The Lived Experience of a Changing Relationship with Tobacco: A Perspective of Individuals
with Serious Mental Illness

by

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Abstract

Individuals experiencing serious mental illness (SMI) have significantly higher rates of tobacco use and although motivated to quit smoking are less successful with quit attempts thus increasing their risk of chronic disease. A qualitative hermeneutic phenomenological study that included photo elicitation was used to gain an understanding of what the lived experience of a changing relationship with tobacco means to those living with SMI. Interviews with nine individuals with varying diagnoses of SMI, and at various stages of changing their tobacco use behaviour were interpreted to reflect six themes of the phenomenon. The findings align with the core concepts of the Trans-theoretical Model and also parallel the consumer driven concept of recovery in mental illness. The mental health care provider's integration of tobacco cessation into practice using a recovery model approach, may serve a dual purpose of improving quit smoking rates as well as supporting the individual's recovery in mental illness.

Key search words: mental illness, smoking, cessation, stages of change, recovery, tobacco reduction

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Chapter 1

Introduction

People with serious mental illness (SMI) live 25 years less, on average, than people in the general population due to preventable and treatable causes of disease such as smoking (Parks, Svendsen, Singer, & Foti, 2006). In North America smoking rates for individuals experiencing a mental illness are twice that of the general population (Lasser et al., 2000). Contributing to this phenomenon is the long standing established use of tobacco within the culture of mental illness which has included the practice of using cigarettes as rewards for treatment compliance (Lawn & Condon, 2006; Lawn & Pols, 2005; Williams, & Ziedonis, 2004). This culture has contributed to the complex circumstances surrounding the decision of the smoker with SMI to continue or to change their tobacco use behaviour which has significant health and wellbeing consequences. Nonetheless, there are individuals with SMI who are motivated by a variety of physical, psychological and social factors to quit smoking (Bowden, Miller & Hiller, 2011; Ferron et al., 2011; Robson et al., 2013; Singer Solway, 2011). The experience of quitting smoking is unique to each individual and is shaped by expectations and explanations attributed to the experience (Gilbert & Warburton 2003). A better understanding of the meaning of the experience for those with SMI who attempt to change their relationship with tobacco is key to ultimately supporting tobacco use reduction and cessation and positively impacting tobacco related morbidity and mortality rates within this demographic.

The Problem

The prevalence of smoking quit attempts for individuals with SMI appears to be very similar to those individuals without SMI but these quit attempts are less likely to result in the individual being successful in stopping smoking (McClave, McKnight-Eily, Davis, & Dube 2010). In the absence of successful sustained tobacco cessation these individuals will continue to be at a

significant increased risk for tobacco related premature illness and death compared to the general population without SMI (Colton & Manderscheid, 2006; Druss, Zhao, Von Esenwein, Morrato, & Marcus, 2011; Parks et al., 2006).

For many individuals, SMI begins in adolescence or young adulthood and has an impact on their ability to obtain higher education and secure or sustain employment due the debilitating nature of their illness (Canadian Mental Health Association [CMHA] & Centre for Addiction and Mental Health, [CAMH] 2010). As education and income are social determinants of health, experiencing this impact also reduces health equity for individuals with SMI. There is also an association between tobacco use and level of education and income. Smoking prevalence is considerably higher among those with less education and low income (Cancer Care Ontario [CCO], 2014, p.19). As well, the prevalence of successful quitting for at least a year in ever-smokers is also lower in the less educated and low income populations (CCO, 2014, p. 27).

Compounding the problem of lower rates of successful tobacco reduction and cessation for individuals with SMI is a mental health treatment culture that has included practices of using cigarettes as rewards for treatment compliance (Hall & Prochaska, 2009). Instances have also been reported where individuals with SMI perceive smoking as helping to reduce symptoms of mental illness and psychotropic medication induced side effects (Forchuk, et al., 2002). Health care providers do not consistently offer smoking reduction or cessation support to individuals with SMI because they perceive these individuals to have a lack of motivation to change their smoking behaviour and believe that quitting smoking will worsen the individual's mental health condition (Hall & Prochaska , 2009; Ratschen, Britton, Doody, Leonardi-Bee, & McNeill, 2009; Sharp, Blaakman, Cole, & Evinger 2009). This remains an unfortunate circumstance as tobacco related morbidity and mortality can be altered through smoking cessation. For example, the risk

of developing lung cancer decreases for individuals who stop smoking where after ten years their risk of lung cancer is about 30 to 50% that of the risk for individuals that continue to smoke (Centers for Disease Control and Prevention [CDC], 1990).

Research gaps identified in the literature include, a) data on the perceptions of the experience that includes what individuals with SMI have and have not found helpful in trying to quit or stay smoke-free, b) how to influence their decision to make a quit attempt c) the role of the tobacco industry in maintaining higher smoking rates in the SMI population, and d) what are the implications physically, financially and socially when these individuals try to quit smoking (Singer Solway, 2011).

Furthermore, literature supports the premise that individuals experiencing SMI are or can be motivated to quit smoking (Siru, Hulse, & Tait, 2009). Yet cessation interventions are often inadequate and infrequently include mental health consumer involvement in their design or implementation (Banham, Gilbody & Lester, 2008). Research therefore is needed to provide an understanding of the meaning of the experience of reducing or quitting smoking for individuals with SMI that involves the mental health consumer in order to improve education and cessation success rates.

Research Purpose

In the absence of more in depth knowledge to inform intervention strategies for tobacco reduction and cessation for individuals with SMI, smoking rates within this population will remain high. The opportunity to gain insight into their individualized recovery process from tobacco dependency and their personal perceptions of self- management and success will help better support tobacco reduction and cessation. Thus, the purpose of this study was to understand the meaning of the lived experience of a changing relationship with tobacco from the

perspective of individuals with SMI. The study was guided by the following research question: What does the lived experience of changing ones relationship with tobacco mean to the individual living with a serious mental illness?

Research Methodology

The contribution towards capturing the meaningfulness of the experience of a changing relationship with tobacco for individuals with SMI was guided by a qualitative hermeneutic phenomenological design. This methodology permitted interpretation of the experience and co-construction of the data between the participants and researcher capturing the contextual life events and perspectives of each participant (Koch, 1995). The method consisted of participant interviews and photo-elicitation combined with researcher journaling.

Significance of Research

Having a better understanding of the meaning of the experience of changing a relationship with tobacco for individuals with SMI provides insight that can help inform health care provider practice in the development of strategies, initiatives and policies to better support this population in achieving their self-determined goals for smoking behavior change. Emerging evidence suggests there is the capacity for modest numbers of individuals with SMI to be able to stop smoking if their cessation supports are tailored to address neurobiological, cognitive, affective and social effects of their illness (Robson et al., 2013). The information obtained and interpreted in this study of those individuals with SMI having presently or in the past contemplated, prepared or succeeded in reducing or quitting smoking provides direction in tailoring these supports. It may also address research gaps surrounding the individual with SMI's beliefs regarding their physical health and the value of a more consumer focused approach to care

supported within the mental health literature (Brunero & Lamont, 2010; Godfrey & Wistow, 1997).

The research has the potential to contribute to reducing tobacco related morbidity and mortality through reducing the prevalence of smoking in a marginalized high risk demographic. The urgency of this type of research cannot be overstated. According to the World Health Organization the extended time for smoking related cancers and chronic respiratory diseases to develop their impact on mortality will continue to rise for at least two decades, regardless of the planned successes of continued initiatives to reduce smoking rates (2009, p. 21).

Finally, research that supports insight into a better understanding and therefore contributes to improved supports to assist individuals with SMI to reduce or quit smoking also has the potential to impact health equity. Individuals living in low-income households often spend a considerably higher portion of their household funds on tobacco compared with high income households which in turn reduces the budget available for other important essentials, (United Nations, General Assembly, 2011, p. 10). The opportunity to improve health equity through increasing financial resources as a result of an absence of tobacco product spending is also significant.

The following chapter will provide a review of the literature. It will begin by outlining the prevalence of smoking in Canada as well for the province of Ontario where the research was conducted in a northern community. The review addresses the overall impact of smoking on chronic disease and years of lost life and the trends in cessation within the general population. The reviewed literature then offers insight specifically into the history and prevalence of tobacco use for individuals with SMI. Addressed are the impacts of smoking on this specific demographic. Highlighted are the motivations, supports and barriers to quitting for the SMI population. Specific attention is given to the role of health care professionals and the impact of

tobacco-free policies. The chapter ends with an overview and applicability of the Trans-

theoretical Model of Behaviour Change and the Consumer Driven Model of Mental Health

Recovery.

Chapter 2

Review of the Literature

This review of the literature will create a comprehensive picture of the interconnectedness of the issues related to tobacco use, cessation and the experience of SMI. It is presented to assist the reader in developing a clearer understanding of the complexity of the problem and the intricacy in developing solutions. This knowledge will provide evidence to support the need for further research to better understand the meaning of the lived experience of individuals with SMI considering or trying to quit smoking.

Prevalence of Smoking in Canada and Ontario

The Propel Centre for Population Health Impact summarized Health Canada and Statistics Canada survey data using weighted estimates to determine the main patterns and trends in tobacco use in Canada in a 2014 report, Tobacco Use in Canada: Patterns and Trends. The report identified that sixteen percent of Canadians in 2012 were smokers, 11.9 % of these smoking daily on average fifteen cigarettes per day (Reid, Hammond, Rynard & Burkhalter, 2014). Males continue to have a higher prevalence of smoking (18.4%) compared to their female counterparts at 13.9%. As well overall prevalence of smoking varies with the individual's level of education (Reid et al., 2014).

In Canada, the prevalence of smoking varies from province to province and from region to region. Canadian Community Health Status (CCHS) 2012 data demonstrates past 30-day smoking rates in Ontario (18%) as considerable higher than in British Columbia (14%) and slightly lower when compared to the 19% national average (Ontario Tobacco Research Unit [OTRU], 2014).

In Ontario, CCO reported that in 2011, 20.6% of adults aged 20 years and older (approximately 2 million individuals) were current daily or occasional smokers, which is a substantial decrease from the 23.0% that smoked in 2003 (CCO, 2014, p.4). This prevalence of current smoking was notably greater in males (24.2%) than females (17.1%). Although male smoking prevalence remained stable since 2003, females demonstrated a significant decline from the 20.3% that were smoking in 2003. On average male daily smokers also smoked more cigarettes per day (median consumption 14.2) than females (median consumption 10.0). Furthermore, according to CCO, in 2011, 50% of daily smokers in the province smoked well below 20 cigarettes (one pack) per day. In contrast however, 32.4% were considered heavy smokers reportedly exceeding 20 or more cigarettes per day, a rate that seems to have declined since at least 2003, but is still considered high (CCO, 2014, p. 23).

Tobacco use, in particular smoking, can again be further singled out particularly with its established prevalence amongst marginalized populations. CCHS data for 2011, as reported by CCO (2014, p. 19), highlights smoking prevalence as being considerably higher among those with less than a secondary school education (32.1%) compared to post-secondary school graduates (15.7%), and among the lowest income group (27.8%) compared with the highest (14.2%). Data from the CCHS 2011/2012 also indicates that 26% of unemployed Ontarians aged 15 to 75 years were current smokers, which was 8% (154,700) of the 2 million smokers of that age group in the province (OTRU, 2014, p13).

In the area of Northern Ontario represented by the North East Local Health Integration Network (NE LHIN), the prevalence of current smoking in 2011 was identified as being 28.4% (CCO, 2014, p. 20). Within the north east LHIN region the Algoma District where this study

was conducted, 2011/2012 monitoring data by OTRU identify current smoking (past 30-day use and 100 cigarettes in lifetime) by individual's ages12+ at 22.7% (OTRU, 2014).

A number of contextual factors need to be acknowledged as influencing the prevalence of tobacco use and mental health outcomes in Northern Ontario. These include the study's rural location and the predominance of Aboriginal people that reside in Northern Ontario. In a Canadian Mental Health Association (CMHA) of Ontario report on rural and northern community issues in mental health it is highlighted that the perception of health declined from urban to rural living, making geographic location a determinant of health (2009). The North East Local Health Integration Network (NE-LHIN) Population Health Profile identifies higher rates of rural living in the region influencing access to health services with twice as many people in Northeastern Ontario living in rural areas (30%) compared to 14% in Ontario (2013). 2011 data from the Cancer Risk Factors in Ontario report identify current smoking prevalence as significantly higher among those over thirty years of age living in rural (23.0%) versus urban areas (19.3%) of the province (CCO, 2014, p. 19).

Finally consideration must be given to the Aboriginal populations in Northern Ontario home to 40 % of Ontario's Aboriginal population where 106 of the 134 First Nations communities in Ontario are located (CMHA, Ontario, 2009). Close to 10% of the region's population is Aboriginal, First Nation or Métis with off reserve population smoking rates of these groups twice as high as the non-Aboriginal population (NE-LHIN, 2013). In the absence of specific Northern Ontario data, it is important to note that the prevalence of smoking reflected in provincial data identifies significant numbers of this demographic smoking. 42.1% of First Nations males and 38.8% of Métis males (living off reserve) were current smokers compared to 24.2% of non-Aboriginal males. For women, 41% First Nations and 32.5% Metis living off

reserve were current smokers compared to 16.8% non-Aboriginal females (CCO, 2014, p. 42).

Finally with the significant numbers of Aboriginal peoples living in Northern Ontario it is also

important to consider the smoking behaviours of this population that live on reserves. Although

2008-2010 First Nations Regional Health Survey data is generalized to First Nations adults

living on-reserve and in northern communities in Canada, attention is drawn to the estimate of

57% of this population being current smokers (First Nations Information Governance Centre

[FNIGC], 2012). It is also significant that one-third of First Nations smokers attempted to quit

smoking in the previous year with women noted as more likely to attempt cessation (FNICG,

2012).

As there continues to be a significant prevalence and incidence of smoking persisting in

Canada and specifically Ontario, there too remains continued concern for the implications on

future population health.

Tobacco Use Risk Factor for Chronic Disease

World-wide, non-communicable diseases (NCDs) also known as chronic diseases are the

leading cause of death and are identified as being responsible for the loss of life for more people

each year than all other causes combined (WHO, 2010, p.1). It is estimated that of the 57 million

global deaths in 2008, 36 million, or 63%, were due to NCDs (WHO, 2010, p.9). The WHO

estimated that 89% of all deaths in Canada in 2008 would be attributed to chronic diseases

(WHO, 2011, p. 45).

Chronic diseases are the leading cause of death in Ontario, with cancers, cardiovascular

diseases, chronic respiratory diseases and diabetes combined leading the list in 2007 of those

responsible for 79% of all provincial deaths (CCO & Ontario Agency for Health Protection and

Promotion [OAHPP], 2012, p. 9). Chronic diseases develop slowly and can take years or

decades to materialize thus with ever growing and aging populations and their continued exposure to risk factors, the impact of these diseases will be a significant health issue well into the future (CCO & OAHPP, 2012, p.10). For the United Nations this future includes predictions for 2030 when these diseases are expected to claim the lives of 52 million people around the world (United Nations, General Assembly, 2011, p.2).

In taking a closer examination at those people within populations that experience increased rates of chronic diseases, evidence highlights a greater impact on those individuals of lower social and economic positions. Marginalized and socially disadvantaged individuals determined by level of education, occupation, income, gender and ethnicity are associated with a greater prevalence of risk factors and increased morbidity and mortality from chronic diseases (WHO, 2010, p. 2). The impact of chronic diseases also results in decreased household income related to the risk factors, poor physical capacity, chronic treatments and the expensive burden of health care costs (United Nations General Assembly, 2011, p. 9). The risk factors associated with increased incidence of chronic disease are also important to note when considering the social determinants of health. Individuals with lower levels of educational attainment are more apt to use tobacco, experience hypertension, be physically inactive and use alcohol (United Nations General Assembly, 2011, p.8).

In considering these risk factors that are associated with chronic diseases, one of the most notorious, responsible for increasing morbidity and mortality is tobacco use in particular cigarette smoking. According to the WHO, manufactured cigarettes are the major form of smoked tobacco (2010, p.17).

Of the ten leading risk factors of death worldwide, tobacco ranked second with 5.1 million deaths in 2004 (8.7% of the total deaths) and ranked number one (1.5 million which was 17.9%

of total deaths) in high income countries (WHO, 2009, p. 11). The WHO estimates close to six million people die from direct and second hand tobacco use and exposure each year and expect this number to climb to 7.5 million by 2020 where it will then account for 10% of all deaths (WHO, 2010, p.1). It is important to note that because of the extended time for smoking related cancers and chronic respiratory diseases to develop their impact on mortality in low and middle income countries will continue to rise for at least two decades, regardless of the planned successes of continued smoking initiatives to reduce smoking rates (WHO, 2009, p. 21).

In 2004, the USA Surgeon General identified a significant number of diseases attributed to smoking: (a)cancers of the stomach, (b) uterine, (c) cervix, (d) pneumonia, (e) abdominal aortic aneurysm, (f) cataracts; and (g) periodontitis that in the past had not been causally associated with smoking (CDC, 2004, p. 25). Ten years later, the USA Surgeon General further causally linked smoking to: (a) colorectal and liver cancers, (b) age-related macular degeneration, (c) congenital defects from maternal smoking: orofacial clefts, (d) tuberculosis, (e) diabetes, (f) ectopic pregnancy, (g) male sexual function-erectile dysfunction, (h) rheumatoid arthritis and (i) immune functions (CDC, 2014).

In Canada in 2002, there were approximately 37,209 smoking attributable deaths which represented 16.6% of all Canadian deaths that year (Baliunas et al., 2007, p.157). Of this, men had a higher rate of mortality from smoking related illnesses than women. (Baliunas et al., 2007, p.157). Of the 37,209 smoking related deaths that year, cancer accounted for 46.8%, cardiovascular disease 27.6% and respiratory diseases 22.3% (Baliunas et al., 2007). Baliunas et al. (2007) also highlight that within these categories there are individual diseases of lung cancer, ischemic heart disease and chronic obstructive pulmonary disease (COPD) that comprise the largest causes of death from smoking.

In Ontario in 2009 approximately 15% of all new cancer cases diagnosed were attributed to cigarette smoking (CCO, 2014, p.11). The incidence of these new cases was higher in men (6,000 cases) compared to women (3,800 cases). For these cigarette smoking related cancers those affecting the lung and larynx have the greatest smoking-attributable disease burden (CCO, 2014, p.11).

Tobacco Use and Years of Lost Life

The negative impacts of tobacco use are not only limited to its direct effects on physiological human health but also on its devastating influence on the users' future. Disability adjusted life years (DALYs) are lost years of healthy life and are the sum of years of life lost due to premature death and disability for certain diseases (WHO, 2009, p.5). The burden of disease is the gap between present health status and the ideal circumstances of living life into old age absent of disease and disability (WHO, 2009, p.5). In 2004, tobacco globally was the sixth leading cause of DALYs causing 57 million years of lost healthy life (3.7% of all causes) and ranked number 1 with 13 million DALYs (10.7% of the total that year) in high-income countries (WHO, 2009, p. 12). In Canada in 2002, expected years of lost life due to smoking related deaths was approximated at 515,608 years (Baliunas et al., 2007, p.157).

When considering the devastating impact to loss and quality of life that lies ahead for many smokers, it is important to highlight the potential to alter the course of smoking related chronic disease with cessation. American statistics for the year 2000 estimate the fraction of lung cancer mortality averted in men and women combined increased to approximately 44%, a number which is believed to reflect the then changes in smoking behaviours and a continuing decrease in risk for ex-smokers (Moolgavkar et al., 2012, p.4). Smoking cessation is also associated with a greatly lowered risk of death for individuals with coronary heart disease (Critchley & Capewell,

2003, p.95). The risk of dying from coronary heart disease is reduced by about half among ex-smokers after only one year of smoking cessation and continues to decrease until after 15 years of not smoking the risk is similar to that of an individual that never smoked (Center for Disease Control and Prevention (CDC), 1990).

With the seriousness of tobacco use, in particular cigarette smoking, well documented over the last several decades and the potential to lower the risks with quitting, what has been the trend in cessation?

Trends in Smoking Cessation in Canada and Ontario

For the Canadian general public hoping to capitalize on this potential reclaiming of future health, research has demonstrated that plans to reduce and or quit smoking are common (Cunningham & Selby, 2010). The Propel Centre for Population Health Impact in a 2014 report, "Tobacco Use in Canada: Patterns and Trends", identified six out of ten Canadians who ever smoked have quit (Reid et al., 2014). For those Canadians still smoking but making plans to quit, 30% plan to make a quit attempt in the next 30 days and two thirds within the next six months (Reid et al., 2014). Planned quit attempts were similar between the sexes with the exception that more males had set targets for a quit attempt in the next 30 days and for all smokers trying to quit, the most frequently used strategy (64%) was to reduce consumption first (Reid et al., 2014).

According to CCO's report "Cancer Risk Factors in Ontario: Tobacco", 53.1% of those adults in Ontario who have ever been smokers had quit. Citing 2011 data from the Ontario Tobacco Research Unit, (OTRU), the report goes on to highlight that a quarter of current smokers had intended to quit in the next 30 days and over 50% planned to quit in the next six months,

however relapsing back to smoking is not unusual for recent quitters with OTRU data suggesting 79% will resume smoking in the following year (CCO, 2014, p.25).

