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'It had to be my choice' Indigenous smoking cessation and negotiations of risk, resistance and resilience

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While Australia is considered a world leader in tobacco control, smoking rates within the Aboriginal and Torres Strait Islander population have not declined at the same rate. This failure highlights an obvious shortcoming of mainstream anti-smoking efforts to effectively understand and engage with the socio-cultural context of Indigenous smoking and smoking cessation experiences. The purpose of this article is to explore the narrative accounts of 20 Indigenous ex-smokers within an urban community and determine the motivators and enablers for successful smoking cessation. Our findings indicated that health risk narratives and the associated social stigma produced through anti-smoking campaigns formed part of a broader apparatus of oppression among Indigenous people, often inspiring resistance and resentment rather than compliance. Instead, a significant life event and supportive relationships were the most useful predictors of successful smoking cessation acting as both a motivator and enabler to behavioural change. Indigenous smoking cessation narratives most commonly involved changing and reordering a person's life and identity and autonomy over this process was the critical building block to reclaiming control over nicotine addiction. Most promisingly, at an individual level, we found the important role that individual health professionals played in encouraging and supporting Indigenous smoking cessation through positive rather than punitive interactions. More broadly, our findings highlighted the central importance of resilience, empowerment and trust within health promotion practice.

Keywords: public health; stigma; risk; trust; Indigenous; smoking cessation; smoking

Introduction

The disproportionately high prevalence of smoking amongst Aboriginal and Torres Strait Islander people in Australia has been well documented (Australian Bureau of Statistics 2006, 2010, Baker *et al.* 2006, Ivers 2001a) and is widely accepted as a major contributor to the excess morbidity and mortality experienced by Indigenous[1] Australians (Vos *et al.* 2007). The failure of mainstream anti-smoking interventions to reduce smoking rates amongst Indigenous people as well as a paucity of Indigenous-specific smoking interventions and evaluation into existing Indigenous smoking interventions (Walley and James 1995, Ivers 2001a, 2001b, Hill *et al.* 2005, Ivers 2008) has contributed to the widening of health inequalities (Hill *et al.* 2005).

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The dominance of individualised, behaviourist smoking interventions in mainstream health promotion is unlikely to adequately address Indigenous health inequality alone (Baum 2009, p. 163) and similarly we are cautious of the potential for victim-blaming and attaching portraits of non-compliance and deviance to the experience of Aboriginality (Bond 2005). We note that the practice of problematising and publicising Aboriginal health behaviours without commensurate action is reflective of the very disadvantage and oppression that creates and entrenches Indigenous health inequalities. Thus in the qualitative research we report here, we focus on the meanings Aboriginal and Torres Strait Islander ex-smokers place on their experience of 'giving up', not with the simplistic assumption that they 'finally' understood the risks associated with their smoking behaviour, but rather with a view to understanding the degree of social, cultural and political negotiation involved in the act of 'giving up'. It is our goal here to illuminate possibilities for anti-smoking interventions to more appropriately engage with Indigenous realities and the broader socio-cultural context of smoking in order to more effectively reduce smoking rates among Aboriginal and Torres Strait Islander communities.

Scrutinising the social in Indigenous smoking cessation

There are various explanations for why smoking rates are higher among some populations than others and they most commonly implicate the social environment, albeit in slightly different ways. A study of the social determinants of Indigenous non-smoking (Thomas *et al*. 2008) found that while there are some variations with age, gender and geographic location, the most significant determinant of Indigenous non-smoking behaviour was socio-economic position. In this study, Indigenous people who had been arrested in the last five years, removed from their natural family or had not abstained from alcohol were also more like to be smokers than those who were not, yet these factors were not as significant in influencing smoking cessation. The authors suggest that the alleviation of social disadvantage is an important tobacco control intervention. Interestingly the socially patterned nature of high-risk smoking populations within the general community are not all that dissimilar in comparison, with smoking rates higher among socio-economically disadvantaged populations, the prison population, those experiencing mental illness, those using other drugs, single parents and those experiencing homelessness (Scollo and Winstanley 2008).

Some researchers suggest that it is the stressful experiences associated with poverty that explains the causal pathways between socio-economic position and smoking rates. Heath *et al*. (2006) study of Indigenous expectant mothers found that stress was the most significant barrier to smoking cessation while others have found that stressful life events hinder smoking cessation efforts (DiGiacomo *et al*. 2007). Similarly, the 2004–2005 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) (Australian Bureau of Statistics and Australian Institute of Health and Welfare 2008, p. 138) found that Indigenous smokers were more likely to report high/very high levels of psychological distress than non-smokers. Roche and Ober (1997) argue that the complex social problems experienced by Indigenous people overwhelm the possibility of investing the necessary time and energy required to cease smoking.

