Original Article

Smoking Cessation Attempts and Common Strategies Employed

A Germany-Wide Representative Survey Conducted in 19 Waves From 2016 to 2019 (The DEBRA Study) and Analyzed by Socioeconomic Status

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Summary

Background: Clinical guidelines on smoking cessation contain recommendations for various evidence-based methods. The goal of this study was to provide a representative analysis for Germany of the percentage of smokers who try to quit smoking at least once per year, the use of evidence-based methods and other methods of smoking cessation, and potential associations of the use of such methods with the degree of tobacco dependence and with socioeconomic features.

Methods: Data from 19 waves of the German Smoking Behavior Questionnaire (*Deutsche Befragung zum Rauchverhalten*, DEBRA), from the time period June/July 2016 to June/July 2019, were analyzed. Current smokers and recent ex-smokers (<12 months without smoking) were asked about their smoking cessation attempts in the past year and the methods they used during the last attempt (naming more than one method was permitted). The degree of tobacco dependence in current smokers was assessed with the Heaviness of Smoking Index.

Results: Out of 11 109 current smokers and 407 recent ex-smokers, 19.9% (95% confidence interval: [19.1; 20.6]) had tried to quit smoking at least once in the preceding year. 13.0% of them [11.6; 14.5] had used at least one evidence-based method during their last attempt. The stronger the tobacco dependence, the more likely the use of an evidence-based method (odds ratio [OR] = 1.27 [1.16; 1.40]). Pharmacotherapy (nicotine replacement therapy, medication) was used more commonly by persons with higher incomes (OR = 1.44 per 1000 euro/month [1.28; 1.62]). Electronic cigarettes were the most commonly used single type of smoking cessation support (10.2 % [9.0; 11.6]).

Conclusion: In Germany, only one in five smokers tries to quit smoking at least once per year. Such attempts are only rarely supported by evidence-based methods and are thus likely to fail. The high cost of treatment must be borne by the individual and thus fall disproportionately on poorer smokers. It follows that there is an urgent need for evidence-based smoking cessation therapy to be covered by health insurance providers, in order to give all smokers fair and equal access to the medical care they need.

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Although smoking tobacco is the greatest avoidable risk factor for a multitude of diseases (1, 2), 28% of the population in Germany still smokes (3). Smokers are at risk of dying prematurely (on average 10 years earlier than non-smokers) as a result of tobacco consumption (4). In Germany, this affects 125 000 people per year. (5). From middle age, smokers lose about three months of their lifespan for every additional year of tobacco consumption (4). For this reason it is of vital importance for smokers to stop smoking as early as possible, completely, and permanently.

The crucial perpetuating factors for regular tobacco consumption are on the one hand operant and classic conditioning processes that affect behavior. On the other hand, they include the effects of nicotine on the dopaminergic, serotonergic, and noradrenergic transmitter systems—among others—as well as neuroadaptation in the sense of upregulation of the nicotinic acetylcholine receptor (also known as the alpha-4 beta-2 nicotinic receptor), which—among others—is also assumed to be associated with the vegetative withdrawal symptoms (6).

During the first two or more weeks of a quit attempt, smokers experience withdrawal symptoms, with increased irritability, aggressiveness, and edginess. Subjectively they suffer from reduced concentration, disturbed sleep, and a compulsory craving for smoking (7, 8). Unassisted smoking cessation attempts end unsuccessfully within 12 months in 95% of cases. Easy availability of tobacco and a low tolerance threshold regarding withdrawal symptoms—which are experienced as aversive—facilitate an early reuptake of smoking after cessation. A low expectation of coping and a high degree of negative affect are negative predictors for successful smoking cessation (9). Poor socioeconomic conditions reduce the chances of successful smoking cessation, probably in the context of a higher prevalence of smoking in this social group (10, 11).

