Smoking goes way of dodo

by Peter Stathis

In the last few years, smoking has been marginalized in the workplace and forced outdoors.

More conscious than ever before of the "healthy lifestyle," North American society has denounced smoking as a hazardous long-term addiction and taken legislative measures to curb and eventually eradicate it.

Beginning this fall, smoking will be prohibited in most of the indoor locations of our university, including traditional venues such as pubs and restaurants.

At this point, the right of non-smokers to avoid second-hand smoke encroaches upon that of smokers who wish to exercise their choice. Considering the large contingent of practising smokers, the further step of prohibiting tobacco sales on campus will cause people to travel off-campus, but it won't necessarily cause them to stop smoking.

The university's new policy will curtail individual freedom — no question about that — but has this decision been made for the best interests of the entire community — smokers and non-smokers both?

The elimination of advertising will not eliminate smoking, though it will reduce the numbers of young people starting

The debate over smoking is really an existential one. To what point will society and its governing bodies force their paternalistic desire for collective welfare before they eliminate the potential for choice of the individuals that make up that collective?

Anti-smoking advocates claim that smoking is cyclic: new smokers (most of them teenagers) are recruited to replace the tens of thousands of older smokers who die from smoking-related cancer and heart disease each year. Tantilized by the tobacco companies' multi-billion dollar advertising campaigns, new smokers view cigarettes as an entry way into adulthood and peer acceptance.

Smoking critics argue further that in light of North America's "war on drugs," it is hypocritical for tobacco companies to continue receiving the tacit sanction of governments to promote and market what is tantamount to drug abuse and addiction.

Smoking has now been classified as a psychiatric disorder in the latest edition the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R). This categorization is political in nature because it reflects the mainstream opinion of society, but also because it allows smoking to be condemned as a behaviour that is both personally and socially destructive.

The psychoactive substance in tobacco cigarettes, **nicotine**, has been proven by clinical pyschologists to be a highly addictive drug that leads to physical and psychological dependence in the smoker. Because the symptoms of nicotine dependence and nicotine withdrawal are similar to those patterns in other, recognized illicit drugs, smoking has, in effect, been categorized as an abnormal behaviour.

The essential problem, however, is that a large part of the population is presently engaged in this "abnormal behaviour". Therefore, the question arises, how can a behaviour which is so **common** possibly be perceived as **abnormal**?

If we accept the medical data which prove overwhelmingly that smoking leads to nicotine addiction which, in turn, leads to long-term health hazards, should an individual retain the right to smoke without being considered a "crazy" person? Examining some current behavioural and clinical research might help to ground this otherwise philosophical argument.

E. Lichtenstein, a behavioural researcher, tried to explain the formation of the smoking habit in four stages: **initiation, maintenance, cessation, and relapse**, all of which involve biological and psychosocial factors. He believed that the onset of smoking comes not from any physical rewards but rather from social factors such as availability, curiosity, rebelliousness, and peer pressure.

Psychosocial concerns such as cigarette cost and the need for self-mastery contribute to the smoker's attempts to stop. Finally, both physical and psychosocial factors (such as withdrawal, stress and frustration, and conditioned craving) explain the relapse back into the habit.

The opponent-process model developed by Solomon proposes that all dependence-causing drugs have three common properties. With nicotine, the initial pharmacological effect is one of **affective pleasure** (a calm euphoria or reduction of stress). With continued use, these feelings diminish and smoking loses much of its affective pleasure. To compensate, a user may increase the amount of tobacco inhaled to maintain a consistent level of nicotine in the body: this is **affective tolerance**. If a smoker quits suddenly, they will experience feelings opposite to those of the initial euphoria: **affective withdrawal**. Eventually, with increased tolerance, the motivation for smoking changes from achieving pleasure to avoiding the unpleasant symptoms of withdrawal.

The smoker will typically feel withdrawal symptoms within 24-hours of cessation. These include craving for nicotine, irritability, frustration or anger, anxiety, difficulty concentrating, restlessness, decreased heart rate, and increased appetite or weight gain.