A study involving the use of free nicotine patches by Indigenous people was found *not* to have significantly impacted upon cessation rates, and this was in part attributed to the fact that smoking is seen as a normal part of life within Indigenous communities (Ivers 2003). Ivers (2003, p. 488) describes smoking as a 'socially

sanctioned activity' within Indigenous communities and points out that it has been a feature of traditional and contemporary cultural life for Indigenous people. Historically, tobacco was used as a measure of social control among Indigenous people, and Roche and Ober (1997, p. 130) noted that, 'sharing a cigarette has also become one of the ways in which Indigenous people have been able to reaffirm, strengthen and maintain their cultural identity in an environment that is often hostile and constantly changing'. They argued that smoking provided a socially acceptable and accessible medication against the ills of racism, oppression and poverty experienced by many Indigenous people. Heath *et al.* (2006, p. 134) argued that the socially patterned nature of Indigenous smoking behaviour meant that tobacco control interventions should extend beyond the use of individual therapies and include family and community-based strategies.

Some researchers suggest that smoking cessation initiatives are hindered by the high smoking prevalence among Indigenous populations. For instance, the Australian Medical Association and Australian Pharmaceutical Manufacturer's Association Report examining Indigenous smoking (2000) pointed out that Indigenous smokers were less likely to have known someone who had successfully quit, and therefore would feel less hopeful in their own ability to quit successfully. Christakis and Fowler (2008) explored the ways in which smoking cessation spread from one person to another in the USA and studied a network of over 12,000 people over a 30 year period and found that quit smoking choices were not always an individual decision. In fact, they pointed out, 'cessation of smoking in one person appears to be highly relevant to the smoking behaviours of others nearby in the social network' (Christakis and Fowler 2008, p. 2257).

Given the significance of social position, social norms and social networks in influencing smoking cessation, social support is essential for successful Indigenous smoking cessation. Non-coercive methods of counselling are important, but similarly counselling support to prevent stressful life events from triggering relapse is also critical to sustaining smoking cessation as it assists with the development of alternative coping mechanisms (DiGiacomo *et al.* 2007). Programmes that offer social support are critical as Indigenous people may be less likely to have supportive family and/or community members (Mark *et al.* 2004, p. 202) and more commonly exposed to environments where smoking bans aren't enforced due to social norms surrounding smoking. There has been some minimal success reported using nicotine replacement therapies and there remains no evidence about Buproprion, however group based interventions tend to have higher success rates among Indigenous people (Power *et al.* 2009, p. 190). Community interventions are often hard to measure, but they may be useful in raising general awareness. There is a general consensus within the research literature, that the motivating factors for Indigenous ex-smokers decisions to quit remain relatively unclear (Ivers 2001, p. 90) (Goodman *et al.* 2009, p. 24). McDermott and Graham (2006, p. 1549) argued that the dearth of qualitative research examining the subjective experience of smoking cessation among highly disadvantaged groups was a significant barrier to the development of effective smoking cessation interventions for them.

Therefore the purpose of this article is to explore the socio-cultural context of Indigenous smoking cessation experiences and more specifically, identify the factors that both motivated and enabled Indigenous people to quit smoking. The study on which this article is based was initially undertaken by an urban Indigenous health service to improve individual and community-based smoking interventions within

the local community, by examining the narrative accounts of Indigenous ex-smokers. Whilst our agenda was not to critically examine public health notions of 'risk', we found that smoking cessation possibilities for Indigenous people were complicated by individual and community navigations between 'health risk' narratives and resilience building strategies.

Methods

The study on which this article is based was informed by a phenomenological approach, in that we sought to enhance our understanding of Indigenous smoking cessation by examining the experiences of Indigenous ex-smokers as narrated by them (Struthers and Peden-McAlpine 2005, p. 1274). Our approach was to 'refrain from importing external frameworks and to set aside judgements about the realness of the phenomenon' (Finlay 2009, p. 8). Here we aim to explore in-depth narrative accounts to gain a richer and fuller understanding of the lived context (Finlay 2009) in which Indigenous smoking cessation takes place. It has been suggested that phenomenological research methods fit with Aboriginal epistemology, in valuing oral tradition and supporting expressions of culture and identity (Barton 2004) (Struthers and Peden-McAlpine 2005). Walker (2003, p. 37) argued that regulation of Indigenous knowledge through Western research paradigms is a form of structural violence inflicted upon Indigenous people which has involved the silencing of Indigenous voices and realities and the invention of restrictive, oppressive and disempowering conceptualisations of Indigeneity. The methodological approach here, which examines Indigenous smoking cessation success stories enables the privileging of Indigenous voices and experiences and helps re-construct imaginings of Indigeneity that are premised on strength rather than social deviance, which are unfortunate yet prevailing features of Indigenous health research discourses (Bond 2005). This study also sought to consider the purposefulness of mainstream anti-smoking campaigns, legislation and smoking cessation aids within the context of these narrative accounts in order to avoid 'Othering' Aboriginality and/or problematising Aboriginal smoking behaviour.

