Smoking in Chronic Obstructive Pulmonary Disease: A Need of the Taken-for-Granted Body

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Smoking is the major predisposing factor for chronic obstructive pulmonary disease (COPD), yet there has been little understanding of the embodied experience of smoking addiction for the person with chronic breathlessness and their close family members. This interpretive study applies Merleau-Ponty's existential philosophy of the body as a philosophical framework. Heideggerian hermeneutic phenomenology was the mode of inquiry used to gain understanding by engaging 15 people who were admitted to hospital for palliative surgery for emphysema, and 14 close family members in a total of 58 in-depth interviews. People with severe emphysema experienced smoking as a need of their taken-for-granted body. This need was experienced as an intense enjoyment, and as a response to triggers for smoking that were still perceived by the automatic body long after smoking cessation. People with COPD and their families described a link between heavy smoking and exacerbations of breathlessness that created a tension between continued smoking behaviour and awareness of smoking-related illness. Failure to overcome the body's addiction to smoking could lead to the person's denial of the relationship between their need to smoke and their worsening breathlessness. The need to smoke can lead to family anger that is mediated by each family member's personal experience of addiction. Even after cessation, the issue of smoking as part of the situation of COPD was in the foreground for family carers, as it was for the breathless people themselves. This discussion highlights the importance of 'the right words at the right time' in assisting a multifaceted approach to smoking cessation.

It is widely understood that people most at risk for emphysema are those with a significant tobacco-smoking history (Halbert, Isonaka, George, & Iqbal, 2003; Margereson, 2001; Petty, 2002). Smoking creates a context of self-infliction for these people with chronic respiratory disease. People whose condition is the result of smoking may experience guilt and shame at having brought the disease upon themselves and their families (Robinson, 2005; Weinmann & Hyatt, 1996; Halbert et al., 2003).

Qualitative research has addressed the experiences of smoking, quitting and addiction in such contexts as adolescence, teenage asthma, pregnancy and mental illness (Johnson, Kalaw, Lovato, Baillie, & Chambers, 2004; Lawn, Pols, & Barber, 2002; Forchuk et al., 2002; York, 1997; Haslam & Lawrence, 2004; Tod, 2003). There are, however, surprisingly few qualitative research reports describing the meaning of smoking as part of the experience of chronic obstructive pulmonary disease (COPD).

The COPD participants in this study had received one of two possible palliative procedures for emphysema, either lung volume reduction surgery or Endo-Bronchial Valve™ insertion. Selection for each of these procedures required that the patient stop smoking. This selection criterion was adopted, not only because of the benefits of smoking cessation in COPD generally, but more specifically due to the well-documented risk of postoperative pulmonary complications in current smokers (Bluman, Mosca, Newman, & Simon, 1998; Pedersen, 1994; Moller & Villebro, 2005).

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This family-centred study sought to gain an understanding of the experience of people living with severe COPD who were current or former smokers. It made possible an exploration of the embodied meanings of smoking and smoking cessation for people as they faced a diagnosis of COPD, and attempted to meet the selection requirements for palliative surgery.

Method

The Philosophical Framework

While Heideggerian phenomenology was utilised as the mode of inquiry (Heidegger, 1927/1996), it was the existential philosophy of Merleau-Ponty that provided a philosophical framework for this study as it allowed attention to the person living within a body that has a unique social situation. Merleau-Ponty held that to be a body is to be tied to a certain world. The body does not exist in itself, but in-the-world. Similarly, perception cannot exist in itself. It is always an embodied perception, influenced by the context of its situation (Merleau-Ponty, 1945/1962). If we consider those people with COPD who smoke, that context is formed not only by the fact that they have difficulty breathing and have a smoking addiction, but also by the myriad of personal concerns and relationships that interact with that reality and shape that particular person's world. Those personal concerns and relationships create the persons *life-world* (Husserl, 1913). Based on the notion that people perceive the world through their body, a smoking addiction may alter the way the body perceives and connects with the world, and may influence their experience of living with chronic respiratory illness.

