A DESCRIPTIVE QUALITATIVE STUDY OF WHAT INFORMS AND INFLUENCES SMOKING BEHAVIOURS IN COMMUNITY DWELLING PERSONS WITH SEVERE AND PERSISTENT MENTAL ILLNESS

by

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Abstract

Smoking establishes poor health trajectories and is the leading preventable cause of death in Canada. Individuals with severe and persistent mental illness (SPMI) have a prevalence of smoking 2 to 3 times that of the general population. While many are motivated to stop smoking, the quit rate in this group is low and their unique reasons for smoking not fully understood. Current understanding of tobacco use among those with SPMI largely comes from quantitative studies that have used pre-determined frameworks for understanding factors that affect and influence smoking behaviours. Little is known about the perspectives of those with SPMI.. In this descriptive qualitative study semi-structured interviews were conducted with thirteen community dwelling persons with SPMI to explore what informs and influences their smoking behaviours. The findings provide an understanding of the importance of smoking to the lives of those with SPMI. For most of the participants, smoking began as an anticipated positive enhancement of their self-esteem and/or identity, but evolved into a stigma with associated negative consequences. Participants perceived smoking as affecting their image, influencing social relations, and helping them adjust to mood changes. Participants revealed the complex ways in which they experienced smoking both as a group and as individuals, and in so doing illustrated the various agents that shape individual health choices around smoking. This study presents unique perspectives from participants' about their motivations for smoking, how they view themselves in relation to smoking, and what factors are important in influencing their personal behaviours around smoking. This study offers important opportunity for increased understanding and contains various recommendations for further inquiry and study.

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CHAPTER 1: INTRODUCTION

Background

Smoking has long been understood as leading to poor health outcomes. Risk of poor health outcomes increases as length of smoking history and frequency of smoking increases to remain the leading cause of preventable death in Canada (Health Canada, 2005; Makomaski Illing & Kaiserman, 2004). Those with severe and persistent mental illness (SPMI) are an identifiable population with (1) increased prevalence of smoking, (2) unique reasons for smoking, and (3) distinct smoking behaviours. All require improved understanding if we remain interested in improving health outcomes in this population.

Improved understanding starts with a process of discovery with the population under study. Applying a qualitative approach, this study aims to improve understanding of smoking behaviours and of the factors that influence these behaviours in community-dwelling persons with SPMI. The overarching research question is: What informs and influences smoking behaviours in community-dwelling persons with SPMI? Previous studies on smoking in SPMI populations have largely been conducted using quantitative methodologies. Applying a descriptive qualitative approach provides opportunity for people with SPMI to provide detailed description of their smoking behaviours and meaningful description of the influences and experiences of smoking. This approach focuses on exploration and description of smoking behaviours from a participant's perspective. Qualitative approaches provide for a depth and breadth of description not achievable with quantitative methods. Such descriptions may help identify and set priorities for further investigation, inform theory, improve understanding as to why people with SPMI smoke, the elements that most influence their smoking behaviour and how smoking cessation efforts may be better tailored to meet the needs of the individual and

person with SPMI. Increased understanding of the influences, motivations, perceived benefits, and barriers to improved health outcomes particular to people with SPMI were expected in the data.

Existing Qualitative Studies

A literature search of CINAHL, EMBASE, MEDLINE, PsycINFO, and Academic Search Premier using the terms "mental illness/disorder" with "smoking/tobacco" and with "qualitative/research" revealed only two qualitative studies that address the questions posed by this study. The studies are worth examining in some detail.

Lawn, Pols and Barber (2002) conducted a study in Australia and interviewed 24 participants. Data were analyzed in reference to four diagnostic categories of mental illness with an aim to identify similarities and differences in smoking behaviours and perceptions of links between smoking and their mental illness. The Lawn et al. study provides a close approximation of the proposed approaches for the current study, but applied grounded theory methods that started with broad questions that were narrowed and defined as interviews progress and themes were identified over time (Hinds, Vogel, & Clarke-Steffen, 1997). Grounded theory seeks to identify social processes and adheres to a purpose of generating theory to offer complete explanation of phenomenon (Speziale & Carpenter, 2007). Grounded theory methods focus upon conceptualizing phenomenon at high levels of theoretical abstraction consistent with theoretical understanding. Qualitative descriptive study approaches generate diverse descriptive accounts of phenomenon while limiting abstraction to the level required to summarize and present data to its intended audience, rather than discover theory (Sandelowski, 2000). These two methods provide somewhat divergent approaches to the data that may significantly influence findings in ways that complement and build understanding of a phenomenon. Nichter (2006) suggests an application

of different methods promotes the possibility of highlighting different dimensions of behaviour. Lawn et al. findings are from an Australian setting and it is not known whether they are applicable to a Canadian context. The current study will build upon the work of Lawn and colleagues.

The second qualitative study was a mixed-method study conducted by Green and Clarke (2005). Data was collected using three focus groups comprised of both smokers and past-smokers who attended outpatient psychiatric clinics at a Winnipeg hospital. Focus groups encouraged discussion of people's attitudes toward cutting down or quitting smoking, but also included questions about smoking history. Green and Clarke's study provided a glimpse of the Canadian context but answered distinctly different questions that did not formally address the individual's perspectives. The qualitative methods used were not fully described. For example, sample size was not justified, methods of analysis were not discussed, and little information was presented to allow assessment of study rigour. The data is limited to three focus groups that appear to have been selected to provide some qualitative information to a primarily quantitative study. Individual narratives are missing or limited in the enquiry of smoking in individuals with SPMI. The Green and Clark study provides an indication of the Canadian context that the current study will significantly expand and augment. The current study aims to provide a richness of data about what informs and influences smoking behaviours in community-dwelling persons with SPMI from their perspective. Qualitative methods can be particularly sensitive to behaviour influences, and effective in hearing the *voice* of teenagers who smoke (Nichter et al., 2006; O'Loughlin, Kishchuk, DiFranza, Tremblay, & Paradis, 2002) as representing a particularly important population to understand in reference to smoking, so too must qualitative research present the voice of those with SPMI. This important viewpoint maintains sensitivity to what

influences behaviours and serves to inform future research, nursing theory, and interventions to improved health outcomes in this population. This study aimed to provide a more rigorous qualitative approach to presenting the voice of community-dwelling persons with SPMI in Canada exploring how and what influences their smoking behaviours. A qualitative descriptive study is an appropriate approach to exploring the phenomenon of interest and making audible the voices of the participants.

Purpose

Within the broader question of what informs and influences smoking behaviours in community-dwelling persons with SPMI the proposed research will explore the voice of the community-dwelling persons with SPMI who smoke. The study addressed the following questions:

1. How do community-dwelling persons with SPMI talk about themselves in relation to tobacco?
2. How is tobacco use perceived as helping them?
3. What concerns do they identify as related to tobacco use?
4. What role does tobacco play in their daily lives?
5. What are the connections between tobacco and health from the perspectives of the participants?

The qualitative descriptive research approach permited an exploratory and descriptive look at the research question and objectives while its design helped maintain the voice of community-dwelling persons with SPMI.

CHAPTER 2: LITERATURE REVIEW

Background and Significance

Prevalence

The literature clearly establishes a prevalence of smoking in persons with SPMI that is significantly higher than the general population in developed nations (Davidson et al., 2001; Diwan, Castine, Pomerleau, Meador-Woodruff, & Dalack, 1998; el Guebaly & Hodgins, 1992; Gonzalez-Pinto et al., 1998; Green & Clarke, 2005; Herrán et al., 2000; Hughes, Hatsukami, Mitchell, & Dahlgren, 1986; Jablensky et al., 1999; Lasser et al., 2000; Morris, Giese, Turnbull, Dickinson, & Johnson-Nagel, 2006). Only where certain cultural contexts yield higher prevalence of smoking in the general population (Mori et al., 2003; Üçok, Polat, Bozkurt, & Meteris, 2004) is there indication that people with SPMI do not have significantly higher rates of smoking. Hughes et al. conducted one of the first studies of prevalence of smoking in mental health outpatient populations that controlled for other factors thought to also influence smoking behaviours that included age, sex, martial status, socioeconomic status, caffeine intake, institutionalization, and alcohol use and found that these factors cannot explain the higher prevalence of smoking in persons with SPMI. Estimates of prevalence of smoking in people with SPMI range from 45–88% compared to prevalence rates in the general population of about 30-33% and those with schizophrenia demonstrate both the highest prevalence of smoking and a strong probability of being defined as a heavy smoker (consuming more than 20 cigarettes a day) (Dalack, Healy, & Meador-Woodruff, 1998; Davidson et al.; Hughes et al.; Jablensky et al.).

Health Trajectories

Understanding smoking behaviours not only assists in understanding and predicting general health trajectories and informing smoking cessation inquiries, it may also inform clinical

treatment of mental illness itself. Smoking or abstinence can obscure psychiatric disorder diagnosis and treatment as smoking has ability to abate anxiety, improve cognition, and cause tremor while abstinence can cause anxiety, insomnia, appetite, difficulty in concentrating, restlessness, irritability, headaches, Parkinsonism (Baker, Brandon, & Chassin, 2004; Glassman, 1993; Hughes et al., 1986).

Individuals with schizophrenia who smoke are often at higher risk for health complications and poor illness trajectories because they smoke heavier than both the general population and other diagnostic groups (Addington, Addington, & Hodgins, 1997). In an Alberta study with a convenience sample of 60 smokers with schizophrenia, on average this group smoked 26 cigarettes a day with a range of between 5 and 75 cigarettes a day (Addington et al.). Findings of the study indicated that approximately one-half of the subjects were willing to attend a smoking cessation group if one were available. Additionally the study supported the notion that individuals with schizophrenia were likely motivated to quit by influences of the same factors as the general population and that such motivations were intrinsically, rather than extrinsically based (Addington et al.) suggesting improved chances of successfully quitting (Curry, Wagner, & Grothaus, 1990). Others with SPMI share some similar health risks because of higher smoker prevalence while motivation to quit might also be similar (Green & Clarke, 2005; Lasser et al., 2000).

Sokal et al. (2004) in citing a study by Dixon et al. (1999), suggest that as general medical conditions worsen psychiatric conditions can likewise deteriorate supporting the suggestions of a causal pathway of smoking leading to worsening medical conditions that in turn leads to intensification of depression and psychosis or other psychiatric illness.

The importance of addressing smoking in this population ranges from concern of improving general health to more specific health promotion concerns that include effects of psychiatric medication, symptom management, and side-effect modification. Smoking has been linked as a risk factor for dyskinesias independent of neuroleptic medication (Brown, Hazel, & Barraclough, 2000; Dalack & Meador-Woodruff, 1996) and is known to influence medication effects (Dalack & Meador-Woodruff; Williams & Ziedonis, 2004; Ziedonis & Williams, 2003). The risks of increased depression resulting for smoking abstinence in those with depression or depressive tendencies commands better understanding, intervention and risk reduction to prevent personal harm (Glassman, 1993). There is continuing need for a unique inquiry of smoking in this population.

Smoking also has potentially significant impacts on other aspects of the lives of people with SPMI connected to other known determinants of health. Smoking has a heavy economic burden on the mentally ill, particularly since most rely on publicly funded fixed incomes (Addington et al., 1997). For example, it is estimated that 44.3% of the US tobacco market is comprised of those with mental illness representing 40.6% of all smokers in the US (Lasser et al., 2000) who collectively spend in excess of US$26.4 billion annually (Kaufman, 2006). Smoking can thus cripple those with mental illness, both physically and financially (Green & Clarke, 2005). This contributes to a marginalization of those with mental illness that negatively influences determinants of health.

Unique Reasons for Smoking & Distinct Smoking Behaviours

Apart from the addictive effects of cigarette smoking affecting all who smoke, studies have presented a number of reasons why those with psychiatric illness may smoke. Most available studies are quantitative and some hypotheses have not yet been fully investigated.

Symptom Management

Smoking is thought to influence symptoms through both direct chemical influence (direct effect) and indirect effect. Studies support smoking to reduce Parkinsonism (Addington et al., 1997), attempts to self-medicate positive and negative symptoms of schizophrenia (Diwan et al., 1998; Glassman, 1993; Lawn, Pols, & Barber, 2002; Leonard & Adams, 2006), attempts to remediate cognitive process as a result of the underlying psychiatric illness (Diwan et al.) or enhance attention and working memory (Sacco et al., 2005), and in one qualitative study, as a way to organize thoughts, time, tasks, and/or avoid decision making (Lawn et al.). While Hughes and colleagues (1986) have speculated about how smoking helps counter neurotransmitter (e.g. noradrenaline) deficiencies, Glassman's work supports a finding of nicotine increasing dopamine release that provides reward and other psychiatric benefit (Glassman). A review by Lyon (1999) also supports this latter hypothesis. Hughes et al. (1986) presents an untested hypothesis that problems of aggression, concentration, or relaxation are aided by smoking. Lucksted's et al. (2000) qualitative study offers some support for this hypothesis. Qualitative studies provide indication that smoking is seen as helping to relieve stress and anxiety, find comfort, promote relaxation, or providing a sense of escape from the distress of feeling unwell (Green & Clarke, 2005; Lawn et al.; Lucksted, Dixon, & Sembly). These findings also support a "self-medication model" of addiction that sees cigarette use to moderate stress (O'Loughlin et al., 2002). However, in certain populations, smoking may precipitate anxiety and depression rather than relieve it (US Department of Health and Human Services, as cited in Hughes, 1999; Klungsøyr, Nygård, Sørensen, & Sandanger, 2006; Ross, 2006; Sheikh, 2006). A study by Patkar et al. (2002) found smoking in people with schizophrenia to be strongly associated with negative symptoms and agree with suggestions of others that it may be explained through one or some of

(1) nicotine as "self-medication" to treat symptoms, (2) nicotine use has modified the clinical presentation of the individual and worsened negative symptoms, or (3) those with prominent negative symptoms are avoidant of social interactions and use smoking to fill time and relieve boredom. The self-medication hypothesis is, however, not universally supported and requires further investigation (de Leon, Diaz, Aguilar, Jurado, & Gurpegui, 2006).

Smoking may influence metabolism of other medications to create an indirect effect (Dalack & Meador-Woodruff, 1996). Hughes et al. (1986) provided a hypothesis based on a view of current literature that smoking may reduce the sedating effects of medication while a study by Forchuk et al. (2002) provides indication that those with schizophrenia smoked primarily for sedative effects and control of negative symptoms. How smoking is perceived to modify side effects of medication, is however, unclear and in at least one qualitative study about 50% of the participants suggested no perceived change to side effects when smoking (Van Dongen, 1999).

