

Smoker's Identity Scale: Measuring Identity in Tobacco Dependence and its Relationship With Confidence in Quitting

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Background and objectives: Persistent smoking behaviours are associated with numerous motives, explaining the absence of a single treatment for quitting. One of these motives may include that of identification. The threat of losing their smoker's identity may represent a significant obstacle to lasting abstinence. The objective of this study is to design a specific identity questionnaire and examine correlations between the degree of smoking identity and persistent smoking.

Methods: Patients attending a smoking cessation seminar completed the Modified Reasons for Smoking Scale, Barriers to smoking cessation checklist and our 6-item Smoker's Identity Scale (SIS) ($n = 170$ questionnaires).

Results: SIS showed good internal consistency, calculated by a Chronbach test ($\alpha = .785$) with no redundant questions. There was a correlation between strong tobacco dependence (measured by the Fagerström questionnaire) and strong smoking identity ($p = .0001$). Strong identity was associated with less confidence in quitting at both 1 and 6 months ($p = .037$ and $p = .002$, respectively). We showed that identity represents an obstacle to quitting in 32% of our patients and is associated with decreased confidence in quitting.

Conclusions and scientific significance: Our study shows that measuring identity in smokers who wish to make a quit attempt may help to identify specific obstacles to abstinence. This may also help in elaborating improved quitting strategies and patient management. Further research is necessary to confirm these results. (*Am J Addict* 2015;24:607–612)

INTRODUCTION

Persistent smoking behaviours are associated with numerous motives, explaining the absence of a single treatment for quitting. Many studies have attempted to describe the motivations for smoking, the main obstacles to quitting as well as the mechanisms maintaining tobacco addiction while attempting to initiate effective treatment.^{1–5}

Tobacco products induce strong dependence. Nicotine causes physical dependence with an irresistible need to use tobacco and withdrawal symptoms. Following an initiation phase, smoking rapidly becomes pleasurable, a means of coping with emotions,⁶ a habit and a behaviour. Fagerström notes the existence of non-pharmacological determinants in addictions such as (a) the habit and conditioning associated with smoking, (b) the role of the object (eg, the cigarette itself) (c) the psychosocial aspects of smoking.⁷ One aspect of these psychosocial elements may include an eventual smoker's identity.

Humans live in groups and collective environments. A person's identity is defined as the way in which one constructs his/her personal relations within his/her environment.⁸ Personal identity includes notions such as "self-consciousness and self representation".⁹ The sociological study of identity seeks to understand the relationships between personal and social identity.¹⁰ Social identity includes everything that enables outside observers to identify a person such as shared status with other groups in society (ie, gender, age, occupation. . .).

Several theories encompassing identity have been proposed to explain in persistent smoking behaviors. Molimard observes that the first cigarette is "an act that requires an initiation and some maturity" and a social group as "a centre

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for cigarette adoption". When constructing identity, he places cigarettes and smoking behaviour in the centre. He also states, "Tell me how you smoke and I'll tell you who you are". When smokers state, "Smoking is a part of me", "Stop smoking? Cut off my arm while you're at it", "I like being a smoker", raising significant objections to the loss of this aspect of their existence. Perhaps they also raise the question of identity. Thus, cigarette cessation may represent loss of identity.¹¹ Falomir and Invernizzi describe the smoker's identity as a significant factor of resistance to change due to belonging to a smoking social group and identifying oneself as a smoker.¹²

Few questionnaires specifically evaluate the existence of a smoker's identity and notably its strength. Currently, no questionnaire specifically evaluates this motivational aspect of smoking cessation. Few studies have examined the correlations between identity and persistent smoking. Thus, the objective of this study was twofold:

- To devise a questionnaire using elements from other tests to specifically target this motivational aspect.
- To examine correlations between identifying with being a smoker and confidence in their quit attempt within a population of outpatients seeking assistance in quitting.

