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Research paper

Resilience and smoking: the implications for general practitioners and other primary healthcare practitioners

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ABSTRACT

Background Smoking cessation counselling is a key component of medical treatment and health promotion activities performed by general practitioners (GPs); however, GPs are often left wondering why their patients continue to smoke in spite of being given information about the damaging health effects and medical treatments. The concept of resilience to smoking is an emerging idea that offers an innovative perspective to smoking cessation.

Aims To understand why some people continue to smoke in spite of well-known adverse health effects, what and how resilience factors impact on people's smoking, and the role and limitations of the GP in fostering resilience to smoking.

Method A qualitative study of 22 oral-history interviews was conducted in Adelaide, South Australia. Interviews were audio-recorded, transcribed and analysed for emergent themes.

Results The main themes of most relevance to GPs are the resilience to health messages, resilience factors associated with smoking abstinence and the common pathways that lead to successful smoking cessation.

Discussion Understanding smoking and resilience can assist the GP to provide more effective and supportive smoking cessation assistance. The GP may assist in the process by fostering the adoption of resilience factors, much of which is already part of routine GP work but may not yet be considered part of a holistic smoking cessation strategy. Through this holistic approach, smoking cessation is likely to be just one of many physical and social benefits, and avoids victim blaming. Broad system change to increase the levels of resilience within individuals and communities may then mean that smokers can stop more easily with brief interventions. Such changes are beyond the limits of a single GP, but provide opportunities to lobby government for future public health programmes aimed at promoting both the internal traits and external resources that are required for resilience building.

Keywords: general practitioners, primary health care, resilience, stress, tobacco smoking

How this fits with quality in primary care?

What do we know?
The emerging concept of resilience to smoking offers a new perspective to smoking cessation. However, much of this research does not address what occurs in a general practice or other primary healthcare setting, nor how these theories may be applied in reality.

What does this paper add?
This research provides a general practitioner (GP) insight into why some people continue to smoke in spite of well-known adverse health effects, and what and how resilience factors impact on people's smoking. As part of a comprehensive approach to smoking cessation, GPs have a potential role in fostering resilience to smoking. The role and limitations for the GP are outlined in this paper.

Introduction

Smoking cessation counselling is a key component of medical treatment and health promotion activities performed by general practitioners (GPs), however, GPs are often left wondering why their patients continue to smoke in spite of being given information about the damaging health effects and being offered assistance. With 85% of the population having some contact with a GP in any given year, GPs may have the potential for improving smoking cessation rates.

Doctors are trained to assess a patient's readiness to quit based on a calculation of a patient's stage of change,[1] then to tailor the information and support to the patient's readiness to quit.[2,3] These stages are pre-contemplation, contemplation, action, maintenance and termination of smoking behaviour or relapse.[1] Motivational interviewing techniques are being increasingly promoted among doctors as a directive patient-centred style of brief intervention to help people explore and resolve their ambivalence about behaviour change, i.e. if they are in the contemplation stage.[2–4] Such an individualistic approach risks negating the considerable psychosocial pressures on the individual to smoke, as well as the environmental infrastructure and political factors that impact on their smoking.

Assuming an unassisted quit rate of 3–5% with abstinence at 12 months,[5] brief advice improves this by only a small but significant increase of 1–3%.[6,7] A meta-analysis of motivational interviewing versus brief advice yielded a still modest by significant increase in quitting (RR 1.27; 95% CI 1.14–1.42). The addition of pharmacotherapy can further enhance quit rates 1.5- to 2-fold.[6,8] Doctors are encouraged to assess every patient's smoking and to give repeated, brief advice at every opportunity in order for these low quit rates to translate into a public health benefit at the population level.[2,3,8,9] The authors felt that these low quit rates demand exploration for more effective approaches against smoking.

The concept of resilience to smoking is an emerging idea that offers an innovative perspective to smoking cessation. Is it possible to increase resilience to smoking such that fewer people will start smoking and more people will quit smoking? This presents a more holistic approach and avoids the individualistic victim blaming approach of, 'If you know that smoking is bad for your health, why do you continue to smoke?'

