Published in final edited form as:

Subst Use Misuse. 2015 ; 50(8-9): 1199–1204. doi:10.3109/10826084.2015.1007757.

A perspective on cigarette smoking during alcohol and substance use treatment

Timothy J. Grigsby, Myriam Forster, and Steve Sussman

Abstract

Individuals in treatment for substance use continue to smoke at higher rates than the general population of the United States. This editorial presents a different perspective on cigarette smoking that might reflect aspects of the subculture of individuals who, representing a heterogeneous population, smoke while recovering from substance use associated problems. We discuss factors that independently and, in combination, influence cigarette smoking during treatment and recovery from substance use. We conclude that more qualitative research is needed to understand which factors, not typically emphasized in standard tobacco cessation programming, may contribute to cigarette smoking cessation for this population.

In 2012, 18.1% of adults reported smoking cigarettes as compared to 1964 when population based estimates indicated that approximately 40% of adults in the United States (U.S.) were smoking (Center for Disease Control and Prevention, 2014; Department of Health Education and Welfare, 1964; US Public Health Service, 1964). This substantial decline evidences the effectiveness of the tobacco control policies enacted as a response to the chain of events stemming originally from the first Surgeon General's report on the hazards of tobacco use. However, these reductions are not uniform with several subgroups still reporting higher rates of cigarette smoking than the general population. Individuals in treatment for, or recovery from, alcohol and substance use disorders¹ are one group that continues to use tobacco (cigarette smoking) at rates that concern health practitioners.² In fact, a recent review of 42 empirical papers on addiction treatment programs³ for multiple substances from 1989

Address all correspondence to: Timothy J. Grigsby, Department of Preventive Medicine, Institute for Health Promotion and Disease Prevention Research, University of Southern California, 2001 North Soto Street, 3rd floor, Los Angeles, CA 90032, Telephone: 949-923-1499 FAX: 626-442-8201, tjgrigsb@usc.edu.

¹The reader is reminded that the diagnosis of a "substance use disorder" (SUD) is a relatively new diagnosis which is based upon a consensus-based taxonomy (American Psychiatric Association: Washington, DC, *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)*, 5th Ed.; 2013) In order that any diagnosis be useful for treatment planning it should "offer", minimally, three critical, necessary types of information: etiology, process and prognosis...which are not always known. Secondly, a diagnosis, when demystified, is simply the outcome of a reliable and relevant information-gathering process to be used for necessary decision making. Thirdly, the underpinnings for diagnostic criteria can be theory-driven, empirically-based, individual and/or systemic stakeholder-bound, based upon "principles of faith", etc. All-too-often the needs or agendas of the classifier (individuals as well as systems) are not adequately considered or noted. Lastly, whereas all diagnoses are taxonomy categories or labels, all labels are not diagnoses. The SUD, given all of the aforementioned, may be a flaw and a barrier to effective intervention planning. Editor's note.

²The reader is asked to consider the implications of such "concern" rarely being translated into tobacco use being a focus in most "specialized addiction" treatment programs, whatever their ideological positions and identification. A conceptual flaw? Editor's note.

³Treatment can be briefly and usefully defined as a unique, planned, goal directed, temporally structured, multi-dimensional change process, of necessary quality, appropriateness and conditions (endogenous and exogenous), which is *bounded* (culture, place, time, etc.), associated with a range of stakeholders with agendas, and can be categorized into professional-based, tradition-based, mutual-help based (AA, NA, etc.) and self-help ("natural recovery") models. There are no unique models or techniques used with substance users- of whatever types and heterogeneities- which aren't also used with non-substance users. Whether or not a treatment technique is

through 2005 found that the prevalence of tobacco use among persons in recovery ranged between 65% and 87.2% (Guydish et al., 2011).