The German S3 clinical practice guidelines (12, 13) recommend psychotherapeutic and pharmacological support for smoking cessation. This includes personal advice or behavioral counseling—such as brief physician advice, telephone counseling, or intensive behavioral therapeutic individual or group

TABLE 1

Relative weighted rates of use of methods to support the latest attempt to stop smoking in smokers and recent ex-smokers who have made an attempt to stop smoking in the preceding year (multiple selections allowed)

Method	% [95% CI]
a. Brief physician advice	5.3 [4.4; 6.4]
b. Brief advice by a pharmacist	3.1 [2.4; 3.9]
c. Behavioral counseling for smoking cessation (individual or group therapy)	1.2 [0.8; 1.8]
d. Telephone counseling for smoking cessation	0.8 [0.5; 1.3]
e. Nicotine replacement therapy (e.g., nicotine patches) prescribed by a physician	2.8 [2.1; 3.5]
f. Nicotine replacement therapy (e.g., nicotine patches) without prescription	4.9 [4.0; 5.9]
g. Bupropion	0.3 [0.1; 0.7]
h. Varenicline	0.4 [0.2; 0.8]
i. E-cigarette containing nicotine	5.4 [4.5; 6.5]
j. E-cigarette not containing nicotine	5.9 [5.0; 7.0]
k. Smoking cessation app on a smartphone or tablet computer	2.2 [1.6; 2.9]
l. Internet page for smoking cessation	3.0 [2.3; 3.8]
m. The book: "Allen Carr's Easy Way to Stop Smoking"	3.4 [2.6; 4.2]
n. Other book on smoking cessation	3.1 [2.3; 3.9]
o. Hypnotherapy	1.5 [1.0; 2.1]
p. Acupuncture	2.4 [1.8; 3.2]
q. Alternative practitioner	1.7 [1.2; 2.4]
r. Will power	59.7 [57.6; 61.8]
s. Social environment (family, friends, colleagues)	17.4 [15.8; 19.0]
t. At least one evidence-based* method (a, c, d, e, f, g, and/or h)	13.0 [11.6; 14.5]
u. At least one evidence-based* behavioral therapeutic method (a, c, and/or d)	6.9 [5.9; 8.1]
v. At least one evidence-based* pharmacological method (e, f, g, and/or h)	8.2 [7.0; 9.4]
w. Combined evidence-based* behavioral therapeutic + pharmacological method (u & v)	2.1 [1.5; 2.8]
x. Nicotine replacement therapy with or without medical prescription (e and/or f)	7.6 [6.5; 8.8]
y. E-cigarette with or without nicotine (i and/or j)	10.2 [9.0; 11.6]

Explanation: weighted percentage [95% confidence interval]; total sample size $n_w = 2169$ (weighted; unweighted: $n = 2158$);

* evidence-based = conforming to German clinical practice guidelines (12, 13)

therapy—on the one hand, and pharmacotherapeutic support on the other hand. For the latter, the following nicotine replacement therapies are licensed in Germany: nicotine patches, chewing gum, inhalers, oral spray, or lozenges, as well as the medications varenicline and bupropion. A combination of both components—pharmacotherapy and behavioral interventions—is most effective in supporting smoking cessation (14); for example, in a recent randomized trial under routine care conditions (15), abstinence rates of more than 25% after 12 months were achieved in smokers managed in primary care practices. Numerous additional strategies are also used by smokers to assist them in their quit attempt, but the evidence for the effectiveness of these is not clear—such as acupuncture, diverse internet-based counseling services, and apps. Smokers also use

electronic cigarettes (e-cigarettes) to support their quit attempt (1).

It is well known that smokers will make use of evidence-based smoking cessation treatment more commonly and more successfully if the costs are reimbursed (16–18). One explanation is that it is more commonly people on lower incomes who smoke—which also holds true for Germany (1, 19, 20). Unfortunately, treatment costs are not at all, or only partially, reimbursed in Germany (21). Participation in group therapy is subsidized only by some health insurance providers in the sense of a preventive measure, but smokers will have to cover pharmacotherapy all by themselves—even patients with chronic obstructive pulmonary disease, in the context of their disease management program (22).

