**Tobacco Awareness grouP Guidelines**

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**Goals:**

* Promote insight into tobacco use behavior
* Identify correlation of tobacco to AOD
* Express a recovery-oriented message
* Promote ambivalence
* Elicit change talk

**Clinical Objectives:**

* Set the Stage - provide a brief overview of the topic of discussion
* Use a client-centered approach to support autonomous motivation
* Emphasize to the group that their verbal contribution is valuable
* Ask the group for their permission to explore the topic
* Approach the topic from the patients’ perspective, experiences, existing knowledge of chemical dependency and drug recovery
* Foster teachable moments
* Establish a group consensus
* Clearly summarize key points of the discussion

**Methods:**

* Motivational Interviewing
* Narrative Therapy
* Psychoeducation

**What Does A Great Facilitator DO?**

* avoids taking sides (neutral position)
* demonstrates confidence and honesty (authenticity)
* is aware of the group mood and behavior of individuals
* demonstrates active and reflective listening
* asks questions that encourages client self-disclosure
* promotes peer to peer dialogue
* has a sense of humor
* can tolerate conflict within the group
* can summarize the discussion simply

**session 1: Tobacco’s Association to AOD Use & Recovery**

**Learning objectives:**

* Identify at least three ways tobacco use is integral to the rituals of using other substances.
* Describe behavioral reinforcement and the shared neurochemical pathways common to all drugs of addiction, including nicotine and the additives in tobacco smoke.
* Identify at least two ways tobacco products have been re-engineered to make them more physically addicting.
* Explain the rationale for improved quality of recovery when stopping tobacco use concurrently with other substances.

**Delivery:**

* Set the stage. Explain that the focus of the session is to explore the role of tobacco use when drinking alcohol and using other drugs.
* Ask for examples of drug use patterns and use reflective listening as patients share their experiences: “Is a cigarette or cigar a part of drinking alcohol or getting high?” “Do you light up the cigarette before, during, or after hitting on the pipe?’” “Is tobacco use sometimes or always part of the ritual?” “Why is it so important…?” [maintains or boosts the high, calms you down] “What if you have a bag of dope, but you don’t have any cigarettes; what do you do?” Use open-ended questions as much as possible and thoroughly explore the thinking and behavior.
* Establish a consensus that for many the use of cigarettes or cigars is a very important part of drinking alcohol and using other drugs. “Would you like to know why this is so?”
* Suggest that the reason we need to challenge our “old views” on tobacco use is because tobacco products have been “re-engineered” to make them more addicting. Describe how additives including ammonia and menthol lead to pairing up tobacco use with other substances.
* Equate the progression of tobacco dependency to other stimulant drugs noting how nicotine promotes the release of dopamine.
* Process how maintaining a pattern of tobacco use increases the probability of relapse to alcohol and other drugs.
* Relate all of the above to the First Step (powerlessness & unmanageability).
* Summarize. Ask each group member for their “take away” from the session.
* Tobacco dependence treatment provided during addictions treatment was associated with a 25% increased likelihood of long-term abstinence from alcohol and illicit drugs (Prochaska et al., *Journal of Consulting and Clinical Psychology*, 2004, Meta-Analysis of 19 Randomized Control Trials with Individuals in Current Treatment or Recovery).
* Nicotine craving and heavy smoking may contribute to increased use of cocaine and heroin (National Institute on Drug Abuse, 2000).
* Nearly one half of all the cigarettes sold in the US are smoked by someone who suffers from a psychiatric and/or a substance use disorder (Lasser, 2000).
* Alcoholics who quit smoking are more likely to succeed in alcoholism treatment (Shiffman & Balabanis, 1996).
* The underlying mechanism of action of menthol is to enable smokers to inhale more nicotine. Inhaling more smoke per cigarette can cause harsh sensations in the throat. Menthol cools that effect, making it easier for larger doses of the poison to go down (Williams et al, 2007). One of the effects of inhaling a higher dose of nicotine per cigarette is that each cigarette becomes more reinforcing and addictive (Foulds, 2010).
* Ammonia is a freebasing agent. Adding ammonia to tobacco mix changes the pH value of the smoke allowing for a faster and higher rate of nicotine delivery [absorption] (Proctor, 2008).
* Nicotine intake primes alcohol consumption (Barrett, Tichauer, & Pihl, 2006; Rose et al., 2004) and alcohol intake acutely increases smoking behavior and nicotine reward (McKee, Krishnan-Sarin, Shi, Mase & O’Malley, 2006; Mitchell, DeWitt, & Zacny, 1995).
* As tobacco smoke enters the lungs, nicotine reaches the brain within seven seconds stimulating the release of large amounts of dopamine. Normally neurons reabsorb neurotransmitters after they have triggered other brain cells (re-uptake). Like cocaine, nicotine prevents re-absorption and leads to a need to re-dose frequently (tobaccorecovery.org, 2008).
* Tobacco affects the dopamine system the same as alcohol, opiates, cocaine, and marijuana (Pierce & Kumaresan, 2006).
* Tobacco use may reduce cocaine-induced paranoia (Wiseman & McMillian, 1996).
* Chronic cigarette smoking compounds both structural and functional alcohol-induced brain impairment. Alcoholic smokers have poorer cognitive functioning relative to their nonsmoking counterparts across a broad range of measures including processing speed, auditory-verbal learning and auditory-verbal memory (Durazzo, Rothlind, Gazdzinkski, Banys, & Meyerhoff, 2006; Friend, Malloy, & Sindelar, 2005).

