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CHAPTER SIX

Me Mutu: Planning to Quit

SECTION ONE: INTRODUCTION

The term Me Mutu has been neologised to provide a contemporary Maori language equivalent to smoking cessation campaign prompts to “Quit.” Me Mutu implies a wish to quit or can be interpreted as a plea to quit. Me Mutu is being used here to categorise the preparatory and actual behaviours used to end smoking. Drawing on the qualitative data collected from all the participants, this chapter describes the quitting experience up to the end of the last cigarette. What happens from that point onwards is described in the following two chapters.

The next section of this chapter, documents the decisions and actions grouped under te taha hinengaro, that is the psychological processes involved in preparing to stop smoking. The quitting methods smokers chose, are detailed in section three, te taha tinana, which focuses on physical preparation for quitting. The fourth section, te taha whanau, examines the actions participants took to generate support for their quit attempt in their whanau, work or social environment. Section five, te taha wairua, identifies forms of spiritual preparation or techniques used to support quitting.

SECTION TWO: TE TAHĀ HINENGARO

This section outlines how participants prepared themselves for quitting psychologically. This involved decision making, setting goals, reviewing previous experience, arming themselves with useful information and educating themselves about smoking and the quitting process.
PSYCHING UP

Of those that had stopped smoking, 2 people thought it was easy because they had done the preparation (1). As one of them explained:

A lot of it was mind stuff... When I first took this job on... in my interview... I was up front and said I smoked and right there and then she said well would you consider giving up if we supported you in a programme. I said I'd think about it and when I was accepted in my nice little letter it said that we're very keen to support you in your giving up smoking... so before I even started this job I was preparing and by the time you came along in March or February I was virtually half way there without doing anything... My mindset really had been preparing and I'd done talking to everybody, my family, my husband. I was cutting my smoking down before I started working here. I was shifting a whole lot of habits before coming to work so coming to work made it less accessible for me to smoke which was good. It assisted my motive really... It was the planning work that was the hardest... I hadn't even given up smoking but it was that prep work... shifting everything... like myself and my girls we used to get together in the evenings; we used to all come to each other's homes and we'd all sit round, cups of tea and smoking and so I stopped that (71).

The other participant set a date to work towards. "I took a month to be determined about it, psychologically, to say, Hey I'm gonna do it, take my time, do it when I'm ready... First of April. I had it written on my form." She felt she was helped by her previous quitting experience. "I had already cut down, heaps. And then I started again, smoking more than I did normally, this is before I cut down... so I had an idea of what my psyche should be 'cos I'd done it before" (70).

Of the participants who were smokefree at follow-up, including those that attended NMSCPs, four attributed their success to an actual decision point or mental process, for example: "When I left you that's when I decided... straightened my head out first, once I got that right I knew I could do it" (114); "...it was mental – emotional" (68); "I'd convinced myself that I hated the taste of it and that the smell of it and everything was really making me sick" (9); "just saying this is it, this is what I've got to do" (4).

Most of the NMSCP participants attended preparation sessions as a group or they met on an individual basis with a programme facilitator.

ACCESS RESOURCES

Four of the participants who were smokefree at follow-up, armed themselves with information, for example, they said:
...seeing my relatives die from smoking. Numbers of Aunts and Uncles who have died from lung cancer... I definitely made sure I got lots of information, readings (98).

I also got all these books from the library about will power, mind power (103).

And I used the notes... which said, let that desire pass and it will pass. I believed that and it did... what information is put out is very important... We had a package, a folder, and it had all the information in it... (70).

Another woman said that her psychology study helped, as she said:

A lot have pushed anti-smoking, giving up smoking, mental health. We did neuroscience and looked at addictions. Gives me more of an understanding... it’s been progressive giving up. I know where my weaknesses are. I read more about smoking, read articles, little pamphlets which helped me understand (100).

A few participants thought there “needs to be extra education” (100); korero that would focus on emotional stuff - personal workshops and anger management (98). One woman suggested that people wanting to quit “look at how and why you started... I wrote a short story... back to 13 years old about my first experiences, my memories - it does help” (68).

Only a few of the participants, who were not smokefree at follow-up, said that they accessed information, for instance, an information pack from Te Hotu Manawa Maori was cited as helpful.

PARTICIPATING IN THE RESEARCH

Participating in the research served a number of purposes for participants, such as providing an opportunity for them to review previous quit experiences. For some participants it was a way of getting support and information. A few participants said their participation in the research helped them in their quit attempt, for example, they said:

I think you’re a great asset. You’ve helped me a lot to stop smoking (55).

The encouragement that you had, just the research that you were doing... and the fact that I want to anyway. It is important, I would like to stop smoking ‘cos I know how draining it is (96).

It has helped a lot though, like talking to you the first time. I think that’s another reason it was so easy for me to give up for that week and a half, ‘cos I realised well there is a lot more Maori smokers (110).

A few participants found “the stuff you gave me” (47) useful, that is, things in the koha pack, such as the sugarfree gum about which one participant said, “since you gave me that I’ve bought that all the time” (52). The process of articulating their
smoking experience, participants said served as a consciousness raising exercise. For example, during an interview one participant said, “you just helped me identify something” (16).

The CO reading boosted one woman’s motivation to quit, as she said:

That’s why I want to give up smoking. ‘Cos it wasn’t until you put me on that bloody thing. That’s doubly higher than smoking, and that was giving me the incentive to give up too (107)

A few participants indicated that they felt obligated to succeed for the research or for me as illustrated by the following quote:

I think I was trying to prove a point to you fellas, not to myself aye. Maybe to myself without thinking but I told my husband when you were coming to see me, give me another 6 months and I’ll finish (42).

If participants had not stopped they felt “guilty about the fact, oh she’s coming next month and we haven’t done it” (64). At one point in the repeated process of quit relapse quit relapse, one participant said she asked herself, “Do I really want to be on this research?” (16).

SECTION THREE: TE TAHAtINANA

This section details what participants did to prepare their body for quitting, for example, reducing the body’s dependency on nicotine by cutting down smoking. The methods used to quit are outlined in this section as they all tackle the physical dependency.

CUTTING DOWN AS A PREPARATORY STEP

Though participants spoke of cutting down the number of cigarettes smoked per day as a quitting method, it appeared to be a preparatory action. For example, 5 participants who stayed smokefree, cut down their smoking before stopping completely. As one participant said, “I cut down and then I just gave up. I got down to 3 a day and then to one a day for about a whole month” (43). Another 2 participants talked about dragging out the time between cigarettes:

My after dinner cigarette which was my most favourite cigarette… I used to not after dinner but I’d do it sort of like before I go to bed so I’d just stretched away from my, I was shifting my habits (71).
I was smoking quite heavily - just couldn't afford to smoke so much, dragging it out. The more I was dragging it out I knew it was good... just made a stand... thought I'm not going to joke myself this time... I really wanted to do it... when I ran out I just didn't bother to go back and buy any (98).

One participant still allowed herself to smoke at night time until she got used to that, as she said:

...at the beginning I didn't stop smoking at night. I crave cigarettes at night, and so I thought okay I'll smoke at night... so I stopped smoking during the day... and then when my packet ran out, then I stopped at night... (103).

One participant said she tried to cut down but it didn't work: "after speaking with you I did try to cut down, but it was really impossible being where others were smoking... at home and at work" (68).

Many the participants who were not smokefree at follow-up tried cutting down first. Some of them believed they could not stop cold turkey, for example, one woman said: "I felt I'd been smoking so long I couldn't just knock it on the head. I had to take it easy" (36). "My wife said I had to take it gradually because the last time I tried to do it cold turkey it just didn't work" (22).

There were two main strategies participants (who were not smokefree at follow-up) used for reducing their tobacco consumption. The most commonly used strategy was to cut out whole smoking events, that is, they would stop smoking in the car, inside their house or in their office, or not smoke at work at all. Others would lengthen the time between cigarettes, for example, "like 3 hours between a smoke" (36) or limit themselves to a particular number of times per day when they could smoke. The following quotes illustrate this method:

I started cutting out the early morning ones and cutting out the evening ones, and I was actually timing it... it's a conscious effort to actually, Oh, I want a smoke and I think drag it out a wee bit longer (63).

I've cut it down to only my breaks, my lunch break and at home after work... I did up a schedule... I put my days, my weekdays on the actual plan and then I have tea break, lunch, afternoon tea and then afterhours. Now when I started coming back to work in January I started cutting out whenever I could. In February I started taking out my morning tea break one, but that didn't work.... (22).

I had cut down to about 8 a day... but actually there were days where I'd only have 3 as well, like I'd have one in the morning, none at work, then come home and have 1 after work, and probably 1 after dinner (73).

What I do is I roll me so much and I got a tin and I put it in there, and then I count it (34).
The one that worked pretty well for a time, and that’s by starting my first smoke a quarter of an hour later each day. A friend of mine had said an hour. I wasn’t that brave. So I had my first smoke a quarter of an hour later each day and then smoked as per usual (16).

Some participants tried to go for as long as possible between cigarettes. I had a period of stopping and starting you know. I’d go for a week and something else would come up and then I’d smoke (59).

Try to work it out like just have so many smokes... see how far it’ll take me... Tiring from the morning all the way through to when all the kids are asleep... That’s when I end up wanting to have a cigarette (56).

Sometimes what I do is when I’ve got about 5 left in my packet then I’ll try and drag those on as long as I can (84).

Often used in conjunction with the above strategy, the other way participants cut down was by reducing consumption at each smoking event. This they did by only smoking half of the cigarette or by rolling slim cigarettes, as illustrated by the following quotes:

I never smoke a full cigarette (99).
What I’ve tended to do is half a smoke, throw it out (117)
...was conserving tobacco by smoking slimmer cigarettes (86).

In order to better monitor their consumption some participants had to stop sharing their tobacco, for example, one couple started buying a pack each rather than having a communal pack. Another woman said:

I no longer share my tobacco with people, ‘cos I couldn’t guarantee how much I was actually putting away... I was actually just taking enough for myself to smoke during the day at work... I used to take 6 papers to work, so I knew I was having 6 and then the next day, I was just taking 5 papers, and 4 papers and then I got down to 3 papers and bludging a smoke and then it went back up again. So I couldn’t improve after 3 (63).

Despite the elaborateness of some people’s method and their industriousness, most of these participants were unable to stop altogether. As the previous quote suggests some participants would hit “a brick wall” when they got down to a particular number and others found they see-sawed up and down, usually ending on an increase. For example, one woman said:

The last one I did... Day 1 I had 14 cigarettes. And then I would start to cut down and I was okay. I’d cut down to 10 and this was over a period of... 2 weeks I’d cut down to about 10 without much difficulty... the end of January, I had actually got down to 6 cigarettes a day. But I hit a brick wall... my own counsellor said to me well you know what you’ve hit is that brick wall and now you’ve got to take the leap and just give it up. And my reaction to that was mind your own bloody business... In my mind I thought, well I’ve failed (16).
Changing brands and buying smaller packs were also tried. For example:

I've used other methods too that haven't worked. It's just related to A & D once again trying to change from tailormades to tobacco rather than buying tobacco 50, getting a 30. And then I even went to buy another brand of cigarettes (16).

What one participant concluded from this attempt was that next time: "I'll cut down first rather than going cold turkey. I'll have a longer period of cutting down" (11).

**NICOTINE REPLACEMENT THERAPY**

NRT is a quitting method that enables immediate smoking cessation but gradual reduction of nicotine dependency.

One participant, who was supported to stop smoking by her workplace, used nicotine patches:

I started using patches - I bought the whole course 3 months ago... I had 6 weeks [on 15mg] and then I went to 10 [mg] and I got through the first packet and I didn't use any more... I tried to complete the course but I just kept forgetting about it. At first... I was forgetting to put them on and I didn't really need them anymore... It was actually strong... I went down to the chemist and he talked to me about it and I actually think I was getting a bigger hit than normal and I think that's why I cruised through it (71).

Of participants, who were not smokefree at follow-up, some had tried to quit using nicotine replacement products, but they did not follow the recommendations for use. For example, the following quote shows this woman did not stay on the patches long enough, probably because of the cost:

"I used the nicotine patches for 7 days... The products are so expensive" (76).

Another participant tried gum that had been supplied to a friend of hers. It was probably too high a dosage for this woman and her own blood-nicotine levels had not been allowed to reduce at all as she continued smoking:

The chew gum, a girlfriend had it and I just couldn't handle the taste of it, it was just so foul. I think I might of tried it, half chewing that. But I was still smoking (66).

Another participant who used the patches for a much longer period also continued to smoke which suggests that the patch dosage was not correctly matched to her nicotine dependency level. The following quote from her indicates some resentment about the cost of the nicotine replacement products, which she knew was
no more than the cost of smoking but smoking at least resulted in a pleasurable experience.

I went away to Australia with this group of... people. None of them smoke. I'm not going to embarrass myself and have a bloody smoke and that was 3 weeks ago... I brought the nasal spray, and geez I don't want to get dizzy or get vomity or whatever so I went and got the patches, and I swapped the nasal spray for the patches. Hopped on this plane, bang 4 o'clock in the morning I had my last smoke, and I banged on the patch, and I flew Auckland to Sydney, to Canberra... That was it. In total on the 4 days I was there, I must of had, and I was still wearing my patches, I must of had about 4. Every day since then I've been wearing a patch. I haven't had one on today, I'm chewing gum - 2mg. The chemist said to me you take these as well, which I use now as well as the patch... I've been having a cigarette everyday.

I'm relating money to the patches. I'm saying come to your senses. Look at this money you're spending on patches. Do you want to spend it all year if you don't kick the bloody habit now? That's what I'm saying to my mind... I'm having to fork out $35 a week, and I'm really thinking it's a waste of money (69).

The following participant did manage to stop smoking using the nicotine gum, even though she used it for only a week. However, she relapsed later.

It was either I had to have a cigarette or go and get some chewing gum now sort of thing. I went back on the Nicotinell. I took the 2mg one and I was only needing it 2 or 3 times a day. So I'm about 6mg a day, which I didn't think was too bad, and then I started cutting it down. Because the first time I gave up that's what I used was the chewing gum and I found it really good. And it was quite easy to cut it off. And for the 5 days I didn't use anything. And even just using the Nicorette was about, it wasn't too bad. Like everyone was just asking me out for a cigarette and I'd just have my chewing gum and it was alright (15).

**NICOBREVIN**

Participants' interpretation of the instructions on how to use Nicobrevin differed. While one participant thought she had to use it in conjunction with stopping smoking abruptly, another thought she had to cut down first.

One participant, who was still smokefree at follow-up, stopped smoking with the aid of Nicobrevin which was paid for by her health clinic, however as she said in the following extract she thinks she probably didn't need it:

It was the Nicobrevin, when you read the instructions on what the Nicobrevin does... what I did too was concentrate on what the Nicobrevin was doing to my body, 'cos it's not a nicotine and that was wonderful. I knew I wasn't putting more nicotine into my body... The chemist recommended the Nicobrevin... I liked the idea that it was herbal... I didn't need this drug. And so I thought, I'll go with that. It was a hasty decision... When I went through it when I got home, I thought oh hey it's telling me I'm not allowed to use it yet, until I've made up my mind to stop, and I had to actually stop 24 hours or so beforehand before I could start taking it. Oh damn, if I'd of known
that I probably wouldn’t of got it... and I thought well hell I’m not wasting the clinics money... And the interesting thing about the Nicobrevin was and I put it down to the fact that I’d already had an advantage, ‘cos I’d done it before, was I didn’t need any. I honestly didn’t need it, and it was, my body told me, ‘cos started to make me feel yucky, in terms of, whether it was psychological or not I don’t know, but I felt a little nauseous, and so the last weeks supply I didn’t take (70).

Another participant stopped smoking with the aid of Nicobrevin, but later relapsed. In the following account of her experience she vacillates over whether or not Nicobrevin really helped:

I went on leave and had 3 weeks off, and I gave up in the 2nd week of my leave... That Nicobrevin was really good, the non-nicotine, the 0800 number. But it’s too expensive. It worked. I found it worked for me, ‘cos I didn’t follow what you’re supposed to do, ‘cos you’re meant to cut down before you start, but I found that I couldn’t do that. ‘Cos it says you work it out a few weeks in advance, say like the first week you drop down say 5 cigarettes and then the next week you drop down another 5 and then the next week until you’re hardly smoking at all and then you go onto the programme, and I thought oh this is a bit hard... I thought a month in advance is a bit much. So I thought I’ll give it a couple of months and then I’ll start. So I hadn’t cut down as much as I was supposed to, but I did cut down... I was on about probably 6 a day from my whole packet. And the Nicobevin didn’t really do anything for me. I’d already sort of done it for myself but... I suppose in the back of mind too I had that thought too, hey I’ve paid this much for it I may as well use it... I’m not going to use that again because of the cost. They give you all this stuff on it, so called research and all these people say yes it works and then you read it and oh it must work then. ‘Cos all these people have said a 2 pack a day man, I gave up straight away, and you sort of think if they can do it... (106).

Another participant and her husband bought Nicobrevin, but she didn’t use it like her husband who continued to smoke while taking Nicobrevin, as she said:

I’ve still got it sitting up there, but I don’t want to waste it. Like [husband] wasted his, he took them and smoked (79).

Three participants commented that they did not use Nicobrevin because of the cost:

Nicobrevin was advised to me by my nurse... I didn’t bother finding out anything about it ‘cos I couldn’t afford it... the Nicobrevin was quite expensive (98).

Other Quitting Methods

Some other methods involved substituting cigarettes with alternatives to assist gradual reduction of dependency on nicotine. Unfortunately, none of the following methods resulted in successful quitting.

One participant used clonididine patches, a method she had previously used:
I still had those Clonidine patches in my drawer... I spoke to one of the mental health nurses and asked them about the expiry, they expired 18 months ago and he said to me just to try them. And they worked... it might have been psychological... I was thinking of having a smoke but I wasn’t stressing out... I didn’t stop at all. That was through the cutting down period so... the last patch I had on I took off a week ago.... And you know what I have noticed? Is that my stress has worsened... (16).

Some participants tried herbal remedies as the following quotes illustrate:

I looked at Nicobrevin... instead I went for homeopathic remedies... No, pills. What were they? One was a spray, which worked on the urge to smoke and the other was a tablet which worked on the withdrawal symptoms. And I took both of them... Nothing. No change. And I’m not saying that that was the homeopathic stuff. I don’t know that I was actually wholeheartedly for the homeopathic remedy. And I don’t know that I was ready when I used it (16).

We tried those herbal cigarettes... they’re yuck, non addictive, you’re just sucking burning paper really... it stunk out the whole house... Only smoked 1 or 2 and threw them away (21).

I even ended up getting some herbal tobacco... it was just disgusting. It was just awful. I’ve still got the packet sitting in my drawer now (49).

I did try another solution Stop Smoke. It’s some sort of herbal remedy from the Chemist. Unfortunately that really didn’t work. You just smear this stuff on your cigarette... It makes it very foul, taste, smells. It smells like gun powder. It was actually by the end of like a week and a half to 2 weeks a little bottle, that’s how long it lasted. I actually got quite immune to it so it really didn’t work at all... it did cut down the smoking to a degree but it was only because of the time consuming thing (32).

Two participants attended formal group programmes, for example, one participant who attended an SOS programme reduced her consumption and another who attended an ISIS programme did stop but later took up smoking cigars. The following quotes describe their experience of the programmes:

I tried the SOS programme...it’s by The New Zealand Heart Foundation... and that’s how I’ve cut back... I mean I didn’t realise how much I smoked until I went to that... I thought I only smoked about 4 a day tops, but ‘cos I did a little diary every time I had a cigarette for the first 2 weeks. I think the most I got would’ve been 63. My average for the first week would’ve been any where in between 50-55 and I was like that’s tremendous. I couldn’t believe it... 2 hours a night, 1 night a week for 6 weeks... On the third week you’re meant to cut everything by half and then in the 4th week you’re meant to pick a day and then just stop (66).

By the end of the programme you’re meant to be confident enough to be a non-smoker. To think of yourself as a non-smoker. Like your reference points have changed, hopefully by the end of the course and keep on assuring that your mindsets are different from when you started... when I was going through the ISIS programme and we smoke in a certain way. As I was smoking that way, I was thinking this is gross, I hate this and my mindset’s changed and I’m no longer smoking as I should be, I’m not smoking to enjoy... so I didn’t realise that my mindset has changed, and I prefer to treat it as it is which is an evil and smoke to not enjoy it. Which is inhale, exhale, inhale, exhale (12).
A man who had stopped drinking alcohol using The 12 Step Programme thought about applying the steps to giving up smoking, but as he said, "it doesn't seem so dramatic as using drugs" (32). Another man "tried" to implement the Steps "but it's harder" (53) he said, because the drug and alcohol counsellors suggested he not attempt smoking cessation in the first 2 years of his sobriety.

Another participant who was familiar with Alcoholics Anonymous "used some of the products" from a programme promoted by the Mormon Church.

I heard... there's some extract that helps you with changing your tastebuds... Cinnamon toothpaste, cinnamon chewing gum... it was really good... I'm not too familiar with their spiritual paradigms but I found very few faults... It sort of fits in really good with the spiritual programme of AA (97).

**ABRUPT WITHDRAWAL OF NICOTINE - COLD TURKEY**

Twenty six participants stopped smoking using the NMSCP which incorporates abstinence from smoking. The unaided quitters used a variety of quitting methods. Of the 12 unaided quitters who were smokefree at the follow-up interview, 8 of them said they stopped suddenly, referred to as "cold turkey" (104), or as others put it: "I just gave up" (43).

The following quotes show some of the planning and preparation participants undertook leading up to quitting cold turkey. For example, one participant who succeeded at quitting, made up her own quit programme:

I bought strongest cigarettes which is Pall Mall and I was absolutely chocka. I could feel it in my bloodstream. I actually took time off. I did it away from work. I did it safely. I took 3 days off so I had a whole 5 days... I did it cold turkey. I just smoked to the last one in the packet (78).

Quitting was not dependent on preparation however, as the following successful quitters explain:

I stopped while I was in hospital. I couldn't eat. I don't know whether it was from the operation or not... I just didn't want it... I think the operations had a lot to do with it (31).

...we had a joint and I was having a cigarette as well and I just had a really bad buzz. I started to go crazy... it was really awful... I just like lost control and I was just like laughing and crying... I got hysterical... I was freaking, I thought I was gonna die... started to have a panic attack and my heart was banging really, really hard and I was freezing cold and I just felt really alone... it probably only lasted a few hours, but it felt forever and like my whole life went through my head... I just had to promise myself, if you make it stop, I'll do anything so I got up, got my dak, got my fags and threw them
in the bin and jumped back into bed and the next minute I woke up in the morning and I was fine (72).

For the participants who were not smokefree at follow-up, stopping smoking by cutting down first was more popular than cold turkey. For those that did try cold turkey, their method typically involved smoking to the end of the pack and not buying any more. For example:

The last time I tried to stop I didn’t buy any smokes at all and I was just like keeping myself busy and then found I got side tracked thinking a cigarette would be a good way to have a break (14).

A few participants ran out of money (91) or just couldn’t afford to buy any:
I just looked at it pricewise and had to figure out, prioritise a lot, found myself doing that every time. It’s more or less come down to one shop a week (40).

A few participants stopped when they became too sick to smoke. “That was probably for about 4 days, ‘cos I couldn’t take it in ‘cos I was coughing too much. I didn’t smoke at all” (93). But, as another participant reveals, when they felt better they start smoking again:
I was really sick, like I had pleurisy which is a illness I get every year never miss, every winter. But this time I got a bit of asthma on top of it. It probably put me out for 3 days and to get rid of smokes... But even after those 3 days I was thinking, yeah I want a smoke. But I actually didn’t go out and have a smoke... But after the 4th day I started getting up slowly (99).

Some participants managed to stop despite how hard it was:
Well it was cold turkey, but life was miserable for everyone around me, but I thought it was good... I found it awfully hard going cold turkey all the same again like before I just had made up my mind and bingo (54).

SECTION FOUR: TE TAHA WHANAU

This section details how the participants prepared their whanau, work or social environment for their quit attempt. What participants did to establish sources of support is outlined also.

GET LOTS OF SUPPORT

Participants, who were smokefree at follow-up, referred to the need for "support systems to be in place," as one person said "just having someone out of the
family or relationship with me to be able to talk to" (98). Having a whanau supportive of smokefree was useful, for example, one participant said: "I was challenged by my whanau to stop so that was it. Challenged with aroha. They said if you love yourself why are you smoking?" (68). Others received good support from the whanau saying:

A lot of people are backing me up all the time. Family especially, 'cos my family don’t smoke. That’s my sister, my mum and my brothers, none of them smoke (114).

Getting congratulations from family and friends, even smokers, makes me feel better (100).

My family was really happy for me. My nephew was telling me to give it up… my nephew did help me to stop smoking (123).

My family don’t want me to go back to smoking (31).

Two participants recommended telling people about the quit attempt so that they can provide support, for example, they said:

...letting people know, because more often than not they are considerate. If they know that you’re genuine… they’re sensitive, and they’ll like won’t smoke around you, or won’t tell you to go buy them smokes (98).

The more I told people the more I got help (114).

Contrary to this one woman deliberately did not tell anybody she was going on the NMSCP so that if she failed she would avoid the disappointment and hurt when her whanau said “…see there you go.” As it was, she said:

It took them a week before they noticed that I wasn’t smoking. They said gee mum we just noticed something about you. You don’t smoke. They got a real shock and they said why didn’t you tell us and then I told them then because I knew that I had achieved it then I could trust myself (126).

Some of the unaided quitters received support from a local health worker (104; 103; 72), or as mentioned above from their health clinic. Participation in the research added to the motivation to quit for some respondents, for example, the following participant who was stopping with the aid of her health clinic also spoke of my contribution to her motivation:

... and that was another commitment, I didn’t want to waste the exercise, so working with, I just didn’t have the energy to do it alone, and so all I needed was that little extra boost from your input and the support of the clinic (70).

Whilst this other participant acknowledged the support of the clinic and the potential to feel obligated to me, she claimed sole agency for her success:

And the medical centre... they paid for my patches and they’ve supported me all the way through... No. I’d made that quite clear at the beginning, that I would give up, not because they’d paid for it, or because I’m owing to you or anything else, I’ll give up because I feel I need to do it for me (71).
Many of the participants, who subsequently were not smokefree at follow-up, still received “support” and “praise” from whānau, work colleagues, friends and social groups. Whānau (mothers, fathers, children, in-laws, cousins) were a large source of “influence,” “encouragement” and “support” for many participants, as the following quotes illustrate:

My son has been quite a big influence, because at school they’ve been made aware of smokers and what it does to people, and of course advertising on television too. If he sees an advertisement regarding the effects of smoking... he comes screaming out here, you’ve got to stop smoking or else you’re going to die and of course I’ve thought to myself, he’s right (93).

I’ve got my kids coming home pesterling me because they’ve got a no smoking thing... it’s got to the stage where my boys now they actually hide my smokes (90).

Ex-smokers were sometimes good sources of support and were seen as role models for quitting, as illustrated by the following comments:

My mother-in-law, she’s given up and she sort of encourages me. I mean she said she started smoking when she was about 9. She gave up when she was 60 something. And the only reason why she did it is because she had a sore leg. But she said, just have a go. And my father, he gave up. He started when he was 7 (13).

I work with a girl who’s been given up for 7 years now and she’s been quite a good influence on me... just encouragement... I guess being with the people who have that affect on you. Positive attitude about it (93).

...and the fact that they were smokers too and we’d get together and she’d talk about how she’d given up... giving me examples of how things are for them. And they were heavy smokers too (99).

**QUIT TOGETHER**

Participants who paired up with a partner or other smoker were able to “motivate” (56) and “encourage each other” (86), for example:

I planned it in advance, ‘cos I thought I’ll get my diet sorted out. I’ll get away from work, get away from any other influence... ‘cos down at mum’s, she doesn’t smoke, she gave up years ago, so it was quite good... she was quite encouraging, my sister also smoked, we started at the same time... So when I was down there and she knew I’d started a diet and that was working and that I was giving up smoking, she actually gave up as well... she’s still stopped (106).

It can be risky pairing up with a partner or others to quit as suggested by the following quotes:
I think I ended up getting quite competitive because she was managing so well and I wasn’t and that would just really aggravate me to go outside and have another smoke (64).

It was me and a girlfriend. We both were going to do it together. And I went round to her house that next day and she said have you had one? I said no, I haven’t had one, didn’t have one all day yesterday but oh I feel like one. She goes, I’ve got some in the cupboard shall we have one? We’ll do it next week, after this packet (7).

SECTION FIVE: TE TAHĀ WAIRUA

Few participants spoke of preparing spiritually for quitting. Two participants, who were not smokefree at follow-up, said they were helped by their faith in God, as one man explained:

The sure-fire way of giving up, in my understanding and my belief is finding your own god… for my own self if I haven’t given up by 1999, the faith that I have in the creator, doesn’t exist... that’s how I give up alcohol was my faith in my God, what I understand to be a higher being to me, my self discussions in my mind, called prayers... that was the same with marijuana, it was my talking to my God.

He was supported by the prayers of others also:

When I do really want to go for a smoke, I feel it and I feel not to want to... also because, they’re able to go over their own experiences being ex-smokers, ex-drinkers to have found a happier sort of living without impurities... it’s because I’m associating with people that are really non-smokers, so it doesn’t really warrant me to slip out and... even when I get home, or even when I leave from there. No. Sundays I don’t smoke (64).

Another participant’s quit attempt coincided with her return to church, as she explained:

Staying spiritually in tuned, I’d say. Because I was trying to go back to church at the same time. So I was reading scriptures and stuff like that (44).

Specific activities preparing te taha wairua for quitting are integral to the NMSCP. Participant feedback on their experience of the NMSCPs is detailed in Appendix S.

SECTION SIX: CONCLUSION

In summary, participants who were smokefree at follow-up appear to have done more preparation and were more likely to choose proven cessation methods.
This chapter has presented the qualitative data about the Me Mutu stage in the process of quitting. Described are the decisions and actions smokers undertake when they are in the contemplation and action stages of the Transtheoretical Model of Change. The next chapter describes what happens for participants who manage to stop smoking and stay smokefree. The experience of those who were unable to stop at all or who relapse is presented in Chapter Eight.
CHAPTER SEVEN

Auahi Kore/Smokefree

SECTION ONE: INTRODUCTION

Following on from the previous chapter, this chapter details the Aukati and Auahi Kore stages of quitting, that is, what happens when someone stops smoking and how they maintain abstinence from tobacco. The information presented in this chapter is based on the qualitative data collected from the 21 participants who were smokefree at follow-up. What NMSCP participants did while on the programme is detailed in Appendix S.

The next section, te taha tinana, records what physically happened when participants stopped smoking. The withdrawal symptoms are described and ongoing changes relating to quitters' physical wellbeing are documented. The third section, te taha hinengaro, details the psychological factors or coping mechanisms that participants used to stay smokefree. Lasting changes impacting on participants' mental wellbeing are presented also. Te taha whanau, the fourth section, describes how whanau or friends reacted to participants' new smokefree status and how these relationships changed. The final section, te taha wairua, describes the spiritual changes participants experienced.

Participants were considered smokefree at the follow-up interview if they had not smoked daily in the last week and they still considered themselves to be non-smokers. For example, 2 participants who had recently smoked on occasion said: “No. I don’t consider I’ve started again” (24); “I see myself as a non-smoker” even though the previous night she had, “had 3 of them in a row” (1).
SECTION TWO: TE TAHĀ TINANA

Firstly in this section the withdrawal symptoms experienced by participants who were smokefree at follow-up are detailed. Lasting physical changes or changes to participants’ physical wellbeing are then presented.

WITHDRAWAL SYMPTOMS

Of the smokers that were stopped at follow-up, 11 (out of 16) reported having no withdrawal symptoms. A further 3 experienced withdrawals no longer than one week. Not surprisingly then, 9 said it was easy to stop smoking. A few expressed surprise saying, “I’ve actually found it so easy, so much easier than I’ve ever thought... Here I was all these years not having given up because I was frightened of the withdrawals and there was absolutely nothing” (5). A further 2 said it depended on where they were, for example, one participant said, “there were different times I nearly couldn’t do it, then other times it was reasonably difficult, and another day I’d say oh a piece of cake” (2).

One NMSCP participant thought the lack of withdrawal symptoms could have been “because we were away from the place, away from home” (5). If she had been at home she thought she “would have caved in 2 or 3 days later.”

Four participants found it reasonably difficult to stop smoking. They said, “I don’t think it’s ever easy for anyone” (98) and “I can see how it’s hard” (100). One woman said, “I don’t know how people give up smoking... it would probably kill a lot of people to give up” (72). Another woman said, “the actual head thing” was extremely hard rather than the physical experience. “The mental attitude was frightening... that doing this, it was forever. And that was extremely hard.” She added, “I’ve never actually experienced it in all my addictions. This is the worst addiction I’ve had because it was that fear” (5).

Eating as a Withdrawal Symptom

Eleven of the participants who stopped smoking experienced increased eating as a withdrawal symptom, as the following quotes show:
I was pigging out a lot and I could see myself putting on weight (68). 

Once you stop, you want to eat a lot straight away (123).

For the first week I wasn’t overly hungry but I think I was eating more than I normally would... I was actually quite hungry for a while, perhaps because I was using up more energy (5).

One participant said, once she had “worked out the connection to stopping” she “got control” (68). Another participant went on a fast, that is, she “stopped my normal eating habits. I was just drinking water and eating fruit and dried biscuits” (71). Another woman went to the gym in response to putting on 7 kilograms in 2 months. Another tried not to eat because for her “I know that if I have something to eat it’s going to make me want a cigarette” (72).

Six of the successful quitters put on weight and 3 did not know if they had or not. One woman, who quit while in hospital following a road crash, “lost a lot of weight and that’s because I couldn’t eat for a while” (31).

Agitation

Seven of the successful quitters experienced agitation, for example, one participant said, “I found myself looking for my cigarettes and I was restless” (24). Others said they felt “really hyped” (68) and “fidgetiness” (98). One participant particularly felt this “at night because there’s nothing going on” (104). A few successful quitters experienced irritability and frustration while going through withdrawals, for example, one woman said, “it was that sort of having no control over my feelings, frustration, irritated” (2).

Anger

Three of the successful quitters experienced anger when they were going through withdrawals. One of the NMSCP participants said, “I just wanted to roll up in a ball and be left alone and I felt amazingly angry” (1). One of the unaided quitters also noted “erratic behaviour.” She said she had “just crazy behaviour, just totally losing it a couple of times... in the beginning I was real snappy, real horrible.... that’s been really hard because I haven’t liked being a horrible person” (98). To deal with
the anger she suggested, "keep yourself away from the whanau" (98). Another participant said:

I started just getting angry at everyone... there were times when I’d get real angry but then I would say to myself, I’m not gonna let them make me start smoking (43).

Not everybody felt angry, one participant said she felt "pretty happy, if that’s a mood. I’m in a happy mood because I was so excited" (70). Another was surprised she didn’t feel angry, as she said, “I couldn’t believe I wasn’t, my fear of being grumpy with the kids was not there. In fact I think I was more patient in the end” (5).

**Changed Sleeping Patterns**

Of the successful quitters, 6 slept better or slept for longer and 7 had disrupted sleep or slept less, for example, one participant said, “I lost my energy. I just wanted to sleep... just those first 3 days” (1). Another said she slept “longer than normal” (114) and another said she “had about the best sleep I’ve had in ages. Like slept really well, same amount of hours but felt like I had really good sleeps” (4). One participant said she “even started to dream more... I went through a period there for the first 2 or 3 weeks of intense dreaming” (5).

Of the participants that stopped smoking, who had disrupted sleep, they complained of “tossing and turning all the time, that was a real pain in the beginning” (98). Another said, “I was finding that I was getting up real early in the morning because that’s the time I have a smoke” (126). “I get less and it’s mainly because I can’t get comfortable, restlessness. And I get up and roam around all night” (104). Even at the follow-up interview a few participants complained that their sleep pattern was still not right (2). For example, one woman said, “I don’t sleep as heavy as I used to” (71) and another said she was on sleeping tablets.

One NMSCP participant tried to use sleep to deal with her cravings, for example, “I tried to sleep, because every time you go hop in the bed you can’t smoke... I went to have a shower because you can’t smoke in the shower” (2).
Coughing

Four of the successful quitters complained of coughing and coughing up phlegm. "I hadn’t been smoking but I’d wake up and feel I’d been smoking hard core the night before and that was horrible, and I’d be coughing, and really dry throat waking up" (98). "That’s still happening now. The last few days I’ve been coughing a lot... a month ago it started, then calmed down, the last few days it’s started again" (98; 114). One participant thought that the coughing could make people go back to smoking because they would think their health was getting worse, which is what happened for her. She said, “when I stopped smoking my health was worse. I was coughing a lot. I was thinking this thing is worse, I was better off smoking. After a while it stopped” (126).

Other Withdrawal Symptoms

Participants complained of some other symptoms, including cravings, strong smelling sweat, acne and flu-like symptoms, as illustrated by the following quotes:

I got cravings, real bad... I either got cravings, like really want, like it was just smell that smell, oh yum I want that, or it was the smell just made me want to spew (98).

I had that smell from the sweat... sweating, really sweating. I had 2 showers a day when I was at Noho Marae (114).

I’ve been getting pimples (114).

A few people spoke of having “nasty little headaches” (72). Some experienced other kinds of bodily aches and pains, for example: “The first week I had major headaches like real frontal headaches so bad that I couldn’t even stand up” (71); “I had body soreness... low grade headache; flu-like symptoms” (78). Diarrhoea and strong coloured urine where noticed by a few people also.

LASTING CHANGES

Participants who were smokefree at follow-up reported improved fitness. Some reported improved sleep, more time and more energy. A few participants thought they were sleeping “less” and “getting up earlier now” (43) which along with the extra energy gave them more time, for example, for “sports” (43). Other quotes illustrating the changes were:
The best thing about it is that I sleep better at night. I used to smoke and then go to bed and I'd lie awake. Now I sleep right through the night (31).

I had heaps of energy... I mean focused stuff... there was so much more time in the day to do things. I couldn't believe it. I'd gained 2 to 3 hours where I'd probably been sitting down rolling, smoking... I've got more time and I'm fitter (5).

I've got heaps of energy now. Oh the gym, that helps too (114).

Being fitter and uninterrupted by the need for regular cigarettes, contributed to improved quality of time, allowing people to do more at home, with whanau and for themselves as the following quotes show:

I'm actually doing more courses now. I'm more involved with my grandchildren. Most of the time I'm going straight from work over to their place and I'm playing with my oldest grandson... I don't really sleep very much. I'm not really doing very much. I mean my house is ultra organised... I'm up really early and my house is tidy. There's nothing for me to do during the week, because I've done everything. So that's why I have so much time... It's just different. I'm a heck of a lot more organised, a lot more focused. I'm not drifting off as much as I used to (71).

I've found that I can do things more without stopping. I mean I may stop for a little while... on cruise mode... now I can concentrate on my course like before I used to be so slow getting into things, now I can understand more (126).

One participant had actually cut down her hours of work:

I've cut down my work. I don't work as long hours as I used to... I think that's about that well thing, looking after myself (4).

Some participants commented on their improved sense of smell and taste:

One thing that I have found now, how it detracts from a person's nice appearance. I've noticed women who are so nicely dressed and their makeup is lovely and they smell of cigarette - it's strong. I don't find it totally off putting, but now I know (103).

I've found the taste buddy things coming up, those sensations again (114).

There's some things I don't like anymore. Some perfumes and stuff that I used to wear I can't wear, makes me feel sick... Certain foods make me feel sick – fried food or the smell of them cooking makes me feel sick...(4).

A few participants now had a sensitivity to cigarette smoke and experienced toxic reactions when exposed to a lot of it, for example:

Cough a lot only when I go to parties (114).

Even at pubs, it was killing me (126).

I know if I'm around smoking at all... I notice a couple of hours later or even the next day I'm quite hoarse. We went out... and I woke up in the morning and I went far out, I just stunk of smoke and I have never had that experience before (4).

Last night we went to the casino for the first time... and I felt sick, and I didn't realise until after why I was feeling ill. I thought, they have a smoking area and a non-smoking area and I should have stayed in the non-smoking area (70).
An unexpected negative of stopping smoking, for one woman was that it changed her singing voice. She said, “what I don’t like about not smoking, it’s affected my singing voice... it’s made my voice more squeaky” (103).

SECTION THREE: TE TAHĀ HINENGARO

This section describes the psychological processes used to sustain quitting (Aukati) and stay smokefree (Auahi Kore). Initial strategies participants relied on to survive withdrawal symptoms are described first, such as replacing cigarettes with something else. The threats to their new smokefree status are outlined next. After the first few weeks, participants had to learn new ways of coping with ordinary life stressors. These sustained changes are presented last.

DO SOMETHING ELSE

One participant thought it helped to have “plenty of alternatives to smoking” (71). Several participants gave examples of alternative behaviours they resorted to instead of smoking, these are listed in Table 32.

<table>
<thead>
<tr>
<th>Alternative</th>
<th>Example</th>
<th>Participant ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delay</td>
<td>It says wait, I'll wait reluctantly, and before I knew, it had passed and thank god I didn’t give into it.</td>
<td>(70)</td>
</tr>
<tr>
<td>Do Something Else</td>
<td>If I'm doing something I don't think about it eat extra dates, nuts used mints sauna helped sweat</td>
<td>(123)</td>
</tr>
<tr>
<td>Drink Water</td>
<td>lime juice in water my willpower and 'cos my brain - I understand how the brain works now... I just switch off. I just do something. I'll grab a water, water is the best thing as soon as I thought of a cigarette, I'd pick up my bottle, my Auahi Kore bottle and I just kept drinking and drinking I have a 2 litre bottle of water by the bed, and that habit, I used to wake up and want a cigarette, so I wake up reach down and uncap it and drink it.</td>
<td>(78) (114)</td>
</tr>
</tbody>
</table>

Participants mentioned a number of alternative behaviours that “replaced” smoking, for instance, “extra work” (98), “sports” (43), reading, gardening and
writing (1). Participants were asked if they found themselves working more than they used to, to check the belief that having given up smoking, people become "workaholics" or as one woman said, she could feel her "manic behaviour amplified" (78). Some participants did think they were working longer hours or doing more generally, but it resulted from "keeping busy" or as one participant pointed out, she now had more time and energy, as she said:

I would do extra work, 'cos the time that I would spend smoking, well I don't smoke now, so I spend longer at my desk doing my work (9).

Some other examples of replacement behaviours are:

Spending heaps. Well not heaps. Like I'm buying me clothes and putting things on lay-by (114).

Gym and walking, drinking water. I eat a lot more fruit, probably lot more lollies than I've ever eaten in my life, but that's cutting back (2).

It's made me ring up friends who I didn't have time for... friends who I've let go by the way. They were busy, I was busy, and we lost contact. Now I'm not so busy I can contact them, and they're so delighted to hear from me, it's good for my ego. I feel great (70).

Another participant increased her consumption of lollies (70). One participant replaced smoking with more regular smoking of cannabis for a short period, as she says:

...it could have been too that extra time, because I had all these hours left. Because I'm a busy person anyway. Once the smoking stops I was sort of left here sitting around, done the dishes. And I mean I'm an outside person but the housework which would normally take me to 10 o'clock to do was over and done with by half past 7 in the morning. I'm sort of thinking well now what the heck do I do? Do I go and get into work now or what? So the dak, for that first week, 2 weeks maybe, that joint that I would have had at night, I actually went and had a joint, over the whole period of the day. And, so I wasn't actually stoned at all, I was just sort of cruising, and, yeah I think I only needed that for about a week after (5).

Another participant suggested that being smokefree aided her motivation to pursue other lifestyle changes:

I decided to do general health reassessment. I suppose smoking certainly helped the motivation, I mean not smoking, the motivation to do all those other things. Where as if I was smoking I'd probably just sit down and have a fag (103).

**Dietary Changes**

Not all of the participants who stopped smoking noticed a change in their dietary habits (1). A few participants reported increased food consumption, because
they “crave fat, butter and sugar” (78) or that they ate more lollies, but this “levelled off” (24) after a short while, for instance:

I’ve stopped smoking, started going to the gym, now I’ve got to start eating the food that I’m supposed to... if I can get back into meditation and fit well I’ll be so bloody healthy I’ll probably get hit by a bus (103).

Other participants “cut down on fat, eating more healthy, drank more O.J.” (100) or started reassessing their diet, for example:

I had to have lollies or chewgum in my bag, everywhere I went, sort of cut down on that... I went to my nurse that was for across the board checkup for weight, health blood pressure and all that... and talked to her about it, ‘cos I wanted to know if I should replace vitamins... because I don’t know much about vitamins, minerals, multivitamins... I try to cut down on fat. Like I drink light blue milk and also starting to drink So Good milk. Just yesterday I saw an iridologist down at the chemist and she’s put me on spirulina and tonic water for my liver. She said I’m in real good condition, quite healthy person, just to look after my liver and look after calcium, my bones, yeah that was it (98).

I took the water back and gave up tea and the coffee. I started eating a lot of fruit that I never used to do... I had to have at least 3 apples a day, apples and pears... I don’t have fat anymore. Well I mean like fatty meat, ‘cause I don’t like Brisket. ‘Cos I can taste it, ‘cos my taste buds... I don’t eat eggs. I used to love eggs. When I smoke I used to love eating eggs... and I love lamb neck chops in a stew, but I can taste the fat even in the meat and I can’t... never tasted those blooming things before... I’m eating margarine, and I hate margarine. I like butter. I’m a butter person. But I haven’t had butter for a while (114).

Some participants noticed changes in their experience of food, for example, the following person who found foods saltier:

I don’t have salt anyway, and if anyone cooks and they put salt in the food well that’s all right. Not having any salt, ‘cause [cook at Noho Marae] didn’t use any, but then when we had some oysters, about 3 days later - oysters have never tasted so salty to me before. It’s like that with all kaimoana now, it tastes really salty to me (4).

Or, participants changed their eating routine or thought they needed to, for example:

One thing I have tried to do is eat breakfast (5).

I actually got rid of the butter in our diet... Changed my diet, not taking any weight off, ‘cos obviously it’s not what you eat it’s how you eat... what I need now, is to see a dietician (70).

Two participants were forced to change their diet after a hospital stay for an accident and an illness as detailed in the following quotes:

...with that happening I was eating 3 meals a day at the proper times... even when I got home I started eating like, I never had breakfast, I’d just have a cup of tea, and now I don’t miss it (31).
Certain things I can’t eat. I can’t eat dairy products now, nothing like that, nothing fatty, vegetables and fruit and a lot of water, that’s all I go on (104).

The quotes above show some participants made changes to their diet, but none of these experiences were extreme or abrupt changes as might be undertaken when undertaking a concerted diet to lose weight. Though losing weight became an issue for several people, their primary concern was staying smokefree.

**INCREASED PHYSICAL ACTIVITY**

Over half of the participants who stopped smoking increased their amount of physical activity. Physical activity was both a distraction from smoking, a replacement behaviour and for some, necessary for countering weight gain. Some took up or increased their involvement in sports, walking, swimming or joined a gym, as illustrated by the following quotes:

I’ve been trying to balance it out with sport. Playing netball and touch. Went and got a gym membership as well... so I don’t have time not doing anything, which is when I want to smoke. I’ve been thinking if I can keep busy, it will help me get over the habit of wanting to smoke (98).

I’ve been trying to get healthier. I’ve been running around the block and stuff (43).

Since I’ve stopped smoking, I’ve started going outside and hitting the golf ball around in the field because, where as normally, we’d go out and sit down and have a cigarette (9).

The good news is that we have started swimming my husband and I. Because he needed to upgrade his health from after his major operation. So we joined the swimming, gym. It’s only happened a week ago. So that’s the exercise that helps... I can’t swim for nuts so it’s a real effort to stay afloat, so that’s good because I think maybe my body uses every bloody muscle that’s never been used in a million years. But what’s happening it’s stressing out my breathing, my lungs can’t cope, I can’t get a rhythm using my limbs and breathing and so I keep running out of breath, and when I run out of breath sometimes it hurts just slightly and I think that bloody smoke, and so all the weight in the world that I’ve put on is not going to make me smoke. I hate what the cigarette has done to me (70).

I was planning to exercise but I just couldn’t cope... but I’m ready now and I start this Sunday probably 3 nights a week. I’m doing rowing (71).

I can go to the gym and get on, gees I can run. Well I haven’t done that for years. I feel really good. I can get on my machine, I do cross training, for first time I was lucky to stay on there for 3 minutes. Now I do 15 minutes. I get bright red in the face, but I’m not going [making hard to breath noises] I don’t get that anymore, you know when you walk up stairs, have to stop tired, coughing... the guy at the gym said to me, we’ll get you moving on exercise first and then we’ll look at your diet... 114).

Go to the gym nearly every day, I suppose some would say that’s replacing one addiction with another, well I don’t bloody care (4).
I'm walking everywhere which I never do. I still go to the gym. Walk every morning (2).

One participant did not think she had increased her physical activity as she had always been physically occupied, though she did acknowledge that she felt fitter. Three participants could not exercise and had increased immobility due to injury or illness.

Some new behaviours were attempts to learn new ways to relax and have more fun, for example:

I’ve been to a few movies. Watched quite a few videos, which I haven’t done, but that’s trying to change things for relaxation… fun things to do (1).

