher via phone and e-mail. Seven met the inclusion criteria and interviews were booked with each participant. I contacted each location to stop recruitment after the sample size (seven women) had been reached and the time set for recruitment had passed. Recruiting participants by this means increased contact with potential study participants to ensure an appropriate sample size. Recruitment was also done using network sampling. Each interviewed participant was given recruitment brochures to distribute to friends and acquaintances who might be interested in the study. One participant was recruited by this method. I also used word of mouth and distributed brochures to professional colleagues and friends to increase awareness of the study and the need for participants. An additional strategy, due to the initial recruitment strategies not attracting an adequate number of participants, was advertising in local community papers such as the Valley Viewer, KV Reader, Hampton Herald, and WesTides. In all instances, information was provided to interested persons, but it was up to them to contact me.

The Participants were each offered an honorarium in the form of a pre-paid Visa card in the amount of fifty dollars to compensate for their time.

Figure 2. Sample and Recruitment



Data collection

Data collection methods that allow participants to offer a rich, detailed, first person account of their experiences is best suited for Interpretative Phenomenological Analysis (Smith et al., 2009). In-depth, in-person, interviews were used to investigate the research question: *How do women cigarette smokers experience and perceive their occupational transition from smoker to non-smoker*? Seidman (2006) suggests "at the root of in-depth interviewing is an interest in understanding the lived experience of other people and the meaning they make of that experience" (p. 9). Seven semi-structured interviews, with open-ended questions, delved deeply into the lived experience of the occupational transition from smoker to non-smoker. A semi-structured interview also allowed for modest investigator control over the interview process and provided guidance

for me, the novice researcher, to ensure key topics were addressed (Kielhofner, 2006). An in-depth, in-person, interview allowed for personal information to be revealed as well as the exploration of topics around the transition of smoking cessation. Issues of importance in the area of smoking were also more likely to be identified and described during the open ended questioning (Kielhofner, 2006).

A semi-structured interview guide (Appendix D) containing open-ended questions and associated probes was used to conduct the interviews. Merriam (2009) suggests "fewer broader questions unhooks you from the interview guide and enables you to really listen to what your participant has to share, which in turn enables you to better follow avenues of inquiry that will yield potentially rich contributions" (Merriam, 2009, p. 104). The developed probes (Appendix D) ensured the depth of information I needed was collected to address the research topic (Kielhofner, 2006).

The primary theme for the interview guide was the examination of experiences and perceptions of the occupational transition from smoker to non-smoker. This theme guided question development and the questions were built to explore and draw out different dimensions of how this occupational transition was experienced and perceived, particularly occupational loss, occupational adaptation, occupational identity and occupational meaning. The questions were developed from my clinical experience and the current literature on smoking, smoking cessation, and occupational transitions. Exploring the participants' lived experience of their occupational transition from smoker to non-smoker helped them share the significance they attributed to these experiences (Merriam, 2009)**.** The goal of the interview guide was to generate information rich data

that would help answer the question: *How do women cigarette smokers experience and perceive their occupational transition from smoker to non-smoker*?

Semi-structured interviews require a significant amount of time to collect data and to analyze. Each interview ranged from 60 – 90 minutes. Although there is value in the one on one interview to build greater trust and rapport, the interviewee still may not want to reveal personal information, which could limit the richness of data collected on the experiences and perceptions of the transition of smoking cessation (Kielhofner, 2006). I felt all of the participants openly shared their transition stories of becoming a non-smoker. Rapport was easily developed and all the women were very willing to share their experiences. All interviews were audio-recorded and then transcribed by a transcriptionist. Once the transcripts were complete, I reviewed them all, while listening to the audio-tapes for verification of data accuracy.

Each participant was e-mailed a draft summary of the initial interpretation of their story, within four months following their interview. The participants were asked to reply back to the e-mail to validate the findings and to gather feedback, and if interested were contacted by phone to review the findings. Four women replied to the e-mail, two of them were contacted by phone to discuss the findings in more detail, while the other two validated the finding over e-mail and did not feel they needed to discuss further.

Data Analysis

The analytical focus of Interpretative Phenomenological Analysis is to direct attention towards the participant attempting to make sense of their reality; however the end result is an analysis of how the researcher interprets how the participant is thinking (Smith et al., 2009). The analysis is a joint effort of both the participant and researcher.

As researcher, I made a concerted effort to build rapport and foster a supportive environment for the participant during the interview process to encourage an open exchange of information and minimize the power dynamic between researcher and participant. Open, supportive body language (e.g. smile, eye contact, nods, verbal support), a comfortable environment (e.g. bottle of water, comfortable chair), and some simple questions to start the interview helped to ease the participant into the interview process and build rapport.

The analysis of the transcribed interviews followed the steps outlined by Smith and colleagues (2009). This approach was designed to encourage reflective engagement with the participant's story. The first step of reflective engagement was to immerse myself in the data. Reading and re-reading the transcript as well as re-listening to the audio recording set the stage to ensure the participant was the focus of my analysis: "Repeated reading also allows a model of the overall interview structure to develop, and permits the analyst to gain an understanding of how narratives can bind certain sections of an interview together" (Smith et al., 2009, p. 82). The second step involved exploring semantic content and how language was used: "The analyst maintains an open mind and notes anything of interest within the transcript" (Smith et al., 2009, p. 83). This allowed familiarity to grow with the transcript as well as to identify particular ways in which the participant thought, understood and talked about a topic. The goal was to develop detailed notes and comments on the data. The third step was to develop themes that were emerging. The themes reflected both the participant's thoughts as well as my interpretation. The fourth stage was mapping how the themes fit together and connected into a superordinate theme. The fifth stage was to move to the next case and start the

process over, treating the next case on its own merits, "to do justice to its own individuality" (Smith et al., 2009, p. 100). The last step after all cases had been analyzed was to look for patterns across all the cases for similarities and differences. This process allowed me to uncover themes within each case, as well as ones that resonated throughout all the participant's stories. The electronic software that was used to assist in data storage and analysis was ATLAS.ti. This software was extremely helpful in organizing and analyzing my data. Computer assisted qualitative data analysis provides the researcher with tools to improve efficiencies in areas such as data storage, text-based searches, code book development, and tagging and retrieval of data (Kielhofner, 2006).

Trustworthiness

It is essential that data collected in a qualitative study are accurate and reflect cultural, social and lived reality; this will build trustworthiness of the data (Kielhofner, 2006). Fortunately, there are many approaches to enhance data trustworthiness. The main approaches that were used in this research study to ensure trustworthiness of the data included triangulation, reflexivity, member checking and audit trail (Johnson & Waterfield, 2004; Kielhofner, 2006; Merriam, 2009; Hammell, 2002).

Triangulation.

Extensive triangulation was not possible, since the data were gathered solely from individual interviews. Triangulation of perspectives was employed, using another researcher – in this case my thesis supervisor – to scrutinize data analysis and results. As the data were being analyzed, samples of coding, memos and superordinate themes were sent to my thesis supervisor for review and feedback. This was used to "encourage a

more reflexive analysis of the data" (Hammell, 2002, p. 178). This is also referred to as peer debriefing or peer review (Kielhofner, 2006; Hammell, 2002). The aim of peer review is to critique interpretations and expose preconceptions (Hasselkus, 1991). A limitation of peer review may be limited by the tendency of peers with similar backgrounds to corroborate as opposed to challenge assumptions as well as the unequal power relationships between researchers (Hammell, 2002). In this study, review by the research supervisor, who has a very different professional background, enhanced trustworthiness.

Reflexivity.

During qualitative research, the investigator will experience a variety of feelings, thoughts and reactions to the people and events they are examining; these will influence data collection and data analysis (Kielhofner, 2006):

> Because we cannot separate ourselves from what we know, our subjectivity is an integral part of our understanding of ourselves, of others, and of the world around us. Consequently, the researcher's values are inherent to all phases of the inquiry process. (Creswell, 1998, as cited in Angen, 2000)

In qualitative research the researcher is a data collection instrument, thus reflexivity is necessary (Kielhofner, 2006): "Reflexivity pertains to the need for a critical examination of the ways in which the researcher and the research process shaped the research relationship, data collection and data analysis" (Hammell, 2002, p. 179).

My occupational therapy background, and literature on occupational transitions and smoking cessation, shaped the way the research was conducted. Realizing I could not

disassociate myself from my experiences and training, I was cognizant of how this would influence the research, especially in terms of how I asked questions and analyzed the data. These influences made me wonder what role the occupation of smoking and related occupations had on struggles to quit smoking and how the importance or the meaning of smoking contributed to smoking relapse.

Not only was my methodology, Interpretative Phenomenological Analysis (IPA), chosen based on my professional and personal background, it also shaped how my research was constructed and interpreted. As a novice researcher I relied heavily on the writings of Smith et al. (2009), to guide how to build, execute and analyze research using the theoretical underpinnings of their approach: Phenomenology, Hermeneutics and Idiography. This did influence how my research was carried out.

In order to be aware of how my own perceptions and experiences influenced the research, I maintained a file of my personal thoughts and opinions, allocating dedicated time after each interview, as well as during the analysis to make notes. Knowing my own history would carry preconceived biases to the research process, I was conscious of actively listening and keeping an open mind during the interviews and analytic process. I wanted to see past my own perceptions to ensure I fully captured and heard the experiences shared by the participants.

Even my own personal experiences of watching loved ones battle to quit smoking swayed me to think a certain way. I knew that I had never been a smoker, but my interest stemmed from having many loved ones (i.e. father, sister, brother, sister-in-law, husband, friends) struggle with smoking cessation and relapse. I watched many of them over the years attempt to quit, and then be drawn back. Awareness of the health hazards seemed

high, but some just couldn't shake it, while others could. I acknowledged nicotine was addictive, but based on my observations I believed there was more to it. How could someone quit cold turkey, and not relapse, while others struggle with this their entire lives or quit for years and then start up again? I wanted to explore how individuals successfully navigated their way through the occupational transition from smoker to non-smoker. I wanted to listen to and learn from their stories.

I was mindful of the research relationship, given that I was not a smoker, nor had ever been one. I worried this would create barriers in building rapport and getting the participants comfortable enough to share personal aspects of their experiences, as well as influence my interpretation of their stories. Smoking friends have conveyed to me, "those people" that shake their heads, or nag them, when they go for a cigarette, do this because they have never smoked and do not understand. In many instances, smokers have been belittled by "those people" and I was concerned that I might be perceived as one of "those people". I was very aware of this concern when I recruited and conducted the interviews; the goal, I explained to the participants, was to explore this topic, not to judge, but rather to learn and understand from their experiences. To my surprise, only one women in this study even asked if I was ever a smoker, and this was at the end of the interview. Although I was very conscious of not being a smoker, nor ever being one, I was able to relate to the participants being female, age 35-55, and employed. This relationship, and the similarities/differences, did influence my interpretation of their stories. Although I was initially worried my lack of smoking would create a barrier, it did not appear to affect the researcher-participant relationship. Although all the women were very willing to share their stories of how they transitioned to become a non-smoker, I do

acknowledge my own perceptions and experiences of being an employed woman, between the age of 35-55 created assumptions in this relationship and how I gathered and interpreted the data.

Due to my lack of first hand experiences of being a smoker, I also realized this could challenge me during the interviews to pick up or understand nuances mentioned by the participants. While this did not seem to happen frequently, I did keep this in mind and sought clarity when I was unsure that I understood the true meaning intended by the participant. Although I have not personally experienced smoking or quitting smoking, I have experienced trying to stop other behaviors, such as eating "unhealthy" foods. I know what I should do and I know how to do it, but I still find myself slipping back because I enjoy it. I know my affection for "unhealthy foods" is by no means the same as the addiction to nicotine and smoking, but it did give me insight into wanting to quit something and the challenges associated with accomplishing that goal. This insight did help me empathize as I listened to each woman's story of quitting smoking, as well as influenced my interpretation of the data.

Audit trail.

An integral component of Interpretative Phenomenological Analysis is to make sense of what is being expressed by the participant. This requires close interpretative engagement on the part of the researcher (Smith et al., 2009). Memoing was an essential component that provided me with an opportunity to remember, analyze, question, and make meaning about the time spent with the study participant and the data that they generated. Time was allocated after each interview to capture my own thoughts and opinions. Throughout this study, I maintained a file on data collected, explanations of

concepts that shaped the study design, procedures in data collection and analysis, personal notes, reflections, e-mails, and copies of all interview guides and notes (Kielhofner, 2006). Accurate record keeping also supported me in the reflexivity process for this study.

Member checking.

Member checking was not only done after my initial interpretations were made, but also during the interview by clarifying and paraphrasing, to ensure I was capturing the data accurately. All study participants were asked to participate in member checking, of my initial interpretations, during the consent process as well as at the end of the interview. Their contact information, during the consent process, was verified to confirm where to send the draft of my initial interpretations as well as the final copy of my research. Feedback on emerging findings and on the researcher's interpretation of each interview was collected from the participants both via e-mail as well as over the phone. Each participant was e-mailed a summary of my interpretation of their story and requested to set up time to discuss. Two participants e-mailed back stating they had reviewed my interpretations and felt I accurately captured their stories. Two other participants were willing to set up follow up phone calls to discuss the summaries in more detail. The other three participants did not reply to the e-mail. These forms of member checking allowed me to validate my interpretations and assumptions of the data. This was also in keeping with the idiographic nature of interpretative phenomenological analysis. Member checking improved the trustworthiness of each individual's data as well as themes, such as similarities and differences that emerge within the group being studied. Of the participants that gave feedback, no one expressed disagreement with my

initial interpretations of their stories. One participant even stated, “you captured it bang on”.

Ethical Considerations

Confidentiality.

All data collected from the participant was treated in a confidential manner. Each study participant was assigned a pseudonym that was associated with their name and contact information. The interview transcripts only used these pseudonyms to identify the participant to protect their confidentiality. The file linking pseudonyms with participants’ real information was stored in a locked file, separate from the actual data. Interview notes, diaries, and audio files were password protected and stored on an encrypted USB drive, stored in a separate locked file in the researcher’s home office. All electronic information was backed up in password protected files on an encrypted USB drive and stored in locked storage. The only people who had access to this information were the researcher, thesis supervisor, and the transcriptionist. A confidentiality agreement (Appendix E) was signed by the transcriptionist and all data transcribed were returned to the researcher at the end of transcription on a password protected flash drive. No data remained in any form with the transcriptionist. The data were reported in the form of themes and stories and none of the participants were identified, names of the participants and identifying features such as workplaces were changed to protect confidentiality.

Informed Consent.

The other consideration for confidentially was the use of participants’ quotes in the final report. During the consent process and again post interview, the participants

were asked for consent to use quotes in the thesis and any subsequent publications and presentations of the study. All participants gave their consent. All data associated with this research study will be retained post completion of the thesis publication for 5 years. The data will then be discarded by shredding all paper copies and CDs, and erasing any flash drives that house data. In this study there was no risk to reputation, since the study participants were self-admitted ex-smokers when volunteering for the study.

Risks and benefits.

The Belmont report on ethical principles and guidelines for the protection of human subjects of research identifies three basic principles that apply to all research involving humans. These are respect for persons, beneficence, and justice (National Institutes of Health, n.d). All three of these were considered and maintained throughout the research process.

This research study offered an honorarium of a pre-paid fifty dollar Visa credit card. This represented a gesture of appreciation and did not represent any undue influence. The honorarium was not dependent on the usefulness of the data collected and the participant still had the option to withdraw at any time throughout the course of the study. No participant withdrew before they had been given a copy of their preliminary findings; therefore, all data were included in the final analysis.

When the participants were initially contacted they were informed that there would be no reimbursement for out of pocket expenses however, they would receive a fifty dollar pre-paid Visa card as a gesture of appreciation. Every effort was made to work around the participant's schedule to minimize costs associated with participation in this study to the participant. Free parking was available for all interview locations.

Since this study's sample was self-identified female ex-smokers ages 35 to 55, there are no anticipated concerns of increased vulnerability of the participants that need to be addressed. Informed consent was obtained prior to conducting the research using a written consent form (Appendix F). The voluntariness of participation was stressed during the review of the consent form to ensure the participant did not feel their participation was being coerced or affected by any undue influence. Based on best practice, after completion of the interview, the researcher re-confirmed the consent for the use of quotations from the participant (Dalhousie University Health Sciences Research Ethics Board, 2007). This ensured the participant had a clear understanding of what they had said during the interview and what could be used as quotes. The consent form (Appendix F) was e-mailed to the participants in advance to allow them time to consider their participation prior to the initial meeting with the researcher. It was discussed in detail at the time of the interview and a duplicate copy, was given to the participant.

Interested ex-smokers were asked to volunteer for one in-depth interview on their smoking cessation transition. This recruitment method attracted participants that were very open and willing to discuss their smoking and felt comfortable with the topic; therefore, this research study posed minimal risk to the participants. Merriam (2009) comments that most people that volunteer to be interviewed enjoy sharing their experiences, knowledge and opinions. This was the case with all participants; they appeared to delight in sharing their stories of becoming a non-smoker. The participants were also provided with a draft copy of the initial interpretation of their story in the months following the interview. They were contacted by e-mail to set up a time to discuss

their feedback of the initial interpretation. Two participants agreed to discuss the initial interpretation over the phone. Each debrief took approximately 20-30 minutes. Notes were taken, but the call was not recorded.

This study would be considered within the range of minimal risk, in that it was likely participants saw the probability and degree of possible harm "to be no greater than those encountered by the participant in his or her everyday life" (Dalhousie University Health Sciences Research Ethics Board, 2007, p.13). Strict adherence to the research design and methodology was followed to ensure risks were minimized.