In comparing the successes of quitting between the sexes in Ontario for 2011, more previously smoking females (53.4%) than males (48.6%) had successfully quit smoking for at least one year (CCO, 2014, p. 26). Center for Addiction and Mental Health (CAMH) monitoring data from 2012, as cited in an OTRU report indicate 8% of the 227,000 ex-smokers in Ontario reported quitting between one and eleven months ago, 14% between one and five years ago, and 78% had quit smoking more than five years ago (OTRU, 2014, p.56). Unfortunately the optimism of these successful changes to this chronic disease risk factor are under shadowed by the overall plateaued rates of quitting by those individuals that continue to smoke. From 2007 to 2012, only minimal changes to the overall quit rates have occurred with no significant increase in the recent quit rate among Ontarians aged 12 years and older (OTRU, 2014, p.55). In areas of Ontario represented by the North East LHIN, 2011 data identify the proportion of ever-smokers who had successfully quit smoking for at least one year as just above 45% compared to 56.5% in the Champlain LHIN (CCO, 2014, p 29).

It is also again important to connect the issue of tobacco use to the social determinants of health and consider the impact on the prevalence of smoking cessation. Unfortunately under a health equity lens, disparity also exists in the prevalence of successful quitting for at least a year in ever-smokers. Percentages of successful quitting for at least one year for those least educated (44.4%) and those in the lowest income quintile (43.5%) were significantly lower than ever-smokers with the highest level of education (61.7%) and the highest income quintile (66.8%) (CCO, 2014, p. 27). Thus, it is not surprising that although the general public has seen a significant trend in smoking rate reduction over many years this decline has not been noted in the

subpopulation of individuals experiencing SMI, a subgroup who are often less educated and often fall in the lowest income quintile. Often SMI begins for many individuals early in life impacting their ability to obtain higher education and secure or sustain employment due the debilitating nature of their illness (Canadian Mental Health Association & Centre for Addiction and Mental Health, 2010).

Prevalence of Smoking and Quitting for Individuals with SMI

In 2004, it was estimated that nicotine-dependent and psychiatrically ill individuals accounted for approximately 70% of cigarettes consumption in the United States (Grant, Hasin, Chou, Stinson, &Dawson, 2004).   No similar Canadian data was available, however data from other industrialized nations identify the last decade as having seen continued high prevalence rates of smoking for those with SMI in particular by the population of individuals with schizophrenia or with bipolar disorder even in the face of increasing tobacco control initiatives (Bowden et al., 2011; Dickerson et al., 2013; McClave et al., 2010). Lasser et al., (2000) found that persons with mental illness were about twice as likely to smoke and that those with multiple lifetime psychiatric diagnoses smoked heavier and at greater rates. Research also has identified heavier smoking and higher nicotine dependence in individuals with schizophrenia compared to the population at large (de Leon & Diaz, 2005). High smoking rates are also identified in populations of people experiencing anxiety disorders, many of whom have been found to be less likely to quit smoking once they have started which is around the onset of symptoms, often in early adolescents, thereby exposing them to smoking's health hazard for many years (Lawrence, Considine, Mitrou, & Zubrick, 2010).

Differences have also been demonstrated between men and women with persistent SMI that smoke. Torchalla, Okoli, Malchy and Johnson (2011) found that although daily cigarette consumption, nicotine dependence level and readiness to change did not differ between the

sexes, there were differences in variables connected to nicotine dependence. As well women with persistent SMI perceived themselves as more addicted to tobacco, made more attempts to quit and for longer durations than men (Torchalla et al., 2011).

The amount of smoking by individuals experiencing SMI also is different depending on the person's type of mental illness as well as the number of concurrent conditions they may have (Dickerson et al., 2013; McClave et al., 2010; Williams & Ziedonis, 2004). For individuals with specific SMI diagnoses, smoking prevalence for current smoking has been demonstrated as high as 59.1% for those with schizophrenia and 46.4% for those with bipolar disorder (McClave et al., 2010). It is also noted that 17.8% of these individuals with schizophrenia and 15.1% with bipolar disorder were distinguished as heavy smokers (McClave et al., 2010). Interestingly, heaviness of smoking has been found to be prevalent in smokers with serious psychological distress (28.8%) as well as those with either phobias or fears (19.8%) who are also more likely to be daily smokers (McClave et al., 2010).

For individuals with SMI the incidence and heaviness of smoking were also associated with lower education, male gender and history of substance abuse, findings similar to trends in the general population (Dickerson et al., 2013). Smoking prevalence reported from the Canadian Community Health Survey (CCHS), is considerably higher among those with less than a secondary school education (32.1%) compared to post-secondary school graduates (15.7%), and among the lowest income group (27.8%) compared with the highest (14.2%) (CCO, 2014, p.19). Data from the CCHS 2011/2012 also indicates that 26% of unemployed Ontarians aged 15 to 75 years, were current smokers which was 8% (154,700) of the two million smokers of that age in the province (OTRU, 2014, p. 13).

The higher numbers for smoking in the SMI population is also a compounded by their poorer results with cessation attempts. According to McClave et al. (2010), individuals with SMI try to quit smoking at the same rate as those who do not experience SMI, however they have less successful outcomes and the quit ratio for smoking decreases as the number of mental illnesses an individual is diagnosed with increases. As well, smokers with schizophrenia experience lower rates of quitting smoking than the general population (de Leon & Diaz, 2005; McClave et al., 2010). Lasser et al., (2000) found quit rates lower in smokers with any present or past history of mental illness compared to smokers absent of any mental illness.

Even with the years of scientific evidence pointing to the negative health consequences of tobacco use, there continues to be alarming rates of smoking amongst individuals with SMI. It is, therefore, imperative to obtain a greater understanding of tobacco use within the culture of mental illness and mental health care in order to impact positive cessation social norm changes within this demographic.

The History of Tobacco Use in Mental Health

For decades, the use of tobacco has held a prominent and perceived useful role in the field of psychiatry and treatment of individuals experiencing SMI. Colby, as cited by Hall and Prochaska (2009) references a 1951 psychotherapy handbook that encouraged patient smoking during therapy sessions as a valuable minor gratification practice. Within the mental health culture there has also been the historical practice of using cigarettes as rewards for treatment compliance (Lawn & Condon, 2006; Lawn & Pols, 2005; Williams, & Ziedonis, 2004). Sadly there are also well-documented influences and behaviours of the tobacco industry targeting individuals with SMI. A 2008 Prochaska, Hall and Bero study of 280 industry records dating from 1955 to 2004 highlight an industry that manipulated the then research agenda, targeted individuals with

schizophrenia as being less vulnerable to lung cancer from smoking and needing smoking to self-medicate their mental health symptoms.

The industry also strategically provided cigarettes to psychiatric facilities and used the patient's need to self-medicate symptoms theory to undermine mental health facility smoking bans (Prochaska et al., 2008). Additional marketing strategies targeted vulnerable marginalized populations including those with mental illness with product value brands, establishing positive relationships with mental health services through provision of charitable donations and grants that helped to ensure their support of opposing smoking bans in mental health facilities (Apollonio & Malone, 2005). Industry documents show clearly that tobacco company research identified segments in the smoking population with distinct psychosocial needs and adjusted product design to target these segments (Cook, Wayne, Keithly, & Connolly, 2003). Grant, et al., (2004) reported that these psychological and personality traits identified by the tobacco industry as targets were very similar to symptoms associated with the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) IV Axis I and II psychiatric disorders. Collectively these practices both past and present have served to undermine the movement to change a treatment culture that normalizes smoking for individuals with SMI and may have contributed to the comorbidities of this vulnerable population.

The Impact of Smoking on Individuals Experiencing SMI

For individuals experiencing SMI there are both physical and socially related comorbidities and effects of smoking. Individuals with SMI die on average at a younger age than the general population without SMI (Colton & Manderscheid, 2006; Druss, Zhao, Von Esenwein, Morrato, & Marcus, 2011; Parks et al., 2006). The majority of these years of lost life for those with SMI are due to natural causes of which a significant portion included cardiovascular disease, cancer

and pulmonary disease (Colton & Manderscheid, 2006; Druss et al., 2011; Parks et al., 2006). Smoking is one of the modifiable risk factors for these natural causes of death (Parks et al., 2006). Druss et al. (2011) found mortality rates varying across mental illness diagnosis with individuals with psychotic disorders mean age of death being 63.4 years compared to 66.0 for those with affective disorders and 74.4 for those without reported mental illness.

Individuals living with schizophrenia are at a higher risk for heart disease and cancer as a result of their tobacco use and are more likely to prematurely die from these diseases than the general population (Brown, Barraclough & Inskip, 2000; Brown, Kim, Mitchell, & Inskip, 2010; Kelly et al., 2011; McGinty et al., 2012). Kelly et al., (2011) found that for those individuals with schizophrenia between the ages of 35-54 years that were smoking a pack of cigarettes a day, there was a 170% increase risk of premature mortality compared to non-smokers. Of particular concern also is the upward trend in cardiovascular mortality in this demographic of individuals experiencing mental illness (Brown et al., 2010). Individuals with schizophrenia and bipolar disease have also been singled out as having a four times greater risk of lung cancer than the general population (McGinty et al., 2012). It is also important to recognize the effects of tobacco on the body for individuals with SMI from a more immediate perspective. The hydrocarbon by-products of tobacco smoking have an impact on the metabolism of some psychotropic drugs, reducing their concentrations and their ability to help reduce or manage the individual's psychiatric symptoms (de Leon, 2004).

In further considering the implications of cigarette smoking for individuals experiencing mental illness, the economic impact of the behaviour must also be examined. The cost of tobacco consumes a significant portion of these individuals income as their decision to purchase cigarettes often supersedes the purchase of food and basic living essentials, which further

impacts health outcomes (Steinberg, Williams & Ziedonis, 2004). An example of this phenomenon is highlighted by Steinberg et al. (2004) who noted approximately a third of monthly spending going towards cigarette purchases in a study of individuals with schizophrenia or schizoaffective disorder. Despite the known negative effects of smoking for individuals experiencing SMI, many barriers to reducing or quitting tobacco use are present.

Internal and External Barriers to Reducing or Quitting Tobacco Use

There are many reasons why people start and continue to smoke that reinforce perpetuation of the behaviour even with the knowledge of its serious negative impact on their health. For those individuals experiencing mental illness, the contributing factors to smoking are even more complex and can present significant barriers to successful tobacco reduction or cessation. Research points to consideration of confounding and causal associations between various diagnoses of SMI and tobacco use which may explain higher rates of smoking and internal barriers to cessation within the SMI population (Ziedonis et al., 2008). There are also perceived positive outcomes of tobacco use that serve as ongoing internal barriers to cessation. Individuals with SMI have smoked cigarettes to self- medicate perceived psychological or physical symptoms of their mental illness as well as to lessen the side effects experienced from some of their prescribed medications (Forchuk et al., 2002; Lawn, Pols, & Barber, 2002; Ziedonis et al., 2008). Lawn et al., (2002) describe this population as using cigarettes as a constant that keeps all other parts of their lives in control. For many with SMI smoking is considered part of their identify, cigarettes are perceived as a friend and the despair often accompanying a SMI diagnosis makes quitting seem pointless (Lawn et al., 2002). Many of the classes of medications used to treat mental illness including antidepressants, antipsychotics and mood stabilizers, have resulted in the unpleasant health risk side effect of weight gain (Torrent et al., 2008; Zimmermann,

Kraus, Himmerich, Schuld, & Pollmacher, 2003). As it is a common belief that smoking decreases appetite, smoking is often used as an effective means to manage medication related weight gain for individuals with SMI (Singer Solway, 2011).

Smoking is described in the literature by individuals with SMI as a stress management tool, filling a need for inclusion, calm, comfort and support and relief of withdrawal symptoms (Singer Solway, 2011). For some individuals with SMI the choice to spend limited finances on cigarettes provides gratification of perceived luxury spending, while others believe there are actual health benefits in smoking (Snyder, McDevitt, & Painter, 2008). There are those that considered smoking as a reliable means of socializing (Snyder et al., 2008). These positive perceptions of smoking can be perceived as barriers to the individual with SMI considering making a change to their tobacco use.

External barriers to successfully changing smoking behaviour for individuals with SMI include a lack of access to quit smoking medications and cessation support groups (Ferron et al., 2011). Gilbert and Warburton (2003) also highlight the concept of withdrawal syndrome that stereotypes a negative experience of nicotine withdrawal, portraying the powerlessness of those quitting smoking to nicotine and undermining the individual's hope of success. This reduces self- efficacy towards outcome success, creating a potential barrier to the individual moving on from contemplating to actually making a quit attempt. One particularly influential external barrier for individual`s with SMI making changes to their tobacco use behavior has been identified as health care professionals.

Health care professionals as barriers.

The attitudes and behaviours of health professionals, who provide care and support to individuals living with mental illness, can also create external barriers to client's quitting

smoking. Staff in mental health facilities, smoke at significantly high rates (Johnson et al., 2009; Ratschen et al., 2009). These circumstances serve to role model tobacco use behaviour to clients as well as present triggers for smoking to individuals with SMI trying to reduce or quit. Literature has highlighted health care providers using smoking with their SMI clients to develop interpersonal contact and rapport, a practice which only further reinforces and normalizes client smoking (Lawn et al., 2002; Lawn & Condon, 2006). Also identified are the beliefs of samples of psychiatric nurses that smoking provides patients the autonomy to make informed decisions in a hospital setting that restricts many of their basic freedoms (Lawn & Condon, 2006). Smoking is often considered a lesser priority when caring for patients in mental health crisis, fostering a lack of support for smoking cessation for this group of mental health professionals (Lawn & Condon, 2006).

There's also a significant lack of knowledge on the part of those working in smoking restricted mental health sites around the issues of mental illness and tobacco use dependency, prevalence and treatment (Ratschen et al., 2009; Wye et al., 2010). This includes physician's being considerably less knowledgeable about the interactions between smoking and anti-psychotic medications and how to effectively use nicotine replacement therapy (NRT) to support smoking behaviour change within the SMI population (Ratschen et al., 2009). Prochaska, Gill and Hall (2004) found that smoking patients in psychiatric facilities had higher rates of nicotine withdrawal symptoms of agitation and irritability, often difficult to differentiate from psychiatric symptoms and that any nicotine replacement therapy provided by health care staff was often at an inadequate dose. Psychiatric nurses, although perceiving themselves as knowledgeable about cessation aids, strategies and resources, were less confident in the ability to help patients with stopping smoking and did not rate providing this treatment as a high work priority (Sharp,

Blaakman, Cole & Evinger, 2009). In addition, Sharp et al., (2009) found only 29.3% of nurses

personally provided or understood their work place to provide intense tobacco dependency

interventions and this practice was more evident with those nurses working in psychiatric

outpatient settings. Of further significance to the issue is findings by Sarna, Bialous, Wells and

Kotlerman (2009) that 20% of psychiatric RNs were current smokers and that of those nurses,

92% were less likely to discuss tobacco use with their patients compared to nurses that were

never smokers. Johnson et al., (2009) also similarly found 22% of community mental healthcare

workers were current smokers and that this could be a barrier to their engaging in some aspects

of smoking cessation practices with clients.

Even with the knowledge of the health and social impacts of smoking on individuals with

SMI and the opportunity to provide assistance, many mental health services frequently fail to

address the issue or provide support, and in some instances actually discourage client cessation

(Ashton, Lawn & Hosking, 2010; Green & Clarke, 2005). Literature points to physician

practices of identifying smoking status in patients with psychiatric diagnoses, but infrequently

following through to provide counselling or supports (Baker et al., 2007; Himelhoch & Daumit,

2003; Thorndike et al., 2001). This smoking cessation counselling is also more likely a practice

of primary care physicians than psychiatrists (Baker et al., 2007; Himelhoch & Daumit, 2003;

Thorndike, Stafford and Rigotti, 2001). The infrequency in helping individuals with SMI to

change smoking practices by psychiatrists is also reflected in the infrequent use of the diagnosis

of nicotine dependence for individuals with SMI as well as examples of limiting cessation

supports for those with SMI that are unfortunately already impacted by conditions predisposing

them to cardiovascular disease (Himelhoch & Daumit, 2003). Traditionally, mental health

providers have not provided optimal tobacco cessation assistance to clients, have believed that

individuals with a SMI are not motivated to stop smoking and that quitting should not be a priority of their care (Johnson et al., 2009; Ratschen et al., 2009; Sharp et al., 2009). Baker et al., (2007), report findings of 14.8% of a study sample of individuals with SMI at baseline assessment as part of a longitudinal randomized control trial were being advised by a health professional that smoking was an acceptable behaviour. Finally, failing to provide adequate support to individuals with SMI experiencing forced cessation during hospitalization may jeopardize hospital care if patients opt for discharge against medical advice to avoid these circumstances (Prochaska, et al., 2004).

Shifting Attitudes and Behaviors of Health Care Providers Towards Cessation

It is also important to recognize that literature points to a shift in behaviours towards capitalizing on opportunities to support individuals with SMI to change their tobacco use behaviour. Examples of this include instances where health care providers have evaluated the benefits of positive and innovative approaches to supporting cessation in smokers with SMI. Griffiths, Kidd, Pike and Chan`s (2010) study of a twelve week tobacco addiction recovery program identified decreased cigarettes smoked, tobacco dependency and increased self-efficacy in avoiding smoking post program. Williams et al., (2011) highlight a CHOICES program where trained mental health consumers supervised by healthcare professionals worked with peers to provide information in a non-judgemental way, which demonstrated positive results in increasing individuals with SMI's readiness to address their smoking.

Individuals working within the mental healthcare field are also beginning to change their attitudes and perceptions that their clients are not interested and cannot achieve tobacco cessation. Ashton, Lawn et al., (2010) reported finding 33% of their sample of mental health care workers believed more than half of their patients wanted quit smoking support, as well, 37%

felt more than half of their patients could quit or reduce with NRT and support. Changing beliefs and attitudes towards social norms around smoking, cessation and SMI are also becoming apparent in practice recommendations being developed for health care professions. The Canadian Action Network for the Advancement, Dissemination and Adoption of Practice-informed Tobacco Treatment (CAN-ADAPTT) guidelines released in 2011 include summary statements that support healthcare providers working with individuals with SMI. These recommendations include the importance of screening persons with mental illness and or addictions to other substances for tobacco use and offering them counselling and pharmacotherapy treatment for their tobacco dependency. Recommendations also include monitoring these individuals for any needed adjustments to their psychiatric medication dosages as they work to reduce or quit their tobacco. The challenge now is to continue this culture shift to further move mental healthcare providers towards increasingly prioritizing and delivering tailored supports to help clients with SMI make positive changes to their tobacco use.

To assist in further denormalizing smoking in the mental health culture, and promote increased opportunities for monitored tobacco reduction and cessation many facilities have enacted smoke-free indoor policies over the last decade. These environmental changes have also highlighted the need for mental health care providers to better assist client with smoking behaviour change, as these policies have presented both challenges and opportunities to individuals experiencing SMI who smoke.

Impact of Smoke-free Policies

Present day social norms make smoking less acceptable in enclosed public places and workplaces. Smoking bans both indoors and, in certain circumstances outdoors are being enacted at multiple levels of government. Although with the best of intentions of reducing

exposure to second-hand smoke and reducing smoking rates, this has left groups of marginalized populations that continue to smoke stigmatized for persisting in what is now considered an undesirable and socially unacceptable behaviour (Bayer & Stuber, 2006; Lawn et al., 2002). Individuals with SMI that are heavily addicted to tobacco may therefore find it uncomfortable and increasingly challenging to re-integrate into community life (Ashton, Miller et al., 2010).

For individuals with SMI who smoke the reality of outpatient and inpatient care can include an environment that bans smoking inside and often outside of psychiatric facilities. This results in involuntary restrictions or forced absences for the smoker with SMI entering care and their reliance on healthcare staff to monitor and manage symptoms of nicotine withdrawal (Kunyk & Els, 2009). These circumstances could have the potential to cause increased patient aggression and can be perceived by staff to potentially negatively impact patient compliance (Harris, Parle & Gagne, 2007; Wye et al., 2010). In the majority of instances where smoking bans have been implemented in psychiatric facilities, there was no significant increase in negative patient behaviour such as unrest, non-compliance or discharges against medical advice that was anticipated by staff (Cole, Trigoboff, Demler, & Opler, 2010; el-Guebaly, Cathcart, Currie, Brown, & Gloster, 2002; Harris, Parle, & Gagne, 2007; Hehir, Indig, Prosser & Archer, 2013; Lawn & Pols, 2005; Smith et al., 2013; Voci et al., 2010).

Effective smoke-free policies have ended the practice of hospital staff smoking with patients or using tobacco as a means of encouraging clinical treatment compliance which collectively in itself is changing social norms in this population (Kunyk, Els, Predy, & Haase, 2007; Kunyk & Els, 2009; Lawn & Polis, 2005). They also have the potential to facilitate collaboration between mental and general health care providers and mental health consumers in creating solutions that support the ban and ultimately help to reduce health inequity (Banham et al., 2008). These

policies can also support the creation of a system of personalized reduction and cessation for individuals in hospital (Kunyk et al., 2007).

With organizational support and increased capacity of mental health staff working in mental health facilities to effectively assist client's with cessation, there is a positive perception that smoke-free inpatient psychiatric facilities can help individuals with SMI quit smoking (Wye et al., 2010). Findings of a tobacco dependence study by Sharp et al., (2009) surveying nurses of the American Psychiatric Association from various practice settings found that clients being treated in tobacco-free settings were more likely to receive intensive tobacco interventions and psychiatric nurses working in these setting more likely to refer them to cessation resources. Smoking bans have not negatively impacted the severity of mental illness related symptoms for individuals during hospitalizations (Kunyk et al., 2007; Smith, Pristach, & Cartagena, 1999). Campion, Checinski and Nurse (2008) suggest that smoking bans in mental health environments have had minimal impact on smoking cessation in the long term potentially due to uncoordinated efforts between inpatient, outpatient and cessation supports. On the other hand, Keizer, Descloux and Eytan (2009) found during long term hospitalization in a psychiatric inpatient facility with a partial smoking ban that there was an increased in movement by patients with SMI towards the Trans-theoretical Model of Behaviour Change stages of contemplation and preparation.