Moreover, resilience has been linked to the social determinants of health[10] and therefore policies and programmes aimed at improving resilience (at the level of the individual and the community) are likely to not only act as a buffer against smoking, but also to improve health and social outcomes.

Resilience can be simply framed in terms of 'bouncing back from adversity and growing from it'. It involves internal (individual) and external (sociological/environmental) factors, and the interactions between them. It can also change over time. Internal factors include: personality, competence, autonomy, problem-solving skills, coping skills, intelligence, having an internal locus of control, and self-esteem. External factors include families and communities, education, social services, social relationships and community ties, paid work, transport, the environment and social policies.[11]

Academic literature on the relationship between smoking and resilience is sparse. Nevertheless, there are studies that have associated lower socio-economic status (SES) and smoking,[12–16] and also many studies that point to the social, economic and political environments within which people live, as the main drivers for inequitable smoking patterns, such as perceived income inequality, perceived well-being and living in a community with a lower degree of trust.[12,15–17] The authors conclude that smoking prevalence is lower in more egalitarian communities with higher levels of social capital. Other studies have stressed the importance of local social networks, including membership of religious groups[18] in providing peer support and alternative opportunities.[19] All such studies stress the need to understand the interaction between individuals and their life-worlds in order to develop more useful and meaningful smoking cessation programmes.

This study is an extension of research conducted by the main research team on resilience, smoking and stress, which focused the main body of research on 'at-risk' groups with high smoking prevalence, namely youth, indigenous Australians and people with mental illness. Within these groups, the team found smoking is often a form of coping (or problem avoidance). Those who had never smoked were more likely than smokers to utilise resilience strategies that included: supportive family and friends; a strong sense of self (which allowed them to resist peer pressure); reasonably strong community ties (which often meant increased interpersonal interactions and engagement); being more willing to seek help from others and more willing to be help givers (often as a result of their community ties); and a variety of other strategies such as exercise, reading/ learning, general 'busy-ness'. There was also a sense that these people had developed and sustained negative ideas about smoking from their childhood, which helped them to abstain.[20–22]

For participants who had managed to quit smoking successfully, there were a number of strategies they employed in order to quit, which they classify as 'additive resilience strategies' and 'subtractive resilience strategies'. The additive strategies included: taking on new activities (e.g. exercise, fitness), taking on new roles (e.g. within community groups, help-giving, peer-support) and taking on new practices (e.g. organised religion, spirituality, faith-based organisations,

peer mentoring, local advocacy groups). The subtractive strategies included quitting or 'leaving behind' certain activities or practices regarded as reinforcing their smoking behaviours by participants (e.g. drinking alcohol, being in certain jobs or even towns), moving away from relationships or friendship groups (if this was seen as having an unhealthy effect on the participant), and in some cases, quitting everything and 'moving on' with their lives. The additive and subtractive strategies often led to, or were part of, a 'life change', allowing successful smoking cessation to occur. A number of cases also described a 'critical incident' which motivated them to quit, such as a health scare, which then forces the adoption of additive and subtractive resilience strategies to support change, which smokers are not yet using.[20–22] Ward *et al*[11] conclude that smoking cessation strategies need to be part of more general supports, group programmes and community options that assist in the adoption of additive and subtractive resilience strategies as part of healthy lifestyle change.

However, much of this research explores smoking and resilience broadly and does not address what occurs in a general practice or other primary healthcare setting, or how these theories may be applied in reality. As the primary author is a GP, her research seeks to determine why some people resist smoking while others continue to smoke in spite of well-known adverse health effects. Of importance are what and how resilience factors impact on people's smoking, and whether the resilience factors found in high smoking prevalence groups would be the same or different to the general population. This paper focuses specifically on the proposition that GPs may have a role in building resilience to smoking, so that people are less likely to start smoking, and better able to quit smoking. It also outlines how this knowledge can be applied in a general practice setting, and what the potential limitations of the GP may be.