The locations for conducting the interviews varied: four of the interviews were in a private meeting room at a local New Brunswick library, two were in a private office in a public building, and one was conducted in the home of a participant, at their request. All interview locations were private and provided a comfortable, quiet location for each participant. Both the library and private office, were central community settings that had minimal safety risks, and provided confidentiality to participants.

In the next chapter, I will present the findings of my analysis using themes that emerged in the data, including a brief interpretation and explanation of each. The final chapter, discussion and conclusion, will compare and contrast these current findings with the existing literature on smoking and occupational science.

Chapter 4: Findings

Twenty subthemes were identified from the data collected during the semi-structured interviews. These subthemes were unprompted concepts and stories that arose frequently and repeatedly among the seven participants as they told their lived experiences of the occupational transition from smoker to non-smoker. As the interviewer, I was conscious not to lead the participants to potential themes heard in previous interviews. In keeping with the double hermeneutic approach of the IPA methodology, suggested by Smith and colleagues (2009), these subthemes, expressed using quotes from the participants, were clustered based on similarities in concept, into five super-ordinate themes to represent both the participant's individualized account of their experiences as well as the researcher's interpretation of these experiences. Within each theme, varying dimensions of occupational loss, occupational adaptation, occupational identity and/or occupational meaning are described. The five super-ordinate themes are: *Because that's what smokers are too… drug addicts; It wasn't just one thing that I said, "ok, I'm done", there were many factors; I did the opposite of sitting around and being a smoker; That lead to my demise many times;* and *I feel like a different person.*

Excerpts from participant transcripts will be used to illustrate each subtheme and to assist in the transparency of the evidentiary base (Smith, Flowers & Larkin, 2009). Each participant will be introduced using a pseudonym to protect their confidentiality; this will also assist the reader in following the story of each individual throughout the report. Editorial exclusions by the researcher are indicated by three dots (…). Text was

only excluded when the content of the text did not add to the richness of the quote in question.

Super-ordinate Theme 1: Because That's What Smokers Are Too… Drug Addicts

The first super-ordinate theme, *because that's what smokers are too… drug addicts*, captures participant thoughts and interpretations concerning what it was like to live as a smoker. It provides a foundation to understand where these individuals were starting from as they transitioned to non-smoker. This theme about being a smoker can be understood in terms of six subthemes that address person (self-perception), occupations, and social environment. The six subthemes are: *The feeling of sharing a smoke with a buddy; I did a lot of sneaking; My day was planned around it; You're an addict; There's a lot of shame;* and *I watched my mom smoke.* These themes capture both the positive and negative aspects of what being a smoker meant to these seven women. They help to paint the picture of how the occupation of smoking created such things as meaning, structure and identity in their lives.

The feeling of sharing a smoke with a buddy.

All the women felt smoking fostered a connection with other smokers and the ability to express oneself and belong through a common occupation. Donna described this as having "*a common evil.*" She continued by saying,

> *It's like alcoholics at a bar… if you have 2 people who love to sit around and get drunk, they're not going to care if they actually have anything in common half the time, they are just happy to sit around and get drunk together, it does facilitate.*

Donna seemed to mean facilitate social connection. Others also explained how smoking created a commonality and closeness. For example, Francine said, *"seems like you're*

kinda connected with someone… it just sort of seems to kick off the night, the first cigarette." Abby and Betty both suggested smoking could provide connection with a good friend or loved one. Abby shared, *"there's the feeling of sharing a smoke with a buddy or my sister, just that commonality with that kind of bond… Let's have a smoke, let's go sit to have a smoke…it's more intimate with a good friend"*, while Betty stated, *"I think it brought mom and I closer together, we had something in common… we'd go on up for whatever and we'd just smoke, not just smoke, but I mean that was something that we did together."* Both Abby and Betty experienced the connection smoking could facilitate.

Claire, Ellen and Greta all described how for them smoking was linked to social gatherings and good times. Claire and her friends smoked together when studying: "*we were all together and it was all good."* Ellen described smoking with a group of friends as "*a social thing*": "*We'd all gather and sit there and puff and puff and puff."* Greta saw smoking as connected to most happy occasions:

> *Every happy memory I have, going to friends' weddings, going to my wedding, anniversary parties, birthday parties, annual events, all of them involved smoking… I think of those people that I love, or those events that I went to, that I had such a great time… they are connected so that's the hardest part is saying to yourself you can have a good time without smoking.*

All seven women felt smoking helped them connect and socialize with other smokers. This added to their occupational identity of being a smoker and reinforced smoking as a valued occupation that did create meaning and social identity in their lives.

I did a lot of sneaking.

At the same time, many of the women felt guilty and ashamed of their smoking. This was demonstrated by their need to sneak around and keep their smoking a secret from their children, family and/or community. Six of the seven women were not completely open about their smoking with others. Ellen was the only woman that openly smoked around family and friends; however, she still expressed feelings of guilt and shame, stating, "*I don't want to be that person.*" Abby's explanation of how she would make up excuses to sneak away for a cigarette illustrate just how far these women would go to hide their smoker identity and project a non-smoking persona.

> *I did a lot of sneaking and I had my little tricks, in the morning I'd get up and take the dog for a walk, I'd get home and I'd have a bottle of spray stuff in the garage and put it on my hands before I went back, cuz it reeks for the first few minutes. When I'd get home I would make some kind of excuse and have to go up the street and have a cigarette.*

Abby built tricks for sneaking a cigarette into her daily routines. Similarly, Betty described the constant planning she had to do to keep her smoking a secret:

> *Make sure the kids are still sleeping and go downstairs and have a cigarette out that door because I could hear them walking if they were waking up… I think when you are a closet smoker there's so many steps that you have to take to not get caught… When you think about how much effort it takes to be this secret smoker…When everybody's in the pool I go to the back of the house and have a cigarette and come out with a tray of crackers, you know… tadaaaaaa.*

Seemingly less routine than Abby, Betty invested considerable energy and forethought into when she could sneak her next smoke.

Donna, Francine and Greta explained the extra stress created in their day-to-day lives by the sneaking around to have a cigarette. Donna knew she couldn't smoke when family visited during holidays, and the anticipation of not smoking raised anxiety:

> *You're not enjoying the holiday you're stressing out before they come over because you know that you can't have a smoke, you don't want to smell for them, there's all that social anxiety about it, but then, the knowing you're going to get stressed out because you didn't have a cigarette and blah-blah-blah.*

Both hiding her smoking from others, as well as, not being able to smoke were sources of stress for Donna. Francine also described stress related to hiding her smoking from family, speaking about hearing a car pull into her yard, and **"***peeking to make sure it's not my folks on a drop in visit, me sitting down there in a cloud of smoke in the garage."* Francine was always on the lookout in fear that she may be caught smoking. Along with the stress it created, Greta particularly emphasized the impact of constant secrecy on her self-perception:

> *Hiding stuff and being sneaky all the time, it's very stressful, it's just very stressful and very degrading, being a sneaky person sucks, and I was sneaking in the morning, noon and night… around my kids, around my husband, around my parents… even my neighbors, I didn't want them to know.*

Sneaking fostered Greta's negative identity of herself as a smoker.

This theme, *I did a lot of sneaking*, captures the influence on how each woman perceived herself as a smoker; guilt and shame seemed to foster the need to sneak off and hide when smoking, and by doing so, made the women feel bad, adding to their negative perception and occupational identity as a smoker. Sneaking cigarettes and maintaining secrecy also created extra stress in their lives. These feelings seemed to aid their desire to change their behaviors and occupational identity, as well as begin/continue their occupational transition to a non-smoker.

My day was planned around it.

Quite apart from the routines of sneaking, smoking created structure in daily occupations for all the women interviewed. Betty would *"plan her day*" around smoking and Greta articulated how smoking structured every aspect of her daily life:

> *Every decision was based on that, every social activity, every timing, clothing, how I wore my hair… if I wore my hair like this, then the smoke might not get in my hair so much and if I put it up when it was damp, it would keep the smell of shampoo in my hair*.

Even everyday decisions that may appear minor were influenced by Greta's smoking.

The women also described how the structure created by smoking provided them with a measurement of time throughout the day. As Donna explained:

> *You measure your day by cigarettes. I would have* X *amount first thing in the morning, I would have one on the way to work… I had two jobs; I had to make sure I could squeeze one in between.*

Smoking structured Donna's occupations throughout her day by giving her a timeframe to plan other activities and occupations around. Francine shared a similar perspective: "*You had one at 7am, you had one at 5 o'clock, go to the gym maybe have one at 7, another one 9 and probably another one before bed… It's a lot of structure."* Francine's daily routine was organized around her smoking.

Both Donna and Francine described fitting smoking in around their other routine occupations. Claire, on the other hand, described her smoking as a way to create structure and meaning during a time in her life that she had limited opportunity to engage in other meaningful occupations:

> *I was all by myself; I never had relatives around… I had the kids; you could not leave the house and go to the gym or anything… I had a lot of limitations so it was easier to smoke than any other thing.*

Claire used smoking to occupy her time when she had limited occupational choices.

The occupation of smoking created structure and purpose in each woman's life. It was viewed as a priority and their day-to-day activities were adjusted to engage in this meaningful occupation.

You're an addict.

Smoking was not only a priority occupation, but in fact, the participants vividly described a lack of control over their smoking behaviors. They knew they should not engage in smoking for many different reasons, such as health risks and pregnancy, but were unable to exercise control over their actions when it came to smoking. Abby likened her uncontrolled behavior to heroin addiction and being possessed:

> *Just such a horrible thing to have, this demon in your life, every day, all day. Sometime you even get to the point where you wake up in the middle of the night and want a cigarette, so it was a long arduous, torturous path…my mom died of a heart attack, she was a heavy smoker as well, and that was terrible and I remember being so pissed off at myself thinking, you idiot…how can we be doing this? I didn't even quit after that… a journey of God, psycho demons in your head constantly, horrible, and long many years, I mean it's got to be likened to a heroin addiction when it's that intense and for that long…I'm not religious but being possessed by some kind of demon.*

Abby's description not only speaks to the lack of control she felt over her smoking behavior, but also to how the lack of control perpetuated her negative self-image. Greta shared a similar story of addictive behaviors stating smokers will *"move heaven and earth to get their crack."* Not feeling in control when it came to smoking, was not only expressed by Abby and Greta, but also commonly described by all the women. Ellen explained how well-known smoking risks, such as cancer, were not enough to control her

smoking behavior: *"I knew the cancer, didn't matter, didn't care… gotta light up, you can't help it, it's a bad addiction, it's unbelievable."* Claire corroborated this by saying, *"you have no control over the cigarettes",* while Donna compared the lack of control as being *"owned", "it's a horrible thing to go through, it owns you…, hook, line and sinker, it owns you."* Ellen, Claire, and Donna seemed to be controlled by their cigarettes, and their need for nicotine.

The graphic descriptions in these quotes convey the power cigarettes, and the addiction to nicotine, have on an individual's occupational choice to engage, or not engage in occupations. Every woman described a lack of control when trying to quit smoking and transition to becoming a non-smoker. Thus, while a meaningful, prioritized occupation, that brought connection and belonging, smoking was not a freely chosen occupation.

There's a lot of shame.

Addiction and lack of control were just a few of the sources for the negative self-image described by all the women. There was an element of shame and guilt associated with being a smoker, as well as shame and guilt concerning failed attempts at quitting. Betty shared the "*disappointment*" she felt in herself as a smoker: "*There's a lot of shame, very much a shame in it, because you want not to smoke, nobody wants to smoke, they really don't."* This comment conveys, not only the shame all the women felt, but how it was amplified due to the lack of control and failure felt when trying to transition to become a non-smoker.

Greta described her smoking self as "that person", distancing herself from a negative image of someone she did not want to be:

> *That person is, the person who gets their dirty look, that's looked down upon obviously, that person who's hiding in the parking lot to have a cigarette behind your car so no one will see, the person that's stinks in the elevator, the person who is pretending she's enjoying the conversation, but all she can wait to do is get to her car and have a cigarette…the person who has quit smoking because she wants to be the different person but falls into the trap when she starts smoking again and has that guilt, overwhelming guilt.*

Greta continued, noting that whereas being a smoker could bring belonging and social connection, returning to smoking after a failed attempt to quit was riddled with secrecy and isolation:

> *There's this transition period between when you quit, and then you fall off the wagon and you start but you don't want anyone to know that you've fallen off the wagon, so now you're alone. That person makes me upset, you don't want to be that hider. I would literally say to myself, you're such a loser, you're such a loser and almost every cigarette I ever had I'd say that to myself and that is a yucky message to say to yourself, so I didn't want to be that person.*

Greta's failed attempts to transition to a non-smoker seemed to add to her negative self-image and her perception that she lacked the control needed to succeed in overcoming her addiction. Her negative self-image and occupational identity as a smoker – and possibly a 'loser' and a failed quitter – worked against her as she tried to transition to become a non-smoker.

All the women shared similar perceptions of themselves as smokers, as well as when they tried, unsuccessfully, to quit. Stories of shame and negative self-images were interspersed throughout their perceptions and experiences of their transition.

I watched my mom smoke.

Despite the commonly held negative perception of themselves as smokers, five out of the seven women explained how their start to smoking was influenced by their social

environment. In particular, they described having other family members and or adult role models smoke while they were growing up, perhaps setting the stage for a modeled or learned behavior. Donna shared how, at age fourteen, she first chose a brand of cigarettes when she started smoking, "*I grew up with my mom as a smoker and I remember going in the store and ordering her brand and that's what I started out on."* Donna was not only exposed to the occupation of smoking at a young age, she also participated in the occupation by going to the store to purchase cigarettes for her mother. As an adult, Donna was already familiar with the smoker identity before she became a smoker herself.

Abby expressed curiosity concerning when her addiction to nicotine really started, describing smoking as ubiquitous when she was growing up:

> *Back then, there were ash trays all over the house, you'd get ashtrays for Christmas presents, you'd get in the car and all the windows would be rolled up and they both would be smoking and we would be laying in the back window, sometimes I wonder if the addiction didn't start then, and even maybe when they were pregnant, I know my Mom smoked when she was pregnant, they all did back then.*

Abby described a life time of being exposed to the occupation of smoking; this was a normal part of her culture and social circle that she thought helped to create the adult smoker she would become.

Betty also shared experiences of being exposed to smoking at a young age and questioned the incongruity of seeing firsthand the health impacts of smoking, but still becoming a smoker herself:

> *My aunt died at 42, she coughed, she smoked just raw tobacco and I remember that at fifteen, so you see all these people smoking, but you still continue to smoke which I find fascinating that a human being does that.*

Betty was clearly puzzled by her own motivations, given that not only smoking but the costs of smoking were part of her social landscape.

These stories of growing up in an environment where smoking was a common occupation that was culturally meaningful may have influenced the initial draw to become a smoker and the value once placed on smoking, as well as posing a challenge to successful transitioning to a non-smoker.

This superordinate theme, *Because That's What Smokers Are Too… Drug Addicts*, is about being a smoker, and smoking as an occupation, explained in the themes: *The feeling of sharing a smoke with a buddy, I did a lot of sneaking, My day was planned around it, You're an addict, There's a lot of shame, and I watched my mom smoke*. The women's stories revealed how the addiction to nicotine created a world of uncontrolled behavior that was dependent and structured on getting their next "*fix*"; daily occupations were organized to ensure access to their cigarettes. All the women found meaning from belonging and from social connections while engaging in the occupation of smoking; It was a meaningful, and prioritized occupation. At the same time, it also had negative consequences on self-image. The lack of control to stop smoking, and sense of failure when they relapsed, not only added to their negative perception of themselves as smokers, but also nurtured a cycle of secrecy and shame. Many of the women were not new to the occupation of smoking; family members and friends modeled this behavior in their childhood environment, before they became smokers, "addicts" themselves.

Super-ordinate Theme 2: It Wasn't Just One Thing That I Said, "OK, I'm Done" There Were Many Factors

The second super-ordinate theme that arose during the interviews was, *It wasn't just one thing that I said, "OK, I'm done" there were many factors.* Each participant shared individual stories of what motivated them to try to quit smoking throughout their

occupational transitions, as well as what supports they found helpful in their quit attempts. The five subthemes that are connected to this theme are: *peer pressure; being a role model; health risks; pregnancy;* and *supports*. These motivations and supports seemed to help these women adapt occupations and move along (as well as back and forth) stages of change throughout their occupational transition from smoker to non-smoker (Prochaska & DiClemente, 1983).

Peer pressure.

The participants' desire to quit, and the negative ways smoking made them feel about themselves, were influenced by "*peer pressure*" and the social stigma associated with smoking. This ranged from friends and family nagging them about their smoking, legislation limiting where they could smoke, as well as negative ad campaigns and advertisements about smoking.

Donna and Greta discussed the "*social stigma*" they felt was associated with being a smoker and how the media and advertisements added to their negative perception of themselves as smokers. Abby felt smoke-free property legislation was a positive influence that would help lessen the pressure if someone was trying to quit:

> *Want to quit smoking, go hang out in bars or restaurants, it never used to be like that… That's a really good thing… There's not that huge added pressure when you go to the restaurant…and there's smoke all over the place. That's huge, that's gotta help a lot of people.*

Betty also found this legislation helped support her quitting, *"then there was no smoking on the property, so that put a kibosh."* For Abby and Betty, simply having more and more places ban smoking on their premises meant the opportunity to smoke was curtailed.

Ellen shared stories about being nagged by her children and friends about the health risks of smoking. Referring to her employer, she said:

> *He bribed me, "oh I'll pay you, I'll do whatever" and I was like, you don't understand...I'm not stupid, but when you quit you gotta quit for you, you're not gonna quit for anyone else or you will fail…it's hard for people who don't smoke to get that, you gotta do it for you, not for Joe-blow down the street, or you will pick up another cigarette.*

Even though Ellen had the insight to know she had to quit when she was ready, the constant pressure from friends and family, did help move her towards wanting to try.