No current representative data are available on the rates of smokers who try to stop smoking every year, which smoking cessation methods they use, and whether sociodemographic characteristics are associated with this use. The latest larger study is from 2012 (23); it showed that 24% of smokers at the time had made at least one attempt to give up smoking in the preceding 12 months (11% had used nicotine replacement, 5% had received counseling from their doctor, and 8% had used e-cigarettes) (23). Representative data on the status quo and an analysis of trends (with the study method remaining the same) would be important as indicators of the need and effectiveness of public health promotion and political tobacco control measures (such as increases in tobacco taxation).

This study therefore aimed to collect data on:

- The rate of smokers in Germany who made at least one attempt to give up smoking within the preceding year, on average as well as over the course of recent years
- The use of evidence-based methods and other strategies to support these attempts
- Possible associations between using such methods and the degree of tobacco dependency, as well as socioeconomic characteristics.

The data source was the DEBRA study (the German Study on Tobacco Use, www.debra-study.info) (24).

Methods

The DEBRA study was approved by the medical ethics committee of Heinrich Heine-University (HHU) Düsseldorf (ID 5386/R), registered (DRKS00011322), and extensively described in a study protocol (24). In sum, DEBRA is a representative, nationwide, computer-assisted, face-to-face household survey of persons aged 14 or older, who answer general sociodemographic questions as well as questions about smoking behavior. Every other month, a new representative sample of approximately 2000 persons is interviewed in the context of the survey covering several topics. The survey participants are selected by means of multistage, multi-stratified random probability sampling (see study protocol [24]) for details. The survey is being conducted by the market research institute Kantar on behalf of the Institute of General Practice at the HHU. In this article, we present weighted baseline data of the initial three years (19 waves) (June/July 2016 through June/July 2019).

Measuring attempts to quit smoking and withdrawal methods

Current smokers and recent ex-smokers (persons who stopped smoking completely within the preceding 12 months) were asked whether they had undertaken one or more attempts to quit smoking in the preceding 12 months. Persons who had made at least one such attempt were presented with a list of cessation methods and asked to select all methods they themselves had employed during the latest attempt (multiple selections

allowed). Two further questions were asked in connection with this smoking cessation attempt:

- Was smoking reduced before quitting altogether or was it abruptly stopped?
- Was the attempt planned or spontaneous?

Furthermore, current smokers were asked how many cigarettes they smoked per day and how soon after waking up in the morning they smoked their first cigarette. These two responses constitute the Heaviness of Smoking Index (HSI, range from 0 to 6 = highest degree of tobacco dependency) (25), which is regarded as an indicator of the degree of tobacco dependency (>4 points = high dependency [26, 27]). The *e-Questionnaire* provides the precise wording of these questions (translated from the original German). Questions that are asked by default as part of the omnibus survey (age, sex, highest school leaving certificate/diploma, and net household income) are not listed.

Statistical methods

Some data in this article are presented weighted in order to be able to draw conclusions about the prevalence in the population of Germany (weighted data are indicated with “ n_w ”). Details about the weighting of the data are described in the study protocol (24).

For the association of socioeconomic characteristics and the use of evidence-based smoking cessations methods we calculated three multivariable logistic regression models, with different dependent variables:

- Use of any evidence-based method (I)
- Use of any evidence-based form of advice or behavioral therapy (II)
- Use of any evidence-based form of pharmacotherapy (III).

The independent variables that were included were:

- Sex
- Age
- Education (as an ordinal variable with five categories)
- Net household income per capita (as a metric variable with 12 tiers equivalent to €1000 per tier)
- Heaviness of smoking index (HSI)
- Survey wave.

In calculating the net household income per capita, the number of persons in a household was weighted according to their need, in accordance with a recommendation from the Organization for Economic Cooperation and Development (OECD) (28) (details of the calculation are recoded in the Open Science Framework [29]). Since the HSI is calculated—among others—from the number of cigarettes smoked per day, it can be calculated only for current smokers. Recent ex-smokers (3.5% of the proportion of the total sample) were therefore excluded from these analyses.