Other Reasons for Smoking

Some additional reasons for smoking may be similar to other smoking populations and include smoking for relaxation, out of habit, and to settle nerves (Dalack et al., 1998; Glassman, 1993; Green & Clarke, 2005; Lasser et al., 2000; Lawn et al., 2002; Van Dongen, 1999). Nicotine has an addictive effect. Factors that motivate smoking are complex and multifaceted with varying degrees of influence that appear to change with the development of addictive smoking making it difficult to quit (Baker et al., 2004). A sense of resignation to the addiction is often voiced (Green & Clarke; Lucksted et al., 2000). Continued smoking can be based on a negative reward system that makes quitting difficult (Baker; Green & Clarke) and may particularly complicate quitting in SPMI populations. This negative reward system is also

supported by addiction theory (O'Loughlin et al., 2002). Hughes et al. (1986) hypothesizes that smoking may be used as a time filler by those who are bored and this is supported by studies in adolescent smokers (O'Loughlin et al.).

Cigarettes may provide a symbol of control, a form of comfort, a ritual (Baker et al., 2004; Lawn et al., 2002). Being a smoker creates a sense of identity, a connection to reality for some and cigarette sometimes become a "friend" that provides what is lacking in other relationships and smoking can provide a means of social connection to others, or a distraction from overwhelming thought processes (Green & Clarke, 2005; Lawn et al.). A sense of despair and hopelessness repress any desire to quit smoking while re-starting after a voluntary or involuntary period of abstinence provides a sense of euphoria (Lawn et al.) that provides positive reinforcement to smoking behaviour. Those with SPMI often perceive reinforcement and acceptance of smoking of peers and those close to them early in their lives, as a rite of passage into adulthood and for many who have been institutionalized, if they entered as a non-smoker, peer pressure, lack of activity, and apparent condoning by the institution promotes conversion to a smoker (Lawn et al.). Smoking is often a major part of daily routine and provides structure and activity to the day (el Guebaly, Cathcart, Currie, Brown, & Gloster, 2002; Van Dongen, 1999). Additionally, individual smoking practices like consumption frequency and inhalation practices may change with underlying changes to mental illness and mood (Van Dongen).

Smoking cessation often receives low or no priority in treatment schemes and family members tend to condone smoking as either helping manage symptoms or citing a reluctance to withdraw one of their few pleasures in life (Lawn et al., 2002; Van Dongen, 1999). Health professionals are not actively helping people with SPMI quit (el Guebaly et al., 2002; Green & Clarke, 2005; McCloughen, 2003). Despite a willingness to quit or reduce smoking, people with

SPMI have reported that nicotine replacement therapies that may be helpful are often unaffordable and mainstream smoking cessation programs are often ill-suited and created a sense of exclusion, feeling judged, misunderstood, and unable to create a meaningful relationship with those assisting them (Lawn et al.).

Little is written about whether people with SPMI link smoking to physical illness. This study may help identify if these links are perceived as well as provide information about whether and how individual understanding and perceptions of these links affect smoking behaviour. While certainly not directly comparable populations, like adolescents, people with SPMI are suspected to verbalize the negative health effects of smoking but not integrate them into health practices (O'Loughlin et al., 2002). Similarly, and also like adolescents it is suspected that people with SPMI are particularly vulnerable to the addictive nature of cigarette smoking and have unique behaviours of which qualitative methods will help increase understanding (Nichter et al., 2006). Lucksted et al. (2000) provided a qualitative perspective about at how people with SPMI in a psychosocial rehabilitation program appear to have good understanding of the health hazards of smoking and how the presence of mental illness may influence the way in which individuals resign to or justify smoking and otherwise frame the its health hazards. Those who quit appeared to emphasize health hazards to smoking as reasons to maintain abstinence despite cravings for cigarettes.

Impact of Smoking

People with SPMI may smoke quite differently than the general population. Studies by Olincy et al and Viegi et al. (as cited in Sokal et al., 2004) found that those with schizophrenia indicated that they inhaled more deeply and are exposed to higher levels of pulmonary toxins that further increase risk of emphysema. It would seem to follow that they would also have

increased exposure to the carcinogens found in cigarettes and therefore have increased risk of cancer based on their smoking patterns.

People with SPMI tend to smoke in higher incidence and heavier than the general population and therefore present a high-risk population for smoking related health complications. The effects of smoking appear to modify drug action that may have clinical significance to the use of medications with this population. When considering tobacco control interventions little is known about how programs might be effectively structured to best help this population. The current study will provide opportunities to understand and identify key influences of behaviour from the smoker's perspective to assist in appropriate tobacco control interventions for use with this population. People with SPMI are an important group to target for smoking reduction because of the high incidence, heavy consumption, and known complications associated with smoking yet psychiatrists appear unlikely to raise the issue of smoking in health promotion contexts (Lawrie et al., 1995). Nurses have essential roles to play in helping this population with smoking cessation (Canadian Nurses Association [CNA], 2001).

As public policy moves to implement increasing bans on smoking, increased taxation, and decreased social acceptance generally, persons with SPMI are affected in ways not fully explored. It is suggested that persons with SPMI face additional barriers to achieving relationships, employment, housing, and other mainstream activities if they smoke (Williams & Ziedonis, 2004). The social impact of smoking to people with SPMI is unclear. While smoking often brings people together in a common activity, social agendas and regulations that limit smoking in public environments modify opportunities for people with SPMI to socially interact and connect with others. The qualitative pilot study conducted by Lucksted et al. (2000) provides some indication of the social meaning of smoking and abstaining and particularly highlights how

'not being a smoker' might set one apart in social settings involving people with SPMI. There is indication that smokers congregate and create unique opportunities for social interaction (Lucksted et al.). The proposed study and use of a qualitative method is expected to provide important insight into the impact of smoking on social and economic aspects of the participants.

Morbidity and mortality rates of cancer are generally elevated in those with schizophrenia (Baxter, 1996b; Lichtermann, Ekelund, Pukkala, Tanskanen, & Lonnqvist, 2001) and the rate of cardiovascular and respiratory disease amongst those with schizophrenia is up to double that of an age-matched control population (Allebeck & Wistedt , 1986; Buda, Tsuang, & Fleming, 1988; Mortensen & Juel ,1990; Tabbane, Joober, Spadone, & Poirier, 1993, all as cited in Dalack et al., 1998). In England persons with schizophrenia were found to have a significantly elevated standardized rate of mortality when compared to the general population that was primarily related to cigarette smoking activity (Dalack & Meador-Woodruff, 1996). Respiratory disorders are estimated at 60% more likely and death from heart disease 30% more likely in a person with mental illness than the general population (Baxter, 1996a) and risks of cardiovascular disease are likewise increased (Davidson et al., 2001). Cigarette smoking contributes to general medical complications of people with SPMI (Sokal et al., 2004) and is a standard cardiac risk factor deserving of treatment attention in a health care system with a goal of truly improving health outcomes of those it intends to help (Cimpean, Torrey, & Green, 2005).

Summary

Smoking establishes poor health trajectories and is the leading preventable cause of death in Canada. Individuals with SPMI have a prevalence rate of smoking 2 to 3 times that of the general population. While current literature indicates that those with SPMI are motivated to stop smoking, the quit rate in this group is low and their unique reasons for smoking not fully

understood. Current understanding largely comes from quantitative studies using pre-determined researchers' frameworks for understanding factors that affect and influence smoking behaviours. Current literature supports notions that some reasons for smoking and some smoking behaviours are unique to community-dwelling persons with SPMI. Existing qualitative work exploring the perceptions of community-dwelling persons with SPMI are limited and offer different approaches to data analysis or data collection than in the current study. While much is known about the physiological effects of smoking on those persons with SPMI, relatively little is know of the individual smoker's perspective about what informs and influences smoking behaviours and how smoking forms a more integrated part of individual identity and how smoking fits within individual definitions of health. Improved understanding of individuals' perspectives will provide new knowledge and augment existing knowledge and literature.

CHAPTER 3: RESEARCH DESIGN AND METHODS

Introduction

Understanding the perspectives of participants through qualitative methodological approaches helps inform future research. Qualitative methodologies also help develop and adopt participant-centered methodologies that increase the validity of studies by increasing the social validity of the research and meaningfulness to participants (Fogg & Gross, 2000). Findings from this study can also importantly inform individual nursing practice. Nurses are in a unique position to assist community-dwelling individuals with SPMI in that they are often the point of care with who these individuals are most in contact. Increased understanding of what affects and influences smoking behaviours in individuals with SPMI is useful in influencing nursing practice to best promote health improvements in this population.

The research questions I have posed are exploratory and descriptive in nature, seeking to understand a phenomenon of interest from the participant's perspective. In as much as the research question should drive the method of qualitative research (Speziale & Carpenter, 2007), a descriptive qualitative approach matches my research questions. In this chapter, I set out the research design and methods for conducting this qualitative descriptive study.

Research Design and Methods

This study was primarily designed to meet the thesis component of the Master of Science in Nursing degree, as required by the University of British Columbia (UBC). Results were submitted through a thesis course at UBC's School of Nursing, and it is expected that a manuscript detailing the study findings will be submitted for peer review and possible publication in a relevant scholarly journal.

The focus of my research was on exploring and describing what informs and influences

the smoking patterns of individuals with SPMI. For this study I chose to apply a qualitative descriptive approach as outlined by Sandelowski (2000). There is no clearly defined approach to qualitative descriptive studies (Milne & Oberle, 2005). Qualitative descriptive studies tend to be more naturalistic in that they employ neither the philosophical underpinnings nor the interpretive requirement to search for higher meaning associated with phenomenology; nor do they require the advancement of findings to higher theoretical concepts or abstractions consistent with grounded theory approaches. A qualitative descriptive study is suitable when detailed descriptions of phenomena and a focus on the presentation of participants' dialogue with the researcher are desired (Sandelowski, 2000). Clearly, the qualitative descriptive method is one method of choice for a research endeavour that seeks to present the voice of the particular population under study. Using this approach, the researcher remains closer to the words and meanings offered by informants and is able to offer a comprehensive summary of a phenomenon in everyday terms, or at least with minimal abstraction, organized in the way that best fits both the data and the audience for whom it is written (Sandelowski, 2000).

In 2005, Gallo, Angst, Knafl, Hadley, and Smith (2005) used Sandelowski's qualitative descriptive approach to examine parents' beliefs and strategies related to the sharing of information about a genetic condition with their children. Gallo et al. described how they used narrative analysis and fundamental qualitative description to identify the particular approaches used by parents to share sensitive information with their children. Their approach is consistent with Sandelowski's position that "qualitative descriptive studies tend to draw from the general tenets of naturalistic inquiry" (Sandelowski, 2000, p. 337). Naturalistic inquiry involves studying something in its natural state, such that variables are neither pre-determined nor manipulated, and no *a priori* commitment is made to any particular theoretical viewpoint (Sandelowski, 2000).

However, researchers using qualitative descriptive approaches are free to include what Sandelowski describes as the tones, hues, or textures of other methods; for example, a qualitative descriptive study can draw on grounded theory overtones by employing some of its methods, such as constant comparison, without producing a theoretical rendering. Sandelowski also proposes that qualitative descriptive studies, like most qualitative studies, can borrow from ethnographic, narrative, phenomenological, and grounded theory methods or approaches to provide hue or overtone without creating methodological error. This enables the researcher to apply phenomenological hues that may allow careful attention to certain words, phrases, or moments of experience, while remaining free of phenomenological renderings (Sandelowski, 2000). Williams (2004) demonstrated how qualitative descriptive design was applied with the phenomenological hues outlined by Colaizzi to explore perceptions of quality of care by patients with comorbidities who required an acute hospital stay.

Milne and Oberle (2005) also employed and explored qualitative descriptive methods in a case study approach. They applied qualitative descriptive methods to describe the self-care strategies that individuals maintain at home and the factors that affect these individuals' decision-making. Milne and Oberle applied a series of four questions: (1) What self-care strategies related to their UI [urinary incontinence] do people initiate and/or maintain? (2) What are the perceived benefits of these self-care strategies? (3) What factors influence self-care choices? and (4) What factors facilitate/impede adherence to behavioural strategies? Milton and Oberle's study objective and the types of questions they asked matched the objectives and questions of my own proposed study, and thereby confirmed that the qualitative descriptive method was appropriate to my research. However, Milne and Oberle's study described a qualitative content analysis outlined by Downe-Wamboldt (1992) that departs substantially from

the method of content analysis that I wished to apply in my study. Downe-Wamboldt's approach was highly influenced by quantitative methods: for example, they use specific forms of sampling to achieve generalizability and coding of data on to which quantitative methods are applied. Although the coding of the data is a qualitative element of the analysis, the coded data is subjected to quantitative techniques. Downe-Wamboldt characterizes her form of content analysis as providing a "mechanism to yield interesting and theoretically useful generalizations with minimal loss of information from the original data" (p. 320). Such quantitative methods, especially with the objective of generalizability, are not normally part of qualitative studies except perhaps as applied to basic demographic descriptive purposes or other easily quantifiable contexts. Milne and Oberle applied generally accepted qualitative approaches to assess the rigour of their study, rather than aligning with quantitative assessments of the quality of their research and data. Their reference to content analysis as outlined by Downe-Wamboldt adds a confusing dimension to an otherwise useful case study approach to qualitative description. Milne and Oberle likely make the mistake that Sandelowski (2000) refers to as an "erroneous reference to" or 'misuse' of methods or techniques, and might perhaps have benefited from limiting themselves to drawing on Downe-Wamboldt's method as a "hue."

Sampling

Sampling was purposeful and encouraged maximum variation to allow an exploration of both the common and unique manifestations of a target phenomenon across a broad range of varied cases (Sandelowski, 1995b). Data collection occurred over a period of approximately six months. Participant selection was limited to those who, at the time of the interview, could easily access and communicate their smoking stories with some degree of thoughtfulness or interpretation. I also made sure that all my participants were able to understand and communicate

in English. Although the imposition of such limits narrowed the phenomenological diversity that might be discovered in a broader sample of people with SPMI, it was also expected to increase the richness of the data. Thorne et al. (1997) validated this type of sampling approach by distinguishing people who are comfortable with events from people who are comfortable with interpretations. Whereas the former tend to simply recount events, the latter can articulate, consider, and share their abstractions and analysis of an experience, and are therefore, better able to inform research. Informants were selected from community-dwelling populations with self-declared SPMI diagnoses in the Vancouver metropolitan area. At the time of the interview, all the informants were past or current cigarette smokers. I was assisted in my sampling by the principal investigator of the research projected called "Cultivating Awareness of the Context of Tobacco Use" (CACTUS), a program of quantitative research into awareness of the context(s) of tobacco use in SPMI populations. Participants in the CACTUS study, which ran concurrently with my own research, were asked if they would consent to being contacted for further research regarding smoking. The ensuing consents provided a pool of potential participants from which I drew names. I then contacted potential participants by telephone to verify their continued interest in participating in research related to smoking. I planned to analyze data as it was collected and to continue sampling until I could be satisfied that themes or data were repeating and that representative coverage of factors, likely to be important in understanding how diverse factors were configured as a whole, had been achieved (Sandelowski, 1995b). Sampling remained flexible, such that I was able to involve one participant who asked to be included when he heard about the proposed study from another participant. I interviewed 13 people in all. Participants were offered a $20 cash honorarium for participating in the research process as an accepted

method of encouraging participation from this population and acknowledging their contribution to the study.