Our study was conducted in an urban Indigenous community located in the outer south-western suburbs of Brisbane[2], Queensland which is home to a significantly high proportion of Indigenous people (Australian Bureau of Statistics 2006). A total of 20 Indigenous people who had successfully quit smoking were interviewed using a semi-structured interview guide. The interview guide encouraged participants to recount personal narratives of smoking commencement, significance of smoking behaviour throughout life, quit smoking attempts and maintaining a smoke-free life. Central to such discussions were the exploration of motivators for behavioural change, and the enablers and barriers to sustaining non-smoking behaviours within an urban Indigenous setting which is the focus of discussion here. Purposive and snow-ball sampling methods were used to recruit participants for this study as the target population remains a relatively small and hard to access group. While the Health Service records smoking status of its clients, it was not possible to generate a list of Indigenous ex-smokers from which to draw a sample. However participation in the study was promoted among clients attending the service and half of all participants were recruited via staff. The remaining participants were recruited using the snow-ball sampling method with an emphasis on encouraging participation from a broad cross-section of the community including age, gender, ethnicity, employment status,

smoking duration and cessation methods. The key criteria for participation included; being of Aboriginal and/or Torres Strait Islander origin, aged 18 years or over and having not smoked a cigarette within 12 weeks of participating in the study.

An equal number of males and females were included in the study but they were of varying ages, and had diverse smoking experiences. All participants identified as Aboriginal and one identified as both Aboriginal and Torres Strait Islander. Over half (60%) were employed while the remaining 40% were either unemployed or not in the work force. Most participants (80%) were aged 35 years and over. The majority commenced smoking when they were younger than 16 years old (75%), with only one participant commencing after the age of 25 years. Over half (65%) of all participants had smoked for 10 years or more with 40% having smoked for more than 25 years, and most had smoked more than 10 cigarettes per day (85%). The age at which smoking cessation occurred was varied, with a relatively equal distribution among each age category. Similarly, this study included both short-term and long-term ex-smokers with 60% having given up in the past five years or less.

While not a requirement of participation, membership to a specific geographical area was common among participants (current or previous resident, family kinship connections and/or worked within the community). All interviews were conducted by the first author who is also a local Indigenous community member. Local knowledge and connectedness was essential to the successful and prompt identification and engagement of research participants. However familiarity and connectedness between researcher and participant both hindered and aided the ability to narrate and scrutinise personal life narratives. Some participants appeared to be preserving existing family and/or professional relationships and avoided intimate reflection while others felt obliged to self-disclose because of an awareness of the researcher's knowledge of their life experiences.

Ethics approval was granted by the Queensland Health Metro South Human Research Ethics Committee and community support was provided by two local Indigenous community organisations. Participants were provided with a 25 Australian Dollar gift voucher for their time which was usually between 30 and 60 minutes. All interviews were conducted at a time and location convenient for participants and audio-recorded and transcribed with the participant's consent. All names were changed upon transcription of interviews and names used here are pseudonyms to protect the identities of the research participants. Some editing of interviews was required because the transcriber was unfamiliar with Aboriginal English and local phrasing. In consultation with the research team, the first author thematically coded all interviews and QSR International's Nvivo 8 qualitative data analysis software was used for data management. The results of the preliminary findings were presented to members of the research team and other Indigenous health professionals for discussion and to elucidate other potential themes.

Findings

In examining the narrative accounts of Indigenous smoking cessation, we used Prochaska *et al*. (1992) theory of stages of behavioural change to logically organise the various themes that emerged from the narratives provided. We use the Health Belief Model here as a heuristic device to unpack the social trajectory from smoker to ex-smoker. Most narrative accounts referred to a *process* of quitting rather than the *act* of quitting and included reflections of pre-contemplation, contemplation,

planning, action and maintenance. In organising the narratives in this way, we have not attempted to operationalise the Health Belief Model in its purest psycho-behavioural manifestation; rather it provides us with a framework to explore the social context surrounding the pathway from once resisting anti-smoking information, to contemplating a change and ultimately becoming an ex-smoker. Indigenous accounts of smoking cessation did not follow a narrative structure that moved smoothly or sequentially through each of these stages though the deployment of this framework is still useful as it provides us with a snapshot of critical points in behavioural change processes from a specific Indigenous socio-cultural context, which to date, has been largely ignored.

Pre-contemplation and contemplations of anti-smoking discourses

Participants in our study described their 'reading' of smoking cessation campaigning and the ways in which their smoking behaviours were influenced. One participant described how the promotion of increased risk of illness and premature death used to inspire smoking cessation was made redundant by the lived reality of such experiences. Here Indigenous ill-health was viewed as a pre-determined reality rather than an avoidable threat.

> I always thought about the health stuff that it wasn't a big deal to me. Because...you work on X community [Aboriginal reserve community] for so long it's just like you knew you were going to die by 45 or 40 or something. You knew that your life was going to end because of diabetes or smoking or something like that or a heart attack. You knew that you were going to go early. (Kathryn, 32 years)

Another participant stated how the broadcasting of health threats on television made her resistant to contemplating smoking behavioural change. For this participant, health promotion was not an altruistic endeavour undertaken by caring health professionals, but instead was symbolic of colonial assertions of power and control over Aboriginal people.