Method

This study is an extension of research conducted by the main research team on resilience, smoking and stress.[20–22] Whilst the initial research focused on 'at-risk' groups with high smoking prevalence, the authors sought participants of varied backgrounds and smoking histories from the 'general population', seeking a spread of gender, SES and age, in order for the results to be more widely applicable to general practice. The method used was qualitative, using in-depth, semi-structured, face-to-face interviews. Participants over the age of 30 years were targeted, in the anticipation that they would have accumulated more experience of challenging life situations compared with those aged below 30 years. Theoretical saturation was sought, with the limitation of a 12-month time frame to complete the research. Funding was through General Practice Education and Training (GPET), and ethics approval was gained from the Flinders University Social and Behavioural Research Ethics Committee.

Participants were recruited through flyers, posters and information packs at general practices, community organisations and Flinders University. All participants provided written informed consent and no participants withdrew. Interviews involved questions about participants' life stories, their smoking stories and how they approached difficulties in order to explore both internal and external resilience factors.

Interviews generally lasted an hour and were carried out by the author at a public location convenient to the participant. The interviews were all audio-recorded, then transcribed verbatim by a professional transcriber. Preliminary analysis, with recording of field notes, was carried out soon after each interview in order to inform the development of subsequent interviews. The data was analysed for emergent themes and patterns, and similarities and differences between the participant groups, both manually and through the use of NVivo version 8, a qualitative data analysis package that assisted the researchers in the management and sorting of data in order for them to develop their theoretical framework.

Results

Twenty-two participants were interviewed, comprising 11 men and 11 women. Of the group, six people had never smoked, 10 were ex-smokers and seven currently smoked.

The main themes identified in this study of the most relevance to GPs are the resilience to health messages, resilience factors associated with smoking abstinence, and the common pathways that lead to successful smoking cessation.

Pseudonyms have been allocated to the participants to protect their identities.

Why patients continue to smoke

There were various reasons that patients continued to smoke despite knowledge of health messages, portrayed in the quotes below.

Sally exemplified how young people do not view health as a key issue:

> 'When you're a teenager, you have no concept of future health and everything. It's more about immediate gratification.'

Similarly, Michael spoke of the invincibility of youth and the increased acknowledgement of health effects with age:

> 'we knew that ... smoking was a health hazard but it's never really sunk in because you're invincible ''it's never going to happen to me'' ... As you get older you start picking [information] up.'

Tracy highlighted how the pleasures of smoking outweigh the perceived risks for some smokers and they take a calculated risk:

> 'I know all the dangers ... but there are lots of other dangers in life and it's something I enjoy.'

For others, the socialising associated with smoking, the going out, alcohol, bonding, talking or smoking as part of who they saw themselves to be, were more important than their health. For some of these, health was not even an active consideration.

The presence of inadequately treated mental illness, psychological or emotional distress, or being placed under a lot of stress, greatly reduced the relevance of health messages. Examples of this are Debra's comment that:

> 'It was soothing and it meant more to me ... than my health at the time because I was so unhappy and so my health wasn't a big priority,'

and Penny's statement:

> 'you actually know that it's bad for you but you're feeling that you're in a pretty awful situation so it's a way of saying well, yes, everything is terrible so I may as well.'

These are typical comments about how the smoking actually helps some people cope and survive their situation, and how the perceived psychological benefits of smoking outweighed the health risks. Health was not a priority in these situations. Most of these smokers were also taking a calculated risk. For some others, their situations were so troubled that health was not even an active consideration.

Smoking was even viewed by a few participants as a source of resilience. Penny explains:

> 'my experience of smoking is one of the things that makes me resilient in coping with a crisis of mood and mental health ... I find smoking soothing ... a very calming thing to do.'

Resilience factors

Those who had never smoked or were ex-smokers spoke of actively taking on activities (termed 'additive resilience factors'), such as physical activities, creative activities like music, writing, art, starting a new course of study, religious or spiritual activities, other hobbies like working in a shed, developing new supportive relationships, having a new focus such as a pregnancy or a new house, or taking on a non-smoking identity. Participants also talked of the need to find something fulfilling and meaningful enough to motivate them to quit, or to take the place of smoking.

