HHS Public Access

Author manuscript

Clin Nurse Spec. Author manuscript; available in PMC 2021 November 01.

Published in final edited form as:

Clin Nurse Spec. 2020 ; 34(6): 282–289. doi:10.1097/NUR.0000000000000555.

Smoking-Related Social Interactions as Experienced by Persons Who Smoked Long-term

Claire Burke Draucker, PhD, RN, FAAN,
Indiana University School of Nursing, Indianapolis, IN

Susan M. Rawl, PhD, RN, FAAHB, FAAN,
Indiana University School of Nursing, Indianapolis, IN

Indiana University Simon Comprehensive Cancer Center, Indianapolis IN

Emilee Vode, BS,
Indiana University School of Nursing, Indianapolis, IN

Matthew Fields, BSN, RN,
Indiana University School of Nursing, Indianapolis, IN

Candice Elkins, BSN, RN,
Indiana University School of Nursing, Indianapolis, IN

Olivia Morgan, BSN, RN,
Indiana University School of Nursing, Indianapolis, IN

Sara R. Perez, BSN, RN,
Indiana University School of Nursing, Indianapolis, IN

Lucy Straber, BSN, RN,
Indiana University School of Nursing, Indianapolis, IN

Lisa Carter-Harris, PhD, APRN, ANP-C, FAAN
Memorial Sloan Kettering Cancer Center, Department of Psychiatry & Behavioral Sciences, New York, NY

Abstract

Purpose/Aims: Smoking-related stigma is manifested in the everyday social interactions of persons who smoke and can result in low self-esteem, diminished self-efficacy, and resistance to smoking cessation. The purpose of this study was to describe smoking-related social interactions as experienced by persons with a history of long-term smoking.

Design: Qualitative descriptive.

Methods: This study is part of a larger study designed to identify factors that influence lung cancer screening participation. Data were drawn from 39 qualitative interviews with persons from the parent study. All descriptions about smoking-related social interactions found in the narratives were extracted, coded, categorized, and summarized with content analytic techniques.

Results: Seven different types of social interactions were identified: (a) being looked down on for smoking, (b) being humiliated for smoking in public, (c) being banished while smoking, (d)

being blamed for one's health problems, (e) not "really" being blamed for smoking, (f) being told "just quit," and (g) being worried about hurting others.

Conclusions: Clinical nurse specialists should promote anti-smoking campaigns that are not stigmatizing, discuss health risks of smoking in a respectful manner, provide evidence-based cessation resources, improve communication with persons who smoke, and address stigma in programs to improve screening for smoking-related illnesses.

Smoking is the leading cause of preventable death in the United States, contributing to more than 480,000 deaths per year.[1] Smoking affects nearly every organ system in the body and is known to cause cardiovascular disease, respiratory disease, and cancer, including most cases of lung cancer.[2] While smoking rates have decreased over the last century, 14% of adults in the United States still smoke, with highest rates in minority and low-income communities.[1] Moreover, children exposed to second-hand smoke are at greater risk for ear infections, asthma attacks, respiratory problems, and sudden infant death, and adults exposed to second-hand smoke are at greater risk for heart disease, lung cancer, and stroke.[3] Residual nicotine and other chemicals left in the environment by tobacco smoke, known as third-hand smoke, are also associated with risk for a variety of tobacco-related illnesses, especially in children.[4]

As a result of strong evidence linking smoking and a myriad of serious health consequences, widespread public health efforts have been initiated to decrease smoking rates and denormalize smoking by changing social norms regarding tobacco use.[4,5] Smoking control measures include comprehensive smoking bans in public places, anti-smoking media campaigns, health warnings on tobacco products, and higher health insurance premiums for tobacco users.[6–8]

While tobacco-control policies have been effective in decreasing smoking rates, increasing cessation attempts, limiting exposure to second-hand smoke, and preventing smoking-related illnesses,[9–11] the policies have also contributed to unintended negative psychosocial consequences for smokers, including public stigmatization.[6–7] Public stigma is the perception that persons with certain attributes are socially undesirable and, as a result, are devalued and discriminated against.[5,12] Whereas in past decades smoking was viewed as a sign of sophistication, mystery, and glamour, it is currently viewed as a deviant habit that endangers others.[5–8] Self-stigma, the internalization of public stigma, is of particular concern as it can lead to low self-esteem and diminished self-efficacy.[6] Self-stigma may be especially problematic in socially disadvantaged communities that have high rates of smoking, are marginalized due to poverty and minority status, and have limited cessation resources.[5]