METHODS

Population Studied

This is a monocentric, prospective study that was performed in the smoking cessation clinic in the Substance Abuse Treatment Service (Centre d'Enseignement, de Recherche et de Traitement des Addictions (CERTA)) at Paul Brousse Hospital; Villejuif, France. Prior to consultation with a physician, outpatients are required to attend an informational meeting. All outpatients attending these sessions between February 2011 and October 2012 were included in this study. All attendees were asked to fill out the study questionnaire prior to the meeting. All complete questionnaires were included in the analysis. The number of patients to be analysed was arbitrarily fixed at 200 subjects; a figure which was considered to have sufficient statistical power for our analyses.

Questionnaire Elaboration

Our questionnaire was comprised of:

- The Modified Reasons for Smoking Scale (MRSS)¹³ to evaluate patient motivations for smoking. Seven items are proposed in response to the question "I smoke because"; we then added a question to evaluate smokers identity component: "it is a part of me", a statement heard in consultation and cited by Molimard;¹¹
- The Abrams "Barriers to Smoking Cessation Checklist",¹⁴ translated and completed by Aubin et al.¹⁵ in the FOCUS study to which we added the statement "it is a part of me";
- Other questions were evaluated from various sources.^{9,11,16}

The final Smoker's Identity Scale (SIS) is shown in Table 1. It was decided to rate each question was rated on a 4-point Likert Scale (completely disagree, somewhat disagree, somewhat agree, completely agree) since the MRSS has already been validated using the same scale. In addition, this prevented patients from responding neutrally. We then examined any eventual associations between these elements and cigarette dependence as measured by the Fagerström Test Nicotine Dependence (FTND)^{7,17} Two questions from the Richmond Motivation Test¹⁸ were added to determine if these elements are associated with less self-confidence in quitting: "Have you thought about quitting within the next month?", "Do you think you will be an ex-smoker in 6 months time?".

Statistical Analysis

The responses to the MRSS and the modified Abrams questionnaire including the item "it is a part of me" were used for qualitative (percentage of responses) and quantitative analysis (ranking for each item). An analysis of the primary component was also performed to determine if the additional identity "it is a part of me" item was or wasn't identical to the others. The importance of the identity component was evaluated using the Cronbach alpha test to calculate internal coherency. Several scorings for this test were compared to define coherent classes: strong identity and weak identity (two classes) or weak, average and strong identity (three classes). A regression analysis for each of the sub-groups was performed for each score. We then retained the classification that represents the highest percentage of the variance for the 6 questions, to retain a maximum amount of information from each question. The initial protocol planned an ANOVA comparing the identified groups with variables such as gender and age; FTND was compared in a secondary analysis. Finally, a Kruskal-Wallis non-parametric test was performed for the two items from the Richmond test and the identity component evaluation to calculate "p" with a 95% interval of confidence.

RESULTS

Study Population

Two hundred patients were asked to respond in writing to our questionnaire; all accepted. One hundred seventy patient

TABLE 1. Smoker's Identity Scale (SIS) questionnaire

I feel like smoking characterizes me as a person.
I can't begin to imagine myself without cigarettes in my life.
I think others couldn't imagine me without cigarettes in my life.
I am afraid if I don't smoke, I won't be the same.
If I quit smoking, I will have to give up a part of myself.
Smoking is a part of me.

This is an self-rated questionnaire using a 4 point Likert scale (Completely disagree, somewhat disagree, somewhat agree, completely agree).

questionnaires were analysed; 30 were incomplete or illegible (response checked outside the box or between boxes). The sex ratio was 53% women to 47% men. 15 (9.04%) patients smoked 10 or less cigarettes per day; 86 patients (51.81%) between 11 and 20 cigarettes; 34 patients (20.48%) between 21 and 30 cigarettes and 30 patients (18.07%) 31 or more, this item was incomplete for 4 of the original questionnaires. The average age for our subjects was 43.900 years (± 11.558). Mean tobacco dependence as measured by the FTND was 6.200 (± 2.142); there was no significant difference according to gender.

Is Identity Perceived as a Cause for Persistent Smoking?