D. Rosenhan and M. Seligman, psychiatric researchers, suggest that nicotine is very affective for two reasons: its fast access to the brain and its short half-life. Because the nicotine in cigarettes is inhaled by smoking, it is quickly absorbed into the lungs and transported to the brain, as opposed to injected or swallowed drugs which pass through the liver and can be broken down before they reach the brain.

Shorter-acting agents, such as nicotine (or cocaine or heroin), also produce more rapid and efficient absorption into the bloodstream and by so doing, create a stronger dependence as opposed to drugs with a longer half-life (such as marijuana) which do not have to be taken several times per day to avoid withdrawal. Thus, nicotine is highly addictive on two counts.

Further research has grouped smoking in with illict and ilegal drug abuse, calling nicotine a "gateway" drug.

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Clinical psychiatrist J. Henningfield reports that the pattern of acquisition and maintenance in tobacco smoking is similar to that of heroin and morphine. Both habits develop quickly and simple exposure to the substance (experimentation) leads to chronic use.

According to M. Gagnon, Health Program Coordinator of the Waterloo Regional Lung Association, the proportion of regular tobacco users who go on to use illicit drugs is much higher than that of non-smokers. A few years ago, the U.S. Public Health Service called smoking the most widespread example of drug dependence in North America.

J. Garcia, J. Best and J. D'Avernas, clinical researchers, report that smokers currently make up approximately one third of the adult population in Canada, with the prevalence roughly the same between males and females. The great majority of the new smokers, however, are teenagers. How do youngsters develop the habit?

Learning theory regards smoking as a behaviour acquired under social reinforcement, typically peer pressure, and specifically modelling, when an individual's sense of self is not yet strongly developed.

Most smokers begin as teenagers when identification within the peer group is an important source of status which replaces that of the family. The smoker gains immediate social acceptance and a feeling of maturity because smoking is considered an adult behaviour forbidden to children. This may also serve as an act of defiance toward authority figures such as parents who disapprove of their child's smoking habit.

Some research has found that teenage smokers tend to be perceived by other teenagers as tough, precocious and sociable. These other adolescents often believe the world is watching their every move, and may begin smoking to imitate those tough, cool models and receive their social acceptance by projecting a mature image.

Young smokers favour the short-term gratification that smoking gives them, without worrying about the long-term consequences to their health.

Garcia, Best, and D'Avernas contend that while smoking produces immediate pharmacological effects, it usually begins as a prominent social activity undertaken with the support of a group. Once smoking has begun, both individual and social pressures act to maintain and increase the smoking habit. They report that "for at least half of all smokers, induction begins before 18 years of age. The onset of smoking during the teen years results in a high probability of sustained use. Of teenagers who smoke more than one or two casual cigarettes a day, 85 per cent will escalate to a lifestyle of regular smoking."

According to Garcia, Best and D'Avernas, **social inoculation** in the classroom setting is the most effective training young children (potential smokers) can receive to resist the psychosocial temptations of cigarettes.

Clinical researchers H. Ashton and R. Stepney assert that smoking is in some ways "contagious." If someone lights up a cigarette, others may model the action who had otherwise been reluctant or are reminded of their "need" for a cigarette. They argue, therefore, that restricting smoking is the first step in stopping this social imitation, especially at school and the workplace where peer pressure is very dynamic.

Through the mass media of television and film, society has over the years romanticized smoking as the behaviour of success. Many smokers associate smoking with the courage, rugged individualism, and social attractiveness of many cultural icons and media role models.

Advertising is critical in maintaining the social acceptability of smoking. The editor of the journal released by the *Canadian Council on Smoking and Health*, K. Baumgartner, counters many of the arguments made in defense of cigarette advertising. "Every day 6,000 adult smokers quit or die in North America alone," explains Baumgartner. The tobacco industry must recruit a sufficient number of young people as replacement smokers, or their sales will fall precipitously."

"Two key functions of cigarette advertising are to attract new users by associating smoking with the glamorous and athletic lifestyles that young people aspire to, and to convince worried adults that by smoking certain brands they can smoke in safety," says Baumgartner. The elimination of advertising will not eliminate smoking, though it will reduce the numbers of young people starting."