Data Collection

Semi-structured, individual interviews formed the primary source of data collection. Interviews lasted between 30 and 60 minutes. Open-ended questions with appropriate probative and follow-up questions were used to encourage richness of data. Each interview began with a question asking the participant to "tell me when you started smoking and how smoking has been a part of your life so far." I conducted all the interviews. Interviews were both audio taped and digitally recorded. Complete verbatim transcription were made of all audio recordings and verified against the recordings to ensure maximum accuracy. I kept a journal of relevant field notes and reflective thoughts, which forms part of the data set. These notes include information about relevant interview context(s), observations about the informant that may help describe this context, observations of items that may have influenced the data or its collection, notes on the participant's general demeanour, and my own general impressions. Journaling in this way helped me capture notable reactions and impressions that immediately came to mind during and after interviews, as well as various other reflective matters that contributed to my assessment for the potential influence of bias on the data. As an experienced Registered Nurse as well as a graduate nursing student with experience working in both community and acute mental health settings in Vancouver, I was strongly aware of the potential pitfalls of bias.

Data Analysis

Data analysis began immediately following collection, and continued throughout the research process. I applied constant comparative analysis, which allowed the continuing data collection to inform and be informed by the emerging analysis. I analyzed transcripts, notes, field

notes, and other relevant data sources, monitoring content for any developing themes that could help to answer the research question. I applied the interview questions to the data to help identify themes and develop codes. After transcribing the interview data, I read and re-read each interview in order to develop an appreciation for its essential features, without feeling the need to move forward analytically (Sandelowski, 1995a). Following this initial step, I further read the transcript and added notes to the page margins on potential themes, storylines, key points, or factual data. When I had completed four transcripts, I began drawing out preliminary or working themes from a review of both the transcripts and the margin notes. I copied textual extracts from the transcripts and grouped them under the various emerging and working themes for further and continuing analysis. I preserved exact dialogue as much as possible during the initial stages of analysis, initially supplementing such dialogue with only small amounts of abstraction and personal thoughts about the data, in keeping with qualitative descriptive methods (Sandelowski, 1995a). I repeated this process for each new transcript, modifying, collapsing, and re-working themes until the analysis was complete. I applied iterative processes to reduce thee data to major themes suitable for discussion. I selected Microsoft OneNote™ as a particular text processing program to aid in my analysis. I selected this program for its ability to organize and collect transcript extracts into various working thematic categories that could all be viewed simultaneously. The program made it easy to switch between document views and move text around, and thus considerably facilitated the iterative process. In addition, the program had a robust search function that enabled searches for phrases and words across multiple documents with high-speed results and user-friendly display formats. Throughout the analysis, I evaluated themes in reference to each other, to individual participants, and to the whole data set in order to determine which themes were significant and to what level of abstraction or interpretation a

theme needed to develop before it could allow for meaningful reductions of data while remaining as faithful as possible to participants' original words. Thus, the process of analysis remained iterative, moving back and forth between distance from and immersion in the data, maintaining a balance between individual cases and a sense of the overall project. Although using the descriptive qualitative method limits the extent of interpretive reasoning, a certain amount of intuition was required to ensure that genuine comprehension and accurate interpretation of particular descriptions were achieved. In addition, I evaluated emerging themes for their provision of structural meaning (Speziale & Carpenter, 2007) in reference to the questions asked in the study.

Overarching approaches to data analysis followed the lines of qualitative content analysis as described by Sandelowski (2000). I systematically sorted and coded data according to theme with the intention of allowing an organizational structure appropriate to the intended audience to emerge. I derived my codes through a dynamic form of analysis of the available data, oriented toward summarizing the information content of the data. In keeping with other qualitative studies, data were analyzed while they were being collected, so that each influenced the other. Following Sandelowski, I kept my analysis reflexive and interactive by continuously modifying my treatment of the data to accommodate new data as well as new insights into the data. I continued to focus on finding description in the participant narratives, moving to higher levels of abstraction only to permit a workable reduction of themes and codes for better comparison between interview data.

I sought to enhance the rigour of the findings in as many areas as possible, including *credibility, dependability, confirmability,* and *transferability* or *fittingness* (Speziale & Carpenter, 2007). I reinforced rigour by frequently returning to the raw data and relying on a

committee of supervisors to review and challenge my findings. I used sampling from informants who had experienced the phenomenon under study to assist credibility. Sampling continued until a repetition of thematic categories was created in the data, which also captured the diversity of perceptions and experiences among community-dwelling persons with SPMI. In the interviews I sought to capture an emic perspective by using open-ended questions and interview guides, allowing informants to tell their own stories and then asking additional probative questions to increase the richness rather than the superficiality of the data (Milne & Oberle, 2005). As an experienced mental health nurse, I remained particularly self-conscious about recognizing and countering any bias toward mental health approaches. For example, I carefully guarded against helping to direct participants' thought processes in an effort to "keep them on track," acknowledging that this potentially interfered with a research approach that was specifically striving to give voice to participants' stories. I also postponed questions from participants during the interview when these questions involved requests for my opinion of any topic area covered in the interview. This helped me to ensure that I did not unduly influence the gathering of information from participants during interviews.

I completed all transcriptions as soon as possible after each interview in order to capture as fully as possible the various levels of the conversation, including non-verbal activities and emotional notations. Using two recording devices helped me to verify those portions of interviews that were sometimes more difficult to understand, and this enhanced the accuracy of transcriptions. In addition, I reviewed all audio recordings and compared them against the written transcript. I used my field notes to augment the context of the transcripts and to enhance my understanding and interpretation of the interview data.

Providing a rationale and clear justification for research decisions not only reinforces

dependability and criticality but also contributes to a study's overall integrity (Milne & Oberle, 2005). In qualitative research, the researcher is an important instrument within the research study and markedly influences the data. Researcher bias cannot always be eliminated and must be recognized and carefully explicated (Milne & Oberle; Thorne, Kirkham, & MacDonald-Emes, 1997). In order to discover and scrutinize my own bias, I engaged in on-going reflective journaling and made field notes, in accordance with Thorne et al.'s recommendations. Member checking is an important, but sometimes difficult process. Milne and Oberle describe member checking as an on-going process that involves clarifying and probing what informants say during interviews, and concluding the interview with a summary that offers participants the opportunity to reflect further on the preceding discussion, and agree or disagree with the researcher. I conducted member checking throughout the interview process.

Peer review, and more particularly, review by a supervisory committee, also helped ensure appropriate rigour in the study. I engaged with the members of my supervisory committee both as a group and as individuals, inviting each member to monitor all aspects of the study and to challenge me as they saw fit, in a periodic and ongoing manner.

Speziale and Carpenter (2007) suggest that maintaining an appropriate audit trail assures confirmability by clearly illustrating the evidence and thought processes that lead to a researcher's conclusions. I maintained an audit trail in various ways. The notations and working documents that reference the sorting and organization of the data constitute a written record of all the major transitions within the analytical process. My audit trail also included detailed references tracing all direct quotations back to their source transcripts (the latter was removed just prior to manuscript preparation).

I was careful to protect participant identification at all times. No identifying information

was placed on any of the data except for a number that only I could trace back to the participant. All identifying data files located on computers were password protected. Data were in a secure environment, and will be kept in hard copy or electronic form for a period of five years following the completion of the study, after which time they will be destroyed.

The fittingness or transferability of research findings refers to the ability of the study findings to have meaning for others in similar situations (Speziale & Carpenter, 2007). I designed the background information and data in the Findings section of the research report to allow potential users to evaluate whether or not the current findings may be applicable and/or useful to them.

Ethics

Ethical approval was obtained from the UBC Behavioural Ethics Research Board before commencing any fieldwork. Prior to each interview, I obtained and confirmed voluntary and informed consent in writing from the participant (See Appendix A).

CHAPTER 4: FINDINGS

In this chapter, I describe the sample of participants and present the study's findings, divided into major themes and sub-themes. It should be noted that these findings are not exhaustive of all the themes located in the data, but represent the study's major findings, as revealed through the application of the data analysis methods described in the previous chapter.

About the Sample

I initially contacted participants by telephone or email and encouraged them to suggest a place in which they would be comfortable meeting for an interview. I advised them that such a meeting place needed to be somewhat quiet, and that they might wish to protect themselves from having other people overhear our conversations. I provided suggestions for a café, a park, or their respective mental health team location were provided as required. With one exception all participants proved able to quickly and easily suggest a suitable meeting place, and to organize their schedules to meet at appointed times and places. Three people I initially approached declined to participate in the study. Interviews took place in both indoor and outdoor cafés, restaurants, group home public rooms, participants' private residences, and public building spaces. Most participants appeared unconcerned about preserving confidentiality in a public setting. Two participants smoked and five drank coffee during the interview process. All participants appeared to participate openly, honestly, and to their full capacity. Most were able to articulate their ideas and feelings clearly, and to answer questions in a thoughtful manner. I interviewed 13 participants, ranging in age from 28 to 64 years old. I included 3 women in the sample. Participant age at starting smoking ranged from 13 to 44 years old, years since mental illness diagnosis ranged from 5 to 46 years, and pack-year histories of smoking ranged from 5 to 50 pack years. Two participants appeared more cognitively challenged to provide detailed

recollections and were somewhat less reflective, but they nevertheless seemed to offer genuine accounts of their experiences and perceptions. All participants presented as capable of understanding the nature of the conversations and of granting informed consent. Guided conversations were causal and comfortable and the participants seemed to enjoy the interview and the opportunity to participate in the study. All but three participants asked me if I smoked, and I informed them that I had smoked at one time. This appeared to confirm a level of understanding that better connected researcher with participant and likely enhanced both our rapport and information exchange.

Although I resisted defining SPMI and thereby limiting who could be included in the study, my sample can be described as demonstrating some common characteristics. All participants regularly attended a community mental health team with professional mental health care workers providing free services, and all these teams included both a psychiatrist and a nurse. All participants took regular medications to assist in the management of their mental health condition and most reported having been periodically hospitalized for treatment for a persistent mental health disorder.

I was aware, and it was confirmed during data collection, that clients of the mental health system sometimes reject psychiatric diagnoses or the "label" of such a diagnosis in an attempt to avoid being seen through the lens of a diagnosis rather than as an individual. I allowed individuals to self-declare their mental illness diagnosis without independent verification. Self-reported mental illnesses included schizophrenia (7), depression or mood disorder (4), and bipolar affective disorder, anxiety, or other disorder (5). Some participants reported multiple diagnoses. My intention was to confirm that sampling included only those with SPMI, not to analyze the data in terms of illness identification. Nevertheless, data emerged during interviews

and analysis, which revealed that the participants with schizophrenia stood out as having a shared experience distinct from the experience of those with other mental illness diagnoses. This is consistent with much of the literature, which also describes distinct experiences for those with schizophrenia.

Findings

Most participants had long histories of smoking and their experiences with smoking were complex and dynamic. Several major themes emerged during interviews, including the private and public image of the smoker, smoking and social relationships, the effect of environment on smoking, the stigma of smoking, smoking for mood management, and the connections between smoking and health. Participants were asked to consider changes over time in terms of their own views and smoking behaviours. Smoking often surfaced as a catalyst for change connected to specific expectations. In this chapter, I explore each of the major themes and present relevant sub-themes; I also discuss smoking as an addiction and examine participant perceptions of the usefulness and/or efficacy of nicotine replacement therapies. Where relevant, I also describe variations related to the participants with schizophrenia.

The Image of the Smoker

Most participants perceived the image of a smoker as largely positive when they first started smoking. However, at the time of the interviews, many years on, and living in a different social climate, participants felt that smoking negatively affected their image. The perceived benefits of being a smoker were important for a variety of reasons. Cigarette smoking was initially seen as a tool for establishing or presenting a desired and desirable image, and as a means to build or maintain social connections. Participants repeatedly connected smoking with the desire to "fit in." The desire to connect socially with others was sometimes understood and

expressed in subtle ways. For example, when asked if he smokes on his own or in the presence of others, one participant explained:

> Smoking in the vicinity of others is nice, because....sharing in the same illicit... enjoyment of the same illicit habit in this society. . . I am not being judged, I am not being looked at sideways, I am not doing anything wrong by them, because they are doing the same thing I am, sort of like the world is one big smoking section to them.

Participants perceived smoking as an agent for (positive) change because of its power to foster social acceptance, which in turn supported notions of increased self-worth and confidence within the smoking world. One participant illustrated the attraction of smoking in terms of self-definition:

> So I emerged from that [referring to a particularly severe bout of depression associated with bipolar disorder] in about February. Feeling like the world was my oyster because I had survived it. I was down to 141 pounds and I thought I need to re ... ummm ... what does Madonna do? ... Had to re-invent myself. And I had a lot of spare time and I felt good. I felt good (with emphasis) for the first time in almost 2 years. So I thought, okay, I am going to put on a beret. I'm going to get fancy clothes. Ah! I'll smoke!

Further along in this interview, the same participant described his mental illness as transforming, and noted how smoking was a positive part of this transformation:

> And I felt like this 16-year-old that was starting all over. It was like: "okay, I'm not the guy who close-cropped his hair, because he didn't give a shit. I'm not the one who never cared about what he wore, because he felt so bad. It was really a total rejection of who I ....what the illness had made me become.... So it was really a total distancing of myself

> from that experience and what it had made me become and smoking was just part of the "okay, I'm carefree now, and I'm stylish."

This participant voiced the belief that smoking could help him distance himself from what the mental illness had made him. For him, smoking was an agent of change that could contribute to the creation of a new and dramatically different image.

Peer groups also figured prominently among the reasons participants gave for starting and/or continuing to smoke. The presence of smokers within peer groups made smoking a shared social activity, which participants saw as necessary to maintaining social contact and achieving a sense of belonging. Two participants' comments in response to the question of why they smoke illustrate the subtle power of peer group actions:

> A lot of my friends had been doing it [smoking]. That's probably the main reason. Because I was around them all the time and that's why I started.