For the individual analyses we used the data available in each case; persons with missing values were

TABLE 2

Association between tobacco dependency, socioeconomic characteristics, and use of evidence-based^{*1} methods to support the latest attempt to stop smoking in smokers who have made one such attempt in the preceding year (n = 1755^{*2})

Characteristic	(I) OR [95% CI] at least one e.-b. method ^{*1} (II and/or III)	(II) OR [95% CI] at least one e.-b. form of advice/ behavioral therapy ^{*3}	(III) OR [95% CI] At least one e.-b. pharmacotherapy ^{*4}
Male sex (reference = female)	0.92 [0.68; 1.24]	1.15 [0.78; 1.68]	0.83 [0.57; 1.19]
Age in years	1.01 [1.00; 1.02]	1.01 [0.99; 1.02]	1.01 [0.99; 1.02]
Highest school-leaving certificate			
– No qualification (= reference)	1	1	1
– <i>Volks- or Hauptschulabschluss</i> (year 9 lower secondary school certificate)	0.98 [0.37; 2.62]	1.43 [0.33; 6.24]	0.86 [0.25; 2.98]
– <i>Real- or Mittelschulabschluss</i> (year 10 intermediate secondary school certificate)	1.17 [0.44; 3.11]	1.64 [0.38; 7.11]	1.27 [0.37; 4.35]
– School diploma allowing entry to a university of applied science or polytechnic or technical college of applied science or polytechnic or technical college	1.57 [0.52; 4.72]	1.26 [0.24; 6.70]	1.99 [0.51; 7.71]
– A-level equivalent/school diploma allowing entry to university	1.14 [0.41; 3.17]	1.53 [0.33; 7.03]	1.14 [0.31; 4.15]
Net household income per capita in tiers of € 1000 ^{*5}	1.16 [0.96; 1.40]	1.03 [0.80; 1.33]	1.34 [1.07; 1.68]
Degree of tobacco dependency as per HSI scale ^{*6}	1.27 [1.16; 1.40]	1.16 [1.02; 1.30]	1.44 [1.28; 1.62]

Results of multivariable logistic regression models (additionally adjusted for the time points of the survey waves).

^{*1} Evidence-based (e.-b.) = conforming to German clinical practice guidelines (12, 13);

^{*2} n = 147 persons were excluded from our analysis because of missing data.

^{*3} Brief physician advice and/or behavioral counseling for smoking cessation (individual or group therapy) and/or telephone counseling for smoking cessation.

^{*4} Nicotine replacement therapy with/without prescription and/or bupropion and/or varenicline

^{*5} Net household income per capita is shown as a metric variable in 12 tiers equivalent to € 1000 per tier.

^{*6} HSI = Heaviness of Smoking Index (25), scale 0 to 6 (= highest degree of tobacco dependency).

CI, confidence interval; OR, odds ratio

not included in the relevant analysis. Since the study is a face-to-face survey, the overall proportion of missing data is very small (in most questions below 1–2%) and can be explained with the simple fact that those surveyed did not want to or were not able to respond.

Results

A total of 38 751 persons participated in the surveys. Of the 11 109 current smokers and 407 recent ex-smokers, 10 915 ($n_w=10\,918$ weighted) responded to the question about their attempts to stop smoking in the preceding 12 months ($n = 601$; 5.2%, not available).

In the total aggregated observation period ($n_w=10\,918$), 80.1% $_w$ of the respondents had not attempted to stop smoking ($n_w=8748$; 95% confidence interval [79.3; 80.8]) and 19.9% $_w$ ($n_w=2169$; [19.1; 20.6]) had made at least one such attempt (12.8% $_w$), 4.2% $_g$ two attempts, 1.4% $_w$ three attempts, 1.5% $_w$ for our more attempts; all data are weighted.

Of the $n_w=2169$ smokers and recent ex-smokers who had made at least one attempt to give up smoking, 66.0% $_w$ ($n_w=1.432$; [64.0; 68.0]) had abruptly

stopped smoking at their latest attempt, and 32.4% $_w$ ($n_w=702$; [30.4; 34.4]) had reduced their consumption before stopping altogether (1.6% $_w$; $n_w=35$ not available). Furthermore, 57.3% $_w$ ($n_w=1242$; [55.1; 59.4]) had stopped smoking spontaneously, and 39.8% $_w$ ($n_w=864$; [37.8; 41.9]) had planned their quit attempt (2.9% $_w$; $n_w=64$, not available, all data weighted).

