

'Passed and cleared' – Former tobacco smokers' experience in quitting smoking

Inger J. Wang¹, Eva Gjengedal¹ and Torill Larsen²

Abstract: The literature contains many reports on cigarette smokers and smoking cessation, but there are fewer qualitative studies on smokers' and ex-smokers' experiences with smoking cessation and health care professionals. The aim of the present study was to give voice to ex-smokers' own experiences with smoking cessation through the health care system. The study collected data from focus group interviews with 28 informants divided into four groups. Results from this study do not point to one particular reason for successful smoking cessation, but instead to the combination of pressures from several factors. The informants seem to have reached a point where external pressure made them receptive to: the fear of diseases, legislation, taking advice from health care personnel, views of children and grandchildren and providing a new identity as ex-smoker. Factors that helped to quit were: recent efforts to make it difficult to smoke in Norway, encouragement to seek help to change their tobacco habits, smoking cessation programmes that are integrated into health care practice, health professionals who demonstrate sensitivity and genuine interest during their meetings with smokers. Health professionals in specialized health care must be made aware of their role as the first important step in their patients' road to quitting smoking. (Global Health Promotion, 2014; 21(2): 57–65).

Keywords: evaluation, health behaviour, health care, practice, prevention, quality of life, tobacco, empowerment, power

Introduction

Worldwide more than five million people die from direct tobacco use and the tobacco epidemic is one of the world's biggest health threats ever (1). The population of Norwegians who smoke has changed over the last 50 years. In 1973, more than 50% of the male population smoked daily as did more than 30% of the female population. In 2012, 16% of the population between the ages of 16 and 74 years smoked daily (2). Despite the reduction in tobacco consumption, smoking is still the most important preventable cause of illness and premature death (3,4). Studies show that most smokers regret having started to smoke (5,6) and in Norway more than four out of five regret ever having started (7). For

many, the experience of quitting smoking is a difficult process and studies show that more than 60% want to quit at any time, 20–30% try every year and less than 5% succeed on their own (8). A systematic review of smoking cessation programmes suggests that group-based programmes more than double the chance of quitting (9). Other studies have reported that close to 35% of participants remain non-smokers one year after completing a smoking cessation course (8,10,11). Advice from doctors and nurses, behavioural interventions, nicotine replacement products and various pharmacological treatments increase the chance of success in smoking cessation (12). Other reviews on doctors and smoking cessation (13) and on nursing interventions

1. Department of Public Health and Primary Health Care, University of Bergen, Norway.
2. Department of Health Promotion and Development, University of Bergen, Norway.

Correspondence to: Torill Larsen, University of Bergen, Department of Health Promotion and Development, Christiesgt 13 Bergen 5015, Norway. Email: torill.larsen@uib.no

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and smoking cessation (14) have drawn the same conclusion. The amount of help provided by health care professionals in Norway has been investigated through self-reported data from general practitioners (15–17), hospital doctors (18,19), dentists (20) and health visitors (15). All of this literature shows that there is a great potential for increasing efforts involving health care professionals who help smokers quit. Other studies have shown that the most important reasons for health care professionals not to intervene were that they felt the effort was wasted because so few smokers quit and that the activity was regarded as time-consuming (3,17).

The literature contains many reports on cigarette smokers and smoking cessation, but there are few qualitative studies on smokers' and ex-smokers' experiences with smoking cessation and health care professionals. Kerr *et al.* (21) examined ex-smokers' and smokers' experiences with smoking, smoking cessation and available help from health personnel. They found that health professionals to some extent had helped them quit smoking. Arguably, there were also many who relapsed and few who got help from the health care system (21). Thus, learning more about ex-smokers' success might make it possible to build better interventions. The aim of the present study was to give voice to ex-smokers' own experiences and the research questions addressed are: (1) What experiences do former smokers have with smoking cessation courses and their everyday life as an ex-smoker? (2) How do they describe their experiences with health care professionals with regard to smoking-related issues?

