



Texto & Contexto Enfermagem

ISSN: 0104-0707

texto&contexto@nfr.ufsc.br

Universidade Federal de Santa Catarina
Brasil

Lucchese, Roselma; Vargas, Lorena Silva; Rodrigues Teodoro, Wender; Borges Santana, Lorrana
Kathryn; Santana, Fabiana Ribeiro

A TECNOLOGIA DE GRUPO OPERATIVO APLICADA NUM PROGRAMA DE CONTROLE DO
TABAGISMO

Texto & Contexto Enfermagem, vol. 22, núm. 4, outubro-diciembre, 2013, pp. 918-926

Universidade Federal de Santa Catarina
Santa Catarina, Brasil

Available in: <http://www.redalyc.org/articulo.oa?id=71429843007>

- How to cite
- Complete issue
- More information about this article
- Journal's homepage in redalyc.org

redalyc.org

Scientific Information System

Network of Scientific Journals from Latin America, the Caribbean, Spain and Portugal

Non-profit academic project, developed under the open access initiative

OPERATIVE GROUP TECHNOLOGY APPLIED TO TOBACCO CONTROL PROGRAM

Roselma Lucchese¹, Lorena Silva Vargas², Wender Rodrigues Teodoro³, Lorrana Katrhyn Borges Santana⁴, Fabiana Ribeiro Santana⁵

¹ Ph. D. in Nursing. Adjunct Professor of the Federal University of Goiás (UFG) – Catalão *Campus*. Goiás, Brazil. E-mail: roselmalucchese@hotmail.com

² Master's student of the Graduate Program in Organizational Management, Federal University of Goiás. Nurse on the City Health Department of Catalão and Coordinator of the Municipal Program of Tobacco Control. Goiás, Brazil. E-mail: lorennavargas19@yahoo.com.br

³ Specialist Nurse in Primary and Family Health Care. Nurse of the Municipal Health Department of Catalão, Goiás, Brazil. E-mail: wenderteodoro@gmail.com

⁴ Nursing Undergraduate Student, UFG – Catalão *Campus*. Goiás, Brazil, Goiás, Brazil. E-mail: lorrana_cmy@hotmail.com

⁵ Doctoral Student of the Public Health Nursing Program, University of São Paulo at Ribeirão Preto College of Nursing. Assistant Professor, UFG, Catalão *Campus*. Goiás, Brazil. E-mail: fabiana.fen@gmail.com

ABSTRACT: This descriptive and exploratory study was performed with the purpose to discuss the use of group operative technology as a coping strategy in a tobacco control program in the primary health care system of a small municipality in the state of Goiás, Brazil. The subjects were 20 individuals who sought the Primary Health Care Unit on their own account, and the sample consisted of nine people who completed the treatment. Content analysis revealed the thematic category: The path followed during the treatment; and three subcategories: Revisiting the desire to quit smoking; Feeling the effects of quitting cigarettes; The challenges for the change. The Fagerström test showed a dependence pattern of three subjects for each level: very high, high and average. The cessation rate for tobacco was 78%; therefore, it is recommended that operative group technologies be adopted in group activities in the program.

DESCRIPTORS: Smoking. Smoking cessation. Tobacco use cessation. Group processes.

A TECNOLOGIA DE GRUPO OPERATIVO APLICADA NUM PROGRAMA DE CONTROLE DO TABAGISMO

RESUMO: Estudo de natureza mista, do tipo descritivo e exploratório, que discutiu o uso da tecnologia de grupo operativo como estratégia de enfrentamento do uso do tabaco num programa de controle do tabagismo na atenção primária à saúde num município no interior de Goiás, Brasil. População de 20 pessoas que procuraram a Unidade Básica de Saúde, em livre demanda, e amostra de nove pessoas que concluíram o tratamento. Do processo de análise de conteúdo emergiu a categoria temática o caminho percorrido durante o tratamento, e três subcategorias: revisitando o desejo de parar de fumar; sentindo os efeitos do (des)uso do cigarro; e os desafios para a mudança. Pelo teste Fagerström, apontou-se padrão de dependência de três sujeitos para cada nível: muito elevado, elevado e médio. O índice de abandono do tabaco foi de 78%. Assim, recomenda-se a adoção de tecnologias de grupo operativo na condução das ações grupais no programa.

DESCRIPTORES: Tabagismo. Abandono do hábito de fumar. Abandono do uso de tabaco. Processos grupais.