Stigma is manifested in the everyday social interactions of persons who smoke. A systematic literature review revealed that persons who smoke report experiencing family disapproval, receiving differential treatment, being thought of as less of a person, being ostracized, being judged negatively, and being subjected to overt negative comments or actions.[6] The review also indicated that while some persons who smoke disagree with or contest smoking stereotypes, many internalized them as self-stigma. Some studies found that smoking self-stigma was associated with shame, guilt, and embarrassment and resulted in defensiveness, resolve to continue smoking, self-imposed social isolation, and failure to disclose smoking

status to healthcare providers. Conversely, other studies found that smoking self-stigma was associated with higher rates of intention to quit smoking and smoking cessation and less risk of lapse or relapse.[6] Self-stigma is especially problematic for persons with smoking-related illnesses, such as lung cancer, because these persons are often perceived to be responsible for their illness.[8] A scoping literature review revealed that lung cancer stigma was associated with depression and anxiety; negative patient-provider relationships; altered communication with family, friends, and healthcare providers; diminished self-esteem and quality of life; delayed care seeking; and decreased social support.[8]

Little is known about how smokers cope with smoking-related stigma, although the broader literature on stigma offers some possibilities. For example, Burgess et al.[5] write that stigmatized persons often engage in impression management by controlling information others have about them. Persons who smoke, for example, may lie to others about their smoking. Stigmatized persons may also provide accounts or rationale for unaccepted behaviors. Persons who smoke may claim that the stress-relief they experience from smoking outweighs its health risks. Other coping mechanisms used by stigmatized groups that are likely used by persons who smoke include avoidance of stigmatizing situations (e.g., smoking in private), strengthening identification with the stigmatized attribute (e.g., bonding with other smokers), and using food and substances as a coping response.[5]

Research indicates that smoking-related stigma is related to a number of factors pertinent to the healthcare of smokers. For example, stigma is associated with health screening behaviors. In a review of the literature, smoking-related stigma and lung cancer stigma were found to be barriers to lung cancer screening with low-dose computed tomography (LDCT).[13] Similarly, in socioeconomically deprived communities, the perception of lung cancer as a self-inflicted disease was identified as a social deterrent to lung cancer screening participation.[14] Moreover, smoking-related stigma served as a disincentive to participation in an early lung cancer diagnosis trial.[15] Perceived lung cancer stigma has also been shown to be related to delayed medical help-seeking behaviors in persons with symptoms suggestive of lung cancer.[16] Smoking-related stigma affects encounters between persons who smoke and their healthcare providers. For example, lower levels of lung cancer stigma were associated with good patient-provider communication even when demographic and clinical factors were controlled.[17] In addition, non-disclosure of smoking status to providers is more common in persons who perceive high levels of smoking-related stigma.[18]

Clinical nurse specialists across all specialties provide care for persons who smoke. Because clinical nurse specialists diagnose, treat, and manage patients, as well as drive practice innovations within their organizations and communities,[19] they are well-poised to address stigma that interferes with patient outcomes. Because stigma is manifested in the context of day-to-day social interactions, it is important to understand these interactions from the perspectives of those who experience them. Because such an understanding can inform strategies to provide optimal care for this population, we chose to focus on the broader phenomenon of social interactions in which smoking plays a role rather than on the narrower phenomenon of stigma. The purpose of this study, therefore, was to describe smoking-related social interactions as experienced by persons with a history of long-term smoking.