It must be recognized however, that although society has grown to accept smoking bans in public place and workplaces, the idea of prohibiting smoking in mental health facilities has been met with controversy. A most recent example is the 2014 move by the Centre of Addiction and Mental Health in Ontario, Canada to ban smoking on the grounds of its three major facilities. Initial media coverage by the Toronto Star, April 21, 2014 was negative citing concerns over the

impact on patient's rights, and on mental health recovery.   Evaluations of the policy and its impact on patient behaviour, treatment and ultimately smoking status will service to shape social norms around smoking and the mentally ill in the future. Insightfully, Kunyk and Els (2009) suggest that smoke-free policies are the starting point to successfully seeing cessation strategies initiated for inpatients with mental illness.

With the growing recognized need by the health community to support smoking behaviour change for individuals with SMI that includes increased smoking restrictions within mental health care settings, a future positive social norm shift away from tobacco use in the mental health community is realistic.

SMI Individuals' Motivation and Supports to Reduction and Quitting

Individuals with mental illness have significant positive attitudes towards their physical health yet exhibit physical health risk behaviours that include smoking at higher incidences than the general population (Brunero & Lamont, 2010; Lucksted, McGuire, Postrado, Kreyenbuhl, & Dixon, 2004). Consideration must be given to other things that might influence the health behaviour choices of these individuals (Brunero & Lamont, 2010). Motivating factors for individuals with SMI to attempt to quit or maintain cessation have included mounting health concerns, costs of cigarettes, pressure from others, unhappiness being addicted, negative role modelling for their children, socializing with non-smokers and having more active lives (Ashton, Rigby & Galletly, 2013; Ferron et al., 2011; Robson et al., 2013; Singer Solway, 2011). Emerging evidence suggests there is the capacity for modest numbers of patients with SMI to be able to stop smoking if their cessation supports are tailored to address neurobiological, cognitive, affective and social effects of their illness (Robson et al., 2013). Reassuring for both individuals with SMI and their health care providers is evidence in the research that not only can those with

SMI reduce or quit smoking but that treating tobacco dependence in individuals with controlled psychiatric illness does not worsen their mental state which dispels past thinking that trying to stop smoking threatens the mental stability of individuals with SMI (Banham & Gilbody, 2010; Currie et al., 2008). This includes the benefits of initiating tailored tobacco cessation treatment with the inpatient psychiatrically ill population without jeopardizing their mental health recovery (Prochaska, Hall, S. E., Delucchi & Hall, S.M, 2014). There are some medications used to treat specific SMI disorders that are also believed to have positively affected the outcomes of quitting smoking specifically by reducing the intrinsic barrier of cravings and thereby helping with changing the behaviour (Ziedonis et al., 2008). Furthermore, cessation focused treatment options that include medications and behavioural therapy used for the general population also work well for individuals experiencing SMI (Banham & Gilbody, 2010). Positive social facilitators to health behavior change for individuals with SMI have been identified as including emotional, practical and mutual support from significant others (Aschbrenner et al., 2013).

There has been much hypothesized regarding the interest of smokers with SMI to change their smoking behaviors. Siru et al., (2009) suggest that more than 50% of all smokers with mental health disorders may be contemplating quitting within six months or preparing to quit within 30 days. There may however be variation in motivation dependent on the individual's type of mental illness, as for example individuals with schizophrenia whose symptoms by nature of the illness include decreased motivation (Griffiths et al., 2010; Siru et al, 2009). Studies of individuals with schizophrenia and schizoaffective disorders with higher rates of smoking, greater nicotine dependence, less self-efficacy to quit and lower rates of ex-smokers still had similar rates of quit smoking attempts to that of the general population (Etter, Mohr, Garin, & Etter, 2004). Ferron et al., (2011) also found over an 11 year study period that 75% of smokers

with co-occurring SMI and substance use disorders tried quitting smoking at least once with 23%

attempting 18-80 times. The prevalence of quit attempts for individuals with SMI appears to be

very similar to those individuals without SMI but these quit attempts are less likely to result in

the individual being successful in stopping smoking (Ferron et al., 2011; McClave et al., 2010).

Research also reported higher proportions of individuals with mental illness making a quit

attempt compared to those without a mental illness (Bowden et al., 2011). Ashton, et al., (2010)

report findings of reduced consumption and significant commitment to try and quit smoking

again for those individuals with mental illness who remained smoking at the end of a 10 week

cessation program. Individuals with mental illness who are having success with quitting are also

often using some form of nicotine replacement therapy as a resource (Bowden et al., 2011;

Currie et al., 2008). Griffiths et al. (2010) report marked reductions in tobacco dependence and

notable increases in self-efficacy to avoid relapse in difficult circumstances in individuals with

SMI participating in group cessation programming.

The Trans-Theoretical Model and Tobacco Cessation

The Trans-Theoretical Model of Behaviour Change has long been a hall mark of

understanding both when and how shifts in behaviour occur (Prochaska, DiClemente &Norcross,

1992). Within this model there are five stages: a) pre-contemplation, where the individual has no

plans to change their relationship with smoking in the next 6 months as they are unaware or

under aware of the health impact of their smoking or has been demoralized by past quit attempts;

b) contemplation, where the individual is weighing the pro and cons of their smoking, aware of

its health impact and is thinking about making a change to the relationship with tobacco in the

next 6 months; c) preparation, where the individual is intending to make a change to their

smoking behaviour in the next month and has tried to do this before in the past year; d) action,

where the individual with hard work and great effort has changed their relationship with tobacco having quit for between one day and six months; and e) maintenance, where the individuals is working not to relapse back to their relationship with tobacco and remain smoke-free beyond six months (Prochaska et al., 1992). The model is also characterized by ten processes of change that include, consciousness raising, self-re-evaluation, self-liberation, counterconditioning, stimulus control, reinforcement management, helping relationships, dramatic relief, environmental re-evaluation and social liberation (Prochaskaet al., 1992). Finally the model includes the core constructs of decisional balance that involves weighing in on the pro and cons of the behaviour as well as integration of Bandura's theory of self- efficacy that involves the confidence to move forward with ones behaviour change (Atak, 2007).

For the individual experiencing SMI the process of changing their relationship with tobacco can be further examined under the self- efficacy construct. As the individual embarks on their behaviour change journey, they may question the effectiveness of their strategies to support reduced or abstinence from smoking and their capacity to succeed (Strecher , McEvoy, DeVillis, Becker, & Rosenstock, 1986). Within the theory of self-efficacy, personal perceptions of efficacy direct whether coping strategies will begin, the amount of effort invested and the duration of sustained behaviour change in the face of adversity (Bandura, 1977). According to Bandura (1977) motivation involves creating expectations for behaviour change and setting self-rewarding responses dependent on achieving that change which drives the individual to match performance to the behaviour standard that meets their outcome expectancy. Efficacy expectations are based on four sources of information that include the (a) experiences of performance accomplishments, (b) vicarious experiences of seeing others succeed or not succeed at behaviours, (c) verbal persuasion of others that goals are achievable and finally (d) emotional

arousal where the level of anxiety and stress impact perceived attainment of success (Bandura, 1977).

Interventions based on the Trans-Theoretical Model of Behaviour Change with individuals with SMI have shown positive movement through the stages towards quitting that coincides with less temptation to smoke and increases in cessation self- efficacy (DiClemente et al., 2011). It is recognized however that significant percentages of smokers with SMI remain in the stage of pre-contemplation where smoking is not considered an issue at this time and there is no motivation to change the behaviour (Lucksted et al., 2004).

As many individuals with SMI are heavily addicted to nicotine and may not have an interest in completely stopping smoking, a harm reduction approach with tobacco use reduction in combination with supportive interventions has been used as a motivational starting point (Banham & Gilbody, 2010; Goldie, Masuhara, Heah, Okoli, & Johnson, 2012). Although at present there is insufficient evidence to support any health benefits of reducing smoking, it has been demonstrated to increase the probability of the individual moving on towards future cessation (Hugh, & Carpenter, 2006).

The reviewed literature reveals a long standing and complex relationship with tobacco for individuals with SMI. This history has influence in the individual's decisions as to whether or not to continue smoking and put their physical health at risk or change their relationship with tobacco. It must also be understood that for these individuals concurrently there has also been the lived experience of a long standing and complex journey towards mental illness recovery. An understanding of this recovery process is therefore necessary to complete the literature review's comprehensive picture of tobacco use, cessation and the implications for the individual with SMI.

The Concept of Recovery

Since the 1990's, the mental health services system has been striving to integrate an approach where individuals with a psychiatric condition seek to recover by working towards achieving personal success (Anthony, 1993). Davidson and Roe (2007) differentiate between recovery from mental illness where individuals become symptom free and recovery in SMI, where the focus is on achieving a quality life with hopes and dreams even in the face of continued illness. The majority of individuals with SMI fall within the recovery in mental illness group (Davidson & Roe, 2007). This is described as non-linear, viewed as a highly individual process versus an outcome, and is characterized by discovery of self- management skills and achieving self-actualization (Carpenter, 2002; Frese & Davis, 1997). Defining recovery for these individuals means having hope and appreciating that they can increase their personal abilities and make choices regardless of the state of their condition (Bledsoe et al., 2008). It also involves the individual with SMI realizing their potential within the uniqueness of their lived experience (Frese & Davis, 1997). Deegan (1988) describes recovery for those with disability as the lived experience of individuals as they acknowledge and prevail over their challenges. Recovery is moving day to day with frequent setbacks towards rebuilding lives with the building blocks of hope, willingness and responsible initiatives (Deegan, 1988). Through the process of recovery, outcomes that include enhanced self-esteem, empowerment and self- determination can be realized by the individual with SMI (Anthony, 1993). Recovery for everyone not only those with a SMI is accompanied by an intense and variable range of emotions but for those with SMI these emotions are often misinterpreted as consistent with their illness and not as a part of their recovery (Anthony, 1993).

There are also factors that help or hinder the individual with SMI's recovery process that can range from a variety of areas not in the least including personal, resources, services and supports (Bledsoe, Lukens, Onken, Bellamy, & Cardillo-Geller, 2008). Initially the process of recovery is described as one of assessing abilities to move forward and considering the benefits and risks which can create ambivalence, fear and anxiety that the road ahead might be insurmountable (Bradshaw, Roseborough & Armour, 2006). Essential to recovery is a focus on the here and now and reflection on the consequences of strategies, gauging of progress and appreciation of successes in the present versus thoughts of more futuristic outcomes of goals that may appear too lofty and serve to undermine the individual with SMI's self- confidence (Davidson, 2007). Also key to recovery for individuals with SMI is their perception of self-concept or self-efficacy where their belief in themselves and their perception of capacity to impact the direction of their lives influences their motivation towards recovery (Markowitz, 2001). The individual with SMI is the expert in their own illness and in order for care providers to effectively support recovery, there is a need to understand the SMI lived experience (Godfrey & Wistow, 1997). Similarly, in order to gain insight into the personal perceptions of self- management and success in recovering from tobacco dependence for the individual with SMI it is important to study the meaning of the lived experience of a changing relationship with tobacco in this demographic.

The reviewed literature created a picture of the complexity of tobacco use in general and specifically for the individual experiencing SMI. It also addressed theoretical concepts including those associated in the mental health literature with understanding behaviour change towards wellbeing, and the reduction or cessation of tobacco use. The individual's perceptions of the experience along the journey, individualized goal setting that includes possible harm reduction intentions and personal evaluations of progress are infrequently addressed or non-existent in the

literature. If we are truly interested in reducing the smoking related morbidity and mortality for the high-risk population of individuals that experience SMI, we need to better understand what it is really like for them to change their smoking behaviour. If we are to gleam this understanding, a logical sequence of inquiry would be to turn to these individuals as the *experts* and through conversation, ask for their insight into the lived experience.

The next chapter will construct the logic behind the appropriate methodology for studying the meaning of the lived experience of a changing relationship with tobacco from the perspective of individuals living with a SMI.

Chapter 3

Methodology

The literature review identified in detail how smoking continues to be a significant Public Health concern that negatively impacts the incidence of chronic disease morbidity and mortality. Smoking in the general population in Canada in particular Ontario although declined, continues to remain high in the population of individuals with SMI. There is an opportunity to reverse the negative health effects of smoking to varying degrees with quitting and individuals with SMI are motivated to quit. There is however barriers that are specific to these individual`s experiences with and treatment of their mental illnesses that have complicated the quitting process. Mental healthcare professionals although beginning to change how they perceive and approach smoking with this population have historically not prioritized the problem or supported cessation. The Trans-theoretical Model of Behaviour Change is identified as being used to effectively assist and support individuals moving towards cessation. Smokers with SMI trying to quit are also experiencing the process of recovery in their mental illness which also impacts their approaches to and perceptions of tobacco use behaviour change. It is identified from the literature that there is insufficient understanding of what it means for a smoker experiencing SMI to change their relationship with tobacco.

This chapter will direct the reader through the philosophical underpinnings supporting a logical methodology that guides a study of the meaning of the lived experience of changing ones relationship with tobacco, from the perspective of individuals living with a SMI. It will highlight the study`s use of Van Manen`s approach, based in Heidegger's hermeneutic phenomenology, in the collection and analysis of data. Ethics approval, the recruitment process, study sample and setting for and method of data collection are discussed. The process and supports for data

analysis are outlined. An extensive description of the audit trail which supports establishing the study`s qualitative merit is described. Finally the chapter concludes with reflection on and identification of the study`s limitations.

Philosophical Underpinnings

In examining this phenomenon, there lies both the experience of changing ones relationship with tobacco combined with having a SMI and the desire to better understand what this is like for someone living this experience. A study of this nature requires a philosophical approach that supports a better understanding of the essence of the phenomenon of this lived human experience.

Heidegger's 1962 interpretive or hermeneutic phenomenological ideals are an appropriate choice for this research in order to move beyond a mere description of the smoker with SMI's experience with changing their relationship with tobacco to look at the meaning rooted in this behaviour. According to Heidegger, "Being" is the meaning of things, in other words what does it mean to be a smoker with SMI trying to change your relationship with tobacco (Mackey, 2005). As well "Being in the World" is the ability to describe how these individuals are inseparable from the world in which they live in, articulated as a state of "dasein" or being capable of questioning personal circumstances (Mackey, 2005). Applying these philosophical concepts to a hermeneutic phenomenological study as explained by Lopez and Willis (2004) will help explore how the perceived realities of a group of smokers with SMI's are influenced by their world termed life-world. It will also help in identifying similarities and differences between the meanings of individual experiences across a sample.

Heidegger's hermeneutic phenomenological philosophy also highlights the need to understand the importance of time. It is in time that all personal experiences are grounded,

therefore past experiences influence the present, and impact on expectations of what will be experienced in the future, as part of the "horizon for all understanding of Being" (Mackey, 2005). As time is paramount to understanding the experience of study participants changing their relationship with tobacco, so too is the need to understand the Heideggerian concept of space. As described by Mackey (2005), unlike the idea of physical space within Heidegger's philosophy, space as applied to this study involves those aspects of a changing relationship with tobacco that are of concern to participants and brought into the foreground of their attention, as well as consideration for what they leave in the background of their descriptions.

Further philosophical underpinnings of Heideggerian interpretive hermeneutic phenomenology that form the methodology of this study include its implications for and application of the hermeneutic circle. As described by Koch (1995), the hermeneutic circle encompasses an individual's background which influences their perceived realities and pre-understandings of their circumstances, as well as the influence of the world on them and in turn their influence on the world termed co-construction. The hermeneutic circle further includes the concept of fore-structure, which involves prior awareness and represents that what is already known or thought about a phenomenon (Mackey, 2005).

Therefore, in applying the concept of the Heideggerian hermeneutic circle to a study of the perceptions of smokers with SMI to changing their relationship with tobacco, it must be understood, as described by Chang & Horrocks (2008), that there will also be presuppositions, knowledge and experiences in existence during data collection. As further explained by Newberry (2012), the hermeneutic circle "involves an ever- increasing development of understanding as we revise our pre-understandings in light of new experiences" (p. 10). The philosophical ideals based from the hermeneutic circle includes the existing world and its

meaning for those individuals conducting and interpreting the research who are expected to acknowledge and identify upfront those ideals and beliefs that might have impact on the data collection or its interpretations (Crist & Tanner, 2003). In Heidegger's philosophy of the hermeneutic circle, there is interpreter participation in creating the data, which is co-constructed with the interviewee and is contextual to each of their life events and specifies each of their perspectives (Koch, 1995).

The study researcher has an existing orientation to the lived world of tobacco smoking as a public health nurse working in the field of tobacco control for over 24 years, which has influence over assumptions and pre-understanding. From this vantage point, the researcher has experienced the significant shifting in (a) social norm changes around acceptability of smoking in public and workplace indoor and outdoor environments, (b) prioritization of the need to increase access and equity to quit smoking pharmacotherapy options and resources (c) a focus towards high risk populations in particular individuals living with SMI and finally, (d) the viewed smoking landscape through a health equity lens. As a member of the public health environment focused on prevention of smoking related chronic diseases, extensive professional energy has been expended to support and coordinate policies that advance smoke-free spaces, and expand options for smoking cessation services. However, being someone that has never smoked, there is a self-perceived lack of credibility to understand the smoker's circumstances, therefore providing direct counselling to individuals that are considering making a change to their smoking behaviour has never been part of the researcher's professional role. The researcher`s lived world also extends personally to include growing up as a child of a heavily addicted smoking parent during the era of school-based tobacco prevention education that included black lung images of ultimate death to all smokers. This lived world also includes being

an adult with children of her own experiencing that parent quitting smoking and the mystery that surrounded that choice, its success and sheer appreciation of the many years of quality life that have followed. This project of hermeneutic phenomenological inquiry therefore is driven by both a professional and personal interest to better understand what it is really like for an individual to change their relationship with smoking. It is further influenced by the exposure to mental health care professionals within a public health environment and their social norm shift in prioritizing the need to address the client holistically and act to reduce the incidence of tobacco related chronic disease in a vulnerable population.

Method

In moving forward with a hermeneutic phenomenological research study rooted in Heidegger`s philosophical underpinnings that investigates what it means for the individual with SMI to change their tobacco use, a method to conduct the data collection and analysis was required. In this study the process of hermeneutic phenomenological reflection as conceived by Van Manen was utilized to direct data collection and analysis. Van Manen's proposed methods and analysis are based in Heidegger's philosophical underpinnings that include using reflective writing in a phenomenology of practice to grasp the personal presence and relational perceptiveness between who the individual is and how they act (Van Manen, 2007). According to Van Manen, "insight into the essence of a phenomenon involves a process of reflectively appropriating, of clarifying and of making explicit the structure of meaning of the lived experience" (1990, p. 77).

According to Van Manen (1990), data collection systematically uses questioning and reflecting in order to describe through the context of written text the structures of meaning of the personal experience (Van Manen, 1990). By incorporating Van Manen's assertions into this

study, data collection has been conducted with attention to thoughtfulness and by displaying a true need and desire to understand what was thought of before on what it means for those living with SMI to consider or make this change (Van Manen, 1990). It is also understood by applying this method, that the analysis of data does not culminate in explanations, but rather results in plausible insights which in the case of this study is into the world of the smoker with SMI considering or trying to change their tobacco use behaviour (Van Manen, 1990). Furthermore, what is uncovered from the data is the participant's awareness and perceptions real or unreal, retrospectively from their personal social context (Van Manen, 1990).

Ethics

Ethics approval for this study was obtained through the Laurentian University Ethics Review Committee (see appendix A). The vulnerable status of the demographic being studied was identified during the ethics review process. Recruitment strategies were planned to safe guard against any potential elements of perceived coercion of individuals to participate by designate recruitment agency partners.

Recruitment

Consistent with the hermeneutic phenomenological methodology of this study, recruitment targeted individuals that would be rich sources of data, which included their experiences of living with SMI as well as having a history of smoking. Three variations of recruitment strategies were used as part of this study. This included posting a recruitment flyer (see appendix B) at the Canadian Mental Health Club 84 site. Interested individuals approached Club 84 staff identifying interest in participating in the study but verbalizing a discomfort with calling or emailing the researcher. As a result, a signup sheet was created to allow interested participants to schedule the first meeting with the researcher on specific dates in a private

meeting room at the Canadian Mental Health Club 84 location. The second recruitment strategy involved the distribution of the study flyer through the Community Mental Health Program office correspondence to clients receiving case management support to change their smoking behaviours. Finally, information about the study opportunity was presented by the researcher to a smoking behaviour change preparation group organized through the Community Mental Health Program. Recruitment posters were provided as well as a sign up sheet for individuals requesting a call from the researcher for more information.

Sample

Literature recommends phenomenological studies of the essence of the lived experience involve approximately six participants in order to support saturation of data collected (Sandelowski, 1995, p.180). Purposeful sampling in this study consisted of nine individuals that were either receiving direct services from the Algoma Public Health Community Mental Health Program or were voluntarily participating in Club House activities at the Canadian Mental Health Association in Sault Ste. Marie, Ontario.

Initially inclusion criteria was to be limited to individuals who were actively making, or maintaining a change to their smoking behaviour and were being supported with intensive tobacco cessation counselling by mental health professionals. Participation however was extended to those living with SMI whose motivation for smoking behaviour change could be categorized into anyone of the Transtheoretical Model's five stages of change from pre-contemplating to maintaining a smoke-free status (Atak, 2008).

