

ความสัมพันธ์ระหว่างการทำหน้าที่ของครอบครัวและสถานะการเลิกสูบบุหรี่ของผู้ที่มีหรือเคยมีประวัติติดยาสูบในกองตรวจโรคผู้ป่วยนอก โรงพยาบาลพระมงกุฎเกล้า

Association Between Family Functioning and Smoking Cessation Status among Smokers in Outpatient Department, Phramongkutklao Hospital

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กองตรวจโรคผู้ป่วยนอก โรงพยาบาลพระมงกุฎเกล้า

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บทคัดย่อ

การวิจัยครั้งนี้เป็นการศึกษาแบบภาคตัดขวาง มีวัตถุประสงค์เพื่อประเมินความสัมพันธ์ระหว่างการทำหน้าที่ของครอบครัวและสถานะการเลิกสูบบุหรี่ของผู้ที่มีหรือเคยมีประวัติติดยาสูบในกองตรวจโรคผู้ป่วยนอก โรงพยาบาลพระมงกุฎเกล้า รวมถึงสำรวจความแตกต่างด้านลักษณะการสูบบุหรี่และทัศนคติของครอบครัวต่อการสูบบุหรี่ระหว่างผู้ที่ยังสูบบุหรี่อยู่และเลิกสูบบุหรี่ได้สำเร็จแล้ว กลุ่มตัวอย่างประกอบด้วยผู้เข้าร่วม 51 คน ได้แก่ ผู้สูบบุหรี่ปัจจุบัน 27 คน และผู้เลิกบุหรี่แล้ว 24 คน (เลิกนานแล้ว 19 คน เลิกไม่นาน 5 คน) การเก็บข้อมูลใช้แบบสอบถามโครงสร้างซึ่งรวบรวมข้อมูลด้านสังคมประชากร ประวัติการสูบบุหรี่ ทัศนคติของครอบครัว และการทำงานของครอบครัวโดยใช้แบบสอบถาม Chulalongkorn Family Inventory (CFI) การวิเคราะห์ข้อมูลใช้สถิติ Chi-square สำหรับตัวแปรเชิงกลุ่ม และ Mann-Whitney U test สำหรับตัวแปรเชิงปริมาณ พร้อมด้วยการวิเคราะห์ถดถอยโลจิสติกเพื่อประเมินความสัมพันธ์ระหว่างคะแนน CFI และสถานะการเลิกบุหรี่

ผลการศึกษาพบว่า ผู้เลิกบุหรี่มีอายุมากกว่า แต่งงานมากกว่า มีการศึกษาสูงกว่า และมักทำงานนอกภาครัฐมากกว่าผู้สูบบุหรี่ ($p < 0.05$) ขณะที่ไม่พบความแตกต่างอย่างมีนัยสำคัญในด้านลักษณะการสูบบุหรี่และทัศนคติของครอบครัวต่อการสูบบุหรี่ คะแนนรวม CFI อยู่ในระดับดี (มัธยฐาน 108, IQR 101–118) โดยผู้เลิกบุหรี่มีคะแนนด้านการแก้ปัญหา (20 เทียบกับ 17, $p = 0.021$) และบทบาท (11 เทียบกับ 10, $p = 0.014$) สูงกว่าอย่างมีนัยสำคัญ การวิเคราะห์ถดถอยโลจิสติกพบว่าโอกาสเลิกบุหรี่เพิ่มขึ้นต่อการเพิ่มขึ้น 1 คะแนนในด้านการแก้ปัญหา (OR 1.27, 95% CI 1.037–1.556, $p = 0.021$) และด้านบทบาท (OR 1.748, 95% CI 1.121–2.724, $p = 0.014$) สรุปได้ว่า อายุ การสมรส ระดับการศึกษา อาชีพ รวมถึงการทำงานของครอบครัวที่ดีโดยเฉพาะด้านการแก้ปัญหาและบทบาท มีส่วนสำคัญต่อความสำเร็จในการเลิกบุหรี่ และควรนำมาพิจารณาในการออกแบบโปรแกรมช่วยเลิกบุหรี่

คำสำคัญ: การเลิกสูบบุหรี่, การทำงานของครอบครัว, ทัศนคติของครอบครัว, ปัจจัยทางสังคมประชากร, การแก้ปัญหาและบทบาทในครอบครัว

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Abstract

This cross-sectional study determined the association between family functioning and smoking cessation status among smokers in the Outpatient Department, Phramongkutklo Hospital, and explored differences in smoking characteristics and perceived family attitudes toward smoking between current smokers and smokers who had successfully quit smoking. Fifty-one participants were enrolled: 27 current smokers and 24 quitters (19 remote, 5 recent). Sociodemographic data, smoking history, family attitudes, and family functioning (Chulalongkorn Family Inventory [CFI]) were collected via a structured questionnaire. Categorical variables were analyzed with Chi-square tests, continuous variables with Mann–Whitney U tests, and logistic regression was used to assess associations between CFI scores and smoking cessation status.