> I used to think they were forcing it on the people to watch it on TV. I just seen it as the health department taking your choice away, your freedom...your right. Whether it's because me being an Aboriginal woman you know, the white man being authority all the time...I don't know but I just see it as the white man telling us you can't do this, you can't do that. I think I might have tended to smoke a little bit longer. I was saying to Maureen, 'They're not going to tell me to give up smoking.' I want it to be my choice. (Aunty Mavis, 55 years)

This distrust towards the state and health authorities is further evidenced in an explanation offered by one participant as to the causes of high smoking prevalence within his community.

> The way [the community] was set up it was set, the lower standard people who the system, who the government considered was a lower kind of people and bunched us all together ...put all the public housing in here and not so much in a lot of the other suburbs. And a lot of these people had alcohol problems and everything and they was just from all over the place and I guess, back in them days, it was smoking was normal. You had the ads where encouraged everyone to smoke. It had, places like this [the local health service] would have cigarette ads in 'em on posters and everything like that. It was, the government wanted it. (Brett, 43 years)

Here, 'government' is seen as not acting in the best interests of the people, and in fact, is seen to be entrenching social disadvantage and reinforcing stigmatisation of such groups. Health risk narratives have contributed to the stigmatisation of smoking behaviour (Bell *et al*. 2010), which have produced mixed results for Indigenous people. For some, it has reinforced distrust and resentment leading to the use of the body as a site of resistance.

> And I think that's the biggest thing, 'cause I grew up in a very close-knit family, my uncles and that, and if you did anything everyone would know. And that stigma of all the aunties all looking down at ya, 'He does this and he does that.' And being in that Christian environment really tended to galvanise you to be more of a Christian or to rebel and say, 'Stuff you.' (Errol, 37 years)

For others, social stigma invoked a sense of guilt which did not engender positive life change, but in fact, reinforced smoking dependency by encouraging increased smoking behaviour. One participant discussed how the experience of stigma from some family members reinforced feelings of low self-esteem which she had attributed to influencing smoking behaviour detrimentally.

> They didn't even make me think about it because, they actually made me feel bad about it [laugh]. If I did have a cigarette they're like, 'What are you doing smoking?' They make me feel real bad and guilty and tell me that I'm wasting my talent. It makes me feel even more worse then. (Tracey, 22 years)

We found that 75% of the people we spoke to described using smoking as a coping mechanism for stress. Participants described how their smoking behaviours were directly linked to how they felt about themselves and the world around them. Negative life events and interactions would often be described as triggers for relapse or an increase in consumption.

> I think that's maybe why a lot of people smoke sometimes because they're frightened about things or they're grieving, that's happened to me as I said before, when my mama died. (Aunty Mary, 59 years)

Another participant noted the unhelpfulness of social stigma and how it would instead reinforce smoking behaviour.

> So I mean that's the key, because I think not only when you bag someone, it makes them feel more, ''Oh well, stuff it. I'm just going to keep going,'' (Aunty Anne, 60 years)

While the health risks of smoking have been used to promote awareness within the community of the detrimental effects of smoking, we found the use of health risk narratives to inspire health behavioural change remained fairly limited and could be counterproductive to smoking cessation efforts among Indigenous people.

Contemplating change and changing life circumstance

All the accounts of Indigenous ex-smokers identified a significant life event and most commonly positive life events as the stimulus for behavioural change. These events included; a new job or promotion, a new or improved relationship, relocation to a new community or workplace, reaching an age milestone, and/or the embracing of a new identity role which was seen as incongruent with one's smoking identity (for

example becoming an expectant mother, a grandparent, community worker or being converted to a new religion). In the following account the participant describes how her behavioural change was made possible by a whole-of-life change.

> Well, see I in the last 4 years when I'd given I mean I've had a big turnover of my whole life, it's been the biggest turnover ever. I've been in X community [Aboriginal reserve community[3]] nearly all my life and I got out of a relationship and that was 11 years of pretty much the same every day and then I like moved to Y community [major regional city] and got a new relationship and I had to learn how to drive, learn how to socialise. It was like smoking was hard to give away but it was part of my whole turn over of my life. (Kathryn, 32 years)

The accounts also indicated the ways that the experience of life changes led to a reconfiguring and critical self-reflection of the participant's own identity. For instance, one participant reflected on the ways in which reaching 40 years of age caused her to reflect on and resent the length of time her life had been oriented around smoking.