**background information:**

**session 2: Use or Recovery? Group Decisional Balance Exercise**

**Learning objectives:**

* Identify the costs and benefits of continued use vs. abstinence of alcohol, tobacco and other drugs.
* Recognize that the rationale for recovery has greater long-term value.
* Discover that similar behavioral defense mechanisms are applied to the use of all substances.

**Facilitator Note:**

A facilitated discussion around the decisional balance activity can be particularly helpful to patients who are in the contemplative stage. The main task for the clinician working with the contemplative patient is to help resolve ambivalence. In any tobacco awareness group there will potentially be patients in all stages of change. Soliciting feedback from all group members is desirable. Group members who are further along in their stage of change readiness will share thoughts and insights throughout the group discussion. Other group members still struggling with ambivalence or those who are pre-contemplative will benefit from exposure to peer input and feedback. The facilitator must maintain a neutral position and give equal time to all group members.

**Materials:** A white board or flip chart and markers.

**Delivery:**

* Ask the patients what they recall from the previous tobacco awareness group and summarize the key points.
* Set the Stage. Explain that today we’d like to explore the *thought processes* related to making a decision to use vs. to choose a lifestyle of abstinence and recovery. Ask the patients for their permission to examine the topic as it pertains to drinking alcohol. Acknowledge that it’s important to respect all points of view and emphasize to the group members that their verbal contribution is valuable.
* Divide a marker board into two columns: *Alcohol Use & Alcohol Recovery.*
* Always begin the process by exploring the thinking that would justify alcohol use. Ask the patients to share and explain their examples as you develop a list under the *Alcohol Use* column.
* Maintain a high energy to the group process by using reflective responses as you paraphrase the comments of group members. As the *Alcohol* *Use* column gets larger frequently summarize the list. Before moving onto the *Alcohol Recovery* column, ask the group if they believe the *Alcohol* *Use* list is complete.
* Repeat the process to develop an *Alcohol Recovery* list using reflective responses, paraphrasing and summarization.
* Once the *Alcohol Recovery* list is complete, ask the group members to review and compare both columns to determine if any conclusions can be drawn.

**\*\*\*** Group members will process the costs and benefits for both sustained use and establishing abstinence. A consensus is often made that the *Alcohol Recovery* column lists things that are longer term and of greater importance, i.e. wanting to live, good health, quality relationships, while the *Alcohol* *Use* column lists things that are more reflective of immediate gratification and superficial, i.e. enjoying the taste, the mood-altering effect, submitting to peer pressure. **\*\*\***

* Cross out the word *Alcohol* and insert the word *Tobacco* in the *Use* column. Cite each item listed and ask the group members if the thought process that justifies a drink is the same to justify smoking a cigarette. The group will discover that the thinking is identical.
* Cross out the word *Alcohol* and insert the word *Tobacco* in the *Recovery* column. Cite each item listed and ask the group members if the thought process for embracing sobriety is similar for why one would stop their tobacco use. Once again, the group will discover that recovery thinking is the same for both substances.
* Process with the group “addict thinking;” identify common behavioral defense mechanisms; ask group members of their experiences of how they may have changed their thinking with regard to the use of other substances.
* Emphasize that as we no longer find a need to defend unhealthy methods of coping when we replace them with healthy coping skills.
* Summarize. Ask each group member for their “take away” from the session.