Parent Study

Data for this study were drawn from a larger study using an explanatory sequential mixed methods design to test a conceptual model developed to predict participation in lung cancer screening (referred to as parent study). All study activities, including those reported here, were approved by the Institutional Review Board of the investigators' institution. Persons eligible for lung cancer screening according to the United States Preventive Services Task Force (USPSTF) guidelines (i.e., aged 55 to 80 years with a minimum 30 pack-year smoking history who are current smokers or former smokers who quit within the past 15 years)[20] were recruited for the study by Facebook targeted advertisements. A sample of 515 persons completed an 88-item web-based survey measuring a number of factors thought to predict screening. A more detailed description of the results of the test of the conceptual model has been published.[21]

Forty participants from the survey study also participated in a qualitative component of the study and completed semi-structured phone interviews in which they were asked to expand upon or explain some of their survey responses. These participants were purposively selected from the larger sample because they varied on the extent to which their scores were consistent with, or conversely, divergent from the conceptual model. The interviews, which lasted between 15 and 60 minutes, were audio-recorded and transcribed. The participants were first asked to describe their decision to screen for lung cancer or not. They were then asked about their thoughts and experiences related to other variables in the model on which they had scored either high or low. For example, one of the variables in the model was medical mistrust. If participants scored high on medical mistrust, they would be asked the following questions: *You indicated on the survey that you did not always trust your healthcare providers. Tell me more about that. Give me an example of a time when you felt distrustful toward a healthcare provider. Did this influence your decision to screen (or not to screen)*? Another variable in the model was perceived benefits to screening. If participants scored low on this variable, they would be asked the following questions: *You indicated on the survey that you do not see many benefits to screening. Tell me more about this. How did this influence your decision to screen (or not to screen)?* A more detailed description of the qualitative component of the study has been published.[22]

Methods

A qualitative descriptive approach as described by Sandelowski[23] was used to conduct the study reported here (referred to as current study). This approach is used in healthcare research when the aim is to provide a straightforward description of phenomena of importance to clinical practice or policy initiatives. Low-inference analysis is used to summarize narrative data provided by those who hold a stake in the research question. For this type of analysis, researchers stay close to the verbatim accounts of participants to describe the data in everyday terms without much conceptual or abstract rendering.[23] Hallmarks of the qualitative descriptive approach include purposive sampling of persons who can provide rich and relevant information, moderately structured interviews focused on the phenomenon of interest, and content analysis that remains close to the surface meaning of the participants' words.[24,25] This method was chosen for the current study because we

aimed to provide a detailed description of smoking-related social interactions in the ordinary language of persons who have experienced such interactions in their everyday lives. Moreover, we sought to present the findings in a pragmatic way that will useful to clinical nurse specialists and other healthcare professionals who aim to address the problem of stigma as it affects the healthcare of persons who smoke.

Data for Current Study

Data for the current study were drawn from the interview narratives from the qualitative component of the parent study. One of the psychological variables in the model was perceived smoking-related stigma. If participants scored high on this factor, they were asked the following questions: *You indicated that you have felt blamed for smoking. Tell me more about this. Tell me about a time that you felt blamed? Did this influence your decision to screen?* If they scored low on this factor, they were asked the following questions: *You indicated that you have not felt blamed for smoking. Tell me more about this. Did this influence your decision to screen?* Although participant responses to these interview questions provided much information about smoking-related social interactions, descriptions of such interactions were also found dispersed through the rest of the narratives in response to any number of interview questions. For example, participants described smoking-related interactions with healthcare providers when discussing medical mistrust or with family members when discussing barriers to or facilitators of screening. The research team thus determined that the narratives contained many rich descriptions of smoking-related social interactions and yielded ample data to address the purpose of the current study.

Data Analysis

The transcripts were analyzed by three senior nurse scientists, two with expertise in cancer screening and prevention and one with expertise in qualitative research, and five senior nursing baccalaureate honors students. The senior scientist with expertise in qualitative research provided in-depth training for the student researchers and directed their analytic activities. Content analytic procedures as described by Miles, Huberman, and Saldaña[26] were used to summarize the data related to smoking-related social interactions. We considered smoking-related social interactions to broadly include all exchanges between participants and any other individuals (i.e., family members, co-workers, friends, acquaintances, the general public, healthcare providers) that centered around the participants' smoking. The analysis occurred in several steps.

First, the research team read all the transcripts in their entirety to obtain a sense of the participants' experiences as a whole while focusing on their smoking-related social experiences. The team members recorded initial impressions of the data as related to the study purpose.

Second, the student researchers independently identified, highlighted, extracted, and coded all text units (i.e., words, phrases, or sentences expressing a singular thought) that were related to smoking-related social interactions. All descriptions of interactions with another person or persons that were in any way linked to the participants' smoking were considered relevant data. The codes were given brief labels that captured the essence of the participants'

remarks.[27] Text units and codes were presented to the senior scientists who verified or refined the codes.