**FOCUS ON THE BENEFITS OF STOPPING**

At least 10 of the participants who were smokefree at follow-up actively focused on the benefits of stopping smoking to maintain their new smokefree status. The following extract shows how this may involve focusing on the ill effects of smoking and that stopping will be a freedom from that:

I knew the stumbling block of why I started again. I didn’t have a commitment to using a particular thought that would keep me committed... what I’d do, I’d think about soreness in my sinuses, think about the yuck feeling in the morning and the effect it was having on my body, so related it very much to my ailments, each time I wanted to smoke. I’d say do I want this... I’d look at what stressed me up and I’d weigh up, is this thing that’s stressing me out worth my health. I had to say it to myself, to convince myself, I’m going to get stressed a lot and am I going to give into it, because at the end of the day, are all those stresses worth my health? ...I firmly believe that all my aches and pains, in particular in my stomach area... at my age I need all the help I can get. From what I eat to keep my oestrogen levels to where they should be, and I know that they’re failing, and that cigarettes are going to make it worse... I think it’s knowledge of what’s happening to your body, is what I’m trying to say, and that in my case, I looked at the stress knowing what it would do to my body, which was already failing in those areas through my age, and cigarette thing was making it accelerate the deterioration... and I thought smoking, I’m going to be a bloody cripple (70).

Others emphasised other benefits, for example, not smoking around children, feeling healthier and cleaner, being free from a bad habit:

I really lay the guilt-trip on myself, ‘cos I don’t really wanna be like that, ‘cos it really looks horrible, it looks ugly (9).

...eventually I saw all the positives about it. Just my kids, smoking while holding them (98).

...healthier, cleaner and I do mean cleaner, inside and out (5).
I like the feeling. I like the sense of not being controlled by something outside of myself. I like the sense of being able to go wherever I like and I don’t have to worry about can I have a smoke or can’t I have a smoke. I like the sense of freedom that it’s given me.

Participants used positive thinking and creative visualisation techniques to affirm their changes, for example:

I couldn’t imagine myself smoking (31).

When I was doing it, it was a bad habit - really, I didn’t need it - I just don’t smoke (100).

I still know overall in the long run it’s better, even though I have to go through all this crap right now, but I’m getting better (98).

Having more money in the pocket was an incentive others focused on. Some participants used the money they were saving to reward themselves, for example:

The economics of it were great. I didn’t have to see that I had enough money in my pocket for a packet of smokes. I wasn’t spending the money like I was. That was an incentive... (24).

I’m going to Australia soon... now my car’s always full and I’ve always got money in my pockets now (114).

Financially it’s an improvement... rewards: every day I put aside $1.50, then when I’ve saved enough I take me and the kids to the movies (100).

...and I bought me some shoes, some other pants for my gym. My sister bought me some shoes for my gym, and my mum paid for my gym fees, the joining fees, and my brother bought those shorts... after smoking I was getting bummed out, and I kept saying to them I want to go to the gym but couldn’t afford it and they said see that smoking, give it a couple more weeks. They were just waiting for me, no she’s not smoking, she’s been fine. No she’s not smoking. So they all came over... I was really wrapped (114).

One participant would “look at the calendar” (100) thus rewarding herself by counting the number of days she had been smokefree.

BE CONFIDENT

Analysis of the quantitative data showed that self-efficacy was predictive of success at quitting. This confidence was sometimes clearly expressed in interviews, for example, participants said:

I feel quite confident, I just don’t have the urge to smoke (2).

I honestly, I just know that I won’t smoke again. I just know I won’t. I didn’t know that before. I was just kind of giving it a burst, actually, I kind of didn’t really even want to give up (72).
I know I won’t smoke, mainly because I’ve got this thing [been sick]. I’ve had that fright, if you’re gonna get well, you’ve been given another chance, don’t blow it with smoking or whatever... slow down workwise too (104).

I’m too scared to have one, just in case. I don’t want to ever restart... Half the time I don’t even think about it... Sometimes I think, God I would never believe that only a few months ago I smoked. And the other times is when I do have a pang (5).

Two participants were confident that they would stay smokefree even in the event of traumatic events, for example, one said:

I know I can handle big stresses - have thought about it and done it - have had family die from cancer they were heavy smokers; had made up my mind and that was it (100; 98).

DEALING WITH STRESS

Some participants found they became calmer, experienced less stress and were less likely to react to stressors, as illustrated by the following quotes:

Calm, ultra calm. Nothing really stresses me that much anymore (71).

After the first week I realised that I smoked to keep myself at a particular stress level, and I actually feel a lot calmer now than what I’ve ever been in my whole life and I realised that smoking actually kept me at a particular level of intensity... things that I thought would bother me don’t bother me. I really feel like I’m on this journey of getting to know myself... I’m less likely to panic now (4).

I watched these others, they appeared quite stressed, they needed to get out there, have a smoke within a certain time, before the meeting started. You could see them trying to hurry and get it done, that’s where the stress comes from, trying to fit it in... I think it’s also about being more relaxed... that’s the difference I’ve found in my lifestyle... I always used to be hyped up, quite stressed, I’d appear quite calm on the surface, but can feel inside you just going rush (2).

...so many things were like go go go... I can make decisions carefully... It’s not as cloudy as it used to be especially that stress part well, I can handle stress and if I can’t handle it I can ring somebody (126).

For other participants “the stresses” (24; 43) undermined their determination to stay smokefree, leading to slips sometimes, for example: “...stress would trigger me off. If I got stressed I just thought oh to hell with the programme, I’m gonna have a smoke and then I thought oh well better wait” (70).

One participant spoke of the difficulty coping with her emotions, triggered off by stressful things:

It’s actually been very stressful since then. Stressful in terms of my emotions... last time I saw you was the anniversary of my daughter dying... my husband’s anniversary’s today; ...he’s going to live back with his dad... my whangai boy and I’m
not dealing with that very well either. I’ve been getting really sad... It’s not the cigarette. It’s everything that I’m bloody pushing down... It’s dealing with me after the cigarettes are gone, that I’ve got to look at me. I’m the problem not the cigarette (1).

**Assertiveness Skills**

Other participants changed the way they responded to provocative situations. Instead of accepting unpleasant situations and avoiding conflict, some participants used assertiveness skills to change situations, for example:

I don’t react. I don’t get very upset about things. It doesn’t bother me. I’m pretty easy going (71).

I think more, more acting rather than over-reacting. I have a clearer head. My education has ruined us. He feels threatened... I was too passive in the past. I have more understanding. I’ve learnt strategies... It’s woken me up (100).

With smoking gone, participants had to learn to cope differently. Participants who used to use smoking as an excuse to escape from conflict, became more assertive, as illustrated by the following quotes:

My cousin... she’s always yelling and screaming at me and I usually put up with it. She’s done some wicked things, and I went to see her and she started yelling and screaming at me and I said, that’s it our relationship’s finished... less willing, less tolerant to put up with any behaviours that I deem inappropriate. Usually when I’m smoking I just put up with it... (1).

Instead of walking out to have a smoke, I’ll stand my ground and I have been quite aggressive. Yeah standing up for my rights and what I believe, like before it would be, why don’t you just leave me alone, go and have a smoke and that’s it. I’ll smoke so many and it will be hey... because I haven’t got that now I’ll stand there, I’ll let out everything of what I’m feeling and thinking, what I believe in, voice my feelings more (98).

I talk a lot more. I stay put until it’s sorted, walking out is not an option anymore. I talk a lot more. I think it’s a big achievement to actually stop smoking. I’ve taken back some of my power. Smoking is about killing yourself. Life is so important, I’ve got no time to waste. It did suppress emotions, smoking was always an option. If you’re arguing with someone, go and have a cigarette; if you’re hungry, go and have a cigarette - it was easy, really easy (68).

I don’t think before I speak. I get angry... look out, you know. I have to hold my temper. I never had that problem before. I thought it through, and then strategised how am I going to deal with this. Go have a smoke, sort it out in my head... now I don’t have that and so I attack, and I have to watch my P’s and Q’s and I’m wondering why I’ve got no friends left (70).

I don’t stand a lot of nonsense. I don’t know whether that’s because I stopped smoking, but or because I’m turning 40 and I sort of think well I got this far, you know but I don’t stand much nonsense now, and I do mean nonsense... I’m really stroppy now. And I mean I’m not, I think being over the top, but if I can’t stand it, I’ll say so... (5).
A few participants spoke of how they were now more aware of other’s smoking and reacting with concern, as exhibited in the following quotes:

...there’s been two key things for me, one has been seeing things and now having to deal with them, whereas before I would have ignored them and gone and had a smoke... certainly I’m seeing the world through different eyes, so that’s a bit scary. Like noticing the number of people that smoke, and it wasn’t as if I didn’t know that before, but just noticing that and noticing the number of people who drink and I knew that before anyway. And noticing things like in going to the gym - you know how invisible we are as Maori people in healthy places. I’m not saying the gym is the most healthiest place to be, but just how invisible we are really. ...for me it just feels like there’s this really clear line... This side over here is where you’re really unwell and you stay unwell or you cross over the line and you choose to be well and be around some well behaviour, well people, an environment that’s well ...lots of changes for me because most of the people I know are unwell and I think that’s where a lot of the grief is for me, most of the people I love are unwell and I find it really hard to be there with them (4).

When our students had a break the other day I said to them, they can all have a break now and go and kill themselves a little bit more if they want ‘n blacken your lungs... this was in Maori aye, and they were all laughing, but I wasn’t. Because there was big groups of them and there was big clouds of smoking coming up. We talk about polluting the river and polluting your environment but you know, meanwhile, while we’re doing that ‘n campaigning against that, you’re filling yourself up with the same pollutants. I s’pose they’re the sorts of things that I’m telling myself when I see someone lighting up, and I watched one of the students the other day... I was watching this woman lighting up, and she, ‘cos it was a side on profile view, watched her light the cigarette and watched her drag in and take a big breath and this big puff of smoke come out of this, really quite a nice, fine looking woman. Really lovely and then you see this big cloud of smoke coming out and it really looks horrible, it looks ugly... (9)

The worse thing for me though, is when I started to look around at other people... it was just so depressing. My eldest cousin, he was at a family meeting and I watched him sit there and he sat there the whole time, just going puff, puff, puff, puff. As soon as he finished one he’d get another one... it was like a suppression, because no one had the guts to stand up and say look this is me and this is what I am and who I am... it’s just like their little crutch... it was awful. I tell ya, you start to notice how many people smoke. Like even when I drive to work, I look in my rear vision mirror and the people in the car behind me that are smoking, the people in the car in front of me that are smoking, oh man (72).

Two participants spoke more directly about smoking as a tool of colonisation and thus, how Auahi Kore is a decolonising position:

Governments and people would rather have you smoking... They’d rather you die than survive, to go on living and to have tino rangatiratanga... Keeping us in the fog. It’s not a mist, it’s a fog, ‘cos it never lifts... without the cigarette, if you’re a wild person, angry person or grieving person you’re starting to get to know yourself and it’s not only knowing your mountain, you’ve got to know who you are in this world... (1).

One participant spoke of a new aversion to “smoking, drugs, anything that’s negative. Anything that’s foreign” (5) and how, at a practical level, she was reinstituting “tikanga.”
I grow my own kai and I've always been aware that you are what you eat, and if you put energy, and you know what's going into your kai, you know what you're consuming. But now I've taken it on to all these other bloody things I'm hitting the roof over... abuse of that Maori tikanga... I can now walk my talk (5).

**Sought Counselling**

Negative affect, experienced during nicotine withdrawals or as a result of other stress, sometimes triggered memories of traumatic past events, as illustrated by the following quote:

I've had recalls of things that happened years ago when I was a kid that might not have been too happy but maybe that is because I've stopped smoking (5).

Participants now had to deal with negative or depressing affect in new ways, for example, by seeking professional help.

...have experienced a lot of grief... And have had to go to counselling for that (4).

I'm waiting for... the counsellor, so I can go and deal with it... (1)

Before I stopped smoking I was like, I don't need any help, I'm not going, but now I think I do... I've had times when I was just crying, in despair and I'm not going to make it (98).

As the following quote shows, some participants believed smoking had helped them block or suppress negative affect.

I would get uptight and then I'd go, I want to go have a cigarette and I'd have it and it was like, oh that didn't work, it didn't make me feel like it's suppose to... it becomes like a crutch for you... like a security blanket... it would make things better somehow... I know now it's just to suppress your emotions... I know I'm going to have to try to adjust to being an emotional person (72).

I realised that when I wanted a smoke, when I was stressed out or worried, lots of times I had a smoke to block out reality... it was just awesome to realise... I get quite depressed, real down in the pits, this is the time when I know I'd be smoking, so I realised I was smoking to not deal with my problems... definitely learning about taking more recognition of my feelings, instead of just not even wanting to acknowledge. Yeah feeling better about myself. Definitely have times of depression but also have times knowing that I would never feel good about myself if I was still smoking (98).

I blocked a lot of things... The more that was on my mind the more I would smoke to the point of choking... my fears and everything really went into that smoke... I was just holding it all in... but now I will cry and things I could never do before 'cause I'm not sitting there hiding it. There's been a big change (126).
Occasionally participants were undermined in their attempt to stay smokefree, by a sense of loss, as one participant said: “Just giving it up I suppose, because you don’t want to give it up” (43). Another participant regretted that he could not smoke just 2 cigarettes a day: “If I thought that I could keep to a couple of cigarettes a day, then I would be happy with that. But I know that’s not possible” (24); and another was aware of the possibility that she might smoke again: “Occasionally, I’m not saying I’ll never smoke again” (2).

One participant sometimes felt uncomfortable with her new experience:
It’s actually quite hard to be feeling better, sounds pretty stupid... I just started to feel really good and I noticed that I could breathe so well and it was actually quite hard feeling that good. It didn’t feel normal... it was actually hard to adjust (72).

Whilst, cravings could occur “seemingly out of the blue” (5), there were more specific incidents that triggered cravings or this sense of loss, especially at first. For example: “I did at first, after kai” (68); “not any more. At first... Happened when I was stressed out” (43).

Some participants sometimes missed the taste, the smell or the hit from smoking, for example: “sometimes I get cravings; sometimes the smell when first stopped, I just ignored it” (100); “I sort of like the smell. I guess the smell of it when it comes. Some days I could throw up and other days I think oh that would be nice. It just disappears. But no, most of the time I can’t stand the smell of it; I can’t stand the smell of smokers” (71).

Other participants missed the actions associated with smoking that had been part of a repertoire of behaviours that went with being on the phone or having a cup of coffee, for example:
There are the odd times like when I’m on the telephone, and I get a pen and stick it in my mouth. That’s what I’ve been doing. Sticking pens and pencils in my mouth, and I don’t know why because I don’t want to smoke. I think it’s just that habit of sticking something there (114).
There’s something that happens every so often that says oh I’d really like a smoke now... It just comes over me and I’ve got this nicotine in my body, and all those silly little smokes are saying to me oh you better have a smoke, top up on whatever’s left. I can’t explain it, there’s no reason, I might wake up in the morning, wouldn’t it be nice to have a cup of coffee and a smoke, but I don’t action it (2).
Some participants missed the social aspect of smoking and the "companionship" (78):

The socialness was a bit of ice in my face... my family, cos we went to a hui, you could just see clearly all the smokers together, like they’re all people that I associate with, but I still stood there and just the smoke was in my face which was a bit of a bummer, like oh no this is yuck, but the socialness about it... I stand there or I just stand away from the smoke, or I go away, I have to, like a couple of times I just had to walk away ‘cos it was too uncomfortable (98).

I think the thing I miss about it is just that sense of like, everyone seems to be sitting around doing something, just a socialisation thing... I don’t miss anything else about it... I just think yeah okay I’ll sit here and do something or I’ll go and read a book (4).

One participant said she missed “taking time out... I forget to take time out and then I’m kind of really tired” (1).

**DEALING WITH SLIPS**

Of the 21 participants who were not smoking at follow-up, 9 had smoked on occasion. Why they smoked and how they reacted is outlined in the following section.

Two participants started to smoke again because they were worried about their weight gain and other stressors:

I bought some smokes on Thursday afternoon about 1pm, that’s after thinking about it a lot on Thursday and I really wanted to smoke and why I don’t know. There’s lots of reasons. I was craving I guess... Oh coffee. I started drinking coffee. I hadn’t drunk coffee for years and years and years. I was told that drinking black coffee half an hour before you exercise speeds up your metabolism, so I tried it and I’d been drinking it for about 4 or 5 days, but only one in the morning before I went to the gym and it’s like this low grade craving and first of all I didn’t know what it was about... and then it got stronger and stronger and stronger and then it was like I remember saying to someone oh I’ve started drinking coffee again and my God would I like a cigarette and it was like I associated the two (78).

...because I put on a lot of weight... and because I was angry at my family... and yet I had no cravings for a smoke... I said I want to go back to smoking to try and get my weight down and something to comfort me was the smoke... I just had one puff and that was it. I started choking and I got a migraine and headaches and because of that one puff I had this horrible long time to get out of my breath like my throat was all sore and it had that taste in it... It was a real foul taste like I had something rotten or the smell of marijuana like I can’t stand even the smell of marijuana. It was like I had smoked that and that was in my throat and I thought I was going to go back to it but I don’t know whether I was too long off it or whatever it was my taste buds couldn’t cope with the taste (126).

One participant gave in to cravings:

There were instances where I didn’t wait for that desire to pass and I sought out a place where I could have a smoke, and that was enjoyable because it was a sneaky thing, and
then regretted it immediately after I tasted it, because the effect on my sinuses just came back for me, so that helped, because I had used that sort of thing as the way of encouraging me to stop (70).

Four participants were triggered off by stress:
I need an operation and need it quick. I had to have a scan, that was $650... The operation’s gonna cost $2500... and then the deal on the house falling through and Accident Compensation.... In this last week. I got up because I can’t sleep with my legs. And the day I heard about the sale falling through, I was wandering ‘round the house half the night, and of course there are smokers in the house, heaps of smokes lying around... It probably is depressing, because I look in my garden and think, oh I need to be out there. But I can’t get out there that much. I do a little bit here, a little bit there, not like I used to... my legs and in the middle of the night and you can’t sleep and you’re wandering around and every day you can’t sit down properly because of the ache... you do get depressed. Is it gonna be like this for the rest of my days... Sometimes at the end of the day you feel I’ve done nothing but battle all day... And that’s the first time I had a cigarette was the day the deal fell through and I was wandering around at night, my legs were hurting and there was a pack of cigarettes on the table and it wasn’t horrible, it was wonderful (24).

Another participant laid up after an accident said:
I think it’s boring. I’m sitting here all day and my husband works and he finishes at 3 and my daughter goes to work and there’s no-one here. When the cleaning lady comes it’s like jabber bird. It’s just boring. When my sister comes by I have puffs of her cigarettes. She goes on at me. I don’t know I just need a puff (31).

Insecurity at work was sometimes a stressor that triggered a slip, as illustrated by the following quote:
Work’s changing. There’s a whole lot of systems stuff at work that’s changing. I still feel totally unsupported as a non-smoker although [the manager] is going to address that and get a smokefree policy in place... She’s always been a non-smoker so that’s really good that we’ve finally got a GM that’s totally smokefree (78).

Four participants were triggered off by other people smoking or were actively invited to smoke with others. One participant was invited to smoke while supporting a friend in grief:
My friend just said oh please just smoke with me. She said we’ve smoked so many cigarettes together and I said yeah not a problem... I had 3 of them in a row...it was just around that woman and I... no, don’t feel guilty, got nothing to be guilty about... people say to me when they pick up a smoke, they go dizzy, they feel sick when they take it, but it feels just like when I had a smoke, it doesn’t have a different feeling. It doesn’t make my mouth yuck. That’s what I find amazing, is that I don’t go dizzy. It doesn’t make me feel I want to throw up, it feels like I can just pick up a smoke, just chain smoke again. But the thing about it is I haven’t wanted a smoke today and I didn’t want a smoke last night when I got home (1).

Another participant also had a friend that she was still smoking around:
I have one friend who smokes, and when she comes and she smokes I want to have a smoke, and as soon as she goes I’m okay... she only comes once a month... it’s only if
she comes up here when I have that one person sitting here in front of my face smoking. And yet if there's a lot of people smoking it's alright... she and I we started smoking together, we went to school together, we were babies together, so our history goes right back to the cradle.... I also find that she's uncomfortable because I don't, and I think that there's that aspect of it as well. I can make her feel more comfortable by just sharing a cigarette with her. Because before she'd come here and we'd have a cigarette and she'd just smoke a cigarette naturally. Now when she comes here she'll blow, she'll go like this [waves her hand] with her cigarette. It makes me more aware that she's smoking and I'm not, blows it away from my face, and all this sort of stuff, which all it does is emphasises... we've always been so close and been so comfortable together in each other's homes, we've had the same pattern all through life, going with boys the same time, smoking the same time, married the same time, had kids the same time, this time we've done something different, and she won't give up smoking. We've talked about it 'cos she did some years back, and really really put on a lot of weight and that is fixed in her mind.... I've worked out that if I see her often, in company of others I will gradually get rid of that because I'll get used to seeing her smoking and I won't feel like smoking (103).

Occasionally... when going drinking... I just wanted one, friend offered me a smoke at training college, he just gave me one... I see people smoking when I'm drinking then I ask people for a cigarette, but next morning I feel horrible (123).

...the other day when we were working, we were working hard. I thought I was working hard and one of the woman was going to have a cigarette and I said, I'll light it for you so I lit it for her and I went yuck, 'cos I thought, oh perhaps I might feel like a cigarette, but I didn't really. So I didn't have one (9).

When they did try to smoke 4 of the participants had an adverse reaction and 4 had no adverse reaction. One of these participants realised that "I can let myself smoke or not smoke at any time, that's a fact" (1). One participant advised against feeling remorse, as she said:

...don't feel guilty, 'cos a lot of people, they're giving up smoking and then they'll have a cigarette and everyone says, you said you were giving up... Because if I had a cigarette with that friend of mine and she never said anything and I didn't feel guilty about it. I thought oh I can, socially people do things that they don't do at other times, so I didn't feel guilty about it, therefore it didn't play on my mind, and as soon as she left it was like it didn't happen, and that's good 'cos I remember other times where I've tried to stop where I just think I can't and throw the towel in completely. And that was through something I read about dieting, using the same principle, you know don't feel guilty if you fall off the diet and have a binge, go get a chocolate bar or whatever, just start again the next day (103).

**HIGH CARBON MONOXIDE READINGS AT FOLLOW-UP**

As a consequence of recent slips or passive exposure to cigarette smoke, 6 of the participants who were smokefree at the follow-up interview had higher than expected CO readings. Two explained their higher reading solely in terms of passive smoking, they said: "...was passive smoking this morning" (78); "...last night we went
to the casino for the first time” (70). This participant also said at home they “use a gas heater.”

The 4 other participants had both been exposed to other people smoking and had recently had a puff themselves. For example, they said:

Had a smoke Friday night, been around smokers this morning and last night (123)

Been around a lot of smokers the last few days at a hui and lit a cigarette for a woman to see if I liked the taste (9).

I had a crowd of people here this morning... they just smoked one after the other. And I have a cleaning lady comes in, this was her morning and she smokes, she has a cigarette hanging out of her mouth while the vacuum cleaner's going. So the whole lot was going, but I haven’t had a cigarette... about 5 o'clock this morning, I had very little sleep and I got up, made myself a drink and I thought oh I’ll have a cigarette with this (24).

Had a puff an hour ago. Others smoking around me in car and at the café (31).

Despite these few slips and occasional puffs on a cigarette, these participants considered that they were still non-smokers.

SECTION FOUR: TE Taha Whanau

This section describes how the actions of whanau and friends helped or hindered quitting and how they reacted to participants’ new smokefree status. This section also describes how relationships with whanau and friends were effected by the changes participants made.

QUITTING TOGETHER

Some of the participants joined with others to quit together, for example, 6 employees of one Noho Marae provider attended their Noho Marae programmes. This enabled them to support each other, as one participant explained:

...being with [X] and [X], it’s that working relationship and it’s having that support, because we did it together and also when we finished there we’d all say every morning hey how you doing, it was constantly there for 8 hours of the day (2).

Three of the unaided quitters were gathered together and supported by their health clinic:
...it was a concerted effort... we had to all go separately to the chemist and let him give us this little lecture which I hated... to get the best help or the best brand that's out in the market (70).

Quitting together added to their motivation as explained by this participant:
So I was able to feel good about, oh hey I’m doing other people good here too, maybe. And I also feel it would help [X] to know that hey I’m doing fine, encourage them to say, we wanna be fine too (70).

Stopping with whanau members enabled some participants to provide support to each other. One mother and daughter pair mentioned the benefit of stopping with each other, as this brother said of his sister: “Actually [sister] and I have been good support for each other because she stays here during the week” (24).

**BECOMING A SMOKEFREE ROLE MODEL**

Becoming a smokefree role model for others, especially children, helped maintain some participants, for example, one said she was “a role model for 14 tamariki” (68). Another was aided by her daughter’s disappointment at her mother’s smoking: “My daughter over that time she was really disappointed going, oh Mum, so that in effect helped me” (78).

One participant was helped by her newfound role as a model for quitting. As she explains in the following excerpt, smokers began to turn to her for advice.

...just looking at others... I was on a course for a week and all the class smoked except me, there was my 2 tutors and 8 other members in the class, and they all smoked. And they’d go out everyday and they were, 4 or 5 times a day so that everybody could have a smoke. And I watched them, the next couple of days they’d be scabbing smokes. And then some had no lunch, ‘cos I knew that they’d spent their money on smokes. I was like why don’t you give up. And they were asking me how I did it, and I told them what I did... my mates are jealous of me being auahi kore... last time I saw him he was smokefree and it was really hard case, ‘cos when he came up and kissed me I went, you’re smoking again, and he went what and I could smell it on him, in his hair. And I just went you smell me... so he rung me up about 2 weeks ago, he’ll try again (114).

**OTHER PEOPLE SMOKING**

Several participants were bothered by other people smoking around them. One participant was unable to stop because of this and it wasn’t until she moved back to her largely smokefree whanau that she was able to stop (68). Others managed to stop but found it hard, for example:
When most of your work mates smoke, most of the students would smoke, it just seems to be everywhere you turn, there's big groups of people smoking (9).

Mainly friends that smoke; just the smoke... and being around smokers it really influences. I'm stronger now, that's their choice (100).

Tea break, 'cause I'm sitting around and they're smoking up a storm... People blowing smoke in your face... Not worried about it as long as not watching people smoking (123).

I just hope I don't go back to smoking. I hope my willpower will stay and I think if she stays away I'll be all right... I don't even think about it until someone comes... It's just because she's here... it's there (31).

Two people had to deal with others actively encouraging them to return to smoking, as they said:

I was conscious of people who said to me, go on, have a smoke... when they'd had a few drinks (24).

When I'm at places, like at friends' places. I don't want to - in my mind, everybody knows that. They sit there and tease me and I used to think nah I don't want it. They'd never force it on me (114).

One participant said he was not bothered by other people smoking and he deliberately did not make his house smokefree so as not to make his visitors feel uncomfortable, as he said:

No. It doesn't worry me. The others in the house, they smoke. Most of my friends smoke and I was quite determined that I would not make my house smokefree because I, though all my friends would understand, I'm sure, I didn't want them to feel uncomfortable in any way at all. And it hasn't worried me (24).

**AVOID SMOKERS OR SMOKING PLACES?**

Neither did this same participant change his pattern of socialising, as he explained:

I belong to the local bowling club and I'm on the bar roster, I go there 6-7 times a week. It's like drinking smoke soup. I was never tempted. But I used to think to myself I'm getting just as much smoke as when I smoked, then I thought I'll give this up but no I'll lose all my social contact...and it didn't make me want to smoke. No, in fact it put me off (24).

When I went home, the first thing I did was went straight to the pub. And I knew if I couldn't handle it that night that was it, I might as well give up. I went in, had my beer, everybody else offering me a smoke, no actually I feel alright, went to the party, went home, next day I woke up, my head was a bit, but I didn't... (114).

Others deliberately avoided smokers or going to places where smoking was prevalent, for about a month, for example:

I just stay away (72).
I did at first... about a month I suppose (103).

...wouldn’t go to my sister-in-laws house, because she’s a hard out smoker. I just kept away for a good month... she’s also been in the last few months a person who’s trying to give up and going back to smoking and trying to give up. So she hasn’t really been determined enough, so I didn’t want her around me ‘cos she wasn’t much of a good example for me to follow... But I’m fine now around her... I can be around her and other smokers... in the first week or month I didn’t want to be around smokers. I didn’t feel strong enough to stand and be in the presence of them, ‘cos I’d just want one (98).

Saturday was the first time I went to the pub in 3 months, no the 2nd time... that’s a real change... it was initially, oh can’t do this, if I go to the pub, I’ll drink. If I drink I’ll want a smoke ‘cos those two went together, and then 3 weeks ago we all went to the football club. I thoroughly enjoyed it. Had some drinks but didn’t have a cigarette (2).

Some changed other social habits and stayed away from smokey venues until they felt strong enough to go back, for example:

We still don’t go to places where we used to. We will go back and we know we will be stronger. We’re not going to be suicidal and go and be silly (71).

If everyone else smokes there is a danger of the newly smokefree person feeling left out, as the following participant did:

...feeling left out of some things. I know people who smoke and they all waft outside to have a smoke... Looking for new friends, has been one of the things for me, I mean outside of work... it’s not so much that I don’t want to be with them, but it’s like everything’s around smoking and drinking... and the other thing for me too is just other women and other lesbians... they’re all smoking and drinking (4).

I was hardly around smokers, on the courses I was doing you got to smoke outside, so you don’t smell it in the building... when I went shopping I’d see smokers galore... it’s a rarity to be around smokers now... when I knew I was going to go smokefree I thought I have to change but I didn’t have to (126).

**SMOKEFREE ENVIRONMENTS**

Several participants said it was helpful “not having smokers around me” (43); “...it was being amongst all these non-smokers” (2).

Having a smokefree environment and largely smokefree whanau helped some participants who were still smokefree at follow-up: “Coming home and nobody smokes” (126). “It’s a lot easier to give up at home, only two people out of 50 in the whanau smoke. We don’t smoke in our whare... I didn’t really have the urge to go out and smoke... there’s a part of me that’s scared I’ll start again if I move away from home” (68). “It’s easy here because my flatmate doesn’t smoke” (72).
This was easier to achieve for those participants who had their own home and no other smokers living with them: "living on my own, where I'm not influenced by others... Living here where everything is pretty natural. In town it might be different, I don't see shops with cigarettes, I don't see people walking by smoking" (103). Even having "no ash trays" around was helpful (78).

For one of the unaided quitters who managed to stop smoking, her brother had given up and "because he wasn't smoking, there was no menthol cigarettes lying around" (9). Another participant, who had had an accident, could not even go out on her own to get cigarettes, as she said, "not having it around. I can't jump in the car and waste money, and if I go out I go with the family... actually I've never ever thought about buying a packet" (31).

Having no one at work that smokes was mentioned as helpful by one woman: "the people, the men I work with they don't smoke either. There's a team of us... and of five of us, I was the only one that smoked" (103). The way she saw it, not smoking was now the trend, as she said, "I think the trend is to not smoke than to smoke now" (103).

**MADE HOUSE SMOKEFREE**

Nearly all of the participants who stopped smoking had smokefree homes already or made their homes smokefree, as the following quotes illustrate:

My house is smokefree and I don't like it in my bedroom or my car, 'cos they're both smokefree now and my poor partner, he's gotta get out there (114).

My own home is smokefree, everybody knows it. When my daughter came back from England and she has about one smoke a day, oh you can't smoke inside anymore, and she didn't care, and most people do now aye, they don't smoke inside (2).

My house is smokefree, that's another thing that made it easier (126).

A few did not deliberately make their house smokefree, but as the following quote shows, smokers were reluctant to smoke in a non-smokers house:

I don't make it so, people just say you don't smoke so they go outside and smoke. I say well it's all right you can smoke away, mainly for me too, they think I might want a smoke, I say no it don't bother me (104).

When I first came out of hospital her and my other sister... did a lot of work for me and both of them smoke but then it didn't worry me and they did a lot. They used to shower me and stuff like that and I never said anything then... she'd understand a lot like
sometimes she’ll just go outside out on the balcony. She does think about me. It’s just that when we’re talking she lights up a cigarette (31).

One participant occasionally allowed special people to smoke in her house:

Every now and then I let people, special people, smoke in the house, only during the daytime, when they’re only here for a cup of tea. Only special people though, not just everybody (5).

Only 2 participants who stopped did not make their house smokefree, as the following quote shows:

No, and I deliberately didn’t do that either because I want people to smoke around me so it has no effect on me (103).

One younger participant, who stopped smoking, lived with parents who smoked in the house, though the mother indicated a loose intention to keep the lounge smokefree (43).

**CHANGED RELATIONSHIPS**

For some participants it wasn’t other people’s smoking as such that bothered them, but that their relationship with the smokers had changed or would change resulting in them losing people or feeling isolated which they did not want, for example, one said, “didn’t mind being around other smokers, what threatens it is being isolated from the socialising that occurs when smoking” (68).

I feared being too different, and that used to stop me. I used to think, just the unsafe feeling, no one would like me, I’m being a smoker for all this time, I don’t know if I’ll still have that friendship if I stop smoking, they might not want to be my friend (98).

One woman noticed a change in her relationship with her husband who was not a smoker himself:

…the relationship’s changed in some ways, it was like [husband] would of really liked me back smoking, at the beginning stage…it knocked his, ‘cos he would buy my smokes for me and he’s a non-smoker. The interesting part is every time I’ve started again the last times, no not every time, most of the times, he’d say look you’re absolutely rotten… he would go out and buy them, and then I’d be back smoking… other people say I’m not behaving like I behaved when I’ve given up before, he said yes you are, you’re worse… he still saw me as being stressed, where other people didn’t (2).
SECTION FIVE: TE TAHAWAIRUA

Several of the participants who had stopped smoking thought there had been changes in their wairua. They spoke of having a greater “awareness” (71), feeling “a lot clearer and more conscious and focused on what I want to do with my life. Not so heavy. Energetic and lively. Full of aroha” (68). They reported that their wairua felt “healthier” (100), “clearer and lighter” (103), “cleansed” (71). One participant explained:

I feel more connected to myself. I have a sense of fulfillment and wholeness about myself (4).

Another 2 participants felt more in control, for example:

Far more intact... I feel in control to a degree... To date I feel quite content (71).

I could handle things more easily now. Before I was so jumpy, nervous or whatever but now I’m more calmer and more patient. It takes me a long time to get angry, whereas before I used to have a very short fuse and now it takes me longer to get angry and I can really look at things, not like when I had the smoke, that was a distraction and I got to go outside have a smoke and I’d think about it... It’s more clearer thinking... so that it does also open your mind and makes your vision far more clearer (126).

Another 2 had a greater capacity for compassion, as they said:

I’ve become a more sensitive person, and caring... it’s made me realise how sad an addiction it is, ‘cos I know what it done to me, I look at other people who smoke, not just smoke, drinking as well... I’m not so cold hearted, my heart’s not so hard to them, more compassion for them and more wanting to reach out and help (98)

I’m going to start doing some healing. That’s another decision I’ve made (4).

Two others were experiencing greater commitment to and involvement in their respective religions, for example, they said:

...taken up spiritualism... I’m a Bahai... I’ve been going to psychic readings. I’ve been going to pulsing... (1)

Also I’m a new christian... at times I did pray as well... it’s only recently that I’m becoming more believing and more wanting to learn more about it... I’ve been getting deeper into it, so that obviously helped. And the next day when I didn’t have cravings so bad, it was like confirmation to me, yes there is help, I am getting help (98).

Some comments suggest smoking has a suppressant effect, that helps block potentially disturbing memories and feelings, for example:

When smoking, I’m aware that my denial is strong, everything is foggy in terms of that self abandonment going back to the black hole what am I trying to fill that up with instead... (78).

It’s allowed massive grief to come up in my bloody face... Something overwhelms me... it might be anger (1).
Some other comments suggest smoking may help suppress experiences associated with te taha wairua, for example, matakite abilities. When people stop smoking these “senses” become more active and insistent, for example:

...can be with a person and know so much already... just from being, talking with them a little while... I don’t know if that’s got anything to do with giving up smoking but I’d be thinking of someone, oh he’ll ring soon, then he’d phone and I’d think that’s a bit strange, it happened quite regularly as well... more aware, more alive (98).

If I look hard enough I can see things... That’s certainly increased heaps over time... In terms of wairua stuff, certainly I associate a lot of the grief stuff is attached to that, because for me I think if that’s happening for me on this level then I know there is some things happening on another level... And so yeah seeing things, not just physical things. A knowing seeing. ...Clearsensing, I’ve always done that, that’s gotten a lot stronger and that’s what I associate a lot of my grief with... picking it up... a whole lot of my own grief from way back in my childhood started to come up as well. That clearsensing thing’s gone full bore. That’s what I mean by that wholeness, like I just feel so connected... smoking was stopping that from happening, I mean it would happen for me as well it just wasn’t so huge and overwhelming... That’s been quite draining in terms of not really fully understanding the extent and the power behind that... When I was smoking I thought I knew, whereas now lots of things happen and I think people’s pain, or whatever it is, is just so huge. So some things happen like even last week, and they just bowl me over, like yeah I was a real mess. And it took me a long time to work out that maybe this stuff isn’t mine... I’ve been surprised by some things I’ve found out about some people since I’ve stopped smoking. It’s just what I’ve seen and being able to sense clearer, so that’s been really difficult (4).

One kuia explains in the following excerpt, that she was raised with a full awareness of te taha wairua. Now she had stopped smoking, her dependency on te taha wairua was not as urgent:

I was brought up with Maori spirituality things and I was taught early not to delve too deeply into it. I was sensing it was there, and it was there when I needed it. If I suddenly need space I could get there quickly... mother was very spiritual and she was able to teach me... So my spirituality is that safety and knowing the Maori tikanga, things that are tapu... koreror Maori... So that hasn’t changed one bit. I have had no weird experiences like my husband did after his heart operation, nightmares where you can’t get out, well they can call them visions. Now he has the visions, see I used to have them. I used to dream and know there was something and say so to him, and he didn’t want to know... So what was happening when I was smoking, I was visiting that space, spiritual space more. Now that I’m not smoking I don’t need to go there. I’m not desperate to go into that area where I am pleading for support from the spiritual connections I believed I had with the tupuna, and my mother probably... I stopped doing that... I don’t visit the spiritual part of my wairua. My wairua is fine, it’s comfortable, it’s like I’m aligned with the earth and the sky, through my, that’s my wairua connections... I don’t have to worry about it, it’s there, I’m safe (70).

One participant who nearly stopped smoking after visiting a tohunga, had an “iffy experience” after smoking marijuana which she believed was a warning for her to stop smoking, as explained in the following excerpt:
...it was like I had been completely left alone, which is kind of hard to explain, because you always feel that people are there... but I was absolutely deserted and I was frantic... it was like a real coldness... I was so cold... I thought it’ll be cool, ‘cos if I die now, then it will stop... I could feel and hear my heart banging so loud... this was panic, this was terror. I was terrified, everything frightened me... it was just awful, it was really bad... I’ve had a lot of scary shit happen but I’ve never been so scared in my whole life... (72)

After stopping smoking she said: “I'm back in the good books” (72).

Another participant has become involved in pastimes, where te taha wairua is particularly important, as she said:

...like the whakapapa and one thing I probably will get into now is native herbs, which I've always been into, but because I've been a smoker I've never felt quite comfortable doing them... I now feel I'm okay to actually be able to do that... I'd say that for me is actually an ongoing thing, having stopped smoking, actually just sort of makes you feel a bit more, responsible; gets you more integrity, is that the word I'm looking for? You know, as opposed to someone who abuses drugs, be they cigarettes or whatever... now I understand why that was such an important issue... I feel strong now or maybe all part and parcel that things have come together at the same time. But definitely stopping smoking has been a big catalyst... you're more open.... Maintaining a balance. Yeah, and that is Maori (5).

Participants were hesitant to speak about te taha wairua activity and did not go in to depth until I had disclosed my own openness via prompts. The Tohunga Suppression Act (1907) and associated efforts by colonisers to stamp out Maori spirituality perhaps has left a stigma attached to such matters. “Seeing” and “hearing” tupuna, for example, are not socially acceptable experiences in Pakeha society. Perhaps some Maori use smoking to block these experiences they have not had the freedom to discuss, learn about or openly utilise. As one participant said, she uses New Age speak “because that New Age sort of seems to not offend as many people as talking about Maori does... I still guard, not that I've got anything 'specially astounding to know, but you're quite wary of what you actually say...” (5).

SECTION SIX: CONCLUSION

In summary, participants who were smokefree at the follow-up interview reported experiencing only light withdrawal symptoms. They appear to emphasise the benefits of stopping and they noted improvements in their fitness and te taha wairua. Nearly all had, or made, their houses smokefree. If they did slip, they did not abandon their new identity as non-smokers and reinstituted abstinence immediately.

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This chapter focused on the quitting experience of participants who were smokefree at follow-up. It described their withdrawal symptoms and showed how they coped with their new smokefree status. The next chapter describes what happened for study participants who were not able to stop or who relapsed.
CHAPTER EIGHT

Relapsing

SECTION ONE: INTRODUCTION

This chapter presents the results of the qualitative data collected from the 90 participants who were unable to stop or who relapsed after a short period of abstinence. They were asked to comment on what caused them to relapse and any changes that they made in their lives during the quit attempt.

The next section of this chapter, te taha tinana, describes the withdrawal symptoms and other changes to participants’ physical wellbeing. Even though they returned to smoking, some participants managed to maintain some positive changes, such as reduced consumption and improved nutrition. These changes are described also.

Te taha hinengaro, the third section, details the psychological factors and coping mechanisms participants used to resist relapse. Participants’ understanding of their return to smoking and their reaction to that is outlined. How others reacted to participants returning to smoking and how whanau and others possibly contributed to that relapse is discussed in section four, te taha whanau. The final section, te taha wairua, describes the spiritual changes participants experienced.

SECTION TWO: TE Taha TINANA

Firstly in this section the withdrawal symptoms, experienced by participants who were smoking at follow-up, are detailed. Whether nicotine withdrawals caused relapse to smoking is then considered. Some data is then presented that suggests relapse can be a gradual process. Finally, the changes to participants’ physical wellbeing are described.
WITHDRAWAL SYMPTOMS

The symptoms of nicotine withdrawal ranged in severity with some participants reporting no symptoms to others experiencing unbearable cravings, headaches, violent mood swings, desperation and insomnia. Staying stopped was especially hard, “really hard” (15) in the first 3 days to 2 weeks.

No Symptoms

Participants who did not stop smoking at all, did not experience any withdrawal symptoms because as they said, “I didn’t even get to that stage” (118). Some participants who did manage to stop were “quite shocked” (90) and surprised that they didn’t experience any withdrawals. Not that they noticed anyway, as one participant said, “Not that I noticed. The family didn’t notice any” (44). Another participant’s family however, disagreed:

According to me I had nothing but if you ask my partner about a week afterwards he didn’t say nothing to me all the way I was giving up, he’s a non-smoker and he took me to the pub on the Saturday and I think I was the worse bugger in the pub because I was like [waves hand] you know smoke in my face. I thought how did I used to do this? I got home and I couldn’t stand the smell of my clothes. I had a shower and threw my clothes in the washing. If you ask me what’s my behaviour been like? Well I think I’ve been brilliant and he said, grouchy when I got home that nothing was done. Instead of getting a smoke I’d go and sulk (54).

Most of the NMSCP participants who returned to smoking reported:

No withdrawals. That’s why I said I could have handled it. It was only when I came home. Like I said I’ve never ever given up smoking. I’ve never tried but those few days there were good for me (111).

A few participants said, “I don’t know what you mean by cravings” (56), so “because I don’t really know what withdrawal symptoms are... probably the withdrawal symptoms were there but I didn’t recognise it” (99). One woman who stopped smoking for a short period while she was in hospital said she, “was on so much medication. I wouldn’t know whether I had withdrawal symptoms or what” (94).
Eating as a Withdrawal Symptom

"Eating more" (117) was a commonly described withdrawal symptom. About a third of the participants who were unable to stop smoking or who relapsed, reported “my appetite was building up a bit” (14). They said they were “forever hungry, always hungry” (66). “I was eating. It was like chocolates and peanuts and everything that went across my path” (65). “I was eating way too much” (90).

Some participants described eating as a substitute for smoking, for example, one participant said, “if I wanted a cigarette I’d just eat” (56). Or as another participant put it, it was because they were having “less of one thing so you double up on another” (40). Others thought they just needed something in their mouth as illustrated by the following quotes:

Because I felt I needed to have something in my mouth, and if I couldn’t have a smoke, which I try, and try and try not to have a smoke, so I go and get something to eat. Like 4 o’clock this morning I was up, having a feed, and my wife’s going, Are you alright? What’s the matter with you? (22).

I think it’s the habitual thing of sticking something in your mouth. I’m not quite sure what it is but I know that when I did stop for that long I really piled on a lot more weight (8).

It’s not hunger at all you just want something to taste in your mouth (83).

Some participants tried to substitute smoking with eating healthy low-fat alternatives as the following participant did:

Getting all these vegetables and these healthy foods, I love vegies anyhow but I got turned off them, so I changed my diet. Noticed that I got into eating heaps of lollies (16).

Like her, however, other participants found it was more satisfying to eat “sugary foods, lollies” (15).

One participant said:

My taste buds came back in really well... I had to get home and cook the meals so that by the time I got to eat I just didn’t like it. But if he cooked I’d appreciate it more and I’d just pig out. So we went on that scheme (54).

The increased eating and, for some participants, increased weight was the “downfall” (39) they believed contributed or led to them relapsing, as the following participants said:

I started eating more which really started to bug me (129).

...my next thought was well eat, so I did, I started eating then I started feeling worse about that because that’s a typical process you eat when you stop smoking. So I
thought, well I don’t want to get fat, so that made it worse. I ended up buying a packet of smokes after that (47).

**Cravings**

For some participants the cravings ranged from occasional, “not like bad cravings, but the old flash” (45) to incessant demands: “I never stopped wanting a cigarette for 2 weeks, it was a complete battle the whole time” (76). Some participants only got cravings “like after meals” (47); “when I had a cup of tea” (65) or “just when I get home, when I come inside and watch TV” (62). Others “hung out badly” (41) as illustrated by the following cases:

Oh I craved for it. Sometimes you can get a bit agitated… I thought about it all the time… Certain times of the day when you know you have a cigarette, you think about it, oh this is cigarette time. I’d be driving down the road and all I’d be thinking about is having a smoke. When you look across you see all these people smoking. It got to the stage where that was all that was on my mind. When I gave up the first time for a year it seemed quite easy and I thought the second time would be easy, but it was harder (13).

I told the neighbours don’t give me a smoke no matter how much I ask. I went out looking in the rubbish for butts (35).

**Moodiness**

Moodiness was another common withdrawal symptom. The severity of participants’ mood swings ranged from feeling “a bit irritable” (6) and “cranky - not much patience - defensive first day” (76) to feeling quite violent, for example: “I got so paranoid I couldn’t handle it… angry, then I go and blow anybody else that’s around me. I went hey cat get out” (85); “very moody… start needing cigarettes and abusing everybody” (96); “I had a tantrum” (12).

The grumpiness and anger was often directed at family, especially partners and children as suggested by the following quotes:

I was getting really on edge… with my family (22).

At first I was really picky if something got to me, if somebody did something I didn’t like… but after a while I just learnt to cope by not actually saying anything and just letting it go. I suppose I did get more argumentative. Everyone told me I was getting more grumpy, but I don’t think I was… I didn’t see any changes in myself, but… Mum said to me that I was different… later on it was you’ve changed again, now you’re this real mellow person and getting on with everybody again (125).
I was bad news, wasn't very good to live with... I started arguing with my old man. He never did anything right (42).

I started to get major anxiety attacks. I wasn't feeling very good... Yes, I was very moody. Because there were times I just couldn't help it. I'd say to him, please can I have a smoke? No. Can I have a smoke? No! And I'd be just like aaagh (49).

I start picking on my oldest son for nothing. Anger. Not violent, physical (84).

...especially towards the kids, it's not so much towards other adults just towards the kids (106).

With my kids I did. I was... Not with anyone else. I think it was because it was so easy to have a moody with your kids, you know? ...It was easy to be less tolerant with them because they just had to put up with me (23).

Directed anger towards children compounded participants' negative feelings about themselves and the quitting experience.

I was sick of being really grumpy. I was quite uptight and was trying to stop it... I knew I was getting grumpy – reacting... it was really scary... Others were too scared to say anything (26).

**Agitation**

Withdrawing from nicotine can leave people feeling “agitated” (85) which participants described using a range of adjectives such as: “Edgy, tedious” (83); “fidgety, jumpy” (22); “frustrated” (91); “couldn’t concentrate” (35); “hypo as... on cloud 9... Wow man, I need something in my hand like a smoke” (41). For some participants this occurred even when they were cutting down (86). The agitation ranged in severity as illustrated by the following two quotes:

Actually after the first day, I felt quite calm, placid. But everyone else noticed I was a bit uptight. That's what they said... It wasn't so much uptight but they could notice that I was fidgety... It wasn't agitation, it was just that I couldn't keep still, I had to keep going, doing stuff (15).