Merleau-Ponty's philosophy has relevance for the embodied perception of COPD-related disability. He theorised that the body's approach to many of its daily tasks is an automatic one. When preparing for routine tasks we employ our body in an unconscious and automatic manner, without having to refer to the objective world. Viewed from an existential perspective, breathing itself is a taken-for-granted skill of the body, and this taken-for-grantedness is diminished with the progression of smoking-related COPD.

The Research Participants

From a total sample of 29 people recruited from three teaching hospitals, 15 had severe emphysema and had chosen to have a lung volume reduction procedure (men: n = 9, women: n = 6, age range 55–77 years, median 63 years). All were previous or current smokers. Their forced expiratory volume over 1 second (FEV_1) ranged from 14% to 51% of predicted. The second cohort of participants were close family members (n = 14, age range 29–82 years, median 62 years). There were seven wives, two children, three husbands, and two siblings.

Data Collection and Analysis

Data were collected in the form of 58 semistructured interviews performed on two occasions at 6-month intervals. Semistructured interviews provided a flexibility of format that allowed the participants to describe and reflect on their experience of living with COPD, while raising and putting their own emphasis on issues of importance. The interviews were tape-recorded to allow the investigator to maintain eye contact and focus on the participant, and to facilitate the accuracy of data for transcription. Data were analysed using hermeneutic interpretation (Dilthey, 1883/1976).

Findings

The findings described the broad experience of COPD that created a context for the person's smoking history. The participants with COPD could no longer take their breathing for granted. Lessened breath meant that the body of the person no longer performed automatically, but required *conscious body management* (Gullick, 2006). The body changed over time in both appearance and effectiveness. As the disease progressed, the personal experience of breathlessness could no longer be hidden, and the dysfunctional body became visible to outsiders in the form of coughing, expectorating, wheezing and, in some cases, the attachment of oxygen bottles. Breathlessness reshaped the person's life-world as it led to a loss of paid work, a loss of hobbies, a loss of social activities and networks, and lessened mobility. These people experienced progressive breathlessness as a *shrinking life-world*.

The Struggle With Smoking as a Need of the Body

A history of smoking shaped the experience of COPD-related breathlessness for the person and family. All of the COPD participants in this study had a long history of smoking addiction. These breathless people had struggled with the tension between their body's need to smoke and a theoretical understanding that it would be best for their body if they stopped. Smoking existed as a need of their *taken-for-granted body*. The suggestion that smoking became, over time, part of the automatic body was reinforced by numerous descriptions of habit and context amongst these breathless people. It was a common experience for the body to recall its need to smoke long after quitting, even though consciously the person did not want to smoke. The impulse to smoke could be linked to tasks or rest periods that acted as triggers. Frances explains, 'I'll be knitting, and I'll still put my knitting down, even 10 years later, and think "Oh, I don't smoke". You know what I mean? Even 10 years later, even though I don't even feel like a cigarette!'

Terry found he craved smoking after dinner, while Catherine's thoughts turned immediately to smoking when she felt stressed in her business. Andy, after more than a year of abstinence confided, 'I miss it as much today as the

day I gave up'. These examples help to situate smoking as a *need* of the body, and an *automatic action* of the body, rather than merely an intellectual choice.

The participants revealed a struggle with their need to smoke. Terry and Gwen both described the intense enjoyment of smoking as a need, and suffered a sense of loss at the thought of giving it up. They were drawn to that enjoyment despite their breathlessness also occupying the foreground of their experience. Even after quitting, Terry remembered and craved that sensation: 'I enjoyed smoking, and even now … I'd love a cigarette. My son comes here, and he goes outside and has a smoke. I say, "Sit in here and I can smell it". I want the smell of his smoke'.

The need to smoke could exist so much in the foreground for the person that they were compelled to smoke one cigarette after the other. Betty had observed her husband Terry's 'heavy' smoking: 'He'd come out here about 2 o'clock in the morning, he'd have to have a cigarette. He'd sit there for hours just reading, having cigarettes. You could scrape it off the windows …'

Times of heavy smoking could bring on experiences of sudden severe breathlessness, and this was certainly the case for Catherine and for Terry. The person with COPD and their family used these periods of heavy smoking as markers when speaking of illness exacerbation. Norman recalls of his wife Catherine: 'She was smoking heavily, and she rang me to say she could hardly breathe … She asked me to take her to hospital, so I rang for help'.