In the face of prohibitive legislation, tobacco companies are redirecting their efforts away from direct media advertising (such as magazines, newspapers, billboards) and into merchandising, retailing and sponsorship. Their newest tactic is to create subsidiary companies to circumvent the ban on using cigarette brand names to sponsor cultural or sporting events. In this way, RJR-Macdonald Inc. can indirectly promote Toronto's annual Molson Indy as Export A Inc., and stay completely within the letter (if not the intent) of the law.

In previous centuries smoking was a socially-accepted behaviour as well as a recreational tool. Even today, no one prevents smokers from smoking in private, they are simply restricted from doing so in public. Thus, the government, which feigns to care about society's general health, scolds smokers publicly with one hand, but with the other, gives its implicit consent to smoke in private. A contradiction remains when we have identified nicotine as a harmful drug, but have allowed its continued promotion and legal sale in corner stores?

Smokers have a selective attention to the details that justify their habit, and conversely, tend to ignore or underestimate those facts which may prove dangerous to them. Most of these denial mechanisms revolve around a circular rationalization that since cigarettes are legal, they cannot be harmful; and since they aren't harmful, people should be free smoke them.

Gagnon points out that the government legislation which provides a smoke-free workplace has motivated many adults to quit, but only because their choice has been virtually removed.

The majority of Canadians have lobbied for anti-smoking legislation and compulsory smoking prevention education across the nation. They argue legislation is necessary to offset the allure of cigarette smoking that comes from social pressures such as advertising, peer groups, and the wide availability of cigarettes.

The government whose traditional role has been to prevent individuals from harming one another is now taking an extra step in trying to prevent individuals from harming themselves: the paternalistic approach.

The trend in Ontario has been to eliminate smoking in public places. Bill 194 has virtually prohibited smoking in all workplaces since January 1, 1990. At the federal level, Bill C-27 has seen a complete ban on smoking on domestic and international flights as well as public bus transportation across the nation.

Garcia, Best, and D'Avernas have stated that "governments that ignore the need for interventions are not acting in the health interests of their constituencies."

Perhaps, we should remind ourselves of the existential perspective once again. How much intervention should a government be allowed in a free society? An autocratic dictate (although well-meaning) blatantly interferes with people's own decision to act and infringes on their personal privacy.

The counter argument to this is twofold: first, smokers should not be allowed to harm themselves — they should be helped — and secondly, they do not have the right to expose others to the hazards of second-hand smoke.

The Canadian government persists in contradicting itself. There is an enormous discrepancy between the rhetoric of its "strong commitment to public health" and its continued subsidies to tobacco farmers and its collection of tax revenue generated from tobacco sales.

Smokers need to feel they have an ultimate choice whether or not to quit; they must not be forced to suffer treatment involuntarily.

According to a January 1990 Report from Parliament, the federal budget for anti-smoking advertising campaigns in 1989/1990 was 1.4 million dollars, but the tax revenue from tobacco sales in 1988 was over 4.5 billion dollars.

Henningfield believes that the continuing use of tobacco despite numerous health warnings makes the theory that smoking is simply a voluntary recreation very unlikely.