> I talk with my doctor "why you smoke?" I don't know why. I feel better when I drink coffee and smoke cigarette, talking with friends. I don't have Canadian friends, but from my town have 100 family here. Every month have, from my country holiday, we are together, party and birthday kids, and Christmas, Easter, always go to church. Outside church smoke and drink.

For this participant, smoking was a powerful link to home and a reminder of an earlier, easier life. Peer groups also operated less subtly, however. Another participant gave a very direct account of the effects of peer pressure:

> Well the reason I started was social pressure. I was in a new clique that everyone smoked and I wanted to fit in and for a month they offered me free cigarettes and then after a month they said buy your own, so I did.

Participants perceived smoking as helping to build social connections, associating it with images of being "cool" and part of the crowd. Some participants belonged to a generation for whom smoking was more common than it is now, and for whom smoking was very much part of a social ritual:

> Because, especially when I was in my 20's more people smoked than didn't. And I remember when I was in school, we used to like throw nickels and quarters together to buy cigarettes, like a community package of cigarettes. And it was, it was bonding.

Participants also viewed smoking as something that "normal" people did, and therefore as something they aspired to in order to be considered "normal" themselves. As one participant explained,

> Mental patients are generally looked down on and if you smoke or do something that other people do in our society … It's just easier to relate to people when you are a smoker and they are smokers too.

This participant also suggested that cigarette smoking was useful for counteracting the stigma of mental illness. The notion of stigma associated with smoking becomes increasingly important in current contexts and is further discussed in later sections.

Physical Appearance as Image

Participants associated smoking with weight control, specifically the idea that smoking could help to prevent an overeating response commonly associated with antipsychotic

medications. Participants believed weight gain would cause heightened self-consciousness, and sometimes saw cigarettes as a substitute for food. Some participants were less concerned with the effects of medication on their eating patterns, but worried that if they quit smoking, the activity of eating would replace the activity of smoking, and they would consequently gain weight. Participants generally perceived overeating as negatively affecting personal appearance.

In addition to expressing concern over weight issues, participants often described the effects of smoking on physical appearance. When questioned about the ways in which smoking might affect her personal physical or general health, one participant responded with a lengthy comparison of her own and her sister's health. In her view, her own health was significantly better than her sister's: whereas she had never had a weight problem, her sister was severely overweight. She went on express the dual concern that she might gain weight if she stopped smoking, but might stain her teeth if she continued to smoke. Throughout our interview, this participant demonstrated an inability or hesitancy to connect the more severe health concerns around smoking with her own body and her own life; instead, she consistently related those concerns with other people whom she deemed to be "much worse off." However, she was able to envision the possible cosmetic effects of smoking on her own physical image. Several other participants also mentioned the staining of teeth as one of the more undesirable effects of smoking; such observations offer important clues to the agents that might be deployed to motivate successful quitting attempts.

Cigarettes and Social Relations

The effect of smoking on social relations was closely bound up with both private and public image, and social stigma. Stigma is discussed in greater detail below. Smoking was seen

to both increase and decrease social connections and relationships. Participants frequently noted that their smoking behaviours were affected by their relationships with other people. Some had quit smoking under the influence of the people with whom they were intimately involved, such as family members or authority figures. One participant described quitting smoking on a family vacation in response to his father's request; on another occasion he quit because a girlfriend insisted he do so. Several participants felt that smoking often hampered their introduction to and involvement with non-smokers with whom they sought closer relationships. When asked what might motivate them to quit or change their smoking behaviours, several participants stated that a positive and intimate personal relationship would operate as a prime motivator.

Smoking behaviours also changed in response to social settings. Participants described smoking more when they were around friends who also smoked. Participants also observed that social events often stimulated increased smoking; indeed, smoking was seen as an integral part of socializing:

> Well, you smoke more when you are in social things. When you are out like, you know, somebody's birthday, you're out and we are all sitting out at a patio like somewhere in Granville Island like a place or a pub and you are having a beer or a drink, or a glass of wine. And as a social thing with people, yeah you are going to smoke more. I do anyway.

One participant commented that 70% of his friends smoke. He found it particularly difficult to resist smoking when he was with these friends, and in fact often smoked more in their presence. Discussing previous quitting efforts, he noted that quitting smoking would likely require him to avoid most of his friends. For him, not smoking significantly reduced social connections and relationships.

Despite its potential stigmatizing effects, which I discuss later, smoking operated to maintain important social connections for several participants. One participant, when asked what the most enjoyable aspect of smoking was, replied simply, "the social aspect of it." Another participant recalled how hospital nurses had provided him with cigarettes or money for cigarettes and explained that he interpreted this as evidence that they "liked" him. For this participant, the provision of cigarettes constituted proof of social acceptance, and reinforced positive relations with health care providers. Participant descriptions of the "culture of smoking" within hospital units exemplify the ways in which smoking affects social relations. One participant even described the smoking room on the psychiatric unit as a "club":

> You go in there. Again, you chat with the people who are smoking. Sometimes there is conflict with the people who are smoking because we are all a little on edge. Ummm, when I am manic and I am coming off that then everybody is my best friend, especially in the smoking room. But, again, it is a safe place.

The Smoking Bond

For some participants, smoking created a remarkable sense of connection with a wide variety of people, a special "bond" between strangers. As one participant put it, "when I see people light up, I feel a commonality when they are on the street" (2). The same participant added

> So, going to the smoking room of this particular pub, which I do on occasion, like twice a month. You feel like you are with the most interesting people in the bar, because you are all doing the same thing and you are all "bad" in a way and there is a lot of banter and you may never see these people again, but it is a comfort zone. And there are fewer and fewer places to do that. So in that particular environment we are all cool, frankly.

. . . you know, smokers like to bond. Because, it's like, we are a dying breed.

When asked if he had any sense of how other smokers with mental illness might respond to him as a smoker, another participant suggested that smoking created a sense of belonging. Here he refers to those with mental illness as "they" and "them:"

R: Yeah, they do, they classify you as one of them, you know.

I: And what does that mean to you?

R: Means, I want just be treated normal, I don't want to be classified, [I want to be] labelled my own way, [not] taking pills forever.

For this participant, being seen as a member of the "smokers" group rather than "the mentally ill" group conferred a sense of being "normal," and appeared to provide some control over societal "labelling."

Cigarettes as Friends

Participants regularly associated cigarettes with pleasurable experiences, and perceived cigarettes as intimately tied to personal identity. Smoking often translated into habits of physical behaviour that not only formed a part of the individual participant's self, but also helped the participant establish a regular routine for the day. These daily routines both created and/or curtailed social interactions with others. Several participants spoke of smoking as fundamental to their definitions of themselves. One participant described smoking as a regular source of profound comfort:

I guess it's probably like wrapping yourself up (gestures the movement), like you know, your favourite blanket which people would do watching TV late at night, or, you know,

> people who have a bunny rabbit or teddy bear on their bed or whatever. It is the same kind of thing, it is a...its security. And it's a way of looking at the world.

Although several participants described smoking as a solitary activity, they also viewed cigarettes as companions:

> Well, if it isn't a best friend it is companionship. And it's linked to pleasurable experiences. You know, that cup of coffee...that glass of wine. There's the issue of the addiction and there is also the question of ....how do I put this...I know what I want to say....ummm, of re-jigging those experiences so that they don't require a cigarette to be a good experience.

This participant previously described quitting as contemplating giving up one's best friend. He now appears more reflective in reframing cigarettes as a companion rather than friend and acknowledges how quitting smoking would entail a major experiential adjustment, a "re-jigging," a complete re-evaluation and reorganization of pleasurable activities.

Creating Barriers to Social Relations

Participants repeatedly described smoking as creating barriers to social relations, barriers that were closely related to, but nevertheless distinct from, the theme of social stigma. One participant described the isolating effects of smoking: "There is kind of a sense of isolation from the rest of the world. I mean, if I sit outside a café that I like to go to and the windows are not open, because the smoke goes inside..." Another participant described how smoking reduced his social contact and connection with friends. When asked about his experiences of social interactions with non-smokers, he replied:

> R: Ummm, I'm learning how to do that. Especially since smoking, you can't smoke in public places, you can't smoke in people's homes. You know I've been to parties where I

might be the only smoker. So if I smoke I miss out on the party. You know, I am out there alone (gesturing as if smoking), and it's not any fun. So you just like smoke this thing like a drug and get rid of it, you know, and then swish out or chew gum or something so that people don't "Oh! Did you have a cigarette? My God you stink!"

This participant also described making intense efforts to conceal his smoking in order to find social acceptance.

Environments

Environment significantly influences smoking behaviours. Participants noted how, in the various settings where people with SPMI gather or live, whether temporarily or permanently, tobacco use invariably affected their interactions.

The Group Housing Environment

Some participants described an underground economy based on the use and trading of tobacco within an apartment complex designed for people with SPMI. Participants stated that this economy sometimes enhanced their social relationships, and sometimes strained them. They described avoiding common smoking areas because people without cigarettes would constantly and irritatingly request free cigarettes. One participant explained that he was particularly popular, partly because he was so generous with his tobacco, cigarette papers, and marijuana. My interview with this participant was interrupted on two occasions when other people approached him and insisted on borrowing tobacco or cigarette papers.

The Hospital Environment

Several participants reported being hospitalized in psychiatric units during particularly acute stages of their mental illness. The hospital environment often re-shaped participants' social experiences around cigarettes. Participants perceived smoking as helping them both to adapt to

the new environment of the hospital and as a way to manage their moods. The social importance of smoking appeared to be amplified on psychiatric treatment units. One participant who had been a patient on such a unit considered those patients who did not smoke to be "really on the periphery," and believed that non-smoking patients were not part of the unit's social network.

One participant held the psychiatric institution responsible for his commencing smoking, while another explained why his smoking increased during his hospital stay:

> People who smoke, do smoke more in the hospital because they don't have very much freedom and they get stressed out and they have nothing to do they just go smoke. . . . some people would look at it like it's being in prison. You are allowed breaks, go out on smoke break about once an hour for smoke breaks and I smoked a lot when I was in the hospital. It's because all the breaks, all the breaks I had, all I did was smoke.

Thus, for this participant smoking constituted a reward system that encouraged increased smoking. Not only was smoking an activity that countered boredom, it also provided a sense of escape from the experience of confinement, and the opportunity to gather with others in a less structured environment.

Other participants suggested that the possession and use of tobacco on a psychiatric unit conferred the power to control social situations:

> Cigarettes are the commodity of choice, money is useless. Even if you don't smoke, you should have cigarettes. Because you can, you know in the hospital there is no privacy, if you want people to leave and leave you alone, or if you have a visitor, I say "I'll give you cigarette if you get yourself out. Okay!" You get favours... and there were power games that went on that were reflected by who got a cigarette.

Another participant noticed that the staff in the psychiatric unit appeared to use cigarettes to control patient behaviour. Staff members were seen to withhold cigarettes when patient conduct did not conform to expectations, and provide cigarettes when patients exhibited good behaviour or were otherwise liked.

I: What is your understanding about who gets to smoke and who does not?

R: People who behave properly.

I: Now, did they tell you that, or you just sort of gathered that?

R: I can just tell, I mean.... I don't throw tantrums usually, or at all, and other people do. When you give staff a hard time, they hold back on you, you know, they just...they want to retaliate, so they won't let you have a cigarette (for example?) when you want to.

Stigma

The stigma associated with smoking had significant implications for the participants' lives. Current social and governmental policies involve high taxation of tobacco, ever-increasing restrictions on smoking in public places, and increased regulation of the sale and use of cigarettes. These factors both express and reinforce the stigma associated with smoking, which serves to marginalize smokers. Most participants revealed a sense of being stigmatized when they described either their self-perceptions, and/or what they believed to be other people's perception of them. Some acknowledged that the stigma they attached to smoking may be self-imposed rather than based on external cues from other people. One participant, who had initially believed that smoking would provide a positive image, described its current stigma: "My image now is that I am part of a group that is being attacked on all sides because of this addiction. . . . now that we are outcasts." For this participant, smoking had begun as the near-magical agent that would change him into a "carefree youth," but over time had transformed his positive self-image

into a resignation to the addiction that made him a social outcast. Other participants commented that the current social climate, in which smoking is no longer viewed as acceptable behaviour, had changed their earlier positive perceptions of smoking into feelings of anger about the public pressure to quit smoking.

Participants internalized the stigma of smoking, and experienced lowered self-esteem as a result. One participant associated smoking with people who were weak, had lower IQ, came from lower socio-economic classes, and were dependent on welfare systems and/or street begging to survive. Not surprisingly, the struggle to reconcile these associations with his own smoking made it increasingly difficult for him to maintain a positive self-image:

> My perception of smokers is, without knowing the person, but if I see them on the street: lower IQ, sort of crude people, I think of them sort of as soft drug addicts, and a bit weak. And I often try and hide the fact that I smoke. This isn't really social stigma, but my own stigma, and I just think what's wrong with me? You know, I'm being weak.

For some participants, smoking was an additional marginalizing force. Participants considered smoking to be more prevalent among undesirable and marginalized populations, and perceived that the public at large associated them with these undesirable populations only because they smoked.

Smoking also affected participants' self-esteem by creating feelings of shame or by encouraging behaviours that participants described as embarrassing or shaming. Two participants described how behaviours resulting from smoking had influenced their self-esteem. The first explained how the need for cigarettes affects his mood and his sense of self-worth, and how he consequently adopts behaviours that entail a further loss of self-worth: "Oh, it drags you down if I don't have one. So I just...ahhh...panhandle or do what I can, borrow, or, beg, or whatever.

Panhandling. That's how we got by, you know." Another participant exemplified not only the loss of pride associated with the terrible need for cigarettes, but also the sense of growing desperation:

> Well since my pride has been swallowed, I just look for butts on the ground ... I have actually dried out tobacco off the ground in the oven of the stove. Believe it or not. I got as far as salvaging soggy butts.

Other participants described smoking as "filthy" or "dirty" and indicated that they themselves felt dirty when they smoked. Participants made various efforts to disguise the effects of smoking, including washing their hands and face, and/or using breath sprays and mouthwashes immediately following each cigarette. One participant described smoking in back alleys to avoid being seen smoking by her friends. Participants either associated current negative images of smokers with themselves, and/or described their struggles to separate these negative images from their self-image. Participants commented on the evolution of smoking from a glamorous pursuit into a despised addiction. Participants felt marginalized by their smoking not only because of its social unacceptability but also because they perceived that smoking identified them as members of a class of persons who were marginalized for other reasons. Participants distinguished between different classes of smokers, but felt that the general public did not recognize these distinctions and instead viewed all smokers as homogeneous members of a single class of marginal persons.