EL TECNOLOGÍA DE GRUPO OPERATIVO APLICADO AL PROGRAMA DE CONTROL DEL TABACO

RESUMEN: Estudio la naturaleza mista, exploratorio y descriptivo, discucion el uso del grupo operativo como la tecnología en estrategia de afrontamiento del consumo de tabaco en programa de control del tabaco, en la atención primaria de salud de la ciudad interior de Goias, Brasil. Población de 20 personas que buscar tratamiento la Unidad Básica de Salud y una muestra de 9 personas que completaron el tratamiento. El proceso de análisis de contenido surgió categoría temática - El camino seguido durante el tratamiento - Trayectoria de un deseo de dejar de fumar, sintiendo los efectos de 'des'uso cigarrillos, los desafíos para el cambio. Por el test de Fagerström, mostró un patrón de dependencia de los tres sujetos para cada nivel. La tasa de abandono del tabaquismo fue de 78%, lo que se recomienda la adopción de tecnologías en la realización de las actividades del grupo operativo en la programa.

DESCRIPTORES: Tabaquismo. Cese del tabaquismo. Cese del uso de tabaco. Procesos grupo.

INTRODUCTION

Smoking is responsible for several health hazards of both smokers and non-smokers; a world epidemic that results in the death of more than five million people every year. By 2030, if urgent measures are not employed, this number is expected to increase up to eight million deaths.¹⁻²

In Brazil, by 2008, 17.5% of the population at the age of 15 years or older were users of tobacco derivatives. This number corresponded to 25.5 million people. Among these people, 45.6% had attempted to quit smoking in the past 12 months and 52.1% were planning to quit.³

In 1989, the Brazilian National Cancer Institute (*Instituto Nacional do Câncer - INCA*), in a partnership with the State and Municipal Health Departments and many sectors of civil society, instituted the National Tobacco Control Program (*Programa Nacional de Controle do Tabagismo - PNCT*). The Program has the purpose to reduce the incidence of young people who start smoking and the risks of passive smoking, and to increase the rates of tobacco use cessation.⁴

Generally, the Tobacco Control Program (PNCT) is performed by a multiprofessional team and follows a protocol of care starting from user embracement, filling out of the medical file constituted by personal data, smoking history, dependence degree, in addition to referring patients to additional interventions related to mental health. The treatment offers support in group activities, as well as individual and pharmacological care.

Regarding group activities, there are positive experiences in applying the cognitive-behavioral approach in the materialization of behavioral changes related to nicotine dependence.⁵ Other studies emphasize the importance of support groups to tobacco users facing the challenge to quit smoking, as they can share feelings and achievements, especially in the primary health care setting.⁶⁻⁷

However, the whole tobacco context is complex and permeated by multiple factors. Therefore, actions directed at this problem must consider its social, political and economic determinants, in addition to the dimensions regarding the conditions that lead people to using tobacco, the nicotine dependence processes, and also the motivation to quit and the factors that sustain abstinence.⁸

In face of the implications involving the offer of effective health actions in tobacco reduction, and adjustment of the Tobacco Control Program

(PNCT) is proposed, so as to using groups; i.e, applying the Operative Group (OG) technology, to provide group care to people who search help to quit smoking.

The OG was created by Pichon-Rivière. The objective of OG is to promote the learning of those involved. This group strategy searches the elaboration of knowledge by means of the relation with oneself and others, led by communication and interplay, which are propitious conditions to a critical reading of reality.⁹ Health is promoted when active and creative attainment of reality exists. This is the learning process,¹⁰ which makes OG an educational technology for approaching many varied themes related to life, namely health. Also, OG can present a care delivery feature, due to its therapeutic ability to promote a reflexive approach by elaborating subjectivities and overcoming stereotypes.⁹

OG, in addition to gathering people with a common objective, aims at the task, with a view to learning to think and overcome emerging and occurring difficulties in the group setting.¹⁰ This movement mobilizes the basic anxieties of each person in the group, and parting from the elaboration of anxiety, opens space for enhancing stereotypes with the will to change. This way, group tasks demonstrate pertinence.⁹ The dynamic process occurring in OG and in the game of roles search for de-constructing the defensive attitude towards changes, slowly giving space to building a project for new achievements and actions in the reality within.¹¹

Thus, the objective of this study was to discuss the use of group technology as a coping strategy in tobacco use within the tobacco control program in primary health care in the municipality of Catalão, Goiás, Brazil.

METHODOLOGY

This present study is a descriptive and exploratory mix-nature study, with a view to describing OG in the care for people who search for treatment to quit smoking. The data presented refer to a research developed in the Basic Health Unit (BHU) in an average size city in the state of Goiás, Brazil.

The study population consisted of 20 people who sought a BHU on their own free will. The sample consisted of nine people who concluded the treatment. The inclusion criteria were: ≥18 years; smoker; psychological screening that evalu-

ated no severe or persistent mental comorbidity disorders; participating in the whole treatment which lasted for a year, with an intensive approach and follow up.