Third, the codes were entered into data display tables[26] to be compared for similarities and differences. Through discussion that occurred over the course of several meetings, the research team combined similar codes into categories that reflected a variety of types of smoking-related social interactions described by the participants. The categories were labeled with names that best captured the type of interaction described.

Fourth, the student researchers wrote narrative summaries of the categories and chose quotes from the transcripts that best exemplified each category. The narrative summaries were reviewed and refined by the senior scientists after a re-examination of the data and further discussion among the team.

Trustworthiness

Several strategies were used to enhance the trustworthiness of the study.[28] The interview transcripts were professionally transcribed and verified by a project manager for accuracy. An audit trail was maintained to chronicle all the methodological and analytic decisions made by the team. The team met regularly and all analytic decisions were made by team consensus following discussion and frequent re-reading of the data.

Results

Participants

Sample.—The results are based on the narratives of 39 participants because one person's data were lost to recording equipment failure. Participants were from 20 states representing all geographical regions of the United States. All had a history of long-term smoking; 21 formerly smoked and 18 currently smoked. Twenty-six participants were women, and 13 were men. Participants were from 55 to 70 years of age, with an average age of 62. Thirty-five were Caucasian, 1 was African American, 1 was American Indian/Alaskan Native, and 2 were mixed race (i.e., African American and Native Hawaiian, Caucasian and American Indian). Twelve were divorced, 10 were married, 7 were never married, 5 were living with a partner, and 5 were widowed.

Smoking-related Social Interactions

Participants described seven different types of social interactions that they experienced related to their smoking. These interactions were labeled (a) being looked down on for smoking, (b) being humiliated for smoking in public, (c) being banished while smoking, (d) being blamed for one's health problems, (e) not "really" being blamed for smoking, (f) being told "just quit," and (g) being worried about hurting others.

Being looked down on for smoking.—Participants described social interactions in which they felt looked down on because they were smokers. A few described how they were "subtly" made to feel guilty for smoking. They claimed that even if others did not "come out and say anything," the participants sensed a "negative attitude." A 70-year-old woman who

formerly smoked said, “Just the vibe you get, you know. I can’t say [others] were not nice to me but….” Some participants experienced similar reactions from others even after they had stopped smoking. A 69-year-old man who formerly smoked said, “Anybody out there who sees me with a cannula in my nose in the supermarket or going anywhere, I see how they look at me. I can just imagine what they are thinking.” Because of the experience of feeling judged, some participants went to considerable lengths to hide their smoking. A 59-year-old man who currently smoked stated, “Like when I was a kid, when I first started smoking, you’d always hide your cigarettes and sneak around the bush and stuff. Now I feel like I do the same thing.”

Participants felt it was unfair that they were looked down on as smokers. To be included in the study, they had to have smoked long-term, which meant they had started smoking when attitudes toward smoking were very different than they are currently. The participants pointed out that smoking was once viewed as a “social thing” that made them feel “cool.” For example, a 57-year-old man who formerly smoked said, “It was glamorous; people looked at it as movie stars did it. It was something that was acceptable.” The participants recalled when the “tide began to turn” and smoking became no longer acceptable.

Being humiliated for smoking in public.—Participants also described social interactions in which they were humiliated for smoking in public. Unlike the participants who experienced subtle messages that smoking was not acceptable, some participants were openly shamed when smoking in public spaces. In some instances, people made disparaging remarks. A 55-year-old man who currently smoked stated, “I’m waiting at the metro and this one guy was all dressed up. He’s like you shouldn’t be smoking, I mean yelling at me. And I was smoking outside.” In other instances, people feigned coughing or waived their hands in front to their faces to show displeasure that the participants had “lit up.” Some participants indicated that they wished people would just ask “politely” that the participants not smoke rather than embarrass them with such gestures.