All in all, these women felt a number of societal pressures against their occupation of smoking; this added to their negative occupational identity as a smoker. Although many women did not like being badgered or shamed into trying to quit smoking, all these pressures and influences did seem to push them along the contemplation process to changing their behaviors and occupations to become non-smokers.

Being a role model.

The social pressures to quit also fostered each women's desire to be a better role model for their children and/or community; they felt smoking was not the image they wanted to represent. Ellen wanted to "*set an example*" for others, and Donna wanted to be a positive role model for her daughter, "*I don't want to be a smoker, I don't want her going down this path with this addiction, it's just too consuming."* Claire was concerned that it was the only thing her kids saw her do, *"I smoke at home, so that's the time I see my kids…so what do the kids see… only that I smoke… I do a lot of other things."* Greta was disturbed by, not only how she modeled herself to others, but also how others perceived her to be: *"How I think others may see me, makes me feel better."*

Wanting to be a better role model is influenced by how each woman perceived herself as a smoker. As presented earlier, there are many negative perceptions of self as a smoker; this affected how the women wanted others to see them, as well as how they wanted to see themselves. Donna summed it up nicely when she stated, *"When you get the negative feedback from non-smokers… all I would see is how I really viewed myself reflected in them."* Even though all of the women quit more than once, this aspiration to be a role model, to be the person (non-smoker) they wanted to be, for themselves and for others, motivated them to continue trying for success in this occupational transition.

Health risks.

Being a role model may also be a challenge if engagement in occupations associated with known health risks is seen by others. All the women acknowledged smoking was a health risk and identified this as a prominent motivator for quitting smoking. Abby said she was "*terrified about her health*", Claire referred to it smoking "*poison*" and Betty stated, "*I knew what I was doing was killing myself."* This motivation alone was not sufficient to successfully quit and stay quit during numerous quit attempts. Although all the women were motivated by the risk to their health, and stated that this was a big factor in their decision to quit, the addiction to nicotine had more control over their behaviours.

Being controlled by smoking was expressed with feelings of frustration and anger by Greta. She knew the risks she was posing for her own health, but was still unable to quit smoking:

> *Everybody knows smoking causes cancer, how could you smoke, how could you possibly smoke knowing all those things? What idiot would continue to do that? Why don't you just go get a razor blade and slit your*

wrists? Why would you do that? …Addiction is crazy, it's just so crazy…I get angry, but that's part of the addiction.

Greta's sense of failure given her inability to transition to a non-smoker, while knowing the many reasons why she should not smoke, only added to her already negative occupational identity as a smoker. Donna described a similar experience, the challenge of knowing what she should do for her health, yet being unable to act on it:

When you're a smoker you can tell that person as much as you want that it's bad for your health, that it costs a lot of money, that it smells, but we all know that, the smokers, we do. And you feel really, really bad about it. That's not helping change the behavior

Thus for Donna, health risks were one motivator, but not enough to break the addiction.

Francine was a casual smoker, only smoking after work and on weekends; many of her daily occupations did not involve smoking. She was the only woman that successfully quit and transitioned to a non-smoker with as few as two attempts. Her level of addiction, as well as engaging in many daily occupations not connected with smoking, may have played a role in her successful transitioning. Although Francine was able to become a non-smoker after her second attempt, she felt similar to the other women about the health risks and the unnecessary *"badgering*" that many smokers endure:

I don't think badgering a grown adult about the health risks of smoking is a productive way to have anyone quit, anyone with their head up knows what smoking does to you"… I always used to get the one that said smoking causes impotency because I figured I don't have to worry about that, I just remember standing there saying, I don't want that pack, I don't want to look at that for a week, the nasty lungs… people know that smoking kills.

Francine, although motivated to quit because of the health risks, found ways to block out the negative reminders of what she was doing to her health by smoking.

All the women knew that smoking had health risks, but the risk to their own health did not motivate them enough, early in their occupational transition to become a non-smoker, to keep them from relapsing over and over again.

Pregnancy.

Although the risk to their own health was not substantial enough to overcome the addiction during first attempts to quit, every woman did share stories of successful, time-limited periods of stopping smoking during their pregnancies and/or while trying to get pregnant. Abby described how easy it was to quit smoking when motivated by her pregnancy:

> *When I got pregnant that was a great motivator...I was able to quit for the most part and I breast fed my son for 9 months, so I had a really good solid time that I didn't smoke…so that was a great motivator …literally when I found out I was pregnant I was looking at the pregnancy test in one hand and I had a cigarette in the hand and I flicked it out the window and that was it.*

For Abby then, it seemed risk to herself was not a strong enough motivator to quit, but potential risk to her baby was. Similarly, Ellen quit during two successive pregnancies:

> *I was successful for a few years because I got pregnant… I got pregnant and then I got pregnant 9 months later, so I went 2 years without a cigarette because I didn't smoke when I was pregnant with my children, and I think that's a big thing… I love my children more than I love my cigarettes…I'd never harm them in any way, so that was a big motivation for me.*

Ellen's acknowledgement of what smoking could do to her children seemed to resonate deeply and support her to quit; however, this did not prevent her from starting to smoke again after her pregnancies were over.

For a limited time, every woman was able to transition to being a non-smoker, when motivated by pregnancy and the potential health risks they would inflict on their

child. The social stigma of not just smoking, but smoking while pregnant, may have also enhanced their motivation to quit smoking. This discrepancy, between inflicting health risks only on themselves, versus on another person, and the potential stigma associated with this, seemed to give the women enough strength and desire to overcome their addiction and give up the occupation of smoking for a period of time.

Supports.

Not only did the women share many motivations concerning their transition, they also found multiple forms of support to help them quit, ranging from medication, friends and family support, to hypnosis, and seeing others quit. Abby felt her biggest support was having her husband transition to non-smoker along with her, *"It was so easy this time… because my husband quit with me."* She also found inspiration from other "*hard core smokers*" that successfully quit. Donna also reached out to others that had successfully quit, "*You do get a sense of support from friends who have successfully quit."*

Betty, Ellen and Greta all felt medications were a big help in their successful transition to a non-smoker. Betty used a nicotine skin patch and found it "*helped a lot because the nicotine is in your system",* while Ellen used nicotine gum stating that *"it took that edginess away.*" Greta felt Champix (an oral medication indicated to treat nicotine addiction) was "*a game changer, in this world of quitting."* Although not all the women used medications, the ones that did, used other supports in conjunction with medication to assist them with their quit attempts.

All the women found using a variety of supports assisted them through their transition process; no single support was used exclusively. Ellen found the smokers help line, a free phone/internet based smoking cessation support service, provided her with a

lot of support as she tried to create a new occupational identity as a non-smoker, "*When I felt weepy… cuz you do, you get moody, I called the smokers help line, I'd just sit there and cry… and they're ok, let's just talk and we did."* Betty found hypnosis helpful, *"I went in for hypnosis with the girls from work and I was like, wow this is amazing."* Claire found *"prayers helped."*

Although many different types of supports were used to help their transition from smoker to non-smoker, every woman felt these helped the occupational adaptation process throughout their journey to becoming a non-smoker. This super-ordinate theme *"It wasn't just one thing that I said, "OK, I'm done" there were many factors"* concerns the motivations and supports that aided the women's occupational transition from smoker to non-smoker. It is illuminated in the themes: *peer pressure, being a role model, health risks, pregnancy and supports*. The women in this study shared many motivations and supports that helped them not only to progress throughout their occupational transition to a non-smoker, but also to get back on the path of trying to quit after relapse. As the women shared their stories, there was not one clear motivator or support that tipped the scales, it appeared to be a combination of many things that created the right environment for their own occupational transition. The social stigma and anti-smoking legislation challenged their self-worth and occupational identity, while at the same time motivating them to want to be non-smokers, for themselves and as role models for others. Although the risks to their health were openly acknowledged, this did not appear to hold significant weight until it had the potential to impact another, as was seen with quitting during pregnancy. Both the various supports used, and the individual motivators to quit were

instrumental in helping the occupational adaptation and the occupational transition to become non-smokers.

Super-ordinate Theme 3: That Lead to my Demise Many Times

The third super-ordinate theme that emerged was: *That lead to my demise many times.* All the participants experienced and perceived barriers to their occupational transition from smoker to non-smoker; many of these barriers had contributed to relapse in previous quit attempts. The three subthemes connected to this theme are *loss; triggers;* and *weight gain.* Occupational adaptation and occupational identity were impacted by the challenges experienced, as well as a sense of occupational loss.

Loss.

One barrier all participants shared was a sense of occupational loss when they quit smoking. Many had used smoking as a way to cope with stress, while others used smoking as an opportunity to have "me" time or as an incentive/reward during their daily occupations. Some of the women felt "isolated" from the group they felt smoking had helped them belong to; they feared the loss of social connections and fun they associated with their smoking occupation.

Claire had used cigarettes to help with concentration and to stay "*sharp.*" She described smoking as "*an easy way to cope.*" Donna also shared a similar sentiment, stating, "*I've had to learn how to manage stress because you don't know how to manage stress when you're a smoker because you manage it through smoking."* When the smoking was gone, so was Donna's mode of stress-management. Francine missed her excuse of needing a cigarette for removing herself from stressful situations, *"It was more*

about removing yourself from the situation and going somewhere to regroup." There was a sense from the women's narratives that the temporary break provided by stopping whatever they were doing to have a smoke was a significant occupational loss when they quit. As non-smokers, all these women needed to find new ways to adapt in stressful situations without relying on cigarettes, as well as build new beliefs in their skills, discovering what they could still accomplish without smoking. Notably, the removal of a mechanism to cope with stress – smoking – was simultaneous with the introduction of an extreme stressor – quitting smoking.

Many of the women shared stories of losing their "me" time when they became non-smokers. Donna explained this by saying*, "You don't give yourself the space that you need once you've stopped smoking, you don't realize that you can just get up and go for a break, it doesn't have to be a smoke break."* Ellen also expressed the feeling that she had lost time for herself, *"It was my five minutes of peace… it was my five minutes of, no mommy, no nothing, I'm just Ellen out there freezing and smoking."* Francine missed it because it was her *"way to unwind."* Betty likened this loss to losing your best friend:

> *You lose your best friend, because it was always there for you, you can't say that about a good friend, "I'm always there for you", no they're not, they're either working or busy, but the package of cigarettes are there, and it doesn't matter three in the morning, you can't sleep, it's there.*

Betty depended on her cigarettes to always be there for her when she needed a friend. All these women had to adapt their occupations and look for new opportunities to incorporate "me" time when they transitioned to being a non-smoker.

Many of the women had used smoking as an incentive to accomplish daily activities. Donna would use it as *a "reward system*" for cleaning. Betty did the same: *"You would reward yourself, if I get that done… or if I get this done, or get the baby put*

down, then I can sit outside and I can have a cigarette." New incentives and reward patterns had to be developed when engaging in day-to-day activities as a non-smoker.

The loss of social connections was also a concern identified by the women. Ellen shared that she felt, *"a little isolated, a little abandoned…and a little betrayed"* by her group of smoking friends. Greta worried that she would never have as much fun as she once did as a smoker:

> *You know that that's wrong…your brain tells you that that's silly and that's stupid and that's not real and that's not accurate, but it feels that way. It feels like I'm never gonna have a really ass kickin' great time again.*

Greta struggled with the potential loss of her social networks and her connection to a fun time.

These women had to replace some of the social activities they once engaged in when they were smokers, with new and/or different occupations that were not connected with smoking to form different experiences and social connections in their new occupational identities as non-smokers.

Triggers.

The avoidance of certain occupations which contributed to the women's feelings of loss, was based on the fact that those same occupations triggered their smoking behaviors. All the participants described environmental cues and activities in their lives that were strongly linked to smoking. Many times, these were the triggers or situations that had previously caused relapse. The triggers could be people, occupations, situations, places, consumables or others things they associated with smoking. Abby described relapsing when she did not alter social patterns after quitting, convincing herself she would be okay:

> *That lead to my demise many times in terms of falling back off the wagon because I convinced myself that I could do that as well, but I had no control and sometime it would just start with just a puff when it was a social situation, having a beer, having a coffee, just one puff, and I think I can do this, and then the next week I might have a whole cigarette with a beer, and eventually… sometimes it took 3, 4,-5 months, but eventually I was buying my own and back on my regular half a pack, ¾ a pack, maybe a full pack.*

Abby eventually gained insight into her triggers, this helped her to manage relapse during her transition.

Donna spoke about identifying "triggers" and cues in her day-to-day occupations that would be linked to her smoking identity and then avoiding them so she would not be tempted to smoke*:*

> *People just need to identify what their triggers are, when they have the smokes, so that you are armed for battle the day that you quit… If someone calls you, you're gonna want to have a cigarette, so whether you avoid a person for a day, who cares… if they're your real friend they'll understand. If fast food is a trigger for you, if you have a nice greasy meal and you really want to have a cigarette after, don't have fast food for a couple days… you really need so much knowledge when you go into a quit, you really do, I wish I could say it was (snaps fingers) like that.*

Donna acknowledged how important it was to know your triggers and plan around them.

Francine admitted her biggest trigger was alcohol, "*It just seemed to go hand in hand with having drinks."* Greta on the other hand, found the social connections the biggest trigger for her. As was reported on the previous page, Greta associated smoking with every happy event she could remember, "*So that's the hardest part is saying to yourself you can have a good time without smoking."*

Over time, the women realized many of the activities they engaged in as smokers were patterns or cues that drew them back to smoking and relapse. Not only did the women have to give up cigarettes when they quit smoking, but they also had to adapt the occupations associated with their smoker identity while trying to quit. This was a huge

occupational loss, not just of the occupation of smoking – a highly prioritized occupation – but also of any associated and therefore risky occupations.

Weight gain.

Although there were many smoking triggers women could avoid, weight gain was not one avoidable. A pervasive barrier to the occupational transition to nonsmoker was the fact that when they quit smoking, all of the women gained weight. They uniformly felt dismayed and discouraged by this weight gain. Claire shared how her weight gain, after she quit smoking, challenged her will and occupational identity, *"Putting on that much weight, that's a problem…you see yourself differently, I was just tiny, and all my clothes a size six, you see yourself differently, you have to have a very strong will."* As Claire notes, she exchanged one negative and stigmatized self-image (as smoker) for another (overweight). Betty also experienced similar feelings about herself when she gained weight after she quit smoking:

> *I've never been more unhappier with myself, my looks, I don't know if it's vanity, but I loathe myself right now and it's terrible, but I know on the flip side I'm not smoking, so I'm proud, so it's really weird, I really hate my body, I really hate being size sixteen, I want to be size ten again*.

The dichotomy of feelings Betty experienced created both a positive and negative self-image, on one hand she was proud of herself for quitting smoking, but on the other, her weight gain perpetuated a negative self-image.

The significance of the weight gain did not outweigh the success women felt for having quit smoking. It did however, change their perception of themselves and create an additional hurdle to overcome during their occupational transition.

The third super-ordinate theme, *That lead to my demise many times*, concerns the barriers women faced during their occupational transition from smoker to non-smoker. It is captured in the three themes of *loss, triggers, and weight gain*. Overall, the women encountered many barriers that created challenges in their occupational transitioning. Occupational loss was a significant obstacle to successful transitioning. This was experienced when knowingly giving up or adapting an occupation that triggered smoking behavior, or when it was linked directly to smoking itself, such smoking as a mechanism for coping and concentration. The women needed to adapt to these losses and learn new skills and build occupational competencies to support their non-smoking identity. Weight gain was also a barrier that challenged how the women viewed themselves and their non-smoking identity, shedding one occupational identity stigmatized for health reasons for another identity equally stigmatized.

Super-ordinate Theme 4: I Did the Opposite of Sitting Around and Being a Smoker

The fourth super-ordinate theme that emerged was**:** *I did the opposite of sitting around and being a smoker.* This theme encompasses three subthemes: *I'm doing things I've never done before; the more you quit, the easier it gets;* and *I replaced patterned behavior with healthier behavior.* The participants described how they experienced a change in doing and adapted their occupations to help them respond to their transition, as well as maintain occupational participation in activities that created meaning and purpose in their lives. Many of the women described a lifetime of quitting, further illustrating the cyclical nature of this type of occupational transition.

I'm doing things I've never done before.

All the women reported changes in their day-to-day occupations to accommodate their smoke free lifestyle. Donna talked about how she engaged in different occupations that were the *"complete opposite"* of smoking:

> *I loved just sitting and getting lost in thought with cigarettes…but I replaced it with a P90X exercise program, where you're up every day doing 2 hours of exercise… I really needed that complete opposite experience…to be completely out of the mind set of being smoker to being in the mind set of, I'm a really healthy person who doesn't smoke.*

Changing her mindset, hence occupations she engaged in, helped Donna become the non-smoker she wanted to be. Ellen also shared how she changed her occupations to help change her occupational identity as a smoker*, "I changed everything and that's a big thing with the quitting smoking, I couldn't just quit, I had to quit a lot of things and I had to change my whole attitude about it."* Greta described how she *"replaced the behaviors with different things"* and tried to *"create a new reality*" as a non-smoker: "*You kinda have to re-invent yourself, so I'm doing things that I never did before, I'm gardening for the first time in my life, my husband is not allowed to mow the lawn anymore, it's mine."* Donna, Ellen and Greta all adapted their occupations to support the reinvention of themselves as a non-smoker.

Not only was occupation used to build and adjust to a new identity as a non-smoker, it also fostered the transition, using occupations unrelated to smoking, to build new routines in their day to day lives. Some occupations were replaced completely, while others were adapted. These changes (replacement and/or adaptations) both helped to support their successful transition, helping to avoid old trigger occupations and to create new interests and occupations as a non-smoker.