In the BHU the Tobacco Control Program (PCNT) was developed, guided by the guidelines of the Brazilian Ministry of Health. However, adjustments regarding group coping strategies occurred. The researchers and the multiprofessional team developed a proposal guided by a therapeutic agreement (objective agreement), specific for OG, which included six OG sessions, followed by a two-week follow-up during the following four months, and, monthly OG sessions until the completion of one year of treatment. The OG were performed between the months of May of 2011 and April of 2012, in two different periods, one in the morning (GA) and the other at night (GB), with a view to meeting the participants' specific needs with the coordination of a nurse and two observers, who took notes about the group movements in the form of chronicles.

In the group sessions, the themes proposed by the Brazilian Ministry of Health were developed: "what encouraged you to seek help"; "understanding why people smoke and how it affects their health"; "the first days without smoking"; "how to cope with obstacles in order to keep not smoking"; "benefits acquired after smoking cessation"; and "the evaluation of the six meetings". Maintenance groups had the following theme: "how I am coping with the smoking cessation process".

The Fagerström test was employed to characterize the dependence level in the study subjects. The test is used in studies and aimed for health services. It comprises six questions about the pattern of tobacco use, which are quantified. The score allows for setting results into categories, with total scores ranging between very low (0 to 2); low (3 to 4); average (5); high (6 to 7); and very high (8 a 10).¹²

The process of analyzing the OG records was conducted by thematic content analysis.¹³ In the presentation of results, the register units were coded into GA for the morning group and GB for the evening group.

The present study was part of a broader research that addresses the processes of change in health care in Catalão. The study was approved by the Research Ethics Committee of Federal University of Goiás (protocol 028/2009). All study subjects were guided regarding the objectives and

procedures, and signed the Free and Informed Consent Form.

DATA PRESENTATION AND DISCUSSION

In the first meeting, 20 people were present, nine of which stayed until the last meeting, translating into a 55% dropout rate. A considerable number, although very similar to other findings demonstrating patient dropout during treatment.¹⁴

The group in this study consisted of five men and four women. Regarding the age, there was a higher frequency of 50 to 60 years (66.7%). Four subjects reported having tried to quit smoking 0-2 times and three subjects had made more than six attempts. The predominant age bracket also is demonstrated in another study with the same study object, demonstrating 0 to 2 attempts to quit smoking.¹⁵

The characteristics of the group, according to Fagerström, demonstrated a dependence pattern in three patients for each one of the levels: very high, high and medium. During OG sessions, there was a significant change in this consumption pattern. From nine participants, seven quit smoking, and one dropped from 33 to 12 cigarettes and the last one presented no expressive reduction. Tobacco use cessation was estimated in 78% among those individuals who participated of the complete treatment. This result was fairly superior to another study,¹⁴ that presented a 34.78% rate of cessation by using the cognitive-behavioral therapy associated with nicotine reposition therapy. From all nine individuals who concluded the treatment, only one underwent nicotine reposition.

The content analysis processes resulted in one theme category and three sub-categories, presented in figure 1 and discussed as follows.

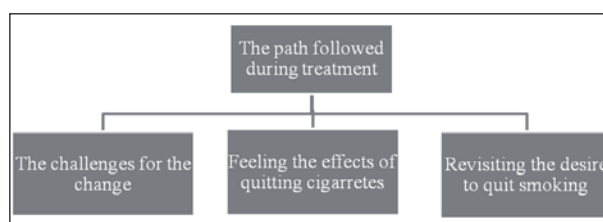


Figure 1 – Category and sub-categories emerged from data content analysis. Goiás, Brazil, 2012

The central category "The path followed during treatment" emerged from the convergence of meaning units representing difficulties and achieve-

ments faced throughout the treatment. Individuals in the study reported, in the OG, why they sought health services to help in the process of smoking cessation. They also expressed what nicotine use and its absence can cause on them, in addition to the effects of abstinence. Challenges and overcoming difficulties composed the end of the treatment.

Revisiting the desire to quit smoking was constituted by the expressions related to the motivation that led to searching for the group. [...] *our clothes smell bad, our hands smell bad, we can't breathe well, have bad breath, the house and the car stink, our teeth are yellow [...]* (GB).

Therefore, being a smoker demonstrates the condition of being differentiated, aggregating less value, above all, when they feel their bad smell and the harms to their appearance. The feeling of guilt arises, and also the fear for what they, intentionally, cause on themselves by smoking.

The identification of features in the group and the motivation to search for treatment is part of the detailed evaluation of these individuals, favoring their choice for the more appropriate treatment strategy.¹⁶

Many reasons to quitting smoking were reported, however the most representative were: health preservation and restoration. *I sought for treatment because I want to take care of myself and I already feel the symptoms of tobacco. I want to quit smoking because I want to live better and longer [...]. Because it harms your health and the relationship with people [...]. I stopped because of my health, to get better [...]* (GA).