Jill expressed the need for something to take the place of smoking:

> 'It's just habit and that's like the hard thing. When you give up what do you do with your hands? You've got to learn to do something else.'

Louise took up running and had a new relationship which gave her a new focus and both were incompatible with smoking:

> 'A boy I wanted to impress didn't smoke and that was it. I took up running ... I just got the running bug ... it's very hard to exercise and to run seriously – and I love just galloping along for like 5 k runs which you can't do if you smoke.'

Another common factor among participants who had either never smoked or had successfully quit was leading a busy, active, full life comprising meaningful activity, though not to the extreme where stress was perceived to be beyond the individual's ability to cope.

Debra's life became busier and was focused around her family since quitting:

> 'I have a nap in the day. I like to read, I do the shopping and then it's time to pick [my daughter] up from school, then it's time – then she's the focus until she goes to bed. Then I have a couple more hours with my partner and he's studying so I've got more things that fill up my life now.'

Michael became busier and more fulfilled with his sporting and volunteer activities when he quit smoking, helping him maintain his abstinence from smoking:

> 'I actually started playing softball again, I got a bit fitter and enjoyed it. I swam nearly every day, went out with a couple of guys I used to work with. Yeah I started getting fitter and I felt healthier with it. Then I started playing softball, coaching softball with the kids and ... I started coaching football ... so I became more involved with kids and their sports and enjoyed it a lot more.'

Subtractive resilience strategies were also used among those who successfully quit, giving up something that had been done before or removing oneself from places or situations where one would have been before. Examples of this include participants concurrently stopping going to the pub, stopping consumption of alcohol or coffee, getting rid of the cigarettes in the house or car, avoiding different people or reducing their stress levels.

Debra learnt how to manage her stress more effectively after she quit smoking, instead of smoking when she was stressed:

> 'What happened was I stopped doing the things that made me stressed ... I don't allow stress to happen ... Now I

recognise when something causes me stress and I stop it and I don't do it.'

Jill avoided other smokers when she was trying to quit:

'I just had to lock myself in the office because all the courier drivers were smoking and it was like ''get away from me''. So I had to hide out from people.'

Louise stopped drinking coffee, alcohol and socialising with certain friends to successfully quit smoking:

'Smoking with coffee, smoking goes well with coffee, goes well with alcohol. I know when I finally, finally quit I had to stop going to clubs with friends and stop even mixing with those friends and doing all the activities. I switched to tea from coffee – tea and Smarties as a replacement for coffee and a smoke.'

Pathways to cessation

Those who were able to successfully quit smoking appeared to follow one of two main pathways to cessation.

The first was where often no previous attempts or several unsuccessful attempts at quitting are made, until the right time when circumstances were conducive and when a reason meaningful enough to quit was found, which led to a firm decision to stop and subsequent successful cessation, usually without much difficulty in comparison with their prior attempts. Participants commonly spoke of the need for something fulfilling and meaningful enough to motivate them to quit, to take the place of smoking, or to 'fill the void'. Such meaningful reasons varied between individuals and included new supportive relationships, being pregnant, having children, the opinions of people close to them, wanting to be healthy and fit, and buying a new house and choosing to spend money on furnishings instead.

All the smokers and ex-smokers already knew of at least some of the health risks of smoking, but continued to smoke as their personal health was not a priority. For some, health became a reason of growing importance with increasing age, but for most, a meaningful reason other than personal health was the decisive factor that motivated the strong desire to 'really want to quit'.

'I think you've got to be ready ... No matter what [my partner] said to me I wasn't ready so I think you've got to have that frame of mind ... I suppose you've got to have a goal that you want to give up, you want to have a baby, you want to be healthier. Each person is different so whatever sort of makes people want to do something. Yeah it's hard to say for each individual.'

For Debra, pregnancy was her meaningful reason to quit:

'I was addicted but I stopped because I had a very, very good reason, a reason meaningful to me.'