I ripped my skin off, that's how agitated I got. When I get very agitated, I rip my skin off (25).

**Changed Sleeping Patterns**

Some participants, but not all, noticed changes in their sleeping patterns, for example some participants suffered from insomnia, while others were “getting sleepy all the time” (64).

Crash out... yeah something bad. Yeah I'd go to sleep about 10.30, watching a movie and then I'd get up about 2 o'clock and stay awake for an hour to help me sleep...get up and have a cup of coffee (42)
About 12 participants reported that their sleeping was “probably better” (11), “easier” (125) and “more relaxed” (54) because they weren’t “waking every so often for a cigarette” (121) or “waking up all dry and mouth all sandpaper” (76) and they weren’t “so drowsy when I got up in the morning and I wasn’t getting as many headaches” (125). They were able to fall asleep faster and sleep more solidly as illustrated by the following quotes:

I slept better... I was just out and I slept solidly... and maybe shorter period of time (26).

A lot better. I’d go to bed at half past 8 and sleep right through to 6 o’clock now. I didn’t do that before (55).

My sleep’s just beautiful. When I put my head down and my eyes are closed, that’s me. I get up and I’m alert, I’m bright and I feel really good inside myself... I even make our bed before I come to work. I never used to do that (22).

A similar number of participants had “disrupted” (95) or “sleepless nights” (6). They “found it hard to go to sleep” (35) and were “sleeping a lot less” (129) “and getting up during the night” (74). A few participants reported having nightmares and disturbing dreams, for example:

I had quite a few nightmares. I actually got used to them... I slept though I dreamt the whole time... I knew I was dreaming, too... Anxiety dreams, really about the kids. I’d wake up and think, something’s happened during the night. I’d have to go and check on them and make sure they’re in their beds (23).

My dreams were... I got through my first week and by middle of my second week I had a dream that I’d had a smoke and I felt really bad and that just reoccurs... My sleeping was fragmented... but the dreams are good, sharp dreams (83).

**Other Withdrawal Symptoms**

When participants stopped smoking, or even when they cut down, they started coughing up phlegm. “When I gave up I developed a cough for about a week maybe a bit longer” (54). This was sometimes quite severe as in the following cases:

Even cutting down, I find that coughing’s real bad, chest hurts... but I noticed when I first kind of cut it by half, the stuff I was coughing was black stuff. I didn’t know... I know now but I didn’t expect it, didn’t think about what was going to happen... I don’t think I want to go through it again. I know my kids don’t, it’s not fair on them... Well when I started coughing, it went on for about 4, 5 days just solid, during the day, most of the night, and it felt like just my whole chest was like bang... it was like having a real severe chest cold (66).

I’ve never coughed so much in my life (83).
One participant said she was “still coughing up black stuff” (115) at the time of the follow-up interview, even though she’d gone back to smoking.

A few participants’ immunity seemed to drop and they “ended up getting the flu but that was because I had so much congestion left, everything coming out” (74). “This sounds stupid... it happens every time when I give up smoking I get colds, coughs, chests, wheeze” (51).

Three other participants also reported developing or worsened asthma, for example: “I just found I got a little bit of asthma” (39); “I got asthma real bad” (42).

I was puffed out. I couldn’t handle it the first day. We were going for walks quite a few times a day and my dog’s a energetic dog and I don’t have the energy to keep up with him... That’s depressing, not so much depressing, it’s upsetting (95).

“Really bad headaches... that sort of just went straight across the head, behind the eyes” (106) were another symptom several participants complained of.

Two participants noticed “a difference in sweat aye, it smelt really different, stronger, my general body odour” (73); “I always did have an odour problem when I got hot and now even I can’t handle it at times and it’s grab the quick draw with the ol’ roll on” (63). This same participant developed a problem with acne also:

Since I’ve cut down, I’ve actually broken out, and I’ve never broken out before and all of a sudden when I try to give up, whether it’s stress? ...I’ve got blackheads and pimples I didn’t have before and this is like my skin isn’t pleasing... it’s awful, it’s horrible and not even all these different soaps and facial creams, hasn’t been helping, except for a couple of beauty serums... and I’ve even been coming out with pimples on my back (63).

Another participant had the opposite problem of dry skin and a rash:

I had diarrhoea... Yeah a rash, it was the nicotine, it was coming through my skin, so I had rash, smell... and I got a ear infection ever since I had cut down my smoking. Is that healthy? And the skin, see my skin’s gone totally dry. It’s not moisture any more. It’s not soft anymore (25).

Others complained of “flushes, hot flushes” (96); “tingly feelings in my feet and fingers” (56); and “sometimes when my eyes would close I’d just wake up, all these funny patterns. Almost like acid flashbacks. I’d be awake and I could close my eyes again I could just see patterns” (23).
Withdrawals as a Cause of Relapse

The withdrawal symptoms were described as too much for some participants to bear as some participants said: “it was too great the pressure... the cravings were just too strong” (95). It was not just the cravings that were unbearable but participant’s reaction to them also, for example, “I was sick of being really grumpy. I was quite uptight and was trying to stop it... I’ve become more relaxed now” (26). As another participant said, “it was the eating that got to me, I’ve never done so much eating” (124).

I was getting sick. I was getting very temperamental; very violent; paranoid and all I could hear was smoke smoke smoke and as soon as I had one ah I can face the day now (85).

Some participants were surprised at the strength of their addiction to nicotine. One couple resorted to smoking butts, “that’s how bad it is, how addictive it is” (86). Other participants said:

I was hoping to feel a lot healthier, for my mentality state and more energy so my mental state can be a bit more positive... it was a challenge, it was just hard... I felt addicted to it. There was nothing really that could replace it. I could drink heaps of water and yuck... The anxiety that I was feeling was really quite tremendous (96).

Not even a day and a half... And then I went through the, okay that didn’t work. I knew by day 2. I got up and I thought, no matter how many times I try to put some real positive thoughts in my mind. Oh God that’s it. So I smoked for a few days... because I work with people who’ve got addictions in alcohol... I actually began to really empathise with my clients on a different level (16).

After attempting to stop cold turkey some participants concluded that it was too hard:

I lasted all of about 2 and a half hours (66).

I tried for a whole evening for the first time... I am desperate to stop. I know for a fact that I can not stop cold turkey (85).

We finished our tobacco and we did fine... we quit the same weekend ‘cos we were just smoking that packet to finish it and that was it, we both decided right we’re going cold turkey and he came home with a packet of tobacco (63).

To which her partner added “and that’s why I didn’t want to go cold turkey because I’d been there and I hated it” (64). This example highlights one of the potential negatives of stopping with a partner, if one person relapses the other is tempted to relapse also.
Analysis of the qualitative data describing participants’ relapse experience revealed that for about half of the participants who were smoking at follow-up interview, relapse was a gradual process. For instance, about 16 participants thought they could have just a puff or just one cigarette and stop as the following participant explained: “I was doing quite well and to help me, I thought I’d have a puff. One puff lead to a cigarette and it was a puff to a cigarette to smoking” (120). Or as another participant said, “I picked up that cigar at the party and then it sat there for a week. Had a couple of puffs, sat there a week and then I went back to it and over a period of time from the beginning to the end of the cigar, which was about 2 weeks maybe a bit more I’d gone from [ISIS inhaling] to [normal inhaling]” (12). What this participant noticed was that her few puffs of a cigar was graduating “back into cigarettes.”

As happened for most of these participants they noticed a gradual increase in their tobacco consumption over time, as the following quotes illustrate:

I just gradually slipped back into it (73).
I was puffing on somebody else’s smoke... then I got a whole one and then thought I’d better buy my own (8).
I thought well I’ll just have one smoke and then a couple of days later I had 2 smokes and then you gradually build-up (46).
The first one, I had one half a cigarette that day and then the next day I had another half a cigarette and that sort of went from half to one and then so on and so on (56).

Several participants returned to smoking but tried to “limit myself” (16) they “didn’t go back to what I used to smoke” (72), they for instance, “dropped down half at least” (55). About 9 participants went “straight back into it” (96; 23) “full on” (89), with a few participants smoking more than what they had smoked prior to stopping, for example, one participant said they “increased instantly. It was like I was trying to make up for it” (84); “I would have made up for the time I gave up” (64).

One couple were trying to stop by cutting down, which they were doing by only buying packs of 10 at a time so as they said: “when they took those 10’s down off the shelf, we increased ‘cos we had to go back to buying ‘em [packs of 20’s]” (21).
Participants reported improvements in their health, ability to taste and sense of smell.

**Improved Health**

Of the participants who were smoking at the follow-up interview, 26 had not noticed any change in their health, or they said, “I’ve gone back to that stage where I’m coughing in the morning now” (11).

About 33 participants thought that their health was worse, for example, they complained of having a “bit more phlegm” (73); or “a bit of asthma” (47) and another said: “My eczema started back up again” (54). One participant said, “my health is deteriorating as the habit lingers on... my medication has gone up since I’ve gotten unwell” (14). Another participant had been put on medication because “my blood circulation especially in my legs is a problem... I’ve been getting a lot of pins and needles in this hand” (99). A few participants had more serious complications develop, for example, one participant “had an unexpected suspected heart attack” (101) another 2 were diagnosed with diabetes.

Over 40 participants, however, reported improved fitness, “less coughing” (42), less asthma, a better singing voice and “no shortness of breath now” (121). The following quotes show improvement in a range of symptoms.

I’m not puffing after a walk... and my skin, I used to have to go to the Doctor every month for my skin because I was breaking out and the last visit I made he says... you give it up and your skin will be pure like a baby (22).

I think I got fewer headaches because I get migraines (77).

My phlegm, as such, is no longer as tarred or as stained as it has been in the past... when I first stopped smoking it was quite dark and over a period of time I noticed it was getting lighter and less tar stained. I’ve noticed that my airways feel a lot clearer. My breathing capacity is a lot better as well (12).

I’m not so sick. I used to go to the doctor’s all the time (36).

**Sharper Senses**

When participants cut down or stopped smoking many of them noticed their sense of smell and taste was “sharper” (8) as illustrated by the following quotes:
I actually could smell things. I felt like I was breathing fresh air and not smelling my own breath (46).

Now that participants could “smell the cleanness” (121) they said things like, “I never knew as a smoker how bad it smelt ‘til I gave up” (121). They became “conscious of it being on my clothes... and I seem to have taken a lot more pride in my own self. I brush my teeth 3 times a day... I take a tube of toothpaste to work” (22). They became more aware of the smell of smoke on other people also:

What’s really a put off is the smell when you’re in close contact with somebody or in this case we’re talking partner (64).

We get people coming into the lunch bar and they’ve just put out a smoke and it just fills up the... it gave me a fright... I didn’t like it. It was horrible (62).

I also find it more uncomfortable in a smoky environment, in a confined area and in the car (116).

I went crazy on smellies because I like to smell nice and aroma things because my sense of smell increased and even if my aunt was talking to me I could smell it in her breath and you know it was not nice compared to my nice smelling room... (83).

I notice I’d go to bed at night, I’ve got wash my hands, wash my face cause I can’t stand the smell of the cigarette and it’s hard when I’m changing the linen all the time (34).

Participants’ taste buds seemed to come alive and they spoke of “enjoying food” (117) and “you could actually taste the proper food rather than have this sort of a plastic cover over the top” (22). As one participant said:

There’s a lot of things that I can taste now that I know I couldn’t before, ‘cause the things I used to eat before that tasted okay, a lot of rubbish things, but now they don’t taste so good. It’s the healthy things that taste really nice (66).

One participant said, “now when I puff on a cigarette I can actually smell and taste the chemicals in the smoke” (56).

**SECTION THREE: TE TAHĀ HINENGARO**

This section describes the psychological processes used during quitting. What participants did to survive the withdrawal symptoms and triggers to smoke are outlined first.
"Keeping busy" was a dominant strategy participants used to help them cut down or abstain. This involved "working 'cos you're doing something all the time" (74); "trying not to think about it" (64). "Going out, doing a class... doing things you enjoy" (39); "reading books, magazines... I concentrated my mind on what I enjoyed doing" (95). "Being active, like going to the gym and playing sport. That was helpful, and having someone to do it with was helpful" (19). A few participants were physically very active at work and with sports and as another participant describes, with social activities:

I went for a lot of walks and running in the mornings and go for walks at night. That was okay because I didn't have to do much and because I play a lot of sport and I do a lot of breakdancing so there's really not any time to have a smoke (125).

The problem with this strategy is that participants could not allow themselves to rest or when they did finally slow down they gave in to cravings, as happened to the following participant: "whilst I was entrenched in the work I didn't have time to smoke... There was no need to go home early, so I worked my butt off, 'cos I wanted to. But as I slowly put right what was wrong and relaxed, hello..." (11).

A new job or course of study offered some participants the opportunity to capitalise on their changed routine, as did the following participant:

When I first started my pre-course before my nursing course, I didn't have a smoke for about 2 days, that was it... I was so busy... I could manage. I could handle a drink without having a smoke, because it was a different environment, different people. That's why I thought I'd be able to handle it... they were people that I weren't familiar with. They didn't know that I was a smoker... so I did things differently... so I thought because I'm having this new routine, a new environment, new people around me, it would be easy (118).

One participant tried to reward herself as a way of staying motivated:

The thing that makes it easier is... praise yourself... and tell other people that you're trying, that you want all those support things... And with the money I bought magazines. I used to spend like $20 a week on books, poem books, magazines, chewing gum, lollipops... (83).

Many participants drank water or used some other dietary substitute whenever they felt like a smoke. Water was a popular alternative, as illustrated by the following example:

The water bottle is probably the biggest thing that helped me... That just goes to show you how many cigarettes you usually have from the amount of times you pick up that water bottle (124).
I've tried different types of tea. When I have a urge to smoke I'll drink tea (66).

Others used chewing gum, lollies, fruit or rice crackers, for example: “I ate gum... the sugarless gum... Ate fruit the next couple of days, other than the gum... rice crackers” (11). One participant chewed on a chopstick (84).

Some people made quitting part of a broader push towards a healthier lifestyle, as did the following participant: “My Powerade... I was drinking a lot of water, filter water... and got into, at breakfast time - cereal. Brown, wholemeal bread, that sort of stuff. Well, what I consider a healthier diet” (47).

**Addiction Philosophy**

Several participants believed it was necessary to “substitute your smoking for something else” (42) or that this would happen naturally as one participant said, “a definite worry for me is that something else will replace it” (40). Another participant said, “I need something to stable me and if I don’t take that cigarette, I’m very scared that I might have a drink or have a marijuana so that’s a definite no no. So I feel safe just having a cigarette” (46). Another participant had taken up running and was training for a marathon, he similarly believed his addiction could be transferred, as he said, “I don’t want to get addicted to it” (47). One participant admitted that “I’ve actually been cutting more on this and puffing on the other” (107) referring to her increased use of marijuana and another believed she “was drinking more cups of teas and alcohol” (7) instead of smoking.

**FOCUS ON THE BENEFITS OF STOPPING**

Focusing on “all the benefits” (117) and reminding themselves of their reasons for stopping was another strategy employed to maintain abstinence or reduced consumption, as illustrated by the following quotes:

Thinking of the children that I have to teach, we graduate in 2 weeks time, trainee teachers. Our school is smokefree (42).

I'm trying to prioritise my children - smoking comes second (115).

I think for me it was for my daughter’s sake. She wanted me to give up (124).
Remembering the negative health effects was especially easy when participants were ill as was the case for the following participant: “I think it was because I thought I was sick. Because I thought I might’ve had cancer in the throat. And what it ended up being was an infection” (46); and when stopping resulted in improved health as it did for the following 2 participants: “just thinking of how much damage it’s going to do. How much more my asthma’s going to improve” (110). “The main thing for me is I’m not going to have that pressure on my chest and a sore throat” (69).

For those participants that managed to stop, however briefly, the positive changes they began to experience gave them more motivation, as they said, “Finding out there’s more that I can do rather than just sit there and have a smoke” (22). “People say I look real good” (115). A few participants said they “enjoyed it without a cigarette... Money have a bit more... I can go to places and I don’t worry about a cigarette” (124). Some “didn’t even miss it” saying they:

...never even thought about it. While I wasn’t smoking it was lovely - I had a lot of money... Became a determination after that, because it felt good. And the house didn’t smell of smoke. It was all those little things that I noticed. And I had a lot of money. That was very important, I had a lot of money (27).

As the previous two quotes indicate “the price, the cost of it is a real good incentive to give up” (73) and to stay smokefree.

The one thing that kept me going with it was the money that I saved. I couldn’t believe how much money you’d have at the end of the week and how much my grocery bill dropped. Kept saying hubby this is great, my groceries are only costing $60 instead of $160... When it got to the end of the week and we actually had money left in the account, I said to him we’ve actually got money. And he said why don’t you go and buy yourself something, you’ve managed to hang out this long, go out and buy yourself a top or something (106).

Some participants developed a distaste for “the smell. I don’t like the smell” (59). “I really liked the feeling of not smelling smoke. I liked that sensation, but not great enough to quit” (117). One participant was the opposite, as she said: “The other thing that helped was actually going around smokers and smelling their smoke... like I didn’t feel like having a cigarette after that... it stopped the craving” (15).
Participants often spoke of the “sheer determination” they had to stay smokefree: “I wasn’t going to give in” (41). “It was just my attitude, my thoughts and my thought processes” (77). “Just a positive mind, a very positive mind” (46). This was something one woman tried to attain using a taped testimony, as she said:

I’ve got this tape and he worships god... but there’s words there that I hold and it's like with society today we’re made to believe that if you eat too much you’re gonna die, if you do this you’re gonna die, and basically what he’s saying is... just stop all the negative thoughts... You do things because society says you have to do it, stop listening to the radio, because all you hear on the radio is negative... And I thought to myself if I can try and get that free mind, with this tape (46).

Pride was another feeling that kept people going, as in the following examples:

“Pride I suppose. I didn’t want to let anyone down, especially myself. I was proud of the fact that I’d been able to stop” (23); “for me it was being proud of being smokefree” (121).

**PERCEIVED DIFFICULTY OF STOPPING**

Not all the participants who had relapsed to smoking perceived stopping as difficult. A few said, “it isn’t really that hard. I’ve done it several times before” (20). “Some days it’s quite easy” (116). As one participant believed, quitting was possible: “It can be done, I know that. But it’s the staying stopped...” (89). Several participants repeated this sentiment that, “I don’t find it hard to stop, I find it hard to stay stopped” (92). A few of the NMSCP participants said that “being with everyone that was giving up it was a lot easier” (125) “it wasn’t so hard, especially being away for that week... it was when I came back” (23).

**PERCEIVED CAUSE OF RELAPSE**

A few participants did not know why they relapsed, for example, they said: “Buggered if I know” (64); “I don’t think there is a reason, for me” (11). Stress and causes of stress, such as traumatic events, “domestics” and withdrawal symptoms accounted for relapse in over a half of participants. Boredom, habit and weight gain were other cited causes of relapse.
Trauma as a Trigger for Relapse

Some participants relapsed when faced with a traumatic event, such as someone’s death, as illustrated by the following quotes:

We lost our mother as well and while she was in hospital, I’d actually given up smoking, well I started again at the hospital (59).

A lot of these tangi got happening… we had 4 of them one after the other (55).

I heard that my friend got killed. I got the phone call, that’s the first thing I went for was a smoke… I just had a smoke and a cup of tea and I had to light up another smoke (22).

At a friend’s tangi… Shock. I reckon if it never happened I would still be smokefree (27).

My friend from work too that weekend, he died. It was awful and I wanted to go to the funeral, but I knew, it was going to be really emotional. He was only 46, of a heart attack… and I couldn’t bring myself to go to the funeral and anyway I was, like I’d had a pretty full on day (72).

Two participants were burgled:

Someone tried to break in, then someone tried to steal my dog, and someone booted in my fence and stole some washing… the depression was just too strong (95).

I got burgled and that was it… I just felt really insecure because they obviously knew I was on my way home because the kids and I had only gone for an hour and a half and it just freaked me out and I thought they’ve been watching me which means they know I’m a solo parent. Just all of that and that took me a long time to get over that… like they’d been through all my drawers and it scared the living daylights out of me… It had a real traumatic influence on me, on my study, on my lifestyle, on my sleep, on everything (77).

Trauma within families triggered other people’s relapse, for instance:

My daughter, I think what really got to me was the slyness of her actions… she ran away from home… she took my Bankcard and withdrew $500 out of my account which was all the money that I had. And my first thought was to grab a smoke because I’ve been having a lot of problems with her for 2 years and what she did that time was the end of it… my first thoughts were no, don’t get a smoke. You’re weak, you’re just using that for an excuse to have a smoke, so don’t go and grab one. And I did that for 2 days and after that, just constant thinking about it for 2 days, I just couldn’t handle it… I’d stopped for 2 months and then when this happened for 2 days I just kept thinking about it, just one smoke, you know, I’ll be able to stop… this is the best way to cope with it is to have a smoke (46).

Another participant gave up her plan to stop smoking when she attended to her cousin who was in a bad car accident:

She had brain injuries. And that didn’t help much either, because it was first to Whangarei and then she was transferred to Auckland. I was down there for a week… I was sitting up the road there and it was just over 2 hours before they managed to, well they had to fly her to Whangarei… Just before the helicopter came, I said, please can someone roll me a smoke, I need a smoke… But I was doing alright and everything.
She was alright for a while there, she was semi-conscious, but then after about an hour and a half her nose started bleeding and that’s when I knew it was serious. I need a smoke, need a smoke to keep calm for her.

Later this participant was diagnosed with diabetes, as she said:

It was quite by chance that they did a blood test and I said to them you’re just wasting your time... And it was so high... So I thought, stuff it I’m going to carry on smoking. I’ve got to have some pleasure in life... my doctor’s still harping on it. I said, yeah. I’ll give it up when I accept it, because I still haven’t really accepted this (58).

Two other participants’ abandoned their quit attempts when their husbands had serious heart attacks, as they said:

About a couple of weeks after the interview, my ex-husband was admitted for a triple bypass... And that wasn’t a good time for me to even think about giving up... We kept going back every weekend for 6 weeks and that was quite stressful... it was touch and go for a little while there with him, and he had to have all his teeth out and that was devastating for him (52).

...that’s just with the stress... It took away circumstances that I couldn’t talk about to anybody else and it was to me, a place to hide, behind the smoke. And they keep me calm... I’ve taken a years leave ...Yeah, well worry I mean, if you love somebody and you’ve had a hard whack, you don’t know whether your husband’s gonna live or die. You can’t explain to your children how you feel... no one to talk to (36).

**Stress**

Over half of the participants who were smoking at follow-up attributed their relapse to “stress” as the following excerpts indicate: “I automatically think of a smoke when I’m stressed out” (58); “just decided it wasn’t a good time to stop smoking” (96); “there’s a lot of shit in the family... you just go, oh I can’t be bothered with this, I just want a fag” (72); “I couldn’t handle the stress. I couldn’t handle the problems... smoking relaxes me, stops me from getting tense. So I don’t have to lash out in violence” (25); “I can see where I went wrong now. I let the pressure get to me instead of using, doing something about it. I just gave in” (23).

Their experience ranged from “a little bit of stress” (47); “a little upset” (93); “nothing major but I had a lot of things to do in one day” (63) to “major stress at work” (73); “not being able to cope” (117); “the works. Stress, financial problems, the children” (56); “the pressure, the build-up of work, kids, finances... of everyday living” (6). Other examples of stressful triggers were:

Sometimes when I cry (41).

The drugs and the symptoms of schizophrenia are very stressful (86).

My shower started leaking into the bedroom and rotted the carpet (95).
It’s just being with the kids, the children. It’s hard enough with your own children but when you’ve got others... the hardest thing was having to have so many people around, especially kiddies around you when you’re trying to do this... I got stressed. I was getting angry (121).

Now everyone’s calling me a grumpy old cow. Someone decided to burn the caravan down at the back on Friday. The landlord’s decided to kick me out because of it... always something that goes wrong (89).

Feeling insecure was a particular kind of stress that several participants spoke of as illustrated by the following quotes:

I’d just finished school and I didn’t know what I was going to do, work or go to Polytech (125).

Huge change in my life and that could have been another factor... the trauma of moving house, packing up my house... having to make real important decisions for myself... wondering where I was going to stay... I didn’t know whether I had a job... I didn’t want to give up my house (120).

Unsure about my work led to stress... only reason I went back heavy, job was unstable... unsure of self (17).

Not feeling grounded... I haven’t got settled. Christmas for me is always a bad time... insecurity mainly (17).

When you’re not in control, that’s when you’ve got to have a cigarette (116).

A few problems within the housing situation, with my friend. She was very unstable. She was becoming unwell and it sort of stressed me out a bit. That’s when I actually started back smoking... the situation at the time was not under control (28).

A few participants felt “pressure” especially when they were undertaking tasks that challenged their ability, for example, “getting into a new job” (8); “the work was so new and it was hard and it was full on” (118).

One of our managers, she died... pressures we had at work it was constant. It was one thing after the other (107).

The boss went away and got sick and I had to step in... I still haven’t caught up (63).

I’m just so busy... the pressure’s on from the family, get the job done, build the house... I’m exhausted (117).

I get frustrated about my assignments, that is when I want to smoke. If I don’t understand what the hell I’m supposed to do (59).

Staff changes and new hierarchy coming in and more demands on what they wanted... I couldn’t find any avenues of getting out of it the so-called down under, so I resorted to a smoke, a drink (54).

As the previous participant indicates, she didn’t know of or use any other way of coping with the stress, which was the case for the following participants also:

Just some concerns I had... churning in my mind... I didn’t have anybody there to talk to (99).
There was something that happened... really stressful and hurtful and I had to be a support for that person and I needed something for myself to help me... I couldn’t speak to someone else about it because it was told to me in confidence (122).

The boss just gave me a bit of a raise to run the place and he just made a real shocking allegation. Just that time I felt like walking out... I was just more pissed off at the fact of what was said... just felt like going outside for a while. When you go outside for a while it’s usually for a smoke anyway, being at work that is (45).

**Domestics**

Problems with partners and ex-partners (19), for example, “an argument with my girlfriend” (23) and break-ups, “my husband left” (89), and arguments within whanau relationships were cited as reasons for relapse by a number of participants as illustrated by the following quotes:

It was quite an emotional thing too. It was not long after a separation and getting back and talking (40).

Sister arrived from Wellington, social drinks were happening and away we went again... sister started arguing with her hubby and she was going I’m going out, I’m going out and never coming back... Because I knew what would happen. I said no, no. I mean, she was really pretty stressed so I ended up going and of course half way through dinner... There was no worries at work. It was only when the crap hit the fan (44).

When I got home to the family I came back to all the family problems... I had one day and I went hard out on smoking... I know within myself that I shouldn’t have done it but I did it... I was that angry... I’m sick of whanau, being involved with my own whanau. I’d like to be involved with others... What makes it hard for me I have all 6 grandchildren in my custody and then I get the parents back here, and this is where a lot of stress out comes in having to deal with their problems as well as the grandchildren. I hadn’t had time for myself, since their father died. This year I was hoping to get away from them, let them deal with their own problems (111).

I think it’s at home. My husband, he’s depressed. He’s got a long-term illness. He whinges constantly. He’s unemployable. It doesn’t matter what I do. And older brother at home gives me jib too - snappy. Smoking gives me a legitimate break away from him (18).

Another participant used smoking to take time out from her partner when things were not good between them:

Stress, basically because it was something to do and I could do it alone - it was a thing to get away from what was happening - stress reliever - when it’s all good I don’t smoke, when life turns to shit I smoke; domestics; relationship stuff (91).

One participant had multiple problems: she felt alone with no adult company, having moved away from her hometown and whanau. She was pregnant and her partner was unemployed so they had limited money, which he was spending going out drinking and smoking. They began arguing. As she said, smoking:
...was the only thing there for me at the time... In the end I just didn’t care about anything - hurt myself - I felt alone... the only way to get around the smell of my partner kissing me, it was disgusting - if I smelt too, it didn’t effect me so much... stressful and depressing (115).

I’d just had an argument with my Mum about what I was doing with my life and it just got to me. I was angry and stressed... I had that one and a couple of days after I was thinking about going back to smoking. I was still arguing with my Mum (125).

**Boredom**

“Boredom” was given as a reason for relapse by many participants (47); in a barren existence smoking becomes “a novelty” (59). “Boredom is probably the biggest one” (53); “it’s when I’m sitting around, doing nothing” (58); “just out of boredom” (62); “it’s something to do” (72). A few participants were bored or became bored due to ailment or injury, as one man said: “I tore a ligament and I couldn’t move... that’s why I got up to maybe 10-15, just nothing to do, put up feet and reading and television” (93); “it helps relieve the boredom. I’m depressed all the time because I can’t go out” (94).

Unemployment in its broadest sense was seen as the cause of boredom by the following participants:

I guess it would’ve been boredom more than anything ‘cos I’m unemployed (110).

I was bored that’s all it was... doing the same thing and my mind went off the cigarette, but if I stopped having a fruit and then I’ll be sitting here for an hour or so, and then I’ll go oh bugger it (34).

But, even employed participants sometimes experienced boredom at work as was the case for the following participant: “all this idle time... I wasn’t as entrenched in the work as I was” (11). A teacher wasn’t able to maintain her abstinence once on holidays: “it was just out of boredom. Like holidays too out of routine, not back at work and that, because I don’t smoke all day at work until I get home and have a cup of tea” (7).

Discussing the boredom with one participant revealed the possibility that his boredom could have been secondary to less obvious discomfort at not feeling part of a social group. As he said:

Well I got a job, working shift work in the holidays. And I think it was the boredom, in the breaks and stuff... I didn’t know anybody there... When you had your breaks you just sort of sat out there by yourself. And no one would talk to you, they don’t talk to the new guy and it’s just like you’re sitting there... Maybe it’s a social thing...
mightn’t even be boredom, it could be just a routine thing. You’re not allowed to smoke in the factory, during working hours... Everyone runs out, it’s smoke time (13).

Another 2 participants linked boredom with feelings of alienation, for example: “I smoke for boredom and loneliness” (115).

I have noticed that in the social scenes, that I’ve become bored. It’s like this conversation’s boring or these people are boring or nothing else is happening. Rather than keep drinking and sometimes I’ve exhausted all avenues for stimulus and entertainment in the environment and it’s like this is pretty boring, let’s have a cigar (12).

Fulltime solo-parents, found: “During the day would be the hardest for me when I’ve got time on my hands” (84); “I find when I’ve got nothing to do and I’m bored I smoke a lot. I can smoke up to 25” (79).

Habit

About 12 participants thought they relapsed because of the “force of habit” (94). “It’s just a impulse. It’s just a habit... Fix... Just got to do it” (39). Smoking was triggered by association with a range of activities, for example, “when I’m going in the car” (93) or “I bring in the washing and it’s sort of like in between washes I thought I’ll have a fag. Hanging up the clothes at night because I have to do all my housework and washing at night... It’s a time filler” (20). Smoking after a meal was automatic, as the following participant said, “I just pick up and I’ve got a smoke in my hand... automatic” (40).

One participant was at a hui where it seemed to her, time for smoking had been scheduled in. As she said: “they had all these workshops and it was like you went from one to the other and it was like a clock. You had about 10 minutes between each workshop and so it was like I’ve got 10 minutes to have a quick puff” (16). She agreed it was habit for her to use the time “for a quick smoke.”

It’s been good when I’ve stopped but I haven’t managed to keep off... to stay off it... I just get used to having the habit. I just light up after a few days... like what I’m doing gets too tiring for me and when I sit down and have a rest I light up a cigarette... when I’m tired of doing things like housework and just want to relax doing something different, I’ll have a cigarette (14).
Weight Gain

Some participants didn’t know or “never noticed” (120) whether or not their weight changed. Either they did not stop long enough for there to be a difference or they were not weight conscious and had not weighed themselves (53). One participant didn’t think “the smoking thing’s weight related at all” (51). Others were aware that they had “stayed the same” (89). “I think I’ve maintained it... We walk and we follow our daughter with her sports to help us” (22).

Some participants lost weight, as they said:
I’ve lost weight though, they reakon the doctors... They said I did. Just after xmas. I’ve lost a bit because of the heat (111).
I’ve actually lost some weight, a couple of kilograms through activity (117).

Losing weight was an ongoing goal for a couple of participants, one who said, “I’m still trying to lose weight” (35) and another started on Jenny Craig before trying to quit. She said:
My consultant at Jenny Craig was really good. She managed to keep a close eye on it... the other times I’d given up I used to replace all the cigarettes with food... so I said to her can you give me any ideas of what I can eat that won’t affect the diet. So she gave me, eat celery and carrot sticks, so I was eating all these vege sticks. So when I got sick of those she said to eat dry crackers, and then when you get sick of the crackers eat fruit. I said to her that I’m sort of fussy when it comes to eating as well, so she said well like for your fruit and vegetables, cut it up small and she was actually suggesting make it the same size as a smoke, the psychological effect of actually holding something in my hand would overcome the rest of it, and that way I didn’t pig out on a whole lot of veges as well. I did the same thing with fruit, cut it up into small little bits and eat it that way, and just sort of snack during the day, and have that on top... That seemed to work... She gave me a hard time when she knew I went back again and I said to her at least I’m still sticking to my diet (106).

Weight gain in other participants ranged from “Just a little bit I think, not a lot” (59) to “I became cardiac material. I actually put on 3 stone” (27). The following quotes represent typical experiences and summarise participants responses:
Even when I was cutting down I was putting on weight (65)
Even my friends noticed it straight away too, they go, you doing weights? (73).
It was the eating that got to me. I couldn’t handle it. I know I was big before, but I got bigger... I put on weight about 17 something and I’ve never been that high in weight (124).
I put on 2 and a half stone. I think that’s a concern now (121).
I went from 8 and a half to 11. I was big (119).
My size fitting on my clothes, I was 20. Then all of a sudden I went zonk, zonk right up to 26. Now with this walking up and down the stairs I get brassed off, I get short winded and I know it’s through being big (34).

The weight gain was unwelcome and worrying for most of the participants that gained weight. Many of them agreed that it “probably” was a factor that contributed to their going back to smoking, as one participant said: “It made it easier for me to convince myself” (122).

I watched the weight going on, that was the other thing… I just gave up and started smoking again… I got bigger. And I lost again when I started smoking again (15).

I didn’t want to put on weight, was chubby at the time... Put on weight, stressed out, be moody as, not really what we needed at the time (96).

It was quite a big problem because see I’ve been anorexic twice in my life and weight’s always been a major problem. I think that’s half the reason why I keep telling myself I need to smoke so I don’t gain weight. But I’ve gotten over that problem and I’m basically telling myself if I gain weight, well let’s get over the problem of smoking first and then I can lose the weight after (90).

I know it was because I was putting on weight again. It was only a week but I was putting on weight again (15).

A few other participants believed they had lost any weight gained when they returned to smoking, as one participant said,

…since I had my last interview I lost a lot of weight through smoking and I think it’s from smoking. That’s one of the things I’m a little bit apprehensive about is putting on weight (52).

It was something to do with the smoking as well as not eating as much (91).

I’m actually eating a lot less now that I’ve gone back (129).

But, one participant said she put on weight when she returned to smoking:

Not when I stopped smoking. When I went back to smoking I put on some weight. How strange is that? I couldn’t believe it... Because I stopped doing physical activities... I stopped the gym.... and I wasn’t doing touch...so maybe that’s what it was all about... That was that tiredness stage. I couldn’t be bothered doing anything (26).

Other Reasons for Relapse

Participants had numerous and varied explanations for their relapse, for example, one participant said, “I sort of tried to blame menopause, tried to blame a lot of things” (42).

A few participants could link their relapse with incidents of strong negative emotions, such as anger and repulsion. Two participants who relapsed recall “feeling
quite rebellious, quite defiant, and I hated everyone" (3); "I think it’s anger, frustration more than anger" (59). A NMSCP participant resented being told “how resistant I was, that I was just in denial.” One woman who was caring for a sick ageing relative was repulsed by the smells associated with his toilet care: “cleaning up after Granddad. It just takes that whiff right away. That’s my major one, the smell, reeky smells.” She didn’t think she could attempt quitting again until “I’m feeling up on top again and I can get back outside and do my mahi” (39).

A few participants allowed themselves to continue smoking because as they inferred, it is acceptable to have at least one “naughty” vice, as illustrated by the following quotes:

I’ve been smoking so long. It’s like I’m giving up a part of me. It’s like I don’t drink alcohol, I don’t do drugs, I don’t burgle or do anything other people do. If I give that up I’ll have nothing to fall back on (95).

I’m my own boss - boredom - relief - I wanted to have another smoke – it’s the only thing that’s naughty for me... it’s quite fun - it is the rebellious thing to do (41).

Other things that participants said undermined their quit attempt included a drop in motivation: “If you’re not sick and you’re smoking, you don’t feel there’s such a urgency or a real major need to give this away” (93); or, ready access to cigarettes, for example: “knowing that if you haven’t got a cigarette, just ask your Bro and he’ll give you a cigarette” (32); trying to stop during “the festive season” (7), that is “the hardest time to get through was this holiday period. It was the Christmas period” (121). The internal struggle, as one participant described it:

This little voice at the back of your head saying, yeah you won’t be able to give up, you won’t be able to hack it. This little voice saying, all it’s going to take is one little thing to set you off (106).

**Stage of Change Now**

Following these interim relapses about a quarter of the participants who were smoking at follow-up tried to stop again and a few said they were “still trying” (92). Three of the NMSCP participants who relapsed “tried to get on another course” (23) or tried to access some other form of support, for example, “I even rang Quitline” (111).
Of participants who had not tried again, one said, “no, because my life at the moment is very unbalanced and I feel it’s not healthy for me to stop right now. Reasons have been because of the fact that I’ve got an addiction with drugs and alcohol. I know I will stop when I feel there is a balance in my life again” (46). Another participant was resigned to her relapse but was certain she would try again, as she said: “all I said to hubby was, oh well it’ll happen again... get the urge and then I just have to be prepared” (44).

QUITTING AFTERMATH

These quit attempts were not wasted, however, as participants were able to learn from their experience, though one participant said, “learning to cope without the cigarettes, it’s been a very slow process” (47). In particular, some participants came to realise nicotine was far more addictive then they had previously thought, as one woman said, “I kind of played down the addictiveness of it” (83). A few participants came to compare their cigarette smoking to other addictions they had had to tackle, for example:

You look at it and say what’s this little thing. I gave up smoking dope. I just gave it up. I could do that but I can’t give this up... Frustrating and annoying and you want to be in control of yourself, your actions, it’s hard (84).

It’s like with gambling, I have to realise those triggers. And for me it’s to be able to deal with those triggers when they arise (47).

Probably after so long it’s just the body just craves it more (81).

First off I wanted to go cold turkey. Tried that, that don’t work... when I looked at all of this up here, it was like yes you’re addicted to nicotine, right? I want to but I can’t just toss it. That’s come through really clear. I never thought of myself as addicted until just going through all this (16).

One woman concluded that she would need to get professional support next time, as she said, “everything I’ve done I’ve actually tried to do on my own. Although I’ve had some support, the verbal support, I have actually tried to do it on my own. And it hasn’t worked” (16).

POSITIVE OUTCOMES

Despite their relapsing to smoking more than half of the participants who were smoking at the follow-up interview reported maintaining some positive changes in
their lifestyle since the initial interview, for instance, increased exercise, improved diet, increased energy levels and improved health.

**Kai Ora**

Over 50 participants became more aware of their eating habits and initiated dietary changes when they reduced or stopped smoking, for instance, they drank more water and juice, tried to eat less fat and less sugar, increased their intake of fruit and vegetables and grains. Several participants made changes in the diet mainly to help control their weight. A few participants were trying to change their diet to control their diabetes. Typical quotes illustrating participants' changes were:

- Changed our diet from boil ups to grills, not too many eggs, not too much butter... actually trying to stop smoking I've also just about not having sugar at all... I found if you get too much sweetness in your mouth you want to smoke again (42).
- Taken on more of the cereal in the morning. I'm not sitting down to a cooked breakfast... it's a balance thing (40).
- I'm trying to make the body a temple and only put good things into it (72).
- I'm not eating lollies or things like that. Not eating MacDonald's (69).
- Sugarfree lollies and gum. Mainly chocolate. I want to look after my teeth. I don't want to give up smoking and be toothless at 40, beautiful! ...watch your teeth because it can be a real good thrill (83).

A few participants found that their tastes changed, for example, one participant “started eating a lot of chicken and fish instead of roast and lamb, cut out red meat. I didn't like the smell of red meat. Started eating tasty cheeses, olives” (76). Another participant said:

- ...my vegetables taste like vegetables when I eat them and fruit... there's a lot of food that I disliked which I'm eating now... I never used to eat kumara, silverbeet. In the way of fruit: nectarines, peaches. I'm eating all those now (22).

Two participants said they “couldn't really afford to change the diet” (96), as one participant said, she had to eat what they could get for nothing. One participant who had been on the NMSCP said: “I wish I could eat all the greeneries we had there but with a big family it's hard to because I've got my mokos here and I can't put them on that” (111). Another participant who had been on the NMSCP changed the way he cooked vegetables, as he said, “ate a lot more vegetables, more not so cooked... found new ways of cooking cabbage without it just being boring, like fried in garlic” (23).
Only one participant reported that they were not able to maintain at least some of the dietary changes and had “gone back” (17).

**Push Play**

About 40 participants reported increasing the amount of exercise they did, particularly they increased or “took up walking” (93). Others said, “I started running” (47); “I’ve been at the gym for about a month... then I go to the pools for a swim” (84); “we play a lot of sports now” (119); “I play touch now” (121); “netball was just starting” (46); “gone back to taiaha” (3). Whilst the increase in physical activity may have occurred initially when participants stopped or reduced smoking they were able to maintain the change. For several of these participants their increase in physical activity was part of a whole lifestyle change towards better health or their more specific goal of losing weight, as one participant said, “I don’t think that I can actually stop smoking without exercise and somebody monitoring a pattern of eating... I need to take care of those all at the same time” (8). About 12 participants maintained previous levels of physical activity.

**Improved Ability to Respond / Increased Assertiveness**

Some participants became “more assertive” (22) when they stopped smoking. Their ability to respond seemed to become more spontaneous, for example, one participant said she was “able to speak out more” (111). Others described it as “more explosive... very quick to react” (23). As they said:

What I have developed is something that helps me analyse without getting into a panic situation or pushing panic buttons... I have more passion. I’ve portrayed more sincerity to the other person (11).

I found I was really honest with everybody (76).

I talk freely to my wife about a lot of things which I never used to... I used to let it build up inside of me but now I talk about it... because smoking it was a way out, or it was a cover-up... go and smoke and just sit there and oh blow it away... I used to take the easy way out... I used to say, oh whatever but now I really think about things and make good decisions... I realise now that smoking had a lot to do with my years wasted (22).

As another participant explained:

If we’re having arguments, instead of sitting there talking about it I’ll just go out and have a smoke, shut the door and he stays in here and I stay out there... we started talking a lot more. Like I sit here and watch TV, if it’s an ad break I’ll go okay and
walk out and have a fag, but instead of having a smoke, we’d talk during the adverts (106).

I didn’t yell so much whereas before I’d get really annoyed and yell... I can sit down and talk to the kids now... more patient (121).

I was listening a lot more as well because you notice what’s around you (122).

Things that happened at work that I felt were quite culturally inappropriate... I really reacted to them... I think that my reactions are stronger when I cut down on the smoking (16).

One participant thought it was because “when you’re smoking, you’re not feeling confident about yourself... as a non-smoker absolutely much more confident... more in control” (12). This participant was able to end a relationship with an abusive, sometimes physically violent partner and get him to move out. Looking back at her use of smoking she said:

Instead of looking at the reality of the situation, I’d forget about that and go off on a tandem and not actually deal with anything. I used it as a coping tool in intolerable situations, when in actual fact all it was doing was making me more intolerable within myself... I used cigarettes as a tool, a bloody ineffective tool... it just acted as a suppressant. All the stuff is still going on and when it would come up again in the past, I’d have another cigarette.

On a similar theme other participants said: “usually when you get stressed you want a smoke straight away, well I didn’t, as I said I got vocal” (107); I thought I had to please everybody before and got to I actually don’t (26).

**Calmer**

Other participants reported an increased sense of calm. They felt “less stressed” (25); “everything sort of ran smoothly” (6). They said:

I think I’m a lot better to live with now (42).

I stopped chewing my nails when I gave up smoking (63).

I felt a lot happier... I took everything in its stride (89).

**More Energy**

Some of the effects discussed above, such as increased calm, improved ability to think and communicate could be partly attributed to the extra time participants had because they weren’t smoking and the extra energy they said they had, for example:

I wasn’t getting so tired (25).
I found myself doing other things... utilising my time more effectively and actually accomplishing more. Instead of having lots of half finished projects around the place... there’s a lot more time on my hands. I’m not sitting down smoking. So I’m actually seeing projects being tidied up, finished and dealt with (12).

I had all this energy... I found I was doing a lot more in the space of time... things were organised (26).

I had more time for [son] like instead of having a cigarette I’d go and read him a story or draw a picture with him (14).

One couple were both working as volunteers and the woman “started doing a lot more handcrafts” (63; 64). One participant “actually had a medication decrease” (29).

My marriage is really happy... communicating better... I mean I don’t even have a problem now with cooking tea, even though I’ve had a hard day some days, I go home and my wife goes, can you cook tea? and I go, oh alright... doing more as a family... I noticed I had a lot more energy and I wanted to utilise it. I thought, I’ll follow my daughter and now that I feel so good, we’re in the process of getting another child through Social Welfare... (22).

Reflecting on the effect of smoking on his life this participant said, “what a waste, all my time I’ve spent sitting around smoking, here I could have been doing all these things... my smoke was more important, it was I’d buy a packet of smokes before I’d buy a loaf of bread that sort of thing.”

Some participants found their houses were “tidier” (27) because as another participant said she could “get up now and it’s all done... make breakfast, clean our house before we go to work. Then come back in the afternoon sort of still got a little bit of that energy left” (42).

I got busier... house cleaning was the biggest one. The house was so clean. The outside, the gardens and that were really well done (15).

As other participants observed:

Smoking took up a hell of a lot of day (76).

I was able to get a lot more done and then I realised how much time I wasted on smoking (77).

**Triggered Memories of Traumatic Past Events**

Having discussed smoking’s function to suppress and block, it shouldn’t have been a surprise but it was, when some participants had feelings about past traumas resurface. A few participants began having flashbacks to sexual abuse trauma, which
was unwelcome and possibly contributed to their relapse to smoking. As the following participants said:

I didn’t want to see it. I didn’t want to know and it’s about sexual abuse... I want smoke in my nose so I don’t have to smell it because it was all part of that incest; was about masturbation with semen all over me... I don’t know how to heal a memory of smell... that fear of smell is more greater in my life (8).

When I stopped smoking for 8 days, I think it was just long enough to let up a heap of shit and it was right in my face, heaps of stuff I haven’t worked through... did I need that in my life right now? No I didn’t... I’ve worked really hard to keep that stuff buried, and I have a really good life with it over there... did I know that a heap of sexual abuse stuff was going to come up? No. I actually believed that I had dealt with lots of that stuff and anything else that would come up was resolvable for me... I think I’ve been working really hard to just hold everything together at times. It’s hard to do everyday functional things, get up go to work (3).

One woman who was sexually abused by three elder siblings said, “some stuff came up and I talked to my parents about it” (76). Other participants had upsetting flashbacks also, for example, one participant “saw my father forcing me to smoke... I had one of my mum dying” (25). A young woman said:

My mum, my grandmother and my doctor seem to think that it’s a psychological problem. I had a friend that passed away; my Dad’s name was all through the newspapers connected to... so they think it stems from there.... I do sort of get a bit depressed it’s not like I sit there and cry for days or anything but I sort of feel the pressure coming on... my friend hated smoking so when I don’t smoke it makes me think about those things... I get confused... and then I feel like a smoke (110).

A couple of participants believed:

...that to stop smoking, I really need to go and work through all those issues that started to surface because they were the triggers. Speaking as a Maori woman, the majority of the things that started to come up, was about cultural identity, isolation from my own land, things that happened at work here that I felt were culturally inappropriate... so there’s still a lot of healing and that essence that needs to be walked through for me... I actually thought I’d worked through a lot of my own Maori issues but then something always crops up... some self-esteem stuff come up. Acceptance... when I cut down on smoking, thinking about areas within my own whakapapa that I haven’t yet discovered (16).

**Negative Aftermath**

Most of the participants who were smoking at follow-up were “disappointed” (97; 27; 95; 17; 76; 106; 66; 25; 28; 91; 26), “bummed out” (19; 49; 96; 6), “brassed off” (11; 47; 34; 107), “peeved off” (45), “pretty upset” (89), “disheartened” (13) and “depressed” that they had returned to smoking. Other adjectives and negative statements that they used to describe how they felt included:

- extremely not good (83; 111)
not very happy (90)
aughty (73)
regretful (12)
guilty (21; 23)
really sick... I wish I never started back (34)
really slack (40)
pretty horrible (44)
really terrible (117)
powerless (32)
a bit let down (14)
pretty disgusted really. It makes me angry with myself for little discipline (8)
stupid after doing everything. I felt like an egg (124)
how boring - back to smoking (77)
I hate it... I can’t stand the smell of smoke either and I don’t know why I’m smoking... I
was calling myself all the names under the sun (121)
I was angry of course, a month, I hadn’t had a smoke the whole month (122).