To respond to this question, we used two questionnaires:

- The most frequent response from the MRSS was “it’s an addiction” followed by “it’s a pleasure” and then “it’s a means to unwind”. “It’s a part of me” ranked 5th, followed by “being sociable”, “stimulant” and “keeps me occupied”. “It’s a part of me” is mentioned by 69% of our population (37% somewhat agreed, 32% completely agreed). The 8-item MRSS has a good internal coherency as measured by the Cronbach ($\alpha = .70$). When the item “it’s a part of me” is added, the Cronbach increases ($\alpha = .73$). A primary component analysis shows that this item is not explained by any other item in the MRSS.
- The Abrams questionnaire evaluates the obstacles to quitting perceived by smokers. “Handling stress” is the main obstacle cited by patients followed by “not knowing how to quit” and “feeling too irritable”. “It’s a part of me” is ranked 6th. If we analyse all items with a response of “very much”, the added “it’s a part of me” ranks 5th (32%), followed by weight control. The primary component analysis shows that this item is not explained by any other in the modified Abrams questionnaire.

Identity Measurement: Smoker’s Identity Scale

One hundred seventy patients responded to our 6-item Smoker’s Identity Scale (SIS). We arbitrarily attributed 0 points to the response “completely disagree”, 1 point to “somewhat disagree”, 2 points to “somewhat agree” and 3 points to “completely agree”. Statistical variance analysis was used to best categorise responses. Defining three categories, 0–6 points (weak identity component), 7–12 points (average identity component) and 13–18 (strong identity component), gave the best result explaining 84% of overall variance. According to these categories, 12% of our sample had a strong identity component, 42% an average one. (Table 2) The internal coherency test shows an alpha of .785. All six items are important and non-redundant in the primary component analysis. None of the test questions can be eliminated or overall coherency would be lost.

There was no significant difference in identity component as measured by the SIS according to gender ($p = .55$). There was however a significant difference between identity and age

(ANOVA test, $p = .045$). The difference was even more significant between the average and strong identity groups ($p = .039$) (Table 2).

We then performed a non-parametric test comparing the three SIS classes with the FTND (Kruskal-Wallis and ANOVA tests). This comparison shows that greater tobacco dependence is associated with higher identity components ($p = .0001$). This difference is significant between weak identity components; however, no significant differences were shown between, the average and strong identity groups a general regression analysis shows that the FTND only explains 12% of the SIS variance (Table 2).

Association Between Identity and Confidence in Quitting

To measure associations between identity and confidence in quitting, we used two of the questions from the Richmond test (“Do you think that you will quit smoking within the next 4 weeks?” and “Do you think you will be an ex-smoker in 6 months time?”). We analysed each question separately using a non-parametric test to compare several samples (Kruskal-Wallis test). These analyses show that when the identity component is strong, there is less confidence in the capacity to quit both in 1 month and 6 months time ($p = .037$ and $p = .002$, respectively). (Table 2) It is worth noting that the same Kruskal-Wallis test for the 4 FTND categories does not show an association between low levels of confidence and increased tobacco dependence at 1 month ($p = .78$) or at 6 months ($p = .70$).

DISCUSSION

Smoking is a learned behaviour that is reinforced and maintained by dependence. During the initiation period, the notion of modelling, imitating adults or peers, is essential. Despite the often adverse effects of the first cigarettes, a young person will continue to smoke in the hope of gaining other benefits, including identity construction.¹⁹ Throughout initiation, young smokers experience increased self-esteem. When smoking status is attained, they accrue the positive image of smokers: more sociable, more confident, more mature, thus improving self-image. Self-consistency also increases though becoming “one of the gang”.²⁰

Most identity studies on have focused on adolescents, showing that they smoke for reasons of maturity, confidence, “cool” attitude, seeking and developing personal meaning.²¹ In their review of the literature, Houssemand and Boyer attempted to uncover various determinants for smoking in adolescent. Personal determinants included gender, age, behaviour with respect to smoking and image. They found that intention to smoke is stronger when self-esteem is lower and when the image of smokers has higher value.²² Barton et al. has similar findings.²³ For other authors, adolescents begin to smoke because the image they have of themselves corresponds with the image they have of smokers.²⁴

TABLE 2. Comparison between groups as classed according to the Smoker's Identity Score.