Information regarding health hazards due to tobacco use is disclosed throughout the world; although it appears that this fact alone is not enough to encourage people to quit smoking. However, the knowledge acquired about health hazards caused by tobacco are demonstrated to aid smokers to relate health problems to smoking.¹⁷ In this present study, individuals' motivation to search for better health was demonstrated to occur after alterations in the general state or experiencing a real health-affecting situations. [...] *I've already stayed with my nephew with cancer, caused by cigarettes, we see absurd things caused by cigarettes and we can't seem to be able to quit smoking [...]. I have insomnia, headaches and throat aches, major depressive disorder, bad skin, unpleasant smell* (GB); [...] *I already have difficulties in breathing, I want to quit before worse symptoms appear [...]* (GA).

Individuals' concerns are based on scientific evidence that target tobacco as the biggest cause of death by cancer, cardiovascular diseases and

pulmonary diseases. Moreover, a risk factor for pulmonary infections, osteoporosis, reproductive disorders, diabetes, and gastric and duodenal ulcers.¹⁸

Motivation to quit smoking is related to health concerns, which demonstrates the awareness of each smoker about the damages from this practice.⁵ Consequently, the search for health becomes the main concern and motivation in the process to quit smoking.¹⁹

Economic issues were also discussed in the OG. The cost of smoking is acknowledged by smokers. However, tobacco consumption has a close relation to poverty. Studies^{5,16} demonstrate higher frequency of smokers among people with lower education and economic conditions. *The cigarette destroys my health and my pocket; I spend more than a thousand per year [...]* (GB).

Smoking also hinders with social acquaintanceship when the smoker has the feeling of inappropriateness and discomfort when coping with desirable models of a community that has been discussing such issues.¹⁷ So much that among the reasons to quit smoking, family well-being stands out, as smokers are seen as anti-social compared to others.⁵

My son can't accept it [that she smokes]. I want to give my son a present, the news that I quit smoking [...] (GA); *I feel ashamed, social exclusion, the smell of cigarette, I give up eating to smoke [...]. I am 54 years old; I've smoked since I was 12 years old... I'm going to look for help because the cigarette damages the people I live with, I feel ashamed when I have to deal with people that don't smoke [...]* (GB); *Cigarette use pollutes the environment, how many people are smoking at this moment [...]* (GB).

Cigarette smoke produced by smokers directly hinders air quality, mostly in closed places. Passive smokers, especially women and children, are the most damaged, as the smoke that is directly produced, not passing through the filter, may contain 50 times more cancer causing substances than the smoke inhaled by the smoker.²⁰

Forest destruction must also be considered, both for tobacco crops and for producing the raw materials for the pre-industrialization of cigarettes by releasing hazardous gases into the environment.²⁰ One of the differentials in this OG was the ecological dimension present in the discussions, which was not observed in other studies.

Feeling the effects from quitting cigarettes was composed by expressions that demonstrated

the feelings resulting from the use of tobacco and its absence. *The more nervous I am, the more I smoke, it calms me down...it's a distraction [...]* (GA); *Cigarettes calm me down, a moment of pleasure [...]* *It eases sadness, a companion [...]*. *It decreases anxiety [...]* (GB).

Reports from smokers associating smoking to feelings of anxiety, anger and loneliness are common. For this reason, the cigarette achieves a meaningful social status in the life of these people, as a companion, a source of pleasure and a way to relieve daily tensions.²¹⁻²²

The feelings that arise are contradictory, as the companion cigarette becomes the aggressor: *I feel awful, I feel the cigarette is finishing me up and outside I see myself blurred, my skin is awful. I look myself in the mirror and I feel awful... dead skin, both from the inside and out [...]* (GA).

Reports about the effects of tobacco use as the triggering agent in the aging process are identified in literature,²² above all when evidence are originated from the comparison between smoker and non-smoker individuals. The individuals feel the effects of aging due to the use of tobacco, especially due to the fact that the age bracket in this study is more advanced and due to the long term habit of smoking, its effects are cumulative and more appearing.

This way, the OG as an educational and care technology has made way to the opportunity of following up the effects felt during tobacco cessation. As the individuals reduced nicotine intake, the symptoms of abstinence were experienced and discussed in the group setting.

Another cigarette disuse effect on these research individuals was weight alterations and increased appetite: *I am eating a lot, gaining weight [...]* (GA). Increased calories intake is related to a better perception of taste and odors, associated to the feeling of anxiety caused by the substance deprivation. However, a considerable part of participants under treatment present compulsive eating during the tobacco cessation process. This way, there may be a risk of developing eating disorders while or a little after tobacco cessation. For that reason, weight gain is among the reasons for recurrences and due to this fact, special care must be driven to this complaint.²³

Craving is another symptom presented during tobacco cessation, defined as an intense desire for using the substance.²⁴ *[...] I have been without smoking since Sunday, I think if I smoke one single cigarette, I will smoke the whole pack [...]*. *My mind keeps thinking about the time to smoke, I get anxious*

about the time to smoke [...]. *My desire to smoke is so much that if someone lights a cigarette next to me, I will take the cigarette from him [...]*. *I was in a strong agony [...]* (GA).