Quitters were significantly older, more often married, more highly educated, and more likely to work outside the government sector than current smokers (all $p < 0.05$). Smoking-related characteristics and perceived family attitudes toward smoking did not differ significantly between groups. Overall, family functioning was good (median total CFI 108, IQR 101–118). Quitters had higher CFI Problem Solving scores (20 [18–21] vs 17 [15–20], $p = 0.021$) and Role scores (11 [10–11] vs 10 [8–11], $p = 0.014$). Logistic regression indicated increased odds of quitting per one-point increase in Problem Solving (OR 1.27, 95% CI 1.037–1.556, $p = 0.021$) and Role (OR 1.748, 95% CI 1.121–2.724, $p = 0.014$). These findings suggest that older age, being married, higher education, non-government employment, and stronger family functioning—particularly in problem solving and role performance—are associated with successful smoking cessation and may inform the design of cessation programs.

Keywords: Smoking cessation, Family functioning, Family attitudes, Sociodemographic factors, Problem solving and family roles

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Introduction

Smoking is widely known as a major risk factor for many diseases, including cancers affecting different organs, heart disease, stroke, and chronic obstructive pulmonary disease (COPD). It also causes addiction and can worsen mental health problems.

In Thailand, smoking rates have been declining for more than a decade. The 2024 Survey on Smoking and Drinking in the Thai Population (Thailand National Statistical Office, 2025) reported a smoking prevalence of 16.5% among those aged 15 years or older, compared with 21.2% in 2007. Even so, smoking remains one of the leading causes of poor health in the country and continues to contribute to serious illness, early death, and economic loss (Tobacco Control Research and Knowledge Management Center, 2023) (Komonpaisarn, 2022).

Nicotine addiction is influenced by several factors. Physically, nicotine activates receptors in the brain (nicotinic acetylcholine receptors) that trigger the release of dopamine. This produces feelings of pleasure and improved concentration, which reinforce smoking and lead to addiction. Other factors also play a role, including psychological, social, and cultural influences. The Theory of Triadic Influence (Flay, 1999) groups these into three main areas: (1) personal factors, such as genetics and personal beliefs; (2) social factors, such as family, friends, and colleagues; and (3) broader cultural and environmental factors, such as social norms, government policies, and religion.

Families are a central part of society and shape how people think and behave. It is reasonable to assume that family members have an important influence on whether a person starts, continues, or quits smoking. Research from other countries (Alves, Perelman, Ramos & Kunst, 2022) (Cho, Jang, Shin, Nam & Park, 2023) (Adler, Abu Arar, Yehoshua, Cohen, Hermoni Alon, Shahar et al, 2023) supports this idea, showing that family relationships can affect smoking initiation, continuation, and cessation. One study (Xia, Gong, Wang, Li & Mao, 2022) also found that poorer family functioning was associated with a greater tendency to relapse. In Thailand, many studies have looked at factors affecting smoking, but relatively few have focused on family relationships. One study (Sornpaisarn, Parvez, Chatakan, Thitiprasert, Precha, Kongsakol et al, 2022) found that having a child or grandchild encouraged smokers to quit.

At present, there is no record of smoking prevalence among patients receiving care at the Outpatient Department of Phramongkutklao Hospital. However, physicians have observed that a considerable number of patients report a history of smoking, underscoring the need for routine brief smoking cessation advice as part of conversation. Although incorporating family influence into smoking cessation counseling is relatively easy, it is often neglected in clinical practice. Evaluating family functioning may also help anticipate whether a patient is more likely to succeed or relapse, allowing physicians to tailor their advice and plan follow-up more appropriately. This study therefore seeks to

determine the importance of family influence in smoking cessation counseling and to highlight the potential benefits of positive family involvement in cessation programs.

Objectives

- To examine association between family functioning and participants' current smoking cessation status.
- To compare sociodemographic characteristics, smoking behaviors, and perceived family attitudes between current smokers and those who had successfully quit smoking.
- To analyze factors associated with smoking cessation

Hypotheses

- Better family functioning is associated with a higher likelihood of successful smoking cessation.
- Sociodemographic factors such as older age, marital status, higher education, and non-government employment may influence smoking cessation outcomes.