A university graduate who had also been an aspiring rugby player blamed cigarette smoking for the lowered physical stamina that caused him to lose his position on a championship rugby team. This participant described how smoking altered his sense of self-worth. Recently

finding himself homeless and without employment, he gradually overcame the shame associated with his need to pick up cigarette butts in order to meet his smoking addiction:

> You know, in the past year, I have run out of money and cigarettes a lot. And I have gone as far as picking them off the ground, butts off the ground, smoking those. I am not ashamed to do it now; I will do it in front of other people. I don't care anymore. I mean, I get so desperate sometimes, I think that, you know, I don't care what people think. Some people say that smoking is dirty and disgusting. Well, I'm sure there's a lot of smokers that say picking butts off the ground is dirty and disgusting. It's all relative, right? Certainly it's risky to my health to pick dirty butts off the ground and light them up. When I was in the hospital...when I was in VGH in February, you know some say "just go over to the TB clinic, nobody wants their butts on the ground." It's kind of a cruel joke, but its true right? (long pause) What do you do, you know, you survive? I am concerned with food and shelter, but I am part of the majority of the people in the world.

The extremity of this man's circumstances caused a profound re-evaluation of priorities, and smoking, in whatever way possible, became a necessary part of his survival.

For other participants, the stigma of smoking seemed to create a certain consciousness that enabled some modification of personal smoking patterns and behaviours. Participants recognized that social beliefs regarding the acceptability of smoking in the presence of non-smokers had changed, and showed awareness of the risks of second-hand smoke. This suggests that external messages, whether subtle or overt, were pivotal in participants' decisions about where and when to smoke.

Participants described learning to be "conscientious" smokers. Two participants, for example, explained that they had adopted special smoking behaviours to protect children after witnessing other adults endangering children through potentially dangerous smoking behaviours:

> I don't smoke in public. It, I've seen a child burned by an adult's cigarette on the arm one day. And that looked pretty stupid for a smoker to be doing. Smoking in public and accidentally hitting somebody with a cigarette.
>
> Like I walk down the street, eh. And I don't mind having a cigarette. But then there's a little lady with a baby there right. And I think, oh my God, I walked right by when I was smoking. Am I a dweeb or what? Oh fuck.

One participant demonstrated responsible or sensitive smoking as follows: "I have always been told that I was a good cigarette smoker. Because, I usually stay downwind from people." Another participant described how other people's responses to his smoking had instilled a sense of shame and guilt in him, and how he then tried to "do the right thing":

> I: How do you think others perceive you as a smoker?
>
> R: Well, if, a lot of people don't like it. If I'm, I find, that's why if I go have a coffee and I sit outside, everyone else is smoking there, but some of the people walking by, I can tell they don't like it. And ahh, I can tell that sometimes if I am at the bus stop people don't like it. They don't like the smell of it. Or they'll get up and move. So I try to do it, I try to be conscientious and do it away from people, but ahhh…I can tell lots of people don't like it.
>
> I: And how does that affect you?
>
> R: Oh, it kind of makes me feel ashamed, shamed sometimes, or, ahh, guilty, yeah. Because I see maybe, somebody pushing a baby carriage and I try to blow it out the other

> way, because I don't want to, I mean, it's pretty bad, if it's a little kid or something like that, so. I try to, try to do the right thing sometimes, but...

The current stigma of smoking has created new barriers to social connection and isolated smokers: "Now that we are outcasts... the opportunity to sit down and be comfortable as smokers is gone. There is a kind of sense of isolation from the rest of the world." Many participants reminisced about the lost freedom to smoke in almost all public and private places. One participant suggested that current restrictions on smoking cause people to group together in common smoking areas, creating situations in which he felt he was socializing with people with whom he would not otherwise choose to associate. In an ironic echo of earlier times when smoking had helped him overcome his shyness and interact with people he considered socially desirable, this participant recognized a changed crowd and described his more recent social connections with smokers in negative terms:

> I think it is the only positive thing from smoking. Because, especially since, well smokers have always sort of been segregated, even when you could smoke openly. People smoked in groups. It's a social thing. And now that smoking has been segregated, you are sort of forced to interact within a closed space with people, and you get to know them. Because I, I am a lot better than I used to be, but I was really very, very shy. So it sort of forced me to interact with people. That I still kind of like, I like the social aspect of. But the social aspect is not as desirable as it used to be because I think, I guess it's being judgmental, but the remaining smokers are less and less the type of people that I want to talk to.

One participant who immigrated to Canada explained in broken English that, in his country of origin, social protocol dictates that it is impolite both to request a cigarette from someone else,

and to fail to offer a cigarette to other people, when you yourself have and are smoking cigarettes. His comments serve as a reminder of how culturally conditioning the social interactions around cigarette smoking can be. Smoking when socializing was such a common practice in his home country that he was convinced a failure to smoke would operate as a barrier to social acceptance within his cultural group. When this participant found himself in a new country with low tolerance for smoking, he continued to socialize predominantly within an immigrant community in which smoking was still accepted as part of the social routine. During the interview, this participant described occasionally asking for cigarettes on the street, a behaviour which, in his mind, linked him to street people.This participant resented being characterized as a street person rather than a mentally ill person.

> In my country only don't have bums. Only bum who ask cigarette, no polite ask cigarette on street or at table. I feel bad if I ask cigarette, my organism ask [*organism asking is roughly his description of a craving*]. Who is no smoker, no understand? And there are many people from, say if you don't pay money why you not stop cigarette.... No, no polite in Canada, in North America, smoke cigarette. More people, different watch if you smoke cigarette [*meaning look at you differently - look down on you*] (interviewer's comment in italics)

Many of the participants were acutely aware of current societal emphasis on smoke-free environments and fears about second-hand smoke, and discussed and interpreted these concerns in different ways. One participant was particularly angered by what he saw as society's and/or the government's obsession with smoking and cancer research, to the exclusion of other equally important social and health problems. His outrage before what he considers to be misguided and oppressive is palpable:

> Social pressure from non-smokers, being treated like a second-class citizen and all the pressure to quit after 30 years, and all the scare tactics from government and the medical community over worst case scenarios that can take place … It's true though, I mean it's all these scare tactics and all this obsession with cancer research. You know, to the detriment of researching thousands of causes and diseases and issues. It's just a morbid obsession in society. The big C. I think it is a mistake. And I think I am a victim of that because I smoke…and because…especially non-smokers that look at me with a cigarette in my hand or my face and then they look at me like I'm doomed, I'm a goner already, that I'm doomed.

This participant's perception of being a "doomed" victim suggests a sense of profound isolation and diminished self-worth.

To sum up, participants struggled with the realization that smoking has become stigmatizing in several ways, creating additional barriers to social acceptance, and forcing them into associations with undesirable populations. For many participants, the stigma attached to smoking was compounded by the stigma attached to mental illness.

Stress, Coping, and Boredom

Most participants tended to smoke more when they felt stressed or anxious. For example, the following participant connects the symptoms of his mental illness with his smoking patterns:

> The lower the mood, the more I smoke. Better I feel, the less I smoke. . . . When I am anxious or, umm, at one point I felt paranoid. Unreasonably paranoid. And I was just smoking continuously. I was all high, I hadn't slept in days, and days, and days. And I was also trying to keep myself awake.

The same participant explained that his heaviest period of smoking occurred in response to a bout of severe depression, and consequently he viewed smoking as mood levelling:.

> I was drinking a bottle of wine every night by myself and smoking about 2 packs of cigarettes. And I did that for maybe 6 months, and said "something's got to change, this is bad."... just about every aspect of my life was bad then. And then after that it [smoking] was just sort of something to do to, to keep me level.

One participant with anxiety disorder likewise described a relationship between mood change and increased smoking, and attempted to use smoking to moderate his mood swings:

> But if I am really stressed, I'll smoke more ... well, if a person has acute anxiety disorder, you know, and stuff like that, you have a cigarette, it seems to take some of your anxiety away a little, but...not totally.

Later in the interview this participant confided that she had re-started smoking in response to stress, indicating that smoking was an important part of her repertoire of strategies for managing stress and anxiety.

Many participants used smoking as a mechanism for coping with stress or anxiety, even though many recognized that it was at worst an ineffective, and at best, only a temporary means of dealing with such feelings. Most participants displayed considerable insight into the fact that smoking could not actually relieve anxiety or stress. One participant stated, "It's sort of like one more cigarette will relieve the anxiety, but it doesn't, obviously. That [is the] misconception." Another participant acknowledged the temporary nature of even the limited relief provided by cigarettes in times of stress:

> ...it does relieve stress I think, my..., very temporarily, but it does help. When I'm stressed and have a cigarette, I feel a bit better. But that's just a very temporary thing,

> because then you get nervous again and want another cigarette, like 20 minutes later or whatever, so, yeah. It doesn't really do anything really. It's just a, habit, bad habit.

In another interview, while discussing smoking as a means of dealing with stress, the participant described using smoking as an escape from boredom or as a "time out" from particularly challenging situations:

> No. It feels like is going to be a benefit because it is a temporary way to step back from a situation. I mean, I have a door near where my office is that is very close to where I am. So I will take a cup of coffee and go out and have break. Instead of smoking 1 cigarette, I will smoke 2. Now that's (emphasized) a relatively new habit. And that is because, I am stuck on something, or I am bored, or I, something that I really want to do or think that I should do that seems really difficult...so I just give myself and extra break from the reality of being in my office and try and tackle something that...and so, it's a kind of escape.

Participants described using smoking as a motivational tool to help manage difficult tasks. Smoking created either a momentary escape, or was used in preparation or as reward for the completion of a difficult task. One participant commented, "I need far more motivation to do things than I used to do. So I am rewarding myself before and after with more cigarettes."

Of course, smoking itself created its own particular stress and anxiety. One participant articulated how smoking cigarettes caused a cycle of stress induction and reduction. Running out of cigarettes was a source of stress, while smoking was his primary means of stress relief. As a result, this participant found himself trapped in what he called "a vicious cycle of constantly having to feed this addiction." In a similar account, another participant noted that, while smoking had a beneficial effect in that it allowed him to relax, it also had a stimulant effect. In sum,

participants consistently attempted to use cigarettes to modify their mood, while also acknowledging that cigarettes actually had only minimal and temporary beneficial effects in this respect.

Participants frequently mentioned that boredom, explained as a mood reflecting both the absence of activity and a longing for activity, affected their smoking patterns. Participants saw smoking as a time filler, as something to do when nothing else was available. The less participants had to do, the more they seemed to smoke. Increased smoking in response to boredom was even more pronounced in hospital settings.

One very high-functioning participant who had just turned fifty and who found himself particularly bored at work, demonstrated some of the connections between boredom, mood, and smoking pattern changes:

> Because I'm basically a very discontented person with my life right now. Without going into any details. I am not happy at work. I am not completely unhappy in my life, but I feel in some kind of need to....I don't know....engage more with the world, get out more, do things. While I am thinking about doing that, I'm sitting here chain smoking (gestures) and going "what am I going to do? What do I do today?" I mean, I have an aunt who is 83 and she wakes up in the morning and says "I'm so excited to get up." And I drag myself out of bed and I go "oh what the hell am I going to do now?" So I sit and I smoke. And I don't even enjoy it that much. . . . It's the time filler. . . It's a time filler . . . (pause) . . . how else would I describe it? . . . But, when I am on my own, it's just like, "Okay! This has become my hobby." This is really pathetic (laughter).

Other participants described smoking in terms of "ruminating" and "killing time." Hospitalization was particularly likely to involve extended boredom, and therefore to cause increased smoking:

> I was smoking a lot more because I was in the hospital and uhhh, ummm I, let me think, uhhh, like when you are in the hospital there's not a lot to do there. Then they just, they talk to you everyday but you have a lot of time to yourself. And I was smoking like a pack and half a day when I was in there because uhhh, I, I was just nervous and I, I, there was nothing else to do really, so I just smoked more. Yeah. Because you wake up early when you are in the hospital, they wake you up early. And then you go to bed early, but, you have more of a day, so I would smoke, uhhh, quite a bit.

Some participants also found the experience of hospitalization especially stressful, and consequently found themselves smoking more heavily than usual. The underlying causes of mood changes in hospital can be complex, even indeterminable, but participants clearly modified smoking behaviour while hospitalized.

Health

Participants were asked to explain how smoking affected both their general health and their mental health. They were also asked whether or not they believed that smoking affected the symptoms of their illness or the effects of their medications, including side-effects. Participant responses are organized under the following headings: General Health Effects, Ties to Mental Illness, and Managing Side-effects and Symptoms.

General Health Effects

Although most participants were aware that smoking led to poorer health, they did not always recognize the seriousness of the physical effects and risks involved. Many participants

related the shortness of breath or the restricted ability to perform physical tasks they had experienced to cigarette smoking, while others showed a more sophisticated understanding of the relationship between smoking and increased heart rate, cardiovascular disease, asthma, cancer, and emphysema. Only two participants proved unable to provide concrete examples of how cigarette smoking negatively affected their health. Several participants recognized smoking as a death sentence, or viewed smoking-induced cancer as an inescapable fate. As one participant explained

> I remember hearing about it when I was very young that US Surgeon General declares that tobacco consumption is linked to cancer. It was big news on that day. Before that no one would have thought so. Now it's like, sort of like, if you didn't know that you are just brain dead or something, right? It's kind of like, now, it's kind of like you are guaranteed to get cancer if you smoke.

However, this same participant also tried to calculate when exactly he was likely to develop cancer, and expressed the hope that, by that time, a cure might be available. Somewhat surprisingly, this calculation helped him to recognize the potential benefits of quitting immediately:

> But, I still think I could quit and benefit from quitting. Even though I am...I am only 46, there's two ways of looking at it. I think I could delay the onset of lung cancer if I quit this year and cleaned up my act. If the onset of lung cancer in my case was 10 years later than it might have been then there might be a more effective treatment for me and I might save myself indirectly that way. In a roundabout way, as opposed getting it within 10 years and suffering and dying right away. I hear it is pretty fatal.

Other participants measured their own health against the health of other people who were clearly "worse off." For example, one participant minimized the effects of smoking on her own health by comparing herself to an acquaintance:

> ... but I plan on quitting when I come back from this trip and join this smoking group. But that's not a lot compared to ... I know people ... my neighbour for instance, I won't name any names. She's a year or two older than me. If I coughed the way she coughs, I would have quit.

For this participant, the presence of dramatic symptoms in someone else seemed to inspire a more serious contemplation of the dangers of smoking.

Participants were asked if health care professionals had discussed smoking with them, and most replied that they had not. Few participants could recall any specific conversations with health care professionals on the subject of quitting or reducing smoking, and, in any case, most participants placed little or no value on such conversations. One participant reflected on what health care professionals had told him:

> My previous psychiatrist, he thinks that 'smoking is part of you, isn't it?' And I said 'yeah...' He didn't.....it wasn't in his interest to, to force that on me, because we had other things that we had to deal with. So nobody has actually cornered me and said 'if you don't quit smoking you are going to lose 10 years of your life.' Nobody has said that to me (laughs). But everybody knows. ....I don't think about that."