Terry links the issues of heavy smoking and exacerbation in the same way: 'I was smoking heavy. Very, very heavy … I found I just couldn't breathe … and the ambulance came out'. This link between heavy smoking and breathlessness in people's narratives defined and situated a tension between continued smoking behaviour and awareness of smoking-related illness.

Overcoming the Need to Smoke

The internal struggle with smoking was prevailed over by people in different ways, with all but one participant eventually overcoming their need to smoke. Some people experienced an event that allowed them to immediately renounce their body's need to smoke. Jim stopped smoking in response to a graphic television advertisement. Frances claimed that no-one would ever tell her not to smoke, but a diagnosis of emphysema led her to give up immediately. 'When it's your life, I think it's different, you know?' For Frances, it appeared that the need to live for the *person in the body* became a stronger motivating force than her embodied need to smoke.

Smoking cessation for several participants was supported by a perception of regaining wellness through surgery, pulmonary rehabilitation and nutritional management. Petra described a complete turnaround in her life following smoking cessation, surgery, and a structured home exercise program. Her 60-per-day smoking habit was broken with the assistance of bupropion therapy:

> It was so difficult. But my doctor prescribed me these Zyban tablets and that helped. Never touched another cigarette again and I never even went through the whole course … But I don't need any oxygen and I have no trouble going from my bedroom now to the lavatory so I hope with exercise I might have improved my living … I push myself, and I think that's wonderful and I have a feeling maybe I'll live another 3 or 4, 5 years, who knows?

The Right Words at The Right Time: Using Vulnerability as Opportunity

For some with COPD, the intensity of their personal struggle with smoking was extreme. This difficulty with cessation occurred despite experiencing overwhelming symptoms and life-threatening exacerbations of breathlessness. Terry gave an emotional account of how it took multiple emergency hospital admissions brought on by periods of heavy smoking, before he could overcome his body's need. Someone said the right words at the right time — a time of vulnerability:

> And they said, 'You've got to stop smoking, you've got emphysema, blah, blah, blah'. And I took no notice of it. I couldn't stop smoking; I'd tried everything in the book. Even double doses of that dangerous drug [bupropion]. They had to put the thing into my mouth and force air into me. And this young doctor got the X-rays and he came up to me and he said 'Phew, you've only got a little bit of lung left. If I was you I'd take care of it.' And it struck me then, and from that day to this, I've never smoked (crying) … Well, he just said it at the right time, you know?

Andy was also able to stop after years and multiple attempts at cessation, because some one said the right words at the right time.

> Oh God … (thinking) I gave up, like everybody else, I've given up hundreds of times. But the time that I really gave up, I was in hospital with this leg thing … they said 'Look, you can keep smoking and lose your leg, or you can keep smoking and not be able to breathe anymore, or you can bloody well give it up'. So I did.

Somehow the mixture of the right words in a particular context of vulnerability was strong enough to allow both Terry and Andy to sever the hold of smoking over their bodies. They finally were able to recognise their body as having too much to lose.

Some participants highlighted the lack of the right words at the right time. Gwen was informed that smoking was the reason for her lack of response to treatment for COPD, her ongoing infections and rapid deterioration. She claims that at no stage was she put in touch with a 'quit' program, or given support or strategies to facilitate smoking cessation. In her husband Greg's words: 'If she was a heroin addict she'd probably get more support than being a smoker'.

Both Sam and Gwen voiced doubts about smoking as the origin of their breathlessness. Sam believed the problem was caused by an industrial accident resulting in

lung trauma, as this was the time he became conscious of breathlessness: 'I don't blame anything on smoking. If a thing is going to happen, it's going to happen'. He was angry and frustrated that he was not eligible for workers compensation for his chronic breathlessness, because the doctors blamed it on smoking.