> Around that time, I think turning 40, definitely. I just thought 'oh my God, I'm 40 and I smoke, still smoke and I feel I'm unhealthy'. It was turning 40 was a big thing for me... and I thought oh 'my God, I'm here in a blink and you know, another blink and I'll be 80', you know, well not 80, you know, 60. Fifty, 60 and I'm thinking, 'I don't want to be smoking still'. (Michelle, 43 years)

In their accounts, participants indicated that the significant life event most often led to the embracing of a new identity and this was particularly important for those who had experienced religious conversions and who had taken new roles either within their family or community as in the following account:

> I went from a tour guide to a youth worker, so it was an employment and positional change. Transition into a new role, and I think one of the challenges for me was that in a sense, if I was going to preach health and talk to young fellas and work with young fellas about life and that, I think I had to do it first before I could tell anyone else. Because while I was voluntary there, I was smoking and everyone else, kids would ask you for smokes, but I just started feeling a bit guilty about it. Because it wasn't good. Like at that age, I realised smoking wasn't good for you. Then that's around the same time when I started going to church and then I became a youth worker in church, and that just piled it on more. (Lloyd, 36 years)

Participants indicated that embracing a new identity empowered them through the development of a 'positive self-concept or personal competence' (Israel *et al*. 1994, p. 152) to see smoking cessation as a real and possible choice in their lives. For some, the new role or identity simply did not 'fit' with being a smoker, providing them with the impetus to reconsider their smoking identity. In such situations, smoking cessation was not simply a behavioural change, but involved the acquisition of a 'new life' and the formation of a new identity.

> And I associate it with, like I used to be a former teacher, that's what I say now, because I haven't been in the classroom for nearly 5 years, so it's nearly about the same time too, so that was my former life, this is my new life. And like being married too, because all the kids know me as Miss Waters I'm now Mrs Robinson. (Pearl, 37 years)

Among the few who recounted a negative life event, it was most commonly a health crisis, although one participant recalled a marriage breakdown. The direct

experience of a life-threatening illness (as opposed to health risk) was a feature of behavioural change contemplation mainly among individuals aged 50 years and over. For many the experience of illness did not lead to quitting behaviour but instead prompted them to contemplate quitting and occurred alongside other individual life change and/or exposure to supportive people and environments. Only one participant indicated how the experience of hospitalisation after suffering a heart attack led her to give up smoking.

> I think the heart attack itself actually gave me a big wake up call... They took me up to must be like a Coronary Care they've got there at the [hospital] or some ward and then they decided to transfer me over to the [hospital] later that night and I didn't know where I was going to and it just looked like death to me. I think that might have scared me 'cause only I had that experience that, because it was so quiet and dark and you know how they have the nurses lights on, just a couple of lights I could see and you could hear a pin drop in that place it was so quiet and it just really, to this day it really scared me. (Aunty Amelia, 59 years)

Interestingly, this participant identified how she'd experienced significant health issues years earlier and still continued to smoke a pack a day. She said that what made this occasion different was the bedside intervention of a quit counsellor and follow up support provided upon discharge – which will be discussed further in the next section. In another case, a female participant spoke of quitting during each of her pregnancies but starting again and only quitting completely when she developed other coping mechanisms to deal with her life stresses. Among those who had encountered a negative life event, it was most commonly paralleled with an increase in supportive environments and/or increase in self efficacy. The following extract from an interview with a male participant indicated how he quit during his marriage breakdown and how this was made possible due to his exposure to a personal self development programme.

> It was '98 yeah, I just split up with me wife. Yeah so, it was to sort of try and get my life back on track and find out a lot of things, what she'd done to me over the years... I actually done this course at the public service and it sort of teaches you. It's a personal leadership course and it sort of teaches you how to deal with your problems and how to, like it's an inner circle and you can't control what anyone else does. So I had to do something like that and so I gave up smoking. (Brett, 43 years)

While alleviation of social disadvantage is an important tobacco control intervention, these accounts demonstrate that smoking cessation is still possible amidst this climate of hardship and social exclusion.

Experiences of smoking cessation

Most participants quit smoking without using smoking cessation aids such as nicotine replacement therapy (NRT), or varenicline, and in fact even among those who did use quit counselling services, nicotine replacement therapy or varenicline, not one participant completed the full recommended 12 week programme. All participants reported some level of scepticism and distrust towards quit smoking aids and discarded their use once they felt more confident in their ability to quit. It was quite common among those who used quit counselling services such as Quitline[4] to be initially sceptical of the counsellor's interest and intent.

> While I was in hospital they came around to me, the Quitline came around to where I was and they spoke to me and they were saying, 'We can offer you all this help with the Quitline' and I didn't really believe them [laughs]. Yeah, but they wasn't, they was really good. 'Cause they said that they would ring and, just to see how things were going and then they did ring to see how I was going. . .I just felt that at least somebody listened and followed up. Like, I thought you know, 'They're not gonna do this,' but, but actually they did and it was about 3 or 4 times that they'd rung back. (Aunty Amelia, 59 years)

Among others, there was a perception that the use of NRT and Varenicline were not cures for addiction but an alternate addiction.

