

Changing Patterns of Tobacco use and Psychological Barriers to Tobacco use Cessation among Those in Early Remission of Alcohol Dependence: A Cross-sectional Study

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ABSTRACT

Introduction: Tobacco and alcohol are the most common combination of substances of abuse. Studies show that tobacco use patterns change when alcohol dependent patients abstain with readiness to change and smoker's risk perception forming the major psychological barriers to quitting tobacco use in this period. This represents an under-studied aspect of nicotine dependence that the present study aimed to explore.

Aim: To study changing patterns of tobacco use and the association between perceived health risks, readiness to change, and nicotine severity among patients of alcohol dependence in early remission who are current tobacco smokers.

Materials and Methods: The present cross-sectional study was conducted in the outpatient services of the Department of Psychiatry at a tertiary healthcare centre in Tamil Nadu, India over a period of two months between June to July of 2025. Ethical clearance was obtained and a sample of 100 patients of alcohol dependence in early remission who smoke were selected. They were evaluated for the severity of their nicotine dependence, addiction and health risk perceptions towards

self and others and willingness to quit smoking. Statistical Package for Social Sciences (SPSS) version 27 was used for the statistical analysis involving analysis of variance, Pearson's correlation and paired t-test.

Results: There was a significant difference between means of willingness to change and smokers' perceived health risk ($p=0.021$), addiction risk ($p=0.026$) as well as severity of nicotine dependence ($p=0.008$). The test also showed that those who had lower stages of readiness to change had lower perceived risk scores (statistically significant for perceived health and addiction risk domains) and higher severity of nicotine dependence. Pearson's correlation shows a significant inverse correlation between severity of nicotine dependence and perceived health risk, addiction risk and harm to others ($p<0.001$).

Conclusion: Patients in poorer motivation stages of readiness to change tended to have higher severity of nicotine dependence and perceived risk towards their health and addiction status. Those who had more severe dependence also had poorer perceived risk. Targeted interventions towards improving motivation to quit and improving risk awareness will aid in tobacco use cessation.

Keywords: Health perception, Nicotine dependence, Readiness to change, Risk perception, Transtheoretical model

INTRODUCTION

Tobacco and alcohol are the most commonly used psychoactive substances globally and in India. Their co-use has synergistic effects on physical and psychological health. According to data from the National Family Health Survey (NFHS-5) 29% of Indian men aged 15 and above consume tobacco and approximately 18.7% report alcohol use [1]. In Tamil Nadu the prevalence of tobacco use is estimated to be 20.6% among men and 1.1% among women, while alcohol use among men remains significant at 33% [2,3].

International literature suggests that approximately 47-70% of individuals with alcohol dependence are also active smokers [4]. In India, this overlap is increasingly evident, yet understudied, particularly in the context of psychological attitudes toward tobacco cessation during alcohol abstinence. Chronic concurrent use is associated with poorer treatment outcomes, increased relapse risk, and heightened vulnerability to cardiovascular, respiratory, and oncological diseases [5].

Studies show that during the early remission phase of alcohol dependence, individuals often deprioritise tobacco cessation stemming from the belief that smoking aids in mood regulation, reduces alcohol craving, or is of lesser detriment to their health compared to alcohol use [6]. Moreover, psychological factors

particularly risk perception and motivational readiness significantly influence cessation behaviour but remain poorly explored in this population [7].

Smokers in early recovery from alcohol dependence tend to underestimate their own vulnerability to tobacco-related health risks. Such cognitive biases hinder motivation to quit and contribute to continued tobacco dependence despite alcohol abstinence [8]. Similarly, the individual's stage of change, as conceptualised by the transtheoretical model, reflects motivational readiness for cessation [9]. Among those in remission from alcohol dependence, many remain in pre-contemplation or contemplation phases with regard to quitting tobacco, despite formal engagement in de-addiction programs for alcohol [10].

The Indian psychiatric and addiction care context presents additional challenges. Resource constraints, high patient loads, and limited integration of smoking cessation protocols into alcohol rehabilitation programs contribute to this treatment gap. Severity of nicotine dependence and motivation to quit nicotine use during the early remission stage is an under-explored area of research, hence the present study aimed to understand the relationship between these variables and perceived risk in tobacco users. Given the high burden of dual-use of alcohol and nicotine products, its health consequences and the psychological barriers that prevent tobacco cessation it

becomes imperative to explore these patterns systematically. There is a critical need to examine the relationship between risk perception, motivational readiness, and actual patterns of nicotine dependence among individuals in early remission from alcohol dependence. This study, conducted in a tertiary care centre in Tamil Nadu, India, aimed to bridge this gap by evaluating the association between perceived health risks, readiness to change, and nicotine severity among this high-risk population with the null hypothesis stating 'there is no significant relationship between severity of nicotine dependence and readiness to change or perceived risk in the tobacco users during early remission from alcohol dependence'.

MATERIALS AND METHODS

The present study was a conducted as a single-centre, hospital-based, cross-sectional study conducted in the outpatient services of the Department of Psychiatry at a tertiary healthcare institution in Tamil Nadu, India, taking place over a period of two months between June to July of 2025. The present study received ethical approval from the Institutional Human Ethics Committee (IHEC) with reference number (IHEC-I/3859/25), dated 2025-06-09.

Inclusion and Exclusion criteria: Patients were eligible if they were between 18 and 59 years of age, fulfilled the diagnostic criteria for Alcohol Dependence Syndrome as per ICD-11 [11], and had been abstinent from alcohol for a duration ranging from one month to one year (qualifying as "early remission" according to ICD-11 standards) [11]. Individuals were also required to be current tobacco smokers and have access to a mobile phone, telephone, or internet service to allow follow-up if necessary. Participants were excluded if they were currently experiencing alcohol withdrawal symptoms, under intoxication, or had recently consumed alcohol and any other substances of abuse besides caffeine or nicotine. Other exclusion criteria included the presence of any other diagnosed psychiatric illness, significant intellectual or learning disabilities, severe medical or neurological comorbidities, or refusal/inability to cooperate with the study procedures.

Sample size calculation: Based on prior data indicating a 53.7% prevalence of persistent tobacco use among alcohol-dependent individuals in remission (Mathew C et al., 2024) [12], the sample size was calculated as follows: $n = Z^2 p(1-p)/e^2$ where 'n' is the sample size to be calculated, 'p' is the prevalence data (in this case 0.537), the 'z' score is taken as 1.96 with a 95% confidence interval and 0.10 as the standard error 'e'. This yielded an 'n' value of 95.51 which was rounded up to 100 as the final sample size.

Study Procedure

Participants were recruited using a consecutive sampling method as per criteria. Each participant was provided with a Participant Information Sheet (PIS) in their preferred language, and the contents were explained verbally to ensure comprehension. Written informed consent was obtained prior to enrolment in the study. Sociodemographic details such as age, gender, marital status, place of residence, education, occupation and family monthly income were collected using a semi-structured questionnaire. Clinical variables such as height, weight, age at onset of alcohol use, duration of alcohol abstinence, longest prior duration of abstinence from tobacco and family history of tobacco use were also recorded.

To assess the severity of nicotine dependence, participants were administered the Fagerström Test for Nicotine Dependence (FTND) for tobacco users with data collected for their level of dependence at the time of assessment as well anecdotally from during their last period of alcohol consumption. This instrument has been accessed under the terms for academic use without disclosing its components as per (Heatherton TF et al., 1991). This version comprises six items assessing daily consumption, compulsion to use, and difficulty in abstaining. Total scores ranged from 0 to 10 and higher scores were interpreted as indicating higher severity of dependence [13].

The Readiness to Change Questionnaire (RCQ), a 12-item self-report instrument, was used to evaluate motivational readiness for tobacco cessation. This questionnaire was developed and copyrighted by ©Heather, Rollnick and colleagues. The questionnaire has been made available online free of cost and the authors have granted permission for academic use. Responses were scored on a 5-point Likert scale (-2=strongly disagree; -1=disagree; 0=unsure; +1=agree; +2=strongly agree) based on the level to which participants agree or disagree with the statement in each question. Scores were summed for three domains: Pre-contemplation, Contemplation, and Action. The domain with the highest total score determined the individual's current stage of change [14].

Perceptions of health and risk were assessed using the assessment of Behavioural Outcomes related to Tobacco and nicotine products - ABOUT™- Perceived Risk 2.2 - ABOUT™- Perceived Risk (formally Perceived Risk Instrument - PRI) 2.2 © 2020 Philip Morris Products S.A. All rights reserved. Permission to use the instrument has been obtained through licensing of the instrument for the purposes of this study. This 27-item scale is comprised of 18 items assessing perceived health risk of the participant and seven items assessing perceived addiction risk to tobacco use of the participant. Both of the above are scored on a 5-point Likert-like scale (0=no-risk; 1=low-risk; 2=moderate-risk; 3=high-risk; 4=very high-risk). The resulting sum score is converted into a final transformed total score for each of the domains. Two further items assessing perceived harm to others from participant's tobacco use are added to result in a sum score (maximum score 8) that is taken as the final score for the domain of perceived harm to others [15-18].

STATISTICAL ANALYSIS

Data were entered into Microsoft Excel 2019 and analysed using IBM SPSS Statistics for Windows, Version 27.0 (IBM Corp., Armonk, NY, USA). Descriptive statistics, including means and standard deviations, were calculated for continuous variables, while frequencies and percentages were used to summarise categorical data. A paired t-test was conducted to compare the difference in severity of nicotine dependence while patient was still alcohol dependent (based on anecdotal evidence) compared to severity of nicotine dependence at the time of the present study. Comparisons between readiness to change and perceived risk as well as readiness to change and severity of nicotine dependence respectively were made using Analysis of Variance (ANOVA) testing. Pearson's correlation coefficient was used to assess for correlation between severity of nicotine dependence and perceived risk scores. The level of significance was assessed for each statistical test conducted and their results were considered significant if the p-value of significance is less than or equal to 0.05.

RESULTS

All the participants that enrolled in the present study were male, representative of the demographic attending the outpatient department. As displayed in [Table/Fig-1] the mean age of patients enrolled was around middle age at 39.49 ± 9.714 years with a mean age of onset of tobacco use of around 20.49 ± 3.33 years during young adulthood. Over 50-60% of the participants were married, belonging to a semi-urban residence, educated from between primary to high school level and did not have family history of tobacco use. The average duration of abstinence from alcohol use was approximately two months with prior longest abstinence period from tobacco use being just one third of that at 20 days. The average Body Mass Index of participants was bordering on being overweight.

[Table/Fig-2] shows that the total sample consisted of male participants and almost two-thirds of the tobacco users were married. 89 (89%) of the patients assessed were from semi-urban or urban residential areas and equally as many were of Hindu religion. Almost equal

Variables	Mean±Standard deviation
Age (years)	39.49±9.714
Height (m)	1.70±0.07
Weight (kg)	71.51±7.38
BMI (kg/m)	24.86±1.89
Duration of abstinence from alcohol (days)	59.46±24.53
Age at onset of tobacco use (years)	20.49±3.33
Longest prior duration of abstinence from tobacco use (days)	20.09±15.74
Family income (rupees/month)	12195±9438.24

[Table/Fig-1]: Clinical characteristics of participants.

numbers had or didn't have family history of tobacco use. The participants were most commonly educated up to middle school level of education and worked in craft and trade related fields (over 1/3rd).

Variables	Frequency (Percentage)
Marital status	Single
	32 (32%)
	Married
	64 (64%)
Residence	Divorced
	2 (2%)
	Widowed
	2 (2%)
Education	Rural
	11 (11%)
	Semi-urban
Family history of tobacco use	52 (52%)
	Urban
	37 (37%)
Occupation	Intermediate or diploma
	29 (29%)
	Primary to high school level
Family history of tobacco use	63 (63%)
	Illiterate
	8 (8%)
Occupation	Present
	43 (43%)
	Absent
Occupation	57 (57%)
	Clerks
	2 (2%)
	Skilled workers and shop and market sales workers
	12 (12%)
	Skilled agricultural and fishery workers
	18 (18%)
	Craft and related trade workers
Occupation	32 (32%)
	Plant and machine operators and assemblers
	17 (17%)
	Elementary occupation
Occupation	1 (1%)
	Unemployed
Occupation	18 (18%)

[Table/Fig-2]: Sociodemographic features of participants.

On average severity of nicotine dependence during alcohol dependence (5.49±2.303) was 0.210 points lower than at the time of the study (5.70±2.549) as measured by the Fagerstrom test for nicotine dependence. However, the difference was found to be not significant ($t_{99}=-0.839$, $p=0.404$). A moderate positive correlation was found between present severity of nicotine dependence at the time of the study versus dependence severity at the time of last drink of alcohol based on anecdotal recall ($r=0.471$, $p<0.001$).

In the study population, data collected revealed that 41 individuals were of the pre-contemplation stage of change, 43 people were of the contemplation stage and 16 people of the action stage of change respectively. While analysing the association between perceived risk and readiness to change in [Table/Fig-3] the tests showed that of the patients across all three domains of perceived risk (perceived health risk, addiction risk and harm to others) showed scores in ascending order from those in pre-contemplation ($n=41$) to contemplation ($n=43$) and finally action ($n=16$) stages of change. This shows the trend that those with poorer levels of motivation to change have significantly lower scores of perceived risk.

In [Table/Fig-4] where we assessed the association between severity of nicotine dependence and readiness to change patients with higher average nicotine dependence scores tend to have poorer levels of motivation to quit tobacco use which is statistically significant ($p=0.008$). Significant negative correlation ($p<0.001$) was found between perceived risk in all three domains (health risk, addiction risk and harm to others) and severity of Nicotine Dependence [Table/Fig-5].

DISCUSSION

The participant's mean age (39.49±9.714 years) and early onset of tobacco use (~21 years) align with epidemiological data on comorbid substance use disorders, underscoring the chronic nature of nicotine use and dependence in this population [2]. The average duration of abstinence from alcohol (~59 days) contrasted with the shorter tobacco abstinence period highlights the common clinical observation of persistent tobacco use despite alcohol remission [3].

According to a study by Leeman RF et al., (2008), 49.3% of participants were married or cohabiting, compared to 64% of married smokers in the present study. In this study, 71% of participants had a high school education or less, while the earlier study reported 45.1%. The mean age was broadly similar, though slightly higher in the Leeman study, where alcohol abstainers averaged 44.93 years compared to 39.49 years here. The present study included only male participants, whereas the Leeman study had a majority female sample (60.3%). There was also a clear difference in smoking initiation: participants in the Leeman study had their first cigarette at an average age of 14.62 years and became regular smokers by 16.58 years, while in the present study the average age of first smoking was much higher at 20.49 years [19]. Another study by Kohn CS reported that 42.1% of the sample was female, whereas the present study included only male participants. The mean age in that study was 36.8 years, which is lower than the 39.49 years observed in the present study. It also found that 41.5% of participants were married or living as married, compared to 64% in the current study. Employment rates were lower as well, with 61% of participants employed in the earlier study versus 82% in the present study [20].

The observation that individuals with higher nicotine dependence have lower motivation to quit reflects the relationship between

Perceived Risk domains	Readiness to change				
	Pre-contemplation (n=41)	Contemplation (n=43)	Action (n=16)	ANOVA f value	p-value
Perceived health risk (Mean±Standard deviation)	44.41±19.09	50.79±21.25	60.69±16.34	F(2,97)=4.039	0.021*
Perceived addiction risk (Mean±Standard deviation)	42.37±23.36	50.86±23.05	59.94±19.29	F(2,97)=3.770	0.026*
Perceived harm to others (Mean±Standard deviation)	3.51±1.91	3.95±2.08	4.19±1.80	F(2,97)=0.876	0.420

[Table/Fig-3]: Assessment of association between perceived risk and readiness to change. p-values with an * (asterisk mark) are significant ($p<0.05$)

Severity of nicotine dependence (Mean±Standard deviation)	Readiness to change				
	Pre- contemplation (n=41)	Contemplation (n=43)	Action (n=16)	ANOVA f value	p-value
Severity of nicotine dependence (Mean±Standard deviation)	6.46±2.54	5.53±2.46	4.19±2.14	F (2,97)=5.145	0.008*

[Table/Fig-4]: Assessment of association between severity of nicotine dependence and readiness to change. p-values with an * (asterisk mark) are significant ($p<0.05$)

Perceived risk domains	Pearson's correlation coefficient	p-value
Perceived health risk	-0.759	<0.001*
Perceived addiction risk	-0.750	<0.001*
Perceived harm to others	-0.519	<0.001*

[Table/Fig-5]: Assessment of correlation between severity of nicotine dependence and perceived risk.
p-values with an * (asterisk mark) are significant (p<0.05)

addiction severity and psychological readiness to quit nicotine use [9]. Furthermore, risk perception of tobacco-related morbidity was shown to be linked to motivation levels, wherein those acknowledging greater health and addiction risk exhibited significantly stronger quitting intentions. This is consistent with broader epidemiological findings correlating elevated risk awareness with cessation success, as well as theories emphasising the cognitive and emotional aspects of risk appraisal in health-related behaviour change [5].

The data revealed a psychological discord between risk (to health) perception and nicotine dependence where heavier smokers perceive themselves as relatively healthier, a phenomenon described in the literature as false health optimism or optimistic bias, which constitutes a significant barrier to cessation [6]. Addressing this misperception is vital for developing motivational interventions tailored to this subgroup of nicotine dependent individuals. Social and emotional triggers, combined with nicotine withdrawal and fear of failure are other major factors which compound the effects of these barriers (Kalman D et al., 2010; Orlando Y et al., 2020) [2,6].

This study reinforces the need for integrated treatment approaches that simultaneously address alcohol and tobacco use disorders. Literature reviews and clinical guidelines advise integrated interventions to improve outcomes, reduce relapse risk and the compounded health burden posed by dependence on both alcohol and nicotine [7,8]. Behavioural therapies incorporating cognitive-behavioural techniques and motivational enhancement have demonstrated efficacy, especially when combined with education to increase risk perception and readiness [2,4].

Increased nicotine dependence after cessation of alcohol was noted (despite not having significance in the study), cautiously suggests tobacco-use may have a role as a compensatory or substitute addictive behaviour in early recovery phases of other studies [3]. Prior studies have demonstrated that tobacco use may increase risks of alcohol relapse, emphasising the need for concurrent treatment modalities [2,10]. Notably, motivation to quit tobacco was predominantly between pre-contemplation and contemplation stages, with risk perception as an important factor affecting progression to the action stage. This supports Protection Motivation Theory (PMT), which identifies perceived vulnerability and severity as key drivers of quitting intentions, particularly in low to moderate nicotine dependence smokers [4].

Future investigations should focus on longitudinal assessments beyond early remission, with an emphasis on dynamic motivational states and sociocultural factors influencing cessation. Personalised cessation plans addressing both the physiological dependence and psychological barriers (e.g., risk perception recalibration), may improve long-term abstinence rates. Such research will be key in refining clinical guidelines to address this high-risk population effectively.

Limitation(s)

The present study has certain limitations. First, the sample was drawn from a single tertiary care centre using purposive sampling, which may introduce selection bias and limit generalisability. Second, the cross-sectional design complicates the establishment of causality for relationships between each of the variables. Third, all data were collected via self-report, introducing the possibility of response bias and anecdotal retrospective data was collected regarding tobacco use to assess nicotine dependence severity during active alcohol

use which can introduce possible recall bias. Fourth, the present study did not incorporate biochemical verification of tobacco use or follow-up data on cessation outcomes. Lastly, the duration of alcohol abstinence was self-reported and not independently corroborated beyond the limited inputs from caregivers.

CONCLUSION(S)

In conclusion, the present study highlights the relationship between severity of nicotine dependence, participant's readiness to change by way of motivation to quit tobacco use and risk perception during the stage of early remission from alcohol dependence. It shows that greater severity of nicotine dependence was linked with poorer levels of readiness to change and motivation to quit they also tended to be less perceptive of addiction risk and risk towards their own health and harm to others as well. These findings emphasise the importance of strategies to promote motivation and risk awareness to optimise outcomes in nicotine dependence management.

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