After 10 years of abstaining from smoking, Gwen admitted a relapse that followed the suicide of her adult son. She had been unable to give up smoking again, despite the implications of her severe COPD, and being the primary carer for her 12-year-old grandson: 'I know I shouldn't smoke … We gave it away for years but when we lost Brad 2 years ago that's when we both seemed to take it up again'.

Gwen presented as a sensible woman, and had seen the results of smoking first hand. She had been the sole carer for her father who was on continuous home oxygen for emphysema, and who had smoked up until an hour before he died of COPD. Her sister and mother were smokers and both died of lung cancer. At her first interview, Gwen freely admitted that she should not smoke. As Gwen's breathlessness got worse over time, her apparent need to deny the relationship between her smoking and her illness increased. Gwen's body needed and enjoyed smoking, but to accept the known danger whilst continuing to smoke was, perhaps, to acknowledge her body's weakness. At her 12-month interview, and following major deterioration, it was easier for her to believe she had 'caught' emphysema.

> So you can't say it's definitely the smoking … Okay, I got emphysema. Everyone can get emphysema, everyone's got it … See when I was a baby I got whooping cough bad, and that kind of weakened me too. I think I'm just one that was the unlucky one that got everything that everyone else got. I'm just the one that caught it.

The Family Dealing With the Persons' Need to Smoke

Gwen's husband Greg, who smoked himself, felt helpless in the face of what he saw as Gwen's self-destructive behaviour:

> She knows it's killing her. We all know it is … She'll sit on this verandah of a morning, and she'll just light one up after the other, after the other … So we've just got to sort of see it through I suppose. You know, the end of it's pretty sad, because it will kill her. It will, for sure. She knows it, I know it, the grandkids know it. Her sons and daughters know it …

Gwen's continued smoking was like an uncontrollable act of shrinking from life that her husband Greg, and the rest of the family just had to just 'see through' until her death.

Rather than trying to deny the danger of smoking, Jack's manner of dealing with the tension between smoking and COPD was to deny the smoking itself. Jack could not admit to his family that his body still needed to smoke. His son Gary explained:

> He still smokes … He does it in private. If you're over at his place, he'll go to the toilet, and he'll come out, and you'll go in afterwards and you can smell the smoke. He'll say that he doesn't smoke; swears blue murder that he doesn't smoke. He'll say, 'I never smoked since your mother died. Why would I do that?' I think he talked himself into thinking that he doesn't smoke.

As in Gwen's case, Jack's example illustrates an apparent difficulty for the person with COPD to face a perceived personal weakness created by the dichotomy of continued smoking against the knowledge of its danger. As Jack exclaimed, 'Why would I do that?'

A few participants had difficulty facing the link between their need to smoke and their breathlessness. Most, however, took on a sense of accountability with regard to smoking as the cause of their current situation. As Petra said, 'I don't want any sympathy. It's all my own doing … And now I've paid the price'.

The person's former or ongoing need to smoke could lead to family anger, and this seemed to be tempered by each family member's personal experience of addiction. Six of 14 family members raised the issue of their anger and frustration over smoking. While families frequently did not *understand* the addiction, they acknowledged the strength of that addiction. Family anger appeared to be greater for people like Gary and Mary, who explained they had not experienced the hold of a strong addiction over their body. What they described was a lack of commonality of embodied experience. This made it hard for them to understand the importance of smoking to the person against a background of loss, illness, and impending death. Mary, for example, was angry at Keith's lack of responsibility for his own welfare:

> The worst thing for me? I know this probably sounds crazy, probably the fact that this condition has come about through smoking, that he's known about, and hasn't done anything about 'til now, and has brought him to this situation. But then again, I'm not addicted to anything … And I just don't know how hard it can be.

Gail admitted using Jim's past smoking as a weapon when she was angry '… and he flew off at me and of course I just turned round and I said to him, I said, "It's not my bloody fault you've got it… You smoked bloody cigarettes"'.