**session 3: Letting Go of Unhealthy Relationships – Stages of Readiness to Change Model**

**Learning objectives:**

* Develop an awareness of the Prochaska & DiClementi Stages of Readiness to Change Model.
* Recognize that ambivalence is a normal and necessary part of behavior change.
* Cite personal examples of past behavior changes to enhance confidence for making additional changes.

**Materials:** A white board or flip chart and markers.

**Delivery:**

* Set the Stage – introduce the topic by asking if anyone has experienced being in an unhealthy relationship. Use reflective listening responses.
* Propose that we become emotionally invested in an unhealthy relationship to a person in a similar way we develop an unhealthy “relationship” to alcohol and drugs. Further explore the concept with the group.
* Write the word “denial” on the top left of a marker board. Ask if anyone can provide a definition of denial as we refer to it in drug treatment. Allow for several responses and establish an agreed upon definition of the group.

**\*\*\*** Denial is a shock absorber for the soul. Until we are emotionally ready to deal with reality, we will find creative ways to avoid reality. **\*\*\***

* Write the word “acceptance” on the top right of the marker board. Ask for a definition, allow for several responses, distinguish the difference between “admitting” and “accepting” and establish an agreed upon definition by the group.

**\*\*\*** When accepting we demonstrate actions to change the behavior. **\*\*\***

* Draw an arrow from the word “denial” to the word “acceptance.” Explain that today’s discussion will explore a “5-stage” process of how we move from being in denial to an unhealthy relationship to a place of acceptance which gives us the willingness and courage to change our behavior and end the relationship.
* Introduce the first stage (Pre-contemplation) by asking if anyone recalls their reaction to the first time someone brought to their attention that their use of alcohol or drugs is a problem. “What did you think when you heard those words for the very first time?” “How did it make you feel?” Patients will report that they did not believe that they had a problem and of becoming angry and defensive. Conclude that (1) in most cases those around us will recognize a problem before we have the ability to see it; and (2) if we don’t see it, there is no reason to believe that a problem exists. Define this concept as “pre-contemplation” or the stage of “before thinking” of having a need to change. Rename the stage “Screw You” and write it on the marker board.
* Write on the board the second stage: “Maybe, Maybe Not” (Contemplation) and relate it to a love/hate concept. Explore with the group their experiences of the pleasure of getting high, yet feeling remorse or guilt after using a drug, ending a relationship and afterward calling or setting up a time to meet with the person, promising a loved one that you will never use again, yet finding yourself getting high only hours after you made the promise. Explain that ambivalence is like a pendulum swinging between thoughts of “love” and “hate.” Process with the group how it feels to be “ambivalent.” Highlight that it’s a normal part of the change process.
* Introduce the third stage “Determination” (Preparation) by writing it on the marker board. Define it as the stage of the process when “we know in our heart and soul that we need to end the relationship.” The willingness to change replaces ambivalence and we become focused on what we need to do in order to end it. Invite the group to offer their personal experiences.
* Identify the fourth stage “Action” and define it as “not only talking the talk, but walking the walk.” Explore with the group action steps that they needed to take to end an unhealthy relationship. Acknowledge that this is a very difficult stage and having the support of others is most helpful.
* Introduce the fifth stage “Used to…” (Maintenance) by writing it on the marker board. Define it as the stage of the process when “we allowed ourselves to be free of the relationship long enough so that we begin to think of it in the past tense: “I used to smoke weed.” or “I used to be with that person, but we’re not together anymore.” Acknowledge that at this time in the process we become comfortable with the change or as it is sometimes stated: “being a grateful recovering addict.”
* Explain how the stages are sequential, fluid and not categorical.
* By using the stage model as a framework ask the group for personal examples of letting go of their relationship to specific substances and people. Does knowing that they were successful in those changes provide hope for additional changes?
* Thoroughly explore with the group how they relate to the model with regard to their relationship to tobacco.

**\*\*\*** Psychological dependence on tobacco = a dependable, long-term, non-judgmental, emotional coping support. People come and go; my cigarette has always been there for me. **\*\*\***

* Summarize: Emphasize that as we identify and embrace healthy coping skills, we will be able to let go of unhealthy relationships to substances.
* Thank the group for their participation and end the session.