Several participants concluded that their quit attempt had been a waste of time, for example, “I tried so hard, it just seemed that it was a total waste of time” (44; 42; 28).

Some participants, came to more negative conclusions about themselves as a result of their relapse. They explained their relapse in self-deprecating ways, that is, they saw their relapse as some kind of failure on their part. For example, they said they were “just too weak” (110); “I didn’t try hard enough” (81); “probably just lack of willpower” (118); “that’s why I’m smoking, ‘cos I’ve got no control” (10).

I’m kind of really weak, self-esteem, you could say sometimes I can’t strive to stick at something... it’s really me, gave up on trying (95).
I get annoyed with myself... keep telling myself that I’m pretty gutless that I can’t get over this hurdle and just chuck it in (20)
You don’t want to let yourself down. You can let other people down but when you let yourself down it’s really really bad because the feeling you get from letting yourself down is pretty bad (83).

What this participant hints at is the potential negative aftermath of relapsing, in the form of feeling let down. Other self-admonishments included, for example:
I set myself up to fail (16)
Wasn’t prepared... I really am being very very mischievous. I’m not really concentrating (69).
I didn’t do it for the right reasons. I was doing it for other people... For me it’s about not having enough faith. Not doing karakia, not surrendering. It’s a learned process... of surrendering. It’s really hard to give up... your will (97).

My self-esteem was down because I’d let myself down... I felt bad about myself for quite a while for smoking... I was so depressed that I actually wanted someone to say to me, it’s okay have a cigarette. It’s alright that you started again. Maybe you can try later. But because I never heard that, it was making me depressed. No one was giving me the okay... I’m a determined person. And I mean let alone let other people down. I don’t like letting myself down and that’s where a lot of the depression came from... every time I see that advertisement, I kicked myself and say, you idiot (46).

It just made it worse inside me... I write it down – here’s another day and I’d just put failure below... I blame myself (111).

When the quitting experience is largely negative with such self-deprecating consequences there is a chance that further quit attempts will be delayed as suggested by the following quote:

I was so annoyed with myself and I felt crook... as a result I haven’t really tried again, which is really bad (51).

Some participants were ambivalent about their feelings, saying: “I’m in two minds about that” (11); “it’s a shade of grey” (64); “sometimes it’s depressing and sometimes it’s okay” (95). They rationalised their return to smoking in a number ways, for example:

I haven’t really knocked myself on the head about it. Because I think okay, it hasn’t worked. I just thought well this is all part of the journey (16).

I felt really let down and then I rationalised it and said oh well next time, just try again. Next time I’ll do it (15).

I felt a bit disappointed when I first returned to smoking, but now it’s just don’t let it worry me. Might be every time I see a anti-smoking poster I think why did I start again? Little question in my mind (29).

Half of me was pissed off with myself and the other half was oh look you can’t do it, just get on with it, which was a shame (118).

I sort of feel like it’s outside me almost. I don’t feel bad about it, I don’t. I just sort of understand how things are... I’m trying not to beat myself up about it too much... part of why we’re smoking is not really my fault, when you think about the amount of money that gets spent on trying to get people to smoke... why I started smoking when I was a teenager and that peer stuff, so I don’t get that people blame me as a person here and now, without acknowledging all the things that’ve made people come to smoke (92).

About 10% of the participants that were smoking at follow-up did not feel bad and were actually “pleased” (22) usually as they had managed to “cut down” (53) as illustrated by the following quotes:

I believe I’ve done really well by knocking it back (99).
I think I'm really incredible... a few years ago used to be 4 packets a day... but I'm smoking a 30 gram packet of tobacco in about 3 days (65).
I've cut down... I've been quite successful. I'm quite pleased (116).
I felt really good, having one cigarette a day (72).

**WHAT ELSE COULD HAVE HELPED?**

The unaided quitters particularly were encouraged to identify strategies that they thought might have helped them to stop smoking and maintain abstinence. Their suggestions coincided with the current range of strategies employed by the New Zealand tobacco control movement, such as more smoking cessation support.

**Smoking Cessation Support**

One man concluded that next time he tries to give up “I think I will go for some assistance” (11). The types of assistance participants thought might be useful were educational programmes that helped develop people’s skills to cope and change, as one participant said, “gotta learn about the change. One doesn’t know how to change” (47); and programmes that offer support.

A few of the unaided quitters suggested “group sessions... we need to be chucked in a room and the doors and the windows shut and you’re not allowed to get out” (73); “maybe get away” (47) because they believed “if you got together in group situation that can help a lot” (93). Existing programmes provided models that participants thought could be utilised for stopping smoking, for example, programmes “like Weight Watchers” (93) or “a support meeting once a week” (129) like AA type support groups, for example:

I think having to re-evaluate who I am as a person and the spiritual programme of AA, I believe that it can be transposed to any facet of your life (97).

Some sort of support. Like if I had a friend that gave up (13).

Maori specific programmes were supported, such as programmes that are “about re-emphasising our Maori kaupapa, the marae... it has to be a holistic programme” (97). One participant suggested “Maori Tai Chi, getting people to move back” to Maori ways. A few other participants wanted to see programmes that incorporated sports.
One participant said she wouldn’t mind trying hypnosis, though she couldn’t afford it and she said, “I don’t trust those sort of things” (35).

Having access to support was important, as one participant said, “there should be somebody” (122), “someone to listen to my problems, someone that can help me with my problems, encourage me to give up smoking, be supportive” (110); even having access to somebody via a “free phone Quitline” (62) was suggested.

Cheaper smoking cessation aids were favoured. “Cigarettes are a lot cheaper to buy than to buy a pack of something to stop smoking” (116), therefore, several participants wanted to see the price of smoking cessation products reduced, for example, “they’ve got stuff out for stop smoking - too dear. If they put those down or had another research and asked people if they’d like to try this stuff” (42); “they should make the chewing gum cheaper or even free” (53); “give away the Nicorette” (39); “because it was $12 a sheet and I couldn’t afford $12 sheet” (56). As one participant said:

I don’t see why they should be so expensive... what’s the big mark up on them for if they’re only tablets, and they’re only little things that you put on your body. It’s just ridiculous. I was just blown away when I went and I asked about the Nicobrevin and I was sort of looking at maybe $30 or $40 and she said it was $180... I just think something should be done about that... that’s grocery money for somebody for a whole week or fortnight (118).

SECTION FOUR: TE TAHĀ WHANAU

This section describes how the actions of whanau and friends helped or hindered quitting and how they reacted to participants’ new smokefree status. This section also describes how relationships with whanau and friends were effected by the changes participants made.

SUPPORT

Some participants said it was important “having the right type of support” (12). This is explained further in the following quote, referring to support from a work colleague:

Not saying things like, give it up, chuck it away. He wasn’t going on like that, he was saying things like, you won’t be so worried about your health... 'cos nothing worked
really but I think when people say to me, gee I haven’t seen you smoke. Don’t you smoke anymore? Even my aunty said, you’ve given up at long last. So you can’t help but want to throw it (99).

Participants appreciated support that was non-judgmental but understanding even when relapse occurred, as indicated by the following quotes:

I’ve had lots of support, lots and lots of support. In particular what I have appreciated is the friends and colleagues and family who have said just take your time, do what you think you need to do... If you have a smoke, don’t knock yourself around or put yourself down (16).

Everyone really, they’ve been so good, they haven’t been judgmental… they’ve just let me do it (72).

I was doing really great. I was getting heaps of support… Just praising me everyday... What was funny, it was a bit of a classic was that when I did have a smoke, they were going oh well, it’s understandable, you’re under stress. So they were pretty easy on me (46).

**Smokefree Environments**

“In the beginning” (66) of their quit attempt, about 25 participants “tried to stay away from heavy smokers” (53). They “stayed home” (122) “stopped socialising” (58) and tried to avoid “smoking friends in person, catching up on the phone only” (76). Others were helped by the implementation of smokefree environments in their workplace, or that there were few smokers at work: “Stopping it in our cafeteria at work was good... that’s gone smokefree” (73); “A drive to stay smokefree and the work environment there’s only two smokers left” (26). One participant was helped when she got a job and found that “no one at work smokes” (62). Avoiding smokers was easier when working in enforced smokefree environments, for example, participants said: “my work environment dictates the non-smokers from the smokers. So all the non-smokers head off on up the stairs and all the smokers head off downstairs. Well I don’t join the smokers” (12).

Some participants however, “couldn’t avoid it, it was just normal” (73). As one participant said, it “doesn’t matter where you go there’s always got to be smokers” (99); “life is life and I mean my whole family smokes, I’d never be able to see anybody” (72). Some participants did not avoid social triggers because “I thought I was strong enough for it” (122). Another participant said, “I just kept it the same because I knew if I had of done that who knows what’s going to happen later on” (125).
Some participants tried making their house and car smokefree. For instance, "I kept smoking outside. I didn’t allow smoking in the house or in the car" (95). Whilst some participants were able to maintain the change, some of them found it hard to enforce because partners, whanau, flatmates or visitors "turn up and smoke inside, so bugger it. We all smoke inside. But it was smokefree for a little while" (28). Or as others said:

There’s always somebody who will walk in with a cigarette (59).
Dad’s the only one that smokes in the bedroom or in the house, well it’s like telling the Queen to give up her Crown (14).
People were kind enough not to smoke in my car, except for my sister and my aunt because she’s bigger and uglier than I am (83).

Some of the participants started smoking inside again because "with this weather, who the heck wants to stand outside smoking?" (44). Or they were gradually returning to previous levels of smoking and associated habits, for instance: “I’ve actually sat again at my kitchen window and had a smoke... which is where I used to smoke before” (16).

**SOCIAL TRIGGERS TO RELAPSE**

Over half of the participants who were smoking at follow-up, commented that their relapse was in some way affected by others smoking around them and the smoking associated with "socialising." Smoking was strongly associated with familial, work and social interactions with others. Just "seeing a person that smokes" (69), or as another participant said they found it "very easy to light up if see someone smoking" (63); and also “as soon as I smelt it” (76); “being surrounded by cigarette smoke” (95); “being around people that smoke” (8) was enough to trigger cravings for a smoke. Many participants believed they had relapsed because as they said:

It’s just because somebody else is doing it (59).
Somebody asked me at work if I wanted one (129).
We do it more just to be sociable. Because I’m with the wrong company... they all smoke (35).

A few participants were unable to stop smoking while their partner still smoked, or as was the case for a few participants, their partner who had also stopped, relapsed.
He’s actually a barrier to me not stopping. He smokes too much (21).
We couldn’t have one smoking in the house (63).

Hubby started again... it wasn’t because I wanted to go back to smoking, I could smell it on him and I used to think yuck that’s horrible... he’d go outside for a smoke, so I’d follow out behind him, and we’d sit outside have a talk out there and then he’d be sitting there having a few smokes, and I said to him pooh that stuff, I don’t know how you could go back to them... He said it does actually help. It makes him feel a bit better. It relaxes me and all the rest of it, and he said do you want one? No. No. I’m alright, I’ve stopped. For whatever reason, then I said for Christ’s sakes give me a smoke will ya and that was it. It was more like a easy way out I would say. It was like I still wanted to fit in. It was like I couldn’t still relate to him (106).

Some participants lived in a world where “everyone smokes” (83), for example they said: “I don’t have any non-smoking friends” (125); “all my whanau smoke” (111); “everyone else started smoking again” (15).

One participant went home for a holiday and lasted 3 weeks before she started smoking again. As she explains her whole family smoke and the repeated daily exposure to a strong trigger situation wore her down.

It’s very social down there, smoking, because they talk and they smoke and they talk and they smoke... just everyone smokes... It’s just being social. It’s there and it’s constant... I went out with everyone else and partied and I still didn’t smoke and I still didn’t drink and had a really good time... when I first got down there I said I’ve been going 6 weeks and then we all just got together for a big talk and everyone spoke and said oh that’s cool and we still sat talking... but then they do that every night. They talk a lot and I just remember being in the conversation but just wanting a cigarette because everyone else had one... I went to work and at work there were smokers and I just went from there to home, from there to home with smoking smoking smoking... I should have removed myself from that situation but I love those mongrels... I could feel it you know going down down down... It’s an activity in which you more or less all partake in and if you don’t you feel stink. You don’t feel stink but you’re just out. You’re just odd (83).

Another participant said: “I feel left out if everyone is drinking or smoking” (41). A few participants, however, did not understand why they felt the need to smoke when others were, as the following participant said:

I don’t feel like that when I’m around people with alcohol though. Like when we have happy hour... I don’t drink and drive at all and I don’t feel the need to drink to fit in. Strange that! (13).

An older woman thought “I’m past that” feeling pressured to be like everyone else, and yet she said, “a lot of it for me is where I am at the time... where I’m at, who I’m with... if I went down to the marae 5 days a week I’d be a heavy smoker” (69), but if she worked for the health centre she’d be a non-smoker.
Discussions with one kuia revealed a pattern of smoking primarily when away from whanau and the marae. When she was at home as she said: “there was always something I had to do... it was just natural to get up off the table and do something...” It wasn’t necessarily about fitting in, as she said, “even though they’re all smoking. I didn’t want to smoke” (99). It was more about having and fulfilling a role within the whanau. Being isolated or alienated from whanau and having no role, no contribution to make to the whanau results in a feeling of discomfort.

The strength of the association between smoking and social interactions was compounded when that social interaction occurred in the context of “going out” (21) “celebrating” (11), “partying” (17) and “drinking” (72). Over a dozen participants reported that their relapse occurred:

When the visitors come over... we had a barbeque and a few beers (34).
My mum had a wedding... after the meal everybody started smoking, so I did (29).
I’d just had a bit too much alcohol to drink and I just got into that mindset of not feeling very well and maybe if I inhaled nicotine I might feel a little bit better. Of course, I just felt worse (12).
We had a social on that night and I had one cigarette and it was automatic, I didn’t even realise I had it in my hand... I was standing next to a girlfriend that was smoking and she put it in the ashtray, and without realising I picked it up, before I knew it I had it in my mouth (6).

Some participants attributed their relapse to their alcohol consumption, for example, they said:
Because you’re not rational in your thinking when you’re drinking (93).
Like here is a situation I’m familiar with, now what’s missing? The old habit came back... didn’t judge, didn’t think... (11).
Going sitting in the pub when you’re trying to give up smoking - bit silly... if there wasn’t any alcohol there it would’ve been sweet as (44).
If I’m not drinking I’m all right... I had 10 stubbies... it was enough to make me forget (34).

In discussion with one participant who only ever smoked when she was drinking socially, she was able to pinpoint that smoking occurred usually after the third glass of wine. She didn’t smoke at wine tastings at work and she wasn’t influenced by others smoking as in the following instance, her friend she was out with was a non-smoker.
It wasn’t just 1 or 2 drinks... 1, 2, 3 glasses, 4 would be pushing it. But I can manage, don’t need a cigarette... for business I never, ever, ever, smoke at tastings... this has got a lot to do with it, something to do with your hands... it’s not the boredom factor... (51).
Considering alcohol’s depressant effect we considered whether she was using nicotine as a stimulant to counteract the effect of excess alcohol consumption.

...maybe it is the stimulant factor as opposed to anything else... that could be it... Your body’s actually doing other things... [starting to labour under] the weight of all that wine... Yeah, because it’s never on the first or the second one, it’s always later I really have that need (51).

Another participant who said, “when I drank, I smoked like crazy” thought it feasible also that smoking may have been used this way, that is, “fagging to get yourself up again” (72).

**Influenced Back**

Theme analysis showed up two main ways in which other people reportedly influenced participants’ relapse. Firstly just “being around other smokers” (129), “their presence. The smell” (79) was experienced as “peer pressure from groups, big groups of smokers, surrounded by them... straight after the game everyone’s smoking up cigarettes galore, rugby league, it’s terrible” (73).

Secondly, smokers directly tried to get participants to go back to smoking, especially other smokers at work, by offering “here want to smoke, you want to smoke?” (22); and urging the person who has quit to join them in a smoke, as illustrated by the following quotes:

They’ll offer them to me all the time... there was some of the ladies at work who are quite heavy smokers and I was telling them I didn’t want to smoke, they didn’t support me at all. They were trying to turn me the other way... also too I was given a couple of cartons (73).

We went out for a break. She said, do you want to smoke? Nah. Nah it’s alright. She goes, oh for Christ’s sake you need a smoke, have one. So I said, oh okay... I was quite happy ‘cos I used to go outside, stand outside in the fresh air and have my stress break. I’d just have a cup of coffee instead of a smoke and I used to stand up wind from them so I couldn’t smell it either, but yeah once she said, go on you need one ‘cos we’d had a really bad day (106).

“A lot of staff members say, cup of tea and a smoke?” (117). This occurred even when colleagues knew the person was giving up smoking, “they’d just say, oh, I forgot.” Or as was the case with another participant, colleagues kept reminding her of smoking whenever they went out for a smoke, for example:

Everyone else was noticing that I wasn’t smoking. They brought it to my attention that I wasn’t smoking... I’m not having a smoke today, but they still come in and get you to go out and have a smoke. So you’d go out with them, which was okay, but they’d be having a cigarette and going, why aren’t you having a cigarette? You’d have to tell
them that you’re trying to give up… like you can be really busy and doing something and then forget about it… I’d keep busy so I wouldn’t think about it… but when people would come they’d bring it up… it was like, oh a cigarette I wouldn’t mind one right now (15).

Similarly another participant was reminded frequently because “a lot of people didn’t know I was giving up… kept asking me for a light” (26).

Two participants in Northland spoke of how difficult it was to stop in an environment where smoking was so normal, for example, one participant said, “it’s expected of you to be in to smoking and drinking… they still try to offer me a smoke. They think there is something wrong with me, they think you’re porangi if you don’t do what they’re doing” (41). The other participant said: “You get on the piss with us and you smoke, well they encourage you to smoke” (42).

A neighbour of one participant, similarly supported her to relapse by saying “if you need to have one, just have it. I said, No I won’t, I’ll just leave it and then she’d offer.” But, this participant did not blame her neighbour in anyway as she said, “she doesn’t make the decision, I do, she just makes the temptation” (6).

In some cases ex-smokers also encouraged participant’s to relapse, for example, one participant said:

I have noticed people saying though, like almost encouraging me to smoke… saying, well you do alright. You’re pretty fit… why give up if you enjoy it so much?… it’s not affecting your health. They’re saying it’s not affecting your health, I think it’s bullshit… bit weird aye (23).

Not all other smokers undermined participants quit attempts, for example:

If they’re having a smoke and I say, can I have a puff of your smoke? They say, No. You’re trying to give it up (42).

They wouldn’t leave their smokes lying around (122).

They didn’t want to smoke around me (89).

Smokes are dear now, people don’t want to give you a smoke, people don’t want to hand smokes out freely. No. Nobody encourages me to smoke (69).

Some participants reject the concept of peer pressure, that they could be influenced by others, for example:

Others can’t really influence you. It’s your decision at the end of the day (8).

One man believed it was selfish of him to divert time away from his family to deal with has nicotine addiction, that is, he said, “For me, to make myself better, well then I’m being selfish opposed to meeting the needs of my family” (97).
Disappointing Others

Partners, participants' children and other whanau were sometimes disappointed that the person had returned to smoking as illustrated by the following quotes:

My family didn’t like it. They kept hiding the cigarettes away from me because I said I’d given up (59).

One man said his wife was “not wrapped about it” (76); “reckons I’m mud” (73) and another participant was ridiculed by his “partner, my kids... you’re all pluck, you couldn’t do it, you said, you said” (117) which made him feel “doubly worse.” One woman laughed and said, “she won’t kiss me unless I brush my teeth... pooh you stink, pooh your hair smells and all that buzz” (9), to which her partner added “I lay a guilt trip on her... we’ve only got $10 and she’ll want to buy a packet of cigarettes and I’ll say, that’s it then, you eat your cigarettes and me and [brother] will go without food for today and the next day and the day after that” (10).

Participants’ children were “disgusted” (23) and vocal in their disappointment as illustrated by the following quotes:

My kids, well they’re not very happy at the moment... my daughter keeps reminding me (121).

My 4 year old... his attitude was, oh Mum don’t smoke (56).

The boys don’t like it... they think it’s a filthy habit (11).

They hate it. They really get into me, oh Dad, and get wild (84).

My son still gets on my case sometimes. My daughter put smokefree signs up (115).

One woman said her children had a mixed reaction to her relapse, for example:

Mixed reaction from my kids. My kids were really looking forward to me stopping but not me being grumpy (26).

One woman's mother just “laughs at me because I only stop for a few days and then I’m back into it” (14) and other mothers said: “thought you said you were going to stop” (17); “you’re so weak, you should just give up” (51).

Some participants said that others gave them “a bit of flak” (44); “everyone looked at me in disgust” (54), “and say, you silly girl” (124) or “they just looked at me and didn’t say a word” (122). Other people “were just like, oh well we knew you
weren’t gonna do it” (49) or “they said, surprised you lasted this long” (106). These kinds of reactions from other people weren’t “very good actually” (49), as one participant said, “I think a couple of the family members thought, that’s what we thought you’d do, which is really hard to accept when you want some support” (121).

Other people’s comments and approach did not have the desired effect, as suggested by the following quote:

I’ve got a re-born again bloody friend who says, you know what’s worse than smoking is? I said, what? Me, she goes. Bloody reformed non-smoker. So she’ll keep me on the track but I dodge her. I evade her because I don’t want to hear what I already know... it makes me want to smoke more (8).

Other people did not always express disappointment because they “didn’t notice” (101) or it “didn’t bother them” (129). They may instead, have been “encouraging” (47) or “waiting to see whether I’ll quit, whether I’m all talk” (32). For example, one participant said:

Everyone was good. Like if I would have a cigarette, they wouldn’t make a big deal about it or sort of try to tell me off, because that would have been to piss me off and I would have said, stuff ya. I can do what I like (72).

Some participants “never told anybody” (27) they were quitting, as one participant explained, “I didn’t tell anyone... ‘cos on previous attempts, people would sort of want to sabotage it, or it’s like a game” (92). One young woman who this happened to, said her family teased her incessantly about stopping until she gave in and relapsed and “that’s when they stopped.” Even though they had tried to get her to go back to smoking she said, “I think they weren’t happy that I’d given up” (125) and gone back to smoking.

WHAT COULD HAVE HELPED?

Thinking about what could have helped participants in their quit attempts, several legislative measures to support cessation were suggested, such as prohibition.

Don’t have cigarettes in the country... Have an alternative (35).

“One of the problems with smoking” said one participant, “was that it was legal” (106). A few participants said, “I’d like to see it banned” (64), for example, they said “just getting them out of the country” (93); “just stop people from buying it,
stop selling them” or at least make it harder to buy them. “If they only sold them for 2 hours a day in one place and one place only” (74).

One participant supported larger warnings being printed on tobacco packaging. He said:

...when I got that carton duty-free from Australia, see the big signs over the cigarettes, doesn’t look very attractive... Sitting there with this flash packet of smokes with Smoking Kills. Everyone’s got a different message on it: pregnant women shouldn’t smoke, lung cancer, heart disease, real graphic things like that. I don’t think that cigarette companies would like it, but shit, too long they’ve been making money off people’s misery (73).

One participant supported denicotinisation, that is, “put less nicotine in smokes” (42).

Some participants thought, “the government should do more” (106) but not all participants saw smoking as a “government problem.” For instance, one participant said, “primarily it’s with me. Secondary it’s with government... I think the government and the tobacco companies have to take some ownership” (117). Another participant said, “my only problem is the government profiting from this addictive industry” (64).

A few participants supported increasing the price of tobacco, for example, one participant said, “bump the price of smokes up real high, like $20 a packet” (42). Others however, were less convinced of this strategy and said, “keep going up in cost and people’ll still carry on buying them” (64). As one participant said:

It brought to mind the more things go up, of course they’re gonna buy it, but they’re also gonna find it harder to buy so what are they gonna do? They’re gonna go out there and do crime. It’s gonna get to that stage where they need to do crime to get $20 for cigarettes, when they used to do crime to get $20 for a bullet (46).

Another participant said, “it’s probably gone up enough already. If they just weren’t available you wouldn’t have to worry about it” (74).

A few participants supported and wanted to see more “sponsorship from Auahi Kore... but along with it provide help for those people to walk the talk” (21).

Smokefree Environments

Several participants wanted to see more environments made smokefree, for example, one participant suggested making sports clubs smokefree, he said, “it’s
shocking, you walk into a club, the whole room, atmosphere is just full of smoke, it’s terrible” (73). One participant said, “stop smoking in hospitals” (55) and another said “I find it easier when I’m around non-smokers” (79). A few participants wanted to see “more signs up” (62).

Some participants thought if they got a job they would be able to stop smoking “because I can’t smoke at work... it was easy because I was occupied” (79).

**SECTION FIVE: TE TAHA WAIRUA**

Participants reported effects on their wairua as a result of nicotine withdrawals, for instance, one woman felt her wairua “was all to hell. Because it wasn’t balanced. Because I was giving away something that I’d had for 30, 40 years” (27). There were also effects on te taha wairua when participants managed to stop smoking even if only for a short period. Some participants who cut down their tobacco consumption reported positive effects on their wairua.

Participants were not asked to define wairua, so it was not always clear that participants had a common understanding of the term. Despite this, some commonality in responses was obtained, in particular participants spoke of a “clarity” (129), of feeling “very clean inside” (22); “lighter” (23). Their wairua “has been enhanced” (64); they felt “more alert, more onto it too. Like lights on and somebody’s home for a change” (22); “more conscious” (46); “more receptive to it... non-smoking increases my awareness... it tends to have a stronger pull on me than other things” (12). Other participants said:

I felt quite spiritual when I wasn’t smoking, quite emotional at times (23).
It’s just opened up my whole outlook to life (64).
I felt really good. I felt on top (117).
I found you had a lot more time to think about things (121).
I’m not abrupt like I used to be, especially with my daughter. It’s more soothing, very soothing... I’m getting more patient with the kids... I just can’t be bothered getting into a row with them (22).

A few participants noticed a change in their “aroha” or their capacity to give, for example, one participant explained when he used to do things he would think “this is worthy of this amount of brownie points... now I just don’t give a damn about that, I
just do it. What will happen will happen” (11). As a result he believed he was receiving “greater benefits... a lot of things have happened... I don’t have to go looking for it. I didn’t need that money it just came.” Another said she became “more giving... I’ve been involved and given more of myself than I normally do and able to speak out more I suppose” (111). She explained this by saying “you become more observant of what’s happening around you... you begin to sense what’s right and wrong” whereas before, she said, “one side of your brain will say yeah and one will say no. If you can’t decide you sit there and watch... But since I’ve become observant... it’s only because I’ve been on the programme that I know the difference between giving up and not giving up. I’d say it is wairua - because it’s choice” (111).

A few participants noticed a change in the frequency, vividness and content of their dreams, visions and other prescient experiences. They “became more perceptive... that’s a Pakeha word. I became more aware of things seen and unseen” (27) that is, matekite abilities were stronger. As this kuia explained, she “had it before... when I was smoking I could see it... that somebody is not well... but when I wasn’t smoking I could actually feel it... I can feel that mämæ.”

“My dreams... they’re not as scary” (22); “...they came more... they became more vivid and they became more clear” (16).

One woman said it was “freaky” and that people thought she “was more psychic.” She said, “my reflexes got pretty cool” as she caught her child falling out of a tree, and “I think smoking’s a poison and I was obviously quite pure when I wasn’t smoking so I was more in touch with everything.” However, once she returned to smoking she said, “I lost it” (76).

My tupuna are actually now saying to me, you’ve taken these steps, so you’ve got to complete it... it will be healthier for you in the physical sense, but deeper than that, in the spiritual sense. We’re talking tapu here. I mean we’re talking my intrinsic tapu which I suppose with me smoking, I’m doing something to that (16).

A participant who later died from her smoking related illnesses said of the changes in her wairua that “it was just too clear and I couldn’t handle it... my wairua was outside... because I’m so used to it being around, but when it stepped outside and showed me... I saw myself dying if I didn’t stop smoking... It showed me the consequences if I don’t. That was quite frightening.” She said she told her psychiatrist and was hurt when he suggested she had schizophrenia, that is, “they were gonna put
me in bloody Tokanui [psychiatric unit]... So it’s not nice to talk to people who don’t understand aye. See what happens when they don’t understand Maori, I think you need to go inside for a while.” To help her understand she went to see “my kuia to ask them... they told me that means you have to give it up... that’s your wairua.” This participant was able to stop smoking while on the NMSCP, but after that was unable to access any further smoking cessation assistance.

The increased sensitivity was not always welcome, as one participant said, “there were things Maori that you don’t really need, because it’s somebody else’s hara and when you are as sensitive as I was, you can get all sorts of hara that’s not good and you don’t want” (27). For example, she spoke of an incident where she felt a woman “was going to commit suicide” and “then you feel you have to deal with it.”

For those participants who were devotees of mainstream religions, “stopping smoking is part of the spiritual journey” (64). They said:

I was more thankful in my prayers (83).

I felt a lot closer to God... I felt that he was talking to me all the time... God was saying to me, good on you... you’re heading in the right direction (46).

To further explain the difference participants experienced in their wairua, when they were smoking they described their wairua as “heavy” (117); smoking “bugs up your whole feeling, your whole awareness” (27); “you have to work harder at it” (23); “things were so clouded... when I was smoking I didn’t have any time to think because I was filled up with smoke” (121). Other participants said:

There’s a part of me that has been suppressed because of me smoking (16).

It blocks off what you’re really capable of... we’ve got the potentials to do things, but we can’t see it. If you’re a smoker, smoking comes first before anything else (111).

A Mormon participant explained how she thought smoking,

...blocks your spirits... I can see smoking can block your wairua because it persuades you, it takes you away from what you know... It’s an inner thing as in God has to be the Number One man and because smoking enslaves you, there’s no way that you can be fully devoted to the Lord if you’re tied to your habit... because it consumes you (83).

A member of the Ratana Church said, “God says that your body is your holy temple... you’re meant to be the same as him. You wonder really who are you damaging” (90).

A few participants compared their wairua while abstinent with their wairua when they were using marijuana and alcohol. They described their wairua as “being clogged up” (64). “It all goes together with stopping drugging and drinking too...
know that if I gave up smoking, I’d get even lighter. I’d have an even better peace” (23).

SECTION SIX: CONCLUSION

This chapter focused on the quitting experience of participants who were unable to stop smoking or who had relapsed before the follow-up interview. The experience of quitting for participants who were smoking at follow-up was largely negative. Withdrawal symptoms were common and ranged in severity and type. Incessant eating, cravings for cigarettes, moodiness and agitation, and upset sleeping patterns were typical reactions to both reducing tobacco consumption and total abstinence. About half of the participants who relapsed, described it as a gradual process. Stressors, boredom, the influence of habitual associations, gradual weight gain and others’ smoking, seemed to wear down participants’ resolve to remain smokefree. Slips led to further slips and eventual return to regular smoking, which was most often experienced as a negative outcome. Many participants who relapsed expressed disappointment in themselves and they believed they had let other people down.

Despite the return to smoking, many participants cited some gains, even if it were only that they had experienced the benefits of being smokefree for a short time. Improved physical health and fitness and clearer wairua were talked about. Stopping smoking was seen by some participants to be part of a plan to improve their holistically viewed health. Thus, some other changes in diet and exercise regimes or other drug use, were maintained. Some participants were pleased to have at least reduced their tobacco consumption.

Many participants still wanted to stop smoking. They wanted better access to cessation support, more environments to be made smokefree and cheaper cessation aids. Whanau and work colleagues could have been more supportive by supporting the implementation of smokefree environments and by refraining from exerting pressure on the recent quitter to smoke.
CHAPTER NINE

Analysis & Discussion

SECTION ONE: INTRODUCTION

In accordance with the research objectives outlined in Chapter One, this chapter presents a discussion of the research findings. The quantitative and qualitative data is considered against previous research, presented in Chapter Three and analysed for evidence to support the hypotheses listed in Chapter Four.

First, the representativeness and strength of the study is considered in section two. Section three proposes an understanding of why Maori smoke according to Te Whare Tapa Wha. Finally, the NMSCP is discussed in section four of this chapter. The data for the Maori smokers who attended a NMSCP is compared with participants who attempted to stop smoking without formal assistance.

SECTION TWO: TE AO TUROA

The whole sample was mainly representative of Maori women, aged 25-44, the group with the highest smoking prevalence rates in the country. Men were under represented in the study, which was not unexpected. Smoking prevalence rates are slightly lower for Maori men (40%) than for Maori women (47%) (TPK, 1999). One of the reasons more men may not have been attracted to the study is because some participants expressed beliefs that smoking is more problematic among Maori women and the research was focused on them, though information about the research did not stipulate this. Pregnant women and rangatahi were under represented in the research.

As participants were drawn from the top half of the North Island, hapu and iwi from those areas are mainly represented by this research, although many participants acknowledged their affiliations to two or more hapu or iwi which included small numbers of many hapu and iwi from further south. At the 1996 Census, “50% of the
Maori population lived in the northern half of the North Island, with a quarter (24%) resident in the Auckland region" (TPK, 1998, p.6). Participants were recruited in both cities, metropolitan and minor urban areas, which sometimes captured people living rurally. The majority of Maori live in main urban areas of 30,000 or more people (62%), though "they are more likely than the total New Zealand population to live in minor urban areas of 1,000 to 9,999 people" (Statistics New Zealand, 1997, p.2). Participants self-identified as Maori and most could name at least one of their iwi, therefore, the study is not representative of Maori who do not identify as Maori, that is who have a compromised identity (Durie, 1996). The sample included an over representation of lower socio-economic participants.

Though the sample was not representative of the total New Zealand Maori population, the smoking statistics were not dissimilar from those obtained by population studies, for instance, on starting age, tobacco consumption, nicotine dependency and intent to quit. Thus, it could be assumed that the statistically significant differences and correlations, and consistent themes that emerged from the qualitative data will have relevance for other Maori smokers.

**Strength of the Evidence**

At the beginning of the project, it was hoped that 40 NMSCP participants would be recruited. The final number of participants in each group (26 vs. 85) reduced the statistical power slightly, though it was still adequate given the information available at the time of starting the study, that is, the resulting sample size was large enough to detect the expected differences. Greater numbers were not recruited because the anticipated number of NMSCPs did not eventuate and the expected participation rates in those that did run was lower than expected. Fifteen percent of participants were unable to be interviewed a second time, they were, however, all from the control group. As ethically required, the intention was to interview as many people as necessary to detect expected differences, thus imposing upon as few people as possible. Despite which, the size of the project restricted the practicality of interviewing larger numbers. Thus, whilst some trends may have been evident, future research with a larger sample would be required to confirm some differences.
Selection Bias

Recruitment through networking alone did not result in sufficient numbers of unaided quitters. Mostly they responded to advertisements placed in local papers. Thus, a selection bias towards people who mix in and actively participate in the Maori community was averted. As the advertisement stipulated participants be Maori, there may be a bias towards people who have a secure or positive identity as Maori (Durie, 1996).

Effect of Participation

The higher than expected quit rates among unaided quitters could be partly attributed to their participation in the research. Assessment itself can have an impact as it raises consciousness (Bell, 1997). The possibility of a research effect on quit rates was mitigated by equal application of the research method to both groups. All participants received similar koha at each interview and were informed there was going to be a follow-up interview. The contents of the koha were carefully selected. Cash or vouchers that could be exchanged for tobacco products were avoided. Participants were not told beforehand that they would receive any remuneration for their participation. At the second interview some participants did say their participation in the research had helped them.

Section Three: Why Do Maori Smoke?

This section proposes an understanding of smoking according to Te Whare Tapa Wha. Te taha tinana concerns the biological aspect of smoking behaviour. Physical impetus to smoke are presented and various measures of nicotine dependence are discussed. Each individual values and prioritises different factors that contribute to smoking. This is discussed under te taha hinengaro wherein also, the Stages of Change model is assessed for its ability to facilitate analysis of the results. How familial and social influences contribute to smoking is classified as te taha whanau. Finally the contribution of te taha wairua, the spiritual aspect, is discussed. The compartmentalisation in to four categories is artificial and highly debatable, but will
facilitate communication and comprehension of a behaviour simultaneously driven by each aspect at once.

TE TAHA TINANA

Smoking has been seen as primarily a psycho-social phenomenon, subject to the individual’s will and, therefore, open to manipulation via peer and social pressure. Primacy is given here to the biochemical basis for smoking, in part to redress past emphasis placed on psycho-social explanations.

Physiologically Driven to Smoke

Research on the pharmacokinetics of nicotine reveal that people smoke because their physiological make up comes to require some of the chemicals, particularly nicotine, delivered by the smoke, as much as it requires the chemicals derived from water or food. Reaching for a cigarette can become just like any other autonomic function, not requiring any processing by the conscious mind. As one participant said, “I just can’t help it... I still smoke because I really need it... I get mood swings if I don’t have it. It’s like a necessity. I would have a smoke over food” (85).

Most of the reasons for smoking provided by study participants can be matched to a biochemical function stimulated by smoking. That is, the talk of participants is metaphoric for biochemical effects, for instance: its use as a weight control device; when asthmatics speak of experiencing short-term benefits in breathing; its effect on relieving stress. As well as being a cheap, easily accessible and very quick way of manipulating physiological and psychological responses, the pleasant, rewarding psychoactive effects of nicotine make smoking particularly addictive.

The reasons given for smoking in this study (see Table 27), mirror reasons given by smokers the world over. Analysis of the reasons revealed that they could be grouped in to two general categories:
Smoking to induce or enhance positive affect (which included the categories Enjoyment, Time out, Stimulant and Social, that is, 12% of cited strongest reasons for smoking); and

Smoking to avoid negative affect (which includes Habit, Addiction, Stress, Boredom, Emotions, Weight Control, Social and others, that is 89% of cited strongest reasons for smoking).

Participants in this study smoked mainly to avoid negative affect. It may be that smokers interviewed for this study who were in the contemplation and action stages of change have a more negative, or realistic, view of smoking and its uses than early smokers and smokers in precontemplation who were not interviewed. It may be that due to nicotine dependency, smoking over time loses its ability to induce or enhance positive affect, maintaining predominantly the ability to reduce or minimise negative affect, some of which is directly caused by nicotine withdrawal.

**Habit**

Study participants were most likely to say they smoked because it was a habit (73%) or addiction (39%), terms used to explain the automatic, compelling, regular nature of smoking and the association with other behaviours or environments, as illustrated by the following quote: “Habit, just a routine with my day. It’s not so much that I crave really it’s just, say if you go to a café for a coffee it’s just an automatic thing” (50). This reason for smoking can be predominantly attributed to biochemical changes. As outlined in Chapter Three, blood-nicotine levels drop over time, causing the brain to signal the need for another smoke, hence the automatic, compelling, regular nature of smoking.

The association of smoking with behavioural and environmental cues, such as the sight of tobacco packaging, the sight and smell of cigarette smoke, seeing others smoking, can similarly be attributed to biochemical changes. Anticipatory changes in the brain, designed to counter pending overstimulation, occur in response to these “conditioned stimuli.” Just like Pavlov’s dogs, who were trained to salivate at the sound of a bell, nicotine dependent smokers begin “metabolising” nicotine even before they light the cigarette. One benefit of this adaptive functioning of the body, in
terms of motivating smoking cessation, is that smoking becomes less pleasurable, hence people's comments that they don't even enjoy it any more. These smokers, called "trough maintainers" (Fagerstrom, 1994) consume a similar amount of tobacco daily, smoking regularly throughout the day, to ensure constant blood-nicotine levels and avoid withdrawal.

Smokers can still achieve pleasurable effects from smoking, by increasing tobacco consumption or varying their smoking pattern. Smokers who use this technique, called "peak seekers" (ibid.), may allow blood-nicotine levels to drop quite low, in order to augment relief from nicotine withdrawal, and/or they binge smoke to induce overstimulation and even toxic effects from nicotine overdose.

Unfortunately, after smoking cessation, environmental and behavioural cues can still trigger biochemical changes in anticipation of the smoke, which now doesn't come. The resulting chemical imbalance is experienced as nicotine withdrawal, for example, craving for a cigarette. This effect will occur until the association has been extinguished, that is, until the conditioned stimuli repeatedly fail to produce the awaited reward.

**Affect**

Nearly half (48%) of study participants used smoking to cope with stress and 23% smoked to cope with emotions. They smoked to relieve anxiety, to release anger, to quell worries, calm down and relax. One quarter (25%) smoked for the pleasant effects, for example, for "enjoyment." Seventeen percent of participants used smoking as a way of taking time out and rewarding themselves.

Some of the psychoactive reactions to smoking, such as changes in levels of β-endorphin, dopamine, serotonin and acetylcholine and changes in EEG activity (Moolchan et al., 1996) are experienced subjectively as positive feelings or emotions, such as feeling happy, relaxed, content and euphoric. If the person is under stress, the stimulation of positive affect can serve to offset negative feelings. Negative affect triggered by nicotine withdrawal can be relieved by smoking. Thus, smoking assists affect modulation by stimulating positive affect and providing relief from negative affect.
**Stimulation**

Five percent of participants said they used smoking as a stimulant, for example, when they became tired but had to keep on working or studying and 29% sometimes smoked to relieve boredom, which is a state of mental weariness brought on by lack of interest, or as some participants said, “nothing to do.” Nicotine does stimulate and improve cognition, hence smokers might say smoking helps them concentrate, figure out problems and perform better at sports or work. Smoking for the stimulating effects of nicotine is thus a pursuit of a positive effect whilst concurrently helping to avoid negative affect.

**Social Smoking**

A third (34%) of participants said they sometimes smoked for the social aspect of it. This category included smoking with others generally, as well as smoking with others over a cup of coffee or tea, or when drinking alcohol, for instance, at the pub or home partying. For 11.5%, smoking was “normal,” in their whanau and social world everyone smoked. Social smoking can also be traced back to biochemical triggers to smoke. For instance, people and social environments associated with smoking can trigger cravings to smoke. Other drugs taken at the same time can trigger cravings to smoke, both through association but also as nicotine enhances the uptake of caffeine and helps to offset the negative affect brought on by the depressant effects of alcohol. The person may be having a good time and uses smoking to enhance their positive experience or the social setting may cause anxiety or insecurity, in which case smoking may be used to avoid negative affect. All four of these:

- Familiar setting associated with smoking triggers craving
- Other drug use triggers smoking
- Smoking used to enhance positive experience; and
- Smoking used to avoid negative affect

could be simultaneously occurring in a socialising context. Thus, even social smoking can be traced to biochemically originated drives.
Weight

Only 5% of participants said they used smoking to help control their weight. Nearly half (49%) however, were concerned about putting on weight as a consequence of stopping smoking. For most of the participants who did put on weight after stopping smoking, the weight gain was unwelcome and contributed to their relapse to smoking. Whilst nicotine has biochemical effects that can be used to help control weight, this function of smoking is likely to be utilised more to avoid negative affect associated with a negative body image.

Psychiatric Comorbidity

Previous research, outlined in Chapter Three, has shown that there are definite interactions between some mental disorders and nicotine dependence. Greater smoking prevalence and consumption exist in populations who have schizophrenia, anxiety disorders, depression and other drug dependencies. Some mental disorders, such as schizophrenia, change the chemical (for example, acetylcholine) balance in the brain to an extent that the nicotine dependent smoker is triggered to smoke to “right” the imbalance. Medicine taken for the disorder brings about biochemical changes that similarly can interact to trigger smoking. Nicotine dependency is compounded as greater tobacco consumption results in smoking becoming associated with a greater range of behavioural and environmental cues.

The heaviest smokers in this study had schizophrenia. They perceived themselves as virtual “chain smokers.” For them smoking was strongly associated with nearly everything they did in a day. As one participant said, having schizophrenia is very stressful.

Depression and anxiety disorders are largely disorders of affect. Thus, it could be said that smokers who have a comorbid condition similarly smoke to enhance positive affect and avoid negative affect.
Cannabis

Fifteen percent of the participants in this study had smoked cannabis in the last week, which is not necessarily heavier than use reported in a national survey, where 13% of Maori had used cannabis in the last 30 days (Dacey & Moewaka-Barnes, 1999). It is not clear from the literature reviewed if any psychokinetic interaction occurs from the combined smoking of tobacco and cannabis. There are only anecdotal reports of Black-American “folk lore” that suggests tobacco intensifies the euphoric effects of cannabis (Wilson, 1998). The smokers of cannabis, in this study, did not infer any co-joint effects.

Nicotine Dependency

Previous research has determined that the level of nicotine dependency is directly related to the blood-nicotine level an individual attempts to achieve on a daily basis. The number of cigarettes smoked per day is a rough indicator of that level, as it is dependent on smoking technique and pattern of use.

Tobacco Consumption

Tobacco consumption among participants in this study was very similar to the distribution of tobacco consumption in the national smoking population. On average they smoked 16 cigarettes per day as against the 1996 national average of 17 (Laugesen & Clements, 1998). A similar number of study participants smoked 11-20 cigarettes per day (43%) as the national average of 44% (NRB, 1996). Slightly more study participants smoked more than 21 cigarettes per day (17%) than the national figure (13%). This was to be expected as Fagerstrom et al. (1996) have highlighted, treatment-seekers tend to be more dependent. In this study however, there was no difference on average FTND score between the NMSCP group and the unaided quitters. Upon classification of the FTND into light, medium and heavy, a significant difference was detected showing that less of the NMSCP group were light smokers (31% v. 53%). The average FTND score of 3.8 for participants in this study was within the range of mean FTND scores (3.07 to 4.30) across nationally representative population samples, though the average of 4.4 for the NMSCP group was not as high as recorded averages for smokers that seek help (5.15-6.55) (ibid.).
**Time to First Cigarette**

A New Zealand national study recorded 14% of smokers taking their first cigarette within 5 minutes of waking and 29% having their first cigarette within 30 minutes (NRB, 1996). In this study, a third (32%) smoked their first cigarette within 5 minutes and a further 26% smoked within the next 25 minutes. As dependency is indicated by time to first cigarette, this could mean that study participants were on average more addicted than indicated by number of cigarettes per day. Efficient smoking technique could account for the difference, or a smoking pattern which, for example, requires several cigarettes to be smoked before going to work. These two suggestions will be discussed below.

It was hypothesised that participants with a low nicotine dependency score would achieve total smoking cessation at higher rates than participants with a high nicotine dependency score. The research did not support this hypothesis as the FTND score was not predictive of quitting. However, actual number of cigarettes smoked per day was predictive of quitting and time to first cigarette, when collapsed into a binary within the first 30 minutes and after 30 minutes code, was predictive of quitting. Thus, supporting the assertion that the less addicted, as indicated by how much a person smokes and how soon after waking they smoke, the more likely they are to succeed at smoking cessation.

It was hypothesised that participants with a low nicotine dependency score would make more positive changes to their smoking behaviour. This hypothesis was partly supported, in that, nicotine dependency was related to whether or not the participants’ house was smokefree at follow-up. Other changes, for example, increasing exercise or improving diet were not related to dependency.

**Carbon Monoxide Monitoring**

Participants’ CO readings were correlated with number of cigarettes smoked per day and FTND scores, thus, the Smokelyser provides an easy, non-invasive method of measuring and verifying tobacco consumption. As number of cigarettes was predictive of quitting, so too was the CO reading. The lower a smoker’s CO reading the more likely they were to succeed at quitting. Where number of cigarettes
smoked per day is difficult to determine because of use of loose tobacco, CO readings could be used as an alternative indicator of consumption.

**Efficient Smoking**

As the financial, social and personal cost of smoking increases smokers economise. As at 1999, the costliness of cigarettes in New Zealand, as a percentage of gross domestic product per capita, was the third highest among OECD countries (Laugesen & Swinburn, 2000). Price increases have been linked to lowered consumption (Laugesen in Wilson, 1998). The most commonly smoked brand used by participants was Holiday, which *The New Zealand Herald* ("It's the heat," 2000) recently reported "have just found their way into the list of top 10 supermarket brands, and roll-your-own tobacco is a growth industry. Both cheap options show smokers are economising in the face of tax increases." Holiday cigarettes have also been reported to have a high nicotine content (Laugesen, 1999). Lower socio-economic participants, who were over represented in this research, are said to be particularly price sensitive.

Analysis of the results revealed a number of ways in which participants changed their smoking behaviour to maximise nicotine intake:

- By choice of type of tobacco product
- By choice of strength of tobacco
- By depth of inhalation; and
- Pattern of smoking.

**Manufactured Cigarettes**

Half of the participants smoked manufactured cigarettes. The more popular brands were the cheapest brands on the New Zealand market. Participants tried to control cost by experimenting with different strength products. Choosing a low-tar cigarette was done to minimise personal health cost. Choosing a low-nicotine cigarette was done in the mistaken belief that it might aid quitting. Some participants cut their cigarettes in half, or spread one cigarette over three separate smoking events by smoking a third then putting it out, returning to the remainder later. Smokers who were rationing number of cigarettes per day, increased the depth of inhalation.
Roll-Your-Owns

The same percentage (28%) of participants, smoked roll-your-owns, as are smoked in New Zealand generally. A further 22% smoked both manufactured and roll-your-owns. Loose tobacco affords the smoker maximum control over their consumption. The equalisation of tax on loose tobacco was supposed to have removed some of the advantage of smoking roll-your-owns. However, some benefits remain, as loose tobacco can be rationed into smaller cigarettes, providing an average of 2 rollies to one tailormade. Therefore, the smallest pack of loose tobacco could be rolled in to more cigarettes than the cheapest pack of tailormades. From 31 January 1998, the smallest allowable tailormade pack size was 20 ("ASH Smoking and Health", 1998).