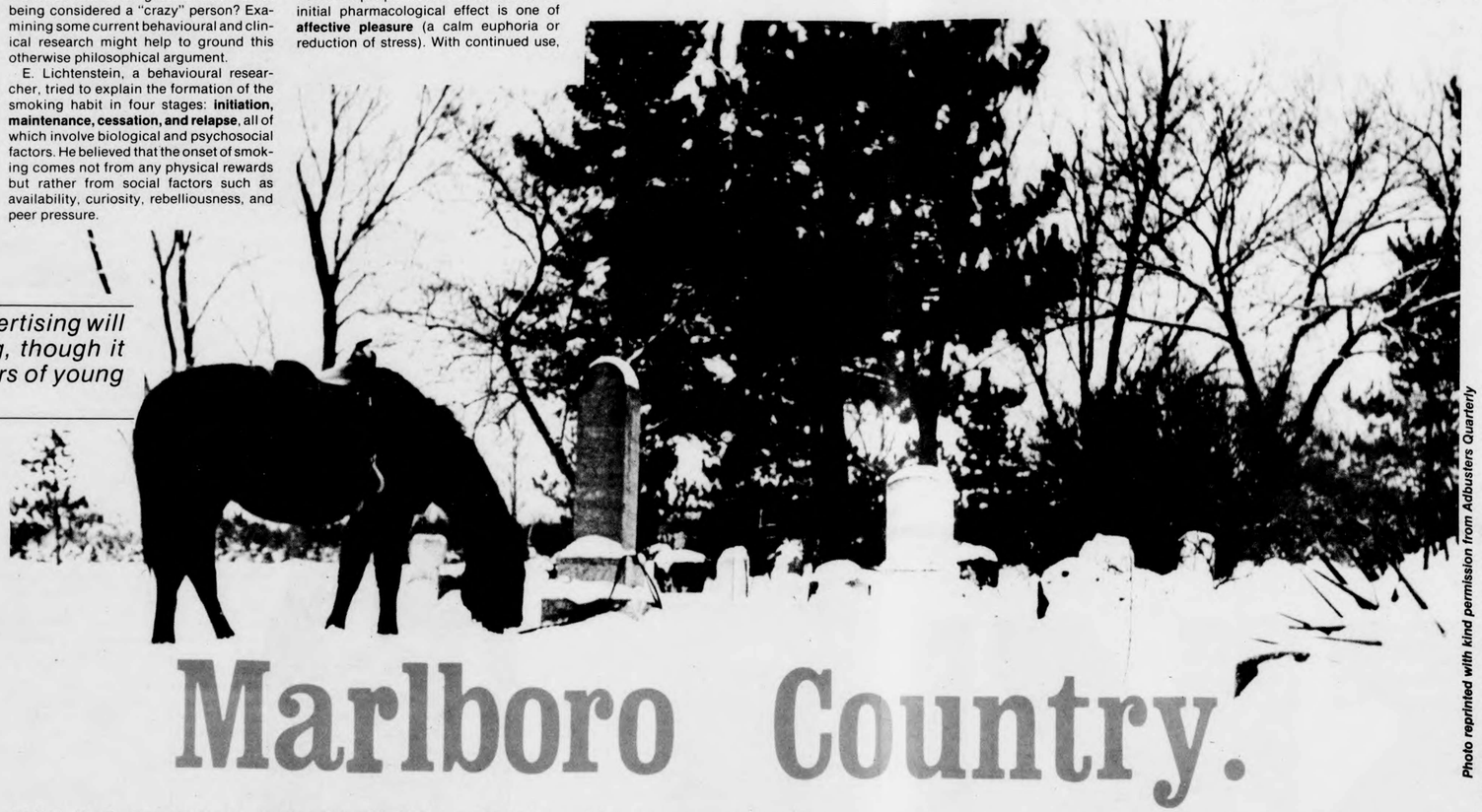
"Previously, there was little reason to treat a disturbed patient any differently if he or she happened to be a cigarette smoker," says Henningfield. It is now apparent that the cigarette-smoking patient should be considered as though it had been discovered that the person abused other drugs."

Using the grounds that addiction is abnormal, we should briefly consider a parallel. If such a common activity as cigarette-smoking is now being viewed as a maladaptive and addictive behaviour, then why has coffee-drinking, which is even more prevalent, not been condemned as a similarly harmful addiction.

"Smokers don't want to be considered psychiatric cases, explains Gagnon. "They want to be thought of as free agents."

Gagnon believes that the medical model to smoking cessation will not work if society thinks of itself as a doctor that automatically knows what is best for the "erring" individual. Smokers need to feel they have an ultimate choice whether or not to quit; they must not be forced to suffer treatment involuntarily.

The non-smoking lifestyle is undoubtedly the best one for the long-term; but is the removal of the individual's personal choice the right approach to take in the short term? I still haven't been able to decide. What about you?



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