Smoking as a coping strategy

The relationship between tobacco smoking and stress has been debated for some time. Adult smokers say cigarettes help them to relax, but also report feeling more stressed than non-smokers (Parrott, 2000). This positive connection between smoking tobacco and relieving stress leads to a regular pattern of smoking. However, when smokers stop, they gradually become less stressed over time (Parrott, 2000). In the drive to reduce the number of smokers, it is important to consider and understand why smoking appears to relieve stress, as tobacco dependency is associated with heightened stress.

Stress Stress has been identified as a cause of some diseases, for example, coronary heart disease (CHD), and some gastrointestinal and skin disorders. However, not all stress has a detrimental effect – some stresses can be beneficial and can promote well-being. While there are some common ways in which we experience stress, not everyone perceives the same events as stressful. For example, an approaching examination can be viewed as a threat or a challenge. It is possible to suggest that what is stressful depends on how a person assesses and understands an event.

Stress and ill health Selye (1976) documented the general effect of stress on the sympathetic nervous system, endocrine system and lymphatic organs, which results in chronic diseases such as CHD, as well as skin disorders and many gastrointestinal problems. Selye concluded that stress is ‘the non-specific response of the body to any demand placed upon it’, and claims that it is not stress that harms us, but distress. Distress occurs when we prolong emotional stress and do not deal with it in a positive way.

More recently, Lazarus and Folkman (1984) identified stress as a process in which environmental and cognitive events combine to determine behavioural, physiological and psychological outcomes. For example, the environment may trigger a stress response, but the environment may in turn be modified by the individual to either increase or decrease stress.

Lazarus and Folkman (1984) describe the first stage of the stress process as an environmental event, which is appraised by the individual in two ways:

- Problem-focused coping, such as smoking cessation.
- Emotion-focused coping, such as smoking a cigarette.

If the event carries the potential for harm, a second process of appraisal occurs in which the individual considers whether he or she has the resources to deal with the threat. If the person considers him or herself capable of coping effectively with the threat, the stress response is not activated. However, if the demands of the situation are believed to be greater than the resources available to cope with them, a stress process is initiated. This involves the emotional experience of stress (including feelings of anxiety or distress), sympathetically mediated arousal (flight or fight response), and some form of stress-associated behaviour, such as avoidance or seeking reassurance.

Coping with stress The harmful effects of stress do not depend exclusively on the characteristics of stressful events. The resources used to cope with these events, such as cigarettes, can also contribute to the harmful effects of stress.

Sarafino (1998) describes coping as the process by which people try to manage the perceived discrepancy between the demands placed on them and the resources available to deal with a stressful situation. There are two broad categories of coping responses:

- Emotion-focused coping, such as smoking a cigarette. This involves an attempt to reduce the negative emotional consequences of the stressor, but without addressing the initial cause of the stress or behaviours;
- Problem-focused coping, such as smoking cessation. These interventions involve an active attempt to deal with, and change, the source of the stress.

Most people do not completely engage in one set of coping strategies when dealing with a stressor, but alternate between the two. Depending on the effectiveness of these strategies, the original appraisal of the event that led to a feeling of stress may change, and the stress process may be exacerbated or moderated.

Coping strategies that are based on social learning theories assume that much of human motivation and behaviour is the result of what is learned through experience, for example social and cultural influences.

Altering how you cognitively process a situation (cognitive restructuring), or changing how you behave in the situation (behaviour modification), can play a large part in assessment and management of a stressful event.

Nicotine dependence and stress Regular smokers experience periods of heightened stress between cigarettes, and smoking briefly restores their stress levels to normal. However, they will need another cigarette to prevent abstinence symptoms from developing again.

REFERENCES
The positive mood changes experienced during smoking may only reflect the reversal of unpleasant symptoms associated with abstinence from smoking (Parrott, 2003; Parrott and Kaye, 1999). The repeated occurrence of negative moods between cigarettes means that smokers tend to experience above-average levels of daily stress. As a result, nicotine dependency seems to be a direct cause of stress but is used as a coping strategy to relieve stress.

**Health promotion and smoking** It is vital that people are encouraged to stop smoking, not just to reduce the costs associated with treating ill health, but also for individual health gains. To enable this to happen, there has to be an infrastructure within the NHS to accommodate health promotion to ensure positive outcomes for people who smoke.

Green and Iverson (1982) define health promotion as ‘any combination of health education and related organizational, economic and environmental supports for behaviour conducive to health’. This definition highlights the importance of finding alternatives to smoking. It is vital to have resources to target smokers, as well as those who might consider smoking (Box 1).

Health care professionals working in different settings will recognise opportunities to become involved in promoting health. Different approaches include:

- **Medical** The promotion of medical interventions to prevent or improve ill health, such as the use of nicotine replacement therapy to tackle nicotine withdrawal;
- **Behaviour changes** Changing people’s attitudes and behaviour, so that they adopt healthier lifestyles. This can be achieved through cognitive restructuring and behaviour modification at an individual or group level;
- **Educational** Giving information about the causes and effects of ill health, and helping people to develop skills for healthy living. This intervention can be used with individuals or groups, and also to target smokers through the media (Naidoo and Wills, 2000).

A range of tobacco-control measures can be effective in reducing tobacco use, and effective support for smoking cessation, delivered through the health care system, can be effective (Box 2).

Such support is currently a core activity routinely offered in the NHS, and these cost-effective measures prevent many thousands of premature deaths (Department of Health, 1999).

The number of people who stopped smoking rose by 86 per cent in 2001–2002 through such interventions (DoH, 2002).

**Box 2. Individual or group approaches to smoking cessation**

Most individual or group intervention models for smoking cessation follow a similar approach:

- Set a specific quit date;
- Identify and interrupt stressors that support smoking;
- Identify and prepare plans for coping with temptations after cessation;
- Teach relapse prevention skills;
- Provide follow-up contact and support.

**Conclusion** Stress is inevitable, and as people age, they have more stressors which have physical and emotional effects (Yang et al, 2005). Preventive measures and the learning of coping methods can reduce the effects of stress and adverse health problems.

The message that tobacco use does not lessen stress but actually increases it needs to be publicised, as this may help many people to stop smoking, keep former smokers who have recently quit from relapsing, and help more young people to withstand the social pressures put upon them to try cigarettes.

The decision as to what intervention to use to address smoking cessation, and how to implement it, becomes one of cost-effectiveness and health economics. One-to-one or group interventions may significantly reduce a patient’s risk of disease, but this will have a negligible effect on the population’s level of disease.

For this reason, approaches that address the population may be considered cost-effective, while individual interventions are seen as outcome-effective. The best approach is to combine the two, targeting high-risk individuals with individual counselling while exposing the population to media and environmental manipulations, such as TV advertising.

The social, economic and health-related costs of smoking to society are enormous, so prevention of smoking should be a priority for all health care staff.

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**Box 1. Health promotion for smokers and those considering smoking**

- Distributing health information, such as smoking cessation leaflets
- Preventive action, such as identifying smokers
- Public policies, such as smoking bans
- Environmental measures, such as improving housing conditions
- Community development, such as enabling communities to identify and meet their needs for better health, for example through smoking cessation groups

Eweles and Sinnott, 1990

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**References**