This phenomenon has gained considerable research attention. For many decades, the predominant belief guiding substance user treatment approaches was that cigarette smoking should not be addressed in the early phases of treatment for fear that incorporating tobacco cessation into the treatment protocol might overwhelm individuals experiencing withdrawal symptoms from alcohol and drugs (Sussman, Forster, & Grigsby, in press). It was thought that intervening on smoking too early in the recovery process could potentially remove a coping mechanism, or soothing agent, for the anxiety and discomfort associated with withdrawal thereby increasing, rather than decreasing, relapse rates. Moreover, cigarette smoking could ostensibly be addressed later in the recovery process after individuals had successfully transitioned through the most difficult and sensitive phases of recovery and entered a more stable period. This assumption was not totally unreasonable given that many treatment providers must address the myriad of acute psychological, physical, social, economic, and legal problems that accrue after years of sustained drug and/or alcohol use. However, Sees and Westley Clark (1993) argued against this assumption and presented findings that suggest individuals entering substance user treatment facilities actually do express an interest in quitting smoking concurrent to receiving treatment for other substance use related problems. Despite this finding and a pattern of similar results in other studies (e.g., Martin et al., 2006; Baca & Yahne, 2009; Ramo, Prochaska, & Myers, 2010), there is no consensus on whether cigarette smoking should be addressed upon entry into a treatment facility or initial utilization of treatment services. The ongoing lack of emphasis on smoking cessation interventions in such treatment services, globally, can be considered a conceptual and planning flaw for treatment providers. Findings regarding the efficacy of tobacco cessation efforts in early recovery have also demonstrated inconsistent long-term effects on smoking cessation (Sussman, 2002; Prochaska, Delucchi, & Hall, 2004; Guydish et al., 2012).

The goal of this paper is to present a somewhat different perspective on cigarette smoking that might reflect an unexplored aspect of the subculture of individuals who smoke while recovering from substance use problems. Our expectation is that this piece may 1) assist researchers by providing some insight as to why (a subset of) individuals in recovery may resist tobacco cessation efforts, 2) contribute to the eventual development of novel intervention approaches that are sensitive to the complexity and diversity of issues inherent to the recovery process, and 3) stimulate awareness of an ongoing flaw in the actual and potential roles of discipline-associated biases and identification with specific treatment

indicated or contra-indicated, and what are its selection underpinnings (theory-based, empirically-based, "principle of faith-based, tradition-based, etc.) continues to be a generic and key treatment issue. In the West, with the relatively new ideology of "harm reduction" and the even newer Quality of Life (QOL) and wellbeing treatment-driven models there are now new sets of goals in addition to those derived from/associated with the older tradition of abstinence driven models. Conflict-resolution models may stimulate an additional option for intervention. Each ideological model has its own criteria for success as well as failure as well as iatrogenic-related harms. Treatment is implemented in a range of environments; ambulatory as well as within institutions which can include controlled environments Treatment includes a spectrum of clinician-caregiver-patient relationships representing various forms of decision-making traditions/models; (1) the hierarchical model in which the clinician-treatment agent makes the decision(s) and the recipient is compliant and relatively passive, (2) shared decision-making which facilitates the collaboration between clinician and patient(s) in which both are active, and (3) the 'informed model' in which the patient makes the decision(s). Editor's note

ideologies (e.g., abstinence, harm reduction, quality of life, wellbeing, reconciliation) in the treatment planning, implementation and assessment process.

“As psychiatrists have often observed, defiance is the outstanding characteristic of many an alcoholic.....” – From the *Big Book of Alcoholics Anonymous*

The literature on tobacco use has found that cigarette smokers are more likely to rate themselves as having a greater need for autonomy, rate themselves higher on risk taking, and have a stronger predisposition towards novelty seeking than non-smokers (Simon & Primavera, 1976; Kreek, Nielson, Butelman, & LaForge, 2005). Currently, cigarette smoking as a social construct is perceived as being a non-normative risk-taking behavior that has been successfully stigmatized to curtail the number of new initiates, especially adolescents (US Department of Health and Human Services, 2012). From a health promotion and disease prevention framework this has been an effective messaging strategy; however, from another vantage point it offers fertile ground—especially for individuals who on principle are not “joiners”—for self-expression. In general, humans strive to be liked and accepted by their peers, but for individuals who may never have felt they “fit in,” or do not desire to fit in, social disapproval is not very persuasive. In fact, it may even elicit a strong desire to reject a particular, widespread behavioral norm that appears too conservative or demanding (i.e., may elicit a “strange” reactance effect). As anti-tobacco policies become more widespread, the symbolic significance of smoking as a sign of independent defiance might increase. Put simply, smoking could be a true rebels' sanctuary. While in treatment or recovery a new—or already established—outlet (tobacco use) may provide individuals with a) access to a neurochemical stimulant that does not dramatically alter behavior, b) engagement in a behavior that symbolically (to the person in recovery) reaffirms independence and autonomy, and c) an opportunity to openly reject the restricted range of acceptable, normative behaviors proscribed by society. It is an outward display of defiance, creating a *de facto* separation from the mainstream, and is among the few substances that will not manifest in the immediate physical, psychological, social, or legal harms of one's drug of choice (e.g., alcohol, opiates, cocaine).