> I felt that I didn't want to replace it with something else, like I wanted to do it just because I wanted to do it, because I knew it was good for me. I didn't want to replace it with a patch. It's not really quitting because aren't you getting nicotine hit at the same time. I don't know, I've never tried it [laugh]. (Tracey, 22 years)

Some participants suggested that the use of smoking aids and supports was evidence of an individual's lack of 'will power', particularly among those who ceased smoking 'cold turkey'. Among these participants, smoking cessation was all dependent upon the individual's 'decision' or 'choice'. Therefore, trust and general attitudes towards smoking cessation supports certainly seems to be a barrier hindering successful smoking cessation.

> It's all in your head, in your mind, you give it away, you beat it, that's it, simple. And that's the only way I can tell people, if you haven't got it, you haven't got it. I never had patches, no. None of this chewing gum, nothing. If you haven't got it in your head or brain, you know the function is, like the smoking goes to your brain, your brain is working for you. If you haven't got that well you might as well keep on smoking. If you haven't got no ticker then you might as well keep smoking. (Uncle Barry, 58 years)

Participants judged other types of smoking cessation supports less critically than pharmaceutical supports. For instance, supportive people and environments were seen as critical to successful smoking cessation among all the participants involved in the study. Social support from family, friends, work colleagues, local health professionals as well as anonymous telephone counselling services were all seen as critical to successful smoking cessation.

> I think if someone's going to give up don't put them down and just be there for them and don't say, 'Oh, you having another go again?' I know that if I've done it anyone else can do it – its having the confidence in that person even if they'd gone back to it, don't put them down I think it just makes them want to smoke more. (Kathryn, 32 years)

Supportive environments were necessary to assist in alleviating the depressing situations that contributed to smoking behaviour and to provide new social networks that buffered against the frequent exposure to smoking environments, and social norms and networks in which smoking was valued. The following extract indicates how the participant felt that a supportive environment helped promote a sense of self-efficacy necessary to try and persevere with smoking cessation efforts.

> I think spiritually, I went back in the church. . .It does play a big role because some of the things like there's a scripture, 'you can do all things through Christ who strengthens you'. . . it's like having another person there whereas before all I had talking to me was cigarettes, the receptors saying to me, 'Have a smoke,' and now I have the other side saying, 'No, look,'. . .the belief was a self-belief. (Errol, 37 years)

Supportive environments included workplaces and settings in which smoking behaviours were not supported both implicitly and explicitly. For instance, workplaces where there were few or no smoking networks were both motivators and enablers to smoking cessation, while smoking bans in public places also assisted in normalising the transition to a non-smoking life. There did however appear to be an intricate line between normalising non-smoking behaviour within a community and demonising individual smokers. In fact, smoking interventions can potentially be counterproductive if exclusion of smokers is the only method by which non-smoking choices are supported. Many participants identified the challenges of smoking cessation and negative smoking cessation narratives within their family, community and/or working life and they explained how the exposure to at least one supportive individual, network and/or environment assisted them significantly in counter-acting those challenges.

> The very first time that I spoke to a young man, our conversation, there was just no pressure, like people say, 'Oh don't smoke. You shouldn't be smoking them, they give you cancer.' And all this sort of stuff, but there was nothing with the Quitline. Well, with that first young man that I spoke to, it was just telling me to be confident about it. It was just all the things that he said to me, and he was very ... not telling me what to do; but he was just calm... (Aunty Mary, 55 years)

Almost half of all participants identified a health care provider as the integral support person in encouraging and enabling smoking cessation. What was intriguing here was despite the distrust and scepticism of Indigenous people towards the state and health authorities, this was overcome through the development of trusting and respectful relationships. Some participants reported that the health care professionals they met respected them and did not talk down to them.

> I tell you, we got the best doctors in the world here... Not talking down to us, talking to us, do you understand? This is what a black fella can't take, he can't take it when a man talks down to him. He can't take that he'll get up and say, 'Yeah, yeah, yeah,' walk out and do the same thing. But when you sit down and talk with him, talk to him, he takes notice. That's what these fellas do here honestly, I tell you the best staff in the world here... (Uncle Richard, 54 years)

Such trusting and respectful relationships between health care professionals, the health care system and the state significantly created the possibility for Indigenous people to be influenced by mainstream health promotion campaigns, access smoking cessation supports and health care services.

Maintaining change – Empowerment & resilience

Many participants spoke of various unsuccessful quitting attempts but attributed long term success to an increased sense of self-efficacy not simply regarding smoking cessation but life more broadly. For many participants, stress remained in their lives, however they had developed what Ward *et al.* (2011) refers to as resilience strategies to cope with such challenges.

> Oh well, I've worked out different ways like and I think that I'm a bit more mature now like, so just doing something like pick up a cigarette, I can work out different strategies rather like going for a walk....listen to some music...or chuck the kids in the car and we'll go for a drive and take them to the park. (Cassandra, 37 years)

One participant pointed out that self-esteem, and life circumstances were closely associated with smoking cessation which led to a sense of control and empowerment in life generally.