Conceptual Framework

This conceptual framework illustrates the relationship between independent and dependent variables. Independent variables include sociodemographic characteristics (age, sex, marital status, education, occupation), smoking-related characteristics (nicotine dependence, age of initiation, quit attempts), and family functioning domains measured by the Chulalongkorn Family Inventory (CFI). The dependent variable is smoking cessation status (current smoker vs. quitter). The framework reflects how family functioning and other influencing factors may affect cessation outcomes.

Research Design

This study employed a cross-sectional design (Analytic Cross-sectional Study) to investigate the association between family functioning and smoking cessation among adults attending the Outpatient Department of Phramongkutklao Hospital.

Study Population and Participants

The study population included adults aged ≥ 18 years with a history of smoking (≥ 100 cigarettes in a lifetime or daily smoking for at least 30 consecutive days). Inclusion criteria were: (1) current or former smokers, (2) ability to read and understand Thai, and (3) provision of informed consent. Exclusion criteria included: (a) current use of other tobacco products, (b) severe or life-threatening medical conditions, and (c) inability to complete questionnaires. Based on prior findings from Parwatha et al. (2020), the required sample size was calculated at 30 participants; after accounting for potential dropouts, a final total of 51 participants (27 current smokers and 24 quitters) were enrolled.

Research Instruments

- Structured Questionnaire: Researcher-developed and adapted from prior studies. Collected demographic and smoking-related information (age, sex, marital status, occupation, smoking history, quit attempts). The six-month threshold was chosen based on the Transtheoretical Model of Behavior Change, which identifies six months of abstinence as a marker of stable cessation (Prochaska, 1984).
- Thai Version of the Fagerström Test for Nicotine Dependence (FTND): Assessed nicotine dependence; previously validated with good reliability (Klinsophon, Janwantanakul & Thaveeratitham, 2017).
- Family Attitudes Question: Measured perceived family views toward smoking on a 5-point Likert scale. This item was adapted from Nagawa et al., who assessed perceived family and peer attitudes toward tobacco use using a 5-point Likert scale ranging from very positive to very negative. Their study found that participants perceiving negative family or peer attitudes toward smoking were more likely to report smoking cessation within the past 30 days (12%) than those perceiving positive or neutral attitudes (7%). (Nagawa et al., 2022)
- Chulalongkorn Family Inventory (CFI): Developed by Prof. Umaporn Trangkasombat based on the Family Assessment Device (FAD). Evaluated family functioning across seven domains (Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, Behavior Control, and General Functioning). Higher scores indicate stronger family functioning. The CFI has been demonstrated to have good reliability and validity in Thai populations (Trangkasombat, 2001).

Data Collection

Eligible participants were recruited at the outpatient clinic by the investigator with assistance from medical personnel, including physicians, nurses, and nursing aides, who had been briefed on the study procedures. Although the sample was not selected through fully random sampling, efforts were made to approach individuals across a broad range of age groups. After obtaining written informed consent, they completed the questionnaires either by themselves or with assistance from trained staff. Data were collected anonymously and securely stored. Data were collected over a period of 7 months, from December 2025 to June 2026.

Data Analysis

Data were analyzed using SPSS version 26.0 (IBM Corp., Armonk, NY, USA). Descriptive statistics were used to summarize demographic and clinical characteristics. Group comparisons between smokers and quitters were performed using Chi-square tests for categorical variables and Mann–Whitney U tests for continuous variables. Logistic regression was used to assess associations between family functioning scores and cessation status, with odds ratios (OR) and 95% confidence intervals (CI) reported. A p-value <0.05 was considered statistically significant.

Ethical Considerations

This study followed the principles of the Declaration of Helsinki. All participants provided written informed consent after being informed of the study's purpose, procedures, risks, and benefits. Confidentiality was maintained throughout the study. The study protocol was reviewed and approved by the Institutional Review Board of the Royal Thai Army Medical Department (Project No. R108q/67).

Results

Of the 51 participants, 27 (52.9%) were current smokers and 24 (47.1%) were quitters. Among the quitters, 19 (37.3%) were remote quitters (abstinent for more than 6 months) and 5 (9.8%) were recent quitters.