This “defiance” does come with a terrible cost. However, that cost is delayed and perhaps can't compete with the perceived benefits of tobacco use for the person entering recovery. Disinhibition is commonly defined as a lack of restraint, an inability to think through the consequences of actions, or a prioritizing of short over long-term goals. Disinhibition, a commonly observed characteristic among substance users, can lead to patterns of behavior that reflect a disregard for social convention, heighten vulnerability for risky behaviors, and facilitate poor risk assessment (Krueger et al., 2002).

“Rebellion dogs our every step.....” –From the *Big Book of Alcoholics Anonymous*

Some of the earliest public perceptions of smokers took the form of a rebel: the loner, the drifter, the troublesome teen, and the rebel without a cause (e.g., the 1967 novel, “The Outsiders” by S.E. Hinton). While not entirely accurate, there is a shred of truth in this perception. Rebellion is defined as multidimensional construct embodying 1) open defiance of, or resistance to, an established authority structure, and 2) exhibiting behaviors that support such defiance or resistance. Generally, rebellion is an act *against* a dominant belief or group to *resist* the influence or power that the one group has over another group or

individual. Although resistance models are usually applied to power differentials between dominant – and non-dominant groups (Fordham & Ogbu, 1986; Factor, Kawachi, & Williams, 2011), many addicts and alcoholics report difficulties interacting with individuals that adhere to social and behavioral norms, have experienced stress and/or trauma as results of these interactions, and have either been excluded from, or chosen to, reject mainstream societal norms. Ultimately, this subset of alcoholics and addicts may come to perceive themselves as being members of an “outsider group” (Sussman, Pokhrel, Ashmore, & Brown, 2007). This outsider group identity may include drug use experimentation as a bonding agent among youth. Arguably, this “out-group” may be defined by characteristics, behaviors, values and world-views uncommon among one's peers. It is possible that this sense of identity carries forward throughout the life course, and continues to influence behaviors, such as cigarette smoking, that serve as a source of bonding.

Negative health behaviors may also manifest as a result of general mistrust in social institutions, often related to repeated negative experiences with service providers and law enforcement agents. For instance, Connors (1995) has proposed that IV drug users may not adopt safe injection practices because of their mistrust of “the system,” and Jackson and Knight (2006) argue that self-destructive behaviors can become a form of coping with stressful living conditions caused by structural inequities. Populations that perceive high levels of mistreatment, stigmatization, and marginalization may adopt attributes and behaviors that over time become a “lifestyle” and an integral part of one's “personality.” Resistance can be thought of as a global trait with many facets governing social interactions, behaviors, and the cognitive appraisal of events. Research on resistance to treatment, and the development of motivational interviewing (Miller, Rollnick & Moyers, 1998), demonstrates how clinicians have helped patients focus on their goals depending on their level of readiness to change a behavior as a means of dealing with resistant personalities. Utilizing these therapies to develop person-centered treatments that address one's level of resistance is an avenue of exploration to curb cigarette smoking during or following treatment for other substance use problems (e.g., Baca & Yahne, 2009).