This effect appears when the individual receives some stimuli which makes him/her relate to an experience with the use of tobacco, commonly associated to the conditioning process developed during the period of use and the factors related to the negative reinforcement.²⁵

Tobacco deprivation causes diverging sensations related to sleeping. Some individuals associate it to an increase in the need for sleeping and some individuals relate it to insomnia. *If I don't smoke, I can't sleep [...]*. *If I don't smoke I feel very sleepy [...]*. *The day I stopped smoking I started to wake up at night [...]*. *I feel very sleepy and when I smoke, it runs through my veins and I feel better [...]* (GA).

Individuals in this research related the use and disuse of tobacco to alterations in their sleeping patterns. Tobacco use interference is associated to insomnia and sleep fragmentation according to the dose of tobacco taken. However, the effects are larger among those who are under the use of tobacco than on those who are under abstinence.²⁶

When indentifying complaints, some cases of difficulties in concentrating were presented so strong that the individual could not perform the activity. *When I am not smoking, I feel difficulties in typing and concentrating [...]*. *I didn't smoke and went to my course, and I couldn't assimilate anything [...]* (GB); *[...] I feel a little air-headed, sometimes I passed two blocks away and I didn't see what I was looking for [...]* *my memory failed me and I feel from the stairway, I still haven't understood what happened, it is as if my mind had been gone [...]* (GA).

Difficulties to start and keep one's attention for long periods of time is an important nicotine abstinence symptom, as it hinders performing routinely activities and upsets those who are trying to restrict the amount of tobacco intake.²⁷ Therefore, identifying the complaints and discussing them are essential actions in group approaches.

"The challenges for a change", the OG enabled revisiting and sharing difficulties from individuals who went under the abstinence syndrome, which usually led to smoking and decreased chances in succeeding in the cessation process. *It's very hard not to smoke in the morning [...]* *The desire to smoke is unbearable [...]*. *The afternoon period is the most difficult for me because I go to sleep at midnight [...]* (GA); *[...] coping with the symptoms of memory lost and dizziness caused by the cigarette [...]* (GB).

The abstinence syndrome is distinguished by a compound of symptoms that are gathered in many different ways and presents variable severances. This syndrome occurs when under the relative or absolute abstinence of a psychoactive substance that has been consumed for a prolonged period. The beginning and evolution of the syndrome are limited in time and depend on the dose and the category of the substance consumed before the consumption cessation or reduction.²⁸

Many people are not able to quit tobacco use as they presented more difficulties in face of the nicotine abstinence syndrome symptoms. This condition determines a certain consumption profile and identifying it among tobacco users might enable actions and strategies for coping with the problem.⁵ Hence, the group proposal has a view to approach abstinence as a reality that intensifies, acknowledging the fragilities in the tobacco cessation process.

Another discussion revisited by individuals was that tobacco consumption is opportunistic in all situations, whether good or bad, masking the real dimension of the problem. *I am putting the blame of not quitting on my grandson's absence [...]. We think the cigarette solves problems, but it is an illusion, it doesn't help at all [...]* (GB).

As contextualized in the prior subcategory, the relationship with the cigarette as a friend and simultaneously as an enemy assumes a contradictory meaning for tobacco users who see it as a source of pleasure and support. Under another point of view, it is also a source of social and human damage. Regarding this last issue, the negative points are the low social tolerance to smokers and health complications.⁷ The social environment, especially the work environment, has played an important role as motivator or obstacle in tobacco cessation, under this contradictory dimension. *It is difficult to quit smoking in an environment filled with smokers and my job is in a bar [...]. I can't take it anymore, if there is a person smoking next to me, I have to smoke [...]* (GA).

Regarding the decisions regarding interrupting cigarette use, work environments are presented as the factor favoring or abolishing the desire for tobacco consumption. Hence, it is presented as an item that deserves higher attention in implementing tobacco free environment policies.²⁹

Also, the feeling of anxiety deposited on routinely relations and demonstrated in cigarette consumption emerged: *I am very anxious, when I'm working I don't smoke, but I feel like going home*

to smoke, mostly because I live by myself [...]. I was concerned about a party, I couldn't take it and I smoked [...] (GA). Reports about anxiety are frequent in medical-psychological follow-ups on people who intend to stop smoking, representing a relevant comorbidity for the planning and effectuation of the tobacco cessation process.³⁰

The work proposal in OG is the elaboration of group anxiety, understood by the pichoniana modality as "fear of loss" (depressive anxiety) of existing structures and the "fear of attack" (paranoid anxiety) of a new situation. This later, originated from new structures in which the person is presented as hesitant due to a lack of instruments in coping with the new situation. The process is analyzed by the interplay of OG roles, the emergence of the representative of anxiety, between the depositary, o depositor and deposited, which is the content of anxiety.¹⁰

Understanding group anxiety allows for re-evaluating stereotyped structures and rethinking reality. It represents a movement of learning, as within the OG there is a possibility of exploring experiences, affections, knowledge around tobacco use, feelings, and practice in the individual and group setting, in face of the problem involving health issues and its psychic, social, economic and environmental reach.