This participant not only noticed that his health care professionals were specifically not discussing the issue of quitting with him, but also used this reflection to comment on his own self-denial about the terrifying effects of smoking. Another participant, who had been

interviewed for an earlier study, explained how a previous researcher's questions had prompted him to think about his smoking and take action to reduce his consumption by ten cigarettes a day. This suggests that health care professionals can contribute to effective smoking cessation initiatives, and that research can constitute valuable intervention.

Participants were asked to talk about how they viewed their current health, which led some to discuss the potential for declining health precipitated by smoking. A lack of urgency bordering on a lack of concern about the negative effects of smoking on health was a common theme. One participant rated his current health as follows:

> So, I would say good, all things considered. I mean, I have a friend who is in her early 70's. She smoked since she was 20. She is quite frail and you know, some of it is our genetic disposition to have certain health issues. It's pretty clear that smoking is affecting her health...but then she's 73.

This participant distances himself from the notions of his own ill health by noting that his friend is much older than he is, and by emphasizing that frail health is to be expected with increased age. He also asserts that genetic pre-disposition is important, thereby disassociating ill health from modifiable behaviours like smoking. Other participants described their own health in similar terms, using references to other, more severely unhealthy people to avoid dealing directly with their own at-risk status.

For participants with limited financial resources, smoking created additional health risks by indirectly causing other unhealthy or risky behaviours, including skipping meals, collecting cigarette butts from the street, panhandling, and begging. As one participant explained, "If I could afford it I'd do it, I'd try not to pick butts out of the gutter and the parking lots and sidewalks. . . . I try not to die of emphysema or whatever it's called." Participants who collected

and smoked cigarette butts recognized that this behaviour potentially increased their risk for emphysema, given that, as one participant explained, butts contain the very last tobacco in the cigarette, in which the highest and least filtered concentration of all the chemical ingredients of the smoked cigarette remain. Participants perceived that rolling cigarettes using only the tobacco from butts created stronger, smellier, and more hazardous cigarettes.

Two participants voiced the belief that self-rolled cigarettes were less harmful to their health than store-bought cigarettes, although for different reasons:

> I think there is more chemicals in store bought cigarettes than in tobacco in the can. Because once in a while when I buy a pack of store bought cigarettes I find I cough. Now I roll my own, and I smoke menthol. And I roll my own, I don't seem to cough.

> I: And you just smoke cigarettes without a filter on them? Just in the paper roll?
>
> R: Yeah. Doesn't cause cancer. They say those filters, they get when they get warm they have a vapour that affects your glands and your lungs. They're right.

Close to one half of the participants connected marijuana use with cigarette smoking. Several participants did not characterize marijuana use as a smoking activity. Participants who used marijuana expressed mixed opinions about the dangers of marijuana compared to the dangers of smoking, although some believed marijuana to be less harmful than cigarettes. Many participants reported that their smoking activity increased and the pleasure of either marijuana or tobacco was enhanced when the two substances were used consecutively or in combination with each other.

> I: What is the most enjoyable cigarette for you?
>
> R: Probably after smoking pot.

R: It's got a good taste to it after, after the pot.

I: The taste is enhanced or it's different then?

R: ahhh, it's enhanced.

To sum up, when asked what they would do if they could do one thing to improve their health tomorrow, many participants stated that they would quit smoking. However, none of them was committed to any clear plan for quitting. One possible interpretation for this apparent paradox may be that participants did not believe that a real understanding or implementation of healthy behaviours was achievable.

Cigarette Packages are an Important Source of Health Information for Some

Although the value and utility of the warning messages displayed on the front of Canadian cigarette packages, which often include a graphic of a diseased body organ, may not yet be fully understood, this study indicates that people with schizophrenia appear to be paying attention to this type of advertising. Participants who self-reported as having schizophrenia demonstrated a strong awareness of and response to the anti-smoking advertisements on cigarette packages. When asked how smoking might affect his health, one participant from this specific population indicated that cigarette smoking is known to cause gingivitis, and connected his own self-consciousness about smoking in public with his source for this information:

I: And where do you find this information about it causing gingivitis and?

R: mmm, on the cigarette package. It even says "don't poison us" as in smoking in public and poison, you know, drifting the smoke on other people who don't smoke, and such.

Another participant with schizophrenia, who was less articulate about identifying the specific effects of smoking, had nevertheless gained a vivid understanding that these effects were negative as a result of cigarette package warnings:

> R: Well, there's a lot of bad things with smoking. That's why, being told that, it's down on cigarette packs. Like this cigarette is bad, this type of cigarette is bad, this is bad for this, this is bad for this...and this...Every cigarette has this, by law has to, has to break down the side-effects of smoking and they all have bad things about it. They even show pictures of it. They show a picture of the organs. The organs are all black. That's pretty scary.

Participants who do not have schizophrenia did not exhibit this kind of awareness or response.

Ties to Mental Illness

Participants generally had a difficult time describing whether or not they perceived that their smoking was affected by their mental health. Most were able to recognize and report that their smoking increased with exacerbations of their mental illness, but very few connected the changes in their mental health with the act of smoking. One participant, however, claimed that smoking had rearranged his brain chemistry in such a way that quitting actually triggered his mental illness:

> I just think, you know, my mental illness was triggered when I quit. And then when I restarted at age 25...like I quit for six months, but I quit cold turkey, and I think that's when the mental illness started, like I deprived myself of the chemicals and the nicotine and then I restarted 6 months later and that's when the mental illness really set in. And kind of like, I was predisposed to it, you know, because I had smoked I guess for 10 years by then.

As discussed earlier, the use of cigarettes to help manage moods and stress partly connects smoking with mental illness. For the participants in this study, cigarette smoking undoubtedly constituted a mechanism for managing and responding to mood changes. Beyond this, however, most participants denied that smoking had any recognizable effects on their mental illness.

No participant reported smoking as affecting their medication(s) or medication side-effects, and, generally speaking, participants did not perceive smoking as particularly useful in managing the symptoms of their illness. Whereas one participant expressed the hope that the right medication might help him resist and/or reduce his smoking, another expressed the belief that his medications actually stimulated cigarette cravings. When asked directly whether or not he experienced any benefit from cigarettes in terms of managing the symptoms of his mental illness or the side-effects of his medication, one participant stated: "No, it's, it's the same whether you are smoking or not, it's just a condition of the mind. Your mind progresses the same way as when you are smoking as when you are not smoking."

Loss of Control (addiction)

Participants reported that, although smoking often started out as a desired and desirable activity, they found that its addictive effects frequently led to unexpected change(s) and a growing loss of control, which detracted from the enjoyment of tobacco and, over time, entailed a sense of resignation to the addiction. One participant saw smoking as having a "death hold" over him.

The smoking behaviours and patterns described by participants with schizophrenia were often more impulsive in nature than those described by participants without schizophrenia. Within this population, smoking was often limited only by personal financial resources and many

participants expressed that they would smoke more if they could buy or obtain more tobacco. One participant stated that his desire to chain-smoke while drinking coffee was only regulated by his lack of money. When asked if he spent all his money on cigarettes, he responded: "Yeah. This is my life. This is my life." Participants with schizophrenia appeared less concerned with controlling their smoking behaviours and often saw smoking as an integral part of who they were. If sought, any sense of control over smoking was most frequently related to making sure they did not run out of cigarettes, or to saving money. One participant who found he was always running out of cigarettes chose to make rolled cigarettes in order to slow down his cigarette consumption.

Although participants spoke of their addiction to cigarettes in different ways, they admitted to a common sense of resignation to smoking, signifying a certain loss of control that occurred over time. Participants gave the following reasons for quitting and/or wanting to quit: the desire to save money, the wish to preserve or foster close relationships, and a concern for their physical health. However, a profound sense of powerlessness, and/or the inability to summon enough willpower to quit, often blocked the taking of any immediate action towards quitting, and/or prevented the fulfillment of quitting goals. Many participants reported making multiple attempts to quit but few were able to describe effectively either how cravings affected them during periods of abstinence or how they had planned to manage such cravings. Those who understood some of their own smoking triggers said they had contemplated plans for managing cravings during future quitting attempts, but none were actively attempting to quit or had any firm plans for quitting.

Participants who reported that they were contemplating quitting remained uncommitted or committed only to non-specific future plans. These participants expressed a general sense of

personal responsibility for quitting. One participant described it as "my own battle," emphasizing the solitary nature of quitting. None of these participants thought that quitting would be easy and many described a belief that a smoking addiction was more severe than a heroin addiction.

Participants with schizophrenia more typically voiced no desire to quit smoking. One participant described how a lack of money curtailed his smoking pattern from 2 packages of cigarettes a day to 4 cigarettes a day, and stated that "he just didn't have a job to support it." Although this participant expressed an indirect desire to quit by acknowledging the risk of cancer and the pain involved in such an illness, he also indicated that he would likely continue to smoke marijuana, stating that it was "not as dangerous as cigarettes." Another participant with schizophrenia expressed what amounted to a determination not to quit:

> I'm pretty stubborn about it, I want to cut back on smoking, but I won't quit. I'm just stubborn about it. ... I pretty much made my mind up somewhere between 18 and 20 that I wasn't going to quit.

This participant expressed a desire to reduce his smoking, but this desire centred on the sense that he was wasting money rather than on health issues:

> Well sometimes I'm up to 2 packs a day. That's $20. That's expensive compared to a half pack a day which would be like $5. You can see my foolishness, it's sort of my grief for the cigarette by smoking 2 packs a day, it's not very bright.

Nicotine Replacement Therapies

Nicotine replacement therapies offer a nicotine substitute to help reduce the effects of withdrawal from nicotine addiction for people who have quit smoking either voluntarily or involuntarily. Almost all participants were familiar with nicotine substitutes in the form of a chewing gum or a trans-dermal patch, and some had direct experience of using them. However,

these products received mixed reviews. Among participants who reported that the gum or patches did not work, there was a sense that these substitutes did not provide the necessary "hit" they were accustomed to receiving from smoking a cigarette, or that they had no noticeable effect. One participant described them as not only a "joke" but also a consumer conspiracy:

> I tried them out because that's all they were offering. They don't do nothing for me, I don't know, what theory they got behind that. It's just, it's the plastic industry, they're gimmicks to sell more and more.

Another participant stated that, although the nicotine gum didn't really work, it was "better than nothing" because it "cut the cravings." This suggests that he did not clearly understand the nature and purpose of the gum, and therefore did not realize that the gum was likely working exactly as it should. Other participants expressed satisfaction with the nicotine patch as a substitute for cigarettes, and found that the patch made the necessary abstinence associated with involuntary confinement more comfortable. Nicotine substitutes did not seem to provide participants with any additional sense of control over their smoking addiction.

Although many participants expressed a loss of control to smoking addiction, approximately three-quarters of the participants did not want to quit smoking. However, within this group several people reported seeking to reduce and/or gain better control over their smoking.

One participant in his sixties retrospectively described a life of few meaningful social connections and noted that he would only be motivated to quit smoking by circumstances that even he considered unrealistic: "Yeah, if I had a wife and a son, or daughter or something, responsibilities, I could quit, but I've never lived like that." Among the participants with schizophrenia, this kind of vision of dramatically different and therefore highly unlikely

circumstances as the only reason that might prompt quitting was a repeated theme; such expectations effectively negated the desire to quit smoking.

Start and Stop Depending on Environment

While there was some indication among all the participants that individuals adjust their smoking behaviour changes according to situation and environment, those participants with schizophrenia described a somewhat unique ability to stop smoking if an authority figure asked them to or if their environment did not permit smoking. One smoker of two packages a day who was incarcerated and required to give up smoking without nicotine substitutes did not find the experience challenging:

> That was fine with me, I didn't have any struggles. They've taken more smoking out of more of the jails. I like that, instead of having to argue with people about cigarettes. So I have been in jail without and I think it is good. I have had no problems going 2 or 3 months without them.

This participant demonstrated an unusual ability to remain unaffected by sudden abstinence from tobacco. He also provided a brief glimpse into the prison system's underground cigarette economy. Jails served as temporary residences for more than one participant and often required smoking abstinence.

A thirty year old participant described quitting without nicotine substitutes on a family vacation, in response to his father's request: "...because they don't like smoke and they weren't going to let me smoking the hotel room. And my Dad just said 'look, don't buy any.' He just didn't want me to, so I didn't."

Among participants with schizophrenia, hospital stays on the psychiatric unit tended to encourage an increased rate of smoking that was correlated to boredom, nervousness, or the

structured outside breaks offered to smokers. Whereas certain environments, such as prisons, and certain authority figures, helped some participants to quit without using nicotine substitutes, hospital environments tended to encourage patterns of increased smoking.

Summary

Participants described tobacco as a commodity and smoking as an activity, and connected both with self- and social image. They linked smoking to the creation of power and influence, affecting all social interactions and relationships. Participants acknowledged both the positive and negative aspects of smoking and explained that cigarettes had complex meaning(s) within their individual lives. On the one hand, cigarette smoking was perceived as an agent of change promoting increased social contact and connection; on the other hand, it was recognized as creating a particular stigma based on the many negative effects associated with smoking. The perceived positive and negative aspects of engaging in smoking can be experienced contemporaneously, or, as participants more often recounted, smoking began as a positive experience that then evolved into a negative experience. Important themes emerged from the data that reflect how smoking affects self-image and self-esteem, and, in particular, how social relations structured around smoking more frequently operate to isolate rather than increase social contact in contemporary contexts.

CHAPTER 5: DISCUSSION

In this study I describe the smoking attitudes and behaviours of a group of community-dwelling persons with SPMI. While numerous researchers have focussed on tobacco use and mental illness, the perspectives of persons living with mental illness have until now been largely ignored. The participants in this study revealed that smoking has been and continues to be important in their lives. For most of the participants, smoking began as an anticipated positive enhancement of their self-esteem and/or social identity, but evolved into a stigma with associated negative consequences. Participants perceived smoking as affecting their image, influencing social relations, and helping them adjust to mood changes. Acknowledging smoking as an addiction, participants often described a sense of loss of control while also paradoxically accepting personal responsibility for their quitting efforts. For many, both smoking and smoking cessation were inextricably connected with finances and the limits thereof.

How participants perceived their personal health in relation to cigarette smoking varied significantly. In responding to my primary research question - what informs and influences smoking behaviours among community-dwelling persons with SPMI - participants revealed the complex ways in which they experienced smoking both as a group and as individuals, and in so doing illustrated the various agents that shape individual health choices around smoking. In this chapter, I relate selected themes and narratives derived from the participants in this study to the subject literature, address the study's limitations, and suggest areas for further research.

