

SANTÉ PUBLIQUE / PUBLIC HEALTH  
SMOKING • WE DO NOT WANT TO QUIT!

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Yes we do not. We are aware of tobacco diseases that we could suffer from. We know that we are slowly killing ourselves. We have also been asked to quit by many physicians, health professionals, family and friends, and to tell you the truth, we do not like anyone telling us more about the harmful effects of smoking. If they were to lecture us from the time we wake up till the minute we go to bed, we still would not want to quit.

We do not want to quit smoking but we do not want to die from it. Yes, we also do not want to die from it. We get terrified whenever we are told there may be a chance we are experiencing health complications related one way or the other to smoking, but we still do not want to quit.

Dreadful diseases affect many nonsmokers therefore what's the point of quitting if it seems we all have equal chances of falling ill? Besides we have been informed recently (*An Nahar*, 20/07/2015) that the attempts of the Lebanese law(s) to prohibit smoking in closed areas have not been effective in shrinking the revenue of the Régie, "the famous Lebanese successor company from the Ottoman Public Debt Administration." Aren't you therefore glad that we are a major source of income to our country? So please leave us alone and preferably forget about us.

Have you been faced with these scenarios? I bet you have been more times than you could remember and until this day, this situation remains as baffling as it ever was.

The biggest tragedy is that over 50% of the Lebanese population smoke cigarettes [1] and over 20% use water pipe [2], yet we do not encounter more than a few patients every month that are willing to quit! Aside from the morbid health system that prioritizes many chronic diseases over the worst, namely smoking, and for reasons that we are all aware of as the economical low price of cigarettes, the expensive cost of nicotine replacement therapy (NRT), the presence of a handicapped legislation to provide smoke-free environments, media advertising

and campaigns, over-the-counter (OTC) availability, and many more enticing factors, we come to speculate about the patients we treat and question whether it is true that all the theories of addiction that we know about are not enough to explain what we face daily. If not, then why do we fail in those whom we treat effectively?

Again, why health hazards • restrictions • taxation increases • traffic control • insurance coverage • free NRT via telephone quitlines • physicians' advices • behavioral training • counseling • group therapy • hypnosis • positive partner support and using evidence-based quit methods (NRT & antidepressant medications) do not work globally in a satisfactory way? [3]

Can we say that there is no clear answer for the unchanging rate of smoking in Lebanon? May we suggest that motives are not as decisive as we have come to believe? How come we often read that the best way to quit is using unassisted cessation, also called "cold turkey," and implementing self-reliance, willpower, and autonomy [4] and that those who seek help are still failing to quit? [7]

The big question goes as follows: why is it that out of more than two million smokers in Lebanon we treat only a minority, who barely succeed at quitting?

Generally, the barriers to quitting smoking endorsed over by multiple studies included: smoking for stress management • enjoyment of smoking • addiction to nicotine • habit • social acceptability of smoking • lack of support to quit and access to quit resources • boredom • pro-smoking living environments • smoking cultural norms • socioeconomic disadvantage • and even genetics [8,9].

However, recent studies have shed light on the psychological and mental health component that accompanies smoking cessation. It was shown that the onset of depression and anxiety seems to be the main reasons of failure [10]. Several studies reveal that smoking cessation triggers depression, irritability and anxiety, not to mention weight gain that is yet another factor contributing to the reluctance of some to give up smoking and therefore resulting in the failure of smoking cessation [11]. In addition, the population of smokers with a past history of psychiatric illness is well known to relapse upon smoking cessation [12].

Does this hypothesis apply to us? In Lebanon, the stressors we live with render Lebanese citizens, whether smokers or not, more at risk for developing anxiety and depression [13-15]. Smokers are not willing to give up the cigarette that relieves their stress during lunch break, driving in traffic, hearing bad news or even watching them and what not. More terrifying is that stressful life

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events and lack of support provide powerful motives for continuing to smoke even during pregnancy with their effects largely independent of the female psychological status [16,17]. Furthermore, a Lebanese study reports that the second most frequently claimed reason for which pregnant women smoke was the relaxing effect of the cigarette and the alleviation of stress [18]. Can these findings contribute to placing a greater emphasis on stress management and psychological well-being of patients who are enrolled in smoking cessation programs? What if patients who are contemplating smoking cessation are reassured that the psychological discomfort they will experience from quitting will be reduced to a minimum, would they then be more willing to take action and more encouraged? We believe so.

This brings us back to the commonly believed notion that for smoking cessation programs to be effective, the presence of a multidisciplinary team is critical in order to guarantee successful cessation. We believe that patients need to be reassured again and again that behind them is a team of health professionals that will boost their efforts to quit, support their physical and psychological withdrawal experiences, and help them maintain their healthy decision over time.

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