Methods

The study described in this paper was part of a larger intervention aimed at reducing smoking among patients at a university hospital in Norway. From 2000 to 2010, a university hospital offered smoking cessation programmes. The programme comprised six 2-hour night classes over a 7-week period with follow-up classes after 3, 6 and 12 months. The course alternated between teaching, counselling and group work. The programme followed Norwegian national guidelines for smoking cessation (22). In the course preparation phase, participants actively worked to become aware of their own smoking patterns and motivation, changes

in smoking habits and gradually reduced their tobacco consumption. To support this process they were offered pharmacological aids. They then entered the phase of smoking cessation, in which they were trained in strategies to avoid relapse. Most trainers were nurses, doctors and physiotherapists who attended parts of the course. The participants also received proposals for a physical activity programme. A total of 86 courses were completed as of October 2010 and the data show that an average of 87% of participants quit smoking by the end of the course (range 77.5–93.8%). Of these, only 47% remained non-smokers after 12 months (42.5–54.7%) (23).

Design

This part of the study applied a qualitative design using focus group interviews. We included four focus groups to enable some variation and to avoid conformity.

Inclusion criteria

Inclusion criteria were that the informants had been free of smoking for at least one year at the time of inclusion and had one or more previous smoking cessation attempts. However, it emerged that two of the informants had not had previous serious smoking cessation attempts. Since they already had been invited and accepted, it would be unethical not to include them. Another desirable criterion was that the first author, who had long-term instructing experience in these courses, had not instructed at any of the participants' courses. However, it turned out that three of the participants had had the first author as an instructor in their smoking cessation course. This was nevertheless not experienced as a problem as the focus was mainly on the participants' personal experiences with smoking cessation and not an evaluation of the course.

Informants

Potential informants were purposefully chosen from the lists of participants who had attended a smoking cessation course between 2001 and 2006 and were invited to participate in interviews.

The study comprised 28 participants, 15 men and 13 women, aged 35–74 years. The informants were

on average 16 years old when they started to smoke (range 12–30 years) and had been smoke free for 1–6 years at the time of the interview.

Interviews and interview guide

The interviews took place from March to September 2007. All interviews were tape-recorded; the first author acted as moderator and the second author acted as co-moderator by taking notes and summaries after the interviews. The importance of gaining insight into the participants' point of view was emphasized. The interview guide had the following topics: smoking history, what triggered smoking cessation this time, experience with the smoking cessation course, experiences of life when smoke-free.

Analysis

Interview data were transcribed, then read through several times by the first author to form an overall picture before categorization of the material began. Then the material was coded and categorized, based on the study's interview guide and according to the informants' answers in relation to the various foci. Data were coded by colour and placed in a matrix. The codes were organized into themes, which were further analysed and subthemes were identified (24). All analyses were discussed with the second author to secure validity and reliability.

Ethics

The study was conducted in compliance with the Declaration of Helsinki and the requirements for data processing outlined in Norwegian Social Science Data Services. In addition, an application was sent to the Regional Committee for Ethics and the study was approved. When informed consent was provided, each informant was contacted to arrange the interview. The transcripts from the interviews did not include any names or background details.

Results

The typical informant was employed and married or cohabiting. Half the selection had a primary or

secondary school education and the other half had a college or university education. Fifty percent had smokers in the immediate family. The typical informant had smoked on average 11–30 cigarettes per day. The participants had on average three previous attempts to quit smoking before they finally succeeded. In the following section, the six main themes emerging through the focus group analyses are elaborated.

From curiosity to addiction

The informants were young when they started to smoke and several mentioned their youthful curiosity about trying, which they described as an urge to seek acceptance by friends. They started out by training to smoke and described a time when smoking almost was seen as an expected behaviour. Doctors, teachers, athletes and politicians were all represented in smoking advertisements as smoking role models and as one informant said:

... it was fashionable and so common to smoke and it was seen as so harmless. Smoking was just a part of life.

None of the informants had intended to become addicted to tobacco and some of them had never regarded themselves as 'real' smokers. Several said they thought they could stop whenever they wanted and said they got 'hooked' whether 'they wanted to or not'. Addiction to tobacco was something that 'just happened'.

I started out by the age of 13–14. At that time it was more sneaking a pack of cigarettes and then we hide in the woods and smoke the whole package, and came back in again all green in your face, feeling awful – but from there it just escalated, and suddenly you were addicted.

