

Intervention for tobacco dependence among people with a mental illness

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**A. Baker, F. Kay-Lambkin, S. Bucci, M.
Haile, R. Richmond and V. Carr**

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people with a mental illness**

NDARC Technical Report No. 192

INTERVENTION FOR TOBACCO DEPENDENCE AMONG PEOPLE WITH A MENTAL ILLNESS

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS	6
1. INTRODUCTION	6
1.1 Context.....	6
1.2 Organisation of this Manual	7
2. BRIEF BACKGROUND TO THE STUDY AND SUMMARY OF RESULTS OF EVALUATION.....	8
2.1 Introduction	8
2.2 Participants and procedure.....	8
2.3 Measures	8
2.4 Design	8
2.5 Content of the Interventions	10
2.5.1 <i>Cognitive Behaviour Therapy (CBT) condition</i>	10
2.5.2 <i>Control Condition</i>	10
2.5.3 <i>Therapists</i>	10
2.6 Summary of Main Results	10
3. THE INTERVENTION	12
3.1 Rationale and principles of treatment.....	12
3.2 Goals of treatment	12
3.3 Monitoring Symptomatology.....	12
3.3.1 <i>Suicide Risk Assessment</i>	12
3.4 Therapist checklist.....	13
3.5 Format of therapy.....	14
3.5.1 <i>Timing and length of intervention</i>	14
Missed appointments	14
3.5.2 <i>Phases of Treatment</i>	15
3.5.3 <i>Conducting the therapy</i>	15
Abstinence versus Harm Reduction Approaches.....	15
3.6 Getting Started.....	15
3.6.1 <i>Case formulation</i>	16
What are the factors that maintain current problems?.....	16
How did these problems develop?.....	16
What is the relationship between the various problems this client has?	17
SESSION 1 - MOTIVATIONAL INTERVIEWING.....	18
Phase 1: Build Rapport.....	18
Phase 2: Strengthen Commitment.....	18
Homework	18
SESSION 2 - PLANNING TO QUIT	29
Review homework and set agenda	29
Introduce the notion of cravings	29
Provide information about cravings/urges to smoke.....	29
Discuss urge management strategies	29
Devise a craving plan.....	29
Homework	29
SESSION 3 - ENGAGING SUPPORT PERSON, COPING WITH LAPSES, COGNITIVE RESTRUCTURING	38

Review past week and homework activities and set agenda.	38
Engage the support person.....	38
Discuss nicotine withdrawal and the use of Nicotine Replacement Therapy.....	38
Discuss the abstinence/rule violation effect.....	38
Cognitive Restructuring	38
Boost motivation.....	38
Homework	38

SESSION 4 - SEEMINGLY IRRELEVANT DECISIONS, DEVELOPMENT OF PERSONAL SKILLS.46

Review past week and homework activities and set agenda.	46
Seemingly Irrelevant Decisions	46
Development of personal skills.....	46
Problem solving skills.....	46
Homework.	46

SESSION 5 - DEVELOP COPING SKILLS, REVIEW & CONSOLIDATE.....57

Review past week and homework activities and set agenda	57
Discuss coping skills training including.....	57
Homework	57

SESSION 6 - RELAPSE PREVENTION, RELAPSE MANAGEMENT, TERMINATION63

Review homework.	63
Rationale for relapse prevention.....	63
Identification of high-risk situations	63
Preparation for high-risk situations.....	63
Regulating the consequences of behaviour.....	63
Using the relapse prevention plan	63
Termination.....	63

SESSION 7 - (BOOSTER SESSION 1).70

Review relapse prevention/management plan.....	70
Discuss tapering of Nicotine Replacement Therapy	70
Make appointment for two week's time.	70

SESSION 8 - (BOOSTER SESSION 2).....73

Review relapse prevention/management plan.....	73
Discuss tapering of Nicotine Replacement Therapy	73
Make appointment for the post-treatment assessment	73

4. REFERENCES.....76

LIST OF FIGURES

Figure 2.1	Study Protocol.....	9
Figure 3.1	Questions for assessing suicidal ideation.....	13
Figure 3.2	The Case Formulation.....	17
Figure 3.3	Pros and Cons Grid.....	21
Figure 3.4	Therapist Checklist – Session 1	28
Figure 3.5	Facts About Cravings.....	31
Figure 3.6	All Purpose Coping Plan	34
Figure 3.7	Facts about Nicotine Withdrawal.....	35
Figure 3.8	Therapist Checklist – Session 2	37
Figure 3.9	Changing Unhelpful Thinking	43
Figure 3.10	Therapist Checklist for Session 3	45
Figure 3.11	Seemingly Irrelevant Decisions.....	48
Figure 3.12	Dealing with Worries about Weight Gain.....	50
Figure 3.13	Problem-Solving.....	54
Figure 3.14	Therapist Checklist for Session 4	56
Figure 3.15	Summary of Refusal Skills	59
Figure 3.16	Summary of Assertiveness Skills	60
Figure 3.17	Summary of Communication Skills.....	61
Figure 3.18	Therapist Checklist for Session 5	62
Figure 3.19	Relapse Prevention Plan	67
Figure 3.20	Therapist Checklist for Session 6	69
Figure 3.21	Therapist Checklist for Session 7 (booster session1)	72
Figure 3.22	Therapist Checklist for Session 8 (booster session 2)	75

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1. INTRODUCTION

1.1 Context

The prevalence of smoking among people with a psychiatric illness, especially schizophrenia, is much higher than in the general population (Goff et al., 1992). Smoking is associated with adverse mental and physical consequences among people with psychotic disorders. People with a psychotic illness who smoke require an increase in medication due to changes in its metabolism. In turn, this leads to increased side-effects, including dysphoria (Wilhelm, 1998). In terms of adverse physical consequences, smoking related diseases are the greatest contributor to early mortality among people with a psychotic illness (Lawrence, Holma & Jablensky, 2001).

Ziedonis and Williams (2003) have recently summarized the numerous biological, psychological and social factors that may act to increase the risk of nicotine dependence among people with psychotic disorders. Biological factors include: enhancement of dopamine transmission with possible reduction in negative symptoms; possibly an influence on stress, anxiety and depression; and genetic influences on the initiation and maintenance of smoking. Social factors that increase smoking risks include: limited education; poverty; unemployment; peer pressure; and the treatment system. That is, as some patients start daily smoking after the onset of schizophrenia, there may be influences from other patients and the treatment environment on smoking behaviours (Peterson et al., 2003).

Despite the high prevalence of smoking, smoking cessation programs have not typically been part of treatment regimens available to people with psychiatric illness. This is possibly due to the belief that the cognitive, social and affective deficits, including the amotivational state typical of schizophrenia present an insurmountable barrier to change for this group (Addington et al., 1997).

In 2000, the National Health and Medical Research Council of Australia (NHMRC) funded a project entitled “Intervention for smoking among people with a mental illness” (Chief Investigators Baker, Richmond, & Carr), which built on results from a pilot study conducted in 1999. The pilot study received funding from the Australian Rotary Health Research Fund and the Community Health and Anti-Tuberculosis Association.

The above projects aimed to evaluate the effectiveness of a six-session intervention followed by two booster sessions for tobacco dependence on the course of smoking and psychiatric symptomatology among a sample (n=298) of people with a psychotic illness. Participants were recruited from the Sydney and the Newcastle regions of New South Wales, Australia. Almost two-thirds of the study sample were either contemplating quitting or cutting down or were preparing to quit smoking. The fact that people with a psychotic illness are interested in giving up smoking attests to the potential likelihood of attracting sufficient numbers of people if smoking cessation interventions were to be offered by mental health services. This manual describes the psychological intervention for smoking cessation evaluated by this research program.

The development of the intervention was informed by various treatment approaches that have been utilised for smokers. The treatment described in this manual combines motivational enhancement techniques, cognitive behavioural strategies, self-help material and nicotine replacement therapy (NRT).

1.2 Organisation of this Manual

The intervention described in this manual was delivered over six weekly sessions, followed by two fortnightly booster sessions, and was conducted on an individual basis.

This manual first describes some of the theoretical and contextual background information relevant to the treatment program, and its evaluation in the randomised controlled trial conducted over 2000-2003. Outcomes for the randomised controlled trial are briefly summarised.

Each subsequent section contains a detailed session-by-session guide to the content of the tobacco reduction intervention evaluated in the randomised controlled trial. Many handouts, homework activities and therapist and client resources are additionally provided.

The intervention was accompanied by use of the SANE Smoke Free Kit (SANE Australia, 1998).

Each session is preceded by a *Therapist Summary Sheet* that lists all the strategies and information to be covered in the relevant session. Each session description concludes with a *Therapist Checklist* to assist with clinical note taking, and ensuring all the essential components of the therapy session were covered.

2. BRIEF BACKGROUND TO THE STUDY AND SUMMARY OF RESULTS OF EVALUATION

2.1 Introduction

The present study is built on a pilot study conducted by Baker, Richmond and Carr in 2000, which showed that conducting and evaluating cognitive behaviour therapy (CBT) plus NRT in a randomised controlled trial among smokers with a psychotic illness was feasible.