Being banished while smoking.—Other participants described social interactions in which they were banished from gatherings because of their smoking. People chided the participants for smoking and demanded they move to another area. In some instances, the participants felt attacked. A 55-year-old woman who formerly smoked stated, “My mom and my brothers, they’re like, ‘Get out.’ I’d go out to her house and we’d sit on the patio and they’re like, ‘You need to move away because we can’t stand that smell and you’re coming out here and we don’t want any cigarettes and stuff like that.’” Some participants would segregate themselves when smoking to avoid the disapproval of others. A 57-year-old woman who currently smoked and worked at a university said, “I feel really uncomfortable smoking around certain people in certain places. So I find an area and go smoke alone or I’ll smoke out the window in my apartment.” Other participants felt banished because smoking was no longer allowed in public spaces they frequented. A 58-year-old woman who currently smoked stated, “You can’t even smoke in a parking lot on campus. I feel like smokers are treated really badly although I totally agree you shouldn’t smoke in buildings.”

Being blamed for one’s health problems.—Some participants described social interactions in which they were blamed for their smoking-related health problems. Several

who had pulmonary illnesses, such as chronic obstructive pulmonary disease (COPD) or lung cancer, or respiratory symptoms, such as a cough or shortness of breath, remarked that others seemed eager to mention that the participants had brought these problems on themselves by smoking. A 69-year-old woman who currently smoked revealed, “I have a nephew that I call and he says, ‘Listen to that cough. You know what is causing that, don’t you?’” The participants were aware smoking contributed to their health problems but felt annoyed when another person took the liberty of pointing out what they already knew. They were particularly offended if someone suggested they should “know better.” A 69-year-old man who formerly smoked was dismayed that people on social media reviled COPD sufferers for smoking.

Some participants were irked when others attributed the participants’ illnesses to smoking because they believed their illnesses could have “just as well” been caused by other factors. Participants also argued that people can “smoke their whole lives” and never become ill. A 59-year-old woman who currently smoked said, “What I really dislike is the fact it is always smoking that is blamed for cancer, when everyone knows full well there are other causes of cancer, and it is very irritating.” A 57-year-old man who formerly smoked listed a litany of possible causes of his COPD beside smoking, including an explosion that occurred at his work site and industrial pollutants used in his job.

Some participants described interactions in which a healthcare provider blamed them for their health problems because they smoked. These participants felt that their smoking history made providers less compassionate. A 64-year old woman who formerly smoked stated, “My first doctor [who] diagnosed me with COPD said, ‘Well, you bought it, you paid for it, now deal with it.’” Other participants said doctors “yelled” at them to stop smoking or “accused” them of endangering their health. A few acknowledged not being “upfront” with a provider about how much they were smoking to avoid being blamed for their symptoms.

Just as participants lamented that being judged for a behavior that was once considered fashionable was unfair, they also felt being “blamed” for their smoking-related health problems was unwarranted because the health risks of smoking were not known when they began smoking. A 56-year-old woman who formerly smoked said, “The surgeon general warnings weren’t like they are now, and people didn’t know as much as they know now.” Other participants blamed themselves for their illnesses because they chose to smoke. While some participants were matter-of-fact about this, some derided themselves for smoking, labeled themselves as “stupid” and “terrible,” and concluded they “deserved what they got.” A 69-year-old man who currently smoked stated, “If I get lung cancer, I’m atoning for my actions. This I know.”

Not “really” being blamed for smoking.—Some participants described social interactions in which they were chided or nagged to stop smoking although they rejected the term “blamed.” These participants said they did not “feel blamed *really*” by remarks about their smoking, because, although the remarks were unwelcomed, they were well-intentioned. For example, a 70-year-old woman who was a former smoker said, “My children rode me from time to time [about her smoking] but it was out of concern.” Similarly, many participants claimed not to feel “blamed” by healthcare providers who frequently brought up

smoking because they had the participants' best interest at heart. These participants did not feel blamed when a provider explained the risks of smoking in a straightforward manner without "sugarcoating" potential health problems and advised, rather than pushed, them to quit. Although these participants did not feel "blamed" when family, friends, or healthcare providers talked with them about their smoking, several indicated that they nonetheless grew "tired of hearing it."