Smoker identity score group (<i>n</i> = 170)	Weak (W)	Average (A)	Strong (S)	p value
N (%)	78 (45.882)	71 (14.765)	21(12.353)	
Age	43.192 (11.558)	42.944 (10.670)	49.762 (13.221)	W vs. A = ns W vs. S = .045 A vs. S = .039
FTND score	5.500 (2.087)	6.732 (1.882)	7.000 (2,449)	W vs. A < .0001 W vs. S = .016 A vs. S = ns
Confidence in quitting at 1 month	1.821 (1.029)	1.437 (.857)	1.381 (1.024)	.037
Confidence in quitting at 6 months	2.269 (.907)	1.845 (.804)	1.762 (.768)	0.002

All calculations are expressed as the mean \pm standard déviation. FTND: Fagerström Nicotine Dependence Test.

According to Gruet, smoking participates in building lifestyle and social identity.²⁵ The tobacco industry has long used this motive to sell social representations and identity. In 2012; Hendlin et al. showed that Camel's marketing strategies in the 90's promoted a cleaned-up alternative underground lifestyle that was attributed to "the cool among the cool" portraying tobacco as an "acceptable rebellion".²⁶ Scheffels' qualitative study showed that brand choice and packaging was associated with smoker's social status, personal characteristics and social identity.²⁷

Several authors have shown that identity represents a significant obstacle to quitting smoking. Falomir and Mugny mention smokers' reactions to anti-smoking campaigns as well as the stakes of maintaining identity.²⁰ Fagerström links smoking to addictogenic substances in tobacco smoke (nicotine and monoamine oxydase inhibitors) in addition to habit development and conditioning, to cigarettes as an object and finally to its social function. He further states that obstacles to quitting may be more related to tobacco's non-nicotine functions than to the nicotine itself.⁷ For Molimard, certain patients both identify themselves as smokers and are recognised as smokers.¹¹ To lose cigarettes is to abandon and to grieve a part of oneself. Falomir claims that the more a smoker identifies with other smokers, the more their behaviour will conform to the prescribed norm and the less they will be motivated to quit.¹² Using the statement, "I like being a smoker", Tombor et al. determined that positive smoking identity was associated with gender (male), age (older), greater nicotine dependence and fewer quit attempts.²⁸ Contrary to these results, SIS was not associated with gender or nicotine dependence as measured by FTND.

To improve treatment, West proposes re-examining the role of identity (for example, "I see myself as a smoker") when changing behaviours.²⁹ A few recent studies have focused on identity valence. Tambor et al. used the statement "I like being a smoker" to determine if identity could be an obstacle to smoking cessation.²⁸

Our statement "smoking is a part of me" represents both a motivation for smoking and obstacle to quitting. Among our patients, it ranked 5th of 8 items included in the MRSS after habit, addiction, stress management, means of relaxing and pleasure.

Thus it would seem appropriate to include it among the motivations for smoking. Adding this item enhances the MRSS's internal coherence (Cronbach alpha increases from .70 to .73). In our sample, 32% completely agreed with this affirmation. In 2009, Fidler and West, proposed to add the item "I like being a smoker" to their initial questionnaire; 17.2% of subjects agreed with this statement.³⁰ The DTDS (Dimensions of Tobacco Dependence Scale) was designed to measure adolescent tobacco dependence. The authors place a great deal of emphasis on the social motives in adolescents.³¹ In the short 27-item version of the WISDM questionnaire, certain items are similar to those in the SIS: item 28 (other smokers consider me to be a heavy smoker) and item 36 (I consider myself to be a heavy smoker). Both emphasize quantity while diminishing personal perception of identity. Similarly, the emotional attachment to smoking (items 11, 22 and 26) explores the benefits of smoking rather than the importance of smoker's identity.³²

To evaluate the importance of the identity component, we designed a specific 6-item questionnaire, the Smoker's Identity Scale (SIS). This test has a very good internal coherence (Chronbach alpha of 0.78). Using logistical regression, we determined that all of the questions were important. The SIS did not show any correlation with regard to gender; it did however, show a weak but significant correlation with age (ANOVA test, $p = .045$). It has strong correlation with the FTND. We cannot, conclude that physical dependence is significant for two reasons. First, Fagerström explains that his test explores overall tobacco dependence and not just nicotine dependence.⁷ Second, the general regression analysis shows that the FTND is only responsible for 12% of the identity component variance. Thus, the SIS represents a specific tool designed to determine the strength of smoking identity. It is brief, simple and may be used by health care professionals in determining identity motive that could be obstacles to quitting.