“We loved to have people call us precocious.” –From the *Twelve steps and Twelve Traditions of Alcoholic Anonymous*

A crucial component in the consensualized and traditionalized treatment of alcohol and substance use disorders is facilitating a close examination of the acute and long term effects of misuse to oneself, important others, one's community, and society. This therapeutic process can help an individual grasp that the loss of self-respect, the fractured or broken relationships with family and friends, financial mismanagement, inability to sustain employment, and/or find joy or satisfaction are direct consequences of drug seeking behaviors and the cognitive, affective, and behavioral changes caused by repeated use. There are several barriers to establishing a clear, well-defined link between tobacco use and self harm or harm to others.⁴ First, the biological and physiological symptoms of tobacco related disease do not manifest for many years making it difficult to perceive quitting as a necessary

⁴The reader is referred to Hills's insightful criteria for causation which were developed in order to help assist researchers and clinicians determine if *risk factors* were causes of a particular disease or outcomes or merely associated. (Hill, A. B. (1965). The environment and disease: associations or causation? *Proceedings of the Royal Society of Medicine* 58: 295-300.). Editor's note.

action. Second, individuals in treatment or recovery tend to remain in environments where smoking is a commonplace behavior among others in recovery and treatment staff alike (Guydish et al., 2007; Guydish et al., 2011) that can reaffirm tolerant subcultural normative beliefs about smoking. These environments can maintain smoking behavior for many years among persons entrenched in recovery. Finally, to be a smoker in the U.S. is to be counted among a “marginal in-group”, and this incongruity may be important in understanding the motivation to use cigarettes in, and after, initial treatment.

Belonging to a small, unique group of recovering individuals tends to be expressed by adopting similar values, behaviors and identification that are distinct from other groups. In recovery circles, non-recovering (i.e., non-using or normal using) individuals are sometimes referred to as “normies.” For example, sometimes people in recovery will talk with astonishment about how a “normie” left a glass half full of wine on a table at a restaurant when exiting. Individuals in recovery, for whom such behavior would be extraordinary, find humor in their own inability to practice such behavior. This language highlights the collective struggle that strengthens the ties between recovering individuals, but also emphasizes the unique characteristics of the group. Recovering individuals tend to find themselves in a new phase of life where they no longer identify with alcohol, other “drugs,” or other drug users, but may also feel estranged from non-users. Even in long-term sobriety, former users are conscious of having exited one social milieu (their old network of drinking/drug using peers) or community, but that they are “different” from their colleagues or members of their current social networks who are not in recovery. That distinction is due to a chronic, life threatening disorder that can have profound, long-term consequences. At times smoking may subjectively help them to feel *as if* they are able to straddle these two worlds by engaging a familiar behavior that produces a comforting physiological sensation but does not (apparently) damage their recovery from mood altering substances.

Conclusions

Among the most adaptive traits of individuals manifesting and/or attributed to have socially-constructed “disabilities,” is the development and maintenance of a self-concept that emphasizes the positive, life altering and enriching aspects of problem solving, adaptability, and flexibility inherent in grappling with the “disability” experience, role and identity (Huebner, 2004; Nario-Redmond, Noel & Fern, 2013; Murugami, 2009). Often this redefined self concept is achieved collectively by positively identifying with a group whose members share the “disability” yet have moved *beyond* the impairment model towards an inclusive, less restrictive view of functionality, normalcy, and well being (Linton, 1998; Altman, 2001). However, in the case of recovering peoples smoking may be a behavior that bonds, bridges and defines this subgroup and therefore requires novel, insightful behavior change approaches. There are several factors that motivate individuals to initiate or continue cigarette smoking while in treatment or later in recovery. A “one-size fits all”, “normie” approach to tobacco cessation may not be feasible when implemented in substance user treatment centers. To better understand how to enhance smoking cessation efforts among persons in recovery, we recommend that addiction researchers further utilize qualitative methods to fully understand and address the interplay of complex motivations, internal and external conditions, as well as a range of known and unknown functions, for cigarette

smoking during treatment and recovery from substance use. Interesting preliminary findings from recent qualitative work (de Tormes Eby and colleagues, 2012) indicate positive inpatient behavior change in smoke-free campuses although these were accompanied by an apparent increase in lying to staff about smoking and increased “dealing” of cigarettes among patients. Unfortunately, the interviews were only carried out with clinic staff and the motivations for continuing or quitting cigarette use among clients remains unknown. Clearly individuals in recovery are a heterogeneous group with a proportion willing to adopt no smoking policies while others continue to use cigarettes despite institutional policies.