Being told "just quit."—Participants described social interactions in which strangers, loved ones, and acquaintances told the participants to "just quit" smoking. Such advice was an irritant to the participants because it was given as if quitting was something the participants had never thought about - which of course they had. A 60-year old woman who currently smoked noted that people would see her smoking and say things like, "Ew. Why haven't you quit kind of thing. Don't you watch the news?" The advice "just quit" also did not acknowledge how difficult it was to stop smoking. Some participants indicated that those who told them to "just quit" did not appreciate that smoking is an addiction or that people may smoke for reasons that are not apparent, such as escape from trauma. A 62-year-old woman who was a former smoker said, "I felt like people blamed me but they did not validate the complexity of the addiction." People suggested to participants that they were stupid or weak if they did not "just quit." A 65-year old woman who currently smoked revealed others said she was "silly" not to "just quit" because she was a registered nurse.

This experience of being told "just quit" occurred in some encounters with healthcare providers. Some participants complained that providers told them they needed to quit smoking but did not provide guidance or practical tools to help them do so. A 70-year old woman who formerly smoked stated, "Each and every one of them [her healthcare providers] said you need to quit smoking, and they say it every time you see them. I'm just one of those people that [think], 'I know it, but give me time and give me some help.'" In contrast, participants appreciated it when healthcare providers "gently" suggested the need to quit, acknowledged that the participants had feel ready to quit, and offered to provide cessation resources. A 73-year-old man who formerly smoked said, "There was always mild [advice from providers who indicated] 'obviously it's not a good idea [to smoke].' He said, "The message that I got was 'If you'd ever like to consider quitting, if you think you're ready, we can recommend this, that, or whatever.' No. I never felt insulted by any healthcare type."

Being worried about hurting others.—Participants described social interactions that stemmed from worrying that their smoking had a negative effect on others, especially children. In some instances, they felt they were a "bad influence" due to their smoking. A 66-year-old man who formerly smoked and was a teacher and coach said, "I spent 37 years teaching school and coaching, and sometimes I didn't think I was a good role model for kids, and I didn't do it [smoking] openly." Others worried about putting others at risk because of second-hand smoke. A 61-year old woman who formerly smoked said, "I've had kids and I'm still smoking, so of course, I'm putting them in danger." A 56-year-old man who was a former smoker revealed that his daughter-in-law would not let him hold his

grandchildren because of the smoke on his clothes. He said, “I was maybe a little hurt but I understood her thinking.”

Discussion

The participants described a variety of types of social interactions that were centered on their smoking or the smoking-related illnesses they had acquired. Consistent with the findings of prior studies,[6] our findings revealed that these interactions were often stigmatizing, such as encounters in which the participants felt looked down upon, humiliated, banished, or blamed for poor health. Also, as had been suggested in the literature,[7] participants had a general sense that this treatment was unfair because they had begun smoking when it was socially acceptable and the extent of the health-related consequences were unknown. Our findings also support prior work on self-stigma;[6] some participants blamed themselves, in some cases quite harshly, for having smoked, whereas others rejected or ignored the admonishments of others. The finding that many participants rejected the term “blame” points to the complexity of the social world of smokers. Many social experiences extended beyond stigma as traditionally conceptualized. While stigma pervaded the social world of many of our participants, they also experienced and appreciated the concern of others, experienced personal regret that extended beyond their treatment by others, and worried about the effects their smoking might have had on others, especially on children, not necessarily because they were blamed by others but because they themselves were aware of the damage their smoking had caused.

The findings should be considered in the context of study limitations. The narratives were obtained as part of the parent study and, as such, did not focus exclusively on social interactions. The semi-structured interview guides included items about a variety of factors, which limited the extent to which detailed descriptions of social interactions were obtained. We recommend future studies focus more specifically on the social world of persons who smoke and obtain in-depth descriptions of a variety of social interactions through the use of open-ended event-focused questions. Such studies will allow researchers to obtain a more nuanced understanding of smoking-related social interactions and explore how they affect persons’ smoking behaviors and healthcare experiences. Another limitation to our study was the lack of ethnic diversity in the sample, which may reflect minority distrust of research on stigmatizing issues.[29] Future research studies, therefore, should include a more ethnically diverse sample to explore group differences in the social experiences of persons who smoke.