Setting

Mental health care professionals working for the recruitment agency partners were consulted prior to the recruitment process for recommendations on settings to conduct data collection. It

was advised that the target population often has had numerous and varied experiences with service providers and received services in a variety of community settings. Therefore to facilitate developing rapport and establishing participant comfort with the researcher, the choice of location was one of familiarity and perceived security as well where transportation to the location was also part of a pre-established accessible routine by the participant. The interview sites were therefore negotiated and mutually agreed upon between the researcher and study participant and were locations where the individual had learned about the study or identified as a regular place for meeting service providers. Locations included a private meeting room at the Canadian Mental Health Club House, a private area of a coffee shop, in the room used to host the smoking behaviour change group or in a meeting room just off the area where the community kitchen group is hosted at Algoma Public Health. One interviewee due to transportation difficulties agreed to participate from home via a phone interview.

Data Collection

It was the intention of the researcher to have an initial meeting with clients to review the study process and consent and then conduct two subsequent meetings thereafter. After one initial meeting with the first client it was recognized that participants would be both prepared and interested in beginning to share their insights directly after consenting to participate. Therefore after consultation with the study's thesis advisor it was determined that the data collection processes occur within two meeting with participants. At the initial meeting and prior to data collection, the study objectives and information letter/consent (see appendix C) was reviewed with the participants. Any presenting questions were addressed after which consent to participant in the study was obtained. The data collection procedure included audiotaped semi-structured interviews, which were conducted by the researcher with each participant on two

occasions for a total of eighteen interviews. Seventeen in- person interview meetings were conducted. These meetings lasted approximately 20-45 minutes and with each participant occurred two weeks apart. During one of the in person interview meetings, audio recording equipment was not available and therefore interview data was collected through reflective journaling completed by the researcher directly afterwards. One audiotaped interview was not done in person and was conducted over the phone due to transportation difficulties.

As described by Van Manen, there are multiple purposes of the hermeneutic phenomenological interview which in this study served as a tool to (a) "explore and gather experiential narrative material" to be used as a resource for "developing a richer and deeper understanding of a human phenomenon," and (b) "develop a conversational relation with a interviewee about the meaning of the experience" (1990, p. 66). The study was guided by the following interview questions:

1. What does it mean to reduce or quit smoking?

2. What has reducing or quitting smoking been like?

3. How has progress on changing the smoking routine been going?

Data collection was also supplemented with the opportunity for participants to use photo elicitation, a technique used by Padgett, Smith, Derejko, Henwood and Tiderington (2013) in a study on homeless and individuals living with mental illness. The researchers found that when participants took pictures related to the phenomenon of interest it provided richer and deeper insights into the meaning of the experience beyond verbal only data. In the current study, participants voluntarily chose to use pictures to help describe the meaning of their experience and were asked to explain what does the picture tell (show) about what it's like to try and reduce or quit smoking? Five participants including two males and three females provided photographs

for discussion at their second interview. The remaining three interviewees were asked to verbally describe what a picture would look like if they had taken one of some aspect of trying to reduce or quit smoking. Two of them participated. The photo's visual imagery were used to gain significant insight into aspects of participant's individualized planned or actual journey in changing their relationship with smoking

Finally, data collection also included reflective journaling by the researcher. This involved documenting relevant insights as they were presented throughout the course of the study. These included perceptions immediately after participant interviews. Dialogue with smokers through chance encounters as well as mental health care providers and cessation specialists, were also documented. Information highlighted from participation in presentations on the topic of mental health and smoking cessation was also included. Journaling assisted the researcher in creating additional sources of "reflective accounts of experiences that were of phenomenological value" to the study (Van Manen 1990, p 73). These insights contributed to the researcher's analysis of the interview themes and helped to create structures of meaning from the data. This process assisted in the development of new understandings and revision of pre-understandings that is consistent with the hermeneutic circle as described by Newberry (2012).

Data Analysis

The data collected through the interviewing process had a hermeneutic direction. Participants assisted in interpreting the meaning of the phenomenon by having the opportunity to validate or comment at interview time two on any emerging themes captured from any completed interview time one data. The emerging themes were further incorporated into subsequent hermeneutic conversations with new participants. This created an opportunity to uncover deeper insight and interpretation from subsequent participant interviews (Van Manen, 1990, p.99).

Following Van Manen's hermeneutic phenomenological approach to data analysis and writing, the journey to unearthing the meaning of the experience involved reflecting on the structures of meaning or the phenomenological themes in the competed participants' text (Van Manen, 1990 p. 79). To derive themes from the data, a detailed line-by-line approach involved the researcher reflecting on what each sentence or group of sentences disclosed about the individual's changing relationship with tobacco (Van Manen, 1990, p.93). Re-occurring or similar structures of meaning were recognized and articulated further through isolation of supporting phrases or statements found in each participant's interview text (Van Manen, 1990, p.93).

Consistent with Van Manen`s fundamental thematic structure of the lived world, this phenomenological research took into account each of the four fundamental existential themes that describe how all individuals experience the world (Van Manen, 1990. p.102). Participants lifeworld reflections included that of : a) spatiality or the lived space, where the experiences being described happened, which directly affected how they felt and the meaning they attached to the experience, b) corporeality or lived body, where their physical presence revealed and concealed something about them and whereby how they felt others perceived them influenced the meaning they attached to the experience, c) temporality or lived time, where their perceptions of their past, present or expectations of the future at that moment in time influenced their perceptions of the meaning of the experience being described, and, d) relationality or lived other, where their perceptions of their relationships with others in their lived space influenced the meaning that was attached to the experience they were describing (Van Manen, 1990, p.101-106). These existentials of spatiality, corporeality, temporality and relationality are interwoven

and identifiable throughout the themes uncovered in the analysis of the study's data (Van Manen, 1990, p.102).

The N-Vivo qualitative software system was used to support data management (Basit, 2003). The system was used throughout the research process to refine the categorizing of data into themes. The software system was also used to assist in the identification of examples from the rich text of participant's narratives of interview one and two that supported the study's identified themes.

Audit Trail

In order to safeguard trustworthiness of findings, explicit documentation and decision trails as highlighted by Cope (2014) were maintained and followed by the researcher.

This process initiated with following the Tri-council Policy Statement for Ethical Conduct Involving Humans (TCPS) section 2B, 10.1 (Canadian Institutes of Health Research Natural Sciences and Engineering Research Council of Canada and Social Sciences and Humanities Research Council of Canada, 2010).The feasibility of the proposed qualitative research including development of the proposed research question, design, targeted sample and any potential concerns with data collection was discussed with recruitment partners.

The audit trail continued throughout the Research and Ethics Board review process. Upon ethics approval, a copy of the approved ethics proposal and letter outlining participant recruitment process was forwarded to the recruitment partners.

Each study participant was assigned a designated code that was used on all data associated with that individual. Each transcribed interview was reviewed with its audio recording by the researcher to ensure accuracy of the transcription. The transcribed interview time one, with each participant was summarized into general discussion themes. The general themes from the first

three study participants' interview time one were reviewed by the researcher's thesis advisor to ensure accuracy in summarizing interview discussions.

Interview time one was completed with the first four study participants before any interview time two sessions were conducted. This was done in order to support summarizing the general themes of the first four participant's interview time one discussions into three groupings. These first four interview time one discussions were grouped for each participant into themes that included (a) themes that were discussed by the participant that were also described by most all other participants to date, (b) themes that were unique to that individual participant's interview time one discussions and finally, (c) any unique themes that emerged from the discussions with other participants that had not been brought up by the interviewee. The examples provided under these general themes were prepared in a written outline by the researcher to review with each participant at their interview time two. This practice was continued as subsequent participants were interviewed and preparation was made for their interview time two. This technique was used to stimulate more fulsome discussion and support the identification of commonalities and differences in the lived experiences of participants during interview time two conversations with participants. Moreover this system of preparation for interview time two assisted with structuring the review of content from the interview time one conversation. This in turn provided the opportunity to employ the strategy of member-checking with participants during interview time two. Curtin and Fosse (2007) describe this strategy as providing the participant the opportunity to review the analyzed data, provide additional context, clarification and contribute to findings gathered to date.

Following completion of the second interview each of the participant's two transcripts were analyzed by the researcher for specific themes. This was completed line by line using a track

change and color coding scheme to identify what the sentence revealed about the experience (Van Manen, 1984, p.62). To limit any single researcher bias and support researcher triangulation of analysis (Curtin & Fossey, 2007), all researcher analyzed transcripts were reviewed by the researcher's thesis advisor, an expert in conducting research using these methods. Four teleconferences and one in-person meeting between the researcher and thesis advisor occurred throughout this process to review thoroughness of transcript analysis and comparisons of perceptions of evolving specific themes from the data. The auditability of how preliminary themes were determined was reviewed with the researcher`s thesis advisor and advisory committee at a face to face meeting with the researcher (Koch, 1994). Final drafts of all study chapters were submitted to the thesis advisor and assessed for congruency with Heidegger`s methodology and Van Manen`s method of data analysis.

Finalized emergent themes congruent with the study`s method of data analysis and supported with rich text examples as well as concluding discussions from the study`s findings were submitted in writing initially to the thesis advisor for review, reflection and validation and then to the thesis advisory committee for review, revisions and approval.

Establishing Qualitative Merit

This study of *the lived experience of a changing relationship with tobacco: A perspective of individuals with serious mental illness* has been evaluated for qualitative merit on several levels. A thick description was provided that demonstrated congruency between the research question and the Heideggerian phenomenological study methodology and Van Manen's hermeneutic approach to data analysis and writing of findings (Cope, 2014). As further described by Cope (2014) thoroughness of data sampling was ensured as no new significant information related to the meaning of the experience of changing ones relationship with tobacco evolved from the final

interviews and analyzed general themes became repetitive. The credibility of data was also ensured with member checking whereby there was validating of general themes with participants and their recognizing of many shared general themes described by other study participants (Curtin & Fossey, 2007). This process also facilitated the collaboration of participants in analysing study data as it was evolving (Curtin & Fossey, 2007). Data and themes were verified with participants following a minimum two- week interval between interviews which supported time triangulation of data (Curtin & Fossey, 2007). This allowed the opportunity for participants to reflect on what they had shared and to explore any changes in their perceptions of the experience. The researcher has also provided an explicit audit trail identifying decisions that directed the study processes from start to conclusion (Sandelowski 1986).

Dependability of data as described by Cope (2014) was achieved through the review and established consensus of decisions throughout the research process with the study's thesis advisor and outcomes with the thesis advisory committee. Confirmability and authenticity has been demonstrated through the use of rich text quotes provided by the participants that reflected the study's themes. Method triangulation of data as described by Begley (1996) was achieved through the use of three different methods of qualitative data collection, the interview, photo elicitation and researcher journaling to describe the phenomenon of a changing relationship with smoking. As well, space triangulation of data was supported with the collection of data on the lived experience from individuals representing two different mental health service agencies (Curtin & Fossey, 2007). Finally, details of the researcher's background and interest in the phenomenon have been reported. In addition, the use of journaling to highlight the insights from the interactions with participants was identified. Together these actions demonstrate the

researcher's active role or reflexivity (Finlay, 2002) throughout the study to develop further insights into the phenomenon.

Limitations

The results presented in this study are of a purposeful sample of individuals living with SMI who had access to or were receiving services from mental health care providers that were community-based, supportive and well versed in the elements of smoking cessation. Therefore the finding are not transferable to the overall population of individuals living with SMI that maybe attempting to make changes to their tobacco use on their own or in unsupported circumstances such as described in some of the literature. However saturation of data was obtained therefore the findings present a point of reference on the experience of the phenomenon.

The researcher's life time of personal experiences and pre-understandings that were the prejudices brought to the interviews with participants must also be recognized as having an influence on the interpretation and analysis of the data (Koch, 1994). Although the audit trail provides the means by which to understand how the author came to the conclusions of the essences of meaning in this study, it is important to acknowledge that others reading the findings will have their own pre-understanding and may arrive at different conclusions from the data (Koch, 1994).

The emotional investment of the researcher as described by Drew which brought both passion and commitment to studying the lived experience of changing a relationship with tobacco for those with SMI was also ever present in influencing the researcher`s perception and interpretation of the study`s findings (1989). It therefore must also be acknowledged as limiting the transferability of the study`s findings.

Finally it must be recognized that the circumstances of conducting a study using interviews for data collection creates a scenario where by: a) the presence of the researcher influences the response of participants, b) the participants sharing and behaviour evokes an emotional response in the researcher, c) the researcher's emotional response to the participants shared information can further influence the interaction and data collected (Drew, 1989). These conditions individually and collectively also present a limitation to the transferability of the study's findings.

This chapter served to summarize the methodology used in the study as well as the methods used to collect and analyse study data. It concluded with identifying the study's limitations. The next chapter will present the interpreted findings from the data that support existing research from the field as well as that which adds new insights to the body of research on this issue.

Chapter 4

Interpreted Findings

The interpreted findings in a hermeneutic phenomenology study are expected to help

determine the key aspects and qualities that characterize what the experience is like and that are

essential to understanding it (Van Manen, 1990, p. 107). The study findings in this chapter are

organized thematically to articulate the lived experience of changing a relationship with tobacco

as an individual with SMI. Woven into these themes that describe the phenomenon are the

existential concepts of temporality (lived time), spatiality (lived space), corporeality (lived body)

and relationality (lived other) that are reflective of participants' lifeworld (Van Manen, 1984).

Phenomenological reflection as described by Van Manen was used to grasp the personal

presence and relational perceptiveness between who the study participants were and how they

acted (2007). This provided the opportunity to gain insight into the essence of the phenomenon

of living with mental illness and journeying towards changing a relationship with tobacco

through clarifying and making obvious the structure of meaning of this lived experience (Van

Manen, 1990). The analysed interpretations of the data highlight participant's awareness and

perceptions real or unreal, retrospectively from their personal social context (Van Manen, 1990).

This chapter presents the interpreted findings from analysis of the study's interview and photo

elicitation data infused with the contributions of insights from the researcher's journaling

throughout the data collection process.

The Participants

This study involved the participation of nine individuals, five males and four females with a

history of SMI that were over the age of 19 ranging in age from 37-64 years (average age

51years). Determination of SMI was made on the basis of participants self-identifying receiving

mental health services reserved for only those individuals diagnosed with SMI and or the

individual's personal self- disclosure of an existing SMI that is classified under the American

Psychiatric Association DSM-IV (See Table 1).

Table 1

Number of Participants per SMI

Self- Disclosed Mental Illness	Number of Participants
Schizophrenia	2
Bipolar Disorder	1
Delusional Disorder	1
Acrophobia	1
Undisclosed but receiving services reserved for those diagnosed with a serious mental illness	4

Information was provided by eight of the nine participants on the length of time they felt they

had been smoking. Of these eight participants seven identified starting smoking during their

adolescent years and only one identified starting in later adulthood after years of intermittent

cigar use. Years of smoking ranged from 4- 46 years with the average duration of smoking for

the eight participants being approximately 30 years.

Consideration was also given to the spiral pattern most individuals take as they move through

the stages of change towards smoking cessation that encompasses potential regression to an

earlier stage of motivation for behaviour change (Prochaska et al., 1992). Therefore participant's

self- description of smoking behaviour change status and activities at the time of the second

interview guided the researcher's determination of their stage of change at that point in time.

(See Table 2).

Table 2

Participant's Stage of Change for Smoking

Stage of Change for Tobacco Cessation	Number of Participants
Pre-contemplation	2
Contemplation	3
Preparation	1
Action	1
Maintenance	2

The structures of the experience that helped to bring meaning to the study's data and explain the phenomenon of changing ones relationship with tobacco as someone who experiences SMI have been categorized into six themes. These are described as: (1) fear of being, (2) burdens of frustration, (3) influencers of change (negative and positive), (4) holding onto resolve, (5) driving forces (corporeality forces and spatiality forces) and (6) embracing hope and sensing inspiration.

Fear of Being

This fear of being is recognized as representing diversities of fearing such as that of self, relationships with others and tobacco itself. In reflecting on the written texts of the study's interviews and described photographs, a sense of foreboding was permeating through the descriptions of six of the nine participants who represented a diverse range in their stage of changing their relationship with tobacco. For some this experience included a lived body sense of fearing themselves and their own responses to the experience, while for others it was a fear found beyond them in the lived space of the external world or with the lived relationships with

others. For all of the participants, tobacco use had been an integral part of their daily routine for most of their lives and served as a source of comfort and strategy for coping with the stress and anxiety of living with a mental illness. Therefore the idea of giving up something that is integral to their lived body perception of survival was for several participants intimidating.

I'd been smoking since I was 14 and you know a pack a day since then so that's a long time of smoking and I was very, very psychologically sort of attached to it, that's the hardest thing you know I find that psychological attachment that security blanket sort of thing and so that frightened me the most like Oh my God how am I gonna survive without my trusty little friends there you know which is the way you begin to think of them (female, F-1).

Trepidation surrounded having the capacity to move forward with attempting a change to smoking and maintaining ones lived experience with others or having to now experience isolation. "*I find it very difficult, I don't know if it's a different mindset that I got as far as I feel but I got to be out here with these people that are smoking cause there a part of my life*". For another "*It would be hard because like I said most of my friends smoke and I'd lose a lot of my friends*" (male, A-2). This concern also extended to fears that even if friendships could be maintained the quality of the relationships with friends that smoked would be impacted. "*I think to that because they're not ready then the dynamics is going to change if they come to my house and I don't smoke*" (female, G-2).

For two individuals there was a uneasiness with making a quit attempt for the wrong reason one of which included doing it for others and not for themselves,

I want to lead by good example ok, but if that's something I enjoy doing ok, then the only example I'm going to leave is if I was to do that and tell her I did it for her is … I'm going to let you control my life and I can't let that happen (male, B-2).

For the second it was,

I remember my mother quit, one day she just said I quit for a year she said, quit cold turkey

and a year later she started again. And what I found out was my grandmother made her

promise to try and quit and she did it for a year and then she started smoking (female, G-1).

For one of these individuals this apprehension extended to making a change to their

relationship with tobacco because of the costs of cigarettes or for health reasons and not because

they truly were of themselves mentally motivated.

I think that if everybody had to pay what is it now I don't even know for a carton of cigarettes

it's gotta be eighty anyways … who could afford it for one thing…it would be a bigger chunk

out of your daily living and there again your being forced"(female, G-2) and *"like some of*

these other girls that are further ahead than me from what I understand they had to quit

because of their health, like their breathing so I think they're having a harder time with it

because... it wasn't there choice… what I found with over the years with some of the people

that did it it's much easier if you know it was your choice to do it (female, G-2).

For one individual there was an apprehension that you can never be done with tobacco based

on observing others quit attempts and that it would be forever present in ones lived space.

What scares me is my sister, my younger sister that I basically started smoking with she quit

for 20 years. Quit for 20 years came back home and the first thing she said to me was give

me a cigarette, she's still says she has to have a least that one cigarette a day (female, G-1).

The theme of fearing was also reflected by one participant's lived time of now successfully

maintaining abstinence from smoking and the concerns as to how this would shape the future.

I wasn't sure if I would be able to be successful or not because I was such a heavy smoker. I was like a 2 pack a day smoker for like 26, 27 years and I didn't know if I would be able to give it up or not (male, C-1).

This theme persisted through this individual`s journey with thoughts that

I didn't think these cravings especially the psychological for just for cigarettes would actually go away and I'm still a little bit leery, like it's been years since I've had cravings even psychological ones but I ah know that periodically that could happen like I could be in a trigger situation (male, C-2).

For this individual, too there was underlying apprehension that quitting smoking would not improve long term health outcomes that were already perceived as being significantly and negatively impacted by their SMI "*It might not necessarily add like a lot of time on to my life span because of my illness*" (male, C-2).

For another individual there was significant distress over potentially appearing as a failure in the eyes of others.

I don't plan on telling any of my friends when I do attempt to quit. I'm not telling my friends at the beginning because I think if I fail that I'm only going to be more discouraged because I also heard that it takes like 7 or 8 times in your life to quit. Well if I tell my friends and I feel bad about it then say the next time want to quit they're not going to take it seriously so that's going to put me in a bad place you know what I mean so I think it's better not to tell them until I know I have a good handle on it (female, G-1).

Finally, fears were identified by pre-contemplating and contemplating participants regarding the impact of quit smoking pharmacotherapies on disrupting their present mental health

recovery. This included how these cessation therapies might impact their present medication regime used to control the symptoms of their mental illness.

> *Some of the NRT's those pills like the Champix and Wellbutrin, those are all antipsychotic medications and like when you have a mental illness you can't really be playing with those medications, like yeah it's going to help you quit smoking but to what cost… it can interact with how effective your pills work or don't work kind of scenario and so it's like that's one thing that kind of like deters me away a little bit about quitting smoking* (female, H-1).

For another participant it was an issue of not becoming addicted to nicotine replacement therapy. "*You may need a higher dose of it but then again will you ever get away from that high dose*" (male, B-2). Finally as summed up nicely by one participant there is a fear that making a change to one's relationship with tobacco is just too hard, "*for a lot of people they're very hesitant about doing that and uh I guess they know how difficult it is to give up smoking and how powerful the cravings are*"(male, C-1).

Collectively these scenarios highlight the impression that regardless of the individual's stage of changing their relationship with tobacco use, the lived experience of this journey evokes a certain degree of fearing self, relationships with others and tobacco, for the individual with SMI.

Burden of Frustrations

For eight of the nine participants their descriptions of what considering or acting on the decision to change their tobacco behaviour were tainted with an underlying perception of exasperation that was palatable. The lived other experience of constant pressure and reminders that they should change their smoking behaviour without any regard for the complexity of the decision, was an added heavy burden to already difficult circumstances.