Anger over smoking was not so apparent where the close family member had smoked. Norman's experience as a former smoker allowed him to draw a distinction between habit and addiction: '[Catherine] couldn't give it up; it's a tremendous addiction … I used to smoke as well, but could give it up quite easily. I didn't smoke like she smoked … it wasn't important to me'.

Even though all but one of the participants had ceased smoking by the final interview, and some had not smoked for a number of years, the issue of smoking was often in the foreground for family carers, as it was for the breathless people themselves. The stories of these participants suggested that smoking formed part of the definition and meaning of breathlessness, and the way people faced the struggle with their body's need to smoke could influence the consequential experience of COPD for themselves and their family.

Discussion

The United States Department of Health and Human Services Guideline (2000) for tobacco dependence recommends the recognition of smoking addiction as a chronic disease (Fiore, at al., 2000). People who are addicted to smoking carry a vulnerability to relapse that continues over time and often requires repeated intervention (Anderson, Jorenby, Scott, & Fiore, 2002). This approach to our understanding of smoking is supported by the findings of this phenomenological study that situates smoking as a function of the *taken-for-granted* body.

This study revealed that some participants had difficulty reconciling their smoking against a context of self-inflicted respiratory illness, and that this could lead to either the denial of their continuing smoking, or denial of smoking as a cause of their COPD and its exacerbations. This finding demonstrates the importance of communicating an understanding of smoking itself as a disease. By situating smoking addiction in a disease framework, it lends acceptance for the person who has difficulty with cessation, and gives them permission to accept medical treatment for that addiction. The recognition of smoking as a chronic disease may also alleviate some of the family anger related to smoking behaviour, and could facilitate constructive family involvement in the cessation process.

The intensity and duration of addiction was substantial for all these participants. However, a variety of prompts for cessation were successful, with no one strategy having universally successful outcomes. This supports the need for a variety of cessation tools to be made available to smokers with COPD, including both pharmacological and psychological strategies.

The narratives of these participants suggested that the right words at a time of vulnerability could lead to success with smoking cessation where multiple attempts, including pharmacotherapy had failed. There is evidence that smoking cessation advice is not given as frequently as it could be. In a recent study of 175,000 adults, 23% of current smokers with COPD had not received smoking cessation advice from a health professional in the past year (Schiller & Ni, 2003). It seems likely that many health professionals assume that someone with COPD has received advice to stop, and that 'nagging' them is unlikely to change their behaviour. It would appear important to continue a dialogue with the person about smoking behaviour in a way that does not demean them, nor portray their continued smoking as a moral weakness. Illness exacerbation may provide a period of vulnerability in which that dialogue may prove effective.

Research has shown a strong dose-response relationship between the intensity of smoking-cessation counselling and its effectiveness. It has been demonstrated that person-to-person counselling is effective, and its effectiveness increases with treatment intensity (Anderson et al., 2002). This supports the notion that all health professionals should take time to talk to current smokers about their smoking habit, and offer cessation support. Hospitals can support this process in a practical way by either commencing, or continuing to offer training in smoking-intervention strategies to equip nurse and medical staff to approach the subject in sensitive and nonjudgmental ways. Clear policies can establish smoking cessation initiatives including specialist clinics as part of institutional culture, and educational strategies for smoking cessation should be taught in nursing, physiotherapy, psychology and medical undergraduate programs. Determining hospital grounds and other public places as 'smoke-free' areas reinforces the link between nonsmoking and health.

Finally, all of the COPD participants in this study had well-developed symptoms of emphysema prior to their smoking cessation. For several, it was the diagnosis of COPD that led to their cessation. This trend for cessation following diagnosis of COPD has been reported by other researchers (Górecka et al., 2003). Unfortunately, as a health promotion strategy it is quite obviously too little, too late. There is a need for a concerted and consistent approach to smoking cessation strategies in the primary health-care setting. If we are to reduce the number of new cases of smoking-related illness, offers of access to aggressive treatment regimes should not be reserved for secondary prevention. For family members and health care professionals, it should be reinforced that *the right words at the right time* may be a powerful motivator for smoking cessation.

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