There were statistically significant differences between smokers and quitters with respect to age, marital status, education level, and profession (all $p < 0.05$). Compared to current smokers, individuals who had quit smoking were generally older, more likely to be married, better educated, and less likely to be employed in the government sector. No statistically significant differences were observed in smoking-related characteristics or in participants' perceptions of their family's attitude toward smoking. (Table 1)

Overall, participants demonstrated good family functioning. The median (IQR) total CFI score was 108 (101–118). Median subscale scores were: Problem Solving – 19 (16–21), Communication – 15 (13–17), Role – 10 (9–11), Affective Responsiveness – 15 (13–17), Affective Involvement – 14 (11–17), Behavior Control – 12 (10–12), and General Functioning – 27 (24–30).

Significant associations with family functioning were noted in the Problem Solving and Role subscales. Quitters had higher Problem Solving scores (20 [18–21]) compared with smokers (17 [15–20], $p = 0.021$) and higher Role scores (11 [10–11]) compared with smokers (10 [8–11], $p = 0.014$). Logistic regression analysis confirmed these associations: Problem Solving (OR 1.27, 95% CI 1.037–1.556, $p = 0.021$) and Role (OR 1.748, 95% CI 1.121–2.724, $p = 0.014$) were both associated with increased odds of quitting. (Table 2)

Table 1. Demographic data, smoking characteristics and family attitude

Characteristics	Overall (N=51) n (%)	Current Smokers (N=27) n (%)	Quitters (N=24) n (%)	p-value
Age				
18-35 years	31 (60.8)	23 (85.2)	8 (33.3)	<0.001
36-59 years	13 (25.5)	4 (14.8)	9 (37.5)	
More than 60 years	7 (13.7)	0 (0.0)	7 (29.2)	

Table 1. Demographic data, smoking characteristics and family attitude (Cont.)

Characteristics	Overall (N=51) n (%)	Current Smokers (N=27) n (%)	Quitters (N=24) n (%)	p-value
Sex				
Male	45 (88.2)	23 (85.2)	22 (91.7)	0.473
Female	6 (11.8)	4 (14.8)	2 (8.3)	
Marital Status				
Single	25 (49)	19 (70.4)	6 (25.0)	0.001
Married	24 (47.1)	6 (22.2)	18 (75.0)	
Divorced	2 (3.9)	2 (7.4)	0 (0.0)	
Education Level				
Below elementary school	2 (3.9)	2 (7.4)	0 (0.0)	0.031
Elementary school	4 (7.8)	0 (0.0)	4 (16.7)	
Junior high school	14 (27.5)	10 (37.0)	4 (16.7)	
High school	17 (33.3)	8 (29.6)	9 (37.5)	
Bachelor's degree	11 (21.6)	7 (25.9)	4 (16.7)	
Master's degree	3 (5.9)	0 (0.0)	3 (12.5)	
Profession				
Government official	31 (60.8)	22 (81.5)	9 (37.5)	0.006
Freelance laborer	4 (7.8)	2 (7.4)	2 (8.3)	
Agriculture worker	2 (3.9)	0 (0.0)	2 (8.3)	
Business owners	2 (3.9)	0 (0.0)	2 (8.3)	
Merchant	2 (3.9)	2 (7.4)	0 (0.0)	
Retired government official	3 (5.9)	0 (0.0)	3 (12.5)	
Others	7 (13.7)	1 (3.7)	6 (25.0)	
Income				
<5,000 THB	2 (3.9)	0 (0.0)	2 (8.3)	0.181
5,000 – 10,000 THB	15 (29.4)	11 (40.7)	4 (16.7)	
10,000 – 30,000 THB	26 (51)	13 (48.1)	13 (54.2)	
30,000 – 70,000 THB	7 (13.7)	3 (11.1)	4 (16.7)	
>70,000 THB	1 (2)	0 (0.0)	1 (4.2)	
Number of Family Members				
2	9 (17.6)	3 (11.1)	6 (25.0)	0.211
3	13 (25.5)	5 (18.5)	8 (33.3)	
4	10 (19.6)	6 (22.2)	4 (16.7)	
≥5	19 (37.3)	13 (48.1)	6 (25.0)	
Alcohol				
Regular	14 (27.5)	8 (29.6)	6 (25.0)	0.895
Occasional	28 (54.9)	14 (51.9)	14 (58.3)	
Never	9 (17.6)	5 (18.5)	4 (16.7)	

Table 1. Demographic data, smoking characteristics and family attitude (Cont.)