The more you quit the easier it gets.

While adapting occupations supported the reinvention of self as a non-smoker, practice in doing so also helped the women gain insights, build skills and occupational competencies into how best to maneuver this transition. Where previously smoking had been an occupation, when they were interviewed the participants described quitting as an occupation. Five of the seven women described a life time of activities surrounding attempts to quit smoking. They shared stories of multiple quit attempts, over many years, since they became a smoker.

Abby spent the majority of her adult life practicing and preparing to become a non-smoker, *"I quit 27 years ago and then I've just gone my whole life trying to quit… either trying to quit, attempting to quit, thinking about quitting",* while Betty shared that with each quit experience, the quit attempts became easier, "*I wish I could sit here and tell ya how many times I quit and started and quit and started…but you know… the more you quit, the easier it gets."* Similar to Betty, Donna found "*practice*" gave her the insights to move one step closer, after each quit attempt, towards her ultimate goal of being a non-smoker:

> *Each time I quit smoking I learned something that helped me…a great reason why the 1st attempt and the 2nd one weren't successful and the 3rd and the 4th and the 5th because there is so much to learn I mean you're-you're restructuring your whole life, you're restructuring how you do things on a day to day basis, minute to minute, your association with friends, with food, with activities, with time, everything is completely shifted and there is no way a person can learn that in one fell swoop…You're practicing quitting each time you do it, you really are, so that by the time you get to the end I knew what worked for me.*

Donna went on to say: "*You're practicing quitting each time you do it, you really are, so that by the time you get to the end I knew what worked for me."* With

much practice, and many trial runs, Donna knew what she needed to do to successfully transition to be a non-smoker.

For many of the women, quitting smoking had been a frequent, cyclically-occurring activity in their everyday life that was meaningful and valued. It allowed them to focus on their goal of being a non-smoker, as well, to learn how to adapt at a pace that was right for their own occupational transition, while gaining insights, skills and occupational competence along the way. The two women that did not experience this were both casual smokers that only smoked after work and on the weekends; they did not have the same degree of addiction or occupational associations with smoking.

I replaced patterned behavior with healthier behavior

Over the many years of quit attempts and insights gained, most of the women felt their success in quitting smoking motivated them to incorporate other healthy occupational choices. Claire tried to "*do all things related to healthy life choices*", while Greta said she "*replaced patterned behavior with healthier behavior.*" Donna described how each particular occupational identity, smoker and non-smoker, was associated for her with different occupational choices:

> *I feel like a totally different person, when I smoke, I'm more anxious, I'm not well rested, will have beers on the weekend, I'll drink crap loads of coffee, I'll eat McDonalds, I'll eat chocolate bars, I'm very black and white about it. When I smoke, I've lost self-respect so everything else might as well go to Hell too… I view it not just as quitting smoking but taking a step towards being as healthy as you can and recognize that that's not the end of the journey, that's just the beginning, start with that and then start exercising.*

To support her new occupational identity as a non-smoker, Donna was motivated to engage in other healthy occupations that supported her new life style. She noted that in

earlier quit attempts she had quit cold turkey, introducing no new occupations nor adapting previous occupations: *"I didn't replace it with any positive behaviors, I did nothing like that, I just sat around and focused on how I couldn't have a cigarette. So that wasn't going to last."* Similar to Donna, Ellen also found that her *"smoking fit into the other bad habits"* but when she quit smoking she too started to make healthier lifestyle choices, such as exercising.

Being a smoker was associated with a broader unhealthy life style, which seemed to foster engagement in other occupational choices that did not foster health, for example, poor eating habits and not exercising. Transitioning to becoming a non-smoker motivated these women to also engage in other occupations they believed enhanced their health. In turn, these new occupational engagements supported their transition to non-smokers.

The forth super-ordinate theme, *I did the opposite of sitting around and being a smoker,* concerns occupational participation and adaptation. It was illustrated in the themes: *I'm doing things I've never done before, the more you quit, the easier it gets,* and *I replaced patterned behavior with healthier behavior.* Changing and adapting occupations associated with smoking allowed the women to "*re-invent*" themselves as non-smokers and to support their new occupational identity. It also allowed them to create new routines and engage in new occupations, further supporting their occupational transition to a non-smoker, for example, engaging in health-promoting occupations that supported their new identity as a non-smoker. Quitting smoking was not a single occurrence for any of the women, it was a meaningful, ongoing and valued occupation that allowed them to gain insights, build skills and occupational competence each time they attempted to quit in their occupational transition to non-smokers.

Super-ordinate Theme 5: I Feel Like a Different Person

The fifth, super-ordinate theme that emerged is *I feel like a different person.* This theme includes three subthemes: *I'm there in the moment; all kinds of time back;* and *I feel much better about myself.* In this section I report on the ways the participants described their perceptions of themselves as non-smokers, as well as what they gained while becoming and being a non-smoker. The vivid illustrations provided by the participants paint a powerful picture of how the occupational transition from being a smoker to becoming and being a non-smoker has impacted each woman's life; from strengthening relationships, improving self-esteem and occupational identity, to having more time to engage in other meaningful and valued occupations as a non-smoker.

I'm there in the moment.

Despite the fact that participants thought smoking had helped them connect socially, at the same time all the women shared stories of being preoccupied by their smoking and feeling they did not gave their full attention to the people around them. As non-smokers, the women felt they were more in-the-moment, capable of deeper connections with others. This insight was gained once they lived as a non-smoker, after realizing the quality of interactions they missed, as smokers.

After Greta transitioned to being a non-smoker, she felt her relationship with her children was "*a lot tighter*" and she had "*more patience*": "*I'm not rushing out to go have a smoke, I'm there in the moment, I'm there, I'm listening, I'm hearing the whole conversation.*" Betty described it as *"quality time*" stating, "*I'm there for them and I'm not preoccupied… to be there and just to listen, not have to worry about going anywhere,*

just being there for them, it's huge." Donna felt she was "*much more present"* as a non-smoker. Describing her time as a smoker she said:

> *You're always giving your attention to when you're having your next cigarette, so you're not 100% there, and you can't always be 100% there, but you're not even 50% there, you're out the door and lighting up.*

Smoking created a distraction for Donna that interfered with being in that moment. Francine shared how her relationship with her mother improved after she quit smoking: *"I'm sure she must notice it without even knowing why, that I'm not rushing her out of the car or getting sharp and short with her."* Francine, when not pre-occupied by her smoking, had more patience with others.

The experiences and perceptions of being less preoccupied aided the women in the development of their non-smoker identities and provided positive experiences of connecting with others as non-smokers, supporting their occupational transitions.

All kinds of time back.

Alleviating the preoccupation with smoking not only allowed the women to be more in the moment, but also to regain time. All the women, even the casual smokers, noted that the occupation of smoking had used up a substantial amount of time on a daily basis. After the women became non-smokers, they all perceived they had more time to engage in other occupations they enjoyed and which were important to them.

Betty found she, "*had a lot more time*" even for little things like "*lying on the couch for a few minutes.*" Claire found being a non-smoker enabled her to *"go, go, go*" and "*not have to stop for a cigarette*"; she felt she was able to "*speed things up.*" Donna shared,*" it's just insane the amount of time you suddenly have on your hands, … days are much slower because you're not breaking them up into little chunks like you do when*

you're a smoker." Finally, Francine felt that she "*got all kinds of time back*" because she wasn't spending time smoking.

The time regained by each woman positively reinforced her occupational transition to being a non-smoker. Participants' new occupational identities as non-smokers not only meant not smoking cigarettes, but also meant additional time to engage in other occupations in their day-to-day lives.

I feel much better about myself.

During the interviews, there was an overwhelming sense of pride, power, and accomplishment that was expressed by all these women when they spoke of successfully quitting smoking. They felt they had overcome a huge hurdle in their lives and perceived themselves as the mirror opposite of how they described and perceived themselves as smokers. Their compelling descriptions of how they perceived themselves as non-smokers and what they gained in their new identities are captured in this section. For example, Claire described quitting simply as *"being in control."* Both Francine and Betty described a sense of accomplishment, with Betty saying, *"a sense of accomplishment, absolutely… to know that I really mean what I say and say what I mean, and staying that way."* Similarly Francine saw quitting as *"a huge accomplishment...I'm not at that mercy anymore, my day is my own…it's the quiet confidence that I hold that I did that."*

As Francine mentioned, she had improved self-confidence for having successfully quit smoking. Others, like Abby, perceived her transition as evidence of her own willpower:

> *I feel totally powerful… I don't have a whole lot of willpower. So that makes me feel even better, I feel good about myself for doing that and*

powerful…I'm in control of my own decisions, I'm the boss of me now, and that's huge.

Being "the boss of me" is an evocative image. Greta, too, spoke of having improved self-esteem, feeling successful:

The biggest thing I think I've gained by quitting is liking myself more…the longer those time lines push out, the more successful you feel and the more empowered you feel, the less of a loser you feel, absolutely.

Ellen echoed this idea of improved self-esteem, focusing on self-worth and self-image when she said, "*I'm worthy, I don't need someone else to pat my back, I'm worthy enough now, it totally changed my self-worth, my self-image. I smell better, my nails grow better… I feel good, I feel pretty."* Finally, Donna spoke of pride, self-respect and control:

I recognize now that who I am is shifting and always will be, whereas before, I was a smoker and that was it, that never shifted… I don't feel bad about my clothes smelling, I can go out with pride…but this version of me, don't mess with her, that self-respect is intact…I feel a lot more in control of things for sure.

Donna's words convey the inner strength she gained when she took back control over her smoking occupations.

The dichotomy between the perceptions of self as a smoker, *versus* the perception of self as a non-smoker, is substantial. Being a smoker, although viewed as a way to connect and belong with other smokers, was plagued with images of guilt, shame, lack of control and a pre-occupation that dictated how time was used. Being a non-smoker, on the other hand, was associated with accomplishment, pride, success, being less pre-occupied and gaining time; the complete opposite of the person they once were. This change in perception of self not only supported the women in their occupational transition to non-smokers, but also helped them to remain non-smokers. The

overwhelming sense of power these women expressed when describing their non-smoker self-image highlights the challenges and struggles they had to overcome in their occupational transition to be a non-smoker.

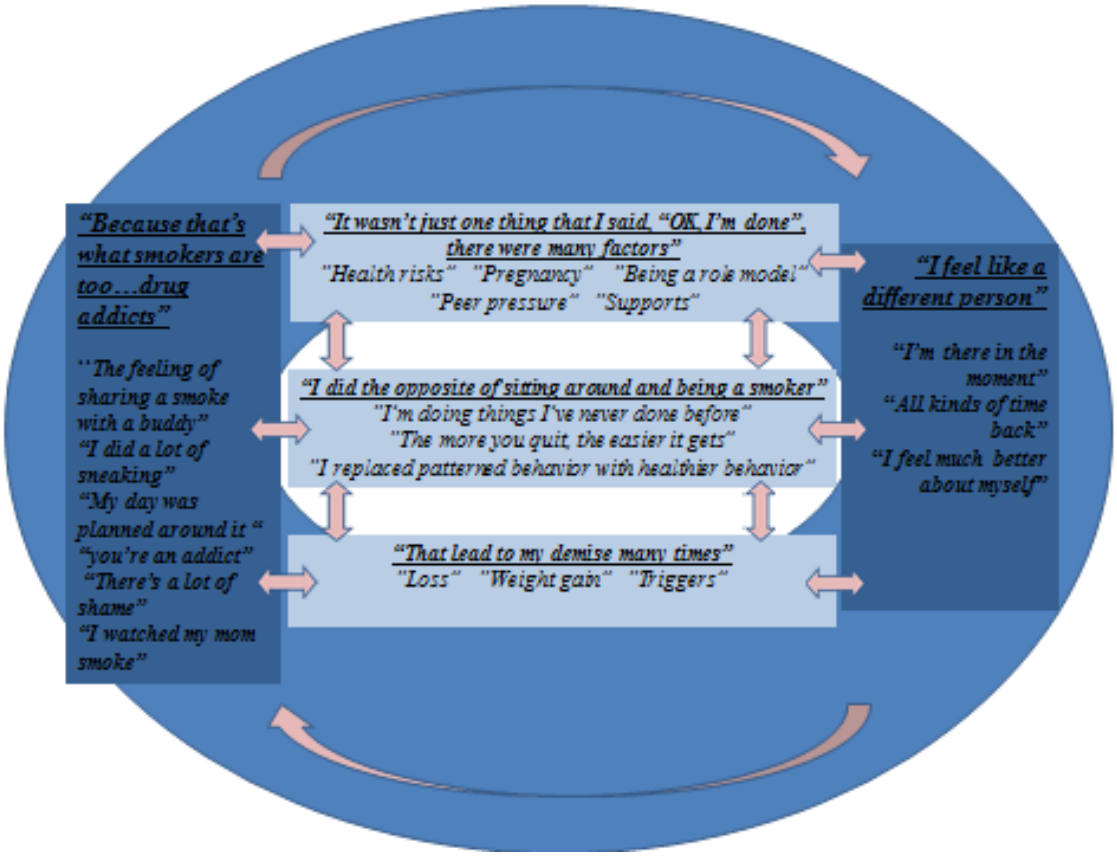
The fifth super-ordinate theme, *I feel like a different person,* concerns becoming and being a non-smoker. It is demonstrated in the themes: *I'm there in the moment, all kinds of time back* and *I feel much better about myself.* The favorable experiences and perceptions of being a non-smoker, shared by all the women, nurtured a positive occupational identity that reinforced their successful occupational transition. Engaging in different occupations to support their new identity as non-smoker provided many insights and benefits, such as stronger relationships and connections, being less pre-occupied, a sense of regaining time, and feelings of personal accomplishment. This awareness supported the women and strengthened their motivation to succeed in their smoking cessation transition.

Summary

All five super-ordinate themes as well as each sub theme are summarized in Figure 3. On the left are depicted the ways women spoke about their occupational identities as smokers and the meanings associated with engaging in the occupation of smoking. In the center, motivators and supports for transition (top), barriers to transition (bottom) and ways women changed and adapted occupations (center), represent the occupational adaptation processes, as well as the supports, barriers and occupational losses that were expressed and experienced throughout the transition process. Finally, on the right we see represented the women's descriptions of their occupational identity of becoming and being non-smokers. The multiple bidirectional arrows between themes denote the

cyclical, back and forth nature of this occupational transition to become a non-smoker. The darker color used in the perimeter symbolizes the dichotomy of the two interconnected yet opposed occupational identities of being a smoker or being a non-smoker, both located within the occupational transition process.

Figure 3.Overview of Experiences and Perceptions of the Occupational Transition from Smoker to Non-smoker



Using the perceptions and experiences of the seven women interviewed, these findings illustrate their lived experiences of the occupational transition from smoker to non-smoker. The stories shared demonstrate how occupation played a role in the formation of the women's occupational identities and meaning creation throughout their occupational transitions. The women also described how practice and building

occupational competence aided their occupational adaptation to overcome barriers and occupational losses associated with the transition from smoker to non-smoker

In the next chapter, I will discuss and examine these findings through an occupational lens using a framework of smoking as an occupation, occupational transitions and occupational identity. I will conclude with limitations as well as implications for research and clinical practice.

Chapter 5: Discussion and Conclusions

The question investigated in this research project is *how do women smokers experience and perceive their occupational transition from smoker to non-smoker?* The data and themes were examined using an occupational lens, to explore four dimensions of the occupational transition from smoker to non-smoker to provide a deeper understanding of the individual experiences and perceptions of seven women, living in New Brunswick, who have transitioned to non-smoking. Occupational loss, occupational identity, occupational adaptation and occupational meaning were used as foundational theoretical concepts to gain insight into this occupational transition process. What developed was a broader conceptual framework to discuss insights into smoking as an occupation, intricacies of the occupational transition process during smoking cessation and the meanings attached to the occupational identity of being a smoker/non-smoker.

The experiences and perceptions shared by the participants highlight the fact that their occupation of smoking was a valued and meaningful occupation that was associated with both positive and negative aspects contributing to their health and well-being. This pull between both the positive and negative did influence the occupational transition process (and relapse). The women's occupational transitions were cyclical journeys of moving back and forth in pursuit of their desired goal, to quit smoking. To successfully transition there was a need to build skills and occupational competence, not only to support occupational adaptation and engagement in meaningful occupations, but also to overcome barriers and occupational losses, throughout the occupational transition process. Although the women struggled with the dichotomy of occupational identities

(smoker/non-smoker), which challenged the occupational transition process, building competence in occupational adaptation, and engagement in meaningful occupations, not only supported the occupational transition process, but also facilitated their occupational identities as non-smokers, by allowing the women to become and express the selves they wanted to be. Not only do the findings correlate with the current literature, adding new insights into the lived experience of women's occupational transition from smoker to non-smoker, but they also challenge common perceptions of smoking and relapse.

This chapter will discuss the study findings using a framework of smoking as an occupation, occupational transitions and occupational identity. Aspects of smoking that support its classification as an occupation, such as meaning and idiosyncrasy, as well as alternative ways to think about "unhealthy" occupations will be discussed in the context of smoking as an occupation. The cyclical nature of quitting and what is needed to adapt, as well as motivations, struggles and occupational loss will be discussed in the context of occupational transitions. The dichotomy of identities, as well as the identity of being a non-smoker, will be discussed in the context of occupational identities. The chapter will conclude with a discussion of study limitations, and implications for research and clinical practice.

Smoking as an occupation

Is it an occupation?