The Image and Social Relations of the Smoker

Participants repeatedly reported that the initial impetus for smoking was related to peer pressure and/or to the belief that smoking could help create an image that would guarantee acceptance into desirable social circles. In this respect, the participants echoed the explanations

for commencing smoking provided by teenagers in a variety of studies (Denscombe, 2001; O'Loughlin et al., 2002; Plumridge, Fitzgerald, & Abel, 2002). The act of smoking – often a shared act – brought a sense of social acceptance, which in turn inspired an increased sense of self-worth and confidence; smoking helped participants to build and participate in social networks. As a result, participants initially perceived the transformative power of smoking as powerful and positive.

All the participants in this study had smoked for many years. Public attitudes to smoking have changed considerably over the last thirty years, and, in contrast to the glamorous tobacco advertisements of the time when most participants started smoking, current images of smoking tend to be negative and to stigmatize smokers. The participants, who had begun smoking in the hopes of enhancing self-image and improving social connections, found their self-esteem diminished by the stigma currently applied to smoking, and the ensuing marginalization of smokers. Although most participants continued to create bonds with other smokers through smoking, and thereby gained a sense of group membership, such membership was largely perceived as negative. Participants identified bonding as occurring with both other smokers and with cigarettes. Those participants who were more focused on the activity or mechanics of smoking found comfort in the routine of smoking and described cigarettes as their "friend." Lawn, Pols, and Barber (2002) described similar findings in their qualitative study.

Smoking affects human relationships in a number of ways, and conversely, relationships with others can be a powerful influence on smoking behaviours. Green and Clarke (2005) found that smoking provided an important means of social connection, and this finding held true for the participants in the current study. Although they noted that smoking limited their social contact with non-smokers, participants in the current study were also aware that being a non-smoker was

not always the best option. The participants recognized that, given how many persons with SPMI smoke, being a non-smoker might exclude them from their peer group. Maintaining membership in the social network by smoking was especially important in situations in which persons with SPMI were co-habiting, either temporarily or permanently, with other persons with SPMI. Clearly, the effects of smoking on the social relations of persons with SPMI are complex; these findings are supported in the literature. For example, in a 2000 pilot study, (Lucksted et al., 2000) reported that whereas smoking created group membership between people with SPMI by fostering social interaction through the activity of smoking and sharing cigarettes, it also limited social contacts with non-smokers within the same population.

Stigma

Stigma has been conceptualized as society's labelling of a person as deviant or socially unacceptable, a process that constitutes and/or entails a form of psychological punishment (Kim & Shanahan, 2003). The stigma attached to smoking often operated to modify the participants' behaviour. Community-dwelling persons with SPMI are stigmatized by multiple factors, including mental illness, poverty, and dependence on welfare (Wilton, 2003). Smoking creates additional marginalization that further threatens individual health trajectories. In order to improve health trajectories in the SPMI population, it is important to understand and address each identifiable element of stigmatization. The World Health Organization has recognized how the impact of the stigma of mental illness leads to decreased self-esteem and worsened health trajectories for people with SPMI (WHO, 2005). In this study, participants reported feelings of shame, lowered self-esteem, and poorer health choices, all related to the added stigma of smoking. It is important that health care professionals pay more attention to helping people with SPMI deal with the additional stigma attached to smoking.

Smoking stigmatizes in ways that create additional social barriers for people with SPMI. Social relationships are important for people with SPMI for a variety of reasons. Participants provided several examples of the ways in which smoking created barriers to building relationships with other non-smokers; in this respect, they echo conclusions of Williams and Ziedonis ((2004) who emphasized how smoking for those with mental illness creates barriers to "relationships, employment , housing, and other mainstream activities" (p. 1068). Stigma also reduces the chances for the successful social interaction commonly regarded as part of effective treatment for people with mental illness (Granerud & Severinsson, 2006). In sum, smoking and the current stigma of smoking potentially create barriers to social interaction for people with SPMI, and thereby reduce their chances of improved health.

Self-esteem

Self-esteem provides an important assessment point for measuring the health status of persons with SPMI. The findings of this study indicate that the relationship between smoking and self-esteem is complex. Many participants started smoking to boost self-esteem, with the expectation of increased social acceptance. This data is borne out in the literature: lowered self-esteem has been shown to be associated with mental illness in adolescence and is a suspected risk factor in smoking initiation (Guillon, Crocq, & Bailey, 2006). The findings from this study advance understandings about the ways in which potential linkages between smoking and self-esteem may be cyclical. Low self-esteem may initially prompt the uptake of smoking as individuals attempt to find social acceptance. For some, smoking can help to create the desired social contacts. However, smoking also leads to further stigmatization and marginalization, and propagates activities related to addiction, all of which *decrease* self-esteem. Thus, smoking establishes itself as an apparently cyclical pattern of improved and diminished self-esteem.

Further investigation into the relationship of smoking to self-esteem in populations of community-dwelling with SPMI may offer other important insights for developing effective smoking cessation programs and improving health among this population. It is likely that this population would benefit from smoking cessation programs that include specific strategies to target the development of skills and cognitive processes for increasing and maintaining higher levels of self-esteem.

Finances

Poverty is almost inevitably stigmatizing. Financial hardship increases people's vulnerability and poverty is recognized as an important determinant of both mental and physical health (Wilton, 2003). Persons with SPMI often face difficult financial challenges due to unemployment and near-enforced dependency on social welfare systems; they are often on fixed incomes. In addition, they tend to have an increased incidence of smoking, and often smoke more heavily than members of the general population (Leonard et al., 2001; Wilton). Consequently, smoking exacts a heavy financial toll among persons with SPMI. Although I did not focus on participants' financial situations in this study, the high price of cigarettes, and the effect of such prices, emerged as a recurring issue during interviews. Most participants were on government financial assistance or had other fixed-income sources, and many participants discussed how their limited financial resources of necessity moderated their smoking behaviours. Participants frequently devised special controls and behaviours to try to reduce the expense of cigarettes. Many participants spoke openly of the "burden" of acquiring cigarettes. In a recent U.S. study of persons with schizophrenia, Steinberg, Williams, and Ziedonis (2004) estimated that approximately one-third of each individual participant's income was spent on cigarettes. In Canada, the rate of adult persons with mental illness living in poverty is double that of the

general population (Wilton). Public policies that increase tobacco prices likely impose a disproportionate financial burden on people with mental illness, a burden which often has serious and unexpected consequences for their health. The participants in this study provided several accounts in which a lack of money, and the consequent unavailability of cigarettes, led to the adoption of poor health habits, a negative outlook, and/or personally undignified conduct. Participants described skipping meals, living in substandard housing, picking butts off the street, or begging and panhandling to obtain cigarettes when money was not available. Thus, for this population, although cigarette consumption might be reduced through increased cigarette prices, any resulting health benefit is potentially offset by other poor health behaviours that may be equally or more detrimental. Increasing cigarette prices by means of taxation is part of a wider social policy designed to curb smoking, and the effects of this policy in relation to vulnerable populations have yet to be explored (Greaves et al., 2006a; Greaves et al., 2006b). This study indicates that public policy regarding cigarette pricing and taxation may in fact promote negative health outcomes in persons with SPMI. The participants' accounts support the recommendations made by Greaves et al. (2006b) for increased research into the effects of public tobacco policies on the health of vulnerable populations, including persons with SPMI. Greaves and her colleagues specifically mention the importance of such measures of mental health assessment as self-esteem and social connection, and urge increased efforts to identify and understand how these and other variables are impacted by public policy initiatives related to tobacco.

Attitudes Towards Health

Participants seemed to struggle to make clear links between personal health risks and smoking: they assessed their own health in terms of other people who were "worse off," or they interpreted smoking as presenting only future risk. Using these perspectives, participants

effectively distanced themselves from the health risks of smoking. Few participants recognized that smoking currently had any effects on their health, and were consequently not prepared to take immediate action to reduce or quit smoking. Although participants had the cognitive capacity to understand the health risks associated with smoking, there was little indication that this awareness would provide sufficient motivation to modify smoking behaviours.

Lawn et al. (2002) found that many persons with SPMI felt a certain hopelessness about their mental illness, which created a "Why bother?" mindset around smoking cessation. The participants in the current study did not reflect this attitude. None of the participants in this study spoke of his or her mental illness with a sense of despair, or blamed that illness for their health problems. Instead, participants related any health problems they might have to purely physical issues (often the result of some personal injury or accident), or to circumstances beyond their control. This may be a reflection of relatively better mental health in the participant sample in this study, compared to Lawn et al.'s sample. Most of the participants of this study enjoyed long periods of stability in their mental health condition, and were consequently more optimistic about their mental illness.

Self-Medication Theories

Many researchers have theorized that the desire to self-medicate explains the increased incidence of smoking and heavier smoking patterns among persons with SPMI (Glassman, 1993; Hughes et al., 1986; Lasser et al., 2000; Leonard & Adams, 2006; Patkar et al., 2002). These researchers have suggested that persons with SPMI smoke to help moderate the symptoms of their mental illness or the side-effects of their medication. The behaviours described by participants in this study challenge these theories. The participants in this study admitted to smoking to manage their moods, but did not offer a single account of using smoking to assist

with symptom relief from their mental illness or with the side-effects of medication. De Leon, Diaz, Aguilar, Jurado, and Gurpegui (2006) found similar limitations to the self-medication hypothesis. In their recent study involving persons with schizophrenia, De Leon et al. adopted a narrower definition of the self-medication theory and looked at whether or not smoking positively affected akathisia. They were unable to find any association between heavy smoking and akathisia, which led them to conclude that a self-medication hypothesis did not help to explain smoking or heavier smoking in persons with schizophrenia. Therefore, both the current study and de Leon et al.'s indicate limitations in the self-medication hypothesis. Some differences between the current study and previous studies of the self-medication hypothesis may be due to variations in the severity or type of mental illness of the participants involved; I have not fully explored these differences. The current study does not offer any particular insight into why persons with SPMI are more prone to smoke.

Boredom and Mood

Boredom might be described as a mood state associated with a disinclination to engage in activity for stimulation (Eastwood, Cavaliere, Fahlman, & Eastwood, 2007). Many participants described smoking to counter boredom, echoing previous research by el Guebaly et al. (2002) and Van Dongen (1999). Both el Guebaly et al. and Van Dongen demonstrated that smoking forms an important but not always major part of daily routine for persons with SPMI by providing specific activity and structure for the day. Faulkner, Taylor, Munro, Selby, and Gee (2006) recently suggested that organized physical activity may relieve boredom, enhance self-esteem, and increase social contact in persons with SPMI. The role of organized physical activity in improving health outcomes in persons with SPMI who smoke constitutes an additional, potential line of inquiry into what agents influence smoking behaviours both

negatively and positively. Follow-up studies are required to explore the ways in which individual functional level affects boredom among persons with SPMI, and to test whether or not community involvement may work to lower this population's experiences of boredom and its dependence on smoking to counter boredom.

Knowledge Acquisition and Application

Persons with SPMI retain and act upon the information they receive about smoking. Cigarette packages constitute one source of information, and social experiences constitute another. Social experiences in particular appeared to inspire some participants to develop a sense of conscientiousness that operated to change smoking behaviours, in an effort to protect others from the harms of second-hand smoke. Participants frequently expressed the desire "to do the right thing." It was beyond the scope of this study to determine the exact source of this increased conscientiousness, but the issue clearly merits further consideration. Discovering the agents that stimulate such a powerful emotion may help to increase our understanding of what can successfully motivate change in smoking behaviours.

Participants stated clearly that health care professionals (HCPs) had not discussed smoking cessation with them. Lawn et al. (2002) found that persons with SPMI often perceive HCPs as directly or indirectly contributing to or reinforcing their smoking behaviours, and the participants in this study confirmed this finding. This was particularly apparent when participants were confined in hospital settings, in which cigarettes and smoking as an off-unit privilege were used as rewards for good behaviour. Further research is required to understand HCPs' perceptions of smoking among persons with SPMI, and to examine what types of interventions are being offered to assist these populations with improved health around smoking. People with SPMI are either not talking to their HCPs about quitting, or these conversations are having only a

negligible impact. Given how often persons with SPMI encounter HCPs, HCPs would appear to be ideally placed to provide smoking interventions.

Addiction

Participants explained that smoking had almost become an intrinsic component of their identity. They described smoking as part of their image, and as part of how they managed situations of stress, anxiety, and boredom. They stated that smoking was an expression of who they are and how they are socially connected with or rejected by other people. Clearly, for this population, cigarettes are considerably more than a delivery system for nicotine. Therefore, smoking behaviours in this population can be neither fully explained nor successfully altered by simply addressing matters of physical health and/or providing nicotine replacement. The participants' narratives support a theory of complex dependency on cigarettes that includes addiction to some of the 4000 other chemicals contained in cigarettes, complex alterations of CNS neurotransmitters, and secondary effects of nicotine such as mood modulation, stress reduction, conditioned cues, cognitive modulation, and weight control (George & O'Malley, 2004). The participants in this study who had tried nicotine replacement therapy gave mixed reports of the benefits of such therapy, thereby offering some support to theories of addiction that extend beyond simple nicotine dependency. The participants who rejected nicotine replacement therapy did so because they felt that the delivery system failed to provide the necessary "hit" or quick delivery of smoking, or believed that the replacement therapy had no effect. This finding supports the psychomotor stimulant and reward theory of tobacco addiction (Baker et al., 2004). Participants reported smoking to alleviate stress and anxiety in the short term. Although they acknowledged the faulty logic of using a stimulant to counter stress and anxiety, they nevertheless continued to use smoking for temporary relief; this finding supports the theory of

negative reinforcement, which suggests that this type of usage increases the addictive effects of smoking (Baker et al.). In its description of these smoking behaviours, this study indicates that the *expectation* that smoking may help reduce stress or anxiety is more important in reinforcing the addiction, than the *reality* of whether or not smoking actually assists in stress reduction (Baker et al.; George & O'Malley). It is also apparent that the relative importance of various motivational factors for smoking varies from one individual to another, such that effective smoking interventions will need to be tailored to the individual.

Addington et al. (1997) found that persons with schizophrenia were motivated to quit smoking by the same influences that motivated the general population, and that the desire to quit was intrinsically, rather than extrinsically, based. In the study by Green and Clarke (2005), their sample also included persons with SPMI who were motivated to quit, and they viewed the presence of current physical health problems as the motivator for quitting. Although the results of the current study are not generalizable, it is worth noting that, in this study, the participants with schizophrenia did not appear to be motivated to quit, although they seemed willing to consider gaining better control over their smoking behaviour. Furthermore, their motivation to modify their smoking behaviour was largely based around financial issues, rather than the "intrinsic" motivation described by Addington et al.