Compared with previous unsuccessful attempts where the ex-smokers had struggled with nicotine withdrawal symptoms, once the circumstances were supportive and a firm and decisive decision to quit was made, most were able to overcome those withdrawal symptoms with relative ease. Many spoke of previous attempts where they used various forms of pharmacological or counselling assistance unsuccessfully until the time was 'right' for them, a reason meaningful enough was found and a firm decision to stop was made.

'I tried several different methods and absolutely nothing worked. I believed – and I still honestly believe – that if you want to give up – and it was a momentous decision for me to give up smoking after all this – these many years of smoking ... I honestly believe that the only way that you can give up smoking is if – you've got to mentally want to give up smoking. You can have all the quackery under the sun, you can have whatever drugs you want and none of it will work unless you mentally want to give it up ... Nothing worked [before] because I really hadn't got to that decision where I really wanted to give it up.'

Examples of protective factors included: having a partner, family member or friend supportive of the decision to quit; the increase in cigarette prices; receiving good mental health management; non-smoking work environments; non-smoking social environments; non-smoking friends; low stress levels; and expressing contentment in life.

Once the firm decision to quit is made, the cessation process then involves the adoption of additive and subtractive resilience factors to maintain abstinence.

The second pathway is where the individual undergoes a series of life changes, comprising of the adoption of additive and/or subtractive resilience strategies (consciously or not), through which resilience is built, to the point where that individual no longer feels the need or the desire to smoke. In this case, smoking cessation is a by-product, and just one of several positive changes. Smoking cessation is then usually achieved without much difficulty. Examples of these life changes involved: a change in employment or relationships, leading to reduced stress levels; the adequate management and support of mental illness; finding a sense of purpose; or the development of a happy, busy fulfilled life; and having a busy fulfilled life which in turn builds resilience and appears to facilitate subsequent successful smoking cessation.

'I think I was a lot happier in myself than I had been for a long time. I was enjoying the study that I was doing at uni. I had a sense of purpose in what I was trying to do. I think I probably felt that I'd come through a crisis period and things were getting a lot better.'

As discussed previously, inadequately treated mental illness, psychological or emotional distress, or being placed under a lot of stress reduces the relevance of anti-smoking health messages. All the smokers and ex-

smokers knew at least some of the adverse health risks, but most emphasised the low priority of their personal health when they were significantly stressed, unhappy or mentally ill. It was not until these states were adequately managed or significant support was present that smokers were then able to follow one of the above two pathways to build resilience and quit smoking.

Discussion

Relevance to general practice

Smoking is a complex and notoriously addictive habit. Understanding the various forms of resilience to health messages, the impact of additive and subtractive resilience strategies, and the pathways that lead to cessation, can assist the GP to provide more effective and supportive smoking cessation assistance. GPs usually counsel patients to quit smoking by communicating knowledge about health risks, but in this study personal health was *not* the motivating factor for most participants.

Most ex-smokers described times of perceived unhappiness and stress or mental illness when they took up and maintained smoking or had relapses or increases in the amount smoked, and it was not until these issues of unhappiness and stress were resolved or mental illness was adequately supported that they were then able to build resilience and successfully stop smoking (again). During those times, their personal health was of very low priority. Tsourtos *et al*[21] also found similar smoking behaviour in relation to stress and poor mental health. This has implications for GPs in a consultation with a patient who continues to smoke despite knowledge of the adverse health effects, to first address the unhappiness, crisis or stress within the patient's life, before they are then able to build resilience and follow one of the pathways to successful cessation. By being empathetic and respectful, as most GPs already are in these situations, the GP can also promote the patient's internal resilience through having their struggles understood, reassuring them of their individual strengths and self-management potential, and having their anxieties alleviated.