Characteristics	Overall (N=51) n (%)	Current Smokers (N=27) n (%)	Quitters (N=24) n (%)	p-value
Co-morbidities				
No	39 (76.5)	23 (85.2)	16 (66.7)	0.12
Yes	12 (23.5)	4 (14.8)	8 (33.3)	
Age of smoking Initiation				
<18 years	25 (49)	12 (44.4)	13 (54.2)	0.488
18-35 years	26 (51)	15 (55.6)	11 (45.8)	
Years of Smoking				
<10 years	30 (58.8)	20 (74.1)	10 (41.7)	0.064
11-20 years	15 (29.4)	5 (18.5)	10 (41.7)	
21-30 years	6 (11.8)	2 (7.4)	4 (16.7)	
Number of Cessation Attempt(s)				
0	6 (11.8)	3 (11.1)	3 (12.5)	0.915
1	19 (37.3)	9 (33.3)	10 (41.7)	
2-5	17 (33.3)	10 (37.0)	7 (29.2)	
>6	9 (17.6)	5 (18.5)	4 (16.7)	
(Quitters) Self-cessation or With Assistance				
Self-cessation	24 (47.1)	0 (0.0)	24 (100.0)	24 (47.1)
(Quitters) Cold Turkey or Gradually Stop				
Cold Turkey	16 (31.4)	0 (0.0)	16 (66.7)	
Gradually Stop	8 (15.7)	0 (0.0)	8 (33.3)	
(Current smokers) Number of Cigarettes Smoked Per Day				
<10	12 (23.5)	12 (44.4)	0 (0.0)	
11-20	15 (29.4)	15 (55.6)	0 (0.0)	
(Current smokers) Time to First Cigarette				
More than 60 minutes	8 (15.7)	8 (29.6)	0 (0.0)	
31-60 minutes	4 (7.8)	4 (14.8)	0 (0.0)	
6-30 minutes	7 (13.7)	7 (25.9)	0 (0.0)	
Within 5 minutes	8 (15.7)	8 (29.6)	0 (0.0)	
(Current smokers) Smoking more frequently on First Hour of Waking Up				
No	17 (33.3)	17 (63.0)	0 (0.0)	
Yes	10 (19.6)	10 (37.0)	0 (0.0)	
(Current smokers) Hardest Cigarette to Give Up				
Other cigarettes during the day	13 (25.5)	13 (48.1)	0 (0.0)	
First few cigarettes	14 (27.5)	14 (51.9)	0 (0.0)	

Table 1. Demographic data, smoking characteristics and family attitude (Cont.)

Characteristics	Overall (N=51) n (%)	Current Smokers (N=27) n (%)	Quitters (N=24) n (%)	p-value
(Current smokers) Difficulty in Refraining from Smoking in Forbidden Places				
No	19 (37.3)	19 (70.4)	0 (0.0)	
Yes	8 (15.7)	8 (29.6)	0 (0.0)	
(Current smokers) Smoking Even If Sick in Bed Most of the Days				
No	24 (47.1)	24 (88.9)	0 (0.0)	
Yes	3 (5.9)	3 (11.1)	0 (0.0)	
(Current smokers) Fagerstrom Test Score				
0-2 (Very Low)	7 (13.7)	7 (25.9)	0 (0.0)	
3-4 (Low)	14 (27.5)	14 (51.9)	0 (0.0)	
5-6 (Medium)	2 (3.9)	2 (7.4)	0 (0.0)	
7 (High)	4 (7.8)	4 (14.8)	0 (0.0)	
Family Attitude				
Very negative	11 (21.6)	6 (22.2)	5 (20.8)	0.756
Negative	21 (41.2)	11 (40.7)	10 (41.7)	
Neutral	18 (35.3)	10 (37.0)	8 (33.3)	
Positive	1 (2.0)	0 (0.0)	1 (4.2)	

Table 2. Family functioning scores as measured by CFI

Family Functioning Domain	Overall Median (P25- P75)	Current Smokers Median (P25- P75)	Quitters Median (P25- P75)	p-value	OR (95%CI)
Problem Solving					
(PS)	19 (16-21)	17 (15-20)	20 (18-21)	0.021*	1.27 (1.037-1.556)
Communication					
(C)	15 (13-17)	15 (12-17)	16 (14-18)	0.06	1.284 (0.99-1.666)
Role (R)	10 (9-11)	10 (8-11)	11 (10-11)	0.014*	1.748 (1.121-2.724)
Affective					
Responsiveness					
(AR)	15 (13-17)	15 (12-16)	17 (15-18)	0.095	1.203 (0.968-1.495)
Affective					
Involvement (AI)	14 (11-17)	12 (11-17)	16 (10-17)	0.958	0.996 (0.848-1.169)
Behavior Control					
(BC)	12 (10-12)	12 (10-13)	12 (10-12)	0.397	0.868 (0.626-1.204)
General					
Functioning (GF)	27 (24-30)	27 (22-28)	27 (25-30)	0.104	1.133 (0.975-1.316)