Rollies were easier to put out to be smoked again later, especially since the burn rate can be controlled by choosing papers not impregnated with fire accelerant. Most of the participants used filters, though a few admitted to keeping the butts, to later extract salvageable tobacco for reuse. Depth of inhalation could be increased to maximise nicotine uptake also.

This study replicated findings of other research that nicotine dependence among hand-rolling smokers is greater than that among those smoking manufactured cigarettes (Darrall & Figgins, 1998). It should be of concern that there is evidence showing that, on average, tar yields of hand-rolled cigarettes are higher than manufactured brands (ibid.). Increased intensity of inhalation can also increase levels of CO in the blood. Therefore, efficient smokers may be inadvertently increasing their relative health risk.

Pattern of Smoking

The qualitative data suggests that decreasing social acceptance of smoking increases the personal cost to the smoker in terms of social disapproval, an insecure sense of belonging, and increased fear of rejection. In New Zealand, where smokers are a decreasing minority, participants said they would readily limit their smoking to areas where smoking is allowed: one’s own home or car but not necessarily other people’s homes or cars; pubs, clubs, restaurants and cafes, casinos, outside of entrance doors to smokefree buildings, bus stops, railway stations and on the street. As described above, in response to the Smokefree Environments Act, some participants
got their nicotine during a morning and evening binge, others pursue an opportunistic smoking pattern whereby they smoked when presented with the chance to have one, for example, while walking between buildings.

Future research could investigate the prevalence of efficiency smoking in New Zealand and investigate implications for morbidity and mortality, weighed against increased cessation activity due to possible decreased consumption.

**TE Taha Hinengaro**

Whilst, chemical and other changes may be occurring in the body, the realm of te taha tinana, the subjective experience, that is, the interpretation occurs in te taha hinengaro. The two experiences are linked and interactive. Thus, the contents of the above section could have been discussed here, emphasising instead analysis of participants’ beliefs about smoking. Instead this section will discuss the quitting process. This is where an individual’s psychology is relied upon to override the now autonomic drive to smoke. Individual’s are appealed to, socially manipulated, encouraged and “facilitated” to change their attitude to smoking, so that they will “decide” to stop. In New Zealand, the problem is not that people don’t want to stop smoking. The reviewed literature and this study suggest a high level of quitting activity among smokers. The problem is either that smokers don’t progress to the next stage of the quitting process or they relapse.

**The Stages of Change Model**

As outlined in Chapter Three, the Stages of Change Model categorises the smoker’s attitude towards their smoking into six stages. Voluntary self-selection into the study ensured participants were at least in the contemplation stage. Whilst, it was preferred that they be in action, 21% of the unaided quitters were not planning to quit in the 30 days following the first interview. They wanted to quit and were planning to do so, but had a longer period of preparation to complete, or they were hoping their involvement in the research would provide some magic incentive to stop them smoking.
Working with Smokers in Contemplation

The Stages of Change Model provides the theoretical basis for using motivational interviewing with contemplators to facilitate their decision to quit. Participants questioned to ascertain motivating factors, reported the same reasons for stopping as recorded in other studies. “Health” was consistently the number one cited reason to stop smoking across the research reviewed and in the previous and current reasons to quit given in this study. Other reasons for quitting were also consistent with the literature, that is, cost, the health effect on others, particularly children, and role modeling. Most of the participants (73%) reported having physical illnesses, suggesting potential opportunity to intervene through the primary health care system.

Age Predictive of Quitting

Participants that were still smokefree at follow-up ranged across the ages interviewed. This varied from previous research, for example, Broughton’s (1993) study that suggested that very little quitting occurred after age 45. In the current study, the youngest (16-24) and oldest (45+) participants were more likely to stay stopped than the largest group of participants (25-44). Only 5% of participants aged 25-34 stayed smokefree.

Preparation/Me Mutu

In some discussions of the Stages of Change Model a preparatory stage is included as part of the action stage. In other discussions it is a separate preceding stage. Here it is presented as preceding action.

Participants did a range of things to prepare them for quitting. None appeared to stand out as particularly useful, though it may help to at least have decided upon a quitting method. Participants who did not know how they were going to quit at the first interview all relapsed within the first week of stopping. The qualitative data presented in Chapter Eight suggests that many of those who relapsed had been ill-prepared for what was going to happen, for instance, the severity of withdrawal symptoms. Symptoms of the body recovering, for example, coughing up “black stuff” was unexpected and frightening; the strength of the anger and loss of control was frightening; the incessant eating or cravings for a cigarette was unexpectedly forceful.
Some attitudes appeared to be unhelpful, for instance, beliefs that smoking is just a "vice" or believing that smokers must have an underlying addictive personality and that quitting smoking would only result in adoption of a worse or other unhealthy behaviour. Participants expressed fear of replacing smoking with alcohol, cannabis, sweets, exercise or excessive labour.

**Education**

Educational level, indicated by last year of schooling, was correlated with age at first cigarette and age at which participants began regular smoking, that is, the earlier participants finished school the earlier they were likely to experiment with and start regular smoking. Educational level was, therefore, correlated with the number of years participants had smoked, with early school leavers having longer smoking histories. They also tended to be more heavily addicted as indicated by the FTND. Earlier school leavers had a shorter time to relapse, suggesting that less schooling inhibits quitting, either as a factor on its own or due to subsequent heavier smoking careers. This analysis is consistent with existing knowledge, for instance Peto’s warning that “the earlier you start, the more you smoke, the longer you smoke for, the greater the risk” (Doll, Peto, Wheatley, Gray & Sutherland, 1994).

**Reducing Consumption as a Quitting Method**

Gradually reducing tobacco consumption is discussed in the literature as a quitting method. Analysis of the qualitative data revealed use of gradual reduction as a preparatory step towards quitting, which was more often defined as total abstinence. Participants spoke of cutting down and then going cold turkey, or cutting down and then using Nicobrevin. They also considered cutting down as a method in itself. As Bell (1997) said stopping smoking is a process rather than a single event. In recognition of this, it is proposed here that cutting down tobacco consumption is a preparatory action. Actual cessation can usually be pinpointed to a quit date, a time, an event, a last packet and is a step in itself.

Participants who cut down with view to stopping smoking completely, sometimes did not do so effectively. For instance, they reduced too quickly for adaptation to occur, or they maintained a similar number of smoking events, but reduced consumption at each event, for example, by cutting the cigarette in half. This
fails to break the association with conditioned stimuli as they still get nicotine at each event. Further, it may be that though they reduce the actual number of cigarettes per day, they improve the efficiency of each smoke, thus maintaining similar blood-nicotine levels.

The quantitative data showed that level of nicotine dependency was predictive of quitting and consumption is correlated with nicotine dependency. That is, lower tobacco consumption and therefore lower nicotine dependency, improves likelihood of quitting. Further, level of nicotine dependency, as measured by time to first smoke and number of cigarettes smoked per day were correlated with time to relapse. The higher the nicotine dependency the sooner relapse occurs. As there is a dose-response relationship between smoking and mortality and morbidity from smoking related illnesses, reducing consumption will produce health gain. Hence, gradual reduction should be actively encouraged and promoted among heavier smokers. The less the population smokes as a whole the more quitting success will become a reality.

Self-efficacy

This research supported previous studies that found self-efficacy predicted success at quitting. Participants with high self-efficacy were more likely to be smokefree at follow-up as hypothesised. Self-efficacy was also correlated with length of abstinence, thus the more confident participants were that they would stop this time, the more likely they were to stop and stay stopped for longer. Participants that were smokefree at follow-up said quitting was easier than those who relapsed. Analysis of the qualitative data from participants who relapsed showed a greater tendency to attribute blame to themselves and they exhibited poorer self-esteem.

Previous Quitting Experience as Preparatory

It is commonly believed that smokers quit and relapse an average of 3 to 4 times (NACHD, 1999). This study supports the notion that each quit attempt is a lesson in the addictiveness of nicotine, individually relevant triggers to smoke, the benefits of quitting and the need to learn alternative coping skills. Thus, previous quitting can better prepare smokers for future quit attempts. Most (88%) of the participants in this study had tried to quit previously, with an average of 2.5 quit attempts per person. However, number of previous quit attempts or having given up
previously did not predict success at quitting this time. The qualitative data presented in Chapter Eight highlights the benefits of quitting even if relapse follows.

**Action/Aukati**

It is proposed that the action stage can be divided into two distinct stages: the act of stopping smoking and the resulting short-term period of nicotine withdrawal, itself a mental disorder distinct from nicotine dependency (American Psychiatric Association, 1987).

The unaided quitters tried a range of quitting methods. Cold turkey was the most common method cited which is consistent with results from other studies. There was a willingness to keep trying and to use different methods. Some of the qualitative data suggests that cold turkey may be an earlier strategy used by smokers. Those that have horrid experiences may not be willing to do it again. Hence, increased use of cutting down as a method of quitting later in a person’s smoking career.

Among the unaided quitters, the method used was not predictive of quitting. Partly it can be difficult to define and some participants used multiple methods simultaneously. Analysis of the qualitative data suggested that participants who relapsed chose methods that are not known for their effectiveness or they did not apply them as recommended. Participants who relapsed seemed to experiment with less effective methods based on a lack of understanding, for example, trying to delay time to first smoke doesn’t recognise the physiological need to dose up on nicotine after the drought while sleeping and the flexibility the body can sustain in terms of the time the dose comes and the amount. Participants tried switching brands in the hope it would put them off, but it did little to reduce blood-nicotine level, especially since participants could too easily alter smoking technique and consumption to ensure similar blood-nicotine levels were maintained. Switching to roll-your-owns, similarly does not necessarily assist with reducing blood-nicotine levels.

Of the participants who relapsed who tried nicotine replacement products, they did not use the product according to the product instructions, for example, stopping after only a weeks use, or the product was not correctly matched to their dependency level.
Surviving Nicotine Withdrawal

Abrupt cessation or radical reduction of nicotine intake can instigate nicotine withdrawal. The symptoms are most severe within the first 2 to 3 days. It is not clear from the research reviewed how long it takes for the neuroadaptation underlying nicotine dependency to be reversed. A recent study comparing ex-smokers with never smokers found brain activation patterns remained different at twenty one days post-cessation (Stein, 2000).

The participants in this study experienced the full range of withdrawal symptoms reported in the smoking cessation literature. The only difference was added effects in te taha wairua for a few participants, who experienced an imbalance, vivid dreams and visions.

Analysis of time to relapse showed that over half (54%) of the unaided quitters relapsed within the first week. Thus, relapse is largely due to inability to survive nicotine withdrawal. However, only 12% cited withdrawal symptoms as the cause of their relapse. Instead they identified negative affect (including stress, others’ smoking, domestics, boredom and tangi) as the reason for going back to smoking. Socialising was not cited as a cause of relapse within the first fortnight, perhaps because one strategy used to assist quitting is to avoid socialising. Weight was not cited as a reason for relapse, though some participants said they didn’t deal well with eating.

As mentioned above, nicotine dependency level was correlated with time to relapse, so that the higher the FTND score the more likely participants were to relapse within the first week. Lower self-efficacy was also correlated with relapse within the first week and the longer participants had stayed at school the more likely they were to survive nicotine withdrawal. All unaided quitters on medication for a psychiatric disorder relapsed within the first week which is consistent with predictions of success for this group (Fiore et al., 1996).

Maintenance/Auahi Kore

Once nicotine and the other byproducts of smoking have been metabolised out of the body, the recent ex-smoker enters the next stage accounted for in the Stages of Change Model - maintenance. In the short-term, the ex-smoker must survive frequent
triggers to smoke. These lessen over time as behavioural and environmental cues associated with smoking are extinguished.

There was a smaller declining percentage of relapse among recent ex-smokers who survived withdrawals. Two weeks after cessation the cumulative percent of unaided quitters who relapsed rose by 9% to 63.5%. By the end of the first month 74% of the unaided quitters had returned to smoking. Another 9.5% relapsed during the second month and 2.5% more relapsed by 90 days, thus 86% of unaided quitters had relapsed by the end of 3 months. This confirmed the advice of DiClemente (1998) not to conduct later follow-ups as most of the relapse would have occurred within the first 3 months.

After the first fortnight, it was socialising and others’ smoking that were the main reported triggers for participant’s relapse. Once they had stopped smoking, participants had to learn other ways of coping with what may have been pre-existing depression or relationship difficulties. Lack of alternative coping skills, especially how to cope with overwhelming stress may undermine attempts to stay smokefree. Some participants relapsed while in shock caused by an unexpected trauma, such as a burglary.

Whilst, weight was not cited as a cause of relapse in the first 2 weeks, weight gain from increased eating would not have become evident until later. The qualitative data shows that weight gain was a factor that contributed to relapse. A few participants who had not been worried about putting on weight at the first interview, were surprised when they began to put on weight and it subsequently became an issue for them.

Some recent ex-smokers thought they could have the occasional smoke, which in most cases led to relapse. Those that did not relapse continued to perceive themselves to be non-smokers even though they had slipped. Thus, identifying as a non-smoker may be protective against relapse.

Relapse is a gradual process that can be arrested if recent ex-smokers have adequate self-awareness to recognise early signs of relapse and if they have appropriate coping skills. Thus, ex-smokers remain at risk of relapsing and may require access to ongoing relapse prevention focused support and support to remain
Factors that helped participants stay smokefree included focusing on the benefits of stopping, having whanau that also stopped smoking or receiving lots of support from others. Smokefree environments also helped by cutting exposure to other people's smoking.

The unaided and some of the NMSCP participants that relapsed believed they could have been helped to stay smokefree if they had some or better access to assistance. Some participants supported stronger legislation, increased taxation and widening of smokefree environments, as all these controls made it harder to smoke.

Twenty five participants felt other smokers purposefully encouraged relapse. In some ways, therefore, ex-smokers are susceptible to the same triggers that initiate smoking among non-smokers.

Relapse

Upon returning to smoking, the Stages of Change Model predicts a return to precontemplation, contemplation or action. Whilst 31% of participants immediately began planning to quit again and attempted to do so, nearly half (49.5%) were in contemplation at the follow-up interview and 6% had lost their motivation to quit all together. The willingness to repeat quit attempts supports other indications of high levels of quitting activity.

Participants who relapsed reported what can be termed a negative “aftermath” (Boustead, 1996). That is, they tended to blame themselves and shared negative self-judgements. For example, returning to smoking was seen as evidence of their weak personality. Thus, it was bad for their self-esteem, possibly contributing to reduced self-efficacy for subsequent quit attempts. Unhelpful reactions from others, such as put-downs, tended to worsen the negative aftermath. Participants who had a negative aftermath, were more likely to share lay beliefs about smoking, that is, they minimised the addictiveness of nicotine and believed quitting was dependent on “sheer determination.” Some participants had unrealistic expectations about their level of dependency. Thus, an overemphasis on a psycho-social explanation of smoking behaviour can inadvertently reinforce the stigma of weakness that attaches to smokers who quit and relapse.
Individual smoking occurs in a whanau and social context. Biochemical drives are moderated by cultural and social norms, their expression shaped by the rules and fashions of the time. The whanau and immediate social group are where the rules and rebellions are played out, negotiated, conveyed to others and passed intergenerationally. If smoking is the norm within the whanau environment, as it has been for well over half of Maori for over a century now, then children’s adoption of adult practices like smoking is, as participants suggested, unremarkable. When both the whanau and social group smoke as a norm, smoking uptake is even more likely.

Smoking Initiation

Explaining smoking in terms of biochemical drives, does not account for smoking initiation, which presumably occurs in the absence of nicotine dependence and prior physical experience of smoking. Naivete must be presumed because research has not determined whether there are, for instance, lasting effects of exposure to nicotine in utero. Similarly, research on genetic vulnerability to nicotine dependence suggests activation of susceptibility is dependent on exposure.

The age at which study participants first experimented with smoking ranged from 4 to 38 years. The average age at which participants began to experiment with smoking was 12 years. Almost half of the participants had tried smoking before they turned 12. Ninety-one percent had tried smoking by age 16, that is, before the end of their school years. Compared with 140 years ago when Maori infants reportedly preferred pipe smoke to breast milk (Maning in Broughton, 1996) we have made some progress restricting smoking initiation to later in life, though still not late enough.

The average age for starting to smoke regularly was the same as the national average of 16. Participants ranged in age for starting regular smoking from 8 years of age to 50 years of age. Similar to previous studies, 88% had started smoking regularly before the age of 20.

Smoking initiation predominantly occurred either with whanau or in the whanau environment or with school peers or in the school environment. More of the
participants in this study (about 70%) reported parental smoking during their childhood than current young people report. I hope this is indicative of a reduction in smoking prevalence among Maori parents of young children today.

Analysis of the quantitative and qualitative data suggests a chronological process whereby additive factors determine smoking initiation. The grounding for smoking initiation occurs throughout the child’s early years and continues as they are raised in an environment largely supportive of smoking. Modelling, that is, smoking by parents, siblings, peers, teachers and other role models provided a childhood environment where smoking was normalised and approved of. Further, there were numerous observational learning opportunities, where children could learn the positive function and uses of smoking, for example, that people use smoking to alleviate negative affect. At some point in the child’s development a trigger event occurs, for example, curiosity about smoking and an urge to mimic; or, some anxiety provoking situation, such as occurs when dealing with change. Emotionally laden trigger events were more likely to occur within the whanau environment, whereas initiation at school was more likely to be of a curious nature. If the child has access to tobacco when a trigger event occurs, they may experiment with smoking. Repeated experimentation leads first to the establishment of strong associations between the beneficial effects of smoking and psychological and environmental stimuli and eventually development of a physical dependency on nicotine.

Contrary to popular opinion, that smoking is a rebellious act, Maori children experiment with smoking to demonstrate and ensure their membership in the family and in their peer group. There is nothing rebellious about adopting a “normal” behaviour everyone else is engaged in. Rather, in this context, smoking is an act of seeking to be similar to adults and significant others, that is, smoking uptake is an approval seeking behaviour.

In conclusion, the results of this study concur with and support the results from previous studies. Over two-thirds of Maori smokers were likely to be exposed to parental smoking during their early years of life. Smoking at home and by other whanau members was as influential in their starting to smoke as smoking among their peer group at school. Their experimentation with smoking is likely to occur at earlier
ages. This earlier age of starting may be one factor contributing to the higher rates of smoking related illness and death among Maori.

**Whanau Environments as Smoking Environments**

Consistent with national statistics, few participants lived on their own. On average there were 4 people to a household. Sixty five percent of participants lived with others who smoked and less than half had a smokefree house. Of those participants who had a partner, 63% had a partner who also smoked, though some of them were also going to give up smoking. Whanau and friends were more likely to be smokers. Thus, it appears participant’s home and social environments were largely permissive of smoking. Even though it was not as easy to smoke at work about half still worked with and smoked with work colleagues.

It is not clear whether this reflects a preference of smokers to befriend, live with and socialise with other smokers. A preference for the company of smokers is less likely to determine relationships with whanau, however. Some of the participants who were still smokefree at follow-up noticed a change in their relationships with smokers. They felt the new difference between them lessened the intimacy previously shared. This could result in feeling isolated if participants did not determine to form new relationships with non-smokers.

Living with smokers was a predictor of relapse, in that those who did not live with other smokers were more likely to be smokefree at the follow-up interview. More of the participants who stopped smoking were able to make their house smokefree. They also seemed to have whanau supportive of quitting, who had either quit themselves or were also trying to quit.

**Contagion Effect**

This study supported the hypothesis that smoking cessation among whanau and friends would be higher for those individuals who achieve cessation. Nearly all of the participants who were smokefree at follow-up, had a partner or one or more whanau members who had stopped smoking already or who were concurrently trying to stop smoking. It appears consistent that whanau that quit together stay smokefree together.
Whanau Support to Quit

About half of the participants wanted to stop smoking because they recognised some effect on children, either a direct effect on their children's health or by role modelling. A quarter wanted to be able to walk the talk and personify values they aspired to or promoted. Only 11% said they were also stopping because others didn't like it. These findings did not align with McLellan's (1998) study in which over half (53%) of her participants identified the influence and pressure from significant others as the most important critical trigger to their having quit smoking.

Participants were specifically asked if their decision to quit had been influenced by others, including whanau, friends and work colleagues. Twenty eight percent said they were influenced by children to quit. Either participants were not being encouraged to quit by others, or they believed they were unaffected by that influence.

Some whanau were not supportive of quitting and encouraged relapse to smoking directly and indirectly. Direct acts included offering cigarettes to the recent ex-smoker, suggesting they wanted to smoke and deliberately trying to trigger cravings, for example, by blowing smoke in the face of the recent ex-smoker. Indirect acts included not respecting and supporting the provision of smokefree environments, or withholding support. Some participants received no support or help in their quitting attempt.

Health Professional Support to Quit

Given that health is the most common reason motivating people to quit smoking and the evidence suggests that even brief advice to quit from health professionals has a significant effect on smoking cessation rates (NACHD, 1999) it was reassuring to find that 77% of participants could recall being advised by a health professional to quit. Not so reassuring is the result that only 28% said the advice had influenced their decision to quit. For the participants in this study, therefore, pressure from children to quit was perceived to be as influential as advice from a health professional.
Some participants who stopped smoking confirmed a positive effect on their \textit{wairua}. They experienced a "clarity" along with improved "sensibility." In retrospect, they could see how smoking had clouded or "blocked" their \textit{wairua} like a fog. The qualitative data showed acceptance among participants that smoking has damaging consequences for te taha wairua and that reinstituting balance was necessary for healing. However, given the secular nature of this research project, this finding needs to be explored further through a different methodology based more in traditional matauranga Maori.

\textbf{CONCLUSION}

This research suggests Maori smoking behaviour is stubbornly sustained by a synergy of factors including all those identified globally, that is, the physiological, psychological and social reasons for smoking. In addition there are spiritual and cultural factors unique to Maori today that potentially encourage and support Maori smoking. This research shows, however, that Maori can successfully stop smoking using a variety of smoking cessation interventions.

A number of variables appear to have potential as predictors of quitting among Maori. These are:

- \textit{Te Taha Tinana}: severity of nicotine dependency
- \textit{Te Taha Hinengaro}: self-efficacy
- \textit{Te Taha Whanau}: living with non-smokers; and, quitting with whanau or friends.

\textbf{SECTION FOUR: THE NOHO MARAE SMOKING CESSATION PROGRAMME}

One of the aims of the research was to evaluate the effectiveness of NMSCPs. A control group of unaided quitters were recruited to provide a comparison group. It
was hypothesised that there would be no difference between the groups at the first interview. This was largely the case. Only a few statistically significant differences were found, but they were minor. Demographically the groups were very similar, though over half (61%) of the unaided quitters were urban Maori living in Auckland, whereas all of the NMSCP group lived in the Hauraki and Waikato regions and belonged to iwi from those areas. From a Maori perspective it could be argued that the participants still living in their tribal areas had some advantage healthwise over urban Maori who may be distanced from their turangawaewae, iwi and whanau. Another potential effect of having different iwi represented in the two groups, is that some iwi, including iwi of Waikato, have received an apology from the Crown and a Treaty settlement in recognition of historic breaches of Te Tiriti of Waitangi. Resolution could be expected to contribute towards healing unseen wairua effects that may have supported smoking.

The NMSCP group had higher levels of nicotine dependency as indicated by the FTND once collapsed into low, medium and high. The groups were not, however, statistically different on the CO reading. Fewer of the NMSCP group had tried to quit previously. If anything, these differences provided advantage to the unaided group.

It was hypothesised that the NMSCP participants would achieve a higher cessation rate than the unaided quitters. The research supported this hypothesis. Thirty five percent of the NMSCP group were smokefree at the follow-up interview, whereas only 14% of the unaided quitters were smokefree. The point prevalence rate at follow-up of the unaided quitters was higher than expected. Estimates of spontaneous quit rates among general smoking populations range from 5-10% (NACHD, 1999). The quit rate for unaided quitters in this study reached similar levels as those attained by the North Canterbury Smokescreen programme (14% and 16% at 3 months) and the pilot Quitline (15% at 5 months). It may be that involvement in the research itself delivered intervention type effects for participants. It may be that motivation to quit was high to begin with, as indicated by reportedly high demand for cessation assistance among Maori smokers over the last several years (PHC, 1994b), though, the reviewed research has found less or only similar levels of intent to quit among Maori smokers when compared nationally.
It was hypothesised that participants who undertake a NMSCP would maintain total smoking cessation longer than unaided quitters. The NMSCP group did last longer before relapsing. The analysis above determined that most relapse is caused by nicotine withdrawal experienced during the first week of cessation. The NMSCP effectively carries people through preparation, provides them with a quit date and cessation opportunity and a highly controlled intensive regimen to counteract nicotine withdrawal. Whilst 15% still relapsed within the first week, a significantly greater number (85% vs. 46%) survived this crucial stage of the cessation process. After this time the NMSCP participants reported vulnerability to the same triggers to relapse as the unaided quitters and if anything appeared more susceptible to relapse in the maintenance stage (50% vs. 32%). The higher quit rates among the NMSCP group can partly be attributed to its effectiveness at treating nicotine withdrawal.

The reviewed literature suggested there was little hope for participants with psychiatric comorbidity, and yet some of the participants who had one or more potential inhibiting factors suggesting poor likelihood of stopping, were able to stop and survive withdrawal symptoms with the help of the NMSCP. They were, however, unable to maintain their new smokefree status. It is proposed that even higher quit rates could be achieved by the NMSCP if it was targeted at smokers more likely to succeed at quitting as indicated by predictive factors.

Higher quit rates at follow-up may have been achieved if there had been a recognisable relapse prevention programme to follow on from the Noho Marae component. NMSCP participants who relapsed believed ongoing support would have helped them to stay smokefree.

**NOHO MARAE SMOKING CESSATION PROGRAMME CONTENT**

Participant feedback on the NMSCP (see Appendix S) was reviewed for the following section.

Both groups experienced similar withdrawal symptoms, except the NMSCP group perhaps had more opportunity to sleep and were eating less because of the controlled diet. For the NMSCP participants the diet helped by distracting attention away from the withdrawal symptoms, as well as assisting elimination, metabolism,
and healing. It also raised participants’ awareness of nutrition. The process of cleansing by fasting and dieting is consistent with the traditional practice of rongoa and is believed to have effects in te taha wairua. An emphasis on physical activity also served to distract from withdrawal symptoms and assist the detoxification process.

The NMSCP, sometimes referred to as a wananga (a learning environment), provides an opportunity to introduce participants to new behaviours. However, nicotine withdrawal can drastically effect people’s behaviour and ability to learn. For instance, in the first 2 days it can be very hard to concentrate, thus activities should not be dependent on cognitive ability. Instead more physical, experiential content should be emphasised. Some people can experience severe mood swings, making them extremely irritable, angry, upset and unpleasant to be around. NMSCP’s should prepare participants for this likelihood and include activities designed to alleviate or provide for socially acceptable expression of these feelings. Attendance should not be taken as assent to be subjected to abusive behaviour from others. The more diverse the group of participants in terms of addiction level and social background, the greater a problem this could be. Light smokers, for instance, who are likely to experience less severe withdrawal symptoms, may be less understanding and accepting of extreme behaviour in others. There may, therefore, be logic in matching participants on level of dependency.

If NMSCP continue a whanau focus, whereby all age groups and types of people can go on together, then optional content may need to be offered to cater for diversity, for example, having youth-oriented activities. A variety and concurrent optional activities may need to be offered throughout the programme to cater for different levels of physical ability and fitness. As participants may have disabilities or medical conditions, such as diabetes, it is important that adequate information about programme content is provided beforehand.

Attendees of the NMSCP said that the support of the group was the most helpful aspect of the NMSCP. How this support is facilitated may need to vary throughout the programme. Participants had diverse preferences regarding level of intimacy and self-disclosure and therapeutic versus social interaction. As ongoing support needs to be strengthened, more emphasis could be placed on establishing supportive relationships between participants, for example, setting up a buddy system.
It was hypothesised that participants of the NMSCP would make more positive changes to their smoking behaviour than unaided quitters. This hypothesis was not supported by the research. The NMSCP group were less likely to return to reduced levels of tobacco consumption if they relapsed. Most gradually increased back to previous levels of consumption. More of the NMSCP group reported being influenced back to smoking by others, suggesting a need to intervene to ensure whanau are supportive when participants return home. There was no difference between the NMSCP group and the unaided quitters in terms of other changes to their lifestyle, such as increased exercise or improvements in their diet. The number of smokefree homes had similarly increased in both groups.

Whilst it appears that the NMSCP’s contribute to broader lifestyle changes, concurrent or subsequent improvements in other areas is a function of quitting and not attributable to the programme. It may be tempting to provide health education sessions on diet, exercise and other health topics to NMSCP participants as they are a captive audience requiring plenty of distraction, but unfortunately nicotine withdrawal probably undermines the efficacy of education delivered at this time. It may be more effective to provide educational sessions during the preparation and maintenance stages of quitting.

**The Effectiveness of NMSCPs**

The NMSCP’s practiced and incorporated a number of the recommendations for delivering effective programmes for Maori that were recorded in the literature reviewed. The NMSCP is based on and works from within a Maori value system, for example, it conforms with Te Whare Tapa Wha. It has a whanau focus and as it is marae based, the whanau could be the site of delivery. As it is held on local marae, it is likely to be more accessible to Maori. It could be said to be a kaupapa Maori programme as it fulfils the criteria. It is delivered in accordance with tikanga Maori. It has been developed from Maori needs, from the bottom up and can be tailored to local kawa. It is managed by Maori, for Maori, with Maori, as Maori practitioners control and deliver the programme. It uses a group approach consistent with Maori preference for community and has the support of iwi.
For those who can make the commitment, a NMSCP is an effective way of completing the first two steps of the quitting process, that is, ceasing all tobacco and nicotine use and surviving the initial withdrawal from nicotine.

SECTION FIVE: CONCLUSION

Smoking must be understood in the context of its own history and the history of its introduction to and use by Maori. When smoking was introduced to Aotearoa, Maori women, as well as Maori men, adopted the behaviour, making them one of the first groups of women in the world to smoke en masse, hence the oft repeated statement that Maori women have the highest rate of lung cancer in the world (see Appendix T). Thus over half of Maori adults and in history sometimes up to two-thirds of Maori adults were smokers. New Zealand tobacco control interventions have helped to reduce smoking prevalence and tobacco consumption for both Maori and non-Maori, but with a pre-existing inequity in prevalence rates and interventions inadvertently targeted at European men, prevalence rates for Maori remain double that of non-Maori.

I do not accept the suspicion that Maori might be genetically predisposed to nicotine addiction more so than other populations. Rather Maori smoke and can stop smoking for the same reasons as other peoples. Given the same opportunity, Maori smokers can stop smoking at similar rates as other peoples. The unique Maori and Pakeha cultures, do however, modulate the expression of smoking and can likewise be used to facilitate quitting. As smoking was introduced, Maori are in the unique position of being able to invoke tradition, as done in the Health Sponsorship Council slogan “Te Ao Maori, Te Ao Auahi Kore/Traditionally Maori, Traditionally Smokefree.” I believe this study supports Maori assertions that interventions will be more effective if developed and delivered by Maori, to Maori.
CHAPTER TEN

Implications For Tobacco Control in New Zealand

SECTION ONE: INTRODUCTION

In addition to testing the hypotheses discussed in the previous chapter, the process of analysis of the data collected for this research, highlighted a number of implications for tobacco control in New Zealand. Opportunities to improve interventions or topics that could benefit from further investigation are presented in this Chapter. Te whare tapa who is used to structure the presentation of these implicatons.

Implications for the way smoking behaviour is measured and assessed is discussed under te taha tinana in the next section. For example, the FTND is reviewed for its applicability to a New Zealand Maori context. Societal attitudes towards smoking and smoking cessation and the need for changes in attitude are discussed under te taha hinengaro. Interpretation and application of the Stages of Change Model is also discussed under this section. Implications for the way Maori smoking cessation interventions are delivered are discussed in section four on te taha whanau and spiritual implications are discussed under te taha wairua in section five. Implications for the broader control of tobacco use by Maori are discussed under te ao turoa in section six, where policy and programme development are considered. Recommendations made throughout the chapter are summarised in the concluding section.
SECTION TWO: TE TAHĀ TINANA

Te taha tinana, has been used throughout this dissertation to encompasses the physical aspects of smoking and nicotine dependency. In this section, the FTND used to measure nicotine dependency and CO monitoring used to measure tobacco consumption are reviewed. The need for further research on Maori and depression is also discussed here.

REVIEW OF THE FAGERSTROM TEST FOR NICOTINE DEPENDENCE

The FTND was used in this study, partly to test its applicability for use in New Zealand with Maori smokers. The FTND was developed to measure dependency on nicotine. Two of the six items, number of cigarettes smoked per day and time to first cigarette, are highly related to physiological measures of smoking. The four other questions, difficulty refraining from smoking in places where it is forbidden, which cigarette the smoker would hate most to give up, whether or not they smoke more in the morning than the rest of the day and do they still smoke if they are so ill that they are in bed most of the day, are behavioural indices (Heatherton et al., 1991). It is proposed that the behavioural indices are subject to social and cultural influence and, therefore, the FTND can not be automatically transferred across cultures. Examination of three of the items below, show why this might be so.

Difficult Refraining

Despite other indications of nicotine dependency, many participants responded that they did not find it difficult to refrain from smoking in places where it is forbidden. As the qualitative data showed, this was probably due to their support for and acceptance of smokefree environments. Participants said they did not mind refraining out of respect for non-smokers. Smokefree areas gave them an opportunity to refrain or they just worked around restrictions. The question was not applicable for some rural unemployed participants who could not recall going anywhere where smoking was forbidden. In New Zealand, therefore, a decade after the introduction of the Smokefree Environments Act (1990), it appears this FTND item is not an accurate behavioural index of nicotine dependency.
The qualitative data suggests that this particular question may not be applicable for use in the New Zealand context, given the now established and predominantly supported Smokefree Environments Act (1990).

**Smoke More in Morning**

The qualitative data suggests that the pattern of use, that is, when participants' smoked, did not always conform to patterns discussed in the literature. The FTND item to determine which cigarette the smoker would hate most to give up and the question regarding whether they smoke more in the morning than during the rest of the day, are based upon observations that after not smoking for several hours while asleep, smokers smoke repeatedly upon waking to reinstate desired blood-nicotine levels. The smokers in this study were just as likely to respond that a night time cigarette was more important to them. The qualitative responses revealed a common dosage pattern, which may be socially or culturally moderated, for example, by changes instituted under the Smokefree Environments Act. Whilst, some smokers would take advantage of opportunities to smoke during the day at work, for example, at morning tea, lunch and afternoon tea, others would not smoke until they returned home. Some participants delayed smoking until after dinner, when, for example, children had gone to bed and daily chores were complete, then they could relax and dose up, both to catch up on nicotine missed throughout the day due to smokefree restrictions at work and to stock up in preparation for the evening drought while asleep. Thus emerged, a smoking pattern with two peaks of smoking a day, one after waking and one in the hours before going to sleep. Therefore, it is proposed that these two items of the FTND are also not relevant to measuring nicotine dependency among New Zealand Maori.

**Application Difficulty**

Some practical difficulties applying the FTND were encountered, because the questions were written in a foreign vernacular, in this case "academic" language and some of the questions were grammatically complex and use uncommon words, such as "refrain." Some participants found the questions hard to understand requiring further explanation and translation in to more common language.
Conclusion

The full FTND may have been useful for detecting differences among smokers of medium to high nicotine dependency, but it appears less sensitive to gradations in severity of dependence among lighter smokers. Both the general New Zealand smoking population and the Maori smoking population are skewed towards light to medium smokers. As suggested by some of the qualitative data, participant's gauged their own tobacco consumption level in relation to others' consumption. Smoking even 10 cigarettes a day can seem heavy if everyone else only smokes 5 a day. As feedback in the form of scores and measurements can be a motivating factor for smokers considering quitting, it is unhelpful to score 0 on level of nicotine dependency, thus denying the addictiveness of nicotine for some smokers who nevertheless feel addicted. Similarly, being labelled a light smoker when a smoker's self-perception was leaning towards heavy, could undermine motivation if their smoking is not considered to be as "bad" as they had thought.

As Laugesen (1999) said, even one cigarette per day can maintain a constant blood-nicotine level, thus maintaining nicotine dependence, however light. Whilst the FTND provides a cardinal measure relative to increasing level of dependency, a measure recognising even relatively low levels of nicotine dependency would be more relevant for use in New Zealand. The FTND may have been developed particularly to assist with the prescription of appropriate doses of nicotine replacement products, which are not recommended for use with people who smoke less than 11 cigarettes per day. In this study even relatively light smokers reported difficulty surviving nicotine withdrawal and though they smoked less than 11 cigarettes per day, if their efficient smoking technique were taken into account they likely could qualify for and benefit from NRT.

The FTND was not designed to detect context specific addictive reactions, such as smoking confined to social occasions including alcohol use. This kind of smoking is considered primarily psychological rather than being driven by nicotine dependence. In a society, where smoking is relatively unusual (only one quarter of the total New Zealand population smoke, and in some sectors of the population smoking prevalence is even lower), even regular social smoking can be perceived as problematic. When particular social contexts trigger a physiological response akin to
the physiologically driven compulsion to smoke experienced by the regular smoker, it is not useful to deny that some level of addiction to nicotine, albeit a conditioned one, exists for that person. When “just one puff” can so readily initiate regular smoking, it would be expedient to pathologise, rather than appear permissive of, even casual tobacco use. Thus, to be relevant to the New Zealand context, a measure of nicotine dependence needs to distinguish between never smoking, regular social smoking, and daily light, medium and heavy smoking.

The FTND as a whole was not predictive of quitting. Actual number of cigarettes, however was. With a larger sample, time to first cigarette as it is currently scored could be predictive of quitting, otherwise a simplified binary within 30 minutes and after 30 minutes as calculated in this study is predictive of quitting success.

It is recommended that: when measuring nicotine dependence, New Zealand studies or smoking cessation interventions, use only two items of the FTND, number of cigarettes per day and time to first cigarette. When scoring number of cigarettes per day, 1-10 cigarettes should rate one rather than zero, 11-20 cigarettes, 21-30 cigarettes 3 and 31 or more 4.

**Carbon Monoxide Monitoring**

The guidelines for interpretation of CO readings, provided by the British manufacturer of the Smokelyser, may need to be tempered with local knowledge. In this study, participants perceived their smoking to be heavier than indicated by the number of cigarettes they said they smoked per day and their CO reading. For instance, the Smokelyser Operator’s manual estimates the average level for smokers is 33 parts per million (ppm). Average CO reading at first interview was only 16ppm, which is consistent with the lower average number of cigarettes smoked per day by smokers in New Zealand. The manual allows non-smokers readings up to 5ppm, due to CO levels in ambient air. Based on the CO readings taken during this study, it would not be unusual for a non-smoker living in rural New Zealand to register 0 ppm. Even a city resident living on a main road might only register 3ppm. Passive smokers could be expected to register higher CO levels. Participant’s seemed to rate their smoking relative to how much they thought other people smoked and what they thought were socially shared standards, which have changed as average tobacco
consumption has dropped. If smokers perceive their smoking to be heavy, and this is a factor motivating them to quit, they should be supported in their assessment and encouraged to pursue as low a CO reading as they can.

In addition to its usefulness assessing validity of research, "scientific" measures such as a CO reading can be used by primary and secondary health care as a screening device, to raise awareness of the ill-health effects of smoking and passive smoking, and to provide an opportunity to discuss risk and bolster smokers' motivation to quit.

**It is recommended that:** New Zealand users of the Smokelyser relate CO levels to a typical non-smokers reading, rather than using the categories of light and heavy provided in the operator's manual.

**DEPRESSION**

A quarter (25%) of participants in this study believed they had been depressed in the previous 6 months and one-third (32%) had had depression previous to that. This could indicate possible existence of higher levels of low grade and clinical depression among Maori than national figures report (that is, about 1 in 7 people, 1 in 5 women, will develop a depressive disorder some time in their lifetime). The definition used in this study however was broad and therefore did not allow for comparison with national prevalence studies. New Zealand research is needed that will first define depression for Maori, secondly determine prevalence and thirdly investigate effective interventions. Any progress in preventing and treating depression could have positive spin-offs for reducing smoking prevalence and consumption. This idea is supported by the emerging success of some anti-depressants (for example, bupropion) which have been found to be effective at increasing cessation rates (Wilson, 1998).

**It is recommended that:** the Ministry of Health or research funding bodies, fund research that will document Maori experience of depression; investigate prevalence of depression among Maori; and, evaluate the prevention and treatment of depression among Maori.
SECTION THREE: TE TAHĀ HINENGARO

Te taha hinengaro, the mental realm, encompasses individual and societal attitudes towards smoking and smoking cessation. The results suggest that a number of unhelpful myths about smoking cessation may be common and need redressing. Particular questions arise from the results and are discussed here, such as the importance of stopping smoking during pregnancy and the emphasis placed on weight gain post-cessation. This section goes on to discuss the need to better match interventions to client stage of change.

DISEASE OR POOR LIFESTYLE CHOICE?

One of the popular myths about smoking is that it is just a bad habit. Whilst 90% of Maori smokers in a 1996 national survey said their smoking was a form of addiction (NRB, 1996), only 39% of the participants in this study said they smoke because they are addicted. Seventy three percent said they smoked because it was a habit, a term used interchangeably with addiction. Even The Concise Oxford Dictionary (Allen, 1990) lists the colloquial meaning of habit as “an addictive practice, esp. of taking drugs.” Other accepted meanings of the term habit, such as “a settled or regular tendency or practice” or “a mental constitution or attitude” (ibid.) serve to minimise the seriousness of nicotine dependency. Even the term addiction, is used flippantly, such as when referring to a “film addict” (ibid.) thus undermining the urgency of nicotine dependence.

The public health system has similarly viewed smoking as a lifestyle choice and thus has favoured public health interventions based on health education. The logic has been that if people only knew the risk and the damage they were doing to themselves and others, they would choose not to smoke. Knowledge alone, however, is no guarantee people will not smoke. Even 4.4% of doctors in New Zealand smoke (Pal, 1998).

The primacy of biology in smoking behaviour has been underestimated and this has prevented allocation of funding for nicotine dependency treatments. Public health efforts need to alter the public discourse and perception of smoking, so that smoking is seen not as a choice, but as a sign of disease, a highly treatable disease.
This could be achieved by a gradual shift to use of more medically oriented terms for smoking, such as nicotine dependence, especially when communicating with policy makers.

It is recommended that: When communicating with health professionals and policy makers, tobacco control advocates replace usage of the terms habit and addiction when referring to smoking, with nicotine dependency.

**SMOKEFREE PREGNANCY**

The literature suggests that pregnancy is a key opportunity to facilitate quitting. Pregnant women were not attracted to this study or to the NMSCPs involved in the study. Stopping for a pregnancy was not seen as very important among participants prompted to express an opinion on this. It would be helpful if future research could determine Maori attitudes towards having a smokefree pregnancy. Such research should investigate the relative importance given to abstaining from tobacco, alcohol, cannabis and other drugs, substances, or activities, while pregnant. Both men and women, young and old, and people with children and without, should be surveyed. Relevant health professionals should also be questioned, including Maori and non-Maori midwives, nurses and GPs.

It is recommended that: the Ministry of Health, or other health research funding body, support research into Maori attitudes towards smoking during pregnancy.

**STAGE MATCHED INTERVENTIONS**

Categorising participants’ cessation experience according to the Stages of Change Model was not problematic. Newly developed Maori smoking cessation focused programmes provide new language suggesting acceptance of the different stages Maori smokers go through. Me Mutu is a term used to prompt quitting and could be said to equate to the stage of contemplation and preparation. Aukati is the actual act of stopping smoking and Auahi Kore is to have reached a state of being smokefree. Within the Aukati stage, however, the research did identify two distinct stages. First the smoker must survive nicotine withdrawal. Having done that, they
must then sustain the change and instigate new and alternative behaviours to prevent relapse.

To decrease smoking prevalence, smoking cessation interventions need to improve people’s chances of getting through the first week following abrupt cessation of smoking. Smokers need to have realistic expectations about what may happen depending on their level of nicotine dependency. They need to know what withdrawal symptoms are so they can accurately attribute cause to the withdrawal of nicotine, rather than to self-perceived personal defects. Providing extraordinary and focused support during this crucial first week should be a priority.

It is recommended that: the Ministry of Health purchase treatment for nicotine withdrawal, matched to client need, that ranges in intensity from brief to residential.

Research on the effectiveness of relapse prevention programmes suggests ex-smokers need tailored tutoring in trigger coping skills and effective ongoing support to ensure maintenance of abstinence and minimisation of slips (Boustead, 1996). It may be necessary to conceptualise relapse prevention as a separate programme requiring different skills of both the recent ex-smoker and smoking cessation practitioners.

At a minimum, smoking cessation interventions may need to address weight (by promoting increased exercise and dietary assessment), stress management and how to cope with negative affect, and others’ smoking. Future research could investigate the relative effectiveness of different forms of support to maintain abstinence among Maori ex-smokers, for example, home visits, phone calls, formal and informal buddy support, perceived positive or negative behaviour of others, smokefree environments, quit campaign advertisements on television, Auahi Kore promotional material, rewards and feeling better. Research could also investigate the effectiveness or ineffectiveness of different coping mechanisms for each of the three main causes of relapse, that is, fear of or actual weight gain, stress and negative affect and others’ smoking.

It is recommended that: the Ministry of Health purchase a pilot Auahi Kore maintenance programme that would investigate the effectiveness of different types of follow-up and support for recent Maori ex-smokers.
Conclusion

Motivation can change, fluctuate and differ depending on what stage of change people are at. It may be that the skills needed to facilitate transition from one stage to another are different from the skills and strategies required to maintain that change (Miller & Rollnick, 1991). Interventions need to account for this and provide stage matched assistance. This study did not determine if it is heavier smokers that are more likely to seek out more intensive interventions, though it was suggested by the results. Access to a range of interventions designed to meet different levels of need would be the optimum, so smokers can progress up a gradient of intensity (that is, stepped care) or directly access stage matched interventions.

To provide a comprehensive programme of stage-matched interventions to decrease smoking prevalence through smoking cessation, the national tobacco control strategy would need to:

- Promote smokefree/auahi kore lifestyle
- Promote quitting
- Provide smoking cessation advice and assistance
- Provide treatment for nicotine withdrawal
- Provide relapse prevention support and assistance.
- Support auahi kore through regulation and legislation, especially by enforcing and extending the Smokefree Environments Act.

SECTION FOUR: TE TAHĀ WHANAU

In this section, te taha whanau, social aspects of smoking behaviour are covered. The results suggest there are a number of opportunities for intervening at the whanau level, some of which deserve further investigation.

PREVENTING SMOKING INITIATION

The school and the whanau provide particular environments, enforced community living, typically authoritarian environments where the young person’s
level of personal control is minimised. The role of others smoking in these environments is important in promoting smoking initiation.

Resiliency factors, for example, knowing that role models will disapprove of smoking behaviour and knowing the ill effects of smoking, could mitigate against smoking initiation. Future research on Maori children who do not take up smoking could help to identify potential resiliency factors that could be strengthened through tobacco control efforts.

Delaying experimentation with smoking among Maori children is a potentially worthwhile goal for the tobacco control movement. Most of the smokefree health education and promotion activity is targeted at young peer groups and delivered through schools. Few programmes have to date promoted smokefree whanau environments. Some parents in this study did not believe their smoking would influence smoking initiation among their children. Health education targeting Maori parents of young children with information stressing the importance of smokefree role modeling and the importance of parental disapproval of smoking could help to reduce parental support for children smoking. Apart from the benefits of reduced uptake among children, if fewer parents smoke, there will be health gains from reduced prevalence of passive smoking by children.

It is recommended that: the Ministry of Health purchase public health programmes promoting smokefree homes, targeting Maori parents of young children.

**STRENGTHENING SMOKEFREE ENVIRONMENTS**

The diversity among Maori extends to living in te ao auahi kore or not. While some people may have a smokefree whanau, no friends who smoke and a smokefree culture at work, others are surrounded by whanau and friends who smoke. There are subgroups of Maori where smoking is still the norm and the current Smokefree Environments Act has little impact, for example, unemployed people or blue collar and low socio-economic urban or rural Maori. Overall because of higher smoking rates among Maori, Maori have greater exposure to smoking in the whanau. The pressure exerted by "everyone else is doing it" may be more influential than accepted and this may be especially so for cultures that preference community over
individualism. "If they can, I can" is a notion that smoking cessation interventions could capitalise on when working with Maori.

**It is recommended that:** Maori smoking cessation interventions target whanau and encourage whanau to quit together.

**GENDER**

None of the male unaided quitters were smokefree at follow-up. There were, however, only small numbers of men in the study overall (22%). Some comments indicated that potential participants thought the appropriate focus of the research was Maori women, as if smoking among Maori men was not as bad. This probably results from a health promotion and media emphasis on high smoking prevalence rates and high lung cancer rates for Maori women relative to other women around the world. Though smoking prevalence rates for Maori men have dropped, deaths from smoking are still higher among Maori men. The role of Maori men in supporting or undermining smoking cessation in the whanau should not be ignored. Neither should Maori men be excluded when providing smoking cessation interventions to Maori.