The results have implications for clinical nurse specialists who lead anti-smoking policy initiatives. Participants described stigmatizing experiences that ranged from subtle indications of disapproval to overt shaming. Clinical nurse specialists should be aware that while many anti-smoking campaigns are based on the assumption that smoking stigma will prompt persons to quit smoking, there can be negative consequences to these campaigns as well, including internalized stigma and lowered self-esteem, and, in some cases, anger, defensiveness, and greater resistance to smoking cessation.[6] Some experts suggest that anti-smoking initiatives should avoid messages that possibly elicit harmful or defensive responses and focus instead on positive cessation strategies. For example, Evans-Polce and colleagues[6] argue, Currently there may be an overreliance on strategies which focus on

negative reinforcement including both strategies to change smoking norms and increase smoke-free public spaces as well as more structurally stigmatizing policies such as basing hiring decisions and health insurance costs on smoking status. Public health smoking prevention and cessation strategies might instead benefit from a greater inclusion of interventions and policies that focus on positive reinforcement and treatment in order to reduce smoking prevalence while avoiding the stigmatization of smokers. (p. 33).

Our findings and those of previous studies also have implications for clinical nurse specialists who provide clinical care or preventive services to persons who smoke. Providers should address the health risks of smoking in a direct, respectful, and informative manner and avoid even subtle suggestions that patients "deserve" their smoking-related illnesses. Our participants for the most part did not object to providers who addressed their smoking but resented it when providers directed them to quit in a forceful ("pushy"), rebuking, or offhand ("just quit") manner. Conversely, participants appreciated it when providers acknowledged that persons had to be ready to quit and when providers offered to provide cessation help when that time came. As good patient-provider communication is linked to lower levels of stigma, strategies aimed at communicating supportively and empathically with patients who smoke may serve to reduce stigma and ultimately improve their health outcomes.[13,17] Moreover, because smoking-related stigma is associated with hesitancy to disclose smoking status to healthcare providers, lower levels of cancer screening participation, and delayed medical help-seeking for smoking-related symptoms,[13,16,18] strategies to reduce smoking-related stigma should be considered in detection and prevention initiatives.

The participants in this study described how smoking affected their everyday social experiences in complex and nuanced ways. The negative consequences of public anti-smoking campaigns, especially stigma, were clearly evident in their narratives. The findings indicate that clinical nurse specialists should promote anti-smoking campaigns that are effective but not stigmatizing, discuss smoking with patients without implying blame, provide evidence-based cessation resources, improve communication with persons who smoke, and include strategies to address stigma in screening and prevention programs.

References

1. Centers for Disease Control and Promotion (CDC). Current cigarette smoking among adults in the United States. CDC website: https://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/index.htm. Updated November 18, 2019. Retrieved November 26, 2019.
2. Centers for Disease Control and Promotion (CDC). Health effects of cigarette smoking. CDC website: https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/index.htm. Updated January 17, 2018. Retrieved November 14, 2019.
3. Centers for Disease Control and Prevention. Second hand smoke facts. CDC website: https://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/general_facts/index.htm. Updated January 17, 2018. Retrieved November 14, 2019.
4. Lowell, D; [November 14, 2019] Thirdhand smoke: What are the dangers to nonsmokers?. Mayo Clinic website: http://www.mayoclinic.com/health/third-hand-smoke/AN01985.Updated July 13, 2017.Retrieved
5. Burgess DJ, Fu SS, van Ryn M. Potential unintended consequences of tobacco-control policies on mothers who smoke: a review of the literature. American Journal of Preventive Medicine. 2009;37(2 Suppl):S151–S158. [PubMed: 19591755]