The *Figure* shows the time trend in the smoking cessation rate over the observation period (that is, at least one quit attempt in the preceding 12 months). After a rise in the first three survey waves to 33.9% in October/November 2016, the attempt rate dropped and was only 15.8% in the latest survey wave (June/July 2019; all data weighted).

Table 1 shows the weighted frequency of use of various methods to support the latest attempt to stop smoking in current smokers and recent ex-smokers, who had attempted to stop smoking in the preceding 12 months (weighted data). From the list of available methods (*Table 1, e-Questionnaire*; multiple selections allowed), 73.1% $_w$ ($n_w=1585$) had selected one method, 15.3% $_w$ ($n_w=332$) had selected two methods, 7.5% $_w$ ($n_w=163$) had selected three

FIGURE

Time trend in the relative weighted rates of smokers and recent ex-smokers, who over the preceding 12 months undertook at least one attempt to give up smoking (black line). Sample size $n_w = 10\,198$ (weighted; unweighted $n = 10\,915$). Dotted grey line = trend line for the attempt rates (polynomial function, $R^2 = 0.79$), blue line = proportion of smokers in the total population ($n_w = 37\,694$)

methods, and 4.1%_w ($n_w = 89$) had selected four or more methods). Nicotine replacement therapy was the relatively most commonly used single, evidence-based, method, with or without prescription (7.6%_w; $n_w = 164$), followed by brief physician advice (5.3%_w; $n_w = 116$). The relatively most often used, single, non-evidence-based cessation strategy was the e-cigarette, with a total of 10.2%_w ($n_w = 222$), of which 4.3%_w ($n_w = 93$) exclusively e-cigarettes containing nicotine, 4.8%_w ($n_w = 104$) exclusively e-cigarettes not containing nicotine, and 1.1%_w ($n_w = 24$) simultaneously e-cigarettes with and without nicotine.

13.0%_w ($n_w = 282$; [11.6; 14.5]) of smokers and recent ex-smokers had used at least one evidence-based method during their latest cessation attempt (Table 1); 6.9%_w ($n_w = 150$; [5.9; 8.1]) at least one form of advice or behavioral therapy; 8.2%_w ($n_w = 177$; [7.0; 9.4]) at least one form of pharmacotherapy; and 2.1%_w ($n_w = 45$; [1.5; 2.8]) a combination of a form of advice/behavioral therapy and pharmacotherapy (weighted data).

Table 2 shows the association between the degree of tobacco dependency, socioeconomic characteristics, and the use of evidence-based methods to support the latest attempt to stop smoking in current smokers. 17.2%_w of current smokers ($n_w = 298$) reported a high degree of tobacco dependency (16.1%_w of female smokers and 18.2%_w of male

smokers). The use of a form of advice or behavioral therapy (odds ratio [OR] = 1.16 per point on the HSI scale [1.02; 1.30]), and also—to a greater extent—the use of a form of pharmacotherapy (OR = 1.44 [1.28; 1.62]) were associated with the degree of tobacco dependency. Furthermore, pharmacotherapy was used more frequently with increasing net household income per capita (OR = 1.34 per €1000 [1.07; 1.68]). Evidence-based methods were used more frequently with increasing age (OR = 1.01; [1.00; 1.02]). According to our data, associations with sex and level of education were less likely.

Discussion

Smoking cessation is of vital importance in view of the devastating health effects of tobacco consumption. In spite of this, our data show that at best 19% of smokers in Germany make an attempt in a year to stop smoking. In an earlier survey of 2012, the rate was 24% (23), and over the observation period of our study (2016–2019) the rate fell even further, to 15% at the end.