Several also expressed the 'craving for nicotine' to be the reason for continuing to smoke and several expressed that they had had a high degree of dependency.

I smoked during all hours and in every place, and in the end I saw the madness in it.

Enough is enough

At some point, all the participants decided to stop smoking and, for many, it was about reaching the limit, that 'enough was enough'. All the informants spontaneously mentioned the Minister of Health, who was responsible for the ban on smoking in Norwegian restaurants. In the beginning, they thought it unacceptable and unfair to no longer be able to make decisions about their own behaviour; for example, by being restricted to designated places to smoke. Several of the informants also said that they felt stigmatized and they perceived the smoking ban to have contributed to the perception that smoking is unattractive and several expressed that they felt embarrassed to smoke. However, feelings of being what they described as 'degraded' or treated as 'second-class' people helped them succeed at smoking cessation. This feeling of being looked down upon was experienced as very uncomfortable, but for many this triggered smoking cessation.

Informants also expressed the fear of illness and consideration for their own and others' health as another trigger. In particular, chronic obstructive pulmonary disease (COPD) was described as a disease they wanted to avoid. Informants wanted to live a healthy life and several also noted that pressure from others was a contributing factor. Some of the participants had not planned to stop when they did, but involuntarily joined family or friends in smoking cessation classes and stopped mainly in the interests of others.

From dependence to independence

The transition from a life of addiction and stigmatization to a life free from smoking gave sincere pleasure and satisfaction:

During the last 20 years, I have had a great desire to quit smoking, without managing it. So, now that I have managed it, I've got a brand new life. I think it's so amazing.

Informants found it especially beneficial to live a life without cigarettes. They enthusiastically described the joy they experienced as: 'it's phenomenal to be without cigarettes' or 'it's wonderful not to smoke'.

Smoking cessation was described as difficult. However, being able to change a habit they had had for so long, and been so dependent on, gave them confidence and improved their self-esteem. Several described it as a 'burden' that had been removed from their shoulders. All expressed that they experienced numerous gains by quitting smoking, which included the absence of symptoms in the respiratory tract, such as coughing, mucus and hawking, and that they had more energy, better endurance, a clear conscience and a better sense of taste. The absence of the odour of smoke was described as very positive:

It's so incredibly satisfying to be rid of just that, the smell.

Willpower, decision and control were described as essential to mastering smoking cessation and they perceived the will to quit as residing 'between your ears'. By joining the cessation courses they had become aware of the importance of taking control of the craving for cigarettes. Such control was emphasized as important and the use of pharmacological aids was widely perceived as necessary for successful smoking cessation.

Respect and competition

The ex-smokers were very pleased to attend the smoking cessation course and for many, the course was seen as crucial for their smoking cessation. Their choice to attend a specialized course in health care was based on their expectation of meeting health professionals with broad experience and good professional standing, which several felt was lacking in their experiences with primary health care. The informants said that courses at the university hospital were seen as more serious and credible and that the hospital's name had a good reputation. Receiving guidance and help for their efforts to quit smoking were very important.

The content, stimulating methods, the absence of finger-pointing by the trainer, respect and interest were all highlighted as important. Several also highlighted that there was some credibility connected to the lung department at the hospital as the host of the courses.

It was solely because it was the lung department at the hospital which arranged it. I had tried to

quit by the help of my private GP earlier and that was not enough. I thought that those who work at the lung department have more experience with this and had a more professional standing and that was important to me.

I think that it was the university hospital and the lung department, it was better in a way, better trainers than you have elsewhere I think. You're in good hands, no charlatan there.

Something happened at that course.... The whole setting was just so very good.

The informants also arrived at the encounter with their own competitive instinct, although the course did not include any competitive elements. The participants wanted to show to friends and others that they could manage to quit smoking. They wanted to 'beat' themselves and, importantly, they wanted to beat the other participants. Seeing who managed to persist and not be the first to 'crack' was vital to many:

In my head, I used all the others for what they were worth, because if he could do it, so could I.

They said that they were motivated by seeing others who had failed to quit. One said that she certainly did not want to be one of them. Returning to the course and saying that 'I have smoked' was perceived as totally unacceptable. They said that it almost became a 'sport' to win.