For people to be receptive to smoking cessation counselling, the time spent providing counselling needs to be appropriate and other changes outside the consultation room also need to occur in the person's life. Knowledge of the common pathways that lead to cessation mean that in primary care, following a patient's story and gaining insight into the context of the smoking, the stresses, crises or conflict within the patient's life and assisting the patient in resilience building may be an approach that leads to an increased readiness to quit and/or an increased ability to quit when an attempt is made. With greater resilience, people will be better able to quit via one of the pathways to cessation described. Either, they find a reason fulfilling and meaningful enough to motivate them to quit, which forces the adoption of additive and subtractive resilience strategies, or the series of life changes results in the building of resilience with consequent lack of desire or need for smoking, and therefore readiness to quit. The GP may assist in the process by fostering the adoption of resilience factors, much of which is already part of routine GP work but may not yet be considered part of a holistic smoking cessation strategy. This may involve the following: treating mental illness; supporting individuals and families in times of crisis; providing appropriate referrals to social/community/counselling services; supporting children, families and parenting; imparting problem-solving skills; providing counselling to build self-esteem; encouraging participation in sport/community/hobby activities; and providing education about constructive ways of dealing with stress, e.g. exercise, meditation, relaxation techniques, talking with professionals, friends or family. Through these, smoking cessation is likely to be just one of many physical and social benefits. This holistic approach looks at the individual within their life-world and avoids victim blaming. Smoking cessation may not be immediate or directly influenced, but it will have a greater chance of success and sustainability.

As a successful quit attempt often seems to involve a meaningful reason leading to a very firm, decisive decision to quit, the GP may have a role in helping to establish this when the time is right. This requires allowing extra time for counselling, making preparations for the quit attempt including guiding the person to incorporate additive and subtractive resilience strategies, and prescribing nicotine replacement or medication if appropriate. When the time was right and the decision was strong, quitting was easy (or relatively easier), compared with multiple unsuccessful attempts before this time.

Limitations/opportunity for advocacy

The first limitation for GPs is that they are restricted to the patients who present to them. Often young adults and teens have already started smoking, and disadvantaged groups have reduced access to medical services. The infrequent GP attendances of these groups present GPs with the challenge of engaging with them at the level required to promote resilience. Nevertheless, each attendance is an opportunity to provide health promotion education, as well as to explore smoking histories, current life situation and resilience factors,

and to build rapport enabling increasingly effective counselling at future attendances.

Another major limitation within a GP consultation is time, and some GPs choose not to raise the issue of smoking for fear of negatively affecting the doctor–patient relationship.[23] The author proposes that an understanding of the cessation pathways can help guide a conversation around issues the patient is facing, for which the GP may provide empathy, treatment and/or referral. This also provides an opportunity for the GP to guide the adoption of additive and subtractive resilience strategies. This is more likely to be acceptable to the patient than advice to quit smoking for health reasons, which dismisses psychosocial difficulties the patient may be facing and may therefore be portrayed as irrelevant. Sufficient time is required, but may be seen as an investment to increase the likelihood of successful cessation and to reduce the smoking-related chronic disease presentations to GPs and emergency departments, hospital admissions, and the societal, individual and family burden of morbidity and mortality from smoking in the future.

Looking upstream, there is much that needs to occur for brief interventions to work. Broad system change to increase the levels of resilience within individuals and communities may then mean that smokers can stop more easily with brief interventions. Such changes are beyond the limits of a single GP, but provide opportunities for advocacy. These would include lobbying government for policies and infrastructure that build resilience, through the promotion of social equity, adequate and satisfying employment, transport, education, a clean and safe environment, social and community services, quality mental health services, stress and crisis relief, skills building, resilience building for children, and support for children and families.

Conclusion

Resilience to smoking is a concept of importance to smoking cessation. This study has revealed common pathways and strategies that lead to cessation, demonstrating the broad changes that need to occur for a smoking cessation attempt to be successful. This has implications for GPs and policy makers. GPs have a role in fostering resilience among their patients by empathising with their patient's life situation, providing psychosocial support, treatment and referrals, and guiding the patient to incorporate additive and subtractive resilience strategies to better enable their patients to quit smoking. The development of future public health programmes should be aimed at promoting both the internal traits and external resources that are required for resilience building.

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CONFLICTS OF INTEREST

None.

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