The proportion of smokers who attempt to give up smoking has thus fallen in recent years. A similar trend has been observed in England (30, 31). Only 13% of smokers in Germany used an evidence-based method in their attempt to quit. In England, an earlier study found a rate of 51% (32). Pharmacotherapy is also used much more commonly in aiding tobacco cessation in England: in 48% of attempts, compared

Key messages

- Only 19% of smokers in Germany make at least one attempt to give up smoking in a given year.
- The rate of smokers who make an attempt to quit in a year has been falling in recent years.
- Evidence-based methods are rarely used in supporting attempts to quit smoking; nicotine replacement is most commonly used (in 7% of attempts), followed by brief advice from a physician (5%).
- Evidence-based pharmacotherapy (nicotine replacement preparations, varenicline or bupropion) are mostly used by smokers with higher incomes.
- The e-cigarette is currently the most commonly used smoking cessation aid in Germany (10 %).

with 8% in Germany (32). In the Netherlands, 24% of primary care physicians prescribe pharmacotherapy in the context of smoking cessation counseling (33). In Germany, only 2% of smokers report having been given such a recommendation by their primary care physician (34). An important reason for these differences probably lies in the fact that the treatment costs for smoking cessation in England and in the Netherlands are reimbursed. In Germany, health insurers do not cover the costs of nicotine replacement therapies and medications, and smokers with lower incomes consequently cannot afford these. Since people on lower incomes smoke relatively more commonly than those on higher incomes (1, 19, 20), this state of affairs deserves a critical look, because as a result, the social gradient in the population's health increases further. Cost reimbursement on the other hand could lead to physicians advising their patients more frequently and supporting them in giving up smoking than is currently the case (34).

We found an association between the degree of tobacco dependence and the use of evidence-based advice/behavioral therapy and pharmacotherapy. The rate of smokers in Germany with a high degree of tobacco dependency (17% with HSI >4) is below the European average (21%) (35). A study conducted in Germany in the early 21st century found that smokers with a higher tobacco consumption and higher nicotine dependence attempted to give up smoking more often (36). An English study showed—much like our own study—that attempts to stop smoking are more commonly supported with evidence-based advice/behavioral therapy and pharmacotherapy with increasing degree of tobacco dependence (32). This can be explained by the fact that smokers with a higher degree of dependency and associated withdrawal symptoms experience greater difficulties in giving up smoking by their own efforts and therefore seek help more readily.

Limitations

The present study is subject to some methodological limitations. The method employed by the market research institute does not allow for calculating the response rate. All data in this study are based on participants' self-assessments. Asking for smoking cessation attempts in the preceding 12 months and the cessation methods used may give rise to recall bias because participants may have forgotten cessation attempts that were only short-lived (37). It is also known that attempts using pharmacotherapy are remembered to a greater extent than unassisted attempts (38). The result of both of these factors may be that the attempt rate of 19% in a year was estimated too low.

As far as the evaluation of the information on the use of different cessation methods is concerned, an important limitation lies in the fact that our data do not include any information on adherence.

A final issue relates to the analysis of the association between characteristics of smokers and their use of different evidence-based cessation methods. Such an analysis can usefully only be undertaken while taking tobacco dependency into account, in order to prevent confounding. To this end, we used the HSI, whose shortcoming is, however, that it uses the number of cigarettes smoked per day as input values; we therefore had to exclude recent ex-smokers from our analysis. This group was small, however (n = 407), compared with current smokers (n = 11 109), and it is not plausible that their response behavior should be very different. For this reason we can exclude any relevant bias of the results.

Conclusion

In Germany, the rate of smokers who attempt to stop smoking is falling, and smoking cessation attempts are only too rarely supported with evidence-based methods. Efforts are therefore needed to reduce the continuing high tobacco consumption in Germany. Smokers need to receive better information via well-publicized measures and in the context of medical care about the advantages and available options for tobacco cessation, and evidence-based methods for this purpose should be easily accessible, nationwide, and free of charge.

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Conflict of interest statement

Prof Kotz is the elected representative of the German Society for General Practice and Family Medicine involved in updating the S3 clinical practice guideline "Screening, Diagnostics, and Treatment of Harmful and Addictive Tobacco Use" (AWMF registry No 076–006).

Prof Batra has received funding from Pfizer into a third-party account. He is a behavioral therapist and has developed his own tobacco withdrawal program ("non-smoker in 6 weeks"). He is the coordinator and director of

the named S3 guideline "Screening, Diagnostics, and Treatment of Harmful and Addictive Tobacco Use".

Dr. Kastaun declares that no conflict of interest exists.

