When I've had just one more cigarette: helping people to give up smoking.

Maxine Linnell

When I was offered a part-time post in the NHS helping people to stop smoking, I turned it down for two reasons. First, I thought I'd feel too judgemental of smokers; second, I thought it would be a very frustrating task.

Then later they asked again whether I would do a two-month contract for three half-days, and I agreed, because I wanted to know if my assumptions would be right. Two and a half years later, I have just left the job, have learned a lot, worked with people I would never have met otherwise as a therapist in private practice, seen some remarkable changes, and discovered empathy for smokers. I have often felt very frustrated too.

I started smoking on my twenty-first birthday, because it was a bad day and I thought I might as well, and stopped four years later when my son appeared, because I didn't want to smoke around a baby. So hand on heart I could tell the quitters I worked with that I had been a smoker: but I didn't struggle to give up like many of them did. The life change I was going through was so big that it eclipsed all thoughts of smoking. I was lucky. Since then I've developed other addictions, particularly to very healthy food which still puts weight on! But I've never seriously considered smoking.

The work began with one to one sessions in GP surgeries. This was most like my therapy work, and the model used combined a short-term person-centred approach with the use of nicotine replacement therapy. We had a certain amount of freedom to work in our own way, and the relationships that formed over the weeks of quitting were powerful. A local rock singer sobbed his way through the process, writing and recording a song about it – but he managed to stop. Lonely people found the contact supportive, and the sessions could sometimes range well beyond the smoking.

Cigarettes were a friend, a stress reducer, a treat, some space, a habit, a rebellion, social glue, and many other things. And nicotine, the one substance out of four thousand in a cigarette which is almost harmless, is the one which hooks onto receptors in the brain and makes it very difficult to give up. So the model we used was one of working with weaning off the chemical addiction with Nicotine Replacement Therapy and finding ways of reducing or replacing the other aspects of smoking with less harmful activities.

Unlike many other addiction services which aim to support the client and do not necessarily promote abstinence, the NHS offers what is clearly a 'stop smoking' service, which assumes that total abstinence is the only approach. On the edges of this, there is some research which shows that cutting down can lead to quitting for some people, but the model of short-term intensive work cannot accommodate the length of time that takes.

There cannot be a smoker in the UK who is not aware of the health risks of continuing. Some of the research on addictions shows that there are two processes at work from moment to moment (West 2006). There is a cognitive decision to stop, which many people make regularly, and then the desire to smoke, which comes up especially when there are cues which would normally lead to smoking – emotional highs and lows, seeing cigarettes or other people smoking, or the times when it's usual to smoke, after a meal or in the car for example. For quitting to work, the cognitive decision to stop always needs to be stronger than the desire to smoke. That's hard to keep going over all the weeks it takes to be free.

On top of that, some of what smoking does makes a lot of sense in terms of its healthiness. I developed a project where I went into companies to run groups, and one of the things I came across was the similarity between activities which reduce stress and smoking. Taking time out, going outside in the fresh air, and taking deep breaths – smoking involves all of that, and in stressful jobs and lives there is a healthy aspect to it. So although cigarettes are a stimulant – that's one of the reasons why they help reduce appetite and keep weight down – the activity of smoking at work gives people permission to lower their stress levels.

Most of all, I saw how difficult many people's lives were, with low pay, hard physical work, the stress of targets and uncomfortable working conditions. As a higher percentage of the population gives up, the people who are left smoking tend to be in groups which already have less access to money, health facilities and educational opportunities. Many of the people I met in companies had little confidence that they could have an impact on their lives. When somebody succeeded in quitting it was life-changing, and could lead to all kinds of other changes. Failure added to a long list of failures, and many would rather not try at all than face that.

For those who did stay with the process, there could be many

emotional times. Most people associate irritation with giving up, and that often happens: one man said his children were behaving very badly since he quit, but his partner did not see any change in them. Other people talked about feeling frightened, anxious, depressed or very tearful – one woman described as like having permanent pre-menstrual tension.

These effects can last for a long time. One man phoned the service in despair. He had given up smoking very successfully some months before, but his life had become meaningless, and he was feeling suicidal. With a hunch that nicotine might be involved I suggested he try some nicotine chewing gum, just to see if it helped. He phoned the next day to say that he was now feeling fine. In time I suggested to anyone with intense feelings that they try some nicotine first, then if it did not work then the emotion was probably real and needed attention. This was remarkably successful, and it may help any therapist working with someone who has recently stopped smoking to be aware of this. It is certainly not the best time to make big life decisions.

People joining the programme were often afraid of judgement, and the approach is entirely positive, leaving the scare stories to public health campaigns. Focusing on the benefits – the cash savings, the health improvements which show almost from the start, the increased fitness – encourages the initial decision to stop and keeps it central. Workplace programmes have an additional benefit: there is a continual source of support, and colleagues can often prevent a relapse happening.

But colleagues and friends sometimes taunt the new quitter, offering them cigarettes and teasing them. As smoking has become socially more unacceptable smokers often group together, and quitting can mean losing a social group. When a group of smokers leaves the smoking room together, it is far easier for them to integrate into the rest of the workforce.

Almost everyone is looking forward to the ban on smoking in public places, seeing it as a huge support in their quitting process. While government figures are based on four weeks of quitting, many people relapse, and one year figures are far lower. Most people have tried to quit several times.

So my judgements faded into understanding and support, but the frustration grew: not so much with the people who smoked, but with those companies who paid lip service to helping them but would not release them from work to attend group sessions, and with the NHS policy makers who brought in increasingly tight targets and reduced budgets, so that we could not work creatively and successfully with the people who wanted our help. In the longer term this seems to be a costly way to work. At this stage in the process of cutting services to reduce budgets, the service has been under threat for several months, with no final decision in sight.

In the service I worked for, all the specialists had qualifications

or training in counselling and psychotherapy as well as specific training in working with smoking cessation. This is becoming less normal as services are provided by nurses and pharmacists.

The deeper issues in addiction – perhaps a search for meaning, comfort, support – cannot be addressed in a service like this, or only peripherally. But it is possible to offer a respectful relationship within which to tackle one of the most harmful addictions, and the many successes are a delight.

References

West, Robert. Theory of Addiction. Blackwell 2006.

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How You Can Help – Has it Helped?

Over the past year or two, this section of S&S has been outlining some simple ways in which each one of us, as readers of S&S and members of AHP(b), can help to raise awareness of our existence to people who might be interested in joining us.

Our consistent need during this time has been to gain new members in order to survive and thrive, and to fulfil our purpose of being a forum for the humanistic approach. It still is.

It is time now, perhaps, to take stock and ask for feedback please. I would be very interested in hearing how you have responded to the ideas in this section – has it inspired you to consider taking any actions, or did it simply not engage with you (and if so, why was that)?

I'd love to hear examples of what actions you have been prompted to take as a result of reading this section, and of any ideas you might have about other ways in which each reader can do their bit in spreading the word.

Please do take a few moments now, whilst it is fresh in your mind, to email me, Jacky Walker, on dsmiv@tiscali.co.uk with your views. They really could help!