While learning, the association between nicotine dependence and alcohol consumption emerged. *When I drink, I smoke more [...]* (GA). Some chemical substances work as triggers to the use of other substances. This present study emphasized the association between problem alcohol consumption and tobacco use.³¹ However, identifying these triggers for tobacco use is perceived as learning in the OG proposal.

Moreover, within the learning process, individuals worked the factors that converged into their starting to smoke, as adolescence, curiosity, copying behaviors, rebellion, independence image, among others. *The biggest problem lies on the adolescence, when we are young we don't think we can become addicted, we don't think about the disease, we have no notion of the danger [...]* (GB).

Adolescence is presented as the stage of life that holds higher influence vulnerability and the search for self-assurance.^{16,32} Revisiting one's condition of life enabled the evaluation of the degree of the OG focus on the task, in other words, the pertinence and operation ability of the OG.¹⁰ People approached the individual dimension of the group indicating an opening for a project of changes.

Group discussions were pertinent for behavioral changes. This phenomenon was observed by means of coping strategies expressions for the alteration in tobacco consumption patterns by reducing consumption and by the challenges for the materialization of these measures. Regarding the attempts on postponing the use, we emphasize: [...] *I set on the clock and control myself not to smoke [...]. I walk, take a shower, drink coffee and only after all this I smoke the first cigarette [...]* (GA); [...] *I am not smoking anymore when I wake up. I have the first cigarette around 8 o'clock. [...]. I smoke the first cigarette at 10, the second one after lunch [...]* (GB).

Among the strategies of tobacco cessation while the treatment, group postponing is one of the chosen methods to mitigating anxiety.³³ Another strategy based by the program is the sudden stop, based on sudden cessation, by choosing a date from which the consumption is completely interrupted.

Guidelines on the strategies to replace smoking represented a significant moment during the group session, as they offered participants the possibility of coping with abstinence and, gradually, substitute the cigarette by something healthier. Hence adhesion to treatment situations was observed: [...] *I will make cigarettes of carrots [...]. I use cloves, ginger and citric fruits [...]. I place the toothpick in my mouth, it is relieving [...]* (GA); *drink water, a lot of water makes me smoke less [...]. I use a candy; it helps me with the craving for smoking [...]* (GB).

Among the aspects that can help on tobacco cessation, family support and from the closest people stand out mitigating the risk factors during the process.²⁹ [...] *If I have someone to talk, then I don't smoke [...]. I have a lot of support from my wife, she is very understanding and she asks me to let go of the cigarette and stay with her, no pressure, just pure motivation [...]* (GA).

The religious factor was also seen as important during tobacco cessation, configuring a protection and strengthening factor for staying abstinent. *The church helps me a lot, I don't even remember about the cigarette [...]* (GA). Compliance to religious patterns includes a compound of values, behaviors and social practices that culminate in the acceptance or refusal of the use of alcohol and other drugs.³⁴

It is understood that many sectors, including social, should be involved in the care for smokers, due to the complexity of the use and abuse of psychoactive substances issue. The support and ability of health teams also stimulate the interruption of consumption, and may determine if the smoker

stays under treatment and feels motivated to enjoy the benefits originated from tobacco cessation. *I remember I am in the group and I decrease cigarette consumption [...]* (GB); [...] *after I left that group, I didn't smoked again, I spent two mornings without smoking [...]* (GA).

The motivation of smokers in tobacco cessation is part of a psychological process; therefore the role of health professionals is to accelerate and keep it, contributing for more health promotion and grievances prevention related to tobacco.³¹ Regarding the group setting, it was demonstrated as retaining the needs of participants. The phenomenon named as belonging, or a sense of belonging to a certain group, strengthens each one's purposes in favor of a common objective.¹¹

One line among participants deserves emphasis and demonstrates the capacity of the group in promoting the construction of a comprehensive view of health: [...] *It is about showing that healthy life is composed of a compound among the psychological, the physical and the social [...]* (GB).

As one of the motivations for the individuals in this study to smoking cessation is the improvement of health, building a broaden concept of health becomes necessary. A concept that goes beyond the promotion of health, policies and the healthy environment entities, and is the acknowledgement of social, economic, political, and cultural aspects. These are all determining factors in the health-disease process.³⁵

CONCLUSION

This present study has approached the new dimensions around coping with tobacco use, based on group work and the OG technology. The experiment explored the context of tobacco use and the determining factors during tobacco cessation, and also the means of coping with this complex condition.