Nicotine dependence and trying to cope with such factors as anhedonia, negative affect, and/or relative lack of mesolimbic dopaminergic turnover also are important reasons that some persons in recovery fail to quit tobacco use (Sussman & Ames, 2008). However, the interplay of the complex and even contradictory motivations involved in self-harming or health promoting behaviors among recovering populations have not been well-addressed in treatment research. More information about individuals who do not express a desire to quit could guide clinicians towards modifications of existing smoking cessation programs that will maximize long-term quit rates. While qualitative research sometimes tends to be underappreciated, we hope that this paper will motivate researchers to expand current approaches, and engage in interdisciplinary dialogues, to tobacco cessation among vulnerable populations such as this one. Ultimately, to summarize, rather than focusing purely on the health risks of tobacco use and overcoming nicotine dependence, treatment facilities might focus on assisting individuals entering recovery, or other ideologically-informed change processes, to disentangle their self-harming behaviors from their expression of dissatisfaction with or opposition to political, social, or cultural norms.

Acknowledgments

This paper was supported by grants from the National Institute on Drug Abuse (DA020138) and the National Cancer Institute (CA009492).

References

- Altman BM. Disability definitions, models, classification schemes, and applications. *Handbook of disability studies*. 2001:97–122.
- Baca CT, Yahne CE. Smoking cessation during substance abuse treatment: What you need to know. *Journal of Substance Abuse Treatment*. 2009; 36(2):205–219. [PubMed: 18715746]
- Center for Disease Control and Prevention. [November 17, 2014] Cigarette smoking in the United States: Current cigarette smoking among US adults aged 18 years or older. 2014. Retrieved from: <http://www.cdc.gov/tobacco/campaign/tips/resources/data/cigarette-smoking-in-united-states.html>
- Connors MM. The politics of marginalization: The appropriation of AIDS prevention messages among injection drug users. *Culture, medicine and psychiatry*. 1995; 19(4):425–452.
- Department of Health Education and Welfare. Smoking and health: Report of the Advisory Committee to the Surgeon General of the Public Health Service. Washington, DC: U.S. Government Printing Office; 1964.
- de Tormes Eby LT, Sparks TE, Evans E, Selzer JA. A qualitative examination of the positive and negative consequences associated with going tobacco-free in substance abuse treatment: The NY State experience. *Nicotine & Tobacco Research*. 2012 nts027.
- Factor R, Kawachi I, Williams DR. Understanding high-risk behavior among non-dominant minorities: A social resistance framework. *Social Science & Medicine*. 2011; 73(9):1292–1301. [PubMed: 21907476]