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► Supplementary material

eQuestionnaire:
www.aerzteblatt-international.de/20m0007

DEBRA Baseline Fragebogen

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Erklärungen

K.A. = keine Angabe

Variablenlabel sind in hellgrauer Farbe gekennzeichnet.

Fragen, die sich nur auf eine Subgruppe beziehen sind in hellroter Farbe gekennzeichnet.

Anweisungen an den Fragesteller sind in hellblauer Farbe gekennzeichnet.

Fragen/ Statements, die zu einem späteren Zeitpunkt (Folgewellen) oder nur bei einem Teil der Wellen gefragt werden sind in hellgelber Farbe gekennzeichnet.

Prüffragen in hellgrüner Farbe gekennzeichnet

Interviewerhinweise in hellvioletter Farbe

202. Darf ich fragen wie alt Sie sind?

Bitte geben Sie nochmals das Alter ein

Jahre [Wert zwischen 14-99 erlauben] [„keine Angabe“ = 999]

Themawechsel!

1. Welcher der folgenden Zustände trifft am besten auf Sie zu? Bitte beachten, dass das Rauchen von Tabak gemeint ist und nicht von elektrischen Zigaretten oder Tabakerhitzern. [smokerall]

Bitte Liste RV01 vorlegen!

1. Ich rauche Zigaretten, und zwar jeden Tag
2. Ich rauche Zigaretten, aber nicht jeden Tag
3. Ich rauche gar keine Zigaretten, aber ich rauche Tabak in anderer Form (zum Beispiel Pfeife oder Zigarre)
4. Ich habe in den vergangenen 12 Monaten vollständig mit dem Rauchen aufgehört
5. Ich habe vor mehr als einem Jahr vollständig mit dem Rauchen aufgehört
6. Ich habe nie geraucht (nie länger als ein Jahr)
7. K.A.

[Wenn Frage 1 = 1 oder 2 oder 4]

2. Wie viele Zigaretten rauchen Sie normalerweise? Oder, wie viele Zigaretten rauchten Sie normalerweise, bevor Sie mit dem Rauchen aufhörten? Machen Sie bitte nur eine Angabe: geben Sie die Menge pro Tag oder, wenn Sie gelegentlicher Nutzer sind, pro Woche oder pro Monat an. [amountcig]

Für „Weiß nicht“ oder „Keine Angabe“ bitte Button oben anklicken!

1. Anzahl pro Tag: <ganze Zahl> [Einen Wert zwischen 1-999 erlauben]
2. Anzahl pro Woche: <ganze Zahl> [Einen Wert zwischen 1-999 erlauben]
3. Anzahl pro Monat: <ganze Zahl> [Einen Wert zwischen 1-999 erlauben]
4. Weiß nicht
5. K.A.

[Wenn Frage 1 = 1 oder 2]

3. Wie schnell rauchen Sie nach dem Aufwachen Ihre erste Zigarette? [FTNDmorning]

Vorgaben bitte vorlesen!

1. Innerhalb von 5 Minuten
2. 6-30 Minuten
3. 31-60 Minuten
4. Mehr als 60 Minuten
5. Weiß nicht
6. K.A.

[Wenn Frage 1 = 1 oder 2 oder 3 oder 4]

4. Wie viele ernsthafte Versuche haben Sie in den vergangenen 12 Monaten unternommen, mit dem Rauchen aufzuhören? Mit ernsthaftem Versuch meine ich, dass Sie vorhatten nie wieder zu rauchen. Falls Sie im letzten Jahr erfolgreich mit dem Rauchen aufgehört haben oder zurzeit versuchen mit dem Rauchen aufzuhören, zählen Sie dies bitte als Versuch mit. [quitattempts]

[Falls Befragte/r Schwierigkeiten dabei hat, eine ganze Zahl zu nennen, unterstützen Sie ihn bitte dabei eine Zahl zu schätzen.]

1. <Ich habe keinen Versuch unternommen> (INT: Wert „0“ wird automatisch gesetzt) [Rückgabewert = „0“]
2. <Ja, ich habe im letzten Jahr **XX** Versuche unternommen> [Rückgabewert = Eingabe Interviewer, einen Wert zwischen 0-100, bzw. 1-100 wenn Frage 1=4 erlauben]; Prüffrage, wenn unerlaubter Wert.