2.2 Participants and procedure

A total of 360 people were screened for the study between March 2001 and October 2002 from Sydney and the Newcastle Region (New South Wales, Australia). Of these, 298 (82.7%) were enrolled in the study. Inclusion criteria were: aged at least 18 years; daily consumption of at least 15 cigarettes; and fulfilment of ICD-10 diagnostic criteria for a psychotic illness. Exclusion criteria were: medical conditions that would preclude use of NRT; acute psychosis (in which case reassessment one month post screening was arranged); and acquired cognitive impairment.

2.3 Measures

Data were collected on demographic characteristics, past and present tobacco use, alcohol and other drug use and mental health history, treatment history, stage of change for smoking, nicotine dependence, reasons for smoking and motivation to quit smoking.

Assessments were scheduled at pre-intervention, post-intervention (15 weeks following the nominal quit date), and 6- and 12-months following the nominal quit date. The “quit date” was assumed to be week three of treatment, given this was the earliest possible session during the treatment phase that participants could decide to quit smoking and commence NRT. For controls, the “quit date” was assumed to be three weeks following completion of their initial assessment.

Assessments were conducted by interviewers who were blind to participants’ intervention allocation.

2.4 Design

The study protocol is displayed in Figure 2.1.

Participants were randomly allocated to an active treatment condition (6-weekly sessions plus 2 fortnightly booster session of CBT plus NRT in addition to self-help booklets) or control condition (self-help booklets alone).

The self-help booklets were developed by SANE Australia for people with a mental illness (SANE Australia, 1998). Copies of the self-help booklets can be ordered from the SANE Australia Bookshop (<http://www.sane.org/>).

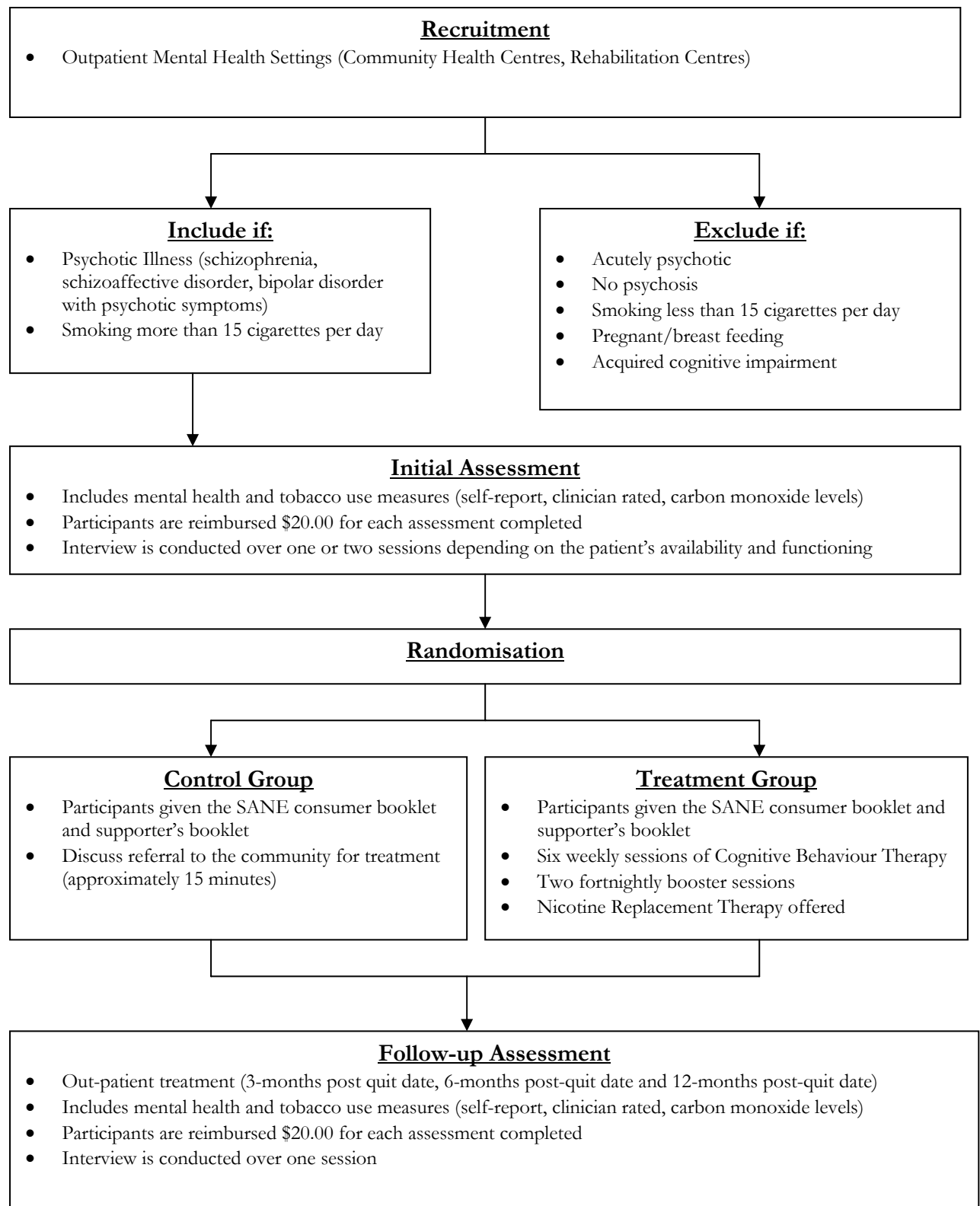


Figure 2.1 Study Protocol

2.5 Content of the Interventions

2.5.1 Cognitive Behaviour Therapy (CBT) condition

CBT was delivered individually to participants by a trained therapist. Therapists followed this treatment manual, revised and expanded from that used in the pilot study, in conjunction with the SANE self-help booklets.

The therapy began by giving personalised feedback of assessment results (including level of nicotine dependence and high-risk situations for relapse) and a motivational interview designed to encourage participants to attempt smoking cessation.

In following sessions, education about the interaction between nicotine and mental illness, medication and cognition was provided. The importance of NRT and the rationale for its use was also explained. Beliefs regarding the relationship between smoking and mental illness were challenged and alternatives identified. In later sessions cognitive behavioural strategies such as coping with craving, relapse prevention and lifestyle issues were discussed. The therapist monitored psychiatric symptoms and medication adherence. Psychiatric management of the participants was provided by their own psychiatrist and community case managers.

2.5.2 Control Condition

Participants allocated to the control condition were assessed at pre-intervention, post-intervention, and 6- and 12-months follow-up and were given the same self-help booklets as the intervention condition at pre-intervention.

2.5.3 Therapists

Therapists were University Graduates (four psychologists and one mental health nurse). A week long training session was held at the commencement of the project. This covered research procedures and role plays of assessment instrument administration and intervention sessions. Videotaped feedback was used to enhance training. Session checklists were employed to guide weekly supervision provided by the first chief investigator (Dr Amanda Baker).

2.6 Summary of Main Results

At pre-intervention, the sample comprised of smokers who were mostly taking antipsychotic medication (82.9%). Schizophrenia was the most common primary psychiatric diagnosis (42.3%). On average, participants were heavy smokers and highly dependent on nicotine. They had begun smoking at an early age and had been daily smokers for about five years before they were first diagnosed with a mental illness. Participants reported having made only a relatively small number of quit attempts. As expected, those with a high dependence score smoked significantly more cigarettes per day and were significantly more likely to cite 'addiction' as a reason for smoking compared to those with a low dependence score.

Although only 27% of the sample was at a stage where they were preparing to quit smoking, 83% were retained at 12-month follow-up. Over three quarters (76%) of those assigned to the intervention condition attended the majority of sessions. Thus, smokers

with a severe mental illness who are ambivalent about change, can be recruited, treated and retained for follow-up evaluation.

The results of the present study indicated that there was a significant reduction in mean daily cigarette consumption (30.5 vs. 25.4, $p < 0.001$) and mean Fagerstrom Nicotine Dependence scores (8.0 vs. 6.3, $p < 0.001$) from baseline to 12-months among this sample ($n=217$). These effects were not differentiated by intervention group. This modest improvement was likely to be related to commitment to being in the project and the assessment process.

However, participants who completed all treatment sessions were significantly more likely to be abstinent at 3-month follow-up (point prevalence) compared to the control group (30% vs. 6.0% abstinent, Odds Ratio (OR) 6.76, $p < 0.001$). They were also more likely to have been continually abstinent for the 3-months since setting a quit date (22.9% vs. 4.0%, OR 7.16, $p < 0.001$) compared to those in the control group.

Participants who completed all treatment sessions were also significantly more likely to be abstinent (point prevalence) at the 6- and 12-month follow-ups compared to those in the control group, (18.6% vs. 4.0%, OR 5.51, $p < 0.001$) and (18.6% vs. 6.6%, OR 3.22, $p < 0.01$) respectively. Thus, being in the intervention group and attending all therapy sessions had a significant effect on smoking behaviours. There were no intervention effects for any other variables (depression, anxiety, and health).

Abstinence from smoking was confirmed using a Micro 11 Smokerlyser which assesses breath levels of carbon monoxide.

3. THE INTERVENTION

3.1 Rationale and principles of treatment

This treatment adopts the assumption of the motivation enhancement therapy (MET) approach that the responsibility for change lays within the client (Miller et al., 1995). The therapist's task is to create a set of conditions that will enhance the client's own motivation and commitment for change. The therapist does this by following the five basic motivational principles:

1. Express empathy;
2. Develop discrepancy;
3. Avoid argumentation;
4. Roll with resistance; and
5. Support self-efficacy.

Following the development of the client's commitment to change, the therapist assists the client in learning skills that will help him/her achieve change (Miller et al., 1995).

3.2 Goals of treatment

The first goal of treatment is to enhance the client's understanding of possible interactions between their smoking habits and their mental illness (symptomatology and medication compliance) and other health problems (potential and existing). The second goal is to reduce the harm (e.g., mental and physical health, financial, social, and occupational) associated with smoking.

The client will identify specific goals and will be encouraged to consider quitting smoking.

3.3 Monitoring Symptomatology

The therapist should monitor symptomatology throughout the treatment program, and be aware that quitting smoking may be a stressor that could potentially contribute to symptom exacerbation.

3.3.1 Suicide Risk Assessment

If you identify at any stage in the assessment or treatment process that your client is experiencing suicidal ideation, use the following questions in Figure 3.1 to assess their level of risk.

If you feel that a client fits in the 'high-risk' suicide category, follow the suicide policy in place at your workplace.

If a decision is made to manage a high-risk suicidal client, the client should be given written information about how to seek 24-hour assistance if required, and they should be closely monitored throughout the intervention.

1. Have you been feeling depressed for several days at a time?
2. When you feel this way, have you ever had thoughts of killing yourself?
3. When did these thoughts occur?
4. What did you think you might do to yourself?
5. Did you act on these thoughts in any way?
6. How often do these thoughts occur?
7. When was the last time you had these thoughts?
8. Have your thoughts ever included harming someone else as well as yourself?
9. Recently, what specifically have you thought of doing to yourself?
10. Have you taken any steps toward doing this? (e.g. getting pills/buying a gun?)
11. Have you thought about when and where you would do this?
12. Have you made any plans for your possessions or left any instructions for people for after your death such as a note or a will?
13. Have you thought about the effect your death would have on your family or friends?
14. What has stopped you from acting on your thoughts so far?
15. What are your thoughts about staying alive?
16. What help could make it easier to cope with your problems at the moment?
17. How does talking about all this make you feel?

Reproduced with permission from Treatment Protocol Project (2000) *Management of Mental Disorders pp. 22-23*, Third Edition, Sydney: World Health Organisation Collaborating Centre for Mental Health and Substance Abuse.

Figure 3.1 Questions for assessing suicidal ideation

3.4 Therapist checklist

This treatment manual has been designed for people with a psychotic illness who also smoke tobacco. It is essential the core components identified in the intervention are discussed. In the randomised controlled trial of the intervention described herein, therapists were required to complete a *Therapist Checklist* (adapted from NIDA, 1989) at the end of each of the eight sessions to monitor session content. These checklists supplemented clinical notes kept on each treatment participant by their treating therapist. The *Therapist Checklist* has been included in this manual, and appears in the session handouts for each session described below.

3.5 Format of therapy

Guidelines for the delivery of the treatment sessions are given for each of the eight sessions (including two booster sessions) in this manual. These guidelines are general, around which a therapist will be able to add his or her own style and experience.

3.5.1 Timing and length of intervention

The CBT program should be delivered over a total of eight therapy sessions (including two booster sessions). Each structured session should be approximately one hour in length.

One or two assessment sessions are undertaken in the week prior to therapy commencing in which key data are obtained from the client, and an outline of the nature and content of the therapy is given. Questionnaire data may be scored in the week prior to the first CBT session, to allow relevant comprehensive feedback to be provided to the client.

A letter is sent to the person's GP, psychiatrist and Case Manager informing them of the person's participation in the study and with contact details of the researchers for any questions.

Ideally, the timing and physical location of the therapy sessions should be as consistent as possible. That is, appointments for the same time and day should be made for each subsequent week, and the place (i.e. consulting room) should be held constant. This may help optimise the establishment of a working rapport with the therapist and assist the client in becoming comfortable with the therapeutic arrangements.

Although weekly sessions are preferable, there will be occasions when clients cannot attend or forget their appointment. In this case, an attempt should be made to reschedule for the same week. If this is not possible, the session should be carried over to the regular time the following week. Missed sessions of more than three appointments in a row, a hiatus of four weeks or two breaks of two weeks are a serious compromise to the effective running of the program.

Missed appointments

The following protocol was implemented in the randomised controlled trial of the intervention described in this manual, when participants in the study missed several consecutive appointments. These strategies may be useful to therapists outside the research situation to encourage completion of therapy.

If an appointment is missed, the following procedures are recommended (Miller et al., 1995):

- telephone the client and clarify the reasons for the missed appointment;
- affirm the client - reinforce him/her for having come on previous occasions;
- express your eagerness to see the client again;
- briefly mention any issues that emerged to date and your appreciation (as appropriate) that the client is exploring these;
- express your optimism about the prospects for change; and
- reschedule the appointment.

If a reasonable explanation for the missed appointment is not offered, explore this with the client and determine whether the missed appointment is reflective of any of the following:

- uncertainty about whether or not treatment is necessary;
- ambivalence about making a change; or
- frustration/anger for participating in treatment.

These issues should be handled in a manner consistent with the MET approach.

3.5.2 Phases of Treatment

Graham (2000) outlines four treatment phases:

- engagement and building motivation for change;
- negotiating behaviour change;
- early relapse prevention; and
- relapse prevention/management.

As clients will move between the different stages of change (Prochaska & DiClemente, 1992, described in Miller & Rollnick, 1991) within and between sessions, the therapist will need to use strategies appropriate to each phase flexibly, rather than in a linear sequence.

3.5.3 Conducting the therapy

At the beginning of each session description below, a *Therapist Summary Sheet* is included, and may be photocopied and taken into each therapy session with the client. The *Therapist Summary Sheet* briefly lists all the techniques, strategies and information to be discussed during the session, and includes a list of all the handouts/homework sheets that supplement the session agenda. Therapists can take these summary sheets into each session and refer to them throughout.

Abstinence versus Harm Reduction Approaches

A harm reduction approach was generally taken with the smoking intervention described in this manual. Clients were provided with the opportunity to set and work towards their own goals for reduction or abstinence. Having said this, however, therapists encouraged a goal of abstinence when it was suggested by the client.

In general, clients were asked to decide on their goal for smoking cessation/reduction in the first two weeks of therapy, with the “quit/reduction date” to take effect from session three. It was during session three that clients were offered NRT (patches) if quitting. Suggestions for delivery of NRT are provided in the detailed account of each session. Such suggestions follow the guidelines contained within each pack of NRT patches.

3.6 Getting Started

In preparation for the first session, it is useful for the therapist to develop a case formulation for their client.

A case formulation is a theory that explains a person’s current symptoms and problems and hypothesises how they developed. It includes information gathered from assessment, therapist observations and client reflections.

Although the treatment protocol for the randomised controlled trial is prescribed, it is based on a general formulation at the level of the syndrome or problems associated with psychotic illnesses and co-occurring smoking use problems. In carrying out the protocol described in this manual, it is important for the therapist to individually construct a case formulation specific to the person who presents for therapy, to gain a better understanding of their presenting problems and to anticipate potential barriers to treatment.

The case formulation detailed below is adapted from Persons et al. (1989), and is a systematic way of synthesising results from assessment with individual information from the client.

3.6.1 Case formulation (Persons, 1989)

The case formulation model conceptualises psychological problems as occurring at two levels, **overt** (cognitions, behaviour, mood) and **underlying mechanisms**. Underlying mechanisms include irrational beliefs and difficulties with problem solving.

Environmental factors play a role in eliciting and triggering underlying beliefs and overt difficulties. One important area of consideration is the link between beliefs about mental illness and smoking. Your formulation about the underlying mechanism will play a central role in guiding your choice of intervention strategies. It provides the basis for the treatment plan, which follows directly from the hypothesis about the nature of the underlying issues of the patient's problem. Use the assessment information to generate working hypotheses about the underlying mechanisms of the overt presentation.

The case formulation has six parts:

1. the problem list;
2. the proposed underlying mechanism;
3. an account of the way in which the proposed mechanism produces the problems on the problem list;
4. precipitants of current problems;
5. origins of the mechanism in the client's early life; and
6. predicted obstacles to treatment based on the formulation.

Below are some questions to consider when developing your case formulation (Graham, 2000, p20-21). Information collected from the assessment will additionally be useful here, and can inform the case formulation.

What are the factors that maintain current problems?

- What factors (e.g. situations, mood, and psychotic symptoms) trigger smoking?
- What factors maintain their smoking/symptoms (i.e. reasons for smoking; effects/problems associated with their smoking)?
- What beliefs are held about their smoking/mental illness?
- What are the positive/negative influences in the social network towards smoking?

How did these problems develop?

- What key early experiences might have shaped the clients view of themselves/world/other people?
- What core beliefs does the client hold about himself or herself?

What is the relationship between the various problems this client has?

- What is the relationship between their smoking and mental health problem?
- What are the links in their beliefs about their smoking and mental health?

Figure 3.2 displays the case formulation summary sheet used in the randomised controlled trial. Revise the problem list and case formulation as required throughout treatment.

<ul style="list-style-type: none">▪ Identifying Information: ▪ Main Concern: ▪ Problem List:<ul style="list-style-type: none">1.2.3.4.5. ▪ How did these problems develop? ▪ How are these problems related to the client's main concerns? ▪ Treatment Plan:
--

Figure 3.2 The Case Formulation

SESSION 1 – MOTIVATIONAL INTERVIEWING

Therapist Summary Sheet

Aims:

- Engagement and building motivation for change in mental health problems and cigarette use.
- Prepare to quit smoking (begin to cut down number of cigarettes per day).

Materials needed for Session 1

- SANE Smokefree handbook (SANE Australia, 1998; pages 4-11, pages 16-17)
- Figure 3.3 – Weighing up the pros and cons of smoking
- Figure 3.4 Therapist Checklist for Session 1

Main areas to be covered:

Phase 1: Build Rapport

1. Present the rationale for treatment
2. Elicit self-motivational statements by asking about:
 - Mental health problems
 - Lifestyle issues
 - Raise the issue of smoking
 - Explore the importance of change
 - Explore confidence for change
 - Decisional balance
 - Looking back
 - Self vs. smoker
3. Affirm and summarise

Phase 2: Strengthen Commitment

1. Ask a transitional question
2. Communicate free choice
3. Consequences of action and inaction
4. Address fears
5. Provide information and advice
6. Set goals
7. Summarise
8. Establish a treatment contract
9. Set homework (high-risk situations)

Homework

SESSION 1 - MOTIVATIONAL INTERVIEWING

Detailed Intervention

Motivational enhancement training (MET; Miller et al, 1995)

MET can be used flexibly, allowing for the therapist to incorporate his/her own style and experiment with different strategies.

Clients will be at various stages of change for their mental health problem and smoking tobacco. Therapists will need to gauge how quickly they can move to discussing smoking directly with each client. In this way they will begin to get an idea about the areas of behaviour change which may be approached earlier with the client and those that may require later or more sophisticated strategies.

Critical conditions for promoting change are accurate empathy, non-possessive warmth and genuineness. Strategies to promote motivation to change include:

- giving ADVICE;
- removing BARRIERS;
- providing CHOICE;
- decreasing DESIRABILITY;
- practicing EMPATHY;
- providing FEEDBACK;
- clarifying GOALS; and
- active HELPING.

The aim over the next few sessions is to elicit self-motivational statements from the client about the arguments for change (Miller & Rollnick, 1991). Self-motivational statements fall into categories (Miller & Rollnick, 1991):

- Problem recognition: *“I guess there is more of a problem than I thought”, “I never realised it was as serious as this”;*
- Expression of concern: *“I’m worried about this”*, or nonverbal cues such as tears, gestures etc.;
- Intention to change: *“This isn’t how I want to be”, “Maybe it’s time to think about changing”;* and
- Optimism about change: *“I think I can do it”.*

PHASE 1: BUILDING MOTIVATION TO CHANGE

The goals of motivational interviewing (p141 Rollnick et al, 1999) are to:

- (i) maintain rapport;
- (ii) accept small shifts in attitude as a worthy beginning;
- (iii) promote some concern about risk;
- (iv) avoid increasing resistance;
- (v) promote self-efficacy and responsibility; and
- (vi) view lifestyle holistically (each aspect usually effects the other).

Presenting the rationale for treatment

The MET manual (1995, p50) gives the following example of what you might say:

Before we begin, let me just explain a little about how we will be working together. You have already spent time completing the assessment that we need, and we appreciate the effort you put into that process. We'll make good use of that information from those questionnaires today. This is the first of eight

sessions that we will be spending together, during which we'll take a close look together at your situation. I hope that you'll find these interesting and helpful.

I should also explain right up front that I'm not going to be changing you. I hope that I can help you think about your present situation and consider what, if anything, you might want to do, but if there is any changing, you will be the one who does it. I'll be giving you a lot of information about yourself and maybe some advice, but what you do with all of that after our sessions together is completely up to you. I couldn't change you if I wanted to. The only person who can decide whether and how you change is you. How does that sound to you?

It is important to better understand how the client sees their situation, before giving any feedback from assessment. Proceed with strategies for eliciting self-motivational statements, approach health and lifestyle issues first and gently fit questions about smoking (and other substance use) into this perspective. The following is an example of what you might say: *The information we have talked about in previous weeks has given me a bit of an idea about what is going on in your life at the moment. But, I really don't know a lot about you and the kind of life you lead. Perhaps we can spend a few minutes with you telling me about a typical day in your life, so that I can understand in more detail what happens? Tell me a bit more about the things you struggled with and how you felt at the time. Can you think of a typical recent day from beginning to end... You got up...*

Allow the person to continue with as little interruption as possible. If necessary prompt with open-ended questions: *"What happened then?"* Review and summarise. If necessary, ask: *Is there anything else at all about this picture you have painted that you would like to tell me?*

If the person does not volunteer information about smoking, ask the following: *Can you tell me where your smoking fits in?*

You could ask the following to explore the person's beliefs about their smoking: *How does your smoking affect your symptoms, or your mood?*

Look for motivational statements elicited by the client in response to this summary. Continue to listen reflectively as they provide more detail about their smoking related beliefs. You may be able to continue with: *While there are good things you are able to see in smoking, you are also finding that in some cases it doesn't live up to your expectations.*

Continue with this discussion until you feel it is appropriate to commence a more formal assessment of the pros and cons of the client's smoking habits. When this occurs, use the following exercise.

Exercise: Exploring the Pros and Cons of Smoking.

- Use the grid displayed in Figure 3.3
- Elicit from the client all the positives they associate with smoking cigarettes and write them down in the relevant quadrant. Consider with the client how important these positive aspects are.
- Repeat this exercise with the negatives of smoking and assess how important these are to the client.
- Ask the client to list the positives and negatives associated with quitting smoking and record in the relevant quadrant. For each issue raised, discuss the importance to the client.

Weighing up the Positives and Negatives about Smoking

Good things about smoking	Less good things about smoking
Less good things about smoking less	Good things about smoking less

Figure 3.3 **Pros and Cons Grid**

Enhancing Motivation to Change

From the previous exercise, establish whether positive reasons outweigh the negative, (an important step in assessing need to introduce principles of motivational interviewing).

If at this stage balance is in favour of the negatives associated with quitting and the positives associated with smoking, use the following techniques to tip that balance in the other direction.

Explore **concerns**:

- *What concerns you about smoking?*
- *What other concerns do you have about smoking?*
- *What can you imagine happening to you?*
- *How much does that concern you?*

Explore **health risks**: (in addition to the interaction between nicotine, mental illness and medication levels)

- *Can you tell me some reasons why smoking may be a health risk?*
- *Would you be interested in knowing more about the effects of smoking?* (If the answer to this question is “Yes”, turn to page 4 in the SANE Smokefree handbook (SANE Australia, 1998) and read through with the client the list of immediate and long term health benefits associated with quitting.

Personal feedback from assessment

- Presenting the client with feedback from assessment is important, however doing so before this point in the first session could elicit resistance and hinder engagement in the treatment program. To minimise this, therapists are advised to wait until they have a reasonably clear picture of how the client’s smoking habits fit into their typical day, and their current concerns about their levels of smoking. Ask the client’s permission to provide feedback from your assessment in the following way:

In getting a feel for what’s going on in your everyday life at the moment, you’ve mentioned several things that are concerning you (summarise these problem areas briefly, using those issues raised by the client in the “typical day” discussion, e.g. quality of life, health, mood, alcohol and other drug use). Would it be OK if I gave you some feedback from the assessment we completed together, because I think it fits into some of these issues?

- Discuss the client’s level of dependence and other salient results from the initial assessment. Talk about the diagnosis of dependence, and the implications of this, including physical and psychological dependence. Check whether the client feels this is an accurate reflection. Ask the following questions:

How do you feel about this?

Does it surprise you?

Financial costs of smoking: (use page 6 in the SANE Smokefree booklet) (SANE Australia, 1998)

- The client may raise the cost of smoking as a factor in their decision to quit. At this time, ask the client:

Do you have any idea just how much you think you would save if you didn’t smoke?

When appropriate, ask the client to turn to pages 5 and 6 in the SANE Smokefree booklet (SANE Australia, 1998) which provides information about how much money clients will save by no longer smoking. Turn to page 6 and work through the exercise with the client (calculate how much money they will save in one year by quitting).

Looking back:

- *What were things like before you started smoking?*

Looking forward:

- *How would you like things to be different in future?*
- *What's stopping you from doing what you like?*
- *How does smoking affect your life at the moment?*
- *If you decide to quit, what are your hopes for the future?*

Self vs. smoker:

- *What would your best friend/ mum say were your best qualities?*
- *Tell me, how would you describe the things you like about yourself?*
- *And how would you describe you the smoker?*
- *How do these two things fit together?*

Summarise

- *So far you've told me that you are concerned you may be damaging your health by smoking. What else concerns you?*

Encountering ambivalence

- If the client is ambivalent, attempt to explore reasons that underlie this. Establish initial reasons for seeking treatment and for wishing to quit. Incorporate information on health and psychological effects of continued use. Guide client through a rational discussion of issues involved, and challenge faulty logic or irrational beliefs about the process of quitting. *Positive reinforcement* and *encouragement* are crucial.

Add any additional information to the list of pros and cons for smoking/quitting as they arise throughout this discussion. Keep going until the pros/cons balance is in favour of the positives of quitting and the negatives of smoking.

Once the client has come to the realisation that there are more positives than negatives associated with quitting, and more negatives associated with continuing to smoke, complete the following exercise. Please note that this may not occur until later sessions.

Exercise: Reasons for quitting (SANE Smokefree Handbook; SANE Australia, 1998, page 7)

- Ask the client to take out the SANE Smokefree handbook and turn to page 7.
- Write down in the space provided, all the most important reasons the client raised as positives for quitting and negatives for smoking.
- This serves as a record of the session, and the client can refer back to that list at a later stage.

PHASE 2: STRENGTHENING COMMITMENT (FROM MILLER & ROLLNICK 1991)

Once the client has shifted towards the idea that for them, the positives of quitting outweigh the negatives, therapists can introduce Phase 2 motivational techniques.

The next phase in motivational interviewing is to consolidate all the issues raised by the client in the first phase, and build on their motivation to change. This works best when the person has moved to the late contemplation or early determination stage of change. Be aware that ambivalence will still be present, and if encountered use Phase 1 strategies as appropriate.

Ask a transitional question

Shift the focus from reasons to change to negotiating a plan for change. Use the following questions:

- *I wonder, where does that leave you now?*
- *Where do we go from here?*
- *What does this mean about your smoking?*
- *How would your life be different if...?*
- *What can you think of might go wrong with your plans?*

Communicate free choice (page 29 MET Manual, Miller et al., 1995)

Although abstinence is the desired goal, a reduction in smoking may be preferred by some. Certainly the client has the ultimate responsibility and freedom of choice to change. Work with the client to decide what their goal for treatment will be.

Consider the degree of dependence, recent patterns of smoking, and previous attempts to control smoking, and discuss these issues with the client. Keep in mind the experience from cannabis intervention trials, which suggests that restricting smoking to weekends or social occasions leads to a slow but steady increase in smoking over time. Clients who decide to reduce their use, rather than quit completely, must have a firm, personal rule for recreational smoking (e.g. only once or week, or to never buy cigarettes).

Regardless of the client's preferred smoking goal, indicate that in the next session they will be asked to nominate a quit/modification date for the following week, that is, a date from which these changes will take effect. Encourage client to start tapering their use now if possible, so cessation/reduction is not as severe. Talk about the following issues with clients now, and address any fears about changing/advantages of smoking as before:

Consequences of **action** and **inaction** (p29, MET manual, Miller et al., 1995)

- Anticipate the result if the client stops smoking, along with the likely consequences. Ask the client:
What would be likely consequences if you cut down on smoking?
What might be the possible negative consequences of not changing?
What might be the benefits of making a change?

Address **fears**:

- *What might be the negative consequences of reducing smoking?*
 - *What are the advantages of continuing to smoke as before?*
- Refer to page 10 in the SANE Smokefree handbook for information about the withdrawal symptoms associated with cutting down and quitting smoking.

Provide **information and advice** (p30 MET manual)

- Provide accurate, specific information when it is requested. The SANE Smokefree handbook is useful (particularly page 10 for information on symptoms of withdrawal).
- When clients seek advice, provide qualifiers and permission to disagree. e.g. *If you want my opinion I can certainly give it to you, but you're the one who has to make up your mind in the end.*
- It may be useful to ask for the client's response to the information provided – *Does that surprise/make sense to you?*

Setting goals (p31 MET manual, Miller et al., 1995)

The client needs to choose his or her own goal(s). Commend abstinence and offer the following points in all cases:

Successful abstinence is a safe choice. If you don't smoke you can be sure that you won't have problems because of your smoking. There are good reasons to at least try a period of abstinence (e.g., to find out what it's like to live without cigarettes and how you feel, to learn how you have become dependent on cigarettes, to break your old habits, to experience a change and build some confidence, to please your partner).

In some cases, therapists may need to advise a goal of abstinence:

It's your choice of course. I want to tell you, however, that I'm worried about the choice you're considering, and if you're willing to listen, I'd like to tell you why I'm concerned.

The following exercise will assist the client to set a goal for themselves for smoking, and to establish a treatment contract with the therapist that will guide future therapy.

Exercise: Establishing a Contract/Treatment goals (SANE Smokefree handbook, pages 16- 17)

Turn to pages 16 and 17 in the SANE Smokefree handbook, and talk through the characteristics of good, realistic goals with the client. Make sure you cover the following points:

- Goals will help regardless of whether you achieve them. Goals the client reaches can be celebrated/rewarded, but others that aren't achieved can be used as learning experiences.
- Goals need to be concrete, specific and realistically achievable. For example, the goal of "quitting smoking" is not as specific or concrete as "I will stop smoking completely by XXX date."
- Once the client has decided on an appropriate goal, turn to page 17 in the SANE Smokefree handbook and complete the treatment contract section with the client.
- Make sure that one of the goals the client lists for treatment is to do with cutting down on cigarettes by a certain date or, preferably, setting a date by which to quit completely.
- Ask the client to sign the contract, and then sign it yourself in the "supporters" section.

Summarise and make a contract for treatment (page 38, MET Manual, Miller et al., 1995)

It is important to obtain a concrete plan from the client in relation to their intention to quit smoking, and how they plan to bring about that change. Reinforce the perceived benefits of change and the consequences of action.

At this point, ask the client to identify any obstacles they foresee may impact on their ability to stick with the treatment/plan. Pages 10 and 11 in the SANE Smokefree handbook discuss obstacles in more detail, and offer some suggestions as to how best to overcome them. If necessary and appropriate, turn to the NOTES pages in the back of the SANE Smokefree handbook, and write down the client's perceived barriers and suggestions for managing them.

It is important to stress to the client that the therapist is capable of helping facilitate change in the client, but ultimately it requires the commitment from the client. This requires certain ground rules (Graham, 2000, p24):

- Attendance – the client should be able to explain the reasons for missing a session.
- Promptness – the client should be on time for sessions or contact the therapist if they cannot be on time.
- Completion of homework – treatment relies on the therapist/client making a decision about the appropriate skills to learn and how best to learn them.

Session Termination and Assigning Homework

Briefly discuss the format for therapy over the treatment period.

Outline the rationale of CBT

- Graham (2000) suggests that the overall objective of CBT is to identify and challenge unrealistic beliefs that maintain problematic patterns of thought and behaviour, and replace them with more adaptive beliefs that will lead to and strengthen behavioural change; to facilitate an understanding of the relationship between smoking/mental health problems; teach specific skills for controlling and managing smoking/mental health problems and developing social support for an alternative lifestyle. Use the following explanation:

Smoking is viewed as harmful behaviour. Once people start smoking regularly, they sometimes learn that it changes the way they feel. For example, some people smoke to help them deal with stressful situations. Others think it will make them more confident and others will use them to keep from thinking about things. After a while, things in the environment, sometimes without the person realising, can trigger smoking. Environmental triggers may include seeing other people smoke, being in the presence of people who are smoking or being in stressful situations. You may even find you have developed your own views about smoking. For example, "Smoking helps me relax and unwind. Smoking can even change the way a person thinks, feels and acts, which can make it a habit that is very easy to start and very difficult to stop. The purpose of our treatment is to help you cope better with those situations in which you tend to smoke, and to help you find behaviours that you can do instead.

Outline the specific elements of the treatment program

- Nicotine Replacement Therapy; enhancement of motivation and exploration of reasons and motives for smoking; urge/craving management skills; identification of triggers for smoking; learning techniques for managing automatic thoughts that accompany smoking; techniques for managing negative moods (anxiety, stress, depression); general coping skills (assertiveness and communication skills,

stress management and relaxation); and relapse prevention strategies. Identify areas that particularly seem relevant to client or evoke interest, for emphasis in upcoming sessions.

Introduction to behavioural self-monitoring

- The first step in learning to manage daily life without cigarettes is to first identify those situations in which the client is most likely to smoke/experience the urge to smoke. Explain that keeping tabs on smoking behaviour over time has an important influence in helping to slow down the 'automatic' nature of an addictive behaviour.
- High-risk situations and triggers for smoking: Elicit client's concerns about high-risk situations and discuss circumstances surrounding these. Introduce the notion of personal triggers and explain how triggers promote thoughts about smoking and lead to an increase in urges.

Exercise: Taking the first step (Becoming aware of your smoking habits).

Taken from page 8 in the SANE Smokefree handbook.

- Ask the client to take out their SANE handbook and turn to page 8.
- Explain that an important first step in quitting is to become aware of the habits that tempt the client to smoke. These habits are called "triggers".
- Go through some of the triggers the client thinks lead to his/her use of tobacco. Prompt with the list contained on page 8 of the SANE handbook.
- Set the client the homework task of monitoring themselves over the next week and writing down the situations in which he/she feels the urge to smoke a cigarette on page 8 of the SANE handbook.

Homework

- Identifying triggers for smoking (using form on page 8 in the SANE handbook).
- Cut down the number of cigarettes smoked per day (in preparation for quitting/reduction goal in Session 3).
- Bring SANE Smokefree handbook to next session.

CBT THERAPIST CHECKLIST (Adapted from NIDA, 1989)	
Client ID Number: _____	Date _____
Session Number: _____	
<i>Please complete the following based on this session:</i>	
1. What issues were covered this week? <div style="margin-left: 20px;"> <input type="checkbox"/> Motivational Interviewing <input type="checkbox"/> Introduction to CBT: Thought monitoring and high-risk situations <input type="checkbox"/> Problem solving <input type="checkbox"/> Managing unhelpful thoughts <input type="checkbox"/> Coping with cravings/urges to use alcohol/other drugs <input type="checkbox"/> Drink/Drug refusal skills <input type="checkbox"/> Planning for emergencies and coping with a lapse <input type="checkbox"/> Relapse prevention </div>	
2. How much time did you spend on each of the aims of this session? <div style="margin-left: 20px;"> Phase 1: Building motivation Rationale _____ mins Elicit self-motivational statements _____ mins Affirm & summarise _____ mins Phase 2: Strengthening Commitment Transitional questions _____ mins Consequences of action/inaction _____ mins Address fears _____ mins Information and Advice _____ mins Set goals _____ mins Discuss high-risk situations _____ mins </div>	
3. Did your client complete the homework set after the assessment session? <div style="margin-left: 20px;"> <input type="checkbox"/> No attempt made <input type="checkbox"/> Some attempt made <input type="checkbox"/> Practice exercises completed adequately <input type="checkbox"/> N/A; not assigned </div>	

Figure 3.4 Therapist Checklist – Session 1

SESSION 2 - PLANNING TO QUIT

Therapist Summary Sheet

Aims:

- Review personal triggers and high-risk situations for smoking.
- Provide information about cravings and urges to smoke.
- Devise a craving plan for to assist in coping with cravings.
- Discuss nicotine withdrawal.
- Set a day to quit smoking.

Materials needed for Session 2

- SANE Smokefree handbook pages (SANE Australia, 1998; pages 9-13, 18)
- Figure 3.5 – Facts about cravings
- Figure 3.6 – All purpose coping plan
- Figure 3.7 – Facts about nicotine withdrawal
- Figure 3.8 – Therapist Checklist for Session 2
- 7 days supply of 21mg NRT

Main areas to be covered:

Review homework and set agenda

Introduce the notion of cravings

Provide information about cravings/urges to smoke

Discuss urge management strategies

1. Urge surfing
2. Distraction and delaying

Devise a craving plan

Homework

SESSION 2 - PLANNING TO QUIT

Detailed Intervention

Review of the week and homework exercise

Start with an informal discussion about general activities, and also determine whether there are any important issues that have arisen, any questions so far.

Review the homework activity with the client (page 8 in the SANE Smokefree handbook), and discuss the triggers for smoking the client has identified throughout the week. If the client has not completed the homework task, ask them to do so now.

Review the client's smoking pattern for the week. Did the client meet the planned goals for tapering? Reinforce positive changes and address minor problems if convenient.

Set the agenda for the session by explaining to the client the issues that will be covered.

Introduction to coping with urges

This section is the main focus of Session 2. Complete the following exercise with the client.

Exercise: Describing a craving/urge (Adapted from Monti, Abram, Kadden & Cooney, 1989)

- Ask the person to explain their experience of a craving/urge for cigarettes. For example, *Tell me a bit more about your cravings – what are they like?*
- Write down each of the feelings/thoughts/physical responses that the person uses to describe their urge in the Notes section at the end of the SANE Smokefree handbook.
- Group together those responses that are behavioural (*e.g.* fidgety), thoughts (*e.g.* "I must have a drink"), and physical (*e.g.* heart races, feeling sick) in nature.

Explain that it is possible to fit the person's experience of cravings into a model:

BEHAVIOURS + PHYSICAL + THOUGHTS = CRAVING

In coping with cravings it is important to address each of these parts.

Provide information about cravings and urges to smoke

Cigarette cravings and urges are the sense of wishing to have a cigarette, or an impulse to seek out and use cigarettes. Urges and cravings tend to increase during withdrawal/or in the absence of smoking. Therefore, if someone is trying to abstain from smoking he/she will experience more intense cravings and urges. The extent of a person's cravings and urges will also be determined by how much he/she dwells on thoughts about smoking.

Provide the client with information about cravings, as listed in Figure 3.4 below.

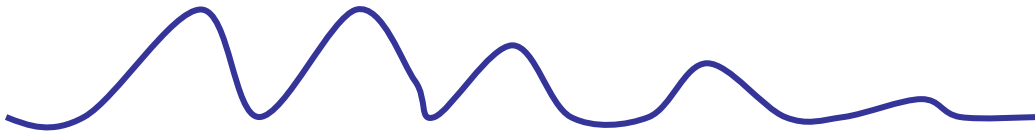
FACTS ABOUT CRAVINGS (Marlatt & Gordon, 1985)

- Cravings/urges to use are a natural part of modifying smoking. This means that you are no more likely to have any more difficulty in altering your smoking than anybody else does. Understanding cravings helps people to overcome them.
- Cravings are the result of long-term smoking and can continue long after quitting. So, people with a heavier history of cigarette smoking will experience stronger urges.
- Cravings can be triggered by people, places, things, feelings, situations or anything else that has been **associated** with smoking in the past.
- A craving can best be described like a wave at the beach. Every wave/craving starts off small, and builds up to its highest point, then it breaks and flows away. Each individual craving rarely lasts beyond a few minutes.



- Cravings will only lose their power if they are **NOT reinforced** by smoking. Smoking occasionally will only serve to keep cravings alive. That is, cravings are like a stray cat – if you keep feeding them, they will keep coming back.

- Like in the diagram below, each time a person does something other than smoke in response to a craving the craving will lose its power. The peak of the craving wave will become smaller, and the waves will be further apart. This process is known as **extinction**.



- Abstinence from cigarettes is the best way to insure the most rapid and complete extinction of cravings.
- Cravings are most intense in the early parts of quitting/cutting down, but people may continue to experience cravings for the first few months and sometimes even years after quitting.
- Each craving will not always be less intense than the previous one. Be aware that sometimes, particularly in response to stress and certain triggers, the peak will return to the maximum.

Figure 3.5 Facts About Cravings

Practical behavioural & cognitive strategies to cope with urges/cravings

Explain to the client that sometimes, cravings cannot be avoided, and so it is necessary to find ways to cope with them.

Below are listed a number of strategies that seem helpful in managing cravings and urges to smoke. These correspond to the behavioural, physical and cognitive (thought) aspects of cravings described above. Help the client to identify the strategies he/she has used and found helpful in the past and add in some of the strategies listed below. Pages 9, 11-13 and 18 in the SANE Smokefree handbook provide some useful tips on managing cravings, stressful situations and boredom. Refer to these pages during the discussion.

Behavioural

- Turn to page 18 in the SANE Smokefree handbook and discuss the “4Ds” of coping with cravings (deep breathing, drinking fluids, doing something else, delaying when you feel like a smoke). Use the following information to discuss the “4Ds” in more detail.

Delaying - avoid situational triggers, particularly during the early phase; delay the decision to use for an hour to try and break the habit of immediately reaching for a cigarette.

Distraction - once the decision to smoke is delayed, distract yourself from your thoughts about smoking.

Doing something else- Brainstorm some alternative options for the client to use as a distraction technique such as going for a walk, calling a support person, relaxation, listening to music *etc.* Once the person is interested in doing something else, he/she will find the urges will go away.

Drink water and/or chew gum (physical).

Cognitive

- Positive talk – by reminding themselves about the short-term nature of cravings (*e.g.* “*this feeling will pass*”) the client’s urges will be easier to deal with. It is important to “decatastrophise” the experience of cravings – acknowledge that they are uncomfortable/unpleasant but also that they will pass.

Relaxation and Imagery

- Relaxation/deep breathing – if cravings develop in response to stressful situations, relaxation techniques and deep breathing exercises can be useful (if a person is relaxed then they cannot be stressed!). Refer to pages 9, 11 and 12 in the SANE Smokefree handbook for more information on dealing with stressful situations.
- The urges that some client’s experience can often be in the form of images. For example, “Irene” found that after a period of four months abstinence from cigarettes that she started to have images flash into her mind which involved her walking to the local shop where she used to buy cigarettes. These images had started to increase her cravings to smoke. Some strategies found to be helpful in managing/transforming this image are listed below, each of these strategies were then rehearsed and practised in the session:

Mastery - For example, “Irene” was asked to conjure up this image and then to imagine herself walking past the shop instead of going in and buying cigarettes. She was then asked to imagine how good she would feel about her achievement.

Alternative - replace the image with an alternative adaptive/“healthy” image). For example, “Irene” was asked to conjure up this image and then to replace it with an alternative image, such as walking along the beach on her last holiday when she was abstinent.

“Fast forward” - unfreeze the image and move it on in time, a few minutes, hours, days *etc.* to enable the client to see that he/she is looking at only a part of the picture which may in fact be a distortion of the whole picture. For example, “Irene” was asked to conjure up this image and then to unfreeze it, fast forward (almost as if pressing a fast forward button on a video), and envisage the usual consequences that follow purchasing cigarettes from this shop. She was asked to describe the immediate, short- and long-term consequences in quite a bit of detail.

“Surfing the Urge” - transform the image from one that feels overwhelming, *eg.* a wave crashing over you, to an image of successfully overcoming the urge/craving by riding/surfing the urge in the way in which a surfer would surf a wave.

Devising a Craving Plan

Following discussion of the above issues, it is time to develop a plan for the client to use to assist in coping with the cravings they may experience.

Exercise: Devising a craving plan (Kadden et al., 1995)

- Use the homework task (page 8 SANE Smokefree handbook) or other high-risk situations for smoking generated by the person during the session.
- Ask the person to circle the triggers he/she feels they can simply avoid or reduce their exposure to (*eg.* not having the cigarettes in the house, not buying them), thereby reducing the likelihood of experiencing a craving.
- Of the remaining triggers that cannot be avoided, go through the coping strategies described above with your client and jointly identify those that he/she can put in place when he/she experiences cravings and urges.
- If your client has not tried any of the coping strategies before (*eg.* urge surfing, relaxation, nominating a support person to call on) encourage them to practice the technique in session.
- Complete the “All-purpose Craving Plan” (Figure 3.4 below) in session, and paste inside the front cover of the SANE Smokefree handbook.
- Ask the client to refer to the plan throughout the week when a craving develops (NIDA, 1998).

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ALL-PURPOSE CRAVING PLAN

Unavoidable High-risk Situation	Coping Strategy

----- ✂ -----

Figure 3.6 All Purpose Coping Plan

Discuss Nicotine Withdrawal

In addition to the above, it is important to educate the client about the nature of nicotine withdrawal. When doing this, avoid emphasising the difficulties associated with nicotine withdrawal.

Refer to the sheet on withdrawal symptoms on page 10 in the SANE Smokefree handbook, and discuss these with the client.

Remind the client that withdrawal symptoms are signs that their body is recovering from the long-term effects of smoking. Withdrawal symptoms are unmistakable signs that they are on the path to recovery.

Additional information about nicotine withdrawal is displayed in Figure 3.5, below. If appropriate, give the client a copy of this information as a summary of this discussion.

NICOTINE WITHDRAWAL – THE FACTS

- Withdrawal symptoms are a positive sign of the **body returning to normal**
- Many smokers only experience **some** symptoms and a few smokers don't experience withdrawal symptoms at all.
- If you do experience symptoms, the worst of them will **disappear within a week or two, especially the SHORT TERM symptoms.**
- Even the **LONGER TERM symptoms** will disappear after **a couple of months.**

SHORT-TERM WITHDRAWAL SYMPTOMS

These withdrawal symptoms are the most common ones that occur when reducing smoking, and will generally only last the first couple of weeks. They include:

- *Craving:* most common but usually only lasts around 5 minutes
- *Irritability*
- *Nervousness*
- *Tension/Anxiety*
- *Sleep Disturbances:* some people complain about strong or unusual dreams.
- *Changes in Appetite:* there is often an increase in appetite, especially for sweet foods. This is because a lack of nicotine is followed by a drop in blood sugar levels in your body. You may feel like eating sweet foods like chocolate to cope with this drop in blood sugar. Also, when you are smoking, nicotine reduces your appetite, so after a couple of days of no nicotine, your taste buds become more sensitive and you will be able to taste things better. These two things combined can make it easy for you to put on weight, so it is important to keep eating healthy foods.
- *Loss of concentration*
- *Increase in activity or tiredness*
- *Constipation*
- *Dry and/or sore throat*
- *Coughing:* when your lungs start working again, they will try to sweep out the tar and mucus that has built up over your smoking life. So you will cough more.
- *Tingling sensation in the extremities:* this is due to an improvement in blood circulation
- *Headaches/light-headedness:* this is a sign that the brain is receiving more oxygen)
- *Sweating*

LONGER-TERM WITHDRAWAL SYMPTOMS

- *Low mood*
- *Forgetfulness*
- *Curiosity about smoking again*
- *Cough*
- *Mouth Ulcers:* approximately 1 in 3 smokers will develop these ulcers, which are also commonly brought on by stress
- *Weight gain*

Nicotine replacement will reduce the intensity and severity of all of the above symptoms

Figure 3.7 Facts about Nicotine Withdrawal

Discuss Nicotine Replacement Therapy

In the randomised controlled trial of this intervention, NRT (patches) were provided to all treatment participants to assist them in reaching their smoking reduction targets. The instructions accompanying the nicotine replacement therapy were discussed in full with the clients. The following information was additionally covered:

Dopamine:

- Different drugs enhance dopamine in different ways. Nicotine enhances memory and helps with attention (sensory gating in schizophrenia). Nicotine acts as both a sedative and a stimulant. Antidepressants may be indicated in people giving up smoking with a history of depression.

Interaction with medication

- Smoking cigarettes alters the metabolism of psychiatric medications and reduces the blood levels of neuroleptics, some antidepressants and benzodiazepines. Nicotine increases the dosage of medication required, so smokers receive higher doses of medication. Nicotine may help voices. Clozapine reduces the need for smoking (unsure why).

Planning to quit

At this point in therapy, foreshadow with the client that as of next session (or as per their quit/reduction date) they should plan to quit and maintain abstinence. Try to enhance the client's optimism in approaching the task, particularly by drawing on past successes.

Homework

- Avoid high-risk situations for smoking.
- Use craving plan during the week.
- Continue to cut down through the week in preparation for next session being the quit date.
- Bring a support person to the next session.
- Bring SANE Smokefree handbook to the next session.

CBT THERAPIST CHECKLIST (Adapted from NIDA, 1989)	
Client ID Number: _____	Date _____
Session Number: _____	
<i>Please complete the following based on this session:</i>	
1. What issues were covered this week?	
_____	Motivational Interviewing
_____	Introduction to CBT: Thought monitoring and high-risk situations
_____	Problem solving
_____	Managing unhelpful thoughts
_____	Coping with cravings/urges to use alcohol/other drugs
_____	Drink/Drug refusal skills
_____	Planning for emergencies and coping with a lapse
_____	Relapse prevention
2. How much time did you spend on each of the aims of this session?	
Phase 1 motivational interviewing	_____ mins
Phase 2 motivational interviewing	_____ mins
Introduction to cravings	_____ mins
Provide information about cravings	_____ mins
Describing a craving	_____ mins
Urge management strategies	_____ mins
Devise a craving plan	_____ mins
Identify a support person	_____ mins
Set a quit date	_____ mins
Discuss high-risk situations	_____ mins
3. Did your client complete the homework set after the assessment session?	
_____	No attempt made
_____	Some attempt made
_____	Practice exercises completed adequately
_____	N/A; not assigned

Figure 3.8 Therapist Checklist – Session 2

***SESSION 3 – ENGAGING SUPPORT PERSON, COPING WITH LAPSES,
COGNITIVE RESTRUCTURING***

Therapist Summary Sheet

Aims:

- Engage a support person for the client and discuss role/expectancies.
- Discuss the abstinence/rule violation effect.
- Identify automatic unhelpful thoughts in relation to cigarette smoking.
- Learn to challenge automatic unhelpful thoughts.
- Strengthen commitment to change.

Materials needed for Session 3

- SANE Smokefree handbook pages (SANE Australia, 1998; pages 10, 14, 15)
- Figure 3.9 – Changing Unhelpful Thoughts
- Figure 3.10 – Therapist Checklist for Session 3
- 7 days supply of 21mg NRT
- Carbon Monoxide Meter (if available)

Main areas to be covered:

Review past week and homework activities and set agenda.

Engage the support person.

Discuss nicotine withdrawal and the use of Nicotine Replacement Therapy.

Discuss the abstinence/rule violation effect.

Cognitive Restructuring

1. Identify unhelpful automatic thoughts.
2. Delay acting on unhelpful automatic thoughts.
3. Challenge unhelpful automatic thoughts.
4. Application to smoking.
5. Discussion about expectancies

Boost motivation.

Homework

SESSION 3 - ENGAGING SUPPORT PERSON, COPING WITH A LAPSE, MAINTAINING ABSTINENCE, COGNITIVE RESTRUCTURING.

Detailed Intervention

Review of the previous week

Review progress, reinforce success and emphasis positive points of progress. Be clear that the final goal of overcoming nicotine dependence is still achievable despite setbacks or failure at this point to meet every goal.

Review the homework tasks. Talk about how well the craving plan worked in practice through the week, and make any necessary adjustments. Elicit the client's concerns or feelings about any problem areas. Provide feedback and encouragement for met goals.

Today will be the person's first day of abstinence. Take a carbon monoxide reading today, and record in the Notes pages of the SANE Smokefree handbook. Do this every other week to reinforce progress.

Engage the support person

The tobacco treatment literature suggests that social support improves outcome significantly. The most appropriate persons from whom support can be obtained are those who are non-smokers and include family members or close friends who are understanding and sympathetic to the client's own goals.

Explaining the supporter's role (if in attendance in this session) using the following points (Miller et al., 1995):

- The supporter cares about the person and changes will have direct impact on both lives.
- The supporter's input will be valuable in setting treatment goals and developing strategies.
- The supporter may be directly helpful by working with the client to resolve the smoking problem.
- Ask the following questions of both the support person and the client:
 - *In what ways do you think you may be helpful to (the person)?*
 - *What has been helpful to (the person) in the past?*
 - *How do you think (the person) might be supportive to you now, as you're taking a look at your smoking?*
 - *Ask the supporter about his/her perceptions of the client's smoking habits. What has it been like for you? What have you noticed about the client's smoking? What has discouraged you from trying to help in the past? What do you see as encouraging?*
- Counter client ambivalence by asking the supporter:
 - *How has the smoking affected you?*
 - *What is different now that makes you more concerned about the smoking?*
 - *What do you think will happen if the smoking continues as it has been?*
- Elicit support from the supporter:
 - *What are the things you like most about (the person) when she isn't smoking?*
 - *What positive signs of change have you noticed that indicate (the person) really wants to make a change?*
 - *What are the things that give you hope that things can change for the better?*
- Elicit client response to supporter's comments:
 - *Of these things (the person) just mentioned, which concerns you the most?*
 - *How important is it for you to deal with these concerns?*

- Explain the supporters booklet:
 - *Spark plug, coach, cheer squad, booster and bystander roles.*

Reviewing withdrawal symptoms

Review withdrawal symptoms with the client and elicit his/her worst symptoms. How difficult does the client find it to cope with these? Reframe symptoms in a positive light, the body is recovering and adapting to being nicotine free. These symptoms are short-term only.

Educate that withdrawal symptoms are often the opposite physical response to that of nicotine. Instead of feeling more relaxed, withdrawal may result in feeling less relaxed and more tense.

Explain the use of NRT and how to use the patches (if appropriate). Use the guidelines that come with the patches. The patch should be put on in the morning to avoid bad dreams.

Dealing with a lapse (the Abstinence/Rule violation effect) (Marlatt & Gordon, 1985)

Slips and lapses are common in the recovery process. Thus, it is important to discuss slips and lapses with your client early on in therapy. While slips are disappointing, they do not mean failure or indicate an inability to change. The client's challenge is to find ways to overcome slips and maintain goals as best as possible. Treat a slip as a learning experience.

Often people will feel very bad about themselves if they have a lapse, and will see it as the end of the world or their attempts at abstinence. The ***abstinence violation*** effect is said to be your client's reaction if he/she had made a decision to stop smoking, and then smoked. Alternatively, a ***rule violation*** effect is said to be your clients' reaction if he/she had decided to change his/her pattern of smoking (e.g. to cut down or to stop) and he/she then had a "slip" and smoked.

If the client returns to smoking on one or two occasions as they previously were, then this is called a **LAPSE**. However, if following this "lapse" the client completely returns to the previous smoking behaviour, this is called a **RELAPSE**.

If your client has a lapse, it is more likely to turn into a relapse if he/she engages in particular distorted styles of thinking and feelings about him/herself (called the ***ABSTINENCE/RULE VIOLATION EFFECT***). An example of this effect is "*I've blown it*"; "*I knew I wouldn't be able stop*"; or "*The treatment didn't work*". The client may then give him/herself permission to keep on smoking by thinking, "*I've messed up already so I might as well keep going*".

The main strategy to help your client cope with the abstinence/rule violation effect is ***to re-evaluate and modify the thinking errors*** that contribute to the effect. The aim is for your client to firstly identify the distortions in his/her thinking that occur in relation to his/her smoking (e.g. minimisation, all or nothing, overgeneralisation). Secondly, you can help him/her to generate a more helpful, less catastrophic and more realistic way of viewing the situation (e.g. a slip/mistake rather than a complete failure):

For example,

Unhelpful thought: "*I've blown it*",

Helpful thought: “I’ve just had a slip and I can get back on track”.

Unhelpful thought: “I knew I wouldn’t be able to stop”.

Helpful thought: “I have been able to make a change...this is only a slip and I will keep on trying”.

Unhelpful thought: “I’ve messed up already so I might as well keep going”.

Helpful Thought: “I’ve just made a mistake and I can learn from it and get back on course”.

Cognitive Restructuring (Jarvis, Tebbutt & Mattick, 1995)

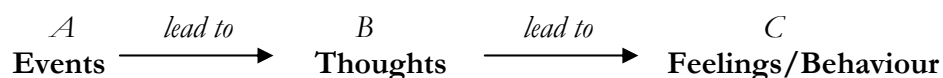
The aim of the remaining session time is to help the client better manage those unhelpful patterns of thinking they have in association with cigarette smoking habits. Through the process of cognitive restructuring, the client will learn ways to challenge these unhelpful thoughts and replace them with more helpful ones. In this way they can learn how to manage their thoughts about stressors and also cope with the cravings they may experience.

The main aim of cognitive restructuring is to assist the client to determine when he or she is thinking negatively or engaging in automatic patterns of thought that lead to smoking. These techniques should assist the client to *interrupt* this pattern of thinking. Also the client should learn to *challenge negative thoughts* and to replace them with more positive ones, or thoughts that lead to the reduction in urges to smoke.

Identifying the link between thoughts and behaviours

- The first step in cognitive restructuring is for the client to identify for himself or herself the idea that their thoughts influence their behaviours and their feelings about everyday situations (including triggers for smoking).
- Present the following rationale to your client.

All people who are trying to quit will have thoughts about smoking, and will increasingly experience urges to seek out and use cigarettes. These thoughts and feelings are quite common, and in themselves do not create problems. Rather, it is important to focus on how people deal with, or respond to, these thoughts and feelings.
- Explain about the link between thoughts, feelings and behaviour using the cognitive model illustrated below (Ellis, 1975). This will enable the client to begin to see the links between their thoughts, feelings and subsequent behaviour:



- Explain that thinking influences the way the client will feel and behave, using the following rationale:

Events/ situations that occur in the outside world do not usually cause our feelings or behaviour; rather it is our interpretation (or thoughts) about those events that will directly relate to our feelings and actions. In some cases, the thoughts that we have about a particular situation can be quite negative or unhelpful, and lead to us feeling bad, angry, irritable, depressed or even with the urge to smoke to help us cope.

Often, the negative or unhelpful thoughts happen so quickly in response to events that people do not even realise what is happening. That is why these thoughts are often referred to as “automatic.” Usually, we suddenly realise we are feeling bad, or are having a craving/urge to smoke. These feelings are often a signal that we have had an automatic thought about the present situation that has resulted in a craving.

Exercise: Demonstrating the link between thoughts and behaviour
(Jarvis, Tebbutt & Mattick, 1995)

- Ask the client to identify an example from the past week where they experienced strong urges/cravings to smoke.
- Help them to identify the A's, B's and C's surrounding that event/situation
- Include any negative/unhelpful self-talk/thoughts the client experienced.

Delaying Action on Unhelpful Thoughts

- The second step in cognitive restructuring is for the client to resist the urge to automatically act on the unhelpful thoughts they experience.
- “Catching” automatic unhelpful thoughts, or becoming aware of them before they are acted upon, can change the thought itself. When a client becomes aware of an automatic unhelpful thought, they need to go through the following process:
STOP, SLOW DOWN and THINK ABOUT the thought.
Do not act upon the thought for a short period of time.
- It is likely that the thought will pass soon without any harmful consequences.

Changing automatic thoughts

- Once the client is aware of the presence of unhelpful automatic thoughts, and the idea that they don't have to act automatically in response to these thought, they can challenge them. This is the third step in cognitive restructuring.
- There are four basic steps that guide the process of challenging unhelpful thoughts. These are displayed in Figure 3.8 below (adapted from Jarvis, Tebbutt & Mattick, 1995). Photocopy this information for the client and discuss in detail during the session.
- Refer to pages 14 and 15 in the SANE Smokefree handbook for further examples of how to challenge an unhelpful thought.

Application to smoking

- Explain the role of negative thoughts in the genesis of depression, anxiety and other negative states.
- Indicate how correcting and overcoming negative thinking will help in the overