

**TOBACCO RECOVERY  
RESOURCE EXCHANGE**

**FACILITATING A  
TOBACCO AWARENESS GROUP**

THE  
**EXCHANGE**  
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## INTRODUCTION

The comprehensive integration of tobacco dependence treatment into the service continuum requires that programs offer assessment of tobacco dependence and provide evidence-based treatment interventions. This includes psychoeducation, in the form of tobacco awareness education for patients, as a way to increase patient knowledge, skills, attitudes, and motivation that contribute to a positive change in substance use behaviors. Additionally, programs need to provide recovery support for patients working toward tobacco abstinence.

The goals of psychoeducation in the context of addiction treatment and recovery are:

- Promote insight into tobacco use behavior
- Identify correlation of tobacco use to alcohol and other drug use
- Talk about the recovery/relapse process
- Identify ambivalence towards tobacco use and elicit change talk

Motivational techniques are effective in helping patients resolve their ambivalence about their tobacco use and move towards healthy change. The techniques and topic areas of the tobacco awareness group help the patient to think differently about their tobacco use. The clinician in the tobacco awareness group does not suggest solutions or teach practical skills, rather, they utilize the tools of Motivational Interviewing such as reflective listening, open-ended questions, affirmations, and summarizing to reduce resistance and elicit change talk from the patients. The more the patient talks about healthy change, the advantages of change, and the disadvantages of change, the more likely it is that change will occur.

By using motivational techniques and group facilitation strategies, the clinician works with patients in a tobacco awareness group (TAG) to resolve their ambivalence about their tobacco use by raising awareness of tobacco related issues and topics. The clinician does not advocate for change, but elicits change talk from the patients, engaging them in the group process. Listed below are several desired outcomes of the tobacco awareness group:

- Normalize and resolve ambivalence
- Raise awareness of tobacco related topics
- Increase motivation to change
- Develop discrepancy
- Help patient move to the next stage of change

It is important for clinicians to understand the difference between a tobacco awareness group and a tobacco recovery group. The clinician in the tobacco awareness group does not tell the patients they need to stop using tobacco or suggest solutions for the patients. The purpose of the tobacco awareness group is to stimulate the patient's thinking, help them to resolve their ambivalence, and move towards healthy change. The tobacco awareness group is about introducing new knowledge and new thinking, while the tobacco recovery group is about taking action and making behavioral changes.

## RE-FRAMING LANGUAGE

To anchor the context and content of tobacco dependence treatment and recovery, we reframe the more familiar public health (cessation) language to language that is more commonly used in the context of addiction treatment and recovery.

This reframing of language is intended to:

- De-normalize and de-glamorize tobacco use in the treatment and recovery culture
- Talk about tobacco use as a biopsychosocial disease
- Talk about tobacco as a drug of choice
- Frame tobacco abstinence as part of one-day-at-a-time recovery

OLD PUBLIC HEALTH/CESSATION TERMINOLOGY	PREFERRED TREATMENT AND RECOVERY TERMINOLOGY
smoking	tobacco dose, tobacco use, tobacco dependence
smoker	tobacco user, person who uses tobacco
habit	chronic disease, addiction, dependence
quit	abstinence, recovery
cessation	treatment, recovery

The content of three topic areas is provided in the format of a script. It is not intended that a clinician use the script verbatim. Rather, each of the three scripts provided should serve as a roadmap. It is expected that counselors will be able to take this material and use it to facilitate tobacco awareness groups in their programs. **Note: the content shown in italics is suggested language the counselor can use when talking with the group.** Additional topics may also be presented in a similar format. The topics included in this resource are:

- Tobacco's Relationship to Alcohol and Other Drug Use and Recovery
- The Path to Healthy Recovery
- The Pros and Cons of Continued Tobacco Use

## **TOBACCO AWARENESS GROUPS: FACILITATION SKILLS TIP SHEET**

### **FACILITATION:**

#### **TO EASE THE COMMUNICATION AMONG AND BETWEEN MEMBERS IN A GROUP**

Are you one of those individuals who begin to panic when someone asks you to “facilitate” a group meeting? Mastering a basic set of skills not only makes you feel more confident and competent, it can also make rising to the challenge a feather in your professional cap.

#### **WHAT DOES A GREAT FACILITATOR DO?**

An effective facilitator helps people both speak to and hear each other in a group situation. A facilitator doesn't exert total control over a group, but rather “applies the grease” when the conversation gets bogged down, or “opens a window” when things get too heated.

The facilitator's primary responsibility is to keep the group on its task. In tobacco awareness groups, the facilitator both presents the topics of discussion and content and helps the members stay focused, encourages their participation, validates individual contributions, and clarifies misunderstandings.

Critically, the facilitator:

- avoids taking sides
- uses the discussion space and time effectively
- demonstrates confidence and honesty (authenticity)
- is not easily distracted
- is aware of the group mood and behavior of individuals
- demonstrates active listening
- asks questions that encourage participants to share more
- has a sense of humor
- can tolerate conflict within the group
- can summarize the discussion simply

#### **GETTING A TOBACCO AWARENESS GROUP OFF THE GROUND**

1. Welcome the members to the group and introduce yourself. Ensure that everyone in the group knows who everyone else is. Have people introduce themselves if they don't know one another.
2. Review the “ground rules” for participation—who will speak, when, and for how long.
3. Review “housekeeping”—who will keep time for the group, the location of the bathrooms, where the exits are, where trash should be deposited, the length and location for any scheduled “breaks.”
4. State the agenda for the meeting: what topic you intend to cover, and how long you expect to spend on each part of the discussion.
5. Proceed to your opening exercise.



**TOBACCO AWARENESS  
GROUP SESSION ONE:**

**TOBACCO'S RELATIONSHIP  
TO ALCOHOL AND OTHER  
DRUG USE AND RECOVERY**



## **FACILITATOR TASKS**

1. State the purpose of the group: discussing tobacco's relationship to alcohol and other drug use and recovery.
2. Acknowledge the traditional role of tobacco use in alcohol and other drug treatment and recovery. (i.e., coffee, cigarettes) while attending twelve-step, self-help meetings.
3. Explore the significance of the role of tobacco use within alcohol and drug use rituals.
4. Share information on how cigarettes have been "re-engineered" to make them more addicting.
5. Equate the progression of AOD dependence to tobacco dependence.
6. Identify the role of tobacco use in the process of AOD relapse.
7. Relate all of the above to the First Step (powerlessness and unmanageability).

## **TOBACCO AWARENESS GROUP SESSION ONE**

## GROUP SCRIPT

### GETTING STARTED

Begin by introducing yourself to the group. Introduce the day's topic. **The content shown in italics is suggested language the counselor can use when talking with the group.**

*The information that we are going to discuss today is about tobacco's relationship to alcohol and other drug use and recovery. As you are well aware, all New York State addiction treatment providers are now assessing and treating tobacco dependence in all chemical dependence service programs. Therefore, we need to challenge the way we have all viewed tobacco use for more than seventy-five years. We will explore the reasons why we are looking at tobacco use in a whole new way.*

Confirm with group members that they understand your explanation thus far. Ask permission to ask them questions about the history of their tobacco use, and the connection to how their tobacco use relates to their alcohol and other drug use.

### **ACKNOWLEDGE THE TRADITIONAL ROLE OF TOBACCO USE IN ALCOHOL AND OTHER DRUG TREATMENT AND RECOVERY (I.E., COFFEE, CIGARETTES) WHILE ATTENDING TWELVE-STEP, SELF-HELP MEETINGS.**

*Tobacco use has been common in Alcoholics Anonymous (AA), the first twelve-step recovery program, since its inception in 1935. Prior to the twelve-step movement, tobacco was commonly addressed in the treatment of alcoholism, a fact that most of us have never really thought about. However, AA's co-founders, Bill Wilson and Dr. Bob Smith and the others in the early movement of AA did not address tobacco in the self-help recovery program. Neither did Jimmy K. and others in the Narcotics Anonymous (NA) movement. Does anyone have ideas as to why the founders of AA and NA may have made the decision not to address tobacco use as a part of their programs?*

(Bill W., Dr. Bob, and Jimmy K. all were heavy tobacco users. Bill W. and Dr. Bob both died because of their tobacco addiction.)

*For many decades, practice wisdom (the idea that treatment should be done in a certain way) was the basis for treatment strategies. That is not to say we throw out the practice wisdom of the past, however, science and research now supports the use of evidence-based practices in the treatment of this chronic disease called tobacco dependence.*

## TOBACCO AWARENESS GROUP SESSION ONE

## EXPLORE THE SIGNIFICANCE OF THE ROLE OF TOBACCO USE WITHIN ALCOHOL AND DRUG USE RITUALS.

*You are probably familiar with the term, “drug of choice,” a term that we have used to describe what we have believed to be the primary drug that a person would choose over any other drug to get high. For some people, that may be alcohol. For others, that may be heroin, or cocaine. Would any of you like to share how tobacco use is very much a part of your drug use ritual?*

Ask if someone is willing to share. Ask what drug they identify as their “drug of choice.” Follow-up by asking if tobacco was very much a part of their drug use ritual. Ask the person who has volunteered to speak if they would describe that experience. You may need to make some clarifying statements and then follow-up with a summarization of what the group member related.

Summarize the information shared by saying, *so every time you drank, or used cocaine, smoking a cigarette was part of the ritual for you.*

Follow up with a series of clarifying questions: *Why? What did tobacco use do for you? Why was it an important part of getting high? Did you ever drink/use without a cigarette being part of the experience?*

So, it was very important to your alcohol or other drug use to have a cigarette be part of that experience. Alternatively, state that: *tobacco was always there. Your tobacco use went hand in hand with your alcohol/heroin/cocaine use.* It is important that your summarizing statement helps the group members come to the realization that “yes, my tobacco use is very important to me.”

Be certain to ask others to share their story (if they are willing) of the association of their tobacco use with their alcohol or drug use. Frame your follow up questions from the position that it is important for you to understand what that relationship meant to each group participant who shares. If no one says that their tobacco use “boosted” their high, you may choose to say that you’ve heard people say *“that smoking a cigarette while using cocaine, or other drug or alcohol, would give them a greater “buzz.”*

After a number of people have shared their experience, you may want to ask the following question: *“What would you do if you had some cocaine or a six pack but didn’t have any cigarettes?”* Generally, most people respond that they would go get some cigarettes before using. Also during this section, one or more group members may disclose that tobacco was actually the first drug that they “picked up” when they were 12, 13, or 14 years old. This provides a point to be explored with the group.

Summarize this section by saying: *From what many of you have just shared; using tobacco is a very important part of your alcohol and other drug use ritual.* Transition to the next point by asking, *“Do you believe that tobacco is addicting?”*

### TOBACCO AWARENESS GROUP SESSION ONE

## **SHARE INFORMATION ON HOW CIGARETTES HAVE BEEN “RE-ENGINEERED” TO MAKE THEM MORE ADDICTING.**

*As many of you have shared, cigarettes have always been there. It almost sounds like perhaps for many of you, tobacco is your drug of choice. Or minimally is a very important part of your alcohol and other drug use. I have found what you have shared to be fascinating. I'd like to share some information with you if that's OK. Some of you may have heard this information before but for many of you it may be new.*

*The cigarette of 2008 is not the same as it was in earlier days. One of the reasons we need to change our thinking about how tobacco use fits into the process of addiction and recovery is because the cigarette of today is a highly engineered drug delivery system. When we talk about how addicting a drug is we are really taking about two things: (1) how the chemical changes or alters our mood, and (2) how reinforcing it is. If we try it once and we like how it feels, we want to do it again. A cigarette is engineered to be highly reinforcing and low in intoxication. So using tobacco is not going to get you the same feeling as hitting on the crack pipe in terms of the way it makes you feel, but we can use them together. That is a reinforcing way as many of you have just described by weaving tobacco use into the rituals of our alcohol and other drug use. Cigarettes are purposely designed not to get us high; they are designed to get us to keep buying them.*

*Back in the 1950's, the tobacco industry wanted to learn how they could increase their sales, so they studied us. They studied people who used alcohol and other drugs. They wanted to understand what happens to a person's brain chemistry when they use heroin, or cocaine or alcohol. They wanted to find what makes use reinforcing. They wanted to understand why the heroin user continues to use despite being uncomfortable when in withdrawal. They wanted to understand why the person who uses alcohol continues to drink despite having two DWIs. They wanted to find out what causes the compulsion to do it again.*

*Through their research and study, the tobacco industry figured it out and did really well. With all the additives that are in cigarettes today, they are affecting a user's brain chemistry in a way that it has never done before.*

Check in with the group members. Ask them *have you heard this information before, or is this new information for you?* Continue by saying that you would like to add a little more information to what we have just discussed.

### **TOBACCO AWARENESS GROUP SESSION ONE**

One of the additives that the tobacco industry uses to make cigarettes more addictive is menthol. Ask group members if they know what menthol is. Clarify any patients' responses by summarizing: *menthol is an organic compound made synthetically or obtained from peppermint or other mint oils. What happens if you have a cold and you put some Vicks, which has menthol in it, under your nose? It opens up your head. It is a dilator; it opens up airways. By putting menthol in a cigarette, taking in the menthol in with the smoke, your bronchial airways open up and you are able to take in more nicotine to keep you addicted with fewer cigarettes per day. The tobacco industry is concerned that if you need a pack or more of cigarettes a day to keep you addicted but you can't afford a pack a day, they have found a way to keep you addicted with half a pack a day by adding menthol because it allows you take in more nicotine.* Ask the group members: *How do you feel when I say that to you?*

*Remember, there are more than 4,000 chemicals in a cigarette; one of those is ammonia. Ammonia works to increase the absorption of smoke in the mucous membrane of the mouth and hence nicotine absorption is increased. What many people don't realize is that every cigarette that you smoke causes damage. There are a lot of health related consequences to smoking. Smoke does a lot of damage to every system in our body.*

### **EQUATE THE PROGRESSION OF AOD DEPENDENCE TO TOBACCO DEPENDENCE**

Ask: *How old were you when you first started using?* Generally, patients will respond 12, 13, or 14.

*Most people start using at a young age and for many people, use progresses very quickly and often they move quickly from the first drug they picked up to another, and another.*

*Picking up in our early adolescence is significant. Adolescence is a critical point in our life. When we are adolescents, we have a lot of developing to do. We have to learn how to cope with stress, we have to develop our identity, we have to learn how to relate to others in all kinds of relationships, develop skills for dealing with anger, loss, disappointment.*

## **TOBACCO AWARENESS GROUP SESSION ONE**

*For example, I am 15 years old and every time I get angry, I smoke marijuana. Then I begin to make the connection in my head, when I get angry, I smoke weed. I don't develop alternative strategies for dealing with anger. This is just one emotion that, as adolescents, we need to figure out how to deal with. If pot works for anger, and we are 14 or 15, then maybe when I feel frustrated or depressed, I will try marijuana for that as well. Because what I know is that marijuana works for me when I am angry. Pot continually becomes more and more important to me. I always make sure that there is some around. If we tie our chemical use to a feeling state, whether it is when I'm bored, happy, angry, partying, and I am using every time I am in that feeling state or with a particular group of people or person or situation then that becomes the main coping method. Can anybody relate this to your own tobacco use?*

Allow people to share any examples and summarize these for the group, before moving on to the next section.

### **IDENTIFY THE ROLE OF TOBACCO USE IN THE PROCESS OF AOD RELAPSE**

*The third point is that if every time you use cocaine and tobacco or alcohol and tobacco together, then the addiction is not just to the cocaine or the alcohol but rather to the interrelated addiction that happens when you use them together.*

*If I make the decision to stop using cocaine or stop using alcohol, but I continue to use tobacco, then half of the "pilot light to my disease" is still lit. Am I not drug craving everyday? Aren't I drug seeking everyday? How many cigarettes do I have left? Who has a cigarette that I can get? Do I have seventy-five cents to buy a loosie (a single cigarette)? We need to medicate the feelings of withdrawal and when we use we get relief. When we think about it, are we not keeping alive "active addict thinking, feeling and acting?"*

*The research tells us that if we keep part of our addiction alive, like when we are continue our tobacco use but stop our alcohol use or our cocaine use, then the probability of our relapsing is significantly higher.*

Continually solicit feedback from the patient group as you present this information. Ask, *do you have something to say about that?* Alternatively ask, *how are you thinking about the information that we are discussing? What's going through your mind as we talk about this?* Help the patients come to the conclusion that if tobacco use is an integral part of their drug use ritual, if they continue to use tobacco they can seriously compromise their recovery from alcohol or other drugs.

## **TOBACCO AWARENESS GROUP SESSION ONE**

## SUMMARIZE

*People, places, and things. What is more significant than another addiction that is so incredibly interrelated to your alcohol or other chemical dependence? If that is true for you, and it is not the case for everyone, what is a more significant “thing” than if I am dosing my body with tobacco every time I use heroin or cocaine? It is our relationship to the chemical. For many people who suffer from the disease of addiction, the relationship that we have with tobacco can be a serious threat to recovery.*

### RELATE ALL OF THE ABOVE TO THE FIRST STEP (POWERLESSNESS AND UNMANAGEABILITY)

*If we take all that we have talked about in group today and put it in the context of the first step (ask who knows what the first step is: powerlessness over the drug and unmanageability of life). Let's relate tobacco use to the powerlessness and unmanageability that we learn in the first step. We all have heard stories of family members or friends who have been told that they must stop using tobacco because of serious health risks. Yet, despite the fact that a person may be having serious problems breathing, maybe even have emphysema or asthma, has had a heart attack, has high blood pressure or is suffering from serious circulation problems, they continue to use tobacco. What is so hard for others to understand is that when we are talking about addiction, all rational thought goes out the window. (You may want to relate a personal story, perhaps a client that you have worked with that illustrates this point) Can you identify the unmanageability and the powerlessness?*

To wrap up this session begin by asking:

*How does all that we talked about today relate to your recovery?*

Allow group members to respond.

*If we equate recovery with giving up things, how long do you think it will stick? Not long. Because we are going to feel deprived and feel the loss. If you continue to go through your day and experience the triggers that used to cause you to pickup, and you don't have an alternative plan or strategy, you're at risk for relapse. Your recovery is not about giving up things, it is about learning that we have choices that we may never have known that we had before and regaining that which was lost.*

*Ask: does anybody have any ideas of alternative behaviors that they may be able to put in place when a trigger happens that we would have responded to with a cigarette, or a drink or a joint? What are the tools of recovery that you want to put in place?*

*My question to you all as we wrap up: what do you think? How do you feel about the message that is being communicated?*

## TOBACCO AWARENESS GROUP SESSION ONE

Professional Development Program, Rockefeller College, University at Albany  
Funded by a grant from the New York State Department of Health, NY Tobacco Control Program

## FINAL SUMMARY

*We learned today that nicotine hits our brain in exactly the same place that other chemicals hit to cause addiction. There is evidence for this from the number of us that weave the ritual of our alcohol and other drug use with tobacco use. We learned that for many of us our tobacco use and our alcohol and other drug use are very much interconnected. Our tobacco use is very important to the process of getting high. We also learned that research tells us if we address all of our chemical dependencies simultaneously in our recovery we will have a better opportunity to learn replacement behaviors and ways of coping and thinking and socializing, reducing the risk of relapse and improving the quality of our recovery.*

### **TOBACCO AWARENESS GROUP SESSION ONE**

Professional Development Program, Rockefeller College, University at Albany  
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## FACT SHEET

Several studies indicate that the prevalence of tobacco use among people receiving treatment or in recovery is dramatically higher than the general U.S. adult population rate of 20.9%<sup>1</sup>:

- 90% among alcoholic inpatients in the U.S.<sup>2</sup>
- 83% among urban methadone maintenance patients in the Northeastern U.S.<sup>3</sup>
- 77% among methadone maintenance patients in the Midwestern U.S.<sup>4</sup>
- 71-93% among alcoholic outpatients<sup>5</sup>
- 85-90% among substance abuse inpatients<sup>6</sup>

People with a DSM-IV-TR diagnosis (not including nicotine dependence) consume 44% of all tobacco sold in the U.S.<sup>7</sup>

People with a co-occurring mental health and substance use disorder consume 70% of tobacco products.<sup>8</sup>

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<sup>1</sup>Centers for Disease Control and Prevention (CDC). Decline in adult smoking rates stall and millions of nonsmoking Americans remain exposed to secondhand smoke. October 26, 2006 Press Release Centers for Disease Control and Prevention, Atlanta, GA.

<sup>2</sup>Bien, T.H., & Burge, R. (1990). "Smoking and drinking: a review of the literature." *International Journal of Addiction*. (12) 1429-54.

<sup>3</sup>Richter, K.P., Gibson, C.A., Ahluwalia, J.S., Schmelzle, K.H., (2001). "Tobacco Use and Quit Attempts among Methadone Maintenance Clients." *American Journal of Public Health*, 91, (2).

<sup>4</sup>Nahvi, S., Richter, K., Li, X., Modali, L., Arnsten, J. (2006). "Cigarette smoking and interest in quitting in methadone maintenance patients." *Addictive Behaviors*. 31(11): 2127-34.

<sup>5</sup>Istvan, J., Matarazzo, J.D. (1984). "Tobacco, alcohol, and caffeine use: A review of their interrelationships." *Psychological Bulletin*. 95(2): 301-326.

<sup>6</sup>Burling, T.A., & Ziff, D.C. (1988). "Tobacco Smoking: A Comparison between Alcohol and Drug Abuse Inpatients." *Addictive Behaviors* 13:185-190.

<sup>7</sup>Lasser, K., Boyd, J.W., Woolhandler, S., Himmelstein, D., McCormick, D., Bor, D. (2000). "Smoking and Mental Illness: a Population-Based Prevalence Study." *JAMA* 284: 2606-2610.

<sup>8</sup>Grant, B.F., Hasin, D.S; Chou, S.P. Stinson, F.S., Dawson, D.A. (2004) "Nicotine Dependence and Psychiatric Disorders in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions." *Archives of General Psychiatry*, 61(11):1107-1115.

## TOBACCO AWARENESS GROUP SESSION ONE

Professional Development Program, Rockefeller College, University at Albany

Funded by a grant from the New York State Department of Health, NY Tobacco Control Program



**TOBACCO AWARENESS  
GROUP SESSION TWO:**

**THE PATH TO  
HEALTHY RECOVERY**

## FACILITATOR TASKS

1. State the purpose of the group: discussing unhealthy relationships to alcohol, tobacco, and other drugs, and the process of making healthy changes.
2. Discuss the biopsychosocial nature of addiction.
3. Define denial and acceptance.
4. Explore Stages of Change.
5. Process participant's identifications of their stage of change re: tobacco.

## GROUP FACILITATOR NOTE

Helping patients change behavior is integral to the work of addiction professionals. The concepts of “patient noncompliance” and clinician perceptions of lack of motivation often focus on patient failure. Understanding patient readiness to make a change, appreciating barriers to change and helping patients anticipate relapse triggers can improve patient satisfaction and lower clinician frustration during the change process.

Researchers have found that people tend to go through a similar process when they make changes and that this process can be conceptualized in a series of stages. The Stages of Change model, part of the Transtheoretical Model of Change,<sup>1</sup> depicts the process that people go through when they successfully make changes in their lives.

The Stages of Change identified by Prochaska and DiClemente are Precontemplation, Contemplation, Preparation, Action, and Maintenance. Understanding the stages of change can be beneficial for both patient and clinician. For patients, knowing their stage can increase their understanding of their own progress. Understanding a patient's stage helps the clinician identify appropriate interventions and supports that may be useful in moving the patient to the next stage of change readiness.

**Materials:** You will need an easel, easel pad, and markers to complete this session with the group.

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<sup>1</sup>Prochaska, J. O., DiClemente, C. C., and Norcross, J. (1992). In search of how people change. *American Psychologist*, 47, 1102-1114.

## TOBACCO AWARENESS GROUP SESSION TWO

## **GROUP SCRIPT**

### **GETTING STARTED**

Begin by introducing yourself to the group. Welcome group members to the second in a series of tobacco awareness groups.

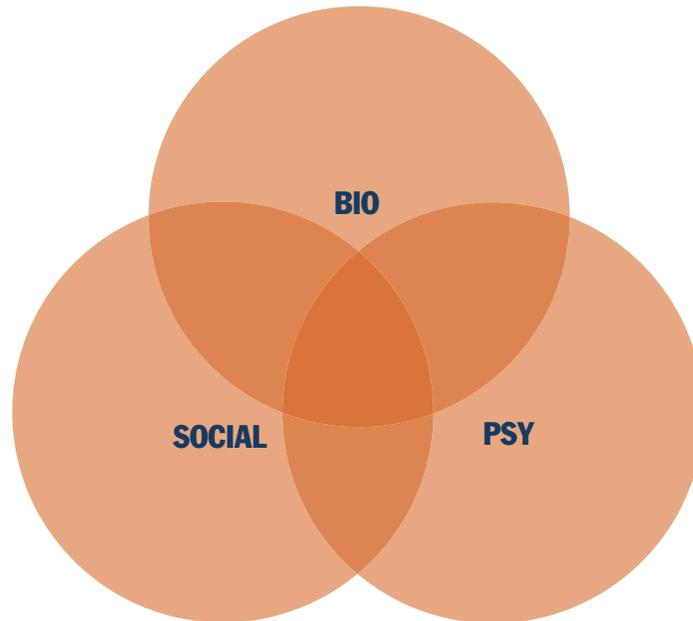
*Today we will be talking about our unhealthy relationships with alcohol, tobacco, and other drugs, (with the emphasis on tobacco), and how we go through a process that results in healthy change.*

Ask the group to talk about their own relationship with alcohol, tobacco, or other drugs, and how that relationship is “unhealthy”. Use reflective listening responses, while recording the patient responses on an easel pad.

## **TOBACCO AWARENESS GROUP SESSION TWO**

## THE BIOPSYCHOSOCIAL NATURE OF ADDICTION

Propose that we become invested in an unhealthy relationship to alcohol, tobacco, and other drugs for a variety of reasons. On the easel pad, draw three large overlapping circles (the biopsychosocial model). Discuss the biopsychosocial nature of addiction.



*What are some of the **biological** reasons for this relationship? What are some of the **psychological** reasons? What are some of the **social** reasons?*

Use reflective listening, while recording the patient responses on an easel pad.

*It's easy to see why it's very hard to "break" an unhealthy relationship. All of the different parts of the relationship (physical, emotional, social), need to be addressed.*

### TOBACCO AWARENESS GROUP SESSION TWO

## **DENIAL AND ACCEPTANCE**

Write the word “denial” on the top left of an easel pad.

*Can anyone provide a definition of denial as we refer to it in addiction treatment?*

Allow for several responses and establish a consensus of the group.

Write the word “acceptance” on the top right of the easel pad.

*Can anyone provide a definition of acceptance as we refer to it in addiction treatment?*

*What is the difference between “admitting” and “accepting?”*

Allow for several responses, and establish a consensus of the group.

Draw an arrow from the word “denial” to the word “acceptance.”

*Today we’ll talk about a “5-stage” process of how we move from being in denial of an unhealthy relationship with tobacco, to a place of acceptance, which gives us the willingness and courage to change our behavior and establish tobacco abstinence. We call this process the stages of change.*

### **TOBACCO AWARENESS GROUP SESSION TWO**

## THE STAGES OF CHANGE

### STAGE ONE – PRECONTEMPLATION (Write it on the easel pad.)

*What does precontemplation mean? “Contemplation” means thinking about something. “Pre” means before. So, literally, precontemplation means “before thinking.” Does anyone recall their reaction the first time someone brought to your attention that your use of tobacco was a problem? What did you think when you heard those words for the very first time? How did it make you feel? Do you recall the first time you thought to yourself that your tobacco use might be a problem for you? How did that make you feel?*

Patients will report that they did not believe that they had a problem and became angry and defensive.

In most cases, those around us will (1) 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 “precontemplation” or the stage of “before thinking” of having a need to change.

*Who thinks they might be in the precontemplation stage when it comes to tobacco use? To inject a little humor, you might say, “Some people call this the ‘screw you stage’”.*

### STAGE TWO - CONTEMPLATION (Write it on the easel pad.)

*Contemplation means that you are thinking about making a change, but haven't decided yet whether you really want to do it (or have the ability to do it.) You are feeling ambivalent.*

Process with the group how it feels to be “ambivalent;” explain that ambivalence is a normal part of the change process.

*Think about some things that you are ambivalent about. Ambivalence means you are thinking two ways about something. There are always pros and cons. What's good about my tobacco use? What's not so good about it? What's good about stopping my tobacco use? What's good about not stopping? People in the contemplation stage are sitting on the fence, trying to decide which way to go.*

*Most patients in addiction treatment are in the precontemplation or contemplation stage of change when it comes to their tobacco use.*

*Who thinks they might be in the contemplation stage when it comes to tobacco use? How did you get there?*

*For those of you who think you are in the precontemplation stage, what would have to happen for you to move to the contemplation stage? How will you know that you have progressed to the contemplation stage?*

## TOBACCO AWARENESS GROUP SESSION TWO

### **STAGE THREE - PREPARATION** (Write it on the easel pad.)

*In the preparation stage, we know in our heart and soul that we need to end the relationship and become abstinent from tobacco. The willingness to change replaces ambivalence and we become focused on what we need to do in order to end it. A person has decided to make changes and is considering how to make them instead of if they should make them.*

*How many of you have firmly decided that you are going to stop using tobacco? Congratulations! You are in the preparation stage. Now is the time to put together your plan to stop using. (If anyone is in the preparation stage, ask about their plans). Your plan should include tobacco treatment medication, supportive counseling, and social support. Research has shown that this combination of treatment methods works best in achieving and maintaining abstinence from tobacco.*

*For those of you in the contemplation stage (still thinking about it), what would have to happen for you to move to the preparation stage? How will you know that you have progressed to the preparation stage?*

### **STAGE FOUR – ACTION** (Write it on the easel pad.)

*Preparation is talking the talk; action is walking the walk. In the action stage, you are actively doing something to change. You are using your plan to stop your tobacco use. Since this is a tobacco awareness group, and probably no one in the group has actually progressed to the action stage, how many of you can imagine yourselves taking action and putting down tobacco? How far down the road might that happen? How would things be different for you if you stopped using?*

Allow the group to talk about this, and respond with reflective listening. Also, note if the questions are eliciting change talk from the group. Listen for the change talk and reflect it back to the group.

### **STAGE 5 - MAINTENANCE** (Write it on the easel pad.)

*Maintenance is the stage of the process when we allow ourselves to be free of the relationship long enough so that we begin to think of it in the past tense: "I used to use tobacco." This is the stage where we are using our relapse prevention plan to maintain a healthy recovery from tobacco.*

Acknowledge that at this time in the process we become comfortable with the change or as it is sometimes stated: "being a grateful recovering person."

Ask the group if they understand the flow of the 5-stage process as described. Explain how the stages are fluid and not exact.

*The stages of change are always active, and a person may move through them once or recycle through them several times before reaching success and maintaining a behavior change over time. In addition, individuals may move back and forth between stages on any single issue or may simultaneously be in different stages of change for two or more behaviors.*

## SUMMARY AND PROCESS

Explore with the group how they relate to the model with regard to their relationship with tobacco, and to other substances that they have used.

*Let's think about the relationship you have with tobacco. What stage of change do you think you're in? What stage of change are you in with regard to alcohol or other drugs?*

Often patients will offer feedback that they thought that they could stop their alcohol or other drug use (drug of choice) and continue to use tobacco. This indicates being in an "Action" stage of change in their relationship to alcohol and other drugs and a "Screw You" (precontemplation) stage in their relationship to tobacco. Use the model to process how they may come to accept also needing to let go of their relationship to tobacco.

Asking evocative questions can raise the emotional level of patients and elicit responses that may include the change talk we're looking for. When talking about letting go of the unhealthy relationship with tobacco, framing the issues about tobacco in recovery language often gets patients to think differently about their tobacco use.

Revisit examples of how group members processed their thinking, feeling, and behavior with regard to the "Screw You" and "contemplation" stages. Ask tobacco-specific open and thought challenging questions:

*I understand that you want to stop using alcohol yet continue to use tobacco. Is it possible that your drug of choice is really tobacco?*

*Is it possible that the disbelief or anger you felt when your spouse first suggested to you that you have a drinking problem is similar to how you may react when we talk about tobacco use as a part of the disease of chemical dependency? If your answer is "yes", what does that mean for you? What does that tell you?*

*Is it possible for you to develop a willingness to let go of all substances, including tobacco? If so, what would you need for that to happen? How will you make that happen?*

Thoroughly process using reflective listening, and listening for change talk.

Thank the group for their participation and end the session.

## TOBACCO AWARENESS GROUP SESSION TWO



**TOBACCO AWARENESS  
GROUP SESSION THREE:**

**THE PROS & CONS  
OF CONTINUED  
TOBACCO USE**

## FACILITATOR TASKS

1. State the purpose of the group: discussing the pros and cons of continuing tobacco use.
2. Review key points participants remember from previous groups and write responses on an easel pad.
3. Ask participants to identify their intentions to continue to use tobacco, attempt to achieve tobacco abstinence, or maintain their tobacco recovery.
4. Complete Decisional Balance exercise.

## GROUP FACILITATOR NOTE

A facilitated discussion around the Decisional Balance activity can be particularly helpful to patients who are in the Contemplative stage in prioritizing their own needs and decisions related to their tobacco use. The main task for the clinician working with the contemplative client is to help resolve ambivalence.

In any tobacco awareness group that a clinician facilitates, 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 precontemplative will benefit from exposure to peer input and feedback.

**Materials:** You will need an easel, easel pad, and markers to complete this session with the group.

## TOBACCO AWARENESS GROUP SESSION THREE

## GROUP SCRIPT

### GETTING STARTED

Begin by introducing yourself and welcome group members to the third in a series of tobacco awareness groups. Ask patients:

*What take home messages – or important points do you recall from the previous session, “The Path to Healthy Recovery?”*

Record responses on an easel pad. Summarize key points, adding any messages that may have not been elicited from the group. Ask by show of hands:

*How many of you would like to establish/maintain tobacco abstinence in your recovery?*

*How many of you intend to use tobacco?*

*How many of you are already in tobacco recovery?*

*Would anyone like to share how many days, weeks, months, or years they have been tobacco-free?*

Follow-up by asking patients for their permission to explore the basis for their decisions. On the easel pad, draw the diagram on the next page. Record responses as elicited.

## TOBACCO AWARENESS GROUP SESSION THREE

## DECISIONAL BALANCE MATRIX

1) PROS OF CONTINUED TOBACCO USE (BENEFITS OF NOT CHANGING)	2) CONS OF CONTINUED TOBACCO USE (CONSEQUENCES OF NOT CHANGING)
3) PROS OF NOT USING TOBACCO (BENEFITS OF CHANGE)	4) CONS OF NOT USING TOBACCO (CONSEQUENCES OF CHANGE)

### TOBACCO AWARENESS GROUP SESSION THREE

## DECISIONAL BALANCE PROCESS QUESTIONS

Ask patients each question in order of 1, 2, 3, and 4. Gather as many responses as possible before moving to the next quadrant.

Quadrant 1: *What are the pros of continued tobacco use?*

Quadrant 2: *What are the cons of continued use?*

Quadrant 3: *What are the pros of not using tobacco?*

Quadrant 4: *What are the cons of not using tobacco?*

Summarize both columns during the exercise to verify that all patient input is listed.

Ask the patients to examine and compare all categories to determine any conclusions that can be drawn from the lists. (It is common that a consensus will be made that the “Tobacco Recovery” (Pros of not using - Box #3) list has much more weight than the “Continued Tobacco Use” (Box #1) list.

Ask the patients to shift gears a minute and ask if the reasons listed could also be used to rationalize a desire to drink? (You can also cross out “tobacco” and write “alcohol” in each quadrant.) The conclusion is “a drug is a drug” or that tobacco dependence is chemical dependence.

Solicit comments from the patients on the “lessons learned” or take away messages from the session relevant to their recovery.

Summarize what the patients have shared and thank them for their participation and contributions.

### TOBACCO AWARENESS GROUP SESSION THREE

## TELL US WHAT YOU THINK!

We would like to get your feedback about this Technical Assistance document,  
**Facilitating a Tobacco Awareness Group**

Please take a moment to fill out this survey and fax it to us at 518.956.7808.

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