The more permissive of smoking whanau are, the less social pressure on the smoker to quit. The whanau can be an important source of support that could be mobilised to assist national smoking cessation goals. This research supports Ellis’ (1995) suggestion that future research explore “the relationship of whanau role models as icons for health promotion and the prevention of illnesses related to smoking” and Hillrice et al.’s (1996) call for research to investigate the effectiveness of different kinds and sources of support, and whether support needs to be stage-matched.

**THE ROLE OF HEALTH PROFESSIONALS**

Future research is needed to investigate Maori client response to advice to stop smoking and assistance given by non-Maori and Maori doctors, nurses and other health workers. Research should investigate health professionals’ decision to address smoking behaviour or not, the content and type of support to quit provided to Maori
clients and barriers to the provision of smoking cessation assistance, for example, how health professionals respond when confronted with polydrug use.

**It is recommended that**: the Ministry of Health or health research funding bodies purchase research into Maori and non-Maori health professional attitudes towards and practice of the provision of smoking cessation advice to Maori clients who smoke.

**CONCLUSION**

Tobacco control at the macro level, for example, the strategies listed above, can be mimicked or undermined at the micro level within the whanau. Thus the whanau may:

- Adopt and promote an auahi kore lifestyle or be permissive of smoking
- Promote and support quitting or belittle and scorn quit attempts
- Provide smoking cessation advice and assistance or share unhelpful myths about smoking that minimise the addictiveness of it and withhold support
- Provide support during nicotine withdrawal by showing understanding of erratic behaviour and providing respite from responsibilities or actively encourage relapse, complain about and react to withdrawal behaviour
- Provide relapse prevention support and assistance through reward and celebration and by tolerating and encouraging new coping behaviours; or actively encourage a return to smoking by offering cigarettes and disallowing any changes that lessen triggers to smoke
- Support auahi kore environments by making whare, waka, marae, kura, sports clubs and housie smokefree, or block and disrespect the implementation of smokefree environments.

The whanau is an untapped resource and for some Maori is a legitimate site and potentially effective site for delivery of interventions. Rather than delivering programmes at the “community” or “public” level, programmes could be designed to be attractive to whanau pursuing auahi kore, and thus might be delivered in homes or on marae. In addition to the example of NMSCP, where whanau are encouraged to quit together, locally run quit and win competitions could require two or more whanau members to quit together with demonstrated wider whanau support in order to win a prize of relevance to the whole whanau.
SECTION FIVE: TE TAHĀ WAIRUA

This section introduces implications for te taha wairua that will have relevance for some Maori.

Nicotine is a psychoactive drug. Introduced to the body, it alters natural functioning, including consciousness. The smoker changes, their thinking is altered, their priorities are changed, their behaviour changes. These changes are largely chemically induced. Individual behaviour, whether affected by drugs or not, is supported or inhibited by society. Whether the drug is heroin, cannabis, alcohol, nicotine or caffeine, the “natural” person is temporarily lost. Unfortunately, regular use incurs more permanent changes, whether it be from neuroadaptation (for example, an increased number of brain nicotine receptors) or cell damage. In which case the natural person is forever lost. This concept is expressed in the Maori slogan “Tobacco attacks our potential” (DoH, 1991).

Smoking is a fundamental breach of tapu in a number of ways and can lead to breaches in tikanga. Firstly, the origin and treatment of the plant itself could have ramifications for users. The plant has been removed from the guardianship of a particular Native American tribe and commercialised for individual profit. Native American tradition that dictated the occasional, highly ritualised use of tobacco was not appropriated along with the plant. The integral mana of the tobacco plant has been abused as have the Native Americans from whom the plant was taken. The process of production of cigarettes incurs damaging costs to both the people employed in its growth and production, but also environmentally, for example, tobacco plantations have displaced food crops and forests. The integral mana of the consumer is similarly exploited, as they are conned into purchase of a product that, if used as intended, will kill half of its users.

In retrospect, it has been argued that tobacco was used to manipulate and control early Maori. There are recorded incidents of tobacco being used as a koha, a bribe and as an item of trade, for instance, in the purchase of land. Tobacco was also exchanged as part of the Treaty of Waitangi signing process (Broughton, 1996). It may be that tobacco’s role in the colonisation of Maori has negative ramifications for today’s Maori and Pakeha tobacco users.
The smoker tramples upon their own mana when they smoke, as the smoke is consumed through the breath which is tapu, but if classified as food, is noa. The psychoactive substances in tobacco "intoxicate" the user inhibiting their wairua, damaging their tinana, reorienting their thinking and changing their behaviour towards others. Nicotine dependency causes people to prioritise their individual tobacco use and in the process they sideline fundamental Maori values, such as manaakitanga, aroha and whakapapa. For example, children do sometimes go without as what little money there is in some families is spent on tobacco first. Babies and children are frequently made ill through passive smoking and sometimes they die from smoking related or exacerbated illnesses. Other whanau also sometimes die from smoking related illnesses from passive smoking. At the extreme, nicotine dependency drives people to steal from others, for example, cash and tobacco are increasingly the target of aggravated robberies of shops and petrol stations. Thus, smoking can lead people to breach tikanga.

**SECTION SIX: TE AO TUROA**

This research contributes to a more thorough understanding of Maori smoking behaviour, from initiation through to quitting and staying smokefree. The analysis implies that there are ways that the overall tobacco control strategy can be improved to more efficiently attain the Government's goals to reduce Maori smoking prevalence and tobacco consumption and to prevent uptake. Greater progress towards these goals will occur by:

- improving targeting
- improving efficacy; and
- improving co-ordination and inter-sectoral support.

**IMPROVING TARGETING**

The current approach is to determine which groups have the highest rates of smoking, for example, Maori women aged 25-44 and which sub-groups will produce greater health gain, for example, pregnant Maori women, then focus on delivering programmes to them (HFA, 1999). There is no doubt that the high rates of smoking
among pregnant Maori women is cause for concern and intervention is desperately needed.

Pregnant women were under represented in this research. Anecdotal data from other smoking cessation interventions trying to attract pregnant Maori women suggests this was not an unusual situation (S. Taylor, personal communication, March 2000). Despite research saying that pregnancy provides strong motivation to quit, pregnant Maori women don’t seem to be taking up the cessation assistance offered to them.

This research supports the theory that Maori smokers can be classified according to the Stages of Change model. It is proposed that the model could usefully be applied to populations of Maori smokers or geographically defined Maori communities. Thus, in a sub-group like pregnant women or Maori women aged 25-34 for instance, theoretically more of the smokers might be in precontemplation and consequently not ready for the smoking cessation interventions targeted at them. Conversely, older Maori smokers with smoking related illnesses, who have received advice to quit, may be over represented in the preparation and action stages of change. The point of debate is this: will greater progress be achieved by targeting groups with higher smoking rates but who are largely precontemplative or by providing smoking cessation assistance to groups who are ready to quit?

This research suggests that internationally established predictors of quitting success, such as severity of nicotine dependency and self-efficacy, can be applied to Maori smokers. Predictive factors enable the identification of smokers more likely to achieve cessation, such as light smokers. Very light smokers are more likely to quit without seeking assistance, but offering light-medium smokers cessation assistance could lead to improved quit rates. More intensive interventions will be needed for populations where there are greater numbers of medium-heavy smokers.

This research suggests that increasing smokefree environments and diminishing smoking prevalence in one’s immediate whanau, social and work environments, creates a peer pressure to quit. In some sub-groups of Maori, smoking is still the norm. Changing that reality or impression of normality may require a concerted push to achieve a critical mass of non-smokers in these sub-groups. The effort required to achieve a drop in smoking prevalence in such groups however may
be much greater than that required to bring about the same drop in prevalence among a sub-group of Maori health workers or teachers. The walk the talk logic often heard at hui, presumes that auahi kore role models in the community will add to the social pressure to quit.

Children raised in an environment largely permissive of smoking, whose parents smoke, are learning that smoking is the norm. To prevent future uptake, it is imperative that parents don’t smoke, children’s homes are smokefree environments and that parents are not permissive of smoking. As the following whakatauki says:

Na te moa i takahi te rata.

The rata which was trodden on by a moa when young will never grow straight; so early influences cannot be altered. (Brougham & Reed, 1963, p.28)

The “forbidden fruit” thesis argues that adult disapproval for smoking hightens the attractiveness of smoking (Pechmann & Shih, 1999). In a society largely permissive of society the rebellious decision would be to not smoke. Unfortunately this is not the case. For some of the participants in this study smoking was not forbidden, their parents may have even introduced them to smoking. This research suggests instead that smoking is attractive more so for its association with maturity and all that that brings. Young people aspire to be like their elders. In Maori this is understood as the tuakana-teina principle expressed in the following whakatauki:

Ma te tuakana ka totika te taina, ma te taina ka totika te tuakana.

It is through the older siblings that the younger ones learn the right way to do things and it is through the younger sibling that the older one learns to be tolerant. (Brougham & Reed, 1963, p.93)

Even the rangatahi in this study were aware of their influence on younger whanau members, pupils or clients, which added to their motivation to quit. This concern is cleverly capitalised on in a Health Sponsorship Council poster depicting an older netball player coaching younger players above the slogan “The only thing you should light up around them is their eyes.”

There is good reason to prioritise purchase of smoking cessation interventions for specific groups, in particular pregnant women, parents and carers of tamariki, role models and longer term smokers at risk for smoking related illness. One risk is that selective provision of cessation support to priority groups may be seen to be exclusionary and, therefore, not consistent with tikanga Maori. Rather than a whanau
focus, individuals are isolated for assistance which is less effective if the social context is going to resist changes in that individual.

With Maori smoking prevalence rates as high as they are at the moment, it is proposed that smoking cessation interventions be targeted at those most likely to succeed at quitting, regardless of their sub-group membership, that is, light-medium smokers, ready to quit with high self-efficacy and a whanau and home environment supportive of quitting. This will result in greater efficacy of smoking cessation intervention programmes. Smoking prevalence will be reduced faster. The contagion effect will be greater. The remaining population of smokers will experience increased marginalisation, thereby, increasing pressure and motivation to quit or reduce consumption. Reduced tobacco consumption will consequently result in reduced levels of nicotine dependency in the population, which in turn will improve quitting success rates. Support for legislative change to increase smokefree environments will be increased. Smoking will become less socially acceptable, thereby decreasing uptake among children. This research, therefore supports the suggestion made by Te Pumanawa Hauora ki Te Whanganui-A-Tara (1993), “focus on those whanau most willing and able to change.”

It is recommended that: the Ministry of Health purchase smoking cessation interventions for smokers most likely to succeed at quitting, that is, light and medium smokers who are ready to quit, have good-high self-efficacy and a whanau and home environment supportive of quitting.

It is recommended that: the Ministry of Health purchase smoking cessation promotion for Maori sub-groups most likely to succeed at quitting.

**Improving Efficacy**

The reviewed literature and this study suggest that there is a lot of quitting activity occurring in the Maori community, but the attempts are not resulting in abstinence. Having convinced Maori smokers to quit, through effective promotion of quitting and the highly successful implementation and enforcement of the Smokefree Environments Act, it seems a shame that smokers are left to their own largely ill-informed hit and miss strategies. Whilst each quit attempt could be considered a learning experience, with access to smoking cessation advice and assistance, it need not be such a long-term trial and error process.
Access to quality evidence-based smoking cessation assistance has been greatly improved in the last year, by the purchase of a national Quitline and mass media campaign promoting quitting, and pilot smoking cessation programmes for Maori women. Greater access to smoking cessation assistance could be provided by purchasing a range of interventions, varying in intensity, content and site of delivery, and by reducing the cost of programmes and smoking cessation aids.

It is recommended that: the Ministry of Health purchase a range of smoking cessation programmes targeting Maori, including NMSCP where demand for it exists at the local level.

The development and provision of the Guidelines for Smoking Cessation (NACHD, 1999) goes some of the way towards improving the efficacy of primary health care practitioners in this area. Effective use of the guidelines, however, could be reinforced by the provision of training.

As smoking cessation for Maori is a relatively new venture, more pilot programmes and evaluation of different approaches will be required, to enable development and identification of the most effective methods of intervention.

It is recommended that: the Ministry of Health pilot and evaluate innovative nicotine dependency treatment strategies that increase the effectiveness of interventions for Maori smokers.

Measuring Effectiveness

Recognition of smoking cessation as a process rather than as a single event and acceptance of the Stages of Change Model suggests that smoking cessation interventions can be assessed for ability to move smokers through the stages of change. Thus, intermediate outcomes are needed to measure changes in knowledge or tobacco use (Chollat-Traquet, 1996).

In addition to measuring prevalence rates and tobacco consumption, the success of tobacco control efforts can be tracked by a shift in the proportion of smokers in precontemplation, contemplation and action. A reduction in the proportion of smokers with higher levels of nicotine dependency should also be evident. An increase in the number of smokefree homes would indicate success at creating supportive environments for quitting.
Due to the relationship between exposure to tobacco use and morbidity and mortality, even reduced consumption will produce health gain. There will be a consequent decrease in risks for non-smokers also, a positive side effect of many tobacco control programmes that is generally not quantified.

This research suggests that the promotion of auahi kore and subsequent increase in quitting activity could have positive effects for other health goals whose intervention strategies include increasing physical activity and improved nutrition. A reduction in polydrug use may also be associated with the pursuit of auahi kore as a lifestyle or vice versa. A number of positive changes associated with participants quitting activity regardless of smoking status at follow-up were identified. Overall participants reduced their tobacco consumption per day and their nicotine dependency. There was an increase in the number of smokefree homes. There was a contagion effect, in that whanau of the participant also tried to quit. There was increased awareness of the negatives of smoking. Half the participants increased the amount of physical exercise they did per week. Half tried to improve their diet also, for example, by increasing their water consumption and consumption of fruit and vegetables; and by reducing fat, sugar and salt intake. Some participants changed their method of cooking. There was a trend, that did not reach significance, that quitting may be associated with decreased caffeine use, possibly decreased alcohol consumption and cannabis use.

Nearly half the participants reported improved health, especially those who stopped smoking. The participants who stopped smoking reported improvements in te taha wairua also. Stopping altogether and even reducing consumption gave participants extra time and oxygen which may have contributed to their enhanced cognitive ability and ability to manage responsibilities and relationships.

It is recommended that: the Ministry of Health recognise intermediate outcomes achieved by smoking cessation interventions and the contribution of smoking cessation interventions to the achievement of other health goals.

**IMPROVING HEALTH SECTOR CO-ORDINATION**

The reduction in smoking prevalence and tobacco consumption will reduce morbidity and mortality rates across a wide range of diseases and disorders. Seventy
three percent of participants in this research reported having current illnesses, presumably requiring contact with primary health care providers. Screening for smoking should be an integral part of primary and secondary health care and smoking cessation should be a treatment goal for all clients presenting with smoking related illnesses and illnesses exacerbated by smoking.

Whilst 77% of participants recalled receiving health professional advice to quit, the qualitative data revealed incidents where participants had not been informed of the possible association of smoking with illness or events, such as a miscarriage. Improved co-ordination is required to ensure Maori smokers are advised and assisted to quit smoking regardless of their point of contact with the health system. Other health professionals, such as dentists, physiotherapists and psychologists could be mobilised to support the promotion of smoking cessation. Existing health promotion providers could be utilised to reinforce and support the national Quit campaign, and should be encouraged to integrate the promotion of quitting with relevant foci, such as health education on diabetes, asthma, cervical cancer and Sudden Infant Death Syndrome. Drug and Alcohol services, experienced as they are in treating drug dependency, could be mobilised to promote and assist with nicotine dependency, though this research suggests some philosophical barriers may exist.

**It is recommended that:** the Ministry of Health purchase co-ordination services that aim to mobilise primary and secondary health care providers, associated health care providers and Drug and Alcohol treatment services, to promote, advise and support smoking cessation.

**It is recommended that:** the Ministry of Health purchase training in the implementation of the *Guidelines for Smoking Cessation* for primary and secondary health care providers, associated health care providers and Drug and Alcohol treatment services.

**It is recommended that:** the Ministry of Health require current health promotion providers to integrate the promotion of smoking cessation in to health education and promotion of other health topics.

This research revealed the positive influence of other tobacco control strategies on smoking cessation, such as legislation to provide increased smokefree environments, tobacco tax increases, health education in schools, Smokefree sponsorship of sports teams and research.

**It is recommended that:** the Ministry of Health continue to purchase a comprehensive tobacco control strategy.
SECTION SEVEN: SUMMARY OF RECOMMENDATIONS

This chapter has presented a number of implications for the current New Zealand tobacco control programme that arose from the analysis of the research results. Further research is needed to progress knowledge or test current assumptions. Recommendations made throughout this chapter are summarised below:

It is recommended that smoking cessation interventions:

Use only two items of the FTND when measuring nicotine dependence, number of cigarettes per day and time to first cigarette. When scoring number of cigarettes per day, 1-10 cigarettes should rate one rather than zero, 11-20 cigarettes 2, 21-30 cigarettes 3 and 31 or more 4.

New Zealand users of the Smokelyser relate CO levels to a typical non-smokers reading, rather than using the categories of light and heavy provided in the operator’s manual.

Target whanau and encourage whanau to quit together.

It is recommended that the Ministry of Health or research funding bodies:

Fund research that will document Maori experience of depression; investigate prevalence of depression among Maori; and, evaluate the prevention and treatment of depression among Maori.

Support research into Maori attitudes towards smoking during pregnancy.

Purchase research into Maori and non-Maori health professional attitudes towards and practice of the provision of smoking cessation advice to Maori clients who smoke.

It is recommended that the Ministry of Health:

Purchase treatment for nicotine withdrawal, matched to client need, that ranges in intensity from brief to residential.

Purchase a pilot Auahi Kore maintenance programme that would investigate the effectiveness of different types of follow-up and support for recent Maori ex-smokers.

Purchase public health programmes promoting smokefree homes, targeting Maori parents of young children.

Purchase smoking cessation interventions for smokers most likely to succeed at quitting, that is, light and medium smokers who are ready to quit, have high self-efficacy and a whanau/home environment supportive of quitting.

Purchase smoking cessation promotion for Maori sub-groups most likely to
succeed at quitting.

Purchase a range of smoking cessation programmes targeting Maori, including NMSCP where demand for it exists at the local level.

Pilot and evaluate innovative nicotine dependency treatment strategies that increase the effectiveness of interventions for Maori smokers.

Recognise intermediate outcomes achieved by smoking cessation interventions and the contribution of smoking cessation interventions to the achievement of other health goals.

Purchase co-ordination services that aim to mobilise primary and secondary health care providers, associated health care providers and Drug and Alcohol treatment services, to promote, advise and support smoking cessation.

Purchase training in the implementation of the Guidelines for Smoking Cessation for primary and secondary health care providers, associated health care providers and Drug and Alcohol treatment services.

Require current health promotion providers to integrate the promotion of smoking cessation into health education and promotion of other health topics.

Continue to purchase a comprehensive tobacco control strategy.

It is recommended that: When communicating with health professionals and policy makers, tobacco control advocates replace usage of the terms habit and addiction when referring to smoking, with nicotine dependency.
CHAPTER ELEVEN

Review of the Methodology

SECTION ONE: INTRODUCTION

This chapter critically reflects on the methodology. In the next section, te ao turoa, the scope of the study is discussed. The representativeness of the results and strength of evidence found is considered. Section two, te taha whanau, discusses how the research was integrated in to the relevant communities. In section three, te taha tinana, the research design, participant recruitment and retention and data collection methods are reviewed. Some project management issues are discussed and the question of research effect on the participants. Section four presents a discussion of the use of Te Whare Tapa Wha as the theoretical framework for the study. Finally, in section six, concluding remarks are made about the research and implications for future kaupapa Maori health research. Recommendations for the development of Maori health research are made throughout the chapter and summarised at its conclusion.

SECTION TWO: TE TAHA WHANAU

The Department of Psychiatry and Behavioural Science was chosen to host this project as it provided an environment where I would be less likely to encounter racism or sexism at a personal level, and where I would have access to supervision and guidance from like minded, that is, psychology trained academics. However, I was the only Maori person within the department, within a Medical School still in the early stages of addressing its obligations under the Treaty of Waitangi. There was a general lack of Maori language, knowledge, tikanga and whanau support.

To counteract this, a research whanau group was established to support me. Unfortunately, two of the whanau moved away and the geographic distance made it
difficult to stay in touch on a regular basis. Individual workload and time constraints further undermined the groups operation. Either the provision of Maori support and guidance should be a function of the institution hosting PhD candidates, or the extra time and remuneration for people’s time and expenses must be factored in to research costs. Time to administer regular whanau group meetings would need to be factored in to the research design also.

In addition to accessing sufficient Maori support, contact with researchers with experience in tobacco control was minimal. New Zealand’s tobacco research capacity is small and established researchers in the area are spread throughout the country. There is a need for better co-ordination of tobacco research expertise to at least enable better networking and to establish a capacity to mentor researchers new to the field. Access to a research and training unit with a dedicated focus on tobacco control would have been useful.

It is recommended that: the Health Research Council or other health research funding body, support the establishment of a New Zealand Tobacco Control Research Centre.

From a kaupapa Maori perspective, research is about building relationships. This project has established commitments I will be expected to maintain. Sending a summary of results to participants and information about new smoking cessation opportunities was one way in which that commitment to participants was partly satisfied. Expressing an ongoing interest in participants, if met outside the research, is necessary. The in-depth interviewing method helps establish a memory of people, which can be a problem when large numbers of people are met in the course of a project.

Consistent with kaupapa Maori health research values outlined in Chapter Two, this project was associated with Maori health programmes. The commitment to the community groups who supported the research requires that the results be reported back to them in person. If I obtain information of particular relevance to the smoking cessation activity of those groups, the relationship provides for an ongoing sharing of expertise.

The commitment to dissemination of results and sharing of knowledge gained extends beyond participants and groups immediately involved in the project. Since
starting work on this project I have been involved in advising the HFA on the development of tobacco control strategies for Maori; developed and delivered a training programme for a pilot smoking cessation programme targeting Maori women and their whanau; provided training to Quitline Advisors; and assisted in the development of the Guidelinedes for Smoking Cessation (NACHD, 1999). The questionnaires developed for this project have been freely shared with other researchers, for example, for evaluations of the New Zealand Pilot Quit Campaign and Pilot Aukati Kai Paipa 2000 project. Advice and support has been provided to undergraduate students referred for guidance on tobacco control related assignments.

Continual involvement in the tobacco control, Maori health and Maori health research communities is a further commitment that has been met by maintaining phone contact or by attending hui. Membership in Apaarangi Tautoko Auahi Kore (the Maori Smokefree Coalition) enabled this and enabled knowledge gained through this research to inform advice at an advocacy level. These duties are recognised by the HRC Maori Health Committee, who provided financial support to cover travel and networking costs. The time for these tasks has to be taken into account when scoping a project, which unfortunately was not understood at the outset of this research. As it became clear that the project would not be completed within the 3 years provided for by the HRC Postgraduate Scholarship, I had to take on occasional contract work, to support myself through the final year and a half of the project.

Attempting to meet kaupapa Maori research standards, for example, travelling to and meeting with Maori health groups, in areas where the research was to be conducted; maintaining involvement in the Maori health research community and remaining accessible as a resource for the Maori health community resulted in a larger workload than originally expected. In retrospect, a smaller study should have been conceived. Further, it was unwise to rely on community groups to run programmes they are unfunded for. The two groups who had originally planned to run programmes never did and it was lucky two other groups came to my attention and were willing to be involved.

The dual accountabilities Maori health researchers face, leads to additional tasks which Universities and research funding bodies need to take in to account when committing to support researchers and their projects.
SECTION THREE: TE TAHĀ TINANA

Whilst, a kaupapa Maori approach does not exclude use of RCTs, working with existing Maori health programmes who had limited numbers of smokers ready to commit to attending a NMSCP precluded randomisation. Establishing a control group against which to compare the NMSCP group was a realistic and scientifically robust alternative. Unaided quitters were recruited in the areas where NMSCPs were run and in comparable areas, to increase the likelihood of similarity between the groups.

Quantitative and qualitative data was collected, which presented problems in terms of the amount of data that was generated. Though much of the qualitative data was quantified, it was enriched and understood with the help of the qualitative data. The qualitative data also gives voice to the experience of participants. The depth of information provided by participants adds credibility to the information presented here. However, for a project limited to 3 years, the increase in workload required to undertake two different types of analysis was excessive.

PARTICIPANT RECRUITMENT

The literature review on kaupapa Maori health research methodology highlighted the possibility that the Maori community may be defensive about and reluctant to participate in research. Already over researched, the response burden on Maori is steadily growing as: our own demands for mainstream research to be ethnically sensitive and to result in equitable outcome for Maori leads to over-sampling by random surveys (NZ Drug Survey, 1999); there is an increasing practice of parallel Maori and non-Maori studies; and there is increasing research activity by Maori, for Maori, as we struggle to meet the ever changing requirements to secure funding, as is required by evidence based health purchasing policy.

To increase the chances of a positive response to this study, wide consultation was conducted prior to the start of any recruitment activity so it was not a surprise to key people in the communities where advertisements were placed, thus not attracting their suspicion and derision. My first name was printed in advertisements to show I was Maori also. A personable informal style of language and interaction with potential participants was employed to distance this research from the clipped
superficial relationships typical of market researchers and phone surveyors. Participants were informed of how the research would be used, that is, to help improve Maori smoking cessation programmes and to attract funding for such programmes, therefore, they would be helping other Maori. That the interview was to be conducted kanohi ki te kanohi (face to face), which is the traditionally preferred mode of communication and at a time and place suited to the participant may have helped also.

**Participant Retention**

It was important to tell participants that their ongoing involvement would be appreciated regardless of whether they stopped smoking or not. Persistent follow-up strategies were employed, for example, repeated phone calls, door knocking and waiting outside participants’ homes. At first I felt whakamaa, but participants were always welcoming and apologetic if they had missed an appointment. Some admitted feeling whakamaa themselves that they had not stopped smoking for the research. Greater effort to secure a second interview was usually needed for participants who had returned to smoking. The participants who were not followed up had moved without leaving a forwarding address. The extra time and effort required to secure as many second interviews as possible incurred unexpected costs and contributed to the extended period taken to complete the project.

**Follow-up**

There was a difference in time to follow-up for the NMSCP group and unaided quitters. The persistent and repeated efforts to follow-up participants contributed to this difference, with maximum effort applied to ensure retention of NMSCP participants because of the small numbers recruited. NMSCP providers helped locate their participants and facilitated follow-up interviews to occur.

**Data Collection**

Choosing to conduct kanohi ki te kanohi interviews in people’s homes and extending the geographic coverage of the research to include Thames, Hamilton and
Northland, resulted in an inordinate amount of time driving. The advantages were that, face to face qualitative interviews allowed for the collection of rich information unlikely to be accessed otherwise. Whakawhanaungatanga was facilitated by meeting in person, as participants could better assess my integrity, what Smith (1999) calls kanohi kitea. Often other whanau were present leading to multiple interviews. As natural an interviewing style as possible was used, providing a less formal approach believed to be more acceptable to Maori participants and less likely to intimidate, offend, or remind participants of possibly negative past experiences of research.

Leaving the second interview to on average 4 months later, weakened the validity of information collected at follow-up as it became subject to the accuracy of memory. Much of the information collected at the first interview on smoking history was retrospective and dependent on the salience of memory also.

At an administration level, data entry was left too late and should have been done as data was collected. It was difficult to enlist Maori transcribers. With the volume of transcribing required several casual staff had to be used. The Pakeha transcribers had difficulty correctly transcribing Maori language and vernacular. After checking a random sample of transcripts against the tapes, I decided to double check all the transcripts. This thorough checking process was another factor contributing to the extension of the research period.

**PROJECT MANAGEMENT**

There were some associated research tasks that were unexpected or took more time than expected, for example, having to resubmit applications for research funding annually. Administration of the research funds, which involved submitting expense claims to the University, took about a day a month and a further 1-2 months for reimbursement to be made. Shopping for the non-perishable food contents of the koha packs was done in blocks of about 40, but the fruit had to be purchased on the way to interviews. Compiling 241 koha packs took time. Preparing for a days interviewing required the preparation of a box or two of bulky koha packs, checking operation of the Smokelyser and packing cardboard mouthpieces, questionnaire forms, audio cassette recorder and tapes, and if staying away overnight, personal luggage. In retrospect, the research project was too big for one person to complete in the 3 years
allowed with the resources provided. The research could have benefited from more
guidance to help constrain the project at the outset.

SECTION FOUR: TE TAHĀ HINENGARO

The literature reviewed in Chapter Two portrayed a history where matauranga Maori has been valued differently and awarded a lesser scientific status and credibility. If Maori aspirations for centrality are to be realised, however, researchers must opt for, test and modify Maori paradigms. Smoking is a relatively new, introduced phenomenon, thus, there was presumably no traditional Maori knowledge regarding its use or for that matter the use of psychoactive substances. Analysing smoking using Te Whare Tapa Wha was without academic precedent.

Throughout the project a tension existed created by the incommensurability of matauranga Maori and Western theory. A Western explanation of smoking seemed to exclude a Maori understanding. In this thesis, the differences don’t appear as stark, as the biological, psychological and social Western model seem to be mirrored in the Maori categories of te taha tinana, te taha hinengaro and te taha whanau. The values and rules governing behaviour implied by each of these “sides” to Maori health are not found in the Western equivalent however. There is no easy translation of Western theory in to Maori or vice versa. Maori smoking can be understood in terms of a Western explanation. It can equally be understood using a Maori paradigm. The reliance on Western language, literature and measures and methods in this thesis may appear to favour the Western explanation. Both actually can coexist, as the Western knowledge does not exclude an overriding Maori analysis. In conclusion, this thesis contributes to contemporary Maori knowledge, rather than documenting or contributing to traditional Maori knowledge.

SECTION FIVE: TE TAHĀ WAIRUA

Undertaking kaupapa Maori or Maori health research in a time of development, characterised by lack of infrastructure, lack of experienced Maori health researchers, yet high demand for research on Maori health, can be challenging for the new researcher. There is no established agreed upon code of ethics for conducting
Maori health research. Therefore, there is no agency monitoring Maori health research activity. There are currently few obligations to disseminate Maori health research results and no systematic collection of research reports or structure facilitating the sharing of results with other researchers.

Consequently, University libraries do not have good collections of Maori health research reports. Having to personally contact and or visit research centres to access libraries of research reports incurred further time and cost, as did the need to undertake a literature review to determine the Maori health research ethics and expectations.

It is recommended that: the Health Research Council investigate the establishment of a Maori Health Research Ethics Committee to pursue the development of a Maori health research code of ethics.

It is recommended that: the Health Research Council fund the establishment of a central clearing house for Maori health research reports and information.

It is recommended that: the Health Research Council fund regular hui for Maori health researchers to present and share research results; and to debate and workshop research methods and ethics.

SECTION SIX: CONCLUSION

The aims of the research were achieved, though it took longer than expected to do so. The methodology provided for scientifically robust results to be produced, resulting in the detection of statistically significant differences. The richness of the qualitative information on Maori smoking contributes to the development of contemporary Maori knowledge needed to effectively address a devastating contemporary problem for Maori. Using a kaupapa Maori health research methodology helps contribute to the development of kaupapa Maori health research as a discipline in itself.

Matauranga Maori allows for coexisting explanations for phenomenon. This thesis is a secular explanation and in no way is it the only possible understanding of smoking, nor is it meant to disavow other more esoteric explanations for Maori smoking. This analysis is context based and culturally based, situated in time and drawing on a sample of the knowledge established to date. There is a lot more science
has yet to discover about the biological bases for behaviour and the interdependence and interactions of genes, different endogenous and exogenous drugs, hormones, neurotransmitters and nutrients. The growing body of knowledge will reveal and explain ever more about how the smoking of tobacco products effects us. Scientific and academic advance will see some of the assertions made in this thesis supported, overturned or corrected.

SUMMARY OF RECOMMENDATIONS

It is recommended that: the Health Research Council or other health research funding body, support the establishment of a New Zealand Tobacco Control Research Centre.

It is recommended that the Health Research Council:

Investigate the establishment of a Maori Health Research Ethics Committee to pursue the development of a Maori health research code of ethics.

Fund the establishment of a central clearing house for Maori health research reports and information.

Fund regular hui for Maori health researchers to present and share research results; and to debate and workshop research methods and ethics.
REFERENCES


Broughton, J. (1999). Injury to Maori: Does it really have to be like this? Dunedin: University of Otago, Te Ropu Rangahau Hauora Maori o Ngai Tahu.


Ellis, R. (1995). Ko tenei te whare awahi kore mo te oranga o nga tamariki! This is a smokefree whare for the health of our kids! [A Health Research Council student summernship report.]


APPENDIX A: GLOSSARY OF MAORI TERMS

<table>
<thead>
<tr>
<th>Maori Term</th>
<th>English Translation</th>
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<tbody>
<tr>
<td>Aotearoa</td>
<td>New Zealand</td>
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<tr>
<td>Aroha</td>
<td>Love</td>
</tr>
<tr>
<td>Atua</td>
<td>God</td>
</tr>
<tr>
<td>Auahi Kore</td>
<td>Smokefree</td>
</tr>
<tr>
<td>Aukati</td>
<td>Stop Smoking</td>
</tr>
<tr>
<td>Hapu</td>
<td>Sub-tribe</td>
</tr>
<tr>
<td>Hara</td>
<td>Sin</td>
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<tr>
<td>Hauora</td>
<td>Healthy</td>
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<tr>
<td>Hui</td>
<td>Meeting</td>
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<tr>
<td>Iwi</td>
<td>Tribe</td>
</tr>
<tr>
<td>Kai</td>
<td>Food</td>
</tr>
<tr>
<td>Kai paipa</td>
<td>Smoke; literally eat pipe</td>
</tr>
<tr>
<td>Kaimoana</td>
<td>Seafood</td>
</tr>
<tr>
<td>Kainga tuturu</td>
<td>One’s true home, for example, on whanau/tribal land</td>
</tr>
<tr>
<td>Kaitiaki</td>
<td>Guardian</td>
</tr>
<tr>
<td>Kaitiakitanga</td>
<td>Guardianship</td>
</tr>
<tr>
<td>Kanohi ki te kanohi</td>
<td>Face to face</td>
</tr>
<tr>
<td>Karakia</td>
<td>Prayer</td>
</tr>
<tr>
<td>Karere</td>
<td>Messenger</td>
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<tr>
<td>Kaumatua</td>
<td>Elder</td>
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<tr>
<td>Kaupapa</td>
<td>Platform, groundwork</td>
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<tr>
<td>Kawa</td>
<td>Protocol</td>
</tr>
<tr>
<td>Kawanatanga</td>
<td>Governance</td>
</tr>
<tr>
<td>Koha</td>
<td>Gift, parting message</td>
</tr>
<tr>
<td>Kohatu</td>
<td>Stone</td>
</tr>
<tr>
<td>Korero</td>
<td>Speak; speech</td>
</tr>
<tr>
<td>Kuia</td>
<td>Elder; often used when referring to elder woman</td>
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<tr>
<td>Kumara</td>
<td>Sweet potato</td>
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<tr>
<td>Kura</td>
<td>School</td>
</tr>
<tr>
<td>Mahi</td>
<td>Work; labour</td>
</tr>
<tr>
<td>Makutu</td>
<td>Magic</td>
</tr>
<tr>
<td>Mameae</td>
<td>Pain</td>
</tr>
<tr>
<td>Mana</td>
<td>Integrity; prestige</td>
</tr>
<tr>
<td>Mana moana</td>
<td>Indigenous rights over the sea</td>
</tr>
<tr>
<td>Mana tangata</td>
<td>Human rights</td>
</tr>
<tr>
<td>Mana whenua</td>
<td>Indigenous rights over the land</td>
</tr>
<tr>
<td>Manaaki</td>
<td>Care for; show respect; hospitality</td>
</tr>
<tr>
<td>Mangai</td>
<td>Mouth; speaker</td>
</tr>
<tr>
<td>Marae</td>
<td>Traditional meeting places</td>
</tr>
<tr>
<td>Matakite</td>
<td>Seer; second sight; predict; intuition</td>
</tr>
<tr>
<td>Matauranga Maori</td>
<td>Maori Knowledge</td>
</tr>
<tr>
<td>Mate Maori</td>
<td>Sickness, especially explained by reference to Maori spirituality</td>
</tr>
<tr>
<td>Mauri</td>
<td>Spirit or vitality; life-force</td>
</tr>
<tr>
<td>Me Mutu</td>
<td>Better / should quit</td>
</tr>
<tr>
<td>Mihimihhi</td>
<td>Greeting</td>
</tr>
<tr>
<td>Mirimiri</td>
<td>Massage</td>
</tr>
<tr>
<td>Moa</td>
<td>Large extinct bird</td>
</tr>
<tr>
<td>Moana</td>
<td>Sea</td>
</tr>
<tr>
<td>Moko</td>
<td>Tattoo; grandchildren</td>
</tr>
<tr>
<td>Nga</td>
<td>Plural</td>
</tr>
<tr>
<td>Nao</td>
<td>Free from tapu</td>
</tr>
<tr>
<td>Oranga</td>
<td>Health; welfare, safety</td>
</tr>
<tr>
<td>Paipa</td>
<td>Pipe</td>
</tr>
<tr>
<td>Papatuanuku</td>
<td>Earth mother</td>
</tr>
<tr>
<td>English</td>
<td>Maori</td>
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<td>--------</td>
<td>-------</td>
</tr>
<tr>
<td>Pataka</td>
<td>Food store</td>
</tr>
<tr>
<td>Porangi</td>
<td>Mad; crazy</td>
</tr>
<tr>
<td>Poroporoaki</td>
<td>Farewell; closing ceremony</td>
</tr>
<tr>
<td>Powhiri</td>
<td>Opening ceremony; welcome</td>
</tr>
<tr>
<td>Rangahau</td>
<td>Research</td>
</tr>
<tr>
<td>Rangatiratanga</td>
<td>Chieftainship, leader</td>
</tr>
<tr>
<td>Ranginui</td>
<td>Sky father</td>
</tr>
<tr>
<td>Rohe</td>
<td>Region, area</td>
</tr>
<tr>
<td>Rongoa</td>
<td>Medicine</td>
</tr>
<tr>
<td>Runanga</td>
<td>Tribal council</td>
</tr>
<tr>
<td>Tai Tamariki</td>
<td>Maori youth</td>
</tr>
<tr>
<td>Taonga</td>
<td>Treasures, property, anything prized</td>
</tr>
<tr>
<td>Tane</td>
<td>Man</td>
</tr>
<tr>
<td>Tangata whenua</td>
<td>People of the land</td>
</tr>
<tr>
<td>Tapu</td>
<td>Sacred, forbidden, confidential, taboo</td>
</tr>
<tr>
<td>Tauiti</td>
<td>Foreigner</td>
</tr>
<tr>
<td>Taura here</td>
<td>Iwi Maori living in another tribal area</td>
</tr>
<tr>
<td>Tautoko</td>
<td>Support</td>
</tr>
<tr>
<td>Te ao auahi kore</td>
<td>Smokefree World</td>
</tr>
<tr>
<td>Te ao hurihuri</td>
<td>The turning, changing world</td>
</tr>
<tr>
<td>Te Ao Tuoro</td>
<td>The environment; the physical world</td>
</tr>
<tr>
<td>Te reo</td>
<td>The language, particularly referring to Maori language</td>
</tr>
<tr>
<td>Te Taha Hinengaro</td>
<td>The mental realm</td>
</tr>
<tr>
<td>Te Taha Tinana</td>
<td>The physical body</td>
</tr>
<tr>
<td>Te Taha Wairua</td>
<td>The spiritual dimension</td>
</tr>
<tr>
<td>Te Taha Whanau</td>
<td>The realm of relationships between people</td>
</tr>
<tr>
<td>Te Tai Tokerau</td>
<td>Northland</td>
</tr>
<tr>
<td>Te Tiriti o Waitangi</td>
<td>The Treaty of Waitangi</td>
</tr>
<tr>
<td>Te wahanga mo te matauranga</td>
<td>Maori epistemology</td>
</tr>
<tr>
<td>Tai Tamariki</td>
<td>Youth</td>
</tr>
<tr>
<td>Teina</td>
<td>Younger relation</td>
</tr>
<tr>
<td>Tikanga</td>
<td>Customs and traditions</td>
</tr>
<tr>
<td>Tino hoha</td>
<td>Very boring</td>
</tr>
<tr>
<td>Tino mangere</td>
<td>Very lazy</td>
</tr>
<tr>
<td>Tino rangatiratanga</td>
<td>Sovereignty; self-determination</td>
</tr>
<tr>
<td>Tohunga</td>
<td>Expert; specialist</td>
</tr>
<tr>
<td>Tuakana</td>
<td>Older relation</td>
</tr>
<tr>
<td>Tupuna</td>
<td>Ancestors</td>
</tr>
<tr>
<td>Turangawaewae</td>
<td>Home turf</td>
</tr>
<tr>
<td>Tutu</td>
<td>Meddle</td>
</tr>
<tr>
<td>Tuturu</td>
<td>Real</td>
</tr>
<tr>
<td>Urua</td>
<td>Cemetery</td>
</tr>
<tr>
<td>Wahi tapu</td>
<td>Sacred place</td>
</tr>
<tr>
<td>Wahine</td>
<td>Woman</td>
</tr>
<tr>
<td>Waiata</td>
<td>Song</td>
</tr>
<tr>
<td>Wairua</td>
<td>Spirit, soul</td>
</tr>
<tr>
<td>Waka</td>
<td>Vehicle, e.g. car</td>
</tr>
<tr>
<td>Wananga</td>
<td>Learning session</td>
</tr>
<tr>
<td>Whakaaaro</td>
<td>Thoughts; opinion</td>
</tr>
<tr>
<td>Whakamaa</td>
<td>Shame, abasement; loss of mana</td>
</tr>
<tr>
<td>Whakanoa</td>
<td>Remove tapu, make common</td>
</tr>
<tr>
<td>Whakapapa</td>
<td>Genealogy; recite one’s genealogy</td>
</tr>
<tr>
<td>Whakatauki</td>
<td>Proverb; saying</td>
</tr>
<tr>
<td>Whakawhanaungatanga</td>
<td>The process by which whanau ties and responsibilities are strengthened (Durie, 1994).</td>
</tr>
<tr>
<td>Whanau</td>
<td>Family, including extended family</td>
</tr>
<tr>
<td>Whanaungatanga</td>
<td>Relationship; kinship</td>
</tr>
<tr>
<td>Whangai</td>
<td>Adopt child</td>
</tr>
<tr>
<td>Whare</td>
<td>House</td>
</tr>
<tr>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>Whare karakia</td>
<td>Church</td>
</tr>
<tr>
<td>Wharepaku</td>
<td>Toilet</td>
</tr>
<tr>
<td>Whenua</td>
<td>Land</td>
</tr>
</tbody>
</table>

Notes on the spelling of Maori words:
Long vowels in Maori are usually represented by a macron or double occurrence of the vowel, for example Roopu. Macrons were not available on the software used to type this thesis and double vowels have not been used consistently on the basis that those readers who understand te reo Maori will know the correct pronunciation. Maori dictionaries, such as those listed below, can be referred to for further information.

Sources:
Barlow, C. Tikanga whakaaro: Key concepts in Maori culture. Auckland: Oxford University Press.
APPENDIX B: THE HONGOEKA DECLARATION FOR MAORI HEALTH RESEARCH

Hui Whakapiripiri, 31 January - 2 February, 1996, Marae, Plimmerton

He Putorino ka tangi
He kupu whakairi ka puta ki te ao.
Korero atu ra mo toku mana motuhake
Tenei te whakapiki koianei te whakakake
Tihei maori ora.

Like the flute that sounds
Words suspended taking a message to the world.
Speak to them of my mana motuhake
Tis on the rise, tis onward morning
Tihei maori ora.

As Maori researchers in the area of Maori health we are committed to working for research which contributes towards hapu, iwi, tangata whenua development. This process means regarding Tino Rangatiratanga and overcoming the negative impacts of colonisation. We acknowledge the Treaty of Waitangi as the basis for partnership between Maori and the Crown and will work to incorporate the values underpinning the Treaty in our work.

As a result of this hui, we declare that:

- we endorse the Mataatua Declaration on the Rights of Indigenous Peoples' over their cultural and intellectual property;
- we believe Maori health research should be determined and coordinated by Maori; working with Maori, for Maori;
- we support Maori determination for our standards of health and wellbeing;
- we will work towards Maori control over policies, priorities and funding decisions relevant to Maori research;
- as partners to the Treaty, Maori reserve the right to use any approach to health research which will benefit our people;
- we will promote and develop kaupapa Maori methodology and methods;
- we are committed to promoting te reo Maori and tikanga Maori as appropriate for Maori health research;
- we believe that research encompasses the past, the present and the future;
- we recognise that there are diverse Maori realities;
- we are accountable to whanau, hapu and iwi;
- we will monitor, critique, and discuss, including in hui and public forums, all research impacting on Maori health; and,
- we are committed to strengthening the community of Maori health researchers and urge all relevant supporting organisations to urgently develop this workforce.
## APPENDIX C: NOHO MARAE CESSTATION PROGRAMME

### EXAMPLE CONTENT

<table>
<thead>
<tr>
<th>Day</th>
<th>Possible Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation</td>
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<tr>
<td>Sessions</td>
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</tr>
<tr>
<td>Daily</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Day One</td>
<td>Powhiri</td>
</tr>
<tr>
<td></td>
<td>Whakawhanaungatanga</td>
</tr>
<tr>
<td></td>
<td>Ground rules</td>
</tr>
<tr>
<td></td>
<td>Housekeeping: where I come from; where I am now; where am I going</td>
</tr>
<tr>
<td></td>
<td>Sharing with a partner; introduce each other; share your rocky road</td>
</tr>
<tr>
<td></td>
<td>History of the whare</td>
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<tr>
<td></td>
<td>Physical activity, e.g. walks, games, musical instruments</td>
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<tr>
<td></td>
<td>Harakeke and crafts, kohatu</td>
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<tr>
<td></td>
<td>Videos</td>
</tr>
<tr>
<td>Day Two</td>
<td>Tai Chi / Whakapakaritina</td>
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<td></td>
<td>Spare time</td>
</tr>
<tr>
<td></td>
<td>Mirimiri: Hand and feet massage</td>
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<tr>
<td></td>
<td>Rongoa available in accordance with kaumatua direction</td>
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<tr>
<td></td>
<td>Videos</td>
</tr>
<tr>
<td>Day Three</td>
<td>Workshops:</td>
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<tr>
<td></td>
<td>Tai Chi</td>
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<tr>
<td></td>
<td>Walk on the beach</td>
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<td>Line dancing</td>
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<tr>
<td>Day Four</td>
<td>Workshops:</td>
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<td><strong>Gather kaimoana</strong></td>
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<td>Tai Chi</td>
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<td>Gym – aerobics</td>
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<td>Ten Pin Bowling</td>
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<th><strong>Day Five</strong></th>
<th><strong>Workshops: Nutrition</strong></th>
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<td>Tools for managing stress</td>
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<td>Hikoi Haere: Visit hot pools</td>
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<td>Free Time</td>
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<th><strong>Day Six</strong></th>
<th><strong>Workshops: Health checks</strong></th>
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<td>Hikoi haere – visit wahi tapu</td>
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<td>Start preparing Kai Hakari</td>
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<td>Kai Hakari</td>
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<td>Individual presentations</td>
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<td>Award ceremony / concert</td>
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<th><strong>Day Seven</strong></th>
<th><strong>Tidy up whare</strong></th>
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<td>How can you help others to become smokefree?</td>
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<td>Support system: who can you contact?</td>
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<td>Evaluation korero</td>
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<td>Poroporoaki</td>
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The above table is modelled on Ringa Atawhai (1998), Te Korowai Aroha o Hauraki, Te Kohao Health and Korowai Aroha Health Centre Noho Marae programmes.

The detoxification diet is an essential component of the Noho Marae Cessation Programme. As explained in the Te Kohao Health Whanau Smoking Cessation Programme (Te Kohao Health, 1998) menu plan:

This is a cleansing time of detoxification. Karakia is an essential component of healing and prepares oneself spiritually throughout the process. A diet of both raw and cooked fruit 'huarakau' and vegetables 'huawhenua' high in vitamins and minerals will be provided for the first three days. Water/wai is used throughout the whole programme which cleanses and purifies the body system. This should be increased approximately 2-3 litres per day.