The relevant point was the quality achievements represented by the learning of participants. Individuals demonstrated changes represented by the cigarette conception, revisiting their own life process related to the consumption and, under a critical reading, built the project of changes and adjustment of the stereotyped behavior. What once was a self-destructive dependence became the motivation for self-care and coping with anxiety.

A condescending and new factor was the concern of smokers with environmental pollution caused by cigarettes; the pollution occurring since

the moment of production, by deforestation, until the moment of consumption, reducing the quality of air within environments.

The group presented a distinguished character for being composed mainly by people from 50 to 60 years of age; experienced individuals with a differentiated view of tobacco as they already present the consequences of consumption or as they have already experienced having family members or friends who had health damages. This factor can be a limiting factor for the research, therefore more studies are recommended with the use of OG on the Tobacco Control Program (PNCT) for future interactions.

Considering these achievements and limitations and, associated to the 78% index of tobacco cessation, the OG technology is recommended in conducting group actions on the Tobacco Control Program (PNCT) as a coping proposal to a challenging issue as the reduction of tobacco consumption.

ACKNOWLEDGEMENTS

We thank the State of Goiás Research Foundation (*Fundação de Amparo à Pesquisa do Estado de Goiás - FAPEG*) for the financial support in performing research regarding the theme Use and Abuse of Tobacco, Alcohol and Other Drugs.

REFERENCE

1. World Health Organization. Reducing risks, promotion healthy life: the world health report 2002 [online]. Geneva (CH): World Health Organization; 2002 [cited 2012 Jul 03]. Available from: http://www.who.int/whr/2002/en/whr02_en.pdf
2. World Health Organization. WHO Report on the global tobacco epidemic 2008 [online]. Geneva (CH): World Health Organization; 2008 [cited 2011 Mai 15]. Available from: http://whqlibdoc.who.int/publications/2008/9789241596282_eng.pdf
3. Instituto Brasileiro de Geografia e Estatística (BR). Pesquisa Nacional por amostra de domicílios: pesquisa especial de tabagismo [online]. Brasília (DF): Ministério do Planejamento, Orçamento e Gestão; 2008 [acesso 2012 Jul 03]. Disponível em: <http://www.ibge.gov.br/home/estatistica/populacao/trabalhoerendimento/pnad2008/suplementos/tabagismo/petab2008.pdf>
4. Ministério da Saúde (BR). Instituto Nacional de Câncer. Coordenação de Prevenção e Vigilância. Abordagem e tratamento do fumante - consenso 2001 [online]. Brasília (DF): Instituto Nacional de Câncer; 2001 [acesso 2012 Jul 03]. Disponível em: http://www.inca.gov.br/tabagismo/publicacoes/tratamento_consenso.pdf
5. Rossaneis MA, Machado RCB. Cessação do tabagismo em pacientes assistidos em um ambulatório de tratamento de dependência do tabaco. *Cienc Cuid Saúde* 2011 Abr-Jun; 10(2):306-13.
6. Eckerdt NS, Corradi-Webster CM. Sentidos sobre o hábito de fumar para mulheres participantes de grupo de tabagistas. *Rev Latino-Am Enfermagem*. 2010 Mai-Jun; 18(Spe):641-7.
7. Veloso NS, Rodrigues CAQ, Leite MTS, Ottoni JLM, Veloso GCC, Rodrigues RM et al. Tabagismo: a percepção dos fumantes em um grupo de educação em saúde. *Rev Bras Med Fam Comunidade*. 2011 Jul-Set; 6(20):193-8.
8. Cavalcante TM. O controle do tabagismo no Brasil: avanços e desafios. *Rev Psiquiatr Clín*. 2005 Set-Out; 32(5):283-300.
9. Bastos ABBI. A técnica de grupos-operativos à luz de Pichon-Rivière e Henri Wallon. *Psicólogo em Formação*. 2010 Jan-Dez; 14(14):160-9.
10. Pichon-Rivière E. O processo grupal. 8ª ed. São Paulo (SP): WMF Martins fontes; 2009.
11. Gayotto MLC, editor. Liderança II: aprenda a coordenar grupos. Rio de Janeiro (RJ): Vozes; 2003.
12. Fagerstrom KO. Measuring degree of physical dependence to tobacco smoking with reference to individualization of treatment. *Addict Behav*. 1978; 3(3-4):235-41.
13. Bardin L. Análise de conteúdo. 3ª ed. Lisboa (PT): Edições 70; 2009.
14. Ramos D, Soares TST, Viegas K. Auxiliando usuários de uma unidade de saúde a parar de fumar: relato de experiência. *Cien Saude Colet*. 2009 Jan-Fev; 14(1):1499-505.
15. Martins KA, Pontes AEB, Fornés NS. Caracterização de fumantes em tratamento para abandono do tabagismo e seu perfil de consumo alimentar. *Brasília Med*. 2009 Jul-Set; 46(3):228-40.
16. Lima MS, Viegas CAA. Avaliação do grau de ansiedade, depressão e motivação dos fumantes que procuraram tratamento para deixar de fumar no Distrito Federal. *Rev Bras Cancerol*. 2011 Jul-Set; 57(3):345-53.
17. Echer IC, Menna BSS, Motta GCP. Fatores que contribuem para o abandono do tabagismo. *Rev Gaucha Enferm*. 2007 Jul-Set; 28(3):350-8.
18. Neal L, Benowitz MD. Nicotine addiction. *N Engl J Med*. 2010 Jun; 362(24):2295-303.
19. Russo AC, Azevedo RCS. Fatores motivacionais que contribuem para a busca de tratamento ambulatorial para a cessação do tabagismo em um hospital geral universitário. *J Bras Pneumol*. 2010 Set-Out; 36(5):603-11.
20. Ministério da Saúde (BR). Instituto Nacional de Câncer. Fumar: faz mal pra você, faz mal pro planeta