> I'm a different person compared to five years ago. Like I wouldn't even talk to you like I'd walk around with my head down. . .I had to learn to socialise with different people, I had to get up and actually talk. . .you know getting on the phone and making arrangements and stuff like that. . .I had other people doing that for me but now I was on my own. (Kathryn, 32 years)

Participants stated that quitting smoking was linked to their sense of ownership over the decision making process. While seemingly obvious, a genuine desire to quit and a sense of ownership over the decision were seen as necessary for successful smoking cessation. Here, the focus was not so much about 'willpower' and more so about taking control. The capacity to take control over the decision to quit epitomises the sense of control necessary to free oneself of addiction and dependency and reflected one's ability to take control over one's life as in the following interview extract:

> I just think that people themselves have to be ready to give up smoking if they want to. I don't think anyone is going to be successful in giving up smoking unless they want to do it themselves and not have it forced on them. Whether that's with patches or I don't know other things they all use, don't know but I think it has to be their choice. (Aunty Mavis, 55 years)

All participants were very proud that they had quit smoking and had a strong sense of empowerment. Recruitment for this study was comparatively easy as participants were proud to identify themselves to the research team and share their stories. Similarly many participants spoke of the encouragement they received when attending health care services after quitting and many proudly recalled the positive reactions of treating physicians. Of great importance in their accounts was the respect that they gained from family and significant others as in the following account:

> For me, a 54-year-old Aboriginal man, honestly I've got the mantle back in my family as the head of my family now. I felt that slipping when I was smoking and when I was drinking heavily. . . But then I saw I got that back now because the kids; they just enjoy me who I am now. . .That Rose she's like an old woman right. She's only 10 year old but she's like an old woman, she'll walk up and she'll say, 'Poppy, you smoking?' Straight out, innocent child, straight out and I don't growl her. I say, 'No baby,' I say, 'It's good, hey?' 'Yeah, it's good' to see me not smoke. Walk away, talk about something else; you know what I mean, just her innocence and everything. But that respect has come back now see. . . (Uncle Charlie, 54 yrs)

All participants recounted how smoking cessation resulted in other positive life changes often including a reduction in alcohol and other drug use plus an increase in physical activity. Among a small number of men, gambling and obesity were identified as negative life changes, though these were seen by them as less damaging to and intrusive upon individual and family life than smoking behaviours. While one participant identified the prospect of economic benefit as a motivator to cease smoking, no one identified it as a benefit of smoking cessation, even when prompted. Most had found alternate uses for the money they spent on smoking and many were surprised at how they had been able to fund their habit. Mostly Indigenous

ex-smokers described improved quality and control of life as the major benefits of quitting.

Discussion

The dominant theme of anti-smoking campaigns is the risk to health, which is used to inspire and motivate contemplation of behavioural change. In our study we found Indigenous meanings attached to these potential health risks varied between resistance, ambivalence and guilt. In short, the 'hinge factor' for quitting smoking was much more complex than a simple recognition of risk to health and could only be fully appreciated when connected to the broader meanings ex-smokers derived from their life experiences. Indeed all participants acknowledged a long standing awareness of the health implications of smoking. The theory of cognitive dissonance has been widely used to explain this phenomenon (McMaster 1991, p. 349) however; we identified unique social and cultural conditions pertaining to Indigenous rejections of health risk narratives within anti-smoking campaigns.

The 'resistance' of Aboriginal people to the anti-smoking message when understood as a social practice rather than a 'yet another' example of Aboriginal deviance provides a stronger starting point for meaningfully connecting with Aboriginal people. As Lupton (1995, p. 133) argued resistance to health promotion advice can occur for a range of reasons including frustration, resentment, pleasure or even an unconscious imperative to take up alternative subject positions. Thus 'resistance' to the non-smoking imperative might constitute anything from 'direct rebellion' to simply adhering to the local habitus (Gjernes 2010, p. 474). Gjernes (2010, p. 473) developed the argument from this that health advice 'seems to trigger identity work' and used this framework to explore the ways in which a particular population of women in Norway make sense of their resistance to health information about exercise, diet and smoking. Among the Indigenous people we spoke with, smoking cessation most commonly was associated with changing and reordering life and identity as a result of a significant life event. It was 'either a precursor to this change process or symptomatic of it' (Willms 1991, p. 1371). The reconfiguration of one's identity was the stimulus for considering smoking cessation possibilities but this change was actualised through the acquisition of new skills, new social networks and/or supportive environments that took place either alongside of and/or as a result of the life event.