6. Evans-Polce RJ, Castaldelli-Maia JM, Schomerus G, Evans-Lacko SE. The downside of tobacco control? Smoking and self-stigma: A systematic review. Social Science & Medicine (1982). 2015;145:26–34. [PubMed: 26439764]
7. Castaldelli-Maia JM, Ventriglio A, Bhugra D. Tobacco smoking: From 'glamour' to 'stigma'. A comprehensive review. Psychiatry and Clinical Neurosciences. 2016;70(1):24–33 [PubMed: 26449875]
8. Webb LA, McDonnell KK, Adams SA, Davis RE, Felder TM. Exploring stigma among lung cancer survivors: A scoping literature review. Oncology Nursing Forum. 2019;46(4):402–418 [PubMed: 31225843]
9. Biener L, Hamilton WL, Siegel M, Sullivan EM. Individual, social-normative, and policy predictors of smoking cessation: a multilevel longitudinal analysis. American Journal of Public Health. 2010;100(3):547–554. [PubMed: 19696387]
10. Wakefield MA, Loken B, Hornik RC. Use of mass media campaigns to change health behaviour. Lancet (London, England). 2010;376(9748):1261–1271.
11. Zablocki RW, Edland SD, Myers MG, Strong DR, Hofstetter CR, Al-Delaimy WK. Smoking ban policies and their influence on smoking behaviors among current California smokers: a population-based study. Preventive Medicine. 2014;59:73–78. [PubMed: 24291748]
12. Latalova K, Kamaradova D, Prasko J. Perspectives on perceived stigma and self-stigma in adult male patients with depression. Neuropsychiatric Disease and Treatment. 2014;10:1399–1405. [PubMed: 25114531]
13. Lei F, Lee E. Barriers to lung cancer screening with Low-Dose Computed Tomography. Oncology Nursing Forum. 2019;46(2):E60–E71. [PubMed: 30767965]
14. Quaife SL, Marlow LAV, McEwen A, Janes SM, Wardle J. Attitudes towards lung cancer screening in socioeconomically deprived and heavy smoking communities: informing screening communication. Health Expectations: An International Journal of Public Participation in Health Care and Health Policy. 2017;20(4):563–573. [PubMed: 27397651]
15. Prout HC, Barham A, Bongard E, et al. Patient understanding and acceptability of an early lung cancer diagnosis trial: A qualitative study. Trials. 2018;19(1):419–419. [PubMed: 30075741]
16. Author. Lung cancer stigma as a barrier to medical help-seeking behavior: Practice implications. Journal of the American Association of Nurse Practitioners. 2015;27(5):240–245. [PubMed: 25736473]
17. Shen MJ, Hamann HA, Thomas AJ, Ostroff JS. Association between patient-provider communication and lung cancer stigma. Supportive Care in Cancer: Official Journal of The Multinational Association of Supportive Care in Cancer. 2016;24(5):2093–2099 [PubMed: 26553030]
18. Stuber J, Galea S, Stuber J, Galea S. Who conceals their smoking status from their health care provider? Nicotine & Tobacco Research. 2009;11(3):303–307. [PubMed: 19246431]
19. National Association of Clinical Nurse Specialists (NACNS). What is a CNS? NACNS website: https://nacns.org/about-us/what-is-a-cns/. Accessed November 22, 2019.
20. Centers for Medicare & Medicaid (CMS). Decision memo for screening for lung cancer with low dose computed tomography (LDCT) (CAG-00439N) Centers for Medicare and Medicaid Services 2015; CMS website: https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=274. Accessed November 22, 2019.
21. Author, Slaven JE 2nd, Monahan PO, Author, Author, Author. Understanding lung cancer screening behaviour using path analysis. Journal of Medical Screening. 2019:969141319876961–969141319876961
22. Author, Author, Author, Author. Understanding the decision to screen for lung cancer or not: A qualitative analysis. Health Expectations: An International Journal of Public Participation In Health Care And Health Policy. 2019.
23. Sandelowski M Whatever happened to qualitative description? Research in Nursing & Health. 2000;23(4):334–340. [PubMed: 10940958]
24. Neergaard MA, Olesen F, Andersen RS, Sondergaard J. Qualitative description - the poor cousin of health research? BMC Medical Research Methodology. 2009;9:52–52 [PubMed: 19607668]

25. Sullivan-Bolyai S, Bova C, Harper D. Developing and refining interventions in persons with health disparities: the use of qualitative description. Nursing Outlook. 2005;53(127–133) [PubMed: 15988449]

26. Miles MB, Huberman AM & Saldaña J Qualitative Data Analysis: A Methods Sourcebook (Third edition). Thousand Oaks, California: Sage Publications, Inc.: 2104.

27. Saldaña J The Coding Manual for Qualitative Researchers. Thousand Oaks, California: Sage Publications, Inc.: 2105

28. Lincoln YS & Guba EG. Naturalistic Inquiry. Beverly Hills, CA: Sage Publications, Inc.:1985

29. Scharff DP, Mathews KJ, Jackson P, Hoffsuemmer J, Martin E, Edwards D. More than Tuskegee: Understanding mistrust about research participation. J Health Care Poor Underserved. 2010;21(3):879–897. [PubMed: 20693733]