- [online]. Brasília: Ministério da Saúde (BR). [acesso 2012 Jun 27]. Disponível em: http://www1.inca.gov.br/inca/Arquivos/web_folder_campanha_tabagismo_2012.pdf
21. Borges MTT, Simões-Barbosa RH. Cigarro "companheiro": o tabagismo feminino em uma abordagem crítica de gênero. *Cad Saúde Pública*. 2008 Dez; 24(12):2834-42.
 22. Suehara LY, Simone KM. Avaliação do envelhecimento facial relacionado ao tabagismo. *An Bras Dermatol*. 2006 Jan-Fev; 81(1):34-9.
 23. White MA, Peters EN, Toll BA. Effect of binge eating on treatment outcomes for smoking cessation. *Nicotine Tob Res*. 2010 Nov; 12(11):1172-5.
 24. Araújo RA, Oliveira MS, Pedroso RS, Miguel AC, Castro MGT. Craving e dependência química: conceito, avaliação e tratamento. *J Bras Psiquiatr*. 2008 Jan-Abr; 57(1):57-63.
 25. Carter BL, Lam CY, Robinson JD, Paris MM, Waters AJ, Wetter DW. Generalized craving, self-report of arousal, and cue reactivity after brief abstinence. *Nicotine Tob Res*. 2009 Jul; 11(7):823-6.
 26. Conway SG, Roizenblatt SS, Palombini L, Castro LS, Bittencourt LRA, Silva RS et al. Effect of smoking habits on sleep. *Braz J Med Biol Res*. 2008 Aug; 41(8):722-7.
 27. Kozink RV, Lutz AM, Rose JE, Froeliger B, McClernon FJ. Smoking withdrawal shifts the spatiotemporal dynamics of neurocognition. *Addict Biol*. 2010 Oct; 15(4):480-90.
 28. World Health Organization. Classificação Estatística Internacional de Doenças e Problemas Relacionados à Saúde. Décima Revisão (CID-10). 8. ed. São Paulo: EDUSP; 2000.
 29. Meier DAP, Vannuchi MTO, Secco IAO. Abandono do tratamento do tabagismo em programa de município do norte do Paraná. *Espaç Saúde*. 2011 Dez; 13(1):35-44.
 30. Santos JDP. Avaliação da efetividade do programa de tratamento do tabagismo no Sistema Único de Saúde [dissertação]. Porto Alegre (RS): Universidade Federal do Rio Grande do Sul; 2011.
 31. Pillon SC, Jora NP, Amorim GP, Domingos JBC, Santos RA. Tabagismo em usuários de um Centro de Atenção Psicossocial Álcool e Drogas: um estudo piloto. *Acta Paul Enferm*. 2011 Mai-Jun; 24(3):313-0.
 32. Martins KC, Seidl EMF. Mudança de comportamento de fumar em participantes de grupos de tabagismo. *Psic: Teor e Pesq*. 2011 Jan-Mar; 27(1):55-64.
 33. Sé CCS, Amorim WM. Ações de enfermagem frente às implicações clínicas do tabagismo na saúde da mulher. *Rev Eletrôn Saúde Mental Álcool Drog*. [online] 2009 [acesso 2012 Jun 4]; 5(1):1-18. Disponível em: http://www.revistasusp.sibi.usp.br/scielo.php?pid=S1806-69762009000100005&script=sci_arttext
 34. Abdala GA, Rodrigues WG, Torres A, Rio NC, Brasil NS. A religiosidade/ espiritualidade como influência positiva na abstinência, redução e/ou abandono do uso de drogas. *Rev Estud Religião*. 2010 Mar; 10: 77-88.
 35. Lopes MSV, Saraiva KRO, Fernandes AFC, Ximenes LB. Análise do conceito de promoção da saúde. *Texto Contexto Enferm*. 2010 Jul-Set; 19(3):461-8.