Thompson (2009, p. 576) suggested quitting smoking signifies an identity shift which requires an ability to reflexively negotiate the surrounding socio-spatial web. This has particular salience for Aboriginal people for whom the stigmatised identity of 'the smoker' is only one among many possible stigmas they must negotiate. Moreover for Aboriginal people who live in contexts where smoking is normalised, they must negotiate their smoking or ex-smoking within both the local habitus of their own community as well as within a wider societal sphere in which smoking is rendered deviant. This reminds us of the relevance of Foucault (1991) analysis of the emergence of governmentality in which power relations are acknowledged to be diffuse emerging not only from the state but from all areas of social life. As Lupton (1995, p. 10) put it self-surveillance via feelings of guilt, anxiety and repulsion towards the self represents powerful aspect of contemporary public health. We argue that these layers of surveillance including the state, the local community and the self are all part of the social context influencing smoking

behaviour, often in contradictory ways. Thus promoting individual resilience to social pressure to smoke can also isolate people from the very social group from which they draw support, solidarity and a shared sense of identity (see Covington 1981 for discussion of this point in relation to smoking prevention among adolescents). This sort of contradiction also has the potential to be further multiplied for Aboriginal people who must on the one hand contend with advice from the state about how to live healthy lives whilst also live with the historical legacy that these same state institutions have been central to the colonisation of their country.

Distrust towards the state and the health care system was evidenced in the high levels of scepticism towards anti-smoking messages and therapies. However promisingly, we found numerous opportunities for individual health practitioners to 'surprise' Indigenous clients with non-stigmatising, and trusting relationship which were conducive to smoking cessation. Distrust was overcome through building relationships premised upon respect, care, commitment and compassion alongside agendas that were empowering and supportive rather than paternalistic or punitive. Engagement which emphasised that Indigenous people 'could' rather than 'should' quit smoking was the critical factor in successful Indigenous smoking cessation. This type of engagement was empowering and necessary to building a sense of self-efficacy in smoking cessation possibilities. However it also enabled individuals to retain autonomy over the decision-making process. This sense of autonomy was a critical building block in reclaiming control over one's life world, of which smoking was a part of. One simply cannot overlook the logic of control and autonomy within an Indigenous context given the colonial experiences of control and regulation within past and present social policy.

We found that life stress was a key driver of smoking behaviour among Indigenous people and resilience was a key driver of successful quitting experiences. Ward's *et al*. (2011) study of smoking cessation among high smoking prevalence populations also identified the significance of critical life events and how additive and subtractive resilience strategies led to successful cessation. In this instance, promoting resilience involves attending to both internal (self esteem, self-efficacy) and external factors (supportive environments). Among the Indigenous people we spoke with, it was social support coupled with personal growth and development that inspired and enabled whole-of-life changes rather than 'potential health risk'.

It is evident that a new platform of engaging Indigenous people in smoking cessation agendas needs to emerge, which emphasises wellness rather than illness. While the ability to influence the occurrence of significant life events as articulated in the narratives included here is beyond the scope of the health care system, the capacity to support resilience building strategies remains. Most promisingly, at an individual level, this study revealed the strategic role that individuals and health professionals play in encouraging and supporting Indigenous smoking cessation. More broadly, these findings highlight the central importance of trust and empowerment within Indigenous health promotion practice. The outcome of empowerment is only possible through empowering processes and interactions and the evidence here suggests a need to shift towards resilience building rather than risk-promoting interventions in order to reduce smoking prevalence amongst Indigenous communities.

Conclusion

Within the dominant risk paradigm of public health, the risks of smoking are both calculable and alarming. Given the disproportionate prevalence of smoking in Indigenous Australia, it is not surprising that there is genuine public health concern about smoking as 'risk behaviour' among Aboriginal people. Yet smoking can be conceived as more than a 'risk behaviour', Aboriginal people are more than a 'risk group' and the public health practices associated with reducing smoking are more than simply instruments of health improvement. There is a social context to all of the above which requires our understanding. Indeed Poland *et al*. (2006) has referred to social context as the 'next frontier in tobacco control'. Importantly they argue this is much more than simply acknowledging the 'social norms' at work but also must (among other things) include: a reflexive practice able to question the tacit assumptions of tobacco control; a capacity to be to 'be transformed' by the experience of engaging with smokers; and an awareness of power relations (2006, pp. 61–62). In taking these aspects of social context into account it is possible to begin to understand smoking as a genuinely social practice. This is not a means to undercut the health harms associated with smoking, rather it is an acknowledgement that the actuarial logic of risk so dominant in public health tells us little about the logics of everyday life in which smoking takes place (Alaszewski and Coxon 2009) and when the broader social context is acknowledged, there is clearly much more to be considered.

Notes

1. The term Indigenous is used to refer to Aboriginal and Torres Strait Islander people and the authors acknowledge that Aboriginal and Torres Strait Islander peoples comprise of two distinct cultural groups.
2. Brisbane is the capital city of Queensland, Australia.
3. The reserve system involved the separation of Aboriginal and Torres Strait Islander people from Australian society during the late nineteenth century to the 1960s into discreet and isolated communities. Government-appointed administrators were able to exercise control over most aspects of everyday life.
4. QuitLine is a telephone service which provides support and encouragement for smokers who want to quit.

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