The profession of occupational therapy has grown and changed over the years, yet one constant is the continual debate and discourse in the literature of what *occupation* entails (Hasselkus, 2006; Kielhofner, 2008; Leclair, 2012; Magnus, 2001; McLaughlin-Gray, 1997; Townsend, 2002; Wilcock, 2006). Many have argued one clear definition of

occupation is needed to advance our profession and assist us to apply, define, research and lobby (Brasic Royeen, 2002; Evans, 1987; Pierce, 2001). Although there is still no consensus on a universal definition of occupation (Watson & Fourie, 2004, cited in Leclair, 2010), numerous definitions, frameworks, and categories have been proposed (Hasselkus, 2006; Kielhofner, 2008; Leclair, 2012; Magnus, 2001; McLaughlin-Gray,1997; Townsend, 2002; Wilcock, 2006). Several definitions share the concept that occupation is experienced by an individual and is subjective, while some others proclaim occupation provide a mechanism for social interactions; organize and shape our daily lives; is the doing of work, play and self-care; is a group of activities and tasks of everyday life; is what individuals do to occupy themselves; is a tool to express identity; is goal directed and meaningful, and is a determinant of health and well-being (Hasselkus, 2006; Kielhofner, 2008; Leclair, 2012; Magnus, 2001; McLaughlin-Gray,1997; Townsend, 2002; Wilcock, 2006).

As demonstrated by the many proposed definitions for occupation, it is a concept that both guides, as well as creates challenges, for the profession. This has been eloquently described by Betty Hasselkus (2006), in her Eleanor Clarke Slagle Lecture, as our profession striving for the common denominator so we can reduce what we do to simple, understandable terms for others, as well as for ourselves. She does not condemn using frameworks and categories to help us understand occupation, but warns us that "models, by their very nature, reach for the inclusive, the common denominator, unity" (p. 629). She cautions that we may only see the commonalities and may be at risk of losing sight of the "unique contexts and individual small behaviors of everyday life" (p. 629).

The current findings demonstrate smoking was an occupation that contributed to the context and personal experiences of each woman in her day to day life. Francine shared how smoking her first cigarette kicked off her night, and Betty felt it created a tighter bond with her mother, whereas Donna loved to just sit and get "lost in thought" while she smoked. The meanings attributed to smoking strongly suggest it should be considered an occupation. If we replaced the word smoking with singing in the examples above, would the value and meaning of this occupation even be questioned? As Pierce (2001) has argued, "Although occupation can be observed, interpretation of the meaning or emotional content of an occupation by anyone other than the person experiencing it is necessarily inexact" (p. 139). Through the lived experiences shared in the findings – the personal, individualized perceptions of how the occupation of smoking created meaning – we are reminded of the idiosyncrasy of occupation and occupational meaning.

Hasselkus (2006) does a compelling job, using everyday occupations related to food, of demonstrating how occupation, defined as the lived experiences of our day to day life, builds meaning and organizes the worlds in which we live. One example she uses is a Thanksgiving meal through the eyes of a caregiver, taking care of her father with cognitive impairments. Watching her father chew and grab for food, made "Thanksgiving beautiful"; the beauty in everyday occupation rooted in a unique history, individual preferences, memories, routines…it was beyond just the act of getting food into the body. I propose that smoking, for these seven women, was far more than the act of inhaling the fumes of burning tobacco to deliver nicotine to the brain. The findings show how the lived experience of smoking created many facets of meaning in their lives

with descriptors such “commonality”, “bond”, “way to cope”, “me time”, “reward”, “fun times” and “structure”.

The findings also demonstrated how smoking structured women’s daily lives, creating a feeling of “more time on their hands” for many women after they quit. Donna explained how she would “measure” her daily occupations using cigarettes, making sure she could squeeze a cigarette in between tasks. Similar findings about time use have been discussed by Helbig and Mckay (2003), in their exploration of addiction from an occupational perspective. They highlight an individual’s needs will determine how they structure their time; with addiction, the use of time revolves around supporting the need to obtain the drug. Not only do they conclude that addiction is occupational in nature, they also propose that people recovering from addiction need to redefine the meanings attached to their use of time, as an inability to do so may trigger relapse. They advocate occupations that support cessation should support new roles, meaningful use of time and self-discovery. This is congruent with the current findings: every woman learned new meaningful ways to spend their time after they quit smoking to support the role of being a non-smoker. This was facilitated by adapting or learning new occupations to replace/create structure once held by smoking. For example, after quitting Betty found she had more time to do “the little things”; similarly, Donna replaced enjoying a cigarette with doing the PX90 exercise program.

Health and well-being.

Connected to the lack of consensus surrounding the definition of occupation lies another debate (Kiepek & Magalhaes, 2011): Are activities traditionally viewed as risky or “unhealthy” such as smoking, considered occupations? Contributing to this debate is

the common undertone or implication that occupation positively contributes to health and wellness (Townsend & Polatajko, 2007; Wilcock, 2006). How does the occupation of smoking, a known health risk, fit into the domain of concern for occupational therapists? Would an occupational therapist knowingly help a client continue to smoke if this was their desired wish? Must all occupations enhance health and well-being? Well-being in the short or long term?

The Canadian Association of Occupational Therapists, in their position statement on occupations and health, support the assumption that occupation positively affects health and well-being (CAOT, 2008). This supposition has also been discussed by others with emphasis on the positive correlations of occupation to health and well-being (Townsend, 2002; Wilcock, 2007; WFOT, 2004). This assumption of occupation leading to health has shaped our professional beliefs, but some argue there is "little evidence in the occupational therapy literature to support this belief" (Law, Steinwender, & Leclair, 1998, p. 81).

Creek and Hughes (2008) suggest one reason for this absence of evidence is the lack of consistency in terminology used to define occupation and health in the occupational therapy literature. In their literature review of occupation and health, they found "doing" does influence health, but health benefits and risks were not always "mutually exclusive" (p. 464). They demonstrated this concept using the example of physical activity: "it carries some risk of pain but also increases the chances of survival" (p. 464). This example again reinforces how individuality and subjectivity of occupation will continue to challenge assumptions about what leads to health and well-being, as this is truly in the eyes of the beholder. Townsend and Polatajko (2007) call our attention to

this point by stating, “The idiosyncrasy of occupations point to an important caveat. Not all occupations lead to health, well-being and justice or have therapeutic value, even if they hold meaning, organize time and bring structure to life” (p. 22). Although smoking is commonly viewed as an “unhealthy” behavior, the current study findings suggest that smoking was a valued and meaningful occupation with both negative and positive aspects that contributed to the health and well-being of the participants. For example, Donna shared how smoking helped her to deal with many daily life stressors, stating that she needed to learn new ways to manage her stress after she quit smoking because as a smoker, she “managed it through smoking”.

The assumption that all occupations lead to health and well-being exemplifies the “common denominator” phenomena discussed previously by Hasselkus (2006). Trying to organize occupation into frameworks or categories may cause us to overlook the unique contexts, complexities, singularities and individual small behaviors of everyday life that can lead to health. All seven women acknowledged the negative health risks of smoking, but this alone was not enough to get them to quit; there were many conflicting facets to smoking, both positive and negative, simultaneously at work. For example, the internal debate Greta had while trying to quit smoking: she wanted to lead a healthier life, but needed to convince herself she could “have a good time without smoking.” Macnaughton, Carro-Ripalda and Russell (2012), explain this contradiction by stating, “Humans are complex beings whose ideas about what makes them who they are and able to live well may not necessarily be related to what makes their bodies healthy” (p. 457).

In this vein, Kiepek and Magalhaes (2011) have explored addiction asking whether occupations are only those meaningful activities that optimize health, or can

other activities traditionally considered 'unhealthy' also be classified as occupations. They found that occupations viewed by society as unhealthy, could still have positive effects for an individual. For example, alcoholism, although associated with injury and illness, was also associated with relaxation, social interactions, enjoyment and stress relief. Similar effects were reported in the current study findings, such as Betty's description of cigarettes as her "best friend" that was "always there" for her.

Positive aspects of smoking did contribute to optimizing health and well-being; however, there were also negative aspects to smoking, beyond the obvious physiological health risks. For example, most women felt guilty and ashamed of their smoking, which perpetuated sneaking around. Many women shared their "tricks" for not getting caught and how sneaking made them feel "degraded" and "stressed". Many times these conflicting experiences worked against each other: on one hand, smoking created feelings of companionship and enjoyment, while on the other hand, feeling like "a loser" for smoking, fostered a negative self-image and additional stress. These findings corroborate the suggestion by Kiepek and Magalhaes (2011), occupations are not inherently healthy or unhealthy, but rather associated with positive and negative consequences, which are at least partially connected to the stigma or legitimacy attached to them socially. We need to challenge assumptions about smoking as an 'unhealthy' occupation and broaden our thinking to include the idea that occupations may have simultaneously positive and negative impacts on health and well-being that are unique to each individual.

Occupational transitions in smoking cessation

Practice: a cycle of quitting.

Much of the literature looking at occupational transitions have explored those that have been imposed by disability, disease, developmental and/or ageing (Gibson, Nochajski, Schefkind, & Myers, 2010; Heatwole Shank & Cutchin, 2010; Heuchemer & Josephsson, 2006; Jonsson, Josephsson & Kielhofner, 2001; Klinger, 2005; Manzi, Vignoles & Regalia, 2010; Pepin & Deutscher, 2011; Wiseman & Whiteford, 2009), but few have explored transitions that were self-imposed and easily reversible, as was seen in this study (the women chose to quit, and could start smoking again). The findings of this study reveal stories of multiple attempts at quitting smoking, as well as movement back and forth from being a smoker to being a non-smoker. It was a cyclical process of transition that could be altered at any time by lighting up a cigarette. This creates various contrasts with some of the current literature on occupational transitions and provides new insights into this concept.

Most of the women shared experiences of multiple quit attempts over the course of their smoking lives before they effectively beat the odds, as approximately only 3-5% of quitters are still abstinent one year after they quit smoking (Hughes et al., 2004). These staggering relapse statistics have been documented extensively in the literature; the majority of smokers that attempt to quit will relapse (Hajek et al., 2009; Health Canada, 2009; Lennox, 1992; Schiffman, 1986; Song et al., 2009; Stapleton, 1998). Although this is a commonly accepted statistic in the literature, it makes one wonder, how did these seven women beat the odds? (Or have they? Is this just part of their journey?) Of course,

based on the statistics in smoking relapse and addiction, their process of transition could start all over again, at any time.

As we have seen from the study findings, a woman's occupational transition to become a non-smoker was not a linear transition from one social position or identity (being a smoker), to a new social position or identity (being a non-smoker). It was a cyclical journey of moving back and forth in pursuit of their desired goal, to quit smoking. As Betty said, "the more you quit, the easier it gets", demonstrating how quitting allowed her to practice, explore and learn at a pace that was right for her. Supporting this notion of a cyclical, back and forth, around and around transition process is the work of Prochaska, DiClemente and Norcross (1992), who wrote, "relapse and recycling through the stages occur quite frequently as individuals attempt to modify or cease addictive behaviors"(p. 1104). Their self-change research showed that 85% of smokers recycled back to the contemplation or preparation stage, considering plans for their next attempt while learning from their current efforts to gain efficacy. Based on these learnings, and various studies demonstrating an average of three to five attempts before smokers become long term maintainers (Schachter, 1982; Vangarelli, 1989, citied in Prochaska et al., 1992), Prochaska and colleagues modified their original stage model, which proposed change in a linear progression, to a model of change that is depicted by a spiral pattern. Relapse appeared to be "the rule rather than the exception" (Prochaska et al., 1992, p. 1104). They suggested a linear progression of change is possible, but rare in addictive behaviors.

The spiral model of the stages of change proposes an individual can progress from pre-contemplation to contemplation, to preparation, to action, to maintenance, but most

will not do this in one attempt. During relapse individuals regress to an earlier stage, some will feel like they have failed and resist thinking about change again (pre-contemplation), while others will regress only to the contemplation or preparation stage. Their model suggests that smokers will recycle through the stages, potentially many times, but most will not return to the beginning; instead, they will learn from their mistakes to build on their next quit attempt. This was evident in the results from the current study. The women all attempted to quit multiple times, often learning through the process. As Donna commented in the previous chapter, a lot needs to be learned to restructure one's own life. Every quit attempt fostered new insights, occupational competence and skills to help move the women closer to being non-smokers.

This concept of "practice" is an important aspect to consider in the context of building occupational competence in the skills needed to transition successfully to a non-smoker. Occupational competence is defined by Townsend and Polatajko (2007) as a repeatable process that allows one to progressively develop from novice to master in sufficiency of an occupational skill to meet the demands of the environment in order to enhance occupational performance. These notions of progressive development through repetition sounds very much like the notion of practice described by the study participants. This concept was also seen in a study by Heuchemer and Josephsson (2006) while exploring the transition of leaving homelessness and addiction. They determined that critical to successful transition was active engagement in the change process, not just an internal, intellectual change, but most importantly a change accomplished by doing. Their participants, transitioning from homelessness and addiction, not only had to think about what they wanted to become, but also had to act out their new plan, explained in

the words of one participant, “You have to work at your change. You have to practice, practice and practice” (p. 166). In the current study, the women trying to quit smoking practiced each time they attempted to quit, developing ways to adapt their occupations, or engage in new ones, to build their occupational competence to support their transition. This was illustrated in Abby’s explanation of how she would “fall off the wagon”, convincing herself that she could have just one “puff” of a cigarette, but through trial and error (practice quitting), she eventually realized that this lead to her “demise”.

Successful transition to a non-smoker did not happen on the first quit attempt, or the second, or even on the sixth or seventh in some cases, but through continued practice to develop occupational competence in skills to change their behaviors, as through the use of new or adapted occupations, the women built different routines and occupational patterns into their day to day lives. This concept of practice is defined by Kielhofner (2009) as: “Consistently participat[ing] in an occupation with the intent of increasing skill, ease, and effectiveness of performance” (p. 155). This in fact, is what the women did; they were able to slowly move towards the ultimate goal (transition) of being a non-smoker by engaging in and adapting occupations that supported their goal, while at the same time, using insights and skills gained by doing, to gradually improve their occupational competence and occupational performance as a non-smoker.

This concept of practice also builds on the occupational adaptation framework proposed by Schkade and Schultz (1992): occupational adaptation is a cyclical process where a person interacts with their environment when they are faced with an occupational challenge with the goal to develop competence and mastery in occupational functioning. To adapt, an individual needs to create an occupational response, evaluate the outcome

and use feedback for subsequent use in the cycle. The final step in this process is referred to as the "adaptive response integration sub-process" (p. 835); from this point, the learnings that have taken place are integrated and/or modified accordingly. Depending on how successful the adaptation process was, these learnings will be used for the next occupational challenge.

In essence, this model describes how occupational adaptation involves practicing through trial and error (a cycle of feedback) to maximize occupational competence and functioning. As shown in the current study, women learned through multiple attempts the importance of occupational adaptation for successful occupational transition. For example, Donna had "so much to learn" in her previous quit attempts that every time she quit smoking she would learn and build new skills to support her next quit attempt: "you're practicing each time you do it". Practicing to overcome her occupational challenge of quitting gave Donna feedback to evaluate the level of mastery and competence of her occupational responses, in turn allowing her to further build and adapt her skills and occupations during her next quit attempt.

Notions of practice and adaptation have also been shown in a very different context, in a qualitative study by Wiseman and Whiteford (2009) exploring the occupational transition of retirement in men. Phased retirement strategies of gradual transitioning and maintaining connections were ways to support occupational competence in meaningful activities, while building new competencies as a retiree. Basically, they could practice the skills needed to be retired, while still engaging in familiar meaningful activities as a worker. The insights gained allowed the men to adapt accordingly to maximize their occupational performance during their transition.

Since all the women in the current study were once non-smokers, one might assume that the occupational transition of smoking cessation would simply be stopping the current occupational behaviors associated with smoking and reverting back to the "once was" as a non-smoker. Unfortunately transition is not so simplistic, as was demonstrated in the women's stories. The transition to non-smoker was a lengthy process that required many of the women to practice, learn from their mistakes, build skills, adapt and try again. This cycle of practice fostered occupational competence and supported occupational performance, allowing the women to successfully transition to non-smokers.

Similarly, when Caponnetto and Polosa (2008) explored the common predictors of smoking cessation they concluded: beyond the physical addiction to nicotine, other factors such as changes in lifestyle and behaviors, play a role in smoking cessation and relapse. They stressed "smoking cessation requires a substantial change in lifestyle and for most smokers it remains a high-effort task" (p. 1183) and positive history of previous quit attempts should be "exploited to boost motivation" (p. 1186). They asserted that if a smoker managed to quit in the past, they will be more likely to quit in a future attempt. Identifying what lead to the relapse in order to prevent it in the future was of particular importance. As previously demonstrated, this gleaning of insights from trial and error (practice), such as learning new ways to cope in a stressful situation to improve future quit success, was shown in the findings from the current study. This begs the question; if it is such a high-effort, substantial change in one's life, why then would anyone even expect for it to happen in one try? Perhaps years of transitioning from a smoker to a non-smoker, filled with relapse, adaptation, new occupations, new skills etc., are what is

needed for most people to adapt to all the changes required to accomplish full occupational competence and performance as a non-smoker?

Although there is some literature looking at relapse as an opportunity to learn from mistakes and try again, there still seems to be an undercurrent in health care suggesting that relapse is failure, or something that should be regarded as substandard or unsatisfactory. Much, if not all, smoking cessation intervention studies measure relapse rates, or lack thereof, as a measurement of success, or failure, of smoking cessation (Stead & Lancaster, 2012). Realizing that the ultimate goal is to have people quit smoking, I am not suggesting we stop measuring quit rates to determine effectiveness of interventions; however, these inherent assumptions create an air of negativity: if you are not one of the 'successful' ones who quit, then what are you? Such perceptions were passionately described by the women when they "failed to quit", they expressed feelings of shame and guilt, disappointment because "you want not to smoke". These negative feelings lead many women back to smoking full-time; instead of viewing relapse as an opportunity to try again, and evidence of the need for more practice to build occupational competence, it was viewed as failure.