Another objective of this study was to measure correlations between identity strength, as measured by SIS, and the degree of confidence in quitting. In our sample, the stronger a smoker's identity component, the less they saw themselves as ex-smokers at both 1-month and 6-months time. However, tobacco dependence (FTND measure) does not modify confidence in quitting at 1 month or 6 months in our sample.

Thus, FTND and SIS do not measure the same dimensions in tobacco dependence. In Fidler and West's study, those who responded that they liked being a smoker were less likely to have tried to quit within the previous year than the other smokers.³⁰ Thus it would seem that considering oneself to be a smoker decreases confidence in quitting. Confidence represents a key element in changing behaviours such as smoking according to Rollnick and Miller.³³ Reduced confidence in quitting in relation with a strong identity component would be in line with Falomir who stated that the stronger the identification, the greater the resistance to change.²⁰ According to Vangeli and West, a complete transition to a "non-smoker" identity may not be necessary to obtain lasting abstinence. In their phenomenological analysis, abstinent smokers had more of an "ex-smoker" identity with continued attraction to smoking.³⁴ Another study by Tombor et al. has shown that smokers who have been abstinent for three and six months consider themselves as non-smokers using statements such as "I think of myself as a non-smoker". Individual "non-smoker" identity was associated with continued abstinence.³⁵ Use of the SIS may enable clinicians and researchers to examine other factors such as peer group perceptions in identity to better predict future abstinence from smoking.

One scale exists that characterizes identity in adolescents, the Smoker Self Concept Scale. It evaluates the importance of being a smoker on self-concept, self-image and personality. The scale contains 5 items rated from 1 to 10. Schadel et al. found a mean score of 23.8/50 (SD=9.1, $n = 199$) and no association with age, education or gender. There was a weak association with FTND scores.³⁶ Smokers with a high Smoker Self Concept Scale (SSCS) were less likely to be abstinent at 3 months, regardless of the results from the Abstainer Self-Concept Scale (ASCS), a questionnaire designed to evaluate projections of becoming a non-smoker. On the contrary, smokers with a low SSCS and a high ASCS had a greater chance of being abstinent at 3 months. This study, as well as ours, suggests that a strong identity component decreases the chances of quitting.

Our study has several limitations. It is performed in a population of smokers who were motivated to attempt to quit smoking, thus the results of this study are not representative of the general population of smokers. This may also explain our 100% participation rate. Another important limitation is that the SIS was administered to patients in one hospital centre in France. It would be interesting to validate this questionnaire in other populations, both clinical and non-clinical, French and international. The use of SIS in clinical practice should be evaluated during pre-consultation to examine if it can be used as a determinant of smoking cessation. It could also be used as part of a cessation algorithm for treatment to determine the most appropriate treatment option based on SIS.

CONCLUSION

Tobacco dependence is influenced by a multitude of factors. In some smokers, it is comprised of a significant personal and

social identity component. We designed a Smoker's Identity Scale (SIS) in order to evaluate identity strength. The SIS is a rapid, simple and specific measure of the identity component in smokers. In nearly one-third of our patients, identity represents a motive for smoking and an obstacle to quitting and it is associated with decreased confidence in their capacity to quit. Future studies should be conducted in order to confirm the validity of SIS in more diverse populations and settings, as well as confirming any correlations with motivations for quitting and outcomes from quit attempts. Characterizing and addressing identity may be helpful in improving clinical management of smokers.

Declaration of Interest

P. Dupont has no conflict of interest to declare. V. Tack has no conflict of interest to declare. L. Blecha has no conflict of interest to declare. M. Reynaud has received consulting fees from D&A Pharm and Ethypharm. A. Benyamina has received speaker honoraria from Bristol-Meyers-Squibb, Euthérapie, Lundbeck and Merck-Serono. He is a member of the board for Reckitt-Benckiser. A. Amirouche has no conflict of interest to declare. H.J. Aubin has received sponsorship to attend scientific conferences, speaker honoraria and consulting fees from Bioproject, D&A Pharma, Ethypharm, Lundbeck, Merck-Serono, Novartis and Pfizer.

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