- Fordham S, Ogbu JU. Black students' school success: Coping with the “burden of ‘acting white’”. *The Urban Review*. 1986; 18(3):176–206.
- Guydish J, Passalacqua E, Tajima B, Chan M, Chun J, Bostrom A. Smoking prevalence in addiction treatment: a review. *Nicotine & Tobacco Research*. 2011 ntr048.
- Guydish J, Passalacqua E, Tajima B, Manser ST. Staff smoking and other barriers to nicotine dependence intervention in addiction treatment settings: a review. *Journal of Psychoactive Drugs*. 2007; 39(4):423–433. [PubMed: 18303699]
- Guydish J, Ziedonis D, Tajima B, Seward G, Passalacqua E, Chan M, Brigham G. Addressing Tobacco Through Organizational Change (ATTOC) in residential addiction treatment settings. *Drug and Alcohol Dependence*. 2012; 121(1):30–37. [PubMed: 21906892]
- Huebner ES. Research on assessment of life satisfaction of children and adolescents. *Social Indicators Research*. 2004; 66(1-2):3–33.
- Jackson, JS.; Knight, KM. Social structures, aging, and self-regulation in the elderly. New York: Springer; 2006. Race and self-regulatory health behaviors: the role of the stress response and the HPA axis in physical and mental health disparities; p. 189-207.
- Kreek MJ, Nielsen DA, Butelman ER, LaForge KS. Genetic influences on impulsivity, risk taking, stress responsivity and vulnerability to drug abuse and addiction. *Nature Neuroscience*. 2005; 8(11):1450–1457. [PubMed: 16251987]
- Krueger RF, Hicks BM, Patrick CJ, Carlson SR, Iacono WG, McGue M. Etiologic connections among substance dependence, antisocial behavior and personality: Modeling the externalizing spectrum. *Journal of Abnormal Psychology*. 2002; 111(3):411–424. [PubMed: 12150417]
- Linton, S. Claiming disability: Knowledge and identity. NYU Press; 1998.
- Martin RA, Rohsenow DJ, MacKinnon SV, Abrams DB, Monti PM. Correlates of motivation to quit smoking among alcohol dependent patients in residential treatment. *Drug and Alcohol Dependence*. 2006; 83(1):73–78. [PubMed: 16314049]
- Miller, WR.; Rollnick, S.; Moyers, TB. Motivational interviewing. University of New Mexico; 1998.
- Murugami MW. Disability and identity. *Disability Studies Quarterly*. 2009; 29(4)
- Nario-Redmond MR, Noel JG, Fern E. Redefining disability, re-imagining the self: Disability identification predicts self-esteem and strategic responses to stigma. *Self and Identity*. 2013; 12(5): 468–488.
- Prochaska JJ, Delucchi K, Hall SM. A meta-analysis of smoking cessation interventions with individuals in substance abuse treatment or recovery. *Journal of Consulting and Clinical Psychology*. 2004; 72(6):1144. [PubMed: 15612860]
- Ramo DE, Prochaska JJ, Myers MG. Intentions to quit smoking among youth in substance abuse treatment. *Drug and Alcohol Dependence*. 2010; 106(1):48–51. [PubMed: 19699041]
- Sees KL, Westley Clark H. When to begin smoking cessation in substance abusers. *Journal of Substance Abuse Treatment*. 1993; 10(2):189–195. [PubMed: 8510193]
- Simon WE, Primavera LH. The personality of the cigarette smoker: Some empirical data. *Substance Use & Misuse*. 1976; 11(1):81–94.
- Sussman S. Smoking cessation among persons in recovery. *Substance Use & Misuse*. 2002; 37(8-10): 1275–1298. [PubMed: 12180567]
- Sussman, S.; Ames, SL. Drug abuse: Concepts, prevention and cessation. New York, N.Y: Cambridge University Press; 2008.
- Sussman S, Forster M, Grigsby TJ. “First Things First”: What's the first thing? *Substance Use and Misuse*. in press.
- Sussman S, Pokhrel P, Ashmore RD, Brown BB. Adolescent peer group identification and characteristics: A review of the literature. *Addictive Behaviors*. 2007; 32(8):1602–1627. [PubMed: 17188815]
- US Department of Health and Human Services. Preventing tobacco use among youth and young adults: A report of the Surgeon General. Vol. 2. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2012.

U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2014.

US Public Health Service. Smoking and health. Report of the advisory committee to the Surgeon General. DHEW publication (PHS). 1964; 1103

Biographies

Timothy J. Grigsby, B.A.,US, is a doctoral student in Preventive Medicine at the University of Southern California, Keck School of Medicine. His research focuses on adolescent and young adult health behaviors with an emphasis on the conceptualization, measurement and determinants of problem alcohol/drug use.

Myriam Forster, MPH, US, is a doctoral student in Preventive Medicine at the University of Southern California, Keck School of Medicine. The focus of her research is the etiology of interpersonal violence and violence-related behaviors. She has a particular interest translational research that can improve prevention strategies in community-level care settings.

Steve Sussman, Ph.D., FAAHB, FAPA, US, received his doctorate in social-clinical psychology from the University of Illinois at Chicago in 1984. He is a professor of preventive medicine, psychology, and social work at the University of Southern California (USC), and he has been at USC for 30 years. He studies etiology, prevention, and cessation within the addictions arena, broadly defined. He has over 460 publications. His programs include Project Towards No Tobacco Use, Project Towards No Drug Abuse, and Project EX, which are considered model youth prevention or cessation programs at numerous agencies (i.e. CDC, NIDA, NCI, OJJDP, SAMSHA, CSAP, Colorado and Maryland Blueprints, Health Canada, U.S. DOE and various State Departments of Education). He received the honor of Research Laureate for the American Academy of Health Behavior in 2005, and he was President there (2007–2008). Also, as of 2007, he received the honor of Fellow of the American Psychological Association (Division 50, Addictions). He is the current Editor of *Evaluation & the Health Professions* (SAGE Publications).