Comparable findings have been shown by Prochaska et al. (1992), in their comprehensive summary of their twelve years of research on behavior change applied to addiction. Many individuals in their research program that regressed to an earlier stage of change, hence relapsed, felt like "failures – embarrassed, ashamed, and guilty" (p. 1104). They found these demoralizing effects could lead to resistance to transition, resulting in a regression back to a pre-contemplation stage of behavior change. Given these discoveries, perhaps we should think of relapse, not as failure to quit smoking, but as an

opportunity to support and continue to build occupational competencies in the skills and occupations needed to successfully transition to the role of non-smoker.

The two women who did not share similar stories of practicing their "whole life trying to quit", were both casual smokers (smoked periodically throughout the day and on weekends). Smoking did not appear to hold the same significance in their daily occupations or have the same degree of addiction as it did with the other participants. Although they were successful after only a few quit attempts, they still described similar experiences of adapting occupations and learning new skills to become non-smokers, but with less occurrences of relapse. The degree of nicotine addiction/dependence has been documented in the literature to have an impact on successful quit attempts and relapse rates (Caponnetto & Polosa, 2008). This may be one explanation for the differences described. In future studies, it would be valuable to specify number of cigarettes smoked each day in the recruitment criteria to enhance the homogeneity of the group.

Just quit already.

As shown in the current findings, varying motivations such as health risks, peer pressure, and wanting to be a "good" role model all helped the women move towards their decision to transition to a non-smoker. This being said, most women stressed the ultimate decision to quit smoking had to be made by them, when they were ready. As explained by Ellen, "You gotta quit for you, not for Joe-blow down the street", alluding to relapse as the outcome if quitting for someone else. This seems contradictory to many of the present day public health approaches used to scare and induce fear to get people to quit, such as a picture of a corpse on the side of a cigarette package. Thompson, Barnett and Pearce (2009), in their paper entitled "Scared Straight", challenge overly simplistic

understandings of risky behaviors, calling for "a raft of strategies" to promote behavior change, including community and individualized interventions (p. 193). All the women in the current study commented on their frustrations with anti-smoking campaigns, stating they contributed to their stigma and shame; however, many felt it did help to move them along the transition process. One such example was Francine's views of the unproductive badgering of "grown adults" about their smoking risks. Arguing that "anyone with their head up knows what smoking does to you", she continued by explaining how she would ask for the cigarette package that implied smoking caused impotency, so she would not have to think about personal health risks while she smoked.

This resistance to being "badgered" into quitting was also shown in a study by Crossley (2002) exploring how individuals negotiate and construct reality and identities with regard to issues of health and wellness. He proposed that health promotion strategies that highlight the dangers of certain behaviors and encourage individual responsibility for health, run the risk of triggering the very behaviors they are trying to inhibit. He demonstrated that too much emphasis on individual control may lead some subjects to assert their desire for independence and rebellion. This was similarly shown in the experiences shared by some women in this current study; being badgered made some want to smoke more. It seemed to be an expression of their own independence, emphasizing that they wanted to quit when they were ready, for their own reasons. As discussed by Macnaughton et al. (2012), this notion has puzzled the public health and medical professions, with the predominant view that smokers are rational agents and only need to be given the facts about the risks of smoking to respond appropriately. This narrow view does not take into account smoking as an occupation and the multiple

dimensions smoking can create and fulfill in a person's life. As we have seen in this study, quitting smoking was not just "butting out". All the women knew about the health risks, but this alone did not outweigh the meaningful, positive facets associated with their smoking, such as rewards and incentives during day to day activities, structure in their daily routines, coping mechanisms in stressful situations and a mechanism to form social connections.

Physiological addiction was certainly a huge barrier to quitting smoking. But other factors added to their struggles to successfully transition from smoker to non-smoker. Some issues identified in the findings include environmental and occupational cues, weight gain and a sense of loss (loss of coping, reward/incentives, and social connections). These factors have all been previously identified as playing significant roles in the success or failure of smoking cessation (Baker et al., 2004; Benowitz, 2008; Cappmetto & Polosa, 2008; Dawson et al., 2012). In a review of the smoking cessation literature, Perkins (2001) found that not only does addiction to nicotine have to be addressed, but also the many other issues that may impact relapse. She proposed there was evidence that social factors may have more influence for women than men on relapse. This cannot be corroborated from the current findings, due to the study design; however, many of the women shared their fears of losing social connections and fun, which had led to past relapses, supporting the importance of social factors on this type of transition. Perkins (2001) also proposed smoking can be associated with a multitude of cues, suggesting the need to adopt alternative occupations and occupational spaces in order to prevent relapse. This is in keeping with the current findings. Donna, for example, describing avoiding eating or drinking particular things if she felt it would lead to her

wanting a cigarette. All the women spoke about triggers and how they lead to their "demise many times"; however, they all eventually learned, through the practice of quitting and relapse, skills to identify, adapt or avoid triggers to improve their occupational competence and performance for their successful transition to a non-smoker. They learned to avoid occupations that were associated for them with smoking.

To successfully support and encourage the occupational transition of smoking cessation, it is imperative for occupational therapists, public health workers and other health professionals to acknowledge the role smoking plays in the individual's day to day life through the lived experiences of what smoking means to them. Although we can see occupation happening around us, the meaning and emotional context may be interpreted inaccurately unless they are communicated by the person experiencing the occupation (Pierce, 2001). This can aid our understanding of how the occupation of smoking, viewed by many as unhealthy, may nonetheless contribute to the well-being, meaning and occupational performance in a smoker's life.

Occupational loss and becoming a non-smoker.

During their transition, each woman adapted her occupations and changed routines to support her role as a non-smoker. Through repetition, habituated patterns of doing emerged that supported their transition; however, as explained by Kielhofner (2009), when an individual is challenged, such as in the case of giving up many familiar occupations associated with smoking, an individual can lose familiarity, ease and consistency in their life. This was demonstrated in the current findings – all the women expressed a sense of loss which added to the obstacles in their transition process. Many women used smoking as an opportunity for "me" time, or as a way to cope with stress

and “unwind”. Ellen felt she had given up her “five minutes of peace”, time to be by herself, when she quit smoking. Others used smoking to connect socially, to improve concentration or as a reward for accomplishing tasks. Betty missed using smoking as the carrot for getting things done: “If I get that done… I can have a cigarette”. These stories support the notion of occupational loss inherent in the cessation of smoking, connected to the individualized meaning smoking held for each woman.

Comparable feelings of loss have been reported in work by Seguire and Chalmers (2000), who refer to it as the “cost of quitting” in young women. They proposed their participants quit smoking and relapsed based on the meaning smoking held in their lives; smoking contributed to social relationships with others, facilitated relaxation and stress reduction, as well as contributed to pleasurable physiological effects of nicotine. Smoking cessation, then, is infused with experiences of loss.

Townsend and Polatajko (2007) suggest occupational loss is an instance, within a transition, that is imposed or unanticipated where one cannot participate in their daily routines and occupations. One such example from the current findings is the use of smoking as a means to cope and manage stress in day to day situations; something noted in other studies of smoking cessation as well (Jarvik, 1991; Seguire & Chalmers, 2000). As shown in the current findings, smoking was used as a mechanism for coping, providing women with such things as time for themselves, a “best friend” and an excuse to step away from a stressful situation. Ironically, smoking, a familiar approach used by all the women to manage stress and to cope with such things as the losses previously described, was simultaneously removed when they quit smoking, an extreme stressor in its own right. In other words, when they most needed a mechanism to cope with the stress

of other losses, the participants also lost their familiar approach to stress management. As described by Donna, she did not learn alternative ways to manage stress as a smoker; all she needed to do was light up a cigarette. As a non-smoker, Donna needed to learn new ways to manage stress without the use of cigarettes in order to fully participate in her daily routines and occupations. Through trial and error, she realized she could still go for breaks when stressed, it did not have to be a "smoke break"; removing herself from a stressful situation was one way she adapted her occupations to support her transition. Townsend and Polatajko (2007), note that if an individual cannot adapt to occupational losses it can elicit many emotions and have a negative impact on one's well-being and health. As discussed earlier, due to the reversible nature of this type of occupational transition, the inability to adapt to such losses could also lead to relapse. Notably, one should be mindful of loss when supporting an individual who has quit smoking. In particular, the means for coping with stress (such as smoking), may no longer fit the role of a non-smoker. Further exploration is suggested to gain a deeper understanding of this topic.

Occupational identity

Dichotomy of identities.

Smoking enabled the women to connect, belong and build an identity with other smokers through a common occupation. Christiansen (1999) proposes "occupation as the principle means through which people develop and express their personal identities" (p. 547). He asserts that every human has the need to express his or her distinctive identity in a way that gives life meaning. He also suggests identity is closely linked to what one does and how they interpret their actions as related to relationships with others. For the women

in this study, inside their smoker circle, smoking created meaning and self-worth, connection and structure. Outside their smoker circle, however, the smoker identity was stigmatized and negatively perceived, influenced by environment and social norms. In a study conducted by Betzner and colleagues (2012) looking at how smoke free regulations affect tobacco consumption, social norms were suggested as having a potential impact on tobacco use. Their study showed smoking was viewed as socially unacceptable, participants felt stigmatized and shameful about their smoking, but despite the negative messages, many smokers felt social norms are what helped them quit or stay quit.

The women in this study also shared similar feelings towards the social/peer pressures they encountered, considering these one of many motivations to quit. So the occupational identity attached to smoking was two-fold: positive in relation to other smokers, an identity of easy-going camaraderie, and stigmatized and shameful in relation to non-smokers and general public health messages. This contrast in how one occupation can construct both a positive and negative identity can also be demonstrated with the example of eating "junk" food. In one peer group, "junk" food may be associated with social pleasures, perhaps a "treat" to be shared with friends, but within another group, such as with a medical professional treating you for obesity and hypertension, it may be may be associated with feelings of shame or failure (Chapman & Maclean, 1993) .

As mentioned, the women described their perceptions of "being a smoker" and "being a non-smoker", as directly oppositional. Although every woman perceived positive aspects of their smoking, they also held negative perceptions about what it meant to be a smoker which challenged their occupational identity. For example, Greta referred to being a smoker as "that person", referring to a person that is "looked down upon" by

society because of their smoking occupation. Alongside the positive aspects derived, these negative perceptions created a world of sneaking and shame for most of the women. This dichotomy was also shown in the work by Abrahams (2008), using her own personal experiences during a transition from full-time employment to a stay at home mother. She felt pulled by two separate social underpinnings, one being her Muslim roots that promoted being at home to raise her child, the other being Western society where working women are expected to be ambitious in their career pursuits. She suggested people can experience an affiliation with more than one cultural/social group simultaneously; therefore, an individual can experience more than one identity through the occupations they choose. This was evident in the current findings, in which smoking was an occupation linked to many happy occasions and "connection" with other smokers creating positive meaning and identity; however, smoking was also an occupation contributing to feelings of shame and failure because of the general societal views on smoking. A challenge arises when cultural/social perceptions are in conflict with each other, such as being a smoker, or being a non-smoker. This conflict, described in the current findings, added to occupational identity struggles, complicating the occupational transition to non-smoker.

Being a non-smoker.

Meaningful occupation allowed the women in this study to become and express the self they wanted to be in their social environment. The Canadian Association of Occupational Therapists suggests "occupations are meaningful to people when they fulfill a goal or purpose that is personally or culturally important" (Townsend, 2002, p. 36). The women's own perceptions of their non-smoker selves were in terms of empowerment,

success, and control, just the opposite of how they described their self-perceptions as smokers. The women, as non-smokers felt capable and in control of their behaviors and occupations. Christiansen (1999) argues that there is a clear interplay among identity, occupations, competence and meaning. Without competent action, one cannot gain recognition from others, nor can one meet one's own "needs for meaning without engaging in occupation in a way that receives social validation" (p.553). As one experiences success, internal views of competency are strengthened; when one completes a task successfully, it adds to their sense of being competent and prepares them for a new challenge (Christiansen, 1999). This was borne out in the results of the current study in that the women, over multiple quit attempts, gained skills to build their occupational competence to support their identity as a non-smoker. These "accomplishments" felt by the women, were not only validated internally, but also through the views of society. This was shown in Greta's explanation of "liking" herself after she successfully transitioned to a non-smoker; she felt "empowered" and "less of a loser". Similarly, Magnus (2001) discussed how engagement in meaningful occupation was perceived as a key factor for women in defining a new identity after disability. The women in her study demonstrated how participation in meaningful occupations, such as leisure activities, increased their feelings of control over their lives as well as creating a positive identity that counteracted the negative meaning they held about disability.

In contrast, in the current study, as part of "reinventing" identities during their occupational transition many women engaged in occupations that were viewed, by themselves and society, as healthy and health promoting. These occupational choices were not only to replace other smoking-related occupations, but also to foster a non-

smoker identity, conveying it to themselves and others. Christiansen (1999) asserts that "occupations are key not just to being a person, but to being a particular person, and thus creating and maintaining an identity" (p. 547) This can be demonstrated in Donna's "black and white" accounts of how each particular identity, smoker and non-smoker, were linked to the occupational choices she made. As a smoker Donna's identity was associated with other bad habits, "I've lost self-respect so everything else might as well go to hell too", while as a non-smoker, she viewed her occupational transition as not just quitting but "being as healthy as you can". This was similarly shown by Van den Putte, Yzer, Willemsen and de Bruijn (2009), in their prospective survey of smokers exploring the effects of identity on attempts to quit smoking. They suggest self-defining opinions are factors in the impetus to quit; proposing behavior change is motivated by an aspired self-identity of being a non-smoker. This concept has also discussed by Markus (1986, cited by Christiansen & Townsend, 2004), suggesting the vision of "possible selves" will motivate an individual to make occupational choices to support their future life story (p. 137). With its strong connection to identity, occupational engagement in the current study helped facilitate the occupational transition and identity change to a non-smoker.

Summary

The occupation of smoking created many facets of meaning in the lives of the participants, with both positive and negative consequences to health and well-being; while also creating many motivations and barriers to the transition process. Acknowledging the lived experiences and meaning of smoking, and the occupational loss and adaptation that may occur during smoking cessation, is critical for understanding and supporting the occupational transition to a non-smoker. Successful transition to a non-

smoker did not happen quickly, it was a cyclical, repetitive process supported by continued practice to develop skills to adapt or engage in new occupations to develop occupational competence, to support a non-smoker identity and enhance occupational performance. Relapse, although viewed by some as 'failure', in fact, fostered these insights and skills, through trial and error, for successful transition. Adapting and engaging in meaningful occupation throughout their occupational transition, not only supported the process, but also fostered occupational identity by allowing the women to become and express the self they wanted to be, to themselves, and in their social environments.

Limitations

While the results may not be generalizable beyond this study, which is not the intent of qualitative research, the results of interviews with seven women, aged 35-55, living in New Brunswick, do add to a growing body of knowledge about how women manage smoking cessation transitions to become non-smokers. It also provides a different and important perspective on smoking cessation, exploring this phenomenon through an occupational lens.

One limitation to the study is the retrospective approach used to explore this transition. The insights present a lived experience in the context of having quit one to two years prior to the interviews. This study explored the experiences and perceptions of seven women after they transitioned to a non-smoker, allowing for a reflective approach to their experiences and perceptions *versus* conducting research with them during the transition or as they were approaching transition. Research adopting a prospective longitudinal perspective might further illuminate the intricacies of this transition as it

happens. Also looking beyond the timelines set in this study might also provide additional learning into the long term maintenance stage of smoking cessation, how identity changes over time, how occupations are involved over time, and how/if this impacts cessation success.

Lastly, this study explored smoking cessation transitions in self-identified female ex-smokers (quit for at least one year, no longer than two). The results may not be transferable to men, or to women who have quit for differing lengths of time. It is apparent that the degree of addiction has implications for occupations and routines associated with smoking behaviors. Conducting a study with more narrow inclusion criteria, such as particular numbers of cigarettes routinely smoked prior to quitting, may provide a deeper understanding of the lived experiences of differing levels of nicotine addiction, the occupational implications involved during the addiction stage, the role of occupational adaptation and loss during transition, and the potentially differing ways occupations are part of achieving and maintaining transition to non-smoking.

Implications for future research

The purpose of this study was to explore, through an occupational lens, the experiences and perceptions of women who transitioned from smokers to non-smokers. Although in the current findings the role and importance of engaging in meaningful occupations, building occupational competence to facilitate occupational adaptation and deal with occupational loss, and re-inventing occupational identity were demonstrated for successful transitioning, more research is needed to expand on these topics and further explore how each work in isolation and together to support an occupational transition of this type.

Many view smoking as a bad "habit", while others argue smoking is an addiction to nicotine. The participants in this study shared how smoking for them created a world of "uncontrolled" behavior that was dependent on and structured around getting their next "fix", where daily occupations were organized to ensure access to their cigarettes. This raises the question, what part of this occupational transition was adapting habits and routines *versus* the addiction itself? Exploring how habits and routines fit within this type of occupational transition is beyond the scope of this study, but additional research in this area is needed to fully understand this interesting and perplexing concept, and the relationships among addiction, habit, and meaningful occupation. The meanings of occupations that are less-than-freely-chosen warrant further scrutiny.