INT: Wenn bei der Befragte keine genaue Angabe machen kann oder will (z.B. unsicher ist, wie viele Versuche es waren, die Zahl nicht schätzen kann) bitte folgende Antwortoptionen vorlesen:

3. <Ja, ich habe im letzten Jahr Versuche unternommen (=mindestens einen), weiß aber nicht genau wie viele> (INT: Wert „9998“ wird automatisch gesetzt) (Rückgabewert = „9998“)
4. <k.A.> (INT: Wert „9999“ wird automatisch gesetzt) (Rückgabewert = „9999“)

Check, wenn ungültiger Wert „Sind Sie sicher, dass die von Ihnen gemachte Angabe korrekt ist? (ja/nein)“ Bei "Ja" weiter mit der nächsten Frage. Bei "Nein": Wiederholung der Frage 25 und eventuell Korrektur der Angabe.

[Wenn Frage 4 > "0" oder wenn Frage 4 = "9998"]

Bitte drehen Sie den Laptop so, dass die/der Befragte mit auf den nächsten Bildschirm sehen kann.

5. Welche der folgenden Sachen haben Sie bei diesem letzten Versuch unternommen, um Ihren Rauchstopp zu unterstützen? [Mehrfachnennung möglich] [quitattempts]

Gibt es noch etwas anderes, das Sie zur Unterstützung genutzt haben?

1. Kurzberatung durch eine Ärztin/ einen Arzt
2. Kurzberatung durch eine Apothekerin/ einen Apotheker
3. Verhaltenstherapeutische Behandlung zur Rauchentwöhnung (zum Beispiel Einzel- oder Gruppentherapie)
4. Telefonische Beratung zur Rauchentwöhnung
5. Nikotinersatztherapie (zum Beispiel Nikotinpflaster) auf Rezept von Ärztin/ Arzt
6. Nikotinersatztherapie (zum Beispiel Nikotinpflaster) ohne Rezept
7. Zyban (Bupropion)
8. Champix (Vareniclin)
9. E-Zigarette mit Nikotin
10. E-Zigarette ohne Nikotin

22. Tabakerhitzer (zum Beispiel iQOS oder heatsticks, Glo oder Ploom tech)
11. App zur Rauchentwöhnung auf einem Smartphone oder Tablet PC
12. Internetseite zur Rauchentwöhnung
13. Allen Carr's Buch "Endlich Nichtraucher!"
14. Anderes Buch über Rauchentwöhnung
15. Hypnotherapie
16. Akupunktur
17. Heilpraktiker
18. Eigene Willenskraft
19. Soziales Umfeld (Familie, Freunde, Kollegen)
20. Sonstiges
21. K.A.

Bitte den Laptop so drehen, dass die/der Befragte nicht mehr mit auf den Bildschirm sehen kann!

[Wenn Frage 4 > "0" oder wenn Frage 4 = "9998"]

6. Erinnern Sie sich bitte an Ihren letzten Versuch mit dem Rauchen aufzuhören. Haben Sie erst weniger geraucht, bevor Sie vollständig mit dem Rauchen aufgehört haben? [quitattemptabrupt]

Vorgaben bitte vorlesen!

1. Erst weniger geraucht
2. Direkt vollständig aufgehört, ohne erst weniger zu rauchen
3. K.A.

[Wenn Frage 4 > "0" oder wenn Frage 4 = "9998"]

7. Erinnern Sie sich bitte an Ihren letzten Versuch mit dem Rauchen aufzuhören. Auf welche der folgenden Weisen haben Sie dies getan? [quitattemptplanned]

Vorgaben bitte vorlesen!

1. Ich habe den Versuch geplant, und zwar für einen späteren Zeitpunkt des gleichen Tages oder für einen zukünftigen Tag
2. Ich habe den Versuch in dem Moment unternommen, in dem ich den Entschluss fasste, mit dem Rauchen aufzuhören.
3. K.A.