Discussion

This study compared current smokers and quitters receiving care at the outpatient department of Phramongkutklo Hospital and found some clear sociodemographic differences alongside selective associations with family functioning. Quitters were more likely to be older, married, better educated, and employed outside government sectors. These patterns align with plausible life-course and social support explanations: older adults may have greater health concerns and more exposure to cessation advice; marriage can provide accountability and day-to-day encouragement; and higher education level often correlates with better access to health information and services (Ruokolainen, Härkänen, Lahti, Haukkala, Heliövaara & Rahkonen, 2021) (Effendi et al, 2024). The association with non-government employment may reflect workplace norms (Lowenstein, Dow & White, 2020), flexibility, or cessation supports (Lin, Li, Chen, Liu, Lin, Liu et al, 2021) that differ from government settings, though this finding may also be confounded by age, education and certain personal contexts.

Notably, smoking-related characteristics and perceived family attitudes toward smoking did not differ between groups. The single-item measure of “family view on smoking” may have been too coarse (Faseru, Richter, Scheuermann & Park, 2018) to capture meaningful variation, especially in households where opinions differ across members or where social desirability affects responses. In contrast, more detailed assessment of family functioning with the CFI revealed associations concentrated in the Problem Solving and Role domains (Guo, Liu, Wang et al, 2023). Quitters scored higher on both subscales, and each one-point increase was associated with higher odds of being a quitter (Problem Solving OR 1.27; Role OR 1.75). These domains map closely to practical processes that can support quitting: families that identify problems early, plan around triggers, share tasks, and maintain clear expectations may help a smoker anticipate high-risk situations, structure routines (e.g., mealtimes, commutes) to minimize cues, and stay engaged with treatment or follow-up. The absence of between-group differences in other CFI domains, combined with generally good overall CFI scores, suggests a potential ceiling effect or that problem-solving and role-clarifying skills are the most relevant aspects of family functioning for cessation in this context.

This study has limitations. The cross-sectional design limits causal inference; families may become more organized after a successful quit rather than drive it. The sample was modest and drawn from a single outpatient clinic, limiting generalizability and reducing power for subgroup analyses (e.g., recent vs. remote quitters). Self-reported measures may be affected by recall and social desirability biases, and the single-item family-attitude question likely lacked sensitivity. Finally, although logistic regression supported the associations for Problem Solving and Role, residual confounding by age, marital status, education, and employment cannot be excluded given the sample size and limited covariate adjustment.

Research Suggestions/Recommendations

Suggestions for Application

Two strategies for intervention that can be used clinically can be deduced from the results. First, demographic patterns (older age, marriage, higher education) highlight subgroups that may need tailored outreach—e.g., younger, unmarried adults or those with fewer educational opportunities—who might benefit from more intensive counseling and navigation support. Second, the CFI results suggest that integrating brief, family-oriented components into cessation care—such as problem-solving training, clarifying household roles during quit attempts, and involving a partner or key family member in planning and follow-up—could be useful even when general family attitudes toward smoking appear neutral or supportive (Faseru, Richter, Scheuermann & Park, 2018) (Whitton, McLeish, Godfrey, James-Kangal & Rhoades, 2020).

Suggestions for Future Research

Future research should include larger, more demographically diverse samples and recruit participants from multiple clinical settings to improve generalizability. Longitudinal and prospective studies are needed to clarify the temporal relationship between family functioning and smoking cessation. Future studies should also use more detailed measures of family influence, distinguish between recent and long-term quitters, and better control for potential confounding variables. Lastly, intervention-based research is warranted to evaluate whether family-oriented approaches, particularly those targeting family problem solving and role performance, can improve smoking cessation outcomes and sustain abstinence over time.

Conclusion

This study suggests that older age, being married, having higher educational background and not working in government sectors may positively influence smoking cessation outcomes. In terms of family functioning, stronger performance in problem solving and role responsibilities appears to be associated with a greater likelihood of quitting smoking. However, the findings should be interpreted with caution due to the small sample size and the predominance of younger male participants. Future research with larger, more demographically diverse samples and conducted in varied settings is warranted to confirm these associations. Despite these limitations, the observed factors may be valuable considerations when designing or implementing smoking cessation programs.

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