Future studies might also further explore 'unhealthy' or negatively perceived occupations to better understand both the positive and negative implications on health and well-being in addition to the impact of dominant beliefs and views of unhealthy or negative behaviors on client-therapist relationships. In addition, research is also needed to explore both the relationship between relapse and developing occupational competence as well as the impact of societal views of relapse on occupational identity and competency building. Finally, further exploration of the dynamics of conflicting occupational identities during an occupational transition is warranted.

Implications for Occupational Therapy

The findings of this qualitative study corroborate the complexity of smoking cessation transitions. As shown, the transition was not just a linear movement from smoker to non-smoker, but a cyclical process that had many facets where occupation played a role. Although the role of addiction has been acknowledged during this type of

occupational transition, this study showed many other factors were at play. During the smoking cessation transition, relapse provided the women with an opportunity to practice building new skills and develop occupational competence in order to adapt and engage in meaningful occupations (as well as deal with occupational loss), in order to develop an occupational identity as a non-smoker to ensure successful occupational performance. These results indicate a potential role for occupational therapists, as they are uniquely equipped to enable clients to engage in everyday living through the use of occupation (Townsend & Polatajko, 2007). As part of enabling, occupational therapists should educate individuals on the cyclical nature of relapse, viewing it as an opportunity to practice and adapt new occupations, *versus* a failure, as well as encourage reflection and coach skill development and occupational adaptation to build occupational competence in order to meet the demands of their environment during their transition.

As previously discussed, the Canadian Association of Occupational Therapists advocates occupational therapists play a role in helping people quit smoking and preventing relapse (CAOT, 2011). Ensuring all occupational therapists have a working knowledge of smoking cessation and are equipped to offer assistance to any clients trying to maneuver this occupational transition would not only provide a valuable resource to those trying to quit smoking, but also advance our profession by contributing to resolution of one of the leading health issues in our society.

Some occupational therapists may need to broaden their view of what the occupation of smoking entails. As demonstrated, an occupation typically viewed as unhealthy created meaning and structure, and contributed to the well-being of the women in this study. In order to successfully support individuals in their transition to non-

smokers, acknowledging the importance and occupational meaning smoking may hold in people's lives is critical to client-therapist interactions. Dismissing smoking as not an occupational issue will only perpetuate the staggering relapse statistics and the present challenges faced in smoking cessation and relapse. This could also have a negative effect on our ability to enable our clients to change behaviors, if we, as occupational therapists, do not fully understand both the positive and negative aspects contributing to the occupation of smoking in the occupational transition process.

Many smoking cessation programs focus on varying aspects of smoking cessation, including managing withdrawal, avoiding triggers and doing activities to distract from smoking. Perhaps programming built on a foundation of occupational participation that addresses the many dimensions of this occupational transition, such as occupational loss, occupational identity, occupational adaptation and occupational meaning, would be a novel, client-centered approach which may reduce relapse rates. Based on these findings, if building skills and occupational competence to foster occupational adaptation and engagement in meaningful occupations is what is needed to manage barriers and occupational loss for successful transitioning, programing that advances these features may further support the occupational transition process for successful transition. Enabling individuals to participate in meaningful occupations that support their transitions to non-smokers might also build their occupational identities and occupational performances as non-smokers. Engagement in meaningful occupations has been shown to provide a sense of purpose and structure, as well as provide social and self-identity (Christiansen, 1999; Townsend & Polatajko, 2007; Vrkljan & Miller Polgar, 2007).

The health implications and costs associated with smoking, as well as the struggles individuals endure when trying to transition to non-smoking, further validates the need for occupational therapy researchers to continue to explore this topic. There is very little occupational science or occupational therapy literature related to the occupation of smoking and/or the occupational transition of smoking cessation. To continue to enhance our understanding, larger studies exploring a similar topic, or other studies examining smoking cessation in men, in different cultures as well as different occupational settings, such as mental health, are needed to continue to gain new insights in this area.

When one is trying to transition to become a non-smoker, the importance of occupation cannot be overlooked. Occupational therapists recognise the importance of attending to an individual within their environment – guided by the meaning and value of occupation for the individual – to enable occupation using a holistic, client-centered approach, directed by the core domain of human occupation (Townsend, 2002). This expertise sets the profession up to play a key role in smoking cessation and relapse prevention, if we come to understand those as intricately connected with occupational meaning, occupational transition, occupational loss and adaptation, and finally, occupational identity.

References

Abrahams, T. (2008). Occupation, identity and choice: A dynamic interaction. *Journal of Occupational science*, 15(3), 186-189.

American Cancer Society. (2011). Guide to quitting smoking. Retrieved from http://www.cancer.org/Healthy/StayAwayfromTobacco/GuidetoQuittingSmoking/index.

Amos, A., Greaves, L., Nichter, M. & Loch, M. (2012). Women and tobacco: A call for including gender in tobacco control research, policy and practice. *Tobacco Control*, 21, 236-243.

ASAM: American Society of Addiction Medicine. (2013). Definition of addiction. Retrieved from http://www.asam.org/for-the-public/definition-of-addiction.

Angen, M. J. (2000). Evaluating interpretive inquiring: Reviewing the validity debate and opening the dialogue. *Qualitative Health Research*, 10(3), 378-395.

Asaba, E. & Jackson, J. (2011). Social ideologies embedded in everyday life: A narrative about disability, identities, and occupation. *Journal of Occupational Science*, 18(2), 139-152.

Atchley, R. (1989). A continuity theory of normal aging. *The Gerontologist*, 29(2), 183-190.

Baker, T., Brandon, H., & Chassin, L. (2004). Motivational influences on cigarette smoking. *Annual Review of Psychology*, 55, 463-491. DOI 10.1146/annurev.psych.55.090902.142054

Banaji, M. (1994). The self in social contexts. *Annual Review of Psychology*, 45, 297-332.

Batra, V., Patkar, A. W., Weibel, S. & Leone, F. T. (2002). Tobacco smoking as a chronic disease: Notes on prevention and treatment. *Primary Care: Clinics in Office Practice*, 29, 629-648.

Benowitz, N. L. (2008). Neurobiology of nicotine addiction: implications for smoking cessation treatment. *The American Journal of medicine*, 121(4A) S3-S10.

Betzner, A. E., Boyle, R. G., Luxenberg, M. G., Schillo, B. A., Keller, P. A., Rainey, J., Capesius, T. & Saul, J. E. (2012). Experience of smokers and recent quitters with smokefree regulations and quitting. *American Journal of Preventative medicine*, 43(5S3), S163-S170.

Blair, S.E. (2000). The centrality of occupation during life transitions. *British Journal of Occupational Therapy*, 63(5), 231-237.

Bochner, S. (1994). Cross-cultural differences in the self concept: a test of hofstede's individualism/collectivism distinction. *Journal of Cross-Cultural Psychology*, 25, 273-283. DOI: 10.1177/0022022194252007

Brasic Royeen, C. (2002). Occupation reconsidered. *Occupational Therapy International*, 9(2), 111-120.

Canadian Association of Occupational Therapists. (2011). Position statement: the role of health professionals in tobacco cessation. Retrieved from http://www.caot.ca/default.asp?pageid=245.

Canadian Association of Occupational Therapists. (2008). Position statement: Occupations and health. Retrieved from http://www.caot.ca/default.asp?pageid=2326

Caponnetto, P. & Polosa, R. (2008). Common predictors of smoking cessation in clinical practice. *Respiratory Medicine*, 102, 1182-1192.

Caponnetto, P., Keller, E., Bruno, M. C. & Polosa, R. (2012). Handling relapse in smoking cessation: Strategies and recommendations. Internal and Emergency Medicine. doi:10.1007/s11739-012-0864-z

Center for Disease Control and Prevention (2002). Cigarette smoking among adults. Unites States, 2000. *Morbidity & Mortality Weekly Report*, 51(29), 642-645.

Chapman, G. & MacLean, H. (1993). "Junk food" and "healthy food": meanings of food in adolescent women's culture. *Journal of Nutrition Education*, 25(3), 108-113.

Chollat-Traquet, C. (1992). Women and Tobacco. Retrieved from http://apps.who.int/iris/bitstream/10665/37510/1/9241561475_eng.pdf

Christiansen, C. H. (1999). The 1999 Eleanor Clarke Slagle Lecture: Defining lives: Occupation as identity: An essay on competence, coherence and the creation of meaning. *The American Journal of Occupational therapy*. 53(6), 547-558.

Christiansen, C. H. & Townsend, E. A. (2004). Introduction to occupation. Upper Saddle River, New Jersey: Prentice Hall.

Clarke, C. (2009). An introduction to interpretative phenomenological analysis: a useful approach for occupational therapy research. *British Journal of Occupational Therapy, 72(1)*, 37-39.

Clark, F., Azen, S. P., Zemke, R., Jackson, J., Carlson, M., Mandel, D…Lipson, L. (1997). Occupational therapy for independent living in older adults: a randomized controlled trial. *Journal of the American Medical Association*, 278, 1321-1326.

Collins, P., Maguire, M.& O'dell, L. (2002). Smokers' representations of their own smoking: a q-methodological study. *Journal of Health Psychology*, 7(6), 641-652. DOI 10.1177/1359105302007006868

Creek, J. & Hughes, A. (2008). Occupation and health: A review of Selected literature. *British Journal of Occupational Therapy*, 71(11), 456-468.

Cronin-Davis, J., Butler, A. & Mayers, C. A. (2009). Occupational therapy and interpretative phenomenological analysis: comparable research companions? *British Journal of Occupational Therapy, 72(8)*, 332-338.

Crossley, M. L. (2002). 'Could you please pass one of those health leaflets along?': Exploring health, morality and resistance through focus groups. *Social Science & medicine*, 55, 1471-1483.

Dalhousie University Health Sciences Research Ethics Board. (2007). Guidance for submitting an application for research ethics review. Retrieved from http://researchservices.dal.ca/research_1482.html.

Dawson, A. P., Cargo, M, Stewart, H., Chong, A. & Daniel, M. (2012). "I know it's bad for me and yet I do it": exploring the factors that perpetuate smoking in aboriginal health workers- a qualitative study. *BMC Health Services Research*, 12, 102. doi:10.1186/1472-6963-12-102

Dean, S.G., Smith, J.A. & Payne, S. (2006). Low back pain: exploring the meaning of exercise management through interpretative phenomenological analysis (IPA). Qualitative Research for Allied health Professionals: Challenging choices. Hoboken, NJ: Wiley &Sons Ltd.

Echebarria-Echabe, A., Fernandez-Guede, E, & GonzaLez-Castro, L. (1994). Social representations and intergroup conflicts: who's smoking here?. *European Journal of Social Psychology*, 24, 339-355.

Elfeddali, I., Bolman, C., Mesters, I., Wiers, R. W. & de Vries, H. (2010). Factors underlying smoking relapse prevention: results of an international Delphi study. *Health Education Research*, 25(6), 1008-1020.

Evans, K. A. (1987). Definition of occupation as the core concept of occupational therapy. *The American Journal of Occupational Therap*y, 41(10), 627-628.

Falomir, J. & Invernizzi, F. (1999). The role of social influence and smoker identity in resistance to smoking cessation. *Swiss Journal of Psychology*, 58(2), 73-84.

Gatchel, R.J., Adams, L., Polatin, P.B., & Kishino, D. (2002). Secondary loss and pain–associated disability: theoretical overview and treatment implications. *Journal of Occupational Rehabilitation*, 12(2), 99-110.

Gibson, R.W., Nochajski, S.M., Schefkind, S., & Myers, C. (2010). The role of occupational therapy in transitions throughout the lifespan. *OT Practice*, *15(11)*, 11-16.

Graham, H. (1994). Gender and class as dimensions of smoking behavior in Britain: insights from a survey of mothers. *Social Science and Medicine*, 38(5), 691-698.

Hajek, P., Stead, L.F., West, R., Jarvis, M., & Lancaster, T. (2009) Relapse prevention interventions for smoking cessation. *The Cochrane Library*, 1, 1-76. DOI: 10.1002/14651858

Hammell, K.W. (2002) Informing client-centered practice through qualitative inquiry: Evaluating the quality of qualitative research. *British Journal of Occupational Therapy*, 65(4), 175-184.

Hammell, K.W. (2004) Dimensions of meaning in the occupations of daily life. *Canadian Journal of Occupational Therapy*, 71(5), 296-305.

Hannam, D. (1997) More than a cup of tea: meaning construction in an everyday occupation. *Journal of Occupational Science*, 4(2), 69-73.

Harder.A.F. (2009). The developmental stages of Erik Erikson. Retrieved from http://www.learningplaceonline.com/stages/organize/Erikson.htm.

Hasselkus, B.R. (1991) Qualitative research: Not another orthodoxy. *Occupational Therapy Journal of Research,* 11(1), 3-7.

Hasselkus, B. R. (2006). 2006 Eleanor Clarke Slagle lecture, The world of everyday occupation: Real people, real lives. *The American Journal of Occupational Therapy,* 60(6), 627-640.

Health Canada (2009). Canadian Tobacco Use Monitoring Survey (CTUMS). Retrieved January 15, 2011, from http://www.hc-sc.gc.ca

Health Canada (2010). Canadian Tobacco Use Monitoring Survey (CTUMS). Retrieved Oct 15, 2010, from http://www.hc-sc.gc.ca.

Heatwole Shank, K. & Cutchin, M. P. (2010). Transitional occupations of older women ageing in place: negotiating change and meaning. *Journal of Occupational Science,* 17(1), 4-13.

Heikkinen, H., Patja, K. & Jallinoja, P. (2010). Smokers' accounts on the health risks of smoking: Why is smoking not dangerous for me? *Social Science and Medicine*, 71, 877-883.

Helbig, K. & McKay, E. (2003). An exploration of addictive behaviors from an occupational perspective. *Journal of Occupational Science*, 10(3), 140-145.

Heuchemer, B. & Josephsson, S. (2006). Leaving homelessness and addiction: Narratives of an occupational transition. *Scandinavian Journal of Occupational Therapy*, 13, 160-169.

Hon, C., Sun, P., Suto, M. & Forwell, S. J. (2011). Moving from china to Canada: Occupational transitions of immigrant mothers of children with special needs. *Journal of Occupational Science*, 18(3), 223-236.

Hughes, J. R., Keely, J. & Naud, S. (2004). Shape of the relapse curve and long term abstinence among untreated smokers. *Addiction*, 99, 29-38.

Jarvik, M. E. (1991). Beneficial effects of nicotine. *British Journal of Addiction*, 86, 571-575.

Johnson, R. & Waterfield, J. (2004). Making words count: The value of qualitative research. *Physiotherapy Research International*, 9(3), 121-131.

Jonsson, H., Josephsson, S. & Kielhofner, G. (2001). Narratives and experiences in an occupational transition: A longitudinal study of the retirement process. *The American Journal of Occupational Therapy,* 55(4), 424-432.

Kelly, C. (2008). Commitment to health theory. *Research and Theory for Nursing Practice: An International Journal*, 22(2), 148-160. DOI 10.1891/0889-7182.22.2.148

Kielhofner, G. (2008). Model of human occupation: Theory and application. Baltimore, MD: Lippincott Williams & Wilkins.

Kielhofner, G. (2006). Research in occupational therapy methods of inquiry for enhancing practice. Philadelphia, PA: F.A Davis Co.

Kielhofner, G. (2009). Conceptual foundations of occupational therapy practice. Philadelphia, PA: F.A. Davis Company.

Kiepek, N. & Magalhaes, L. (2011). Addictions and impulse-control disorders as occupation: A selected literature review and synthesis. *Journal of Occupational science,* 18(3), 254-276.

Klinger, L. (2005). Occupational adaptation: perspectives of people with traumatic brain injury. *Journal of Occupation Science*, 12(10), 9-16.

Laliberte-Rudman, D. (2002) Linking occupation and identity: lessons learned through qualitative exploration. *Journal of Occupational Science*, 9(1), 12-19.

Law, M., Cooper, B., Strong. S., Stewart, D., Rigby, P., Letts, L. (1996). The person-environment-occupation model: a transactive approach to occupational performance. *Canadian Journal of Occupational Therapy*, 63(1), 9-23.

Law, M., Steinwender, S. & Leclair, L. (1998). Occupation, health and well-being. *Canadian Journal of Occupational Therapy*, 65(2), 81-91.

Leclair, L.L. (2010). Re-examining concepts of occupation and occupation-based models: Occupational therapy and community development. *Canadian Journal of Occupational Therapy,* 77(1), 15-21.

Lennox, A. (1992). Determinants of outcome in smoking cessation. *British Journal of General Practice,* 42, 247-252.

Liddle, J., Carlson, G., & Mckenna, K. (2004). Using a matrix in life transition research. *Qualitative Health Research*, 14(10), 1396-1417.

Lucas, K., & Lloyd B. (1999). Starting smoking: girls' explanations of the influence of peers. *Journal of Adolescence*, 22, 647-655.

Lyons, M., Orozovic, N., Davis, J., & Newman, J. (2002) Doing-being-becoming: occupational experiences of persons with life-threatening illness. *American Journal of Occupational therapy*, 56(3), 285-295.

Macnaughton, J, Carro-Ripalda, S. & Russell, A. (2012). Risking enchantment: How are we to view the smoking person? *Critical Public Health*, 22(4), 455-469.

Magnus, E. (2001). Everyday occupations and the process of redefinition: A study of how meaning in occupation influences redefinition of identity in women with a disability. *Scandinavian Journal of Occupational Therapy,* 8, 115-124.

Makomaski Illing, E.M. & Kaiserman, M. J. (2004) Mortality attributable to tobacco use in Canada and its regions, 1998. *Canadian Journal of Public Health*, 95(1), 38-44.

Manzi, C., Vignoles, V. L. & Regalia, C. (2010). Accommodating a new identity: Possible selves, identity change and well-being across two life-transitions. *European Journal of Social Psychology*, 40, 970-984.