The following dialogue between three participants could serve to illustrate this competition element.

For me it was all about winning, for me it was crucial to quit smoking, it was a personal victory to me.

But I would not say that those who didn't manage were losers because I know how hard it is to quit.

But they didn't win this time.

Although ex-smokers were happy to live without smoking, several said that they missed 'something'. Others said that they had forgotten that they had smoked and therefore hardly missed anything about

it. The main impression was that something that was nice and important in life was gone, but they happily paid the price because they did not want to start smoking again.

Sensitive meetings with health professionals

The ex-smokers' meetings with health professionals prior to entering the smoking cessation course had both positive and negative aspects. They recalled experiences from good meetings as well as those they found difficult and provocative. Episodes were described in which they felt they were viewed by health professionals as smokers and not human beings:

If you arrive with a scratch, the cigarette is blamed.

Some others noted that they had not been asked about their smoking habits. This felt more like a lack of interest and commitment by the doctor, and several expressed that they had both expected and wanted help to quit smoking or at least to be questioned about this. At the same time, some of the informants stated that they did not want interference from health professionals as they 'knew best themselves'. Several expressed the view that these meetings had changed over time: from the time when doctors rejected that smoking and disease had any connection, to the time when the Minister of Health presented the clear message that smoking must be fought and regulated, to today's intensive advertising campaigns about help with smoking cessation. Thus, they said they experienced increasing external pressure to try to quit smoking.

Passed and cleared

The informants were unanimous about their future smoking status. Smoking was seen as 'passed and cleared'; they were completely finished with smoking behaviour and would not look back. They would not give up their new identity as non-smokers, fully aware that this would require focus to avoid 'that one' cigarette. Several said that they did not want to go through the trouble of another smoking cessation attempt.

They expressed both concerns and a distinct ambivalence in their meeting with current smokers.

On the one hand, they said that they themselves had managed to quit smoking, so surely others could do the same; on the other hand, they felt genuinely sorry for today's smokers, especially those who become ill from their smoking. Related to this, they also expressed the fear of COPD, simultaneously claiming that they would feel embarrassed if it happened to them.

The informants also saw it as an important aid for them to live in a society with restrictive tobacco measures, as in Norway. These restrictions helped them to remain non-smokers. They did not want to be looked down upon again or to be stigmatized:

I think the web that has closed up makes it harder to resume smoking.

At the same time, the informants said that they did not want to be forgotten by health professionals after they quit smoking. They would appreciate someone caring about how things turned out for them.

Discussion

The point of departure for this study was to explore ex-smokers' own experiences with smoking cessation through the health care system. Results show clearly that the ex-smokers feel good about their smoke-free situations. The experience of managing to quit smoking is expressed with gratitude, pride and excitement.

An important finding from this study is the crucial role of social norms in relation to governing our behaviour. Initially, it was the social pressure that made the informants start smoking and in the end that was also what made them stop smoking. Results showed that the informants were socialized into smokers through a 'smoke school' and aligned with smoking role models. Our informants, who did not intend to become addicted to tobacco, experienced that over the years something happened as the norms of society changed; suddenly they went from being an 'in group of smokers' to being an 'out group of society'. This research is consistent with international and national strategies that argue that strict smoking policies are effective (25). Norwegian health authorities' restrictions were perceived as a trigger by the ex-smokers in this study and the restrictions were an important reason to consider behavioural

change. The restrictions and the use of designated smoking areas made the smoker more visible and thus they became visible as 'those who smoke', leading to a feeling of being stigmatized and looked down upon; a feeling so unpleasant that it affected their wish for, and later success in, smoking cessation. Arguably, the restrictions and stigmatization contributed to the feeling of social pressure, which in turn served as a kind of motivation. They went so far as to say that they were 'happy about the restrictions'. This finding is consistent with studies from Scotland (26), Ireland (27) and Australia (28).