Although neither constituted a major theme within the current study, both cannabis and caffeine were mentioned consistently enough in the data to suggest that further study of their respective importance and usage might yield valuable results. Some participants viewed cannabis as less harmful than cigarettes, and at least one participant mentioned that, although he might consider giving up tobacco, he would never stop smoking marijuana. A number of researchers have explored the links between cigarette smoking and cannabis use, in mental health

populations (Martinez-Ortega, Jurado, Martinez-Gonzalez, & Gurpegui, 2006) as well as other population groups (Amos, Wiltshire, Bostock, Haw, & McNeill, 2004), and their findings suggest a unique relationship between the two addictions that may impact smoking patterns and the ability to quit. Martinez-Ortega et al. claim that "high nicotine dependence may be considered as an expression of individual psychopathologic vulnerability ... that should be taken into account in smoking cessation interventions" (p.1727). Further examination of the unique relationship between cannabis use and cigarette smoking in SPMI populations is warranted. Probing the question of why individuals will contemplate quitting cigarette smoking while retaining cannabis smoking may provide insight into how people assess the respective health risks of the two addictions, and how perceived benefits may create a preference for cannabis over cigarettes.

Throughout this study, participants indicated strongly that cigarettes and coffee "go together." The relationship between heavy coffee consumption and smoking has been explored within both populations of community-dwelling persons with schizophrenia (Gurpegui et al., 2006; Strassnig, Brar, & Ganguli, 2006) and other mental health populations (Martinez-Ortega et al., 2006). Caffeine and nicotine are easily-obtained stimulants, and the heavy concurrent use of both substances offers an opportunity to hypothesize about its use. Strassnig et al. suggest that the pharmacological effects of stimulants may reduce anhedonia and promote pleasure in persons with schizophrenia, hypothesizing that increased caffeine consumption constitutes an attempt to self-medicate similar to the attempt to self-medicate with nicotine described above. However, the increased prevalence of caffeine use by persons with schizophrenia in the absence of smoking has not been established. Gurpegui et al. observe that persons with schizophrenia who consume caffeine are likely to be heavy consumers, echoing Addington, Addington, and Hodgins (1997),

who note that persons with schizophrenia who smoke are likely to be heavy smokers. Strassnig and his colleagues found that caffeine and nicotine have a complex effect on the neurotransmitters in the body that affect dopaminergic activity; they suggested that nicotine may reduce the stimulant effects of caffeine by activating enzymes that cause the body to degrade caffeine more quickly, thereby creating the need for increased coffee consumption to produce the desired stimulant effect. The effects of caffeine and nicotine on the availability of dopamine, the major neurotransmitter targeted by antipsychotic treatments, may offer clues as to why persons with schizophrenia may find it less difficult to quit smoking intermittently. Other researchers have hypothesized that heavy caffeine and nicotine use may be part of a particular psychopathologic vulnerability in certain individuals, which often also includes the use of alcohol and illegal drugs (Martinez-Ortega et al.). Clearly, the relationship between nicotine and caffeine merits further research. Furthermore, the concurrence of smoking and coffee consumption is a reminder to clinicians of the need to assess for and address *all* addictions for likely withdrawal effects and/or compensatory pattern-of-use changes during the implementation of any smoking cessation activities.

According to the participants in this study, the concept of change, as a symbol as well as a reality, forms an important part of smoking, and this perspective may lead to potential new gateways to quitting for smokers who have SPMI. For participants in this study, the desire to change was a common motivator in taking up smoking, and it is possible that the same desire could operate successfully as a motivator to quit. Indeed, some participants sought change through quitting smoking, and expected that a number of positive consequences would follow this change, including improved social relationships, enhanced self-image, levelling of mood(s), and being perceived as doing the right thing. A better understanding of the role that change plays

in the lives of persons with SPMI may help to develop more successful quitting strategies for this population. The participants in this study did not describe change for improved health status as part of their desired-change discussions. Although many recognized that quitting smoking was important for their health, very few were actually motivated to quit smoking for this reason. Participants who demonstrated changes in their smoking behaviour were inspired by the expectation of various other benefits.

Given how important change was for the participants, change theory would most likely be useful for future research efforts in this area. Indeed, it may also be useful to analyze the data collected for this study with specific reference to change theory. I postpone any detailed analysis of the data in reference to change theory as time impractical and propose it as potential future analysis. The participants' focus on change suggests that the Transtheoretical Model of Change created by Prochaska and DiClemente, and the concept of motivational interviewing derived from this model, may be usefully applied to community-dwelling persons with SPMI who smoke as a means of influencing behavioural change. I suggest the Transtheoretical Model as it is the model most often associated with change and addiction theory, but other models that focus on change have not been fully explored and may be suitably applied to this population and their notions of change. To date, many of the researchers who have applied the Transtheoretical Model to SPMI smoking populations have focused specifically on persons with schizophrenia (Addington et al., 1997; Dalack, Becks, Hill, Pomerleau, & Meador-Woodruff, 1999; Dalack & Meador-Woodruff, 1996; Esterberg & Compton, 2005; Forchuk et al., 2002). With this study, participants provide information that suggests potential broader application of the Transtheoretical Model of Change to smokers who have schizophrenia as well as to smokers with other mental illnesses. Additionally, this study provides clues to what may motivate persons

with SPMI to re-evaluate their smoking behaviours. Issues of image, social connection, and self-esteem are likely more important motivators for change than are concerns over personal health trajectories. Participants rated smoking as a secondary concern, behind many other aspects of their lives, including the problems of basic subsistence and control over their mental illness. As noted by Finnell (2003) in other addiction settings, before the Transtheoretical Model of Change can be successfully applied to mental health populations, any underlying mental illness must be effectively managed.

Participants also described how important cigarettes were in helping to manage times of stress and anxiety. Participants described variously increased patterns of smoking during periods of exacerbated mental illness, particularly those periods that involved hospitalization. Individuals attempting smoking cessation while also tackling this type of situation may require special assistance. Esterberg and Compton (2005) state that persons with SPMI have the capacity to undertake decisional balance exercises and effectively weigh the benefits and disadvantages of smoking against each other to motivate change. However, this was not apparent among the participants in the current study, in spite of the similarities in the participants' levels of readiness to change in both studies. The recurrence of change as a theme in participant interviews confirms that discussing change and using motivational interviewing techniques constitute important and useful methods for promoting improved health behaviours in community-dwelling persons with SPMI. This study supports previous research indicating that psychiatric diagnosis does not influence readiness to change (Rogers et al., 2001) and that interventions aimed at helping those with SPMI quit smoking will still continue to require individual adaptations to be meaningful and effective (Rigotti, 2002). This study also indicates that the use of motivational interviewing

approaches to smoking cessation and health promotion in populations with SPMI merits further consideration and research.

Limitations

The findings of this study are limited for a number of reasons. Because the study was primarily descriptive in nature, depth was limited to a certain extent as I endeavoured to maintain a broader perspective of the phenomena under study, and to recognize multiple areas that may warrant further investigation. This focus remains consistent with descriptive methods as a first step to increasing understanding, but may limit more immediate depth in the findings. Using subsequent and alternate qualitative methods may bring greater depth to the research in select areas. Furthermore, interviews were limited in length because most participants evidenced fatigue after approximately 40 minutes of guided conversation, and this in turn limited the depth of the data. Follow-up interviews should be considered as a means to increase the depth of the data.

Several methodological aspects of this study may affect its findings. Firstly, all participants were residents in the city of Vancouver, British Columbia. The city of Vancouver offers something of a unique social and meteorological climate that may influence individual perceptions of stigma, prevalence of smoking restrictions, and tobacco habits of other smokers. The year-round mild climate permits year-round outdoor activity, which in turn allows for easy access to outdoor tobacco-related activities. Vancouver was one of the first cities in North America to adopt strict no-smoking policies in public indoor venues, including restaurants and bars, and these policies reflect a more general anti-smoking sentiment. People living in cities with more liberal attitudes towards smoking will likely have different experiences and perceptions around tobacco use.

Second, women may appear to be somewhat under-represented in the sample. However, while not claiming a lack of gender differences, no significant gender differences were noted during data collection that would cause me to recruit additional female participants to increase this sample component. Nevertheless, adding more women to the sample may provide an additional perspective not currently available in the existing data set.

All participants were in active treatment with a community mental health team, and were in stable condition at the time of interview and for at least three months prior to interview. Significant differences in findings may result from investigations with those with less stable histories of mental illness, or those who do not have regular support from community mental health teams. Furthermore, mental health team support may vary significantly in geographic locations outside the city of Vancouver.

My personal influence on the findings should be also noted. In qualitative studies such as this, the researcher and participant co-create a dataset through the process of interviewing. I attempted to bracket and recognize my own biases by applying reflective thinking and journaling, and by writing down any initial and overriding impression(s) of each interview immediately following that interview. I personally conducted and transcribed all the interviews. During each interview, I periodically checked my understanding of the participant's views with the participant, as a form of member checking. I always introduced myself as being from a Nursing School, although I was conscious of the fact that such an introduction might create an association with a professional healthcare worker that could potentially stifle participant responses. In the end, no such stifling occurred; on the contrary, the introduction appeared to help build both rapport and trust between myself and the interviewees. Interviews were necessarily time limited and the study was therefore limited to a preliminary examination of

smoking in this population. I chose to use the qualitative descriptive method devised by Sandelowski (2000), which worked fairly well except in one respect: I found I needed to import a higher level of interpretation than Sandelowski suggests in order to condense the data description and analysis. Sandelowski's method does not offer clear guidelines for an interpretive approach to analysis and may not be the most effective method for this type of student research.

Finally, I feel it is important to mention the effect(s) of the research process on the participants. For three of the participants, engaging in the research process actually created an intervention. One participant stated that talking about smoking was "helping him come to grips with it." Another participant described reducing his smoking by 10 cigarettes a day after being interviewed for an earlier quantitative study. A third participant noted that the fact that smoking was being academically studied in this way indicated to him that the negative effects of smoking must be more important and relevant that he had initially believed. In sum, this study serves to remind all researchers, and particularly novice researchers like myself, that research is potentially an intervention in and of itself, and that researchers inevitably affect both study participants and the resulting data.

Conclusions

It is clear that individuals view smoking differently and likely require individual approaches to tobacco reduction. For people with SPMI, adjunctive physical activity may provide increased benefit(s) during tobacco cessation efforts by offering opportunity for enhanced social contacts, potentially improving self-image, and possibly countering boredom. In addition, as suggested by participants, addiction to other substances, including cannabis and caffeine, may require special attention during smoking cessation efforts.

In the discussions conducted for this study, participants repeatedly emphasized the importance of change. I would suggest, therefore, that change theory and motivational interviewing techniques remain viable approaches to assisting individuals with SPMI to achieve improved health outcomes, including addressing smoking addiction. Given how prominently the themes of stigmatization, decreased self-esteem, and marginalization resonate through the participants' comments, it seems likely that efforts to improve individual perception in these areas will help to motivate health improvement strategies. The fact that two participants voluntarily made efforts to reduce smoking following a research intervention suggests not only that people with SPMI can change their smoking behaviours, but also that health care professional intervention can be an valuable part of motivating such change. The importance of close personal relationships with non health care providers was a significant theme in the participants' narratives. Participants did not voluntarily discuss relationships with health care professionals, nor did participants mention such relationships as being "key" in their lives. Although it was outside the scope of this study to probe this issue further, a more in-depth exploration may be useful in determining how perceived stronger relationships between people with SPMI and significant health care professionals might motivate individual health improvement strategies around smoking.

In this study I offer some important initial insights into how community-dwelling persons with SPMI regard and experience smoking in their lives. Future research might include a more in-depth inquiry into some of the more significant elements among the findings. The emergence of the theme of additional stigma in the lives of people already affected by other stigmatizing factors suggests it may be useful to inquire into the basic social processes of maintaining self-esteem, and how these processes function for people with SPMI. Grounded theory may be

particularly useful for further exploring the themes of smoking as an agent of change, and/or the management of smoking stigma. Phenomenology and institutional ethnography could also be used to examine how changing attitudes to smoking manifest in policies and regulations that influence health in persons with SPMI who continue to smoke.

In contrast to the findings described in earlier literature, the participants in this study did not identify smoking as alleviating medication side-effects or aiding in symptom management; clearly this finding merits further inquiry. It may be that smoking offers this type of side-effect and symptom management to people with more severe mental illnesses. Alternative inquiry methodologies like grounded theory or quantitative methodologies may be useful in theorizing and measuring how smoking is and is not used for side-effect and symptom management.

Information is an essential component of promoting better health among persons with SPMI who smoke. This study indicates that, whereas some persons with SPMI remain smokers by choice, after determining that the benefits of smoking outweigh its harms, other persons with SPMI appear unable to take action to quit smoking, even though they want to. People with SPMI constitute a large and important audience for health and smoking messages, and they likely benefit from a diversity of message presentations. I recommend further inquiry into evaluating the use and effectiveness of alternative sources of information for people with SPMI in assessing the effects of smoking on their health.

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THE UNIVERSITY OF BRITISH COLUMBIA

CONSENT FORM

Title of Study: A qualitative study exploring what informs and influences smoking in community dwelling persons with severe and persistent mental illness.

Principal Investigator/Faculty Advisor: Dr. Joy L. Johnson, Professor
School of Nursing,
University of British Columbia

Co-investigator: Lyle G. Grant, MSN Student
School of Nursing, University of British Columbia

Purpose:

The purpose of this study is to learn more about what influences and informs smoking behaviors and patterns in persons with mental illness. This study is part of research conducted for a graduate thesis of Lyle Grant (co-investigator). The final thesis document will be available as a public document through the University of British Columbia. You have been asked to participate in this study because you are a client of one of the Mental Health Teams or identify yourself as having a mental illness and because you currently smoke or have smoked cigarettes. ***Your participation in this study is voluntary. You may decide not to participate or you may withdraw from the study at any time and it will not impact your care and treatment at the Mental Health Team in any way.***

Study Procedures:

If you take part in this study, you will be asked to spend about 45-90 minutes with Lyle Grant (co-investigator) in a location that is convenient for you. You will be asked to talk about your experiences with smoking. You can refuse to answer any questions that you do not feel comfortable answering. Your participation is not a test of any kind and if you have a Mental Health Team your decision to participate does not affect any of your treatment with your Team.

Risks:

There are no known risks associated with participating in this study.

Potential Benefits:

You may not receive any direct personal benefits from participating in this study, however, the information you provide will assist with improved understanding of smoking. This information can help direct further research and the development of health promotion programs that may benefit those with mental illness who smoke.