McLaughlin-Gray, J. (1997). Application of the phenomenological method to the concept of occupation. *Journal of Occupational Science*, 4, 5-17.

Mee. J. & Sumsion, T. (2001). Mental health clients confirm the motivating power of occupation. *British Journal of Occupational Therapy*, 64(3), 121-128.

Merriam. S. B. (2009). Qualitative research: A guide to design and implementation. San Fransicso: Jossey-Bass.

National Institutes of Health, Office of Human Subjects Research. (n.d). The Belmont Report: Ethical Principles and Guidelines for the protection of human subjects of research retrieved from http://ohsr.od.nih.gov/guidelines/belmont.html

Pepin, G. & Deutscher, B. (2011). The lived experience of Australian retirees: I'm retired, what do I do now? *British Journal of Occupational Therapy*, 74(9), 419-426.

Perkins, K. A. (2001). Smoking cessation in women: special considerations. *CNS Drugs*, 15(5), 391-411.

Pierce, D. (2001). Untangling occupation and activity. *The American Journal of Occupational Therapy,* 55(2), 138-146.

Pilnick, A. & Coleman, T. (2003). "I'll give up smoking when you get me better": Patients' resistance to attempts to problematize smoking in general practice (GP) consultations. *Social Science & Medicine*, 57, 135-145.

Prochaska, J. & DiClemente, C. (1983). Stages of process of self-change of smoking: toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, 51(3), 390-395.

Prochaska, J.O., DiClemente, C.C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist,* 47(9), 1102-1114.

Prochaska, J.O. & Velicer, W. F. (1997). The transtheoretical model of health behavior change. *American Journal of Health Promotion*, 12(1), 38-48.

Rebeiro, K.L., Day, D.G., Semeniuk, B., O'Brien, M.C., & Wilson, B. (2001) Northern initiative for social action: an occupation-based mental health program. *American Journal of Occupational Therapy, 55(5), 493-500.*

Salive, M. E., Cornoni-Huntley, J., LaCroix, A. Z., Ostfeld, A. M., Wallace, R.B., & Hennekens, C.H. (1992). Predictors of smoking cessation and relapse in older adults. *American Journal of Public Health*, 82(9), 1268-1271.

Schkade, J. K. & Schultz, S. (1992). Occupational adaptation: Towards a holistic approach for contemporary practice, part 1. *The American Journal of Occupational Therapy,* 46(9), 829-837.

Seamark, D.A., Blake, S.D. &Seamark, C. J. (2004). Living with severe chronic obstructive pulmonary disease (COPD): perceptions of patients and their carers. *Palliative Medicine*, 18, 619-625.

Seguire, M. & Chalmers, K. (2000). Addressing the 'costs of quitting' smoking" A health promotion issue for adolescent girls in Canada. *Health Promotion International,* 15(3), 227-235.

Schiffman, S. (1986). A cluster-analytic classification of smoking relapse episodes. *Addictive Behaviours*, 11(3), 295-307.

Schwartzman, A. J., Atler, K., Borg, B., & Schwartzman, R.C. (2006). Fueling the engines: a role for occupational therapy in promoting healthy life transitions. *Occupational Therapy in Health Care*, 20(1), 39-59. doi:10.1300/J003v20n01_03.

Seidman, I. (2006). Interviewing as qualitative research: A guide for researchers in education and the social sciences. Third edition. New York: Teachers College Press.

Smith, J.A., Flowers, P., Larkin, M. (2009). Interpretative Phenomenological Analysis: Theory, Method and Research. London, ENG: Sage Publications Ltd.

Stapleton, J. (1998). Cigarette smoking prevalence, cessation and relapse. *Statistical Methods in Medical Research*, **7**, 187–203.

Stead, L. F. & Lancaster, T. (2012). Behavioral interventions as adjuncts to pharmacotherapy for smoking cessation. *The Cochrane Library*, 12, 1-78. DOI: 10.1002/14651858

Song, F., Huttunen-Lenz, M., Holland, R. (2009). Effectiveness of complex psycho-educational interventions for smoking relapse prevention: an exploratory meta-analysis. *Journal of Public Health*, 32(3), 350-359. doi:10.1093/pubmed/fdp109

Thompson, L.E., Barnett, J. R. & Pearce, J. R. (2009). Scared straight? Fear-appeal anti-smoking campaigns, risk, self-efficacy and addiction. *Health, Risk & Society*, 11(2), 181-196.

Townsend, E. (2002). Enabling Occupation: An Occupational Therapy Perspective. Ottawa, ON: CAOT Publications ACE.

Townsend, E., & Polatajko, H. (2007). Enabling occupation II: Advancing occupational therapy vision for health, well-being and justice through occupation. Ottawa, ON: CAOT Publications ACE.

Treloar, D. & Gunn, J. (2012). Caught in the tapestry of tobacco: Why I smoke. *Contemporary Nurse*, 41(1), 51-57.

Van den Putte, B., Yzer, M., Willemsen, M. C., & de Bruijn, G. (2009). The effects of smoking self-identity and quitting self-identity on attempts to quit smoking. *Health Psychology*, *28*(5), 535-544.

Vrkljan, B. H. & Miller Polgar, J. (2007). Linking occupational participation and occupational identity: An exploratory study of the transition from driving to driving cessation in older adulthood. *Journal of Occupational Science,* 14(1), 30-39.

Weaver, K. & Olson, J.K. (2006). Understanding paradigms used for nursing research. Journal of Advanced Nursing, 53, 459-69.

West, R. (2005). Time for a change: Putting the transtheoretical (stages of change) model to rest. *Addictions*, 100, 1036-1039.

Wilcock, A. (2006). An occupational perspective of health (2nd ed.). Thorofare, NJ: SLACK Incorporated.

Wiseman, L., & Whiteford, G. (2009) Understanding occupational transitions: a study of older rural men's retirement experiences. *Journal of Occupational Science,* 16(2), 104-109.

WFOT: World Federation of Occupational Therapists. (2013). Position statement: Activities of daily living. Retrieved from http://www.wfot.org/ResourceCentre.aspx

Appendix A

Recruitment Script for Pharmacies and Medical Clinics

Pharmacy Script- "Hello, my name is Kerrie Luck and I am conducting a research study as part of my post-professional masters degree in occupational therapy at Dalhousie university. The goal of this study is to gain a greater understanding of the experiences and perceptions of the transition from smoker to non-smoker in women. I am recruiting women, age 35 to 55, employed who have quit smoking cigarettes in the past 12 to 24 months. My request is to have staff within the pharmacy place a recruitment brochure, that will be provided, in every customer's bag to assist with recruitment. It will be up to the potential participant to make contact with the researcher if they are interested in participating and meet the inclusion criteria. Your assistance would be greatly appreciated, but you are under NO obligation to agree to this request".

Medical Clinic Script- "Hello, my name is Kerrie Luck and I am conducting a research study as part of my post-professional masters degree in Occupational therapy at Dalhousie university. The goal of this study is to gain a greater understanding of the experiences and perceptions of the transition from smoker to non-smoker in women. I am recruiting women, age 35 to 55, employed who have quit smoking cigarettes in the past 12 to 24 months. My request is to have medical clinic staff distribute recruitment brochures, that will be provided, to anyone they know has quit smoking in the past to increase their awareness of the study. It will be up to the potential participant to make contact with the researcher if they are interested in participating and meet the inclusion criteria. Your assistance would be greatly appreciated, but you are under NO obligation to agree to this request".

Appendix B

Recruitment Brochure

Are you female, age 35-55, employed, and have successfully quit smoking for at least twelve months, but no longer than 24 months

Would YOU like to share your quitting smoking story?

PARTICIPANTS NEEDED FOR

OCCUPATIONAL THERAPY RESEARCH

We are looking for volunteers to take part in a study that will explore the daily experiences of transition from smoker to non-smoker

As a participant in this study, you would be asked to participate in 1 interview, lasting 1-1½ hours, to share your experiences and perceptions of quitting smoking.

The volunteers in this study will receive a 50 dollar Visa card as compensation for their time.

For more information about this study, or to volunteer for this study, please contact:

Kerrie Luck, BSc.O.T., Reg NB(C)

506-333-1152

Email: Kerrie.Luck@dal.ca

This study has been reviewed by the Research Ethics Board, Dalhousie University, Halifax NS.

Appendix C

Recruitment Poster

Are you female, age 35-55, employed, and have quit smoking

for at least twelve months, but no longer than 24 months?

Would YOU like to share your quitting smoking story?

PARTICIPANTS NEEDED FOR

RESEARCH IN OCCUPATIONAL THERAPY

We are looking for volunteers to take part in a study that will explore the transition from smoker to non-smoker.

As a participant in this study, you would be asked to participate in 1 interview, lasting 1-1½ hours, to share your experience and perceptions on quitting smoking.

The volunteers in this study will receive a 50 dollar Visa card as compensation for their time

For more information about this study, or to volunteer for this study,

Please contact:

Kerrie Luck, BSc.O.T., Reg NB(C)

506-333-1152

Email: Kerrie.Luck@dal.ca

This study has been reviewed by the Research Ethics Board, Dalhousie University, Halifax, NS

Appendix D

Semi-Structured Interview guide

How do cigarette smokers experience and perceive their occupational transition from smoker to non-smoker?

As a reminder, you are not compelled to participate in this interview. If you do choose to participate, you are free to withdraw at any time without prejudice. Similarly, if you choose to participate in this interview, this information will be maintained in confidence.

Interview Questions:

1. Please tell me a bit about yourself, like, where you are from, work, family life and such.

2. Tell me about quitting smoking – how you decided, when, how it went and so on.

Probes: When? How long smoked and how much? Reasons for quitting? Motivations? How much control was felt? Supports and barriers? Challenges?

3. How many times had you tried to quit smoking before this last time? Were there any differences between past attempts and this time?

4. Can you talk a bit about your journey from being a smoker to being smoke free?

Probes: What helped you stay focused to quit? Hardest part about quitting? How did you cope? How did you manage the changes?

5. How has quitting smoking changed what you do day to day?

Probes: home, work, social life. How did smoking structure what you did before? What had to change about what you do in order to succeed? Did you develop 'replacement' activities?

6. If you think about a typical day or week in your life of being a smoker, and now as a non-smoker, what has changed, especially in terms of what you do or don't do?

Probes: Do you miss certain aspects of smoking? How do you cope with this?

7. Can you talk about how smoking was connected to relationships with other people? How quitting smoking has affected relationships?

Probes: Partner, friends, family, work colleagues, strangers?

8. What do you miss, if anything, about smoking? What have you gained by quitting?

9. How has quitting smoking changed the way you think or feel about yourself?

Probes: do you see yourself differently now that you have quit smoking than before? Is there a 'smoker identity' and a 'non-smoker identity' that fit for you? What did being a smoker mean to you?

10. When you think about smokers and those who have quit smoking, what advice might you have for those trying to make the transition? **Probe:** draw out activities

11. What advice might you have to those who want to help others quit smoking successfully?

Probe: friends, family, professionals

Additional

Anything else you consider important about your quitting smoking that you would like to share with me?

Other comments?

(Ensure key details from the interview narrative include: how long since quit, how long was a smoker, how much smoked at peak)

Additional probes:

Why do you think that is?

Can you explain/expand?

Can you tell me more about this?

What do you mean?

Can you walk me through that experience?

Reconfirm consent for those who have initially agreed to have their quotes used:

"As discussed during the consent process, are you willing to have quotes from our discussion used in the presentation of this study?"

Appendix E

Confidentiality Agreement

Confidentiality Agreement Transcription Services

I, _____, transcriptionist, agree to maintain full confidentiality in regards to any and all audiotapes and documentation received from Kerrie Luck related to her study on Occupational Transition from Smoker to Non-Smoker in Women. Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews, or in any associated documents;

2. To not make copies of any audiotapes or computerized files of the transcribed interview texts, unless specifically requested to do so by Kerrie Luck;

3. To store all study-related audiotapes and materials in a safe, secure location as long as they are in my possession;

4. To return all audiotapes and study-related documents to Kerrie Luck in a complete and timely manner.

5. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audiotapes and/or files to which I will have access.

Transcriber's name (printed) _____

Transcriber's signature_____

Date _____

Appendix F

Consent Form

STUDY TITLE:

Transition from Smoker to Non-Smoker

PRINCIPAL INVESTIGATOR:

Kerrie Luck, BSc.O.T., Reg NB(C)

Kerrie.Luck@dal.ca

(506) 333-1152

Dalhousie University School of Occupational Therapy

5869 University Avenue

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SUPERVISOR:

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Dalhousie University School of Occupational Therapy

5869 University Avenue

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Phone (902) 494-6555

E-mail brenda.beagan@dal.ca

Introduction

We invite you to take part in a research study being conducted by Kerrie Luck who is a graduate student at Dalhousie University, as part of her Post-Professional Masters Degree in Occupational Therapy. Your participation in this study is voluntary and you may withdraw from the study at any time without consequence to yourself. The study is described below. This description tells you about the risks, inconvenience, or discomfort that you might experience. Participating in the study will not benefit you directly, but we might learn things that will benefit others. You can discuss any questions you have about this study with Kerrie Luck.

Purpose of the Study

The goal of this study is to gain a greater understanding of the experiences and perceptions of the transition from smoker to non-smoker. The learnings and insights gained will not only add to the understanding of how some smokers manage their experiences of this transition successfully, but may also illuminate areas to improve and support this transition for smokers whose experiences hinder their ability to successfully quit smoking.

Study Design

This study is a qualitative exploration of the experiences of women that have become non-smokers in the last 12- 24 months. An individual interview with 6-8 participants will be conducted to better understand their experiences.

Who can participate in the Study?

You may participate in this study if you are female, age 35 to 55, employed and self-report you quit smoking cigarettes in the past 12 to 24 months. If you do not meet all the above mentioned criteria you need not sign up for participation in this study.

Who will be conducting the Research

The principal investigator in this research project will be Ms. Kerrie Luck. She will be the main person you will be in contact with for this research project. The supervisor for this study is Dr. Brenda Beagan who holds an appointment with the School of Occupational at Dalhousie University.

What you will be asked to do

This study will invite you to participate in one audio-recorded, in-person interview lasting between 1 to 1½ hours. The interview questions will explore your experiences and perceptions of your transition from being a smoker to becoming a non-smoker. You will be provided with a draft copy of the emerging findings in the months following the interview. At that point you will be contacted by phone for feedback. If you choose to provide feedback, this will take between 20-30 minutes. The purpose of this follow up is to allow you to review and reflect on the interpretation of your story. Once the study has been completed, you will be sent a summary of the final report, either via e-mail or mail, as you prefer.

The interview will take place at a local New Brunswick library in a private meeting room (or an equivalent quiet space of your choosing). There is no preparation needed to participate in this study.

Possible Risks and Discomforts

This research study poses minimal risk to you as you only have to provide information during the interview that you are comfortable sharing about your past experience of a successful smoking transition that has lasted at least 12 months. If you feel any emotional or psychological distress due to any of the questions, please feel free not to answer. You may ask to withdraw from the study at any time and for any reason, with no need to explain to the researcher. If you withdraw, please indicate to Kerrie whether or not it is okay to keep and use the information you have already provided, or if you would like it erased. After you have been given preliminary findings for your feedback, it will no longer be possible to withdraw your information from the analysis.

Possible Benefits

There are no direct benefits to you from participating in this study. Indirectly, there may be benefits by generating new knowledge and insight that could assist others in the transition from being a smoker to becoming a non-smoker.

Compensation / Reimbursement

At the beginning of the interview, you will be given a pre-paid fifty dollar Visa card as a gesture of appreciation and to compensate you for your time. No direct expenses for your participation are being reimbursed. You may still choose to stop the interview at any time and may keep the gift card.

Confidentiality & Anonymity

All data collected from you will be treated in a confidential manner. Each study participant will be assigned a pseudonym (a false name) that will be used to identify you, the recording of your interview, and the typed copy of your interview. The file that links

your pseudonym with your real name will be stored in a locked file, separate from your actual interview. Interview notes, diaries, and audio recordings will also be stored in a locked file. All electronic data will be stored on a password protected encrypted USB drives. The only people that will have access to this information are Kerrie Luck, her supervisor, and the person who types up the interview (transcript) who will have signed a confidentiality agreement. No data will remain in any form with the transcriptionist. All identifying names and places will be removed from the transcript of your interview.

Any quotes used from your interview will not disclose your identity. Your name will be changed to the pseudonym, and any identifying information such as a workplace will be removed or altered. All data associated with this research study will be retained after the thesis is finished for 5 years. The data will then be discarded by shredding all paper copies and CDs, and erasing any USB drives that house data.

Questions

If you have questions about this study you can contact the primary investigator, Kerrie Luck at 506-847-7227. You will receive a copy of this consent form for your records as well as for the contact information for the primary investigator.

Problems or Concerns

If you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, you may contact Catherine Connors, Director, Research Ethics, Dalhousie University for assistance at (902) 494-1462, *ethics@dal.ca*

CONSENT FORM SIGNATURE PAGE

Study: Transition from Smoker to Non-Smoker

I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I hereby consent to take part in this study. However I realize that my participation is voluntary and that I am free to withdraw from the study at any time until I have been given preliminary findings for my feedback.

Name of Participant (Please print)

_____

Signature of participant

_____

Date (d/m/y) _____

I also give permission for the following (marked with an "x")

____ To have my interview audio recorded

____ To have the investigator contact me for follow up feedback for this study

____ To have portions of my interview quoted in the thesis, presentations and other writing, without identifying me (this will be re-confirmed after interview)

Signature of participant

_____

Signature of primary investigator

_____

Date (d/m/y) _____

You will be given a signed copy of this consent form