Only natural herbs and seasonings, no salt or sugar, are used to enhance the flavour of the food in the first three days. Neither are participants fed dairy products, bread or sweets. On day four, bread and margarine, milk, eggs and fish, tea and coffee are introduced to the menu. On day five white meat such as chicken may be introduced; fish may be battered and sweets, such as a rhubarb and apple sponge may be served for dessert. On day six red meat such as lamb and beef may be cooked for dinner and served with dessert, for example trifle.
APPENDIX D: RECRUITMENT MEDIA

Newspaper Advertisements / Articles:
The New Zealand Herald
The Western Leader
The Central Leader
The North Shore Times
Manukau City Courier
Waitakere Week
The Weekender, in Hamilton
The Hauraki Herald
The Rawene Community Newsletter
The Northland Times
Health Research Council Newsletter
Next Week

Radio Coverage:
Nga Iwi FM, Paeroa
Big River, Dargaville
Tainui FM, Waikato

Television Coverage:
TV One’s Marae

Maori Health and related Groups:
Te Hauora o Te Tai Tokerau hui-a-iwi
Northern Drug and Alcohol Network hui, Hoani Waititi Marae, Auckland
Auckland College of Education Centre for Social Work
Hauora Hokianga, Rawene
Hauora Whanui, Kawakawa
Dargaville Hospital
The Northern Region Smokefree Network, Whangarei Hospital.
Hui Whakatipu, (Health Research Council hui for Maori health researchers)
Public Health Association Conference, Hamilton, 1998
Department of Psychiatry & Behavioural Science, Auckland School of Medicine
Want to give up smoking?

Maori smokers wanted for research on stopping smoking.

Maori (aged over 16 years) who are regular smokers of cigarettes, but who are going to try to stop smoking, are wanted for a study looking at what helps people give up smoking. Participation is voluntary and confidential. You will be interviewed three times over a 6 month period.

For more information contact:

Marewa Glover
Dept. Psychiatry & Behavioural Science
Auckland School of Medicine
University of Auckland

(09) 833 8525
Marjorie Clover

Cessation Methods
Main Smoking
Effectiveness of
Research on the

Phone 778 7599 ext 6241
Marjorie Clover
Audland Regional Hospital
Health Research & Development Section

Phone 778 7599 ext 6549
Marjorie Clover
Audland Regional Hospital
Health Research & Development Section

If you have any comments about this project, you may

Contact
Marjorie Clover
Audland Hospital
Health Research & Development Section

{name}: 02) 277832
Name: 07) 3796 6370
Direct Phone: 07) 3499 6590

If you want to know more please phone

The research is approved by the Research Ethics Committee.

and guide the research.
smoking interventions will have a
relevance, and other ethical
peers (Audit and Research and Audit
Committee) to the research on smoking.

ACKNOWLEDGEMENTS

Marjorie Clover
NGA MIHI

Ko Ngatokimatawhaorua toku waka, Ko Hokianga toku awa, Ko Nga Puhui Nui Tono
toku iwi, Ko Ngati Hine raua ko Ngati Manu
oku hapu

Nga mihi nui ki a koutou, e hoa ma nga
rangatira ma, nga kaimahi auahi kore ma, tena
koutou, tena koutou, tena koutou katoa

INTRODUCTION

In June, 1996 I was awarded a Health
Research Council Postgraduate Scholarship to
undertake a Doctor of Philosophy Degree
(PhD) at the University of Auckland School
of Medicine

To qualify for a PhD, a student must complete
at least 2 years fulltime research on a topic of
their choice. I chose to study The
Effectiveness of Maori Smoking Cessation
Methods. I hope to finish and graduate in
1999. Aue!! Seems a long way off...

Smoking cigarettes is still the biggest killer of
Maori people. Despite the devastating losses
we have suffered in terms of illness and death
to smoking, many smokers find it too hard to
stop. This research aims to help improve
smoking cessation services for Maori by
increasing our understanding of quitting
behaviour

There are three main parts to my study

- Consultation on the design of a kaupapa
  Maori health research study
- Interview smokers who attend a Maori
  smoking cessation programme
- Interview Maori smokers who want to
give up but who will be trying to give up
on their own without the help of a
'formal' program.

WHO WILL BE INTERVIEWED?

I want to interview 160 Maori smokers (aged
over 16 years) who want to give up smoking
to find out what things help people give up
smoking

Smokers may be about to try a formal
smoking cessation programme offered by their
local health service provider, or perhaps they
are going to attempt to give up on their own

Participants in the research will be interviewed
three times once at the beginning, then 3
months later and finally 6 months later.

Each interview will take about 35 minutes to
45 minutes. The interviews will be conducted
at a time and place convenient to the
participant (for example, in their home if that
is best)

Participation is entirely voluntary and
participants can withdraw from the project at
any time without giving a reason why. All
information will be kept strictly confidential

I am interviewing in the following areas:

Te Tai Tokerau / Northland
Tamaki Makaurau / Auckland
Hauraki / Thames & Coromandel
Kirikiriroa / Hamilton
Rotorua
Gisborne

Closing date for participation is April 1998

KAUPAPA MAORI
HEALTH RESEARCH

A concurrent goal of the research is to
increase understanding of kaupapa Maori
health research

As part of the research, I am writing a report
summarising the korero about kaupapa Maori
health research. This report will be circulated
for comment and to facilitate ongoing
discussion about Maori health research

My research design will trial a kaupapa Maori
health research method based on the
recommendations of the report
APPENDIX G: POSTAL REMINDER OF UPCOMING INTERVIEW

[name & address]

15 June 1998

Research on reducing Maori smoking

Tena koe

I first interviewed you for my research on 19 February 1998. I would like to interview you again on **Thursday 18th or Friday 19th June 1998**. I am coming up to interview people in Hamilton on Thursday & Friday. If neither of these days suits you, please let me know.

Could you please call me on:  
**0800 AUKATI**  
**0800 285 284**

to let me know what time suits you.

Even if you haven’t stopped smoking, your experience of trying to stop is important to the research. I will also give you an assessment of your smoking and advice on what you could try next time.

Noho auahi kore mai
Naku noa
Na

Marewa Glover
APPENDIX H: INFORMATION LETTER FOR PARTICIPANTS IN ENGLISH

REDUCING MAORI SMOKING: THE ELEMENTS OF AN EFFECTIVE SMOKING CESSATION PROGRAMME.

INFORMATION FOR PARTICIPANTS

Ko Ngatokimatawhaorua te waka. Ko Hokianga te awa. Ko Ngatia Puhi Nui Tonu te iwi. Ko Ngati Hine rau ko Ngati Manu oku hapu. Ko Marewa Glover toku ingoa. Tena koutou, tena koutou, tena koutou katao. I am a student in the Faculty of Medicine and Health Science at the University of Auckland, studying towards my Doctorate degree with the support of a Scholarship and research funding from the Health Research Council.

I invite you to participate in my study on Maori who want to stop smoking cigarettes. Your participation is entirely voluntary and you may withdraw from the project at any time without telling me your reasons.

This research aims to help improve smoking cessation services for Maori by increasing our understanding of quitting behaviour.

I want to interview 160 Maori smokers (aged over 16 years) who want to give up smoking to find out what things help people give up smoking. You may be about to try a formal smoking cessation programme offered by your local health service provider, or perhaps you are going to attempt to give up on your own. If you agree to participate in the research you will be interviewed four times over a period of one year: once at the beginning, then 3 months later, 6 months later and finally 1 year later. Each interview will take about 35 minutes to 45 minutes. The interviews will be conducted at a time and place convenient to you (for example, in your home if that suits you best).

The researcher can understand intermediate level te reo Maori, so the interviews will be conducted mainly in English, but you may respond in Maori if you wish. Te reo Maori versions of this information sheet and the consent form are available if you want a copy. With your permission parts of the interview will be recorded on audio-tape and typed up later. The audio-tapes and written transcripts will be marked with a code number only (not your name). Your personal details will be locked away and kept strictly confidential.

If you have any queries or wish to know more about the study please phone Marewa Glover on (09) 373 7599 extn. 6549. If you wish to participate in this research please fill in a consent form and return it to the researcher. Thank you very much for your time and help in making this study possible.

Should you have any concerns or complaints arising from your participation in this research you may contact Marewa Glover, Dr Peter Adams (supervisor) or Rob Kydd (Head of Department), through the Department of Psychiatry & Behavioural Science, Faculty of Medicine and Health Science, University of Auckland, Private Bag 92019, Auckland, phone 373 7599 extn. 6549; or Dr Paparangi Reid, Te Ropu Rangahau Hauora a Eru Pomare, Wellington School of Medicine, Box 7343, Wellington South, phone (04) 385 5924. If you have any queries about ethical matters relating to this project, you may contact Dr Dennis Moore, Chairperson, Human Subjects Ethics Committee, C/o Registry, University of Auckland, Private Bag 92019, Auckland, or phone 373 7599 extn. 6204.

Approved by the University of Auckland Human Subjects Ethics Committee on 11 June 1997 for a period of two years. Reference 1997/157.
APPENDIX I: INFORMATION LETTER FOR PARTICIPANTS
IN MAORI

E mahaki ana te ritenga kaipaipa Maori:
Nga wahanga papai o tetahi whakahaeenga ki te katia I te ritenga kaipaipa.

Nga tohu whakamohio mo nga kaiwhaaki.


He tauira ahau kei te Tari Rongoa me te Hauora Putaiiao o te Whare Wananga o Tamaki Makaurau, e whakaako tonu ana mo taku potae rata. Ka tautoko te Kaunihera Rangahau Hauora I ahau ki te karahipi me te putea rangahau hoki.

He tonoa tenei ki a koe, ki te uru mai I toku mahi rangahau mo nga tangata Maori e hiahia ana ki te katia I te kaipaipa. Kei a koe te mana ki te uru mai, ki te unuhia ranei, te mahi rangahau nei, I roto I te waa katoa o taua mahi. He pai mau ki te waiho I ou take mo aua mahi unuhia.

Ko te hiahia o te rangahau nei, ki te whakapakari I nga whakahaeenga katia I te kai paipa, na te whakanui I nga mohiotanga o te noho kati.

Ka pirangi ahau ki te korerorero mai ki nga tangata kaipaipa Maori, kotahi rau ono tekau (ko tekau ma ono o ratou tau ke), mena ka hiahia ratou ki te mutu I te kaipaipa. Ko te take o te mahi nei ki te whakaatu I nga tohu awhina ki te mutu I te kaipaipa. Hei a koe ki te timata tetahi whakahaeenga ki te mutu I te kaipaipa, hoatungia e tetahi o nga tari hauora pea, e timata ana koe ki te mutu I te kaipaipa, kei a koe anake, ranei, he pai ena. Meheomega, ka whakaae koe ki te uru mai I roto I tenei rangahau, ka korerorero te kairangahau ki a koe I nga waa e roto ara. I te timatanga o te rangahau, me nga marama tokoru iwi te waa katoa. Toru tekau ma rima ki te wha tekau ma rima meneti te roa o te waa korerorero. I whakamahia te waa koreroro I te waa me te wahi pai ki a koe (he tauira: kei to whare, meheomega, he wahi pai tena ki a koe).

Ahua mohio te kairangahau nei I te reo Maori, engari, I te waa koreroro, I koreroro ia I te reo Pakeha, engari, he pai ki te whakatuku I te reo Maori. Kua whakamaoritia tenei pepe whakahohio me te pepe whakaae, mau I mau. Na to koreroro whakaae, ka whakaripene etahi wahanga o nga waa koreroro, ka huri whakatuhiahi a muri. I whakaingoatia te ripene me te tuhituki e te tatai puku anake, ehara I te ingoa o te kaikorero. He hunahuna to ingoa me to turanga, he mea ngaro.

Kei a koe he patai, hiahia koe ki te whakanui to mohiotanga mo te rangahau nei, waai mai ki a Marewa Glover, ko te tatai waea, ko (09) 3737599, aho 6549. Ka hiahia koe he whakaaaki, whakaoitia te pepe whakaae, ara, whakahokia taua pepe ki te kairangahau. He mihi whakawhetai mo to awhi ki te tautoko I te rangahau nei.

Kei a koe he whakaaro, he rarararu mo te mahi I te rangahau nei, me korerorero mai ki tetahi, etahi ranei o enei tangata, ko Marewa Glover, ko Dr. Peter Adams (kaiwhakahaere mahi), ko Rob Kydd (Tumuaki o te Tari), te Tari Putaiiao o te Hinengaro me te Noho, te Tari Rongoa me te Hauora Putaiiao, te Whare Waananga o Tamaki Makaurau, tatai waea 3737599, aho 6579, ko Dr. Paparangi Reid, Te Roopu Rangahau Hauora o Eru Pomare, Te Whare Waananga Rongoa o Te Whanganui a Tara, pouaka pouapeta 7343, Te Whanganui a Tara ki te Tonga, tatai waea 385 5924. Meheomega kei a koe he patai mo nga ahua tikanga o te rangahau nei, koreroro, tuhituki ranei ki a Dennis Moore, Tiamana, Komiti A.H.S.E., C/o Registry, Te Whare Waananga o Tamaki Makaurau, pouaka pouapeta 92019, Tamaki Makaurau, tatai waea, 373 7599, aho 6204.

Kua whakaae e te Komiti A.H.S.E. o te Whare Waananga o Tamaki Makaurau I te ra tekau ma tahi o Pipiri 1997 mo nga tau e rua. Reference 1997/157
APPENDIX J: CONSENT TO PARTICIPATE FORM

UNIVERSITY OF AUCKLAND
CONSENT TO PARTICIPATE IN RESEARCH

Project: Reducing Maori Smoking: The elements of an effective smoking cessation intervention.

Researcher: Ms. Marewa Glover

I have had this research project explained to me and I understand it. I have been able to ask questions of the researcher and have them answered. I understand that I am free to withdraw from the study at any time or withdraw any of the information that is about me from the study at any time prior to the information being analysed. I may do this without having to give any reason, and without suffering negative repercussions of any sort.

I further agree for the interview to be tape-recorded and for a written transcript of the interview to be made from this tape. I understand that the research tapes and full transcripts will be marked with a code number only and not my name, and that they will be kept strictly confidential.

I agree that anything I say in the interview may be quoted or cited in presentations, reports or publications arising from this research. Such quotations will be anonymous, with any potentially identifying details removed or changed. I reserve the right to stipulate certain areas of conversation or details I talk about as not available to be used as part of the research findings.

I agree to take part in this research.

Signed: 

Name: (please print clearly)

Date: 

Approved by the University of Auckland Human Subjects Ethics Committee on 11 June 1997 for a period of two years. Reference 1997/157.
APPENDIX K: KOHA CONTENTS LIST

Interview One
Auahi Kore Drink Bottle
Fruit, e.g. Kiwifruit
Peppermint Tea
Nuts & Raisins
Cruskits
Sugarless Gum
Smokefree Peppermints
Eucalyptus Tissues
Smokefree Pen
Auahi Kore Stickers

Follow-up Interview
Bag of Kiwifruit or other Fruit
Mixed Herbs
Popping Corn
Auahi Kore Cap
1 x bottle of Mineral Water
APPENDIX L: INTERVIEW SCHEDULE AT ENTRY

Maori Smoking Cessation Research: Interview One

Group: ____________________________
Date: ____________________________

Smoking History

1. Did your parents smoke when you were a child?
   Father   Yes / No
   Mother   Yes / No

2. Did other whanau living with you smoke when you were a child?
   Siblings Yes / No
   Grandparents Yes / No
   Cousins Yes / No
   Other ______

3. How old were you when you started smoking?
   First tried: _____________________
   Regular smoking: ___________________

4. Why did you start to smoke in the first place?

5. Have you ever thought about giving up? Yes ☐ No ☐

6. Have you ever tried to give up smoking? Yes ☐ No ☐

7. How many times have you seriously tried to stop smoking? ________

8. Have you ever given up smoking? Yes ☐ No ☐

9. Why did you want to stop smoking those previous times? and how (i.e. what methods) did you use to give up smoking each time?

10. If you have quit smoking, why did you start again?
Current Smoking

11. Type of cigarettes smoked: Roll-Your-Own ☐ Pipe ☐
    Manufactured cigarettes ☐ Cigars ☐ Other ☐

12. Do you regard yourself as a:
    light ☐ medium ☐ or heavy ☐ smoker?

13. Number of cigarettes smoked per day:
    1 to 5 ☐ almost half a packet ☐
    almost 1 packet ☐ almost 1 and 1/2 packets ☐
    almost 2 packets ☐ more than 2 packets ☐

*Note: A packet of cigarettes is defined as one standard packet of 20 cigarettes.*

14. How many packets (of 20) do you smoke per week?

15. What brand of cigarettes do you usually smoke?

16. Why do you smoke now?

Which of these reasons is the strongest one?

17. How soon after you wake up do you smoke your first cigarette?
    Within 5 minutes ☐
    6-30 minutes ☐
    31-60 minutes ☐
    After 60 minutes ☐

18. Do you find it difficult to refrain from smoking in places where it is forbidden e.g. in cinema, in wharehoui, on a plane?
    Yes ☐ No ☐

19. Which cigarette would you hate most to give up?
    The first one in the morning? ☐
    All others ☐
20. Do you smoke more frequently during the first hours after waking than during the rest of the day? 

Yes ☐  No ☐

21. Do you smoke if you are so ill that you are in bed most of the day? 

Yes ☐  No ☐

22. How many people (including yourself) live in your household? ________

Who are they?    Partner  Other:

Tamariki (How old?)

Kaumatua

23. Which of them smoke?

24. Any smokefree areas in home?

25. Do the people you see most frequently outside of work (e.g. your close friends) smoke? 

Yes ☐  No ☐

26. Where do you do most of your socialising, and is it easy or difficult to smoke there?

27. Do people at your workplace smoke? (Work can include voluntary work on Marae, Committees, Sports Teams). 

Yes ☐  No ☐

and; Is it easy to smoke at work? (Why?)

Are there people at work whom you smoke with?

28. Do you plan to stop smoking in the next 30 days?

Yes ☐  No ☐

29. How are you planning to stop smoking, e.g. what method and why?

30. What have you done to prepare yourself for this quit attempt? (Also - have you done other courses / programmes that might have helped you?)
31. Why do you want to stop smoking?

Health □ Cost □ It’s time □ Not necessary □ Sport □

32. On a scale from 1 - 7 how confident are you that you will succeed at stopping smoking this time? (1 being “I won’t be able to do it” to 7 being “I’ll definitely stop this time”) “Do you think you will be successful in this attempt to quit smoking?”

<table>
<thead>
<tr>
<th>I won’t be able to do it</th>
<th>I should be able to do it</th>
<th>I’ll definitely stop this time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Not confident</td>
<td>Reasonably confident</td>
<td>Very Confident</td>
</tr>
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33. What will you miss most about smoking?

34. What thoughts have you had about how stopping smoking might effect your weight?

35. Are you pregnant or planning a pregnancy? Yes □ No □

36. In the last six months, have you been diagnosed with any of these health problems?

- Heart problems
- Breathing problems: asthama, bronchitis, pneumonia
- Poor circulation: gout
- Blood pressure: high blood pressure
- Any cancer

37. Have you had depression, recently or in the distant past? Yes □ No □ If yes, could you describe what you went through, your symptoms?
39. Has a Doctor, or other health professional, ever advised you to stop smoking?

Yes □ No □

What kind of health professional and when?

Did that influence your decision to stop smoking? Yes □ No □

40. Has anybody influenced your decision to stop smoking?

41. Do you regularly (at least once a week) use any of the following drugs?

- Tea / Coffee □
- Marijuana □
- Alcohol □
- Medication for anxiety / depression □
- Other □

42. How often do you have a drink containing alcohol?

- Never □ Monthly or less □ 2-4 times a month □
- 2 to 3 times a week □ 4 or more times a week □

43. How many standard drinks do you have on a typical day when you are drinking?

- 1 or 2 □ 3-4 □ 5 or 6 □ 7-9 □ 10 or more □

44. How often do you have 6 or more standard drinks on one occasion?

- Never □ Less than monthly □ Monthly □ Weekly □ Daily or almost daily □

45. If smoke marijuana - is it mixed with tobacco? how much, how often?

- Are you worried about withdrawal symptoms?
  - Moodiness □
  - Agitation □
  - Eating □

Other comments about stopping smoking:

CO Reading:
Personal Details

1. What month and year were you born? __ / __

2. Male / Female

3. Iwi:

4. Town / City of Residence ___________________________

5. Are you:  Married □  De Facto / living together □
             Single □  Divorced / Widowed □
             Have a partner who lives elsewhere □

   If you have a current partner, do they smoke?  Yes / No

6. What class were you in when you finished school? _________________

7. What is the highest educational qualification you have obtained?

   School Certificate □  University Entrance/Sixth Form Certificate □
   Bursary □  University Diploma □
   Trade Qualification □  University Degree □
   Access or Tops □  Other (please specify)____________________

8. Do you work outside the home?  Yes □  No □

   If NO: go to question 9

   If YES: is this employment paid or unpaid?  Paid □  Unpaid □

   Is this employment full-time or part-time?  Full-time □  Part-time □

   What is your occupation?______________________________

9. Do you receive a benefit?  Yes □  No □

   If YES: which benefit?  Unemployment Benefit □

   Invalids Benefit □  Sickness Benefits □

   Domestic Purposes □  Other (please specify)

10. Are you eligible for a Community Services Card?  Yes □  No □
APPENDIX M: INTERVIEW SCHEDULE AT FOLLOW-UP

Maori Smoking Cessation Research: Interview Two

"Since I saw you last:"

Date: _______________________

Current Smoking

1. Have you stopped smoking all together? Yes □ No □ If Yes Go To 22
2. Have you smoked occasionally □ or, have you returned to regular smoking? □
   
   If occasional only: What happens to cause you to smoke?

3. When did you start smoking again? (Gradually increased or?)
4. Why did you go back to smoking?

5. What do you think about returning to smoking?

6. Have others influenced your return to smoking? Yes □ No □
   (If Yes, How?)

7. How have others reacted to your return to smoking?
8. Do you still want to stop smoking? Yes □ No □ Ambivalent □
9. Do you seriously intend to stop smoking in the next 6 months?
    Yes □ No □
10. Do you plan to stop smoking in the next 30 days?
    Yes □ No □
11. How are you planning to stop smoking, e.g. what method and why?

12. Have you tried to stop again? Yes □ No □
13. Number of cigarettes smoked per day now:

- 1 to 5  □
- almost half a packet  □
- almost 1 packet  □
- almost 1 and ½ packets  □
- almost 2 packets  □
- more than 2 packets  □

*Note: A packet of cigarettes is defined as one standard packet of 20 cigarettes.*

14. How many packets do you smoke per week?

15. Type of cigarettes smoked: Roll-Your-Own □ Pipe □

- Manufactured cigarettes □
- Cigars □
- Other □

16. What brand of cigarettes do you smoke now?

17. How soon after you wake up do you smoke your first cigarette?

- Within 5 minutes  □
- 6-30 minutes □
- 31-60 minutes □
- After 60 minutes □

18. Do you find it difficult to refrain from smoking in places where it is forbidden e.g. in cinema, in wharenui, on a plane? Yes □ No □

19. Which cigarette would you hate most to give up?

- The first one in the morning? □
- All others □

20. Do you smoke more frequently during the first hours after waking than during the rest of the day? Yes □ No □

21. Do you smoke if you are so ill that you are in bed most of the day? Yes □ No □

*Quitting Behaviour*

22. When did you stop smoking?

23. What withdrawal symptoms did you experience? None □

- e.g. Moodiness □
- Agitation □
- Hunger / Eating □
- Sleep More □ Less □
24. On a scale from 1 - 7 how hard was it to stop smoking? (1 being "It was very easy" to 7 being "It was extremely hard")

<table>
<thead>
<tr>
<th>No Problem</th>
<th>I Coped Okay</th>
<th>I nearly couldn't do it</th>
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</thead>
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<tr>
<td>Very Easy</td>
<td>Reasonably Difficult</td>
<td>Very Hard</td>
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</table>

25. What made it easy or hard to quit smoking?

26. What helped you stop smoking?

27. Did you do anything special in your effort to give up smoking? Yes □ No □
(If yes to question 15) What was that?

For participants who attended a programme: "Thinking back to the stop smoking programme"

28. Did you complete all □ or, just about all of the Noho Marae programme? □

29. Overall, what about the programme helped you most?

30. Overall, what was least helpful about the programme?

31. Was there anything about the programme that you didn’t like?

32. How do you think the program could be improved if at all?

Relapse Prevention

33. What has helped you to stay smokefree?

34. What things make it hard to stay smokefree?

35. Have any of your whanau or friends stopped smoking because you have?

36. Have any of your work colleagues stopped smoking because you have?
37. What changes have you made in your life since becoming smokefree?  
   e.g. made where smokefree ☐  
       exercise ☐  
       diet ☐  
       where you socialise ☐  
       getting counselling ☐  
       other ________

38. Any smokefree areas in home?  
   whole house ☐

39. Are there things you miss about smoking?  
   Yes ☐  No ☐  
   If yes, how do you cope with that?

40. What do you do instead of smoking?  
   e.g. another drug ☐  
       extra work ☐

41. How has stopping smoking effected your weight?

42. Are you pregnant or planning a pregnancy?  
   Yes ☐  No ☐

43. Have you noticed an improvement or worsening of any of these health problems?

   Heart problems
   Breathing problems:  
       - asthma  
       - bronchitis  
       - pneumonia  
   Poor circulation  
       - gout  
   Blood pressure  
       - high blood pressure  
   Any cancer  
   Depression
44. Do you regularly (at least once a week) use any of the following drugs?

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<tr>
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<tr>
<td>Tea / Coffee</td>
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<td>Marijuana</td>
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<tr>
<td>Alcohol</td>
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<tr>
<td>Medication for anxiety / depression</td>
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<tr>
<td>Other</td>
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</table>

45. How often do you have a drink containing alcohol?

- Never □
- Monthly or less □
- 2-4 times a month □
- 2 to 3 times a week □
- 4 or more times a week □

46. How many standard drinks do you have on a typical day when you are drinking?

- 1 or 2 □
- 3-4 □
- 5 or 6 □
- 7-9 □
- 10 or more □

47. How often do you have 6 or more standard drinks on one occasion?

- Never □
- Less than monthly □
- Monthly □
- Weekly □
- Daily or almost daily □

48. If smoke marijuana - is it mixed with tobacco? how much, how often?

Other comments about stopping smoking:

CO Reading:
**Demographics**

1. Any change in marital status? Yes ☐ No ☐

2. Do you work outside the home? Yes ☐ No ☐

3. If NO: go to question 9
   If YES: is this employment paid or unpaid? Paid ☐ Unpaid ☐
   Is this employment full-time or part-time? Full-time ☐ Part-time ☐

4. What is your occupation? ____________________________

5. Do you receive a benefit? Yes ☐ No ☐
   If YES: which benefit? Unemployment Benefit ☐
   Invalids Benefit ☐ Sickness Benefits ☐
   Domestic Purposes ☐ Other (please specify)

6. Are you eligible for a Community Services Card? Yes ☐ No ☐
APPENDIX N: CARBON MONOXIDE EXPLAINED

Carbon monoxide (CO) is a toxic, colourless, odourless, tasteless gas. It is harmful in any concentration and can kill. It is formed from incomplete combustion at high temperatures where there is an insufficient oxygen supply - with smokers, at the end of their cigarette. When inhaled, CO competes successfully with oxygen in the bloodstream forming Carboxyhaemoglobin (COHb), starving body tissue of the oxygen essential to “feed” the body’s needs. Thus, the heart must work harder constantly - a contributing factor in heart disease.

While CO in the body varies from 1 individual to another and depends on location - town or country - smokers have much higher CO concentrations than non-smokers. CO concentration is time-related. It is higher just after smoking than two hours later. It also increases during the day with cigarette consumption and can remain in the bloodstream for up to 24 hours, depending on several factors, including physical activity, sex of the individual and intensity of inhalation.

Carbon monoxide is measured in parts per million (ppm CO) and Carboxyhaemoglobin in percentages (%COHb). The two are comparable. CO readings relating to lung/breath and COHb to blood gas.

Clinical research has shown that a useful relationship between Carbon monoxide (CO) and Carboxyhaemoglobin (%COHb) is obtained after a short period of breath holding. CO readings show the levels of poisonous CO inhaled, while COHb shows how it replaces vital oxygen in the blood.

As a general rule of thumb, Carbon monoxide levels in ambient air should not rise above four parts per million (4ppm). The average level for smokers is about 33 parts per million (33ppm). Heavy smokers return higher readings still (Bedfont Scientific Ltd. Operators manual).
APPENDIX O: PARTICIPANT ASSESSMENT EXAMPLE

Maori Stop Smoking Research

Your Smoking

Assessment for [First Name]
Smoking at Interview 1
21 November 1997

Smoking History
First tried smoking at age 9.

Started smoking regularly at age 9.

Have seriously tried to stop smoking at least 2 times. Stopped smoking for 1 week.

Started smoking again because of the withdrawal symptoms.

Have smoked for about 26 years in total.

Smoking Frequency
No. of cigarettes smoked per day: 60 (manufactured cigarettes.)

At the time of our first meeting you considered yourself a heavy smoker.

Your carbonmonoxide reading was 30 parts per million in your breath. This suggests you were a heavy smoker.

Motivation to Stop Smoking
- The positives

You wanted to stop smoking because you know it's not good. It is not good for the children. Your children have asthma. You have a cough and chest pains.

You were intending to stop smoking in the next 6 months by cutting down. You were reasonably confident that you would succeed at stopping smoking this attempt (self-efficacy score: 5). You were going to progressively cut down the number of cigarettes smoked and then just stop.

- The negatives

Putting on weight was a worry.

The negatives will decrease your motivation to stop and need to be addressed and counteracted, for example, switching to a low-fat diet and exercising more so you don’t put on weight.
Understanding Your Addiction to Smoking

There are 3 main parts to an addiction to smoking:

- **Biological**

  The brain adapts to having nicotine and needs it to feel normal. If the nicotine supply runs out the brain reacts negatively by triggering strong negative feelings (e.g. anger, anxiety, panic). Sometimes even physical pain, cramps or headaches are triggered also.

  Fagerstrom Nicotine Tolerance Score: 7

  A score of 7 on the Fagerstrom Nicotine Tolerance questionnaire confirms that you were “very addicted” this represents a high physical dependence on nicotine (the addictive drug in cigarettes).

  You smoke almost continuously, especially when bored and stressed.

  You were worried about withdrawal symptoms, mainly moodiness and agitation.

  If you are unable to maintain a cutting down approach you would need to use nicotine replacement products - I would recommend that you use the 15mg patch and the nicotine nasal spray. You would need to use these for three months and then wean off slowly by switching down to a 10mg patch for a month and then down to a 5mg patch for a further month or two. Most people relapse within the first 3 months of stopping smoking.

- **Psychological**

  People learn to associate smoking with certain things (e.g. friendship, love, ‘being cool’ looking slim and attractive). Repetitive behaviours, such as, smoking with a cup of coffee or smoking when talking on the phone, develop into habits until one action automatically triggers the other.

  You need to learn to replace smoking with a less harmful action, such as, eating low-fat sugar-free products; drinking water or eating fruit when socialising.

- **Social**

  Smoking is everywhere, it is part of the environment / everyone is doing it. Sometimes it is easier to fit in with everyone else and do what they are doing.

  Your home environment supports continued smoking.
## APPENDIX P: KEY TO PARTICIPANT CODING

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Research on reducing Maori smoking

Tena koe [first name]

I interviewed you nearly two years ago for my research on Maori smoking. I am just finishing writing up the results and hope to be finished in a couple of months. Thank you again for your participation in the research. A summary of the results are included for your information.

Also, I wanted to let you know about a Maori smoking cessation pilot programme offering support, quit-coaching and free nicotine replacement products (nicotine patches and/or gum) to Maori whanau. Please let others know about it as it is a one-off opportunity and so far seems quite effective at helping Maori smokers who really want to stop.

The Auckland contact is:
    [contact]
    Ngati Whatua o Orakei Health Clinic
    521 2884

There is also a new free National Quitline service for all smokers: 0800 778 778 - please encourage smokers you know to ring up for a free quit pack, even if they are only just thinking about quitting.

My contact number, if you have any questions, is: 833 8525.

Noho auahi kore mai
Naku noa, Na

Marewa Glover
COMPARISON OF MAORI SMOKERS UNDERTAKING A NOHO MARAE STOP SMOKING PROGRAMME WITH A GROUP OF UNAIDED MAORI QUITTERS: SUMMARY OF FINDINGS.


I interviewed 130 Maori women and men, aged 16-62, before their quit smoking attempt and about four months later I was able to find 111 of them for a second interview to see how they went. 26 people went on a Noho Marae Stop Smoking Programme, where they stayed at a hui for five days and stopped cold turkey. The other 104 smokers were going to try and stop smoking on their own.

The main results of the study were that:

- More of the Noho Marae group were able to stop smoking (9 out of 26 which is 35% of the Noho Marae group versus 12 out of 85, i.e. 14% of the unaided quitters).
- The light smokers were more likely to stop smoking than the heavier smokers.
- The smokers who were very confident that they would stop smoking were more likely to stay stopped.

Smoking History
- 70% (92) remember their parents smoking when they were a child
- participants tried their first cigarette on average at 12 years
- they began smoking regularly on average at 16 years
- over half (57%) started to smoke in the home environment or at school
- participants had been smoking for an average estimated 18 years
- 88% (114) had tried to quit before an average of 2.5 times
- 78% (101) had managed to stop smoking previously.

Smoking at First Interview
- The average number of cigarettes smoked per day was 16.
- 65 (half) smoked tailor-mades, 36 (28%) smoked roll-your-owns and 29 (22%) said they smoked both.
- 56 (43%) of households were smokefree.
- 97 (75%) said that most of their friends smoke
- 100 (77%) had been advised to stop smoking by a Doctor or other health professional.
- only 36 (28%) said Doctor advice influenced their decision to stop smoking.
- 36 (28%) said they had been influenced to stop smoking by their children.
- "Health" was the No.1 reason for quitting this time (111 people = 85%).
- 69 (about half) were stopping because of the cost (53%) and/or for children (51.5%).
• “Walk the talk” was a reason for stopping for 33 (25%) participants.
• Of all the reasons given for why they smoke, habit (73%) was the most common reason followed by stress (48%), then addiction (39%).
• About half (49%) of participants were worried about putting on weight if they managed to stop smoking.

Smoking at Follow-up

• about half (53%) had returned to smoking at levels similar to their consumption prior to this quit attempt
• overall participants in the study reduced the number of smokes per day
• participants also reduced their level of addiction; this was supported by their reduced carbon monoxide reading (on average from 16.3 to 13.7).
• the most common withdrawal symptoms were constant eating (43%) and moodiness (40%). Sleepiness or not being able to sleep (31%), agitation (28%) and cravings (10%) were also mentioned frequently. Other symptoms included for example, headaches, aches and pains, diarrhoea or constipation.
• Reasons for relapse were stress (15%), other people smoking (15%), some kind of domestic upset (11%) and withdrawal symptoms (11%).
• 28 participants said they were influenced back to smoking by other smokers, for example, smokers asking them to smoke, offering them cigarettes or blowing smoke in their face.
• Smoking cessation triggered or coincided with other changes in peoples’ lives. Nearly half (49%) reported an increase in regular exercise; 41% changed their diet in some way and 20% changed where they socialised. Caffeine drink consumption dropped from 92% to 77%. There was a small reduction in alcohol use also.
• 72 (65%) said their house was now smokefree (compared with 43% at entry).
• 48 (43%) said their health had improved; 23% felt they were worse and 33% reported no change.
• 29 (26%) increased their weight; 13 (12%) thought they had lost weight and 63 (57%) thought they weighed the same.

Conclusions

• Maori smokers who attended the Noho Marae Stop Smoking Programme were more successful at stopping smoking and staying smokefree than the unaided quitters.
• The less you smoke the more likely you are to succeed at stopping.
• The greater your confidence that you will stop the more likely you will stay stopped.

This is a very brief summary – if you want to read more detailed papers written about the study, ask me to put you on my mailing list.
Participants were asked to say how they would describe depression. Qualitative responses were collected from 68% of participants. Nineteen participants discussed the task of defining depression. They suggested the need to distinguish between simply feeling down, stressed or worried and depression. There was an acknowledgement that you could feel sad now and then, or burned out, but these were states that could be easily recovered from. Similarly, depression was seen to go "beyond grief." Depression was seen to worsen over time if an initial violation was not resolved, becoming a more permanent state. A few participants said there were many types of depression and that there were different Maori words for the different types.

Content and theme analysis resulted in four categories of response, that is, statements about:
- Symptoms
- Causation
- Treatment; and
- Specific comments about a Maori theoretical understanding of depression.

SYMPTOMS OF DEPRESSION

Comments describing the symptoms of depression were made by 50% of participants. These comments have been grouped according to Te Whare Tapa Wha:
- Tinana: how depression might be experienced physically in the body
- Hinengaro: how depression is experienced in the mind, thoughts and feelings
- Whanau: how depression effects peoples relationship to others, their behaviour
- Wairua: how depression is experienced spiritually.

TINANA

A range of physical symptoms were cited by participants, particularly these were related to a loss of energy, a loss of motivation, a loss of ability. The following quotes illustrate how depression can be experienced in the body:

Everything just slowed right down, slowed right right right down, where my concentration was completely gone. I had absolutely no energy what so ever. I slept for 5 weeks (41).

I'm sleeping but I'm sort of sleeping at 2, 3 o'clock in the morning and then sleeping till 10, 11 in the morning sort of thing (29). ...not sleeping, only sleeping for a couple of hours (31); Insomnia (34).
I'm so tired. I noticed that I suffer from a loss of appetite, I know that that's associated with depression. Sometimes I go and eat because I'm doing something for the kids and I'm not actually hungry, before I was hungry and I wanted something to eat. Anxious (36).

Restless (41).

Couldn't be bothered doing anything, couldn't be bothered getting out of bed, just totally lethargic, moody, irritable (34); just like dragging yourself through the day (25). Lethargic, a behavioural change (41); acting out of character (31).

Not able to function in a normal context (30); (40); inability to cope with anything. I mean even the good things people who are depressed can't cope with them (48). Not being able to plan my days, not being able to get out of bed, not being able to want to get out of bed even, it's about getting really isolated and sad and suicidal ideation, thinking about it, not knowing I wouldn't but thinking how it would be a lot easier if I wasn't here (40); (36).

Harder to take care of myself (24). I don't do anything. I just sit there, lie there actually all day. I've just come out of quite a bad one actually. The last couple of days I didn't shower for three days and that's not me (29).

Crying all the time, just feeling like you can't cope. Suicidal where I've had to ring people (44). Crying all the time, didn't even know why the hell I was crying... (31); (24); (34); (54). I suppose I was just sad, crying most of the time. I quit school, felt even more worse (18).

Probably irrational, probably slow to comprehend, slow to respond, in a daze (34). I couldn't think or anything (37).

Unable to effectively communicate. It's frustrating, and I get depressed, get emotional and upset and act out which I hate doing. Immediately regret it (29). You're incapable of dealing with the emotion yourself, so you have to resort to something to blot it out (39).

**HINENGARO**

Depression was seen to affect people's thinking, their perspective, typically trending towards negativity. Feelings also tended to be mainly negative. The following quotes illustrate the range of severity of these experiences:

- Always putting things down and having an attitude problem... Just doesn't know how to talk about things without depressing herself (31). Always got a gloomy answer; can't see the sunshine... Sees no light, sees no sunshine; no hope at all; miserable (33); (31). Feeling down all the time (40).

I'd wake up in the morning, say early 5 o'clock, and then I'd have this feeling come over me like oh god, another day, what am I going to do today? I don't want to do anything today and if the weather's bad, I'll say what an awful day. And there's nothing nice about anything. Where do I want to go? What do I do? Who should I ring up? Where will I go? I don't want to ring anyone up. I don't want to go anywhere. I just want to disappear under my bed clothes. I don't even want to go to sleep. That's not pleasant... That's depression (57).

Deep sadness that would be very hard to overcome without any support... not happy (30); (42).
My depression is pissed off (37). I'm frustrated (31). The grumps and the mood swings (36); (42). ...for ever really angry (52). Fatigue, and lethargic, not wanting to deal with anything, or anyone in general really. Just wanting to be on my own. Before that I'd be angry, really angry, and then really depressed and hopeless and in despair and stress (23).

I was going a big loony (32); you think you're going to go nutty or something if you don't get out of a particular situation (61).

Not feeling good about yourself (29). I've felt alone, hopeless, helpless (42). I feel like I haven't a future (52).

I did have a rock bottom (28). Right down... Sunken more or less right down in the gutter (31). I just thought nothing was worth living for ha ha ha ha... I really didn't think there were any answers to my life and where I was heading at that time so well the best thing is chuck yourself over the bridge girl – true... at that stage I didn't feel depressed. I was quite happy, but I knew that the life that I was leading was not going to take me anywhere (33).

It felt like hell (40); a big black cloud (41); Shit! Going to hell and not coming back... Just not wanting to be in reality, in the world of reality. You don't want to be here (35). ...because you live in a black hole, when you're in depression (44). I can feel this feeling like death around (60).

**Self Destruction**

These negative thoughts and feelings sometimes manifested in self-destructive behaviour, ranging from poor selfcare to deliberate self-mutilation and attempted suicide. Sometimes the destructive behaviour is targeted at others. These experiences are illustrated by the following extracts:

When you dislike yourself, what do you do, you destroy yourself. Smoking is part of that... I couldn't really do too much to destroy myself 'cos I've got too many other people to think of... not suicidal, but smoking is suicide in the long run isn't it... premeditated suicide... you hurt yourself by cigarette smoking or drinking a lot or walking down a bad alley by yourself, putting yourself at risk (29).

My appetite hasn't been very good no. I've been eating terribly. Not really loss of appetite, just eating all the wrong food that I know is no good for me and then I won't eat at all. I won't eat for a day and then I'll eat horrible food again and then I'll stop again sort of thing so it's not really good for me (29).

Drugs you know they take it out on drugs, crime... lashing out, so that they can get some form of help, so it's imposed on them rather than having to ask for it. And oh yeah, I have to go and do an anger management thing now (31).

I was wasted for 3 days (w21). Heavy drug use, heavy alcohol use... I medicated myself, really (w36). To calm me down I used to drink a lot. I could go through a bottle of rum in one night (w52).

I got into drinking... I gave up on myself and life and I didn't care about anything anymore. I went out and got drunk quite a bit for a couple of months there and one night was the start of all my troubles: 3 litres of red wine and $100 forgery note that was given to me, ended up getting me into a lot of trouble... I didn't care about getting caught (29).
The only place that I'm still doing it to myself is that I do the cigarettes. I do it with food and I do it with sex... that's part of that addictive cycle... I see it as a way of nurturing and it's looking at what else I can do for myself that nature's myself in a healthy way (52). ...it feels like smoking is filling out a kind of a barrier for my safety around other people (40).

Smoking again came in a lot (36); (16); (29). I was just smoking because it was there. I knew physically it wasn't helping me. I knew the facts, but you just don't give a toss about the facts when you're in that state of mind. You either turn infantile or you can't think straight (22).

I was taking it out on my nine-year-old....why don't you just f... up (31). My patience... at nothing, you know the kids do the littlest thing and I lose it (24).

Wanting to slash their wrists or physically forcing somebody to listen to what they need to say (29).

I was like a time bomb. If anybody, if any man got in my way I would use anything to hit them I think, so it took me into prison. I beat up a man really badly (52).

Suicidal thoughts (41); (28).

A couple of times I cut myself, and I remember it was to get bail, to get out of custody. Another time I drank a bottle of vodka and sliced my wrists, but I wasn't trying to kill myself. 'Cos next morning I woke up and sobered up and went straight to the hospital and got myself sewn up (41).

Suicidal at one point, at just one particular time. Attempted (30); (31). I hit rock bottom and I needed to escape from all the stress and I was looking to blame somebody. [suicidal?] I did attempt it. I took a whole lot of pills all at the same time, but it didn't work (19); (16).

Whanau

Relationships with whanau are affected, initially through the withdrawal of the person with depression and their diminishing capacity to function. Their relationships suffer further if the depression is 'acted out' in a destructive way.

Withdrawal (41); (40); (42); (38). Mine was needing to be totally alone... I'd had enough of people (49). I wouldn't talk to anybody. I completely blocked myself out (16).

It's a state of mind where you feel very alone and can't trust people... [sister interjects: rejection of your whanau] with being unable to trust people your whanau and unsupportive and very unstable not very clear thinking (26).

I'm a prick and a jerk (41). I took my hate out on the world... angry very much, yeah I just hated the world, just didn't want anybody in my life (32). ...blew cool (54).

Wairua

Feeling as if I had lost total touch with myself... being an empty shell... just some how losing touch with my wairua, losing touch with my whatumanawa, my emotions, losing touch with those... like I was living in a dark hole somewhere... for me it wasn't so much that they were gone. I had some how just lost the connection... but certainly it felt like I was in this bloody dark hole (42).
AETIOLOGY OF DEPRESSION

Forty two percent (42%) of participants made descriptive comments revealing their beliefs about the aetiology of depression. Depression was seen to result from endogenous states or in reaction to two sorts of external stressors: direct experience of abuse and stressful life events. Example statements for each of these types of stressors are presented below.

ENDOGENOUS STRESSORS

Physical illness, infertily and drug abuse were endogenous states that some participants believed led to the development of their depression. Pre-existing psychological states, such as low self-esteem or an identity crisis were also possible contributors to the development of depression.

I got sick. I had hypothyroidism... most of the women in my family have had it (41).
...sick with bronchitis (26).
I put it down to I've got something in my system. And it's making me angry (57).
It had to do with periods at the time, you know how you... get PMS, pre-menstrual tension (36).
After I had baby I had post-natal (26).
Lack of having more children. Not having more children. That's a very big part of it... To see him growing up like an only child makes me sad (30).
Heavy drug use, heavy alcohol use (36). I was also an alcoholic and a drug addict as well... the abusing of alcohol and drugs just brought my life to a point where my life became unmanageable (28).
I smoked marijuana for 26 years... I used to smoke more dope than cigarettes. I gave up alcohol for 10 years and substituted it with marijuana. I drank and I smoked for 18 years. Then I gave up drinking, then hard out smoking... that was stress related and my depression... the depression I'd say came with the drinking, when I first started drinking... I don't feel depression now. I used to when I was drugging and drinking... with the marijuana it was from sitting around fantasising and feeling sorry for myself and having stupid ideas floating around in my head (41).
The marijuana depression in people, the alcohol depression in people that really quickly enhances the depression (26).
When I gave up smoking was the only time and I really became depressed (34).
Before I had any awareness of who I was (52). Was to do with faith and religion and all that sort of thing. Just questioning everything? Yeah in general... crisis of identity (44).
Low self esteem (34). Feels like I've been in this vulnerable place for a long time (40).
...and poor role modelling standards in my family as well (36).

EXTERNAL STRESSORS - VIOLATIONS

Violations of all sorts, including physical, sexual, emotional and financial abuse, were cited as causes of depression. Participants had experienced a wide range of forms of
abuse, from sexual abuse as a child, rape as young women, to violence from a spouse. One woman had experienced workplace bullying. Put downs and deliberate isolation by whanau were mentioned by others. Colonisation, as a specific form of abuse, was also mentioned by a few more politically educated participants.

In some shape or form violations – abuse… violation on violation on violation (42).
Life's been full of shit and I'm depressed about it (29).

**Physical Abuse**

When released from hospital on own had no support; don't have a trade no more, not working. - money factor (41 [brain injured in violent attack]).

My father was really really violent… Then I married my children's father he was really a violent man (52).

Boyfriend … he lost his job before Christmas and he started to take it out on me, but before that because of a lot of alcohol in our relationship we fought a lot, and he was a heavy smoker and also if he didn't have tobacco he'd spin out at me… and then Thursday he just got really abusive to me and I said that's it I'm going to ring the police and he come running after me and said I'm going to kill you, I'm going to kill you, so I rung the police got him out. Friday he came back threatened to kill me. I went to the police station made out a report. Saturday he tracked me down here, tried to kill me… so I live in fear (33).

**Sexual Abuse**

I had an uncle live with us who used to sexually abuse me until I went away to boarding school… At 18 I was raped… I went through a court case that had… a devastating effect on me because nobody believed me, not the policeman, nobody… what really pissed me off was that wasn't my destiny (52).

I lived in that black hole since I was 16 years old… that was connected to my sexual abuse … the grieving of losing, I’ve never ever been a child. I’ve been an adult since I was 5 years old… and it was the death of my mother (44).

My son was drugging… The guy that I was staying with molested my son… affecting his school… didn't want to go to school, school sucked. I was looking at my kids, they were going down and I was going down. And I didn't want them to go down (31).

**Emotional Abuse**

I was bought up in a family where my mother and father never married. I'm now 52. Today that's a norm but it was not a norm then, so we were seen as bastards by both sides of the family (52).

Being put down a lot (36).

I did not feel good about myself because I was told that (20).

Other whanau, they offload all their shit onto one member of a family. You know? And what happened is … everybody thinks she's useless, not worth nothing, all that stuff …
Because everybody had told her for years and years and years she's useless, bloody useless, f-ing useless, not much good (60).

I had a really bad relationship... it was pretty abusive (18).

He's a heavy drinker swearing at us (24).

I was married for 10 years and he never hit me, but I put it down to mental abuse because, in the end he drove me insane and I started beating him up. I beat up my husband. I didn't like myself for it, so I told him to move out... when I separated from him, yeah he followed my life around, hit on a lot of my girlfriends, you know, he turns up here and thinks he owns the place... (29).

My kids and their father were running me down a lot swearing a lot at me, not hitting. I was trying to do my best for all of us but it just wasn't good enough... I was just getting it from everywhere (37).

And my kids, I've got a lot of things on my plate. We are fundraising for my husband's unveiling and his family cut us off... it makes me sick they run me down, they don't give a stuff about my kids... (31).

It was triggered from work. When I first started it was fine but then they changed me on to another shift and the shift they changed me onto wasn't a very good shift, and they just basically started picking on me from the time I walked in the door 'til the time you're out, yeah 12 hours of continually picking... The whole lot of them were bullies, 3 of them were bullies, supervisor was the worst (34).

Financial Abuse

He had Alzheimer's and in that year I lost all our home, lost everything, ... he just changed things all around everywhere and I just had everything go and I was left with $2000 worth of debts (52).

I received that court paternity order... The DNA testing all the way, the results came back, I was the biological father, and then the Inland Revenue stepped in (32).

Isolation

Isolation and alienation from whanau (42). Isolation... doing it purposefully and also the other way, it happening (36).

Nobody's listening to me (37). No one listens to me at all and no one understands me (43).

...at my husbands legs and said there's something wrong with me and started to cry, go to the gym that was his only saying, didn't even pat me on the back or whatever... cold man (54).

I don't have much family close (23). Lack of communication with family and friends (31). No support (34). Being stuck by yourself in the house all the time (28). ...suffered a state of loneliness (44).

Used

Whanau expectations of you – pressure... uncle has high expectations. I cop it (54).
Got two more kids dropped on me (36)

Woman's role, unfair workload (54).

...oh, manipulation mainly (51).

**Colonisation**

The content, time and something called decolonisation that kicked off a whole lot of stuff... definitely sadness... about what's happened to Maori... the stories people told I found that incredibly hard not to take it on (40).

I hate society what it does to Maori people. I hate it when they put 90% Maori blame (44).

They put me in a psych unit. Shock treatment me so I could forget ... that's an abuse what Pakeha do to us... I put it on the governing of psychiatrists because they don't know nothing about Maori spiritual path (44).

**EXTERNAL STRESSORS – STRESSFUL LIFE EVENTS**

Many other stressful things that happen in people's lives were cited as contributing to depression, for example, people dying or being killed:

Mum had gone, dad was gone ... and nobody was kind, poor old sad [her name]. I can laugh now but it wasn't funny (39). When my dad was dying no one knew quite what to do with me. It went beyond grief (34).

My dad died of cancer and he told all of us in August. My sister took off to Christchurch and she didn't want to come back and he was waiting for her to come back (22).

I never got over my mother's death (44).

I had 9 babies. Two of them lived, one was stillborn, the rest were miscarriages (52). It had everything to do with my pregnancies, because my miscarriage, I carried over 28 weeks and then I lost the baby (19).

When child died, the one with meningitis - 4 months old (29).

I lost a sister this year, not long ago... in a head on. And I lost my dad, she was coming up for his unveiling ... His was cancer, he died of cancer (38).

Husband's death... for a few years I knew, from the time I met him I knew that he was gonna die, because he didn't want to do nothing to cure it... I started going to church, but the people at church get on top of you so I gave up (31).

I married a man who went … and got killed (52).

Depression was also seen to result from unresolved hurts or guilt left to simmer over years, or similarly, having a constant stream of worries:

Hurts - unresolved hurts (42). Emotional resentment over the years (39). Used to be a lot of self-pity (41).

At the bottom of all of it, she got pregnant when she was 15 and she adopted her baby out. Nobody knew about it (60).
All the guilt stuff going on and the rest of the family don't have a clue... and some of it's been going on for years. They don't understand all the feelings that they're going through (26).

Having a constant problem all the time (31). ...there were a lot of stressful things (31). Worrying about this, that and everything (51). A lot of things in my mind (52). Running a household, 3 kids, no money, all that stuff (28).

Business related, my bottom line figure isn't looking too healthy (41). Burnout from work (40). Work was, it bred depression (43).

Always on the go and I think that's what burnt me out (36).

Relationship problems and break-ups, and whanau problems were seen to trigger or add to the development of depression:

My mother and father parted ... He was an alcoholic (52).

Problems with my marriage... Domestic problems, between myself and my partner, stress... gets me down (36). Marital problems. I'm not married in the eyes of the law but I've been with my partner many years and we have a child. Bad marital problems (32).

I broke up with my second wife... Whanau things at same time (36).

Stressful circumstances e.g. unveiling, whanau (53).

Whanau, hapu, land, marae issues leads to friction between whanau members (54).

Then the father to the three little ones, he's going I want to see the kids ... he was on drugs... I had three little ones and it was the holidays, having them screaming around you as well (31).

My son had his van repossessed. I had to go to Australia and get my other son, he was ready to kill somebody because his wife was having an affair and now he's back in Auckland, in N.Z. and he's drinking a lot and I'm worrying about the grandchildren over in Australia (52).

Major life changes, such as stopping work or moving to a new area were mentioned by a few participants. Two participants cited imprisonment as a factor in the development of depression for them:

I've always had my own money. Yeah came back to money. I left this job was they demoted me for somebody that was, this is early years, and I had these bills and I didn't know how to pay these bills, that's what happened for me (54).

Giving up work, change of life style all at once (57).

It was moving up here and missing Auckland. I think it was settling in to a new environment and another thing too I ended up getting my liver checked out and that had a lot to do with it too (25).

It took me into prison (52). I got thrown into the jail cell ... that's just a normal downer in somebody's life that's all and what that did, was increase stress I suppose (29).
TREATMENT

Thirty one and a half percent (31.5%) of participants mentioned some form of treatment they had received or that they thought people needed. The following quotes show that treatment forms ranged from self diagnosis and self-help, getting support from whanau, to use of primary and mental health care services.

I diagnosed myself, thinking oh gosh this is part of the PMS and then I started taking evening primrose and stuff like that (36); (57).

I decided I was going to take the next 6 months off (43).

Gave myself some time to lick my wounds... I know one thing for sure, I'll never waste my life over a relationship. I probably have a real arrogant attitude sometimes, I pretty much won't allow myself to buckle down to a lot of things. I won't allow myself to sort of break down and cry. It's not in me, I pretty much teach myself how to be stone cold you know, to myself... I don't not recognise my problem but I try not to make a mountain out of a mole hill, although some people might say oh poor bugger, I don't want people's pity or the fact that it is a problem, I just suffocate it, suffer big, get it out of my face and then go on again. I can't afford to. I don't believe you should dwell on things too long (36).

I've always been a person who doesn't let anything affect me seriously. I don't let anything get me down (42).

I'm always busy with work and busy at home (48).

I have the tools now not to stay there (52).

Just read or I'd write (49).

Pehanga - 2am time when there was peace in the home, time to karakia, to have hahi. 2 'til dawn, pao, waiata; your mahunga is alert... Able to share with husband and speak back... I'm able to act which stops me from becoming depressed (54).

The family just aroha just helped me through (44). Just talked to family (23). My whole whanau came and helped me, so you know, some really positive changes kind of started to happen, that's why I was able to stop (21). My mother picked me up with that one just by her comfort and having that support there for me (26). Mum was there for me. Sometimes she'd be here 'til 12 o'clock at night just hard out talking (31). I've like, pulled myself out of that through friends and cousins (29). Having my family up here too it's strengthened me (44).

I suppose I met a person (52).

When I left the children's father things became different. I went into lots of religions. I used to go in and out of religions but they weren't the right things, and I went into what they call the Bahai faith and that allowed me to be Maori and it also allowed me to go and look at the issues... End up learning about myself (52). So I did a lot of work (42). I'm sort of looking at myself more (44). [Suicidal?] at times I did feel that way, I'm just too scared to leave my kids, that's what snapped me out of it... I started going to church... soul searching (23); (31).

People need someone to talk to about why they're feeling down and different reasons why they're feeling down... sit down and talk to them and let them get quite angry (26). It was a matter of just sitting quietly with her and finding out what's going on (60).

I went into peer counselling as well and that helped put some things into perspective plus I talked a lot with [work colleagues] and my family too and most recently did, moved some major stuff for me personally with my Mum (40).
A and D programme only last year, residential... fortunately no medication (39). A support house for addicts and alcoholics... I just needed help to sort of like get myself off it and get myself back on track again (28). I was getting counselling for D and A (31).

15 years under counselling and I’m still under counselling for sexual abuse (44).

Medical team at the hospital and found that I definitely had hypothyroidism (41).

Doctor started talking about Prozac but I pulled myself out of there real quick (40). I did go to the doctors and they stuck me on something (20). I was put on Prozac (36); (33); I was prescribed Aropax and Prozac... and I see a psychiatrist every now and then... I have a therapist who I see every week (19). Going to a counsellor, medication (36); (29). I wasn't sleeping so they gave me sleeping pills (31). I went on St. Johns Wort ‘cos I don’t like taking drugs, so I asked them if they could give me a herbal remedy for it (34). I was taken off Prozac, I didn’t like the stuff... weaned myself off, went to mental health... someone there and they put me on Aropax (26). I was put in hospital... [medication?] A drip (16). I had to go through counselling. I had to go and see a doctor... they tried to get me into Manaaki House (32).

I ended in hospital... saw a psychiatrist, he said something to me, I said to him I think I am crazy that’s how I see it. He said you’re not. He made me believe in myself. Next thing I just snapped out of it (37). I was put into Carrington Hospital (52). You get a psychiatrist in the hospital like Tokaanui for a start and you’ll get most of them saying you’re a schizophrenic but it’s not... they put me in a psych unit. Shock treatment me so I could forget (44).

**THEORY**

A small number (10) of participants entered into a more detailed discussion of depression.

Depression for me is when all your systems your wairua, your tinana, your hinengaro, it’s all just unbalanced (36).

I suppose when we talk about tino rangatiratanga, I start with me, and depression I’m saying is not one of them (52).

As far as I’m concerned Maori people had the most horrible depression you can ever had, worse than Pakehas...like a lot of things it’s to do with your tipuna. Like I communicate with my mum, she’s been dead 31 years now, we just had her 31st anniversary and you know all my life since she’s been dead, I was 11 years old when she died, I have been communicating with her since and they put me in a psych unit - (44).

With Maori, depression happens at a later more critical stage as opposed to non-Maori. The crisis it’s been there for a long time... I think because they always feel they have to cope... I think it's more about maintaining their mana within them and that they don't need help and that they can handle anything sort of thing rather than reaching out... deal to it themselves, especially when it's not a sort of physical misfortune or bad thing that's happened to them like a disability... until there's a crisis... they take it out on drugs, crime... violence, you know, lashing out, so that they can get some form of help... Too proud (31).

If the first issue is not resolved and then the two issues worsens the depression and then to have a third and fourth one, if they haven't actually gained the ability to work through number one how on earth are they going to work through number three and four? ...the Beck, the symptoms are there because they're symptoms... a lot of them are
the same. It doesn't cover the spiritual aspect - their whole ihi, wehi, mana; their mana disempowered... When we're looking at our history and we're looking at our Maori families and depression, because we have been for generations now Maori, me being one of them, who have been separated for various reasons in that right from our tupuna, so looking at it like that we've actually all been in a depressed state for generations (42).

One participant proposed a model depicting the progressive deepening states of depression, which she experienced as receding from the forehead back to the base of the skull. As she said:

If it keeps going it gets more and more severe. Suicidal tendencies, right at the end. I see it like that... I actually believe that our people know about these things and this was one of the things they talked about in te whare wananga. It was all about you, to maintain your state of mind and your body to keep it all in balance with one another. They discussed it that night, I think that te kawae runga is the, they said it was the upper jaw bone, I believe that it's your mind and the different states that you can take yourself into and the lower jaw bone would be the reality... the common world, and in the writings of Percy Smith he calls it esoterical and the lower jaw bone he talks about it being terrestrial. I think that our people knew of safety measures of not getting to such a bad extent and they had all these different practises, but we've lost a lot of that, the practises are about keeping good health (26).

I come into contact with so many types of depression, like depression of the acute psychotic person who's depressed, and then there's the people that many years ago were sexually abused and all of a sudden it's just come back to them and really haunting them and they're feeling really suicidal because of it; and then there's people that something happens one day and they're not feeling that good, they're just feeling down. I don't know they're all different (26).

It sort of comes in cycles (44).
INTRODUCTION
This appendix presents the results of the qualitative data collected from the 26 NMSCP participants about their experience on the programme. They were encouraged to comment on the most helpful and least helpful components of the programme and ways that the programme could be improved. Feedback on the particular activities each of the programmes included, was largely reliant upon participant recall rather than their being systematically questioned about each activity.

SECTION ONE: QUALITATIVE DATA RESULTS
The following section presents participants’ feedback on the NMSCP. The majority of participants commented positively about the programme, regardless of whether they eventually returned to smoking or not. For those who did return to smoking, most of them did not attribute their relapse to any failure of the programme.

THE PREPARATION SESSIONS
Three of the participants did not attend any of the preparation sessions and another two only attended one. One participant said there were a lot of people who only came to one session rather than attending the three or four that were offered.

THE FOOD
The food was the most salient topic for feedback. Twelve participants had some complaint about the food ranging from: "disgusting I hated it" (124; 3; 120; 28), "I thought the diet was ghastly" (24) to "the peanuts and things went a bit overboard" (2; 5; 6). Four people thought they became ill because of the food, for example, one woman said she "got sick from too many raw veges" (124). She may have been referring to the "diarrhoea" (25) and "wind" (1), which a few people suffered from, as one participant said "the food gave me the runs for about two or three days" (28). Another developed cramps possibly from the decrease in salt in her diet (1); she also said, "I don't know if it was the detoxing of the food or if it was the cigarettes, but I lost my energy" (1). Despite these complaints, nearly all the participants accepted the diet and attributed their success partly to the diet. Typical comments were:

... it was there for a reason and I accepted that... I just worked it out for myself. It was a complete change from the usual things. Whereas I sit around and have a cup of tea at home here, the first thing I had was a smoke. There was no cup of tea there or coffee. You know, the usual things that you eat with your breakfast, lunch and dinner wasn't
there. So therefore, I reasoned that they were breaking the association and I think that worked (24).

That wasn't any use to me that kind of food. I sort of ate more... it was very interesting. If you have food like that I really notice you can't think of any thing else. You can't even think about smoking. All you're thinking about is food. I found that really quite helpful (126).

I hated it but I think it worked, it really did. It took our minds off every cigarette you ever wanted (124; 124b).

Detox awesome, really helped. I reckon it really helped me, cause it took my mind off the smoking (114).

Whilst several participants thought the diet helped them by distracting them from the withdrawal symptoms (114; 24; 2; 126; 129; 124; 124b; 127; 120) one participant explained that for her "it wasn't so much that it diverted people's thinking away from smoking, which I saw as a valuable part of it, was it just heightened people's awareness of themselves and their own bodies in another way, so I saw that that was really valuable" (4). This perspective was backed up by another participant who said "one of the biggest benefits of doing that programme was the food, it made you think about what you're putting into your body" (129).

Four of the participants were of the opinion that the diet "wasn't bad. It cleans you out that's the good thing" (127; 6; 111; 28). The detoxification process was not explained at one of the hui about which one person said, "that's what actually blew me away was these people couldn't understand, that were moaning about the diet" (5). She explained, "for our old people, that knowledge of cleaning yourself out before healing begins is really well-known... I think a fast is not a problem, because that comes back to establishing that mauri; you're here, you're here to give up smoking and part of that you have to cleanse your body to speed that process up." If this was explained she believed people would have complained less about the food because she said, "I think once people understand, they endure." She may have been right as indicated by the comments of one participant who said, "I didn't expect my body to go through hell" and "without that preparation you get stuff like what happened to me" (3). This participant did not understand why "we have to detox our bodies to give up smoking" and questions to that effect went unanswered. It wasn't unimaginable to this participant that certain items "like the meat" or "tea and coffee" might be taken out of the diet, but it was unfathomable that there was "no variety" and "no spices, there was no herbs, there was nothing to give any of the food a taste." When "food and emotions... are so closely linked it's not funny," A few other participants also commented on how unnecessarily tasteless and unimaginative the food was (120; 114). A further problem that went with "the really bad food" was "the attitudes that came with that" (3). Whilst people complained about others moaning about the food, those moaning about the food did not appreciate being told to "pretend it's like MacDonald's, just pretend it's like a big fat juicy steak" (3).

Eleven participants enjoyed the food, they said, "I really appreciated the food... but then I like that sort of food anyway" (4; 2; 111; 127; 25; 26; 125; 6); "the food was excellent... I think that was a real clincher" (5). Three participants eat that way at home. For instance, one participant said she was "a vegetarian so..." (25) and another said, "I didn't see any difference in it because at home we eat salads all the time, so it
didn't really shock me" (125). Three participants actually thought the diet could have been stricter, for example, one participant said, "it was a good cleansing. Could of been a lot more to it, but I'm not a dietician" (6); "you've got to be staunch... I think we cheated. We had those rice waffles things... I think if you're going to do it you have to do it properly" (114). Another participant thought "you could just bring it back to traditional kai, and that would just be fowl and kai moana and water. So you omit all the starches... I actually think we could have gone on a more stringent fast" (5).

In some cases the diet on the Noho Marae led to more permanent changes, for example, "I now don't have much salt. I think I felt if there was no salt it was rotten, it was awful but now I just accept it.... there were a lot of lifestyle changes in there even looking at diet stuff, I never would of looked at that" (2). Another participant said "I learned how to cook some really neat things" (26) and another said "I try and do that now" (124b).

The participant who developed cramps associated with a medical condition admitted that "I didn't go to the preparation programme. Maybe I would have learned there that it was going to be salt free" then she would have been sure to take the necessary medication with her (1).

**PHYSICAL ACTIVITY**

Those that did go for walks enjoyed it (129; 27; 124; 124b; 23; 29; 25; 6). A few participants thought they did not go on enough walks (23; 6). One was especially astounded that:

...there was very little use of our environment... in fact that was quite infuriating, to be in the middle of the bush like that and not use it... here we are espousing Papatuanuku and all this stuff and being healthy and pure and here's all this stuff around us. The most that the actual organisers incorporated in that was a quick trip down to the creek to get stones. I thought that was an absolute crime (5).

Another's attitude was: "the bush was there, if you went for a walk, you went for a walk" (24). One participant did not appreciate being told to go for walk, for example, "when free time was over it was walk time" (3).

Twelve participants "appreciated" and "enjoyed" the Tai Chi and going to the gym as part of the programme (114; 4; 2; 5; 126; 124; 122; 111; 23; 120; 29; 26; 125). It became a regular new habit for five of them. However, not everyone could take part in the physical activities because of other health problems and the gym require Doctor's approval in some cases. Neither will everyone like every activity on offer, for example, one participant couldn't quite get in to the Tai Chi but really liked the Haka Hula (114). Hence the need for alternatives as suggested by a few participants, for example, one older woman said, "there were a lot of exercise ones but I think there should be a lot of women's handcrafts... for those that are limited like me" (111). One participant who could not take part in the physical activities said she "really enjoyed" watching people having fun and playing sport (1). Another participant did go for walks but found she was "huffing and puffing." She did however make walking a new regular behaviour (114).
Ten participants did it, for example, they said, "I went to ten pin" before I enjoyed that" (114; 115).

WORKSHOPS

Ritual Farewell to Cigarettes

Two of the programmes had a ritual burning of participants' cigarettes and the other two programmes had a ritual burial of the cigarettes and planting of a tree. Thirteen of the participants commented on this ritual. Two participants said they missed out on it. Nine participants found the ritual moving, useful or just "all right". Typical comments were:

That was a good start (111; 23; 29).
I think the tree, when he did that tree, that was awesome and all the speeches... I enjoyed the speeches (114).
That was all right... I think we were all a bit self-conscious perhaps (5).
I found that very emotional... there was a lot of stuff in that ritual for me (1).
That was like a turnaround point. You knew that you there for a week and that you weren't going to get any more smokes (29).

It sort of symbolised that if you bury the smokes you can bury the habit (127).

One participant "actually quite liked seeing everybody participating in that ritual, but I don't think it assisted me in anyway... I found that frustrating, the burning of the cigarettes did nothing for me" (24). For the participant who perhaps was getting the most out of the burning ritual, she started to feel angry because she thought others "were laughing away at it... playing with it" (1). It did not help her that she saw others being flippant. Two participants "didn't think much of" it because "someone chucked an empty packet in and I didn't have any to put in" (124; 124b). One woman said "I made sure to smoke my last smoke before so I wasn't going to bury my smokes" (122).

The Mission Statement

Four participants commented positively about the mission statements they were required to write. Whilst they enjoyed it and thought it was good, one participant "wasn't quite sure... what it all meant and how it would be used as an ongoing thing" (4). Another thought that the "mission statement occupied maybe too much of the time" (5) and one "felt like there was pressure on... to get it done" (6).

The Sharing Sessions

Five participants thought the "group discussions were good" (127; 111; 29; 28) "because then you realised you were not the only one having those same withdrawal symptoms and everyone's feeling the same. You don't have to feel guilty about it"
One participant thought there "could have been more" sharing sessions (4). Three participants thought the sharing that went on "amongst ourselves, the ones who were giving up smoking" (25) was good also. For one person this was better than the sharing with the facilitator's because "I don't think they heard us" (25). One more participant said "I wasn't listened to that's what made me so angry" (3). This participant acknowledged that the facilitator's "kept making offers to anyone that may have been struggling" and needed one on one counselling but for her they had not established their ability in that area, as she said, "even if I did put it on the table, what were they going to do?"

Of those who liked the group process, one participant still found it "brought up my impatience, my tolerance, it brought up control issues that I had... to control the whole group, just hurry up. Don't take all day to bloody do it" (1). "It was like a AA meeting and got to me" (3) said another. One woman thought "there was a lot of reliance on sayings, sayings from out of books" (5). Another "found it very difficult talking about how I was feeling" (27) and another participant commented that the sharing sessions "can get a bit intense" (6).

Only one participant thought the sharing sessions "were a total waste of time" (24). Several of the activities were not his type of thing, as he said "it just wasn't for me." He "found it very feministic, geared towards militant women... and they wanted to pray about twenty times a day, that sort of thing really did get on my nerves... they'd sing those dry songs, awful songs, where they sing the same six words a million times." He also thought that it wasn't the right time for "some of that deep, deep, deep thinking stuff... first couple of days you're stressed out, giving up smoking, trying to have to think about all that, what I term, rubbish."

**Own Process**

Because some participants did not like particular activities they were asked about their preferential process for self-change. Eight of the participants actually thought their preferred process was a more personal or physical one, as they said:

I preferred to be left on my own and sleep. I hate people gabbering in my ear... I would just rather lay down and leave me alone, reading a book. Yeah reading and writing (1).

... not the sort of person - mingling type person (114).

...never really been a group person... I get hoha with people. It all seems so fake in a group. I never seem to bond with strangers, they weren't my kind of people (115).

I actually go the other extreme and revert into myself if I'm going through a hard time... mine is more withdrawing inside (5).

I'm not very good at group work. It didn't work for me and I know that. I'm a really good team player if we've got a project to work on, but when you're talking about our personal stuff, I have to do the groupie thing, hell no... I'd rather do things on my own... I know that I'm very physical (3).

Two participants were uncomfortable with the intensity of the group sessions. They said: "I don't mind sitting around talking, it was the depth of that, the intimate sharing... no I'm not into that. I close off" (2); and "I really didn't know what this was about... it was a bit intense and not easy to let your emotions go" (6).
Journal Writing

Six of the participants commented positively about the journal writing. As they said, "that was good" (124; 127); "I enjoyed writing the poems and things. I enjoyed sitting down and doing some artistry work in terms of journaling" (1). "I thought it was valuable, but there was a lack of explaining about how people could use it" (4). Three of the participants that returned to smoking confirmed that they "didn't keep that one up when I came back" (122); "it's once we walked out of here this is where the challenge is, it's going home" (111); and "I wanted to keep notes to remind myself what went on there and I did put in there all suggestions, but I can't think of what they are now" (124).

The Education Sessions

Four of the participants talked positively about the insight they gained into the addictiveness of nicotine, as one said, "learning about where the cravings come from... that was a lot of education there" (126) and the chemicals in cigarettes, for example, "what I remember most about that course is about the chemicals. I always think about that when I pick up a cigarette" (25; 125). "I didn't know how much stuff, poison was in that smoke. I knew it wasn't good for us. I knew like it had tar but I didn't know it had all these other chemicals" (126).

Whilst one participant thought "all the speakers were neat" (114) some participants liked some speakers better than others depending on their own interests. Two participants particularly enjoyed one guest speaker who talked about self-esteem, "she involved each one of us and she wasn't like a teacher. She came down and she spoke to us, she made us laugh and she made us join in" (122; 111). Two participants would like to have seen other people brought in, for instance, "our own kuia who could've taken them through the tikanga" (5) or "you need other skills you need to learn about yourself" (6), for example, "learning how to communicate" (115). One participant commented that the hui did teach her new ways of dealing with stress (126).

All of the programmes gave participants an opportunity to hear from previous programme participants about the withdrawal experience and staying smokefree. One participant said "they were good. That was really good of them to come over" (5).

In terms of improvements to the programme, one participant missed out on some of the sessions because she fell asleep. Four participants said some of the seminars "were tino hoha" (27) "totally boring" (124; 124b; 122). They qualified their comments, however by explaining "but again it was part of that structure... some things I learned" (27); "it was just because I think they were at the wrong time because at that time we were at the hardest day and to have something like that put on you, I think they could have started off with a bit of activity" (124). Another said "my head wasn't in it, wasn't focused" (120). Two participants suggested that some of the more intellectually demanding education sessions should be moved to the latter days of the programme, but the information on nutrition and health checks would be good to have at the beginning (126; 124).
**Mirimiri**

One of the programmes had a guest mirimiri woman come in to do reflexology and one of the other programmes ran a workshop facilitating participants giving massage to each other, which included one participant who could do Reiki. Four people commented positively about the massage sessions. For one person it "was a turning point and something happened... from that moment on I said to myself, I don't really want to smoke... From a Maori perspective it's that spiritual healing stuff" (2).

Two participants were positive about the massage session but had concerns also: "sometimes you've got to be careful because you're invading a person's space, they don't say what they're going to do... sometimes people aren't always as open, they might look open but they're not" (6). Unfortunately, the guest mirimiri woman "upset one of the men... She told him you're going back to smoking there and then and he was really upset about that" (124), "that probably was the biggest booboo that went on in that hui" (124b). The particular man this happened to, did go back to smoking and he confirmed that this woman's prediction undermined his quit attempt.

Not everybody received massage because as one person said "I missed out on that too. I slept a lot" (126) and "I don't think she had enough time to do everyone so there were some that just watched and waited on the side hoping to get a turn but that didn't happen" (122).

**The Celebration**

On the final night of the hui a celebration feast and awards ceremony, with invited whanau members, was held. Ten participants commented, mostly in the positive, saying "the concert was really good fun," (1; 4; 111; 6) "it was choice" (124), "excellent" (124b); "that song that we did was massive" (127). Only one participant said anything negative about the celebration and that was because they felt uncomfortable having to perform: "I hated that, being in front of everybody" (23). Two participants missed out because they "didn't stay right to the end" (24; 125). One participant who returned to smoking used the certificate to help them stay smokefree: "that certificate we got I used to have that in my bedroom but somehow it managed to come off my wall" (129).

**Whanau Involvement**

Some participants attended the hui with whanau members, for example, siblings, cousins, partners, a daughter and her mother. Some had had whanau members go on a previous programme, and one participant was attending the hui for the second time because she had gone back to smoking but also to support her mother who said, "I didn't want to go by myself" (127). Sometimes participants' whanau members came in for parts of the hui. "I had two come in but they didn't like it, because of the food" (111). One participant, however, did not tell her whanau what she was doing because she said, "I reckon you shouldn't tell anybody so you won't feel hurt so I find it's better to keep it to yourself because you're not a failure..." (126).
CRAFTS AND GAMES

Eight participants commented on the painting of kohatu, most of them positively saying "that was good" (1; 4; 23; 25; 6). Only one person did not believe in this activity because she said, "you shouldn't be painting stones, that's my theory, because stones are stones" (5). One participant thought it would have been good to do this activity earlier so that people could just go and do it when they wanted to (2). Two participants missed this activity (6), one because he had to leave early. He said he valued the one somebody picked out for him and he keeps it on his hearth as a reminder (24).

FREE TIME

Of the twelve participants who commented on whether or not there was enough free time, eight thought there was enough time (27; 122; 3; 23; 127; 125; 6) with one participant saying she had to make the time so she thought there was enough choice (5). Some participants were happy to occupy themselves, for instance, "if there wasn't anything for us to do you could do it for yourself. I went for walks if we weren't doing anything and I spent time reading, because if I'm not doing something physical I like to read. So I went to the library and got a whole pile of books" (125). Some participants left periodically to go to work or attend courses.

Four participants thought there was too much free time and not enough optional activities (4; 2; 124; 124b). The facilitators had said that "you needed time to yourself, you'd probably sleep a lot, but yet I didn't" said one woman, "I found I was floundering and that I was looking for some physical activity... and I'd become irritated because there was such a lot of free time" (2). Other participants who thought there was too much free time said "looking at it from an addictions point of view and a dependency point of view, then certainly there has to be some structure, some guidance in there... now is the time to break those patterns and establish some new ones. If smoking for a lot of us is around sitting around and doing nothing well then sitting around and not smoking with nothing to do is the same thing" (4). Two others said "once you get that free time, it started to get to you. It didn't make me want a cigarette but it made me really bored... the hardest thing was having time to yourself" (124; 124b). With regards to optional activities, one woman said: "I think they went overboard with things to do. We had plenty to do. I think we were pampered" (122).

MAORI CONTENT

Eleven participants commented on the perceived level of Maori content. One of these participants was positive, saying "from a Maori perspective it's that spiritual healing stuff, that wairua stuff that's going on... there was a presence and that's a real contradiction in Pakeha terms" (2). For her and six other participants te taha Maori and the amount of karakia was "fine" (2; 26; 27; 29; 120) "really good... wonderful" (6). One of these participants said they "didn't notice too much of it... I just started learning Maori, so right now I'd probably say give me as much as you can but, no I thought it was all right" (23). One of the other participants said he was "brought up with it. I didn't have to display it" (24). Therefore for him, the amount of prayers was
over the top. Three participants thought there was "a lack of Maori in it" (5; 28; 25).

Two participants would like to see the programme improved in terms of helping people understand what is being said in Maori and why things are done a particular way, for example, they said:

...you should explain it in English (25).

Sometimes you can feel a bit embarrassed, out of place, even though you've every right to be there because some of our Maori I don't understand and I'm not alone there's a lot of us there, makes me feel awkward... some of the things they think we understand but we don't... even some of the words I'm still picking up... it's just my upbringing didn't have it (6).

Three participants were disappointed that the hui was not held on a marae, because "if you're targeting Maori people you come to them. You don't take it away to a bloody, another little venue that's pretty... the marae is the place to have a hui like that." They thought the marae offered a number of benefits: "Everyone recognises there's a mauri that has to be adhered to"; "you also have the old people"; "you would open it up to the community" and "there's a whole different feel at a marae... it's happy, it's fun and people support each other naturally without having to get into a structured sort of group" (5).

You've got the aroha and you've got your ancestors. It's your tinana too, because your tinana really needs to be on a marae to do the cleaning, which is why it didn't work for me... if I did it on a marae, that's where it would work for me (25).

The marae would be a great place too, because we have spiritual well-being there as well (6).

**THE VENUE**

Seven of the participants were very positive about the venue: "the environment was good" (129; 28); "the environment that we had was choice" (114), "perfect" (23; 25) "beautiful" (26). One participant felt the venue factored in the success of the programme, "I think the valley had a lot to do with it as well, there was something quite spiritual... tupuna and wairua... because it was on our own whenua, you'd have to say there was tupuna there" (2); "it actually made you think a lot too. Made your head clear" (25); and "it's away from everyone. You're not influenced by those who are smoking" (28).

**FOLLOW-UP**

Participants kept in touch with each other to varying degrees, as one participant explained "you'd been off the programme and went back to our normal lives, it was harder and you'd grown apart and one might live some way down the road and one or two might not have a phone" (122). In addition to geographical distance from each other being a barrier, one programme was held just prior to the Christmas holiday period which one participant thought contributed to "the lack of after support" (124). "If we'd done it before and not so close to Christmas then the support would be there but being so close to Christmas everyone goes away" (124).
One facilitator endeavoured to keep in contact with participants by phone and one on one visits, which was appreciated: "she never gave up on me you know and she just kept coming" (111); "chased us round and she phoned a couple of times" (127). Two of the participants were also receiving treatment with acupuncture which was part of the ongoing visits.

Six participants expressed discontent about the lack of organised after support they could access, for example, "there was no after support... that's where a lot of people fell down. We went along on a couple of Mondays and that was okay but then it just sort of fell to bits" (24). But as one of the facilitators said:

Whanau was set up to be self supporting, so that a dependency doesn't happen, so that each person can be responsible for it... I don't want whanau to be seen as a place where facilitation takes place... I want whanau to be a support group but each person to take up a leadership role in it (1).

Other comments included:

We were supposed to ring if we needed support so I ring them and they're never home (124).

We needed someone, but we had no one to turn to we just had each other, but we were all going through the same thing you see. It was no good (25).

We never had a support person to go to if we felt like a smoke or like how I was under stress and that, someone to go to when I was feeling like that. You know, sort of talk me out of it sort of thing. There wasn't much support in that way... we had support group meetings and that but I mean, who's there after the meetings? Who's going to take your call if you need it after hours?... one of the facilitators, because they know what they're talking about. They can give you that advice if you need it (28).

We met once, if more it would've been better (120).

Some participants continued to ring each other, or they would catch up when they saw each other at hui at the Marae (5; 126; 125). One participant said, "I tried to ring different ones, but no response" (111).

Three participants did not think follow-up support would have made any difference, as one said, "I think there was nothing else anybody else could have helped me with" (120); "if I had have rung everyone it would have been all my problems. I didn't want to talk to anyone about my problems, they say negative things, I wanted to contain it myself" (115). One participant didn't feel she needed the ongoing support, for her "my support comes from I know I've done it and that's all I need because I've achieved what I wanted to" (5).

**GENERAL FEEDBACK**

Fifteen participants, thought the programme was "very good" (27; 111); "good fun" (29); "to get started it was good" (23). They said: "it was run very well" (24; 6). "I enjoyed the programme" (124; 124). "I am very grateful to them" (24). A few participants who returned to smoking still believed that the programme worked (122) as two participants said, "it works, it's just up to the individual" (28); "there was nothing wrong with the programme. I blame me" (111).
Three people thought that, "if they ran another course I would go on it" (24; 124; 114). Three participants who went back to smoking said they would recommend the programme to others, as one said "I've recommended this programme to a lot of people" (124; 111; 28).

Most Helpful

Sixteen participants found being part of a group was most helpful. "Being with other Maori who were stopping as well" (129) who were "people that had a common goal, and that sense of belonging to a group of people that were there for the same reason" (2; 122) was mentioned a number of times (111; 23; 6; 125). The support aspect of stopping in a group was also mentioned several times (27; 124; 23; 28; 6). Typical comments were:

Among the group there were people of like mind... we were able to support each other... Being able to sit down and talk to people... that was a big help (24).

Being part of the group was nice (1).

Feeling a commitment to the group, to that group kaupapa, to carry on what I chose to be a part of... everyone that was there, whether it was their intention or not, they just showed their vulnerabilities at different times, and different strengths - that was good...

The commitment of other people helped me a lot. Seeing that everyone that was on the course, on the wananga - their level of commitment, for me I found inspiring (4).

The support... I'd rather be in an environment where there's support (127).

Eleven participants liked how the programme kept them occupied, "away from all thoseenticements... It took your mind of a lot of things... when I was on that Noho Marae not once did I want cigarette" (114). "Being in a place where there was no smokes" (23) and "I couldn't smell it" (127). "I found that if I was busy I didn't need a cigarette" (27). Another participant said "not having other stresses around really helped... being away from cooking and kids" (4); "being away from home" (5; 6), "it was a different environment from here... I wanted to get away from everybody" (111; 115). "If I had of been home during that time there was no way I could have done it. There were things to do and going for walks and the aerobics, it was all really good" (125).

Some participants highlighted particular activities that they thought were most helpful, for example, four participants thought the detox diet was the most helpful feature of the Noho Marae (114; 4; 26), even though it was hard for one woman who was pregnant. "The talks about our bodies and what it does... learning about where the cravings come from... and why we were going through the things... really made me think" (126; 124; 127), "the exercise" (124b; 127), "the sharing sessions" (28), "the confidence building" (29) and "the packs that we got. They were awesome. They had real neat books, awesome stories in those books" (114) were also mentioned. The most helpful activity for one participant was the ritual burning of the cigarettes (4). Then she went on to say "the whole lot for me contributed significantly to me being smokefree today." Two others said they "enjoyed" the whole programme (124b; 111).

Three participants thought "the environment itself" was helpful, as one participant said, "if you can create that meditative space" (5; 4). "Just the environment and the energy of the whole place. It was in nature and I love that, because I love being by
bush and by sea and water" (25).

Two participants said that what really helped them was "being positive... I didn't want to become another statistic" (120) "knowing that I was doing it for myself" (126).

**Least Helpful**

A few of the participants thought "the counselling fell down" (24). The behaviour of some of the other participants was disruptive and not tended to adequately. For example, these participants said:

...a lot of them were actually quite unnerving because they were like little kids... moaning about the diet, moaning about not smoking. You needed a lot of energy to get past all that emotional shit that they were all going through which to me was over the top... I found it really de-energising all these women bitching about bloody diet, the frickin food, no cigarettes... I think it was a good excuse for a lot of people to throw a lot of tantrums (5).

Another participant "could see people at risk" but the programme facilitators did not attend to them. One participant thought it was that "some people actually felt sorry for themselves, I don't mean that as a put down, but like that was just where they were heading and what was happening for them that time" (4). The way in which participants tried to support each other was not always helpful for people, as one person said, "they weren't helpful for me. But I do know they were helpful for each other" (3). Some participants who were counsellors by profession extended their skills towards fellow participants, which was not always perceived as appropriate. A few participants had misunderstandings or outright arguments with other participants, which one explained by saying "I knew what was going on afterwards. She was just looking for an excuse to smoke" (23).

Four people thought "the sharing, now that's a personal thing for me, I thought was the least helpful. I got irritated by it and people, sharing of stuff, and feelings... I don't mind sitting around talking, it was the depth of that, the intimate sharing." For her "at that stage of giving up" all she wanted to do was "just give up smoking, not that sharing, how I'm feeling blah blah blah e.t.c." (2; 26; 115). For another participant some of the activities were too New Agey, for example he said, "you don't need all that bloody spiritual stuff, putting things on a flax mat and writing down on a piece of paper what your thoughts are... what a load of rubbish... I just couldn't relate to it even one little bit" (24). He did say, however, "but that was just me."

The lack of structure in the programme was the least helpful aspect of the programme for a few participants. As they said:

...just not really knowing each day. It kept on changing at the last-minute... nobody was really certain what we were going to do (1).

There was a lot of time for people to spend on their own... there was a lack of explaining about how people could use it [journal writing] at those times. All the tools were there, but the way in which they were used, I didn't think they were used to the extent that they could have been (4).

Another participant disliked the incoherent organisation, she thought "there was too much breaking, people were going back to work, coming and going" (5).
This was associated with another problem in her opinion. She felt "the commitment wasn't established at the beginning... it was quite messy... everyone was sort of like in little units on their own." She expected to "do things as a group... I didn't feel that we actually had that tapu-ness there, that synchronicity of mind... I don't think the group was there as a unit." For her too, "the others seemed to be not quite committed." This "lack of cohesion" was something she felt the organisers could have done better by "establishing the mauri of the group," ensuring the group's commitment. Other participants apparently were "threatening to leave and that sort of thing broke the mauri" (5).

One person said: "changing the food didn't help. I thought we could have done exactly what they were doing on a normal diet" (29) and another also said the food was the least helpful aspect of the programme, "yet I know it's good" (120). "Sitting down too long" (127) and "worries about home, worrying about home life, kids and that" (6) were also not helpful.

**What They Disliked**

Whilst a few participants enjoyed the whole programme and had no dislikes, twelve participants did not like some aspect of the programme. Five participants repeated that they "really hated" (3; 28) or "didn't like the food" (114; 111; 23).

Four participants disliked the behaviour of other people, including sometimes the facilitators, for example, one participant was "bugged" by the facilitators not pitching in with the housekeeping tasks: "all of us got in and did something... wash dishes, sweep the floors, check the wharepaku... I thought they were tino mangere... I felt sorry for the cook, because she did all that by herself... I went peel potatoes and do all the veges" (27). Two participants were not convinced that the facilitators "knew what they were doing, because they had a slightly different group from what they normally would of had... people that could read, and clicked on quickly, easily, and move on the needs of the group, where they didn't read the group very well" (3). One participant thought that the facilitators did not understand what the participants were going through because the facilitators themselves were not smokers, even though one of the facilitators did say she was an ex-smoker. This participant was unconvinced that the facilitators fully understood the dynamics of addiction (3). Another participant said, "I didn't like the people who were running it. Sorry." Two participants disliked the behaviour of fellow work colleagues involved in the programme with them.

The only thing that one participant disliked about the programme was when the mirimiri practitioner told a man he was going back to smoking (127). Another participant said "when we had the people coming to talk, I felt lying on those mattresses, I think we should have been sitting up" (122) and one of the younger participants said, "the seminars were too long" (127).

One participant found the programme "very urban. Extremely urban." For example, "that painting of the kohatu, I actually found very cityish too" (5). The rigid, "very loose" (3) and "incoherent" (5) structure of the programme was disliked also, but this
has been discussed above.

**How Could the Programme Be Improved?**

Five participants thought "the programme could have more structure" (4; 3; 26). The preparation sessions also needed to prepare people for the range of changes they might have to face, for example, "whole life changes" (4). Participants need to know who the participants are going to be, what is planned, why they are doing certain things, for example, the diet (124), and there needs to be plenty of choice in terms of activities (1; 3; 111) as some people may not like planned activities, for example, painting stones. As one participant said, "there really was no choice. I thought to myself a few times I'm not going to do it, bugger it" (24). There were suggestions for more "creative" (127) activities like "handcrafts" (111).

Several participants suggested having more (6; 27; 124) and optional physical activities, for example, utilising the bush walks (23; 25). One participant thought there were too many different physical activities and she would have preferred to have learned "a few of those things more in-depth for example Tai Chi, do a bit every day" (115). Not only did some people want more physical activities but they thought there needed to be more fun, "because for me it was like taking the big step of giving away cigarettes I wanted a bit of fun, some laughter and some waiata or some tears... there didn't seem to be no fun in it, it was serious" (27).

One of the younger participants thought "they need to get rangatahi on there" but she said "none of the young ones like just to sit down, they like to tutu." She suggested the need for "some trips" and more activities they could participate in as a group. She thought there were too many "lectures. Cut down on them, they seemed to go forever" (127). A few participants wanted more educational workshops (111), for example, on anger management and how to deal with family issues; communication (115); assertiveness training and nutrition (6). One participant thought "they should smarten up on their councillors that are giving talks" (24). Another participant suggested having the guest speakers come later on the week because then they would be "more alert" (126), except for the talk on the detox diet which needs to be at the beginning of the week (124). In the first few days, because of withdrawal symptoms, some participants found it hard to concentrate, for example, "when people were talking I'd even forget their names..." (126).

Two of the older participants would have liked "more therapeutic input, why do we do what we do" (129) ask questions "about what's really happening" (111). Two participants suggested having more videos. Whilst one wanted "more videos on smokers illnesses... more educational videos on the body" (6) the other participant wanted "just good entertaining videos" (23).

Five participants thought the food could have been improved. Firstly there needs to be a good explanation as to the actual purpose and process of the detoxification diet (25; 6). A rigid diet may meet with a high level of dissatisfaction with people feeling "they were being deprived" (4; 5; 114). Two people thought "just not be so strict on the food" (29; 3).
Two participants felt "one thing that was definitely missing was a lack of Maori in it" (5; 25). One wondered "if that maori had been established... it might have been a better success rate. Considering too we were all Maori people there." This participant was disappointed "that some people started smoking again... we should have been able to utilise that time really constructively and I mean everyone. You know it just seems an awful waste... of time, energy, the place, for people to actually resume smoking" (5). She thought the programme could be improved by bringing in local Maori role models who don't smoke and don't drink, local kuia. The other participant, would have liked to have seen more explanation of Maori concepts and language for those who did not understand (25). One participant would have liked to have seen "more along the spiritual side" (115).

The follow-up provided by the different programmes varied, with weekly 'whanau' support meetings being established by one provider and more one on one contact being provided by the other. The follow-up support needed to be more frequent and consistent. A few participants supported the idea of setting up a buddy system (122; 28). Some participants would have liked access to a hotline service: "I felt there needed to be a hotline" (24), "someone to go to when you think you're going to have a smoke" (28). While others were not convinced of its usefulness: "that 0800 number, quick fix" (114).

It probably goes without saying that it is important to ensure that the environment is suitable for disability aids, for example, walking sticks, as one participant had an accident and had to go home early.

One participant thought the programme needed to be longer. "For a heavy smoker the programme needs to go for about two weeks or longer. I've never tried giving up smoking. I was a heavy heavy smoker. We only had three days. How can you expect a heavy smoker to give up in that? A week would do it. That would have cut it" (111). Apparently her hui was cut short.

**Barriers to Attending NMSCPs**

Some of the study participants who did not attend a programme had intended to but missed out for various reasons. As a result, none of the participants booked to go on the Dargaville NMSCP showed up for the hui. Two participants could not get the time off work (117). One had organised to have the week off, but then the Dargaville NMSCP was postponed and she was not informed in enough time to change her plans. "Fortunately" she said "it was so ingrained in my mind that that day came and I did" stop smoking (103). Another two had family crises occur (102; 56). Another two cited work and "time factors... it just didn't fit in... it really needs to be like a Friday to Sunday" (74). These two did go along to the Dargaville NMSCP at night time after work and said, "it was excellent" (74). "I thought it was good, they had a meeting, a bit of a karakia, and a talk about how long they'd been smoking and how long they'd given up and that. I quite enjoyed it actually" (74b).
APPENDIX T: POETRY

10th World Conference on Tobacco or Health, Beijing: Plenary

noted speakers
  the world over note
shocking statistics
English man, French woman
  Chinese diplomat

blown up to movie-screen size
  little black bars
compare cancer rates
  the world over

New Zealand Maori women
  shoot off the graph
leaving the world's women behind
  leading the world in
lung cancer deaths

the stark black and white graph
  ripping heart
tears bubble up but recede
  unshed unwelcome
in this international forum

unseen five Maori women
  sit scattered among the audience
unreal I miss them
I wish we had been together for this
  speaking about us
for this
  reduction of us
to a black bar on a white graph

we could have silently stood
  to put a body a face a life
to the anonymous lungs
  these foreigners count
Opening Ceremony 10th World Conference on Tobacco or Health: Tian'anmen Square

Our foreign feet tread
  ignorant of the dying place
of thousands

Camera shots will later prompt
  exotic memories, not the
brown tint - fear
of green-uniformed men
  (little more than boys).

We are here to save the world
  from yet another enemy
but, we fight an unsung war
  "World War III" we call it
another "holocaust."

Did those students fall for this -
  changes that would lead to
0.7 million Chinese deaths and rising
  Capitalism's sanctioned death
by tobacco?
NICOTINE

"Give it up!"
"Throw it away!"
"Just stop!"

you say
have you tried
to break the chains
that bind
so deep in the brain
that bind
my fears, my pain
that bind
my sense of self
that bind
nicotine
APPENDIX U: LIST OF GROUPS PRESENTED TO

Policy Advice:
Health Funding Authority (Provide advice on development of Service Specifications for a pilot smoking cessation for Maori women)
National Health Committee (Working group developing smoking cessation guidelines for primary health care providers).
GlaxoSmithKline, Zyban Advisory Panel

Training:
Te Hotu Manawa Maori, Develop training content for Aukati Kai Paipa 2000 (Pilot Smoking Cessation Programme for Maori women). Train Aukati Kai Paipa Coaches (Module I & Module II Relapse Prevention).
The Quit Group: Train Quitline Advisors; Train Quit For Our Kids Smoking Cessation Co-ordinators.
Te Hotu Manawa Maori, Guidelines for Smoking Cessation Training (16 one day workshops throughout New Zealand)
The Goodfellow Unit, Auckland School of Medicine, Training
Women’s Health Action, Training Workshop

Papers:
10th World Conference on Tobacco or Health, Beijing, August, 1997
Hui Whakatipu (Maori Health Researchers Hui), December 1997
National Smokefree Conference, Wellington, 23 June 1998
Public Health Association Conference, July 1999
Youth Smoking Symposium, July 1999
Apaarangi Tautoko Auahi Kore National Hui, October, 1999
11th World Conference on Tobacco or Health, Chicago, August, 2000

Lectures:
Auckland Medical School, Course no. 575.717: 20 May 2000; 10 October 2000
University of Auckland, Sociology Stage III, 26 May 1999
University of Auckland Disease Management Nurses: 3 August 2000
Unitech, Nursing students: 11 March 1997; 14 May 1997; 4 May 1998
University of Waikato, 0518.514 Foundations of Community Psychology, 26 July 1999

Media articles:
The New Zealand Herald
Interview for Inside New Zealand documentary on youth smoking cessation. “Dying to Kill Themselves.”

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