A related point may be that the ex-smokers not only may be 'victims' of stigmatization but also to some degree of self-stigmatization. Our study suggests that some of the ex-smokers never regarded themselves as real smokers, or they did not want to. At least they were not happy to be labelled as smokers. In a way they sympathized with what may be called a stigmatizing health policy. After having quit smoking they were aware of looking down upon people who still smoke. Hence, both external and internal stigmatization seemed to reinforce each other as effective agents against smoking. Research suggests that smokers who have experienced stigmatization as smokers are more inclined to quit than those who have not experienced it (29). Stigmatization can thus be a tool that can work effectively in public health policy (29). In contrast, other studies (30) show the opposite, that perceived stigma did not contribute to smoking cessation. The literature is thus divided when it comes to the benefits (31). In this study, stigmatization clearly contributed to smoking cessation.

In addition to being influenced by society's restrictions and social norms, the ex-smokers also complied with wishes of relatives wanting them to attend the courses, especially the younger generations. Scheffels found that today's youth regard smoking as stigmatizing, immoral and an expression of lack of control (32), which suggests that the perceptions and views of the younger generation also serve as a kind of external pressure through stigmatizing the smokers. This factor was an incentive to the participants in this study.

Another factor found to be important is the health care professionals. The ex-smokers' experiences with health care professionals prior to entering a smoking cessation course had both positive and negative aspects, but they all agreed that smokers should be viewed by health professionals as human beings, and

not only as smokers, and that meetings should be characterized by respect, interest and trust. The ex-smokers described the meetings with the course leaders as a meeting with 'the absence of pointing fingers'. This was important to their change of behaviour, which is noted in other studies (8,13,14,31). Studies show that health professionals do make a difference even though the effect seems limited (3,12–14). According to Lund, this may be because of the limited time spent discussing smoking (3). This could mean that there is a great potential for improvement and that it is important to know more about how health professionals should act toward smokers to contribute to their motivation to quit and to avoid stigmatization. The informants in our study did not want yelling or pointing of fingers but, at the same time, some needed punishment and others a reward. Not to be questioned by health professionals was regarded negatively by many and was seen as a lack of interest; being questioned about smoking was actually something they expected.

Strengths and limitations

First, this study included few informants and thus the results must be interpreted with caution. However, many of the results are supported by others, suggesting that the findings are credible and might be generalizable. Second, the first author was responsible for the smoking cessation project at the hospital and was employed in a leading position at the department where the course originated, which could be both a strength and weakness for the study. The strength is the researcher's ability to identify with the informants. A possible weakness may be over identification and failure to be open to other approaches. However, the informants were explicitly told that the researcher was interested in identifying both positive and negative experiences and that their experiences were of primary interest to the researcher. Another limitation is that this study only talked to successful ex-smokers and due to the small sample the results may not apply for everyone, but did however work out well for some.

Conclusion, practical implications and further research

The ex-smokers were very pleased to be smoke free. They felt that smoking was a closed chapter

and they felt 'passed and cleared'. Success at being able to quit smoking was a source of pride and improved their self-esteem and control. The ex-smokers stated clearly that the government's restrictions on tobacco along with their fear of becoming ill because of their smoking habits were essential for them to stop smoking. Making it difficult to smoke helps ex-smokers avoid returning to their habit of smoking. The Norwegian Government has kept its line on restrictions and one sees that there is a decrease in smoking (33). As a paradox, however, among youth there is a nearly identical increase in the use of snuff (34).

Another point to be highlighted is the health professionals' role. Health professionals in specialized health care should be made aware of their role as the first important step in their patients' road to quitting smoking. It is thus important for information about methods to stop smoking to be integrated into health care practice. Smokers should be encouraged to seek help to change their tobacco habits by health professionals who demonstrate sensitivity and genuine interest. It would be interesting in future research to study health care professionals' attitudes toward smokers and smoking cessation.

In summary, the results from this study do not point to one particular reason for the success of smoking cessation programmes, but instead point to a combination of social pressures from several factors. The informants seem to have reached a point where both the external and the internal pressures made them receptive to the fear of diseases, legislation, taking advice from health care personnel, views of children and grandchildren and having a new identity as an ex-smoker. Findings from this study support a strict tobacco policy and that such policies help prevent relapse for smokers trying to quit. The findings also support a role for physicians and other health professionals as an important first step in helping some smokers to quit.

Conflict of interest

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