Until it is drilled into their head ok, you're always going to have people telling you need to quit you need to quit you need to quit, ok we see it all over the television, government telling you, you need to quit you need to quit you need to quit (male, B-1).

For three participants who remained in a relationship with tobacco, the experience of lived space, where seeing or being around other smokers at times when they themselves were trying to make a change was irritating. For one individual,

I felt for me that and the fact I was involved with a lot of smokers in my life I had a very hard time breaking away from that habit to sit there and talk with someone who had a cigarette in there hand and not smoking yourself especially after being a heavy smoker…there was frustration there, the fact that they were sitting there smoking and you weren't" (male, A-1).

For another, "*I choose to go out because I don`t want to sit around the house all day long so again that's going to bring me right out to the smoking world, O.K. I`m not gonna get away from it*" (male, B-2). And finally "*you see somebody else sitting there with a smoke and your trying to quit you know it's like aw give me that* (female, E-2).

For many of the participants there was extreme vexation with past unsuccessful quit attempts and relapses back into smoking. This past lived time left its traces on present attempts at behaviour change and often negatively shaped any perception the individual had of a future as a non-smoker. "*I've tried in the past about 12 times and never managed to see it through to the bitter end. I've only gone a couple weeks and then started up again,*(male, A-1)… *it's a struggling experience don`t get me wrong like I told you I went on the patch, strong patch this morning and I had 3 cigarettes*" (male, A-2). For others "*I've tried the patch, I've tried the Nicorette gum, tried cold turkey. I guess I'm just not ready to quit*" (male, B-1)

or

I would start smoking again which was very discouraging at the time you know, you go long

periods of time without a cigarette and all of a sudden you have to start it right at the

beginning again… it gets the better of you, like you're gonna be going to the store buying a

pack cigarettes, like logic just flies out the window (male, C-1)

and "*I've gone possibly, let me think now 2 days, 3 days without a cigarette but it was hard, it*

was hard… before I caved in" (female, E-1).

Underlying frustrations were also apparent in participant's discussions surrounding the

supports recommended or available to individuals with SMI trying to change their relationship

with tobacco. Impressions of support services not meeting expectations were the lived

experience of others.

I`d be chewing on that straw, drinking water, exercising and keeping yourself busy cause like

I phoned the Smoker`s Helpline and this is what they said to do, exercise, keep yourself busy,

clean your house, do whatever and like O.K. I`ve done that and what now (female, E-1).

These frustrations extended as well to recommending options that were unrealistic to the

individual with SMI,

the patch and whatever, the gum and whatever … I think the Smoker's Helpline said the patch

you know and then there's no way I can afford it, like when it comes to the end of the month

because I'm on a disability you only got so much money and that's stretched to the end of the

month and the end of the month is the hardest (female, E-1)

and

I just asked here now what's covered and basically I guess the ones with the anti-depressant I

think are the ones that are covered but I'm not even sure, covered through like ODSP and you

know like what direction are you gonna go are you gonna go for the anti-depressants when

you're not depressed you know or what but the rest of them I heard are costly

(female, E-2).

For another individual

it started out OK for me, I was on the patch through the STOP program at Public Health and

it seemed to be going ok for me on the 21mg patch but then when I dropped down to the 14mg

it was just too big a drop (male, A-1).

And for other it was

O.K. you can get support through the telephone O.K. but I don't think that ah that talking

about it is going to be any sort of support O.K. that's like telling and alcoholic or an addict

just get through today O.K. well I can get through today but what's gonna happen tomorrow

morning when you're not there or I don't see this big advertising of a darkened lung or

something you know the supports are out there o.k. but they're not gonna stare you right in

the face 24 hours a day (male, B-2).

And finally for one participant

the smokers hot line would phone every second day, the only thing that bothered me about

that was that they have to be 24 hours a day because most people with problems happen in

the evening and they close at 9 o'clock and usually that...any time after that is when the

person has that alone time, that's when they need somebody to talk (male, I-1).

For many individuals the lived time experience of past trials with nicotine replacement therapy

were memories that continued to impact present and future choices for quit smoking supports

"*the gum I tried many, many years ago for something for my mouth but I'd rather have smoke*

going into my lungs than how strong the Nicorette was at that time" (male, B-2) and "*another*

time I tried the patch, and the nightmares were just unbelievable, like they were so real"(female, G-1).

This burden of frustration in being supported to make a change to ones relationship with tobacco is as well compounded by the perception of not feeling first supported through their recovery from mental illness. As described by one individual, "*People with mental health issues are being turned away, O.K. and through no fault of their own, I can't say that through the fault of this other person inside this body their going out and doing something ridiculously stupid*" (male, B -2).

For another

> *it's moving next to your tension buttons, you gotta get rid of the tension buttons around your life and set your own inner compass but there are people there that grab that thing and put it over here or hide it on you so you can't really straighten out yourself because their the boss sort of say* (male, I-1).

These experiences were perceived as relationships that were non-supportive and undermining. The burden of frustration was also conceptualized from the text of participant's interviews as it reflected futility in smoke-free policies to support prolonged tobacco use abstinence once an individual with SMI returns to the community as well as aggravation with the short sightedness of governments in being part of the problem and not the solution with this population.

> *Admissions to hospital have in the past 6-8 months had me cut down drastically to 6-8 cigarettes a day because of smoking rules within the hospital. I ended up trying to hold it back down to half a pack a day but now I'm back up to my original pack, pack and a little bit more a day, and I find that, that's not really conducive to living a long healthy life* (male, A-1).

From another participant "*they shouldn't put barriers up to make it more difficult to give up things that they wish you to give up for health reasons or whatever reasons it may be, they should make it as easy as possible*"(male, C-2)

and

> *they're not the experts, they're not the ones that are going to know what it's like to quit O.K. that's just like an alcoholic or an addict or someone that over eats or gambles or whatever it is, unless you actually are experiencing it and tried to experience the other side of it you have no right to say what I can and cannot do* (male, B-2).

Finally for one individual who had quit their relationship with tobacco and was maintaining abstinence there was frustration in where the quit attempt had lead them. This lived body experience is articulated as "*now I'm psychologically attached to the security blanket of the lozenges*" (female, F-1) and "*I still don't feel a real sense of accomplishment because I'm still using the lozenges so it's not quite the same as not feeling a need for that you know substance*" (female, F-2).

Collectively the voices of those living with a SMI identify an unfortunate underlying tone of frustration, which extends across the existential concepts of lived time, space, other and body. This lived experience of changing tobacco use behaviour for those with SMI is tainted with exasperation that creates barriers and impedes positive movement through the stages of change towards cessation.

Influencers of Change

The willingness and capacity of the individual with SMI to attempt or successfully change their smoking behaviour is interpreted as being manipulated by diverse negative and positive entities that correspond to Van Manen's existential concepts of the lifeworld.

Negative influencers.

Throughout the rich text descriptions of participants there were a number of negative influencers that became apparent as having significant meaning to the lived experience of the individual's relationship with tobacco and thereby collectively impacting the decisions on any behaviour change. For all of the participants smoking was or had been an important part of their lived time. For many years it started with being role modeled by significant others and being a socially accepted norm during impressionable times of their lives. This meant the behaviour was so deeply ingrained in their persona that to make such a behaviour change truly would be a major life event. Successful sustained smoking cessation on the other hand was not a familiar behaviour that had been significantly role modelled. For one individual

> *my sister yea she's smoked for about 30 years now and my dad as we were kids he smoked as we were kids growing up he smoked then he quit smoking for about 10, 15 years and then started up again after that* (male, A-2).

Others expressed "*I grew up with tobacco in my life, my whole life. Ok my dad has smoked from ever since I can remember and I know that my sisters and I used to steal his cigarettes out the back door*" (male, B-1) and "*my mother was a heavy smoker so I was always breathing in second hand smoke*" (female, C-1).

For another

> *I grew up in a house that everybody smoked, company smoked, everybody smoked. It was just like, I don't know it was just like different then, nobody I knew back then quit, you never hear about people quitting back then* (female, G-2).

Another significant negative influence to the lived experience of making changes to one's tobacco use for these individuals was their lived body experience with a SMI. Tobacco use was

perceived to have benefits to the coping with or relief of symptoms of mental illness. For four of the participants this was expressed directly.

I find it definitely in my case with a mental health issue that you have a hard time relaxing as far as with my particular diagnosis, I seem to be keyed up a lot more and having that puff on a cigarette helps me to relax (male, A-1)

and "*I tend to have a pessimistic view of life in general and like I said with meds and that I'm on it kind of keeps me stabilized*" (male, A-2).

For another individual

well they told us with our illnesses that it ah calms the voices if your schizophrenic, I do not know if I had a little bit of auditory hallucinations when I was psychotic but hearing the calming voices and that didn`t really apply to me but some people it does so they continue to smoke (male, C-2).

For others, *"I know I smoke more when I`m stressed out and I could try and quit then but I think I`m setting myself up for failure and it would be too challenging"* (female, G-2) and *"having agoraphobia I don't go out that much any way…I mostly stayed and smoked at home*" (female, F-2).

The lived experience of having a SMI also negatively added additional pressure to the perceptions of lived time, adding urgency and significance in the present to making a successful change to ones relationship with tobacco for future wellbeing.

Being a psychiatric patient, the medications, the neuroleptics they're hard enough on your organs to begin with, some of the newer ones are better than the older ones like Haldol… you need higher dosages of the neuroleptics for them to be effective if you smoke and like the interaction with the medications and your organs and like taking these drugs ah smoking, it's

just makes it more difficult (male, C-2).

For several participants part of the lived experience of having a SMI also meant existing in a lived time of financial hardship where there were limited funds to use for supports to help them potentially be more successful with their quit attempt. "*It's difficult for individuals on fixed incomes like we are, like most people that are psychiatric patients are on fixed incomes*" (male, C-2).

Another consideration expressed by participants and negatively influencing the meaning of their lived experience with tobacco use and thereby impacting their progress towards a changing relationship was the physiological and psychological power tobacco has had over their lived body. As one individual described

at the time when your attempting to quit and you get an overwhelming desire for a cigarette or whatever, the cravings are extremely intense, they're hard to describe unless you're a smoker yourself...once I had a cigarette, like 10 minutes later I would want another one and uh the craving was just unbelievable (male, C-1).

For another individual

the cravings set in and I want to smoke, I want a cigarette and that's when it ends, you take whatever you got, you run out and get a pack of cigarettes and there you go, it's just that you want that cigarette, you need that, it's like a drug...it hits you just like a lightning storm (female, E-1).

Two individuals described the psychological triggers to smoking as "*I have habits so like the phone rings I'm sitting and I have a cigarette. I have to have my coffee and my cigarette in the morning just to feel like I'm ready to face the day*" (female, G-1) and

the hard thing is to try to divorce your behaviours from the cigarette and the coffee, the

cigarette and the telephone, the cigarette and the whatever and so that takes a while to do and

oh the worst and the hardest was the cigarette after you eat especially after supper and the

first one in the morning after I woke up was always the most difficult (female, F-1).

For another

you feel it's like the need to smoke you're keyed up or whatever you want to call it and you

want to be out there with your thoughts and be out there and have a cigarette and like I look

at it too coffee and cigarette go hand in hand, it's just a morning wake up ritual (male, A-2).

As described by one individual smoking psychologically helped fill a void of isolation

it's like a companion, like if you go out and you're sitting on a park bench by yourself you

know the taking out of the cigarette and lighting it it's like someone suddenly sitting there

with you, you're by yourself kind of thing, which is an odd thing that that's how it works

(female, F-2).

Several participants highlighted the psychological impact of their lived space involving being

around others that are smoking and how this triggered a desperate lived body need for them to

smoke.

I found that ah I associated like being around people that were smoking… just the smell of the

smoke wanted me to have a cigarette … if you're around other smokers there's no possible

way you can quit. You can tell them O.K. I'm quitting, I can't be around you, you know what

ever, and I have tried it, I'd gone over to somebody's place where they did smoke and I was

trying to and it didn't work" (female, E-1).

The meaning of this experience carried through all of the stages of change even with those

having ended their relationship with tobacco and being abstinent for significant periods of lived

time. *"when I happen to see somebody with a cigarette and I`m talking to them that I sort of get this urge to you ah maybe ask them you know give them, 50 cents for one or something like that which I do on occasion"* (female, F-1).

Two participants summed up the depth and breadth of the meaning of the lived body addiction. For one,

everything for a smoker is a trigger, there is no real trigger unless you`re trying to quit if you`re trying to quit then you got triggers out there, I`ll take a picture of my ash tray, of my television of my bathroom, I`ll take a picture of anything because there are no triggers for someone who smokers" (male, B-2).

For the other

I have to say because of the COPD I don`t know that I would have been able to do it without already having gotten to that extreme and so I can sympathizes with a lot of people that don`t have that because it is a very difficult thing to do very difficult and to be honest if I wouldn`t have had the COPD … whether I`d been really able to go through it I don`t know to be honest I don`t know, that`s how hard it is" (female, F-2).

Another negative influencer of the lived experience of individuals with SMI considering or making changes to their relationship with tobacco was the impact of decision makers whose actions even at times with good intentions created barriers. For all participants the ineffectiveness of governments to provide effective and realistic supports for behaviour change or to create the lived space that did not undermine quit attempts could be drawn from the narrative text and photograph explanations. The lack of government enforcement of contraband tobacco was highlighted as having substantial meaning as a negative influencer for smokers with SMI. For one individual *"having access to the reserve here and being able to go freely as I want*

to just you know basically keeps a smoker smoking" (male, B-1). For other participants this ease of obtaining contraband tobacco was explicitly believed to make smoking affordable for those experiencing SMI.

> *Well it's sort of like the old days with prohibition with moon shine God knows what those people were drinking then you know for a little bottle of something, ...but you still needed to in vibe your addiction and for $20 a bag you know well that's a lot cheaper than the lozenges even with the vouchers that I get it's still more expensive for me to use the lozenges than if I was buying cigarettes at the reservation* (female, F-2).

The present lack of affordable tobacco cessation pharmacotherapy in these lived times of health inequities for smokers with SMI also had a considerable implication as a negative influencer on the meaning of the experience. As one participant describes

> *you know for low income people, not just people like psychiatric patients which about 80% of them smoke by the way...the aids should be made free of cost, they can be very expensive in themselves and if a person is only smoking half a package a day or a package every 4-5 days they might not want to go out and spend the 40 or 50 dollars a week on patches and aids they perhaps cannot afford* (male, C-1).

This individual further explicitly articulated this point through photography depicting the lack of support by government and whose relationship with smokers fell short of expectations (Figure 1).

Figure 1: Picture of a closed door

I took a picture of the door closed because like it represents the fact that the government is not providing enough assistance like financially for people of low incomes not just necessarily psychiatric patients but anybody of a low income bracket and so like the door sort of like shut against them like to given them that incentive to quit (male, C-2).

Finally for seven of the nine participants their experiences were negatively influenced by lived relationships. Actions and behaviours of others brought on disappointment because it was anticipated that there would be more support extended. For some, their relationship with a significant other was not conducive to creating an environment that would allow them to cope with the additional stress of trying to make a change to their tobacco use. "*I was in an abusive relationship before so I was just smoking to uh you know to keep myself sane*" (female, H-1). For another participant "*I went out with that guy for a while, and he was a smoker and things you*

know were pretty intense" (female, F-2). There too were feelings where one's quit attempt was specifically undermined,

> *I find too sometimes that people that smoke they're kind of intimidated when you say that you`re trying to quit, because they know deep down that they should be too you know, yea they`re not ah I don`t think there as supportive* (female, G-2).

The lived experience of other's responses to a participant's intentions or actions to make a quit smoking attempt were also not met with empathy "*I had a friend come over and she had told me I was starting to get cranky and I guess irritable or something or the other but I didn't notice it, but she thought I was*" (female, E-1) and from another "*I've tried to quit smoking before, ask my daughter, she said I was so miserable that she even offered to go get me a pack of cigarettes*" (female, G-1). As well for some, they were met with others lack of confidence which in turn served to lower the participant's self-efficacy towards their quit attempt.

> *A prime example of that is my landlord I was telling you back to the social aspect of things they both smoke and that and I said I'm psyching myself up I going to start the patch today, and he just looks at me and says I'll believe it when I see it as far as, because he know in the past I've tried 12- 14 times to quit and I've never followed through with it…he nods that and says I'll be in a wheel chair before you quit smoking* (male, A-2).

Positive influencers.

For participants considering or acting on making a change to their relationship with tobacco, their rich text descriptions also highlighted significant positive influencers that had meaningfulness to their lived experience. The three participants that had ended their relationship with tobacco and were in the action and maintenance stages of change for smoking cessation,

recognized the positive contributions of nicotine replacement therapy (NRT) or other smoking aids towards lived body successes with quit attempts.

> *I went back on the patch and used the gum. Then the cravings just they went away… it would have been impossible for me to quit without a nicotine supplement or without aids but it was difficult enough as is but it really, really, helped a lot* (male, C-1).

For the other individual there was acknowledgement that the choice of NRT or aid in no way mimic the act of smoking which was very important psychologically in breaking the patterns associated with smoking.

> *I started off with the lozenges and found that I really like them a lot and so for the first 3 days I was using lozenges just rather than cigarettes, I found initially with the lozenge it would help with my nicotine craving but at the same time it wasn't giving me that deep sense of breathing and a oh that sort of sense of relief* (female, F- 1).

as well this individual found that *"at one point I did try somebody's… they have those cigarette things now,…but that's way too much like smoking, it's to the same. You don't really break the behavioural connection to things"* (female, F-1). This however was not the same experience for another participant who was in the stage of actively making a change to their smoking behaviour. In this circumstance, using an e-cigarette without nicotine to help not smoke as it was perceived as just vapor, worked well for their need to mimic the smoking motions with the hands and it was felt it was also cheaper $10/week for refills versus the cost of cigarettes. "*I take a few puffs I put it down and I'm good till the afternoon till I have few more puffs*" (male, D-2).

These descriptions help to articulate the diversity in meaning of the positive influencers and the unique lived body experiences of every individual attempting to make a change with their relationship with tobacco.

Who the experts are... we're the ones that are facing this and you as a non- smoker per say can say you gotta do this and do this but what may work for me maybe totally different than what might work for somebody else (male, A-2).

For several of the participants the lived relationships with community supports made the difference in the quit attempt being positive and potentially successful or not and provided a feeling of being supported and not alone on the journey to changing their smoking behaviour. For one individual having additional direction from community support on using NRT aids more effectively promoted an increased self-efficacy towards the next planned quit attempt.

So they allow you to stay on the 21 longer and they come right out and say by all means if you think you gonna need more, buy more, it's when you feel comfortable to drop down from the 21 then do it not because it says on the box well you got to drop it (male, A-2).

For another the support of a group meant having help to tailor supports that would be effective in changing the smoking relationship experience. "*I started going to a smoking cessation group … and using as many aids as possible and finding which ones were more suited for me and which worked best for me*" (male, C-1). The opportunity to further express the meaning of the experience of having positive supports through photography was also demonstrated.

There is a sign in the neighbourhood … it's a sign dealing with people if they have a desire to quit smoking here`s a number you can call, so I took that picture because there's more of this information available in the communities, like in advertisements and that about ways to try to help people to quit or to suggest that perhaps they should consider quitting (male, C-2).

For two participants having access to cessation supports was a positive influencer that meant increasing their knowledge on how best to approach a quit attempt and with that knowledge

came power to contemplate moving forward with a quit attempt. "*They gave me a lot of reading information and stuff like that which was very helpful too*" (female, F-1).

and

other times it was like I felt like such a failure but I didn`t know at the time that it takes more than one you know attempt where as I`m finding out all this information which I`m not going to be as hard on myself, I`ll just keep trying that`s all (female, G-2)*.*

For five participants, having lived space conceptualized to support not smoking meant increased self-efficacy in the potential success of a quit attempt. For one individual this meant sticking to the same routine every day for others it meant other things. "*I've also started any classes I can attend I try and do because I'm not sitting at home having a cigarette you know what I mean*" (female, G-1).

For another the lived space provided an opportunity of a distraction,

sometimes I can go four to five hours now without having a cigarette because if I`m playing on the computer it can be three and a half to four hours before I have a cigarette because I was doing something with my hands (female, H-1).

There was also the lived body experience of "*drinking of a lot of water which is good for your health too it helps*" (female, F-2) or "*I tried to make it as easy as possible as I could on myself*" (male, C-1)*. " I tried to do things that I disassociated with smoking so I would avoid triggers*" (male, C-2).

and finally

now I look at it as far as I can find or I do have other relaxations in place so I can move forward and say yes I can do it now… I have other methods to fall back on to help me through the humps (male, A-1).

For a number of participants changing social norms around the acceptability of smoking that included environmental smoking restrictions and increasing opportunities to circulate in smoke-free environments meant a lived space with less exposure to the triggers to smoke and removed the onus on them to make the choice not to smoke as it was already made for them. "*It's becoming anti- social to smoke anyway. At one time, when I was younger you could go down to the mall and smoke at any table in the mall and you could smoke anywhere*" (male, C- 1). As expressed by another participant, "*the hospital makes it a little bit harder because the smoking area is like a walk you know and have it and to come back again that is a challenge*" (female, E-2).   Another also implicated the hospital policy as positively influencing smoking behaviour change "*on a couple of occasions where I would have been brought into the hospital I had no problems not smoking*" (male, B-1). For a third individual having their favourite place to go become a non-smoking environment also helped to disassociate the behaviour with the location. These feeling were articulated through a photograph and described as

> *the library is my go to place just to, well I know I go there to well… I could get lost there for hours and I don't need a cigarette cause there's so much information there you know, even about smoking, anything you want to know it's there and when I'm there it doesn't bother me the smoking at all"* (female, G-2).

Photography was also used to expound on these feelings of having options of spending time in non-smoking environments.

> *The Art Gallery, I like to go there at least once a month, I just like to see what's happening there and there too it's like involving yourself in something totally different you know than smoking, I've never smoked there so wouldn't think of it either* (female, G-2).

This feeling of being in a place not surrounded by other smokers also instilled a sense of relief from the pressures to fight the triggers to smoke. A photograph taken by one participant described "*There's a bench back here and then …you hear the waterfalls and you just sit there and listen… tranquility*" (male, I-2). (Figure 2)

Figure 2: A picture of a smoke-free place of tranquility

On the flip side, the lived experience of observing others in a smoking space for one participant created a sense of discomfort that in its self positively influenced their resolve to continue to contemplate a change to their relationship with tobacco.

Thank god I still think like that... When I do see people smoke I I'm so glad I kept that because that will probably give me a little bit of strength because I see when people are smoking they think they're being… they think they're relaxed. How the hell do you get relax by ...and if you listen you hear the stress…you hear that (male, I-2).

The value of the lived relationships of approval and support was singled out by six of the nine participants meant that there were others routing for them to succeed, willing to help if asked and there just to provide comfort. For one participant this meant that even neighbours cared

> *one of the tenants now they're an elderly couple,… he also sees me outside the apartment complex smoking a cigarette whatever and he says if you quit smoking 6 months I'll take you out to the restaurant and I'll buy you whatever meal you want* (male, A- 2).

For others "*even my mind frame is changed a lot more than what it is cause I've gotten into a healthy relationship so yeah I could probably see myself quitting this year*" (female, H-2) and

> *just getting more information by just going walking with the people and they'll give you a hand if you're willing to open up and talk to them, but you have to be willing to talk to them, there not just going to tell you and there is people on the walking group that will be able to say "why don't you talk to this person* (male, I-2).

For another, "*luckily the people I was hanging around with then two of them didn't smoke and now my best friend that I see more frequently is not a smoker and that helps a great deal*" (female, F-1). Finally for two participant's, pets were a positive influence on their delaying smoking or remaining smoke-free.

> *And now when I go out for a walk with my cat… the whole thing is good for me cause he get's me out, he's my agoraphobia therapist … and with all the green and everything that really helps and I don't have that same need to smoke* (female, F-2).

and for the other significance was shared in a photograph of their cat. (Figure 3)

Figure 3: Picture of an intuitive beloved pet
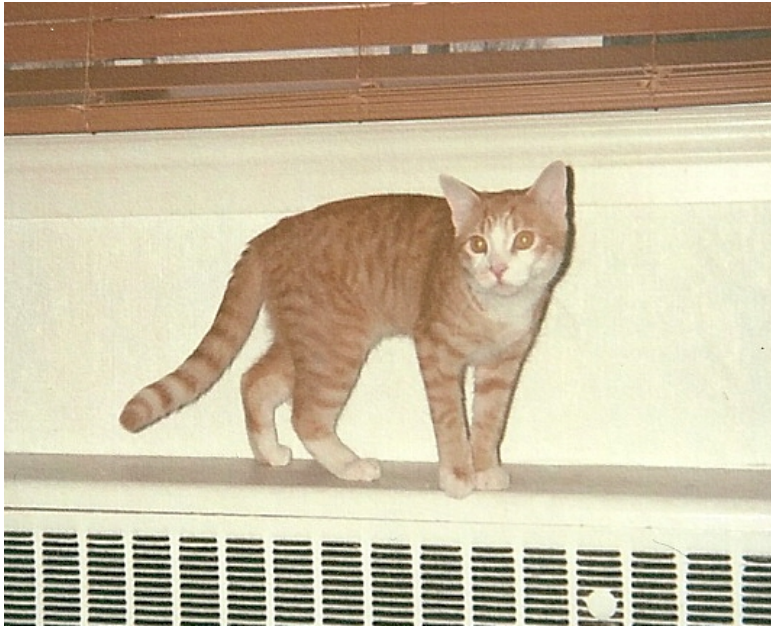
I couldn't really have a smoke because the cat was laying on me… because he knows that there's something wrong with me and he just plops right there you know… it's weird how cats just pick up on things that you wouldn't think that they actually would pick up on (female, H-1).

Holding onto Resolve

Coming through the rich text descriptions of participants was expressions of holding onto resolve in the face of adversity experienced within the lived space, lived time and lived body. For one individual there was the determination to ensure the lived space would be conducive to optimizing the chance of success with quitting smoking by informing others that *"I cannot visit you right now because… your smoking acts as a trigger, like I will want to have cigarette and I might relapse and give into that desire so I cannot visit you at this present time"* (male, C-2). For another individual their frame of mind was influenced by lived time where the past helped

them to hold on to their resolve that smoking was not going to be a part of their future. "*I'm never going to think about smoking, just I think about all the money I spent with smoking that I could have spent on better things*" (male, D-2).

For several participants there was determination to persevere in attempting to make a change to their smoking knowing up front that there was no guarantee of successful outcomes regardless of the effort put forward. This lived body experience of the changing relationship with tobacco was described by 5 of the 9 participants across the range of stages of behaviour change. For one individual

it's something that I definitely want right now in this point of my life and I have the mindset that I will continue to want. I know there are going to be struggles ahead but I feel that this is the hump for me as far as the attempt to quit smoking. I finally went over that hurdle psychologically now that I am ready to put my mind set into it 100%

(male, A-1).

For another "*you really have to psych yourself up and pick a quit date and go for it and get all your ducks in a row and really make that attempt* (male, C-1)…*I want to be smoke-free for the remainder of my life*" (male, C-2). From the perspective of someone not considering a quit attempt at the time there was resolve to be the one in control of the decision as to whether there would be an attempt to change the relationship with tobacco.

If I'm going to quit, it's going to be on my own initiative and that's going to be because I want to quit and I'm the only person that can do that, no one can do it for me, no one can tell me to do it, it's got to be in me (male, B-1).

Finally experiencing the meaning of holding onto resolve was captured with visual imagery through one participant who described

what comes to mind right now for me would be a set of stairs or slope with a happy face on the end of it...something like a burden carrying over your back going up the slope and the burdens like the pack of cigarettes and eventually I'm gonna get to that sunrise or happy face at the end of the tunnel or at the top of the hill (male, A-2).

Driving Forces

For all participants the experience of considering or making a change to their relationship with tobacco was motivated by corporeality (intrinsic) and spatiality (extrinsic) forces compelling them towards a decision to try or maintain quitting smoking.

Corporeality forces.

For six of the nine participants their lived experience with considering or attempting to change their relationship with tobacco meant being driven by an internal desire to improve the odds of an increased life expectancy. For one participant this motivation was coloured by the experience of living with mental illness, "*because of the medications I'm on and the nature of the illness it takes a certain amount of time off your life span to begin with and the smoking it just accelerates that process*" (male, C-1). Noticing that smoking was beginning to result in unpleasant physical symptoms that were traditionally characterized as warning signs for smokers meant it was time for one participant to quit smoking. *"I've been trying to quit smoking cause it affects me, I've been coughing up stuff in the morning and I've never coughed up stuff like that before"* (male, D-2).

For another individual being diagnosed with a smoking related illness and realizing its ultimate impact on quality of life meant having the choice to become driven to make a tobacco use behaviour change decided for them by their body.

I had to go through all this breathing stuff and they said yea that's not good but they said if you quit smoking there might be some regeneration and that goes on so that was positive and well you know I don't have to smoke to live but I do have to breathe to live so that's something to consider seriously…I'll have one cigarette then I'll think yea well O.K. but I can immediately feel it like it's the minute I smoke it I can feel my lungs really say we don't like this (female, F-1).

For others "*the number one concern is health issues I want to live a little longer than smoking a cigarette will allow me to live…most definitely I'm going to be trying again quitting smoking*" (male, A-1) and *"I'm trying to better myself, like I want a happy life and I'm thinking about summertime and just all these changes starting to come about, made me thinking about smoking"* (female, G-1).

For those individuals that have given up their relationship with tobacco the positive experiences of improved health and feeling better were driving forces to help avoid relapsing back to smoking and to maintaining a smoke-free life style.

You certainly will be healthier and feel better about yourself… you notice like after 2 or 3 weeks of not smoking that when you go for a walk it's easier to breathe, it's easier to walk it's easier to exercise, its, you just, you notice the benefits almost immediately (male, C-2).

For another participant, corporeality forces were expressed with photography. (Figure 4)

Figure 4: Picture of food (better tasting)

"I find that food tastes so much better it's amazing …it tastes so good whereas before you couldn't really pick up all that subtlety of all the various spices and everything so that's very nice" (female, F-2).

   The lived experience of changing ones relationship with tobacco also meant having a new perception of self that included evolving into a person with opportunities to be a role model and share some of their lessons learned with others.

   I know a lot about smoking cessation from going to groups and everything so I wanted to help other people too as much as I could … I try to show people like just by going to the groups that's they know how difficult a time I had giving up smoking and I tried to show them that if I could do it they could do it too (male, C-1).

And from another individual that was in the maintenance stage of behaviour change *"I'm becoming friendly with someone who is in this knitting group and she still smokes but ah she's*

considering it but she's going through all the same difficulties as ah it's hard to let it go and all of that" (female, F-1).

Spatiality forces.

For all of the nine participants, their lived experience of being driven to consider or attempt to change their relationship with tobacco meant the prospect of having more money in their pockets and less anxiety of living with too tight a budget. For one individual *"I'm on medical disability and there isn't a lot of leeway as far as cash flow to afford the cost of cigarettes* (male, A-1)...*I know for one that it will help me to spend more money with my children",* (male, A-2) for another *"the financial benefits are important as well, it gives me a lot of additional money that I can use in other areas like to help increase my quality of life"* (male, C-2). Having to spend less money on cigarettes for others meant the difference in just regularly having the basic essentials of living *"I had thoughts on it because I get close to the end of the month and you run out of money"* (female, E-2). Money was also a driving force for those maintaining their quit attempt with nicotine replacement therapy,

> *that`s partly not necessarily that the 1 mg is that bad for you, it is expensive so that`s when you get into the money aspect of it because why would I be spending this money for 2 mg or 1 mg when I could be using it for other things* (female, F-2).

For several participants, making changes to their smoking behaviour also meant having the opportunity to live in a more positive space which was a driving force for change. One participant used photography to express the meaning of this lived experience.

> *I was such a heavy smoker and I'd live there for a number of years like you would get this heavy buildup of nicotine on the ceilings and walls and that and it took a great deal of effort*

to get that off and to move furniture around and everything…so you can see now it's clean

and it's a lot better and a lot healthier (male, C-2).

For others the constant reminders of smoking's impact on the atheistic or health of their space was a driving force for their contemplating a change to their relationship with tobacco.

I have friends that smoke around me, it's like sometimes we get in the house together and it

like holy crap that's a lot of cigarette smoke, yeah and sometimes my eyes actually feel like I

can tell when there's too much smoke in the house cause oh yeah my eyes will just burn

(female, H-1).

And for another

yeah it's gross, yeah you can't see the ground for the butts, it's so gross…yeah it makes me

not want to do that or else if they're going and their fingers orange all the way down here and

you know yeah that bugs me (male, I-).

For one participant the importance of creating a healthier space extended to pets and the perception that they were a positive driving force in staying the path to end the relationship with tobacco. (Figures 5-6)

Figure 5: Picture of cat in clean air

Figure 6: Picture of two cats in clean air

"Oh the local clean air society was that those two were on the rampage being insistent that clean air was going to be in the place for their lungs and their well-being and so they took it seriously"(female, F-2).

Strategies used to support a successful quit attempt were also perceived as a space that contributed to a more positive living environment and helped to motivate a sustained quit attempt. "I*t gives an atmosphere of health I suppose, sort of a virtuous circle rather than the vicious circle of junk foods and cigarettes ah you know, being a couch potato that whole nasty sort of thing"* (female, F-2)*.*

Embracing Hope and Sensing Inspiration

The final theme that emerged from the rich text of the interviews and descriptions of photographs was interpreted as the potential for individuals with SMI to develop optimism and inspiration from their attempts to make or sustain a change to their relationship with tobacco. For over half of the participants there was a demonstrated capacity to carry their fears of being, burdens of frustrations and influencers of change while holding on to their resolve and capitalizing on forces of corporeality and spatiality. This in turn enabled them to reach out towards a lived time of hope and be inspired by themselves or others to make an attempt to achieve tobacco use behaviour change in the face of living with a SMI. For one individual preparing to make a quit attempt,

> *I know that there's going to be slip ups along the way but I'm trying to hope that I can stay focused like and say that in the end its going to work…realize I'm a human being and mistakes are made and that's how we learn…you gotta kind of flip everything up into a positive ending…like I've tried 14 times I haven't been able to do it then what makes you think I can do it this time… I've got say O.K. I've gotta try and learn from my mistakes I've had 3 cigarettes today so far and that's not a good start but maybe it will only be 2 maybe it won't be any and eventually I say I've gotta put the mind set and determination behind me*

and yes I can make it this time and just keep plugging away and realize the fact that all you

can do is try (male, A-2).

For another individual contemplating a quit attempt

I think I'm better prepared this time only because I'm aware now of changes and there's just

so much more information than ever when I tried to quit before, like I don't feel like I'm going

to be alone on this journey (female, G-2).

Being able to continue to reduce the amount smoked and use break times at work to take walks

instead of smoking, even in the face of perceived stressful life circumstances for one individual

meant there was hope to ultimately quit smoking in the future. "*That's actually what keeps me*

still wanting to quit when the time is right...it's just not right, right now" (male, I-2).

For one individual maintaining a prolonged abstinence from tobacco meant increased self-

efficacy that they had achieved successful behaviour change.

Nothing really acts like uh trigger for me anymore and I have no desire whatsoever for

cigarettes and I'm thankful for that and hopefully that will continue…like I know they happen

periodically but they become less frequent and less intense over time so if it were to happen

again I'm sure I'd be able to deal with it alright so I'm not too worried or concerned about it

(male, C-1).

For another participant having relapsed back into a relationship with tobacco as a result of

current stressful life circumstances there was still patience and hope for a return to past lived

times of peacefulness that would be conducive to making another quit attempt. "*For now, I just*

have to be patient and I've been patient for so long I have hardly no patience left, burnt out,

mentally"(male, I-2). This meaning of the experience of patience with life's ups and downs and

as someone living with mental illness was described through photographs that depicted recovery.

(Figure 7)

Figure 7: Picture of a tree that survived adversity

> *W*hen I went bankrupt and lost my house and everything I had a willow tree in my front
>
> yard and I took branches off it and put it in water and it grew roots and this tree is 19
>
> years old and I braided the tree as sticks in the ground...it started here and it wrapped
>
> around and it's perfectly round and its braided...that's the only thing I have left of
>
> everything I had and it's a tree that I took from my yard there and brought here, just two
>
> sticks and a bucket of water (male, I-2).

A second photograph depicted the individual having created something that like them hasn't

fallen apart and even through its weathered rough times has shown great resiliency. (Figure 8)

Figure 8: A picture of a resilient creation.

I had old windows and I used to glue glass on the windows and hang them from the trees and make the path to my compost and this is about…it hung outside for probably almost 30 years and nothing fell off of it yet it's weird in rain storms and everything and I now have it pinned on my mom's little shed in the back (male, I-2).

In the end for one individual living in recovery from SMI and having successfully ended their relationship with the tobacco, the lived body experience was inspirational.

I never realized or it never occurred to me that I knew it would be difficult but it was probably the hardest thing I have ever done…It was such a feeling of euphoria; it was just incredible, I was so glad to be over all of that. And I was so happy I was off the cigarettes after so many years (male, C-1).

In summary the analysis of rich text and photograph descriptions provided by participants coupled with the journalled insights of the researcher throughout data collection have culminated in bringing meaning to the study's data. The phenomenon of changing ones relationship with tobacco as someone with SMI is described in this study as a lived experience with six themes. The themes portray meanings of lived body, space, time and of other through human relationships as that of experiencing a fear of being, burdens of frustration, influencers of change (both negative and positive), holding onto resolve, driving forces (forces of corporality and spatiality) and embracing hope and sensing inspiration.

The final chapter of this thesis will relate the study's findings to the existing literature highlighted in chapter two. The unique perspectives of the phenomenon derived from the study's findings are presented. Future implications for practice to address and support individuals with SMI to change their relationship with tobacco are discussed. Recognition of the role existing smoke-free policies play to support tobacco use behaviour change and the importance of further policy development are examined. Opportunities for future research to validate and expand on the study's findings and investigate the implications of practice and policy recommendations are highlighted. The chapter concludes in summarizing a shift in understanding of how best to support tobacco dependency for the individuals with SMI. The potential positive impact of using a strengths-based recovery approach to supporting individuals with SMI to change their relationship with tobacco is emphasized.

Chapter 5

Discussion

The study findings identified the lived experience of the individual living with SMI considering or acting on making changes to their relationship with tobacco as one that is persevered with exasperation and courage. The significance of and the fortitude exhibited in considering and making this journey often goes unrecognized by its traveller especially when successful sustained cessation is not the achieved outcome. The value of this process in quitting smoking is also very often under appreciated by those within the individual's support circles. This is underscored in the interpreted narratives of participants. Making a change to a relationship with tobacco was most often viewed more as an event repeated many times with or without success versus each quit attempt being part of one goal directed journey.

The rich text descriptions from participants in this study highlighted several circumstances and understandings of the phenomenon consistent within the literature. The interpreted narratives resonate with the ambivalence depicted in the literature. Cigarettes are perceived as a tool for socializing, a friend providing calm, comfort and means of coping with the symptoms and stresses associated with SMI, therefore making it difficult to give them up (Ashton, Rigby & Galletly, 2013; Forchuk et al., 2002; Lawn et al., 2002; Snyder et al., 2008; Singer Solway, 2011; Ziedonis et al., 2008). Study participants also described the changing social norms of smoking that include smoke-free hospital properties as providing opportunities to test cessation strategies which are reflections also supported in the literature (Keizer et al., 2009; Kunyk & Els, 2009).

Literature exists that supports this study's theme of positive and negative influencers. It is however characterized differently as personal and reinforcement factors or in the theme of motivating quitting and overcoming obstacles to staying quit that influence the smoker's

decisions to make or sustain a quit attempt (Snyder et al., 2008; Singer Solway, 2011). Singer

Solway provides descriptions from smokers with SMI of their experiences trying to quit that are

similar to some of those described by participants in this study (2011). Three of several themes

identified from Singer Solway's (2011) research: 1) garnering will power and inner strength, 2)

seeing what it's like and relapsing, and 3) accomplishing after quitting, resonant closely with

those identified in the present study. The present study however offers its own unique

interpretations of the phenomenon with six themes and how they relate to lived time, space, body

and other. It also demonstrates how these themes transcend all stages of change of the TTM, and

parallel many of the concepts in mental health recovery theory.

The Parallels to the Trans-theoretical Model of Behaviour Change

Having a better understanding of the meaning of the phenomenon takes those looking in from

the outside on a vicarious walk down the participant's path towards changing tobacco behaviour.

This path is interpreted from the findings of this study as one where individuals experience; (1)

fear of being, (2) burdens of frustration, (3) influencers of change (both negative and

positive),(4) holding onto resolve, (5) driving forces (corporeality forces and spatiality forces)

and (6) embracing hope and sensing inspiration. These themes can be linked with the four core

constructs of the Trans-theoretical Model of Behaviour Change described in the literature that

include: a) stages of change, b) decisional balance, c) processes of change and d) self-efficacy

(Atak, 2007; DiClemente et al., 1991). This model has been criticized for not having

qualitatively distinct categories and underestimating motivation to quit smoking (Herzog, 2008;

Herzog & Blagg, 2007; West, 2005). It does however continue to be used throughout decades of

literature as a means of better understanding smoking cessation (Anderson & Keller, 2002;

Armitage &Arden, 2008; Prochaska, & DiClemente, 1983; Prochaska et al., 1992; Prochaska,

Hall, Delucchi & Hall, 2014; Prochaska, Velicer, DiClemente, & Fava, 1988).

Stages of change.

There are five stages that individuals progress and regress through that are identified in this

core construct of the TTM: a) pre-contemplation, where the individual has no plans to change

their relationship with smoking in the next six months as they are unaware or under aware of the

health impact of their smoking or has been demoralized by past quit attempts; b) contemplation,

where the individual is weighing the pro and cons of their smoking, aware of its health impact

and are thinking about making a change to the relationship with tobacco in the next six months;

c) preparation, where the individual is intending to make a change to their smoking behaviour in

the next month and has tried to do this before in the past year; d) action, where the individual

with hard work hard and great effort has changed their relationship with tobacco having quit for

between one day and six months; and e) maintenance, where the individuals is working not to

relapse back to their relationship with tobacco and remain smoke-free beyond six months

(Prochaska, et al., 1992). The six themes identified as reflecting the lived experience in this

study were not restricted to any particular stage of change within the TTM model. For example,

participants were recognized as experiencing fear of being that included their concerns regarding

smoking triggers, which was evident whether they were merely thinking about quitting or had

been successfully tobacco-free for some time. Not spending money on cigarettes and thereby

having more cash for daily living expenses was a driving force for participants regardless of their

stage of behaviour change. Pre-contemplators were interpreted as holding onto the resolve that

any future quit attempt would be on their terms and their way while individuals in the

maintenance stage were determined that they would remain smoke-free.

It is important to recognize however, that literature addressing criticisms of the TTM model raises valid points that were representative of the participants lived experience as well. Examples of these include differentiating the potential to change smoking behaviour for those in pre-contemplation. Pre-contemplators that had made an unsuccessful quit attempt within the year may differ and show more potential to change future smoking behaviour than pre-contemplators that made no recent effort to quit (Etter & Sutton, 2002). As well some literature points to pre-contemplators as actually still considering cessation and contemplators as actually making unrecognized efforts to try and quit (Herzog & Blagg, 2007). These circumstances could be interpreted as part of the lived experience found in the rich text of the study participants. Of the two individuals identified in pre-contemplation one had made a quit attempt within the last 12 months. This individual although frustrated with the outcome continued to allude to the need for more resources in order to be successful which alludes to the potential to move to contemplating another quit attempt at some point. The other participant in pre-contemplation had not made any attempt to quit in some times and demonstrated less potential to move towards making a quit attempt any time soon. The three individuals identified in contemplation although not interpreted as preparing to make a quit attempt within the near future did highlight behaviours of delaying cigarette use and incorporating alternate activities that limited smoking. These could be interpreted as them actually making unrecognized efforts towards quitting.

Decisional balance of pros and cons.

Study participants regardless of which stage of change they were in and across each of the study's six themes, were found to be weighing the pros and cons of their decisions. The TTM decisional balance construct is reflected in examples of the study's theme fear of being, where the cons of potentially being isolated from friends were measured against the pleasure of the

social experience of smoking with others. This is also demonstrated in the theme burden of frustration where being around other smokers although enjoyable, might be just too hard a smoking trigger to handle when trying to quit. Negative and positive influencers were included in examples of the power of the addictiveness of tobacco being an uphill battle in contrast to considerations that the effectiveness of nicotine replacement therapy would manage withdrawal. Pros to make a change were reflected in the themes of holding onto resolve with examples of determination that there was light at the end of the process and driving forces with examples of improved health and finances tipping the scales in moving forward towards making a change. Finally, within the theme of hope and inspiration there were decisions made that were weighted towards the pro side to eventually succeed at an attempt to quit smoking than on the con side to continue the relationship with tobacco.

Processes of behaviour change.

Understanding how changes to smoking behaviour happen and move participants toward cessation is identified in the TTM construct's ten processes of behavioural and cognitive change (Prochaska & DiClemente, 1983). The degree of engagement in these processes varies dependent on stage of change the individual is progressing through (Anderson &Keller, 2002; DiClemente et al., 1991). These processes could also be identified in this study's six themes that are reflective of the meaning of the lived experience of changing ones tobacco behaviour as an individual having experienced SMI. The processes of needing dramatic relief and stimulus control were more apparent in the themes of fear of being and burdens of frustration whereas negative and positive influencers of change can be linked to the need for environmental re-evaluation, helping relationships, contingency management and social liberation. Examples within the themes of driving forces addressed the process of consciousness rising and counter-

conditioning whereas holding onto resolve demonstrated strategies of self-re-evaluation and self-liberation. The process of self-liberation was also reflected in the theme of embracing hope and sensing inspiration where there was commitment and recommitment to move forward with quitting or staying smoke-free.

Self-efficacy.

A fourth construct of the TTM adapted from Bandura's theory of self-efficacy involves the confidence individuals have in being successful and staying successful with behaviour change (Atak, 2007; DiClemente et al., 1991). Bandura's theory of self-efficacy in particular can be interpreted as interwoven throughout the six themes reflected as categorizing the phenomenon of tobacco behaviour change when living with a SMI. According to Bandura (1977) motivation involves creating expectations for behaviour change and setting self-rewarding responses dependent on achieving that change. This in turn drives the individual to match performance to the behaviour standard that meets their outcome expectancy (Bandura, 1977). Within the theory of self-efficacy, how strongly an individual perceives they have the capacity to achieve success, directs whether coping strategies will begin, the amount of effort invested and the duration of sustained behaviour change in the face of adversity (Bandura, 1977; Bandura, 2004). Self-efficacy is influenced by four sources of information that impact the individual's belief of whether they will succeed in changing their relationship with tobacco (Bandura, 1977). These sources of information include performance accomplishments, vicarious experiences, verbal persuasions and emotional arousal (Bandura, 1977). Throughout the study's themes are examples of these four sources of information that had influence over participant's personal efficacy to change their tobacco use behaviour.

Participants experienced being frustrated with or at the other end of the spectrum, being positively influenced by past quit attempt performance accomplishments. This served to inform their expectations of success and impact their motivation moving forward. The experiences of reaching desired achievements or meeting with disappointments as described by Holloway & Watson significantly influence self-efficacy (2002). Participants that experienced some success with quit attempts held strongly onto their resolve that their relapses back to smoking were minor setbacks. For others that believed they had tried everything and nothing was working or felt they were bogged down with life's circumstances, self-efficacy was lower. Through triangulation of data in interviewing, researcher journaling and participant's taking meaningful photographs, individuals were better able to describe their own interpretations of the lived experience of trying to become tobacco-free. For some participants, photo elicitation in particular helped them to articulate intermittent setbacks with their recovery in mental illness or with the instability of their life's circumstances, which they recognized as undermining their plans to consider or act on making a quit smoking attempt. For others photographs were able to convey the significance of their pets as a positive influencer or spatiality driving force in being an anchor of unconditional support in both their journey towards mental well-being and their recovery from tobacco dependence. This supports existing literature such as that identified by Wells (2009), on the benefits of animal assisted interventions to human physical and mental health. Wells highlights how pets unlike humans are viewed as non-judgemental, can be counted on in difficult times and may serve as a social facilitator in reducing stress and enhancing performance (2009, p 531).

For some study participants their decisions to quit smoking were informed by a feeling of fear and apprehension after having vicariously watched others struggle with quitting or relapse back to smoking. As well, not having the opportunity to witness many cessation peer role models

further limited participants indirectly experiencing that feeling of success. The opportunity to see others perceived as being in the same circumstances as themselves accomplish a task, in particular if the task is perceived as being hard, has significant impact on an individual's self-efficacy (Deegan, 1988; Holloway & Watson, 2002; Sterling, Esenwein, Tucker, Fricks, & Druss, 2010; van Gestel-Timmermans, Brouwers, van Assen, & van Nieuwenhuizen, 2012). Negative influencers of being in social circles of smokers also served to vicariously normalize smoking (Snyder et al., 2008).

There were examples of the self-efficacy of participants being influenced negatively by receiving information through the verbal persuasion of others who pointed out their lack of effective coping with withdrawal symptoms or persisted in highlighting unsuccessful past quit attempts. In other instances credible sources of information (Holloway and Watson, 2002) for example the quit smoking helpline, were discounted as they were perceived as not understanding the difficulty, frustrations and effort of the individual's situation.

Individuals rely to a certain degree on their physiological state of arousal to help them determine just how stressful the circumstance before them is to be perceived (Bandura, 1977; Strecher et al., 1986). Participants in this study demonstrated holding onto their resolve. That is, with the right mindset and more cessation knowledge and supports they were increasing their odds of success. This helped to produce a reduction in the stress of moving forward with a quit attempt. The impact of experiencing this positive emotional arousal was demonstrated though both corporeality and spatiality driving forces. For some participants notable improvements to their health and the reinforcement as a non-smoker of being able to help others with their quit attempt positively instilled a sense of success. This is also demonstrated by one participant's euphoria in finally being able to sustain tobacco-free status and experience a sense of inspiration.

This emotional arousal supported the confidence going forward that they would not relapse back to smoking.

The availability of practical coping strategies at the individual's disposal also positively influences ones self-efficacy (Bandura, 1977).   Personal perceptions of efficacy in this study were influenced by, some participant's thoughts that they now, unlike in past attempts, were better armed with some type of new strategies. This included for example adjusting dosages of NRT or staying on this therapy longer, having information about supports in the community to help quit, or better timing emotionally, such as being in a positive relationship in comparison to past quit attempts. By attributing past unsuccessful quit attempts to ineffective strategies or resources which are perceived as modifiable, the failure of not quitting smoking is not met with hopeless but with optimism for success in the future (Anderson &Jennings, 1980). This is opposite to the individual feeling that they were unsuccessful because they actually didn't have the ability to accomplish the task (Anderson & Jennings, 1980; Singer Solway, 2011).   The strength of these positive influencers as coping strategies and at times the formation of a quit plan was a key factor in participants establishing their stage of behaviour change for tobacco cessation and their holding on to their resolve. This was done with the realization that they would face adversity and have no guarantee of ultimate success.

For some participants the burden of frustration with past quit attempts and the perceived lived body experience of the power both psychologically and physically of their tobacco use was overwhelming. Whether it was being around other smokers or experiencing withdrawal symptoms, a high degree of difficulty with the task of making a quit attempt was created. This served to keep these individuals detained in the pre-contemplation or contemplation stage of

behaviour change. As highlighted by Bandura (1977), the confidence an individual has in their effectiveness to master the behaviour will affect whether they try and how hard they try again.

Most participants described the opportunity to experience improved finances as one of the major spatiality driving forces for their present or future tobacco cessation behaviour change. This lived experience of improved finances meant the potential promise of improved quality of life as someone living with SMI. This was the bar set as a self-rewarding outcome dependent on their achieving a tobacco-free or nicotine replacement-free lifestyle. Singer Soloway (2011) also point to other positive experiences as well as better health identified by former SMI smokers. What was apparent from participant's interpreted descriptions was the degree to which their fear of being, burden of frustration, influencers of change, holding onto resolve, driving forces, sensing hope and experiencing inspiration impacted their perceptions of self- efficacy in becoming a non-smoker.

These interpreted descriptions conveyed poignant emotions of trying and retrying over and over again to consider or change their relationship with tobacco. Through this holding on to resolve and experiencing of corporeality and spatiality driving forces towards continuing to consider a change to their tobacco use, participants demonstrated the significant resiliency of individuals with SMI.

The study themes have been discussed as demonstrating linkages with the major constructs of the TTM. These themes also mirror many of the key aspects and processes identified in the literature that describe the mental health consumer's ideas of recovery from and in mental illness (Anthony, 1993; Anthony, 2003; Bledsoe et al. 2008; Bradshaw et al., 2006; Carpenter, 2002; Davidson, 2007; Deegan, 1988; Forchuk, Jewell, Tweedell, &Steinnagel, 2003; Weinberg, 2013; Zolnierek, 2011). The potential broader therapeutic benefit of tobacco cessation for individuals

with SMI is alluded to in the literature (Prochaska, et al., 2014). This literature however does not specifically address any parallels in the processes that characterise tobacco dependence and SMI recovery. Literature exists that does supports the need for integration of physical health that includes modifiable risk factors with mental health into a wellness approach that frames personal recovery as a picture of achieving optimal overall health (Camann, 2010).

The Parallels to the Mental Health Recovery Model

Similarly, the meaning of the phenomenon of struggling towards changing a relationship with tobacco for individuals experiencing SMI has significant parallels to the many aspects of their recovery in mental illness. For study participants the prospect of working towards or maintaining a tobacco-free life evoked divergent extremes of feelings of fear and frustration to hope and sensing inspiration. This is consistent with literature on recovery whereby recovery for everyone not only those with a SMI is accompanied by an intense and variable range of emotions (Anthony, 1993; Farkas, 2007). For those with SMI these emotions are often misinterpreted as consistent with their illness and not as a part of their recovery (Anthony, 1993).

Individuals with SMI considering or trying to quit smoking worry they are losing their most effective tool for coping with stress, as well that they might become isolated from social circles, or be quitting for others and not themselves. Concerns of being able to survive nicotine cravings, that quitting is too hard or that they will disrupt their mental health recovery in the process plague this population trying to change tobacco use behaviour. These thoughts of apprehension as described by Bradshaw et al. (2006), are also characteristic within the concept of recovery in mental illness.

Initially this process of recovery too, is described as one of individuals assessing abilities to move forward and considering the benefits and risks which can create ambivalence, fear and anxiety that the road ahead might be insurmountable (Bradshaw et al., 2006).

Conversely for study participants there was also optimism of being able to stay focused through the slip-ups and learn from them. As well there was relief of not having to go through the process alone. There was optimism that reducing cigarette consumption could ultimately lead to cessation, where triggers would be managed and the hardships of quitting not unlike life's can be weathered. Consistent with the concept of recovery as described by Bledsoe et al. (2008), participants described feelings of embracing hope that what they had learned from past quit attempts and had new knowledge on cessation supports that would make things different this time or next time.

Participants were acutely aware they would experience the challenging negative influencers of triggers to smoke, nicotine withdrawal and the stressors associated with living with SMI. This is similar to the process of mental illness recovery where there are also personal, resource, service and support issues that help or hinder the individual's success (Bledsoe et al., 2008). However for several study participants, they remained optimistic they could prevail the next time they tried to quit or that they could sustain a present quit attempt

For all study participants, setbacks of relapse had been experienced in past quit smoking attempts. However for most there was a willingness to consider, make or strive to maintain a change to their tobacco use in the future. There was also foresight to consider or plan responsible initiatives such as using NRT or electronic cigarettes, frequenting non-smoking environments and substituting positive health behaviours to help prevail over these foreseeable challenges. In parallel, Deegan (1988) describes recovery for those with disability as the lived

experience of individuals as they acknowledge and prevail over their challenges. Recovery involves rebuilding lives with hope, willingness and responsible initiatives in the face of frequent setbacks and is a deeply personal experience based on one's own aspirations (Drake & Whitley, 2014; Deegan, 1988; Ridgway, 2001; Weinberg: 2013).

All study participants regardless of their stage of change for tobacco cessation felt a sense of control that they were in the driver's seat throughout the process, that no one could do this for them. They had to want it for themselves when they were ready. Participants acknowledged that they were the "experts" in the phenomenon and therefore had to be the architects of their tobacco relationship break up. This again parallels the process within the concept of recovery in mental illness, which is described as non-linear, viewed as a highly individual process versus an outcome, and is characterized by discovery of self- management skills and achieving self-actualization (Carpenter, 2002; Frese & Davis, 1997).

For study participants, the mere accessing of supportive resources, gathering information, and conceptualizing coping strategies succeeded in building cessation confidence for those contemplating or maintaining a change to their smoking. Most participants held on to the resolve that they would continue to pursue quit attempts in the future for a variety of corporeality and spatiality driving forces. Examples of these include improving health, new perception of self, having more money for other things, and creating an improved and healthier living environment which are also supported in the literature (Dickerson et al., 2011; Ferron et al., 2011; Robson et al., 2013; Singer Solway, 2011). For those that had ended their relationship with tobacco there was resolve that they would remain smoke-free the rest of their lives. Not unlike the Trans-theoretical Model of behaviour change for smoking cessation, a key element also to the concept of recovery in mental illness is the perception of self-concept or self-efficacy. The individual's

belief in themselves and their perception of capacity to impact the direction of their lives influences their motivation towards recovery (Markowitz, 2001).

Finally, for all but one study participant the relationship with tobacco had endured for many years and for all participants through many attempts at a breakup. But even for heavily dependent smokers there was continued optimism that the next time might be the time that ends or changes the partnership with tobacco. Again this in not unlike these participant's journey towards mental wellness where defining recovery means hope, feeling they can increase their personal abilities and make choices regardless of the state of their condition (Bledsoe et al., 2008). This study describes the individual with SMI attempting to change their relationship with tobacco as experiencing fear, frustration, influence, resolve, determination, hope and inspiration. This new insight presents the opportunity to validate these emotions with the individual and help improve their opportunity for success with their self- determined outcomes. The significance of drawing parallels between the processes characterizing the journey of quitting smoking for the individual with SMI and those attributed to the consumer-driven model of recovery in mental illness is in the opportunity it presents to influence and guide future practice and policy. These include: 1) integrating tobacco dependency supports with in mental health recovery services, 2) building hope that tobacco behaviour change is attainable, 3) treating this change as a journey and not an event, 4) focusing on the present, 5) using a strengths-based approach to tobacco dependency treatment,6) offering a variety of behaviour change options, 7) using peer-led support strategies, 8) offering alternative to tobacco use, 9) maintaining tobacco dependency recovery during hospitalization, 10) smoke-free environments.

Practice and Policy Implications

    Integrating tobacco dependency supports.

If we begin to recognize the parallels between the processes of recovery in mental illness and recovery from tobacco dependence, we can begin to capitalize on community mental health supports that are already in place for the mental health consumer's SMI recovery. Examples from the themes were fears cessation would impact the balanced mental health medication regime. There were also concerns NRT would not be effective in managing withdrawal symptoms.   Frustration that behavioural strategies were inadequate to meet ongoing psychological challenges to quitting was also identified. The study's themes that characterize individuals with SMI contemplating or working towards changing their complex relationship with tobacco demonstrate the need for additional monitoring and contact throughout the process. The opportunity to provide this additional care resides in the existing supervising and checking in that occurs with community mental health services. Research supports the effectiveness of integrating delivery of tobacco cessation supports within existing mental health care services over referring these individuals to specialized cessation treatment (Hall & Prochaska, 2009; Hitsman et al., 2009; McFall et al., 2005; McFall et al., 2010). The delivery of supports during regular mental health case management highlighted in the literature includes examples of : a) tobacco cessation training for mental health care professions, b) having cessation medication protocols that allow the professionals to choose options that meet both the medical needs and personal preference of the individual with SMI, c) routinely including cessation medication as part of the quit plan, d) extensive assessment of clients tobacco use and dependency and cessation needs, e) provision of education, cognitive behavioural counselling, motivational interviewing, and self- help materials, f) assistance in identifying social supports and g) adding

additional follow-up to support behaviour change relapse prevention (Hall & Prochaska, 2009; Hitsman et al., 2009; McFall et al., 2005; McFall et al., 2010). The integrated approach to supporting tobacco cessation for individuals with SMI also provides the needed monitoring of the effects of reduced smoking on the individual's psychiatric medication regime (Lawn & Pols, 2005). The hydrocarbon by-products of tobacco smoking have an impact on the metabolism of some psychotropic drugs, reducing their concentrations and their ability to help reduce or manage the individual's psychiatric symptoms (de Leon, 2004). Therefore individuals with SMI who reduce or stop smoking may experience elevated levels of some of their psychiatric medications in their blood stream and need to have the amounts of these medications checked and potentially lowered to prevent them from reaching unsafe levels (CAN-ADAPTT, 2011). The maintenance and frequency of contact of the mental healthcare provider with the mental health consumer in supporting SMI recovery also provides the opportunity to cost effectively support at the same time tobacco behaviour change within this system (Hitsman et al., 2009).

Camann (2010) highlights the role of psychiatric nurses in helping patients with SMI contextualize their perceptions of health, lifestyle choices, strength and illness. These professionals provide assistance in creating a personal recovery image of wellness supported by self-determination and choice (Camann, 2010). The addition of tobacco dependency recovery care into psychiatric nurse's routines as an integrated approach can also be interpreted from the Register Nurse's Association of Ontario (RNAO) best practice cessation guidelines (BPG). Included in these BPG for all nurses are recommendations to include intensive smoking cessation intervention and counselling tailored to the needs of diverse populations when knowledge and time are available, and to re-engage clients in the cessation process to prevent anticipated relapses (RNAO, 2007). Literature has demonstrated that with increased capacity

building on how best to offer cessation support to patients, nurses are becoming more engaged in supporting their patients to quit (Sarna, Bialous, Kralikova, Kmetova, Felbrova, Kulovana, & Brook, 2014). Furthermore the College of Nurses of Ontario (CNO) recognizes the therapeutic nurse-client relationship that includes; trust, respect, professional intimacy, empathy and power to advocate (CNO, 2013). Each of these strategies would help individuals with SMI to create realistic, affordable NRT supported, tailored quit smoking plans. Coatsworth-Puspoky, Forchuk and Ward-Griffin (2006) described the opportunity for the nurse in a developed relationship to help the individual feel comfortable, validated to work towards goals and to develop confidence in skills.

Mental health care professionals such as: a) psychiatrists, b) psychologists, c) social workers, d) case-managers, e) personal support workers, f) nurses and g) community mental health hubs programmers that integrate a tobacco dependency recovery model into their existing work can help their clients trying to quit experience what is described by Bradshaw (2006) as a sense of being known and understood by their provider. Being supported in this way provides consistency to the quit strategy and supports ongoing evaluation of short- term goals that builds self-efficacy. Individuals with SMI are seeking supports for recovery from their mental health care provider that make them feel like someone is in the trenches with them helping them to maintain perspective and hope and truly rooting for their success (Anthony, 1993; Bradshaw et al., 2006). So too should tobacco cessation supports mirror these processes and create relationships with the individual with SMI of being their tobacco behaviour change personal trainer or coach that celebrates their accomplishments along the journey. It must be recognized however that within this role as coach it is not the practitioner's responsibility that their client quits smoking. Their role in recovery must be to support and empower the individual through

their unique and self- directed behaviour change plan that is tailored to meet their self-determined goals (Anthony, 1993; Carpenter, 2002; Deegan, 1998; Xie, 2013).

Building hope for tobacco behaviour change.

In recovery it is essential to build hope within the individual by helping them to define themselves by their strengths and appreciate that all their positive small steps matter (Weinberg, 2013). This too is important to building self-efficacy in the mental health consumer to recover from tobacco dependence. It must be reinforced to these individuals that all the fears, frustrations, ambivalence, unsuccessful past quit attempts, trial and errors in dealing with negative influencers or prolonged use of NRT to prevent relapse described as examples under the themes of this study, are not failures but valuable and essential elements in moving towards success. This is all part and parcel of the challenging process of changing ones relationship with tobacco which must be validated for the individual with SMI. It is, as described by Bradshaw et al., the invisible work of recovery (2006). The ups and downs of relapsing are part of the journey. It is important for individuals with SMI to recognize they are not a failure at quitting smoking. They are someone working towards recovery from tobacco dependence.

Supporting a journey versus an event.

Extending across the six themes of this study were participants feelings, reactions and beliefs regarding the multitude of attempts they described having made to try or successfully stop smoking. Individuals with SMI must begin to recognize quitting tobacco is not an event. It is a journey and relapse is part of the recovery just as it is in their mental health recovery process. It is also important for mental health care providers to understand this reality. Just as the literature describes recovery in mental illness as an incremental and lengthy process that requires fortitude and patience by all parties (Anthony, 1993; Davidson, 2007), this too is required not only of those trying to quit smoking but those supporting them (Kunyk, 2009). Supports and treatments

for those living with SMI who are making changes to their relationship with tobacco need to have extended and maintenance options available to facilitate tobacco dependency recovery (George & Ziedonis, 2009; Hitsman et al., 2009). Examples of this are highlighted from the study, where participants identified strategies of not reducing the dose of NRT as quickly or staying on NRT longer than what is recommended on the medication's package insert to increase their chances of avoiding relapse back to smoking after a quit attempt.

Focusing on the here and now.

Participants in this study shared their frustrations with past quit attempts, their previous experiences of being influenced by other's smoking and how being driven by corporeality forces of wanting better health were not enough in the past to help them stay smoke-free. Just as focusing on the present is one of the basic tasks of recovery in mental illness described by Davidson (2007), so too should this be the emphasis of the practitioner supporting the client with SMI's tobacco behaviour change. In applying this task of recovery, the individual is supported in moving beyond past quit attempts to considering them as lessons learned. There is refocusing on the here and now and the outcomes of strategies being used which helps to realistically gauge progress and foster appreciation for their short term successes (Davidson, 2007). These can include reducing tobacco consumption, making significant changes to practices of when and where tobacco is used, gathering information and trying out various smoking cessation aids.

Employing a strengths-based approach.

Drawing on the strengths-based approach to mental health recovery, Farkas (2007), the individual with SMI contemplating or acting on making a change to their tobacco use must also be helped to create a tailored tobacco dependency recovery plan that identifies their talents and interests. Hammond (2010) identifies key components of a strengths-based approach as : 1)

drawing on motivations and hopes, 2) fostering empowerment, 3) supportive relationships, 4) collaboration and 5) fostering learning and growth, in order to help the individual meet the challenges before them . Guo and Tsui (2010) highlight that individuals still have personal capacity regardless of their problems or disadvantaged surroundings. It is however important to look at what strategies they use, resources they have, what guides their behaviours and what their social norms are in comparison to society at large (Guo & Tsui, 2010). Identified from participants in this study included examples of frustrations over limited financial resources to support cessation aids and for some there was the positive emotional resource of a pet to assist them in dealing with the stress of quitting smoking.

Anthony (2003) highlights that the real deal breaker in the success of mental health recovery programs may lie in the best practice processes that occur between the mental health consumer and the practitioner. These processes include how initiatives are carried out within a built therapeutic relationship that empowers individuals to assist in setting behaviour change goals that are part of a person-centred plan and carried out in an environment that meets the consumer's needs (Anthony, 2003; Xie, 2013; Zolnierek, 2011). Interpreted from the narratives of participants in this study was the understanding that they were the "experts" in what was practical and doable to their cessation plan. These individuals had learned many lessons from past quit attempts that would be helpful next time around, and in several cases there was resiliency to survive failure and try quitting again. Helping individuals with SMI identify the strengths they possess and interests they have, is essential to building a tailored tobacco behaviour change plan. This can assist in supporting strategies that are realistic to their unique circumstances of tobacco dependency. A realistic and tailored plan is key to building the individual's self-efficacy in achieving a changed relationship with tobacco. Integrating a

strengths-based approach to treating tobacco dependency is critical to producing increased

successful tobacco use behaviour change outcomes for individuals with SMI.

Offering a variety of behaviour change supports.

Individuals in this study identified their personal fear, frustration, influence, resolve, drive

and hope in achieving cessation each using their own unique choices of support options that were

or were not helpful in their quit attempt. Literature identifies how each individual's journey in

SMI recovery is also unique and with this it too is important to offer a wide range of support and

options that are recovery triggers (Carpenter, 2002; Deegan, 1988). Mirroring this idea, are

tobacco dependency treatment and support options identified by study participants that include

options that are: 1) financed, 2) flexible, 3) realistic, and 4) driven by an understanding of the

meaning of the lived experience through involving the mental health consumer as the "expert" in

the development and delivery of the quit plan. In order to create a tailored tobacco behaviour

change plan there must be a smorgasbord of menu options available to choose from and tryout

(Ashton, et al., 2010; Campion et al., 2008; Griffiths et al., 2010; Kunyk et al., 2009). Dickerson

et al (2011), further highlight a need for quit smoking resources that are relevant and easily

available to individuals experiencing SMI.

Employing peer support strategies.

Included in these menu options should be the opportunity for the individual to participate in

peer-led support groups. Examples from this study demonstrated the positive influence of

learning new knowledge, effective strategies, and support resources from others who also are

living in mental health recovery and were trying to quit smoking. This is supported in recovery

literature that being surrounded by peers making the same journey brings hope and strength to

each other and has a positive effect on empowerment as well as self-efficacy beliefs (Deegan,

1988; Sterling et al., 2010; van Gestel-Timmermans et al., 2012). These groups can provide an opportunity to role model accomplishments and mentor others along the journey. It is however, important to involve peer facilitators at various stages of recovery and not only those having achieved total success (Deegan, 1988). As highlighted by Deegan, role models who are only a little ahead in the process of recovery might be more inspiring versus than those whose accomplishments seem more advanced and thus discouraging (1988). Therefore groups that include participants contemplating through to maintaining not smoking would be of value.

Examples of employing peer to peer education with positive outcomes are starting to be demonstrated in tobacco cessation literature were SMI consumer driven programs are reaching out to peers to talk about tobacco use and cessation (Williams et al., 2011). Williams et al., highlight a supervised peer program that offered individuals that had experienced SMI: 1) an employment opportunity, 2) cessation and professionalism training, 3) opportunities to provide peer cessation education and consulting for provider agencies (2011).   Dickerson et al. (2011), also point to an interest and willingness of individuals with SMI that have successfully recovered from tobacco dependence to help their peers trying to quit smoking. Highlighted in this study's theme of corporeality driving forces, was an example where the opportunity to be a smoking cessation peer leader helped to reinforce the desire to stay smoke-free. It was also perceived as an important way to instill hope in others.

Offering alternatives to tobacco use.

Important to recovery in mental illness is the need to maintain routines, avoid boredom, establish optimal degrees of challenge that do not overwhelm, and support experiences of feeling of mastery and pride (Bradshaw et al., 2006). These elements were also highlighted by participants in this study as part of the meaning of their lived experience of contemplating or

acting on making changes to their relationship with tobacco. It is therefore important that strategies to facilitate these experiences be incorporated into the individual with SMI's tobacco behaviour quit plan. The valuable uses of alternate activities to support mental health recovery or specifically tobacco dependency recovery are documented in the literature (Anthony, 1993; Dai & Sharma 2014; Gauthier, Snelling, & King, 2012). Consistent within the literature, participants in this study describe doing non-mental health or tobacco cessation focused activities such as walking, yoga, visiting smoke-free spaces and joining activity groups to support their tobacco dependence recovery.

Maintaining tobacco dependency recovery during hospitalization.

The first implication for practice supported by the findings of this study is the need to integrate tobacco dependency recovery support into mental health care provider practice. This too must include the hospital setting. The identification of smoking status upon admission and the assessment of stage of behaviour change are critical to maintaining the status of any preadmission reduction or quit attempt and supporting the management of withdrawal in an environment (Kunyk et al., 2009). Caman describes the benefits of psychiatric nurses using a recovery model approach to support client integration of health behaviours (2010). This type of strengths-based approach would also be essential to support continuation of tobacco behaviour changes during hospitalization and ongoing tobacco dependency recovery.   Also important is the need to continue to build hope for the individual that existing or imposed smoking cessation can be managed effectively and comfortable during hospitalization. Initiating innovative, appropriate and practical options for smoking cessation during times of hospitalization for mental illness can help to engage smokers with SMI in the cessation process and move them positively through the stages of change (Prochaska et al., 2014). Offering a variety of behaviour

change options including NRT timely and at the right dose and with ongoing monitoring of

effectiveness is also necessary (Kunyk, 2009; Leyro et al., 2013). As well, offering alternative to

tobacco use that keep individuals preoccupied from smoking during the stressful time of their

relapse in mental health recovery is important (Dai & Sharma 2014; Gauthier, Snelling, & King,

2012). Participants in this study highlighted examples where they were able to successfully

reduce or maintain smoking abstinence when hospitalized at a facility that banned smoking both

indoors and on the property. The challenge was identified in maintaining that tobacco use

behaviour change once discharged from hospital and moving forward with their recovery in

mental illness in the community. Recognizing tobacco dependency recovery not unlike recovery

in mental illness is a journey speaks to the need to ensure tobacco dependency recovery support

needs are included in hospital discharging planning (Lawn &Pols, 2005; Lawrence et al., 2011).

Smoke-free policies.

The development of smoke-free policies in hospitals where mental health care is received but

also in the community is essential to supporting the success of individuals with SMI in changing

their relationship with tobacco. The interpreted rich text descriptions of participants in this study

identified the positive influences of the lived space that is smoke-free in creating distractions to

smoking and de-normalizing its association with being out in community or being hospitalized.

Recovery can be nurtured in supportive environments (Deegan, 1988). Not being exposed to the

triggers of seeing others smoking or associating the behaviour with the environment is a

significant element to supporting sustained quit attempts. It must be recognized however that

these smoke-free environments particularly in hospitals are but only one piece of the puzzle in

contributing to the positive changed relationship with tobacco for the individual with SMI.

Campion et al., (2008) suggest that smoking bans in mental health environments have had

minimal impact on smoking cessation in the long term potentially due to uncoordinated efforts between inpatient, outpatient and cessation supports. As identified early, this supports the need to integrate tobacco dependency supports into community mental health services and hospital settings. It also recognizes the practice implications for supporting tobacco behaviour change for individuals with SMI as a journey versus an event where the extended time to recover from tobacco dependency transverses mental health care that often fluctuates from community to hospital and back to community.

Future Research

Literature identifies that individuals with SMI are motivated to quit smoking (Ashton, Miller et al., 2010; Ashton et al., 2013; Etter et al., 2004; Hall & Prochasks, 2009; Siru et al., 2009). It identifies that quit attempts are made for a variety of reasons (Ashton et al., 2013; Ferron et al., 2011; Robson et al., 2013; Singer Solway, 2011). Literature also addresses how successful individuals with SMI have been at quitting and what impacts success (Ashton, Miller et al., 2010; Bowden et al., 2011; Currier et al., 2008; Griffiths et al., 2010;Prochaska et al., 2014). Literature also speaks to the lived experience of quitting as being influenced in many ways, as overcoming obstacles and as requiring an inner strength (Snyder et al., 2008; Singer Solway, 2011). This study however goes further to categorize the meaning of the experience of considering or trying to quit smoking for individuals with SMI into six themes which include: a) fear of being, b) burdens of frustration, c) negative and positive influencers of change, d) holding onto resolve, e) corporeality and spatiality driving forces, and f) embracing hope and sensing inspiration. Further research is needed to explore the applicability of these themes that evolved from this study to the meaning of the phenomenon in other smoking populations of individuals with SMI. Findings also identify parallels in the literature of the lived experience of

recovery from and in mental illness and the lived experience of quitting smoking identified in this study. This points to a need to view quitting smoking through a recovery from tobacco dependency lens versus an unique event repeated many times. Further research is needed to validate the parallels in these two processes of recovery. It is also important to determine the effectiveness in drawing these parallels for the individual with SMI to help them better understand and appreciate their journey towards quitting smoking. . Evaluation of practices and policies that respond to the findings identified in this study's six themes would help to further refine opportunities for individuals with SMI to quit smoking. This includes further research into a) the impact on smoking cessation and relapse outcomes for individuals with SMI, when tobacco dependency recovery supports including NRT are integrated into the individual's existing community mental health supports, b) the perceptions of self-efficacy to quit smoking by individuals with SMI that receive a strengths-based approach to supporting their tobacco dependency recovery.

The findings in this study aligned within the four core concepts of the TTM. Future research should continue to quantitatively measure movement through the stages of change for tobacco cessation for individuals with SMI. This will continue to assist in better understanding social norm changes around interest in and attempts at quitting smoking in this population. Research however should also begin to qualitatively assess the impact of positive smoking behaviour changes on key elements of mental illness recovery such as self-worth and self-concept. The use of photo-elicitation as a strategy to support a qualitative methodology in this study provided an opportunity to enhance the interviews with more enriched descriptions triggered by participant's reflection of the meaning of their photographs. Future studies should continue to consider the integration of this strategy as a feasible and gratifying way to help the population of individuals

with SMI express their connection with those things in their life that hold significant meaning

but are hard to articulate verbally (Padgett et al., 2013).

Conclusion

The findings in this study support existing literature on the Trans-theoretical Model for

tobacco use behaviour change but also present a unique parallel to literature on the process of

recovery in mental illness. As highlighted by Davidson and Roe (2007), the term recovery offers

an alternative, constructive means of addressing the needs of the mental health consumer.

Helping individuals with SMI and health care professionals refocus the way they think about

their past and present quit smoking attempts as a recovery from tobacco dependence may hold

significant promise in the individual's positive movement through the stages of change towards

sustaining tobacco abstinence. Supporting individuals with SMI more effectively to end their

relationship with tobacco may serve to foster their ongoing success with recovery from or in

mental illness. Individuals in recovery from SMI are striving to reclaim control of their lives.

The opportunity to not be controlled by their dependency on tobacco would be conducive to this

goal. The desire to live a longer, personally meaningful and self- fulfilling life would be

supported by improvements to their financial circumstances once they are no longer burdened

with the costs of purchasing tobacco. Smoking is also well understood by individuals with SMI

as a behaviour that ultimately leads to physical illness. The opportunity to enhance the

perception of recovery in mental illness as someone who not only has found stability with their

mental health but also improved their physical health by quitting smoking helps to foster self-

efficacy and create a positive self- concept of wellness. Finally the stigma associated with

smoking stands in the way of improving self-esteem and expanding opportunities for individuals

with SMI to reintegrate into their communities where tobacco-free environments are the social

norm. Addressing tobacco dependency as a recovery process, that involves establishing

individualized, realistic, self- determined goals and conveys hope will also help to remove the

stigma of helplessness and futility that has been identified in this population

A shift in understanding.

As this was a qualitative study employing the philosophical underpinnings of Heideggerian

interpretive hermeneutic phenomenology, it is important to reflect on the hermeneutic circle.

The hermeneutic circle relates to what was believed and what is now understood about what it

was like to experience SMI and quit smoking. Having had some understanding of the

complexities described in the literature that are the contextual reality of individuals with SMI

who use tobacco provided only a slight hint at what was to be the co-constructed interpretation of

the phenomenon. There were pre-understandings that tobacco use is deeply ingrained in the

mental health care service provider and consumer culture. Individuals with SMI are motivated to

change their tobacco use behaviour but have low quit rates. There are inadequate resources of

nicotine replacement therapy and counselling supports reaching this demographic. These

barriers were considered to be significantly responsible for the low smoking quit rates amongst

individuals with SMI. This study's finding support new understandings of the journey towards

tobacco cessation for this population. These understanding include: a) parallels in the strengths-

based mental illness recovery process and the journey towards recovery from tobacco

dependency, b) the significance in developing the individual with SMI's self –efficacy towards

quitting smoking, c) the depth and breadth of poignant emotions described in the themes of

being fearful, frustrated, influenced, determined, driven, hopeful and inspired throughout the

stages of tobacco behaviour change, d) the connectedness of these themes to the individuals

experiences of lived space, lived time, lived body and lived relationship or other, e) the resiliency

of individuals with SMI to continue against significant odds to attempt to improve their wellbeing by trying to quit or sustain smoking cessation and f) the opportunity that exists to potentially positively influence the individual's recovery in mental illness through their accomplishing sustained successful tobacco cessation. These new understandings could significantly influence how tobacco dependency for individuals with SMI is both viewed and treated in the future. These include: 1) integrating tobacco dependency supports within mental health recovery services, 2) building hope that tobacco behaviour change is attainable, 3) treating this change as a journey and not an event, 4) focusing on the present, 5) using a strengths-based approach to tobacco dependency treatment,6) offering a variety of behaviour change options, 7) using peer-led support strategies, 8) offering alternative to tobacco use,9) maintaining tobacco dependency recovery during hospitalization, 10) creating smoke-free environments.

By modifying practices and policies to support tobacco use behaviour changes based on the interpreted needs of smokers lived experience of SMI and tobacco dependency there is the opportunity to improve their odds of successfully quitting smoking. Ultimately the benefits of quitting smoking may go beyond improving the physical health of the individual with SMI and may also have a positive impact on their lived experience of recovery in mental illness.

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Appendix A

APPROVAL FOR CONDUCTING RESEARCH INVOLVING HUMAN SUBJECTS

Research Ethics Board – Laurentian University

This letter confirms that the research project identified below has successfully passed the ethics review by the Laurentian University Research Ethics Board (REB). Your ethics approval date, other milestone dates, and any special conditions for your project are indicated below.

TYPE OF APPROVAL / New X / Modifications to project / Time extension

Name of Principal Investigator and school/department	Janet Allen (Nursing)
Title of Project	The Lived Experience of a Changing Relationship with Tobacco: A Perspective of Individuals with Mental Illness
REB file number	2013-10-11
Date of original approval of project	November 26, 2013
Date of approval of project modifications or extension *(if applicable)*	
Final/Interim report due on	November 26, 2014
Conditions placed on project	Final report due on November 26, 2014

During the course of your research, no deviations from, or changes to, the protocol, recruitment or consent forms may be initiated without prior written approval from the REB. If you wish to modify your research project, please refer to the Research Ethics website to complete the appropriate REB form.

All projects must submit a report to REB at least once per year. If involvement with human participants continues for longer than one year (e.g. you have not completed the objectives of the study and have not yet terminated contact with the participants, except for feedback of final results to participants), you must request an extension using the appropriate REB form.

In all cases, please ensure that your research complies with Tri-Council Policy Statement (TCPS). Also please quote your REB file number on all future correspondence with the REB office.

Congratulations and best of luck in conducting your research.

Susan James, Chair

Laurentian University Research Ethics Board

Appendix B

Are you someone who has struggled with mental illness?

Are you presently working on cutting down, quitting or staying smoke-free?

Are you interested in sharing your thoughts into what the experience of reducing or quitting smoking has meant for you?

A research study that can give you this opportunity is looking for participants

You would be interviewed 2 times by the researcher to share your experience of

reducing or quitting smoking

A $5 Tim Horton's gift card for your participation in the study is provided

Confidentiality is assured

To learn more, contact: Janet Allen, Laurentian University Master's Nursing Candidate, at allenj.research@gmail.com or at 705-206-3064

LaurentianUniversity
Université**Laurentienne**

Appendix C

Research Study Information Letter/Consent

Study Title: *The Lived Experience of a Changing Relationship with Tobacco: A Perspective of Individuals with Mental Illness*

Researchers*:* Janet Allen, RN, BScN, MScN candidate; Sylvie Larocque RN, PhD, Associate Professor,

Laurentian University

We are looking for your participation in this study as someone who has used tobacco and is also receiving help to achieve mental wellness. The purpose of the study will be to better understand what it means for you to experience an attempt to reduce or quit smoking.

- Being in this study is voluntary and I know I can stop at any time.

- I have read or had the information letter about the study explained to me by Janet Allen, a

  Laurentian University Masters of Nursing Student.

- I was able to ask any questions about the study and get satisfactory answers to my questions.

- I will be meeting with the researcher 2 times for about 30-45 minutes at a public location that

  works for both of us and at a time that fits into my schedule.

- I am O.K. with study interviews being tape recorded so that the valuable information I share is accurate.

- I know that a summary of the information I have shared at the first meeting will be shared with me at the second interview so I can make sure the information is correct.

- I will be given a disposable camera to take pictures that help me share my experience of reducing or quitting smoking, but to protect others privacy I will not take pictures of people.

- I will have the opportunity to talk about up to 5 of my pictures at the second interview with the researcher

- I will return the camera and any pictures if I decide to stop being part of the study so the researcher can disposed of them and any information I have shared in an appropriate manner.

- My name will not be used in the recording or reporting of the information I share or in any parts of the interview and or photographs that are included in public articles, presentations, and/or reports written about the study.

- If I decide to stop being in the study it will have no impact on any of the services I am presently receiving

- I know that talking about reducing or quitting smoking may be helpful, but if at any point it makes me feel upset, the researcher will provide me with a list of resources where I can get support and encourage me to connect with my mental health case worker or mental health community support for assistance.

- I know that all the data collected during the study will be securely retained by the researcher until it is no longer being studied after which time it will be disposed of in the appropriate manner.

- I will receive a $5 Tim Horton's gift card regardless of whether I finish all the interviews

- I was informed that I may contact the Research Ethics Office at the Laurentian University Research Office toll free at 1-800-461-4030 ext.3213 or email ethics@laurentian.ca regarding any ethical issues or concerns I may have about the research itself.

I, _____ agree to participate in the following study.

NAME: _____ **(**please print)

SIGNATURE: _____

DATE: _____

Contact Information of Researcher:

Student investigator: Janet Allen, RN, BScN, MScN candidate

Phone: (to be activated upon ethics approval)

Email: allenj.research@gmail.com

Thesis Supervisor: Sylvie Larocque (RN, PhD, Associate Professor, Laurentian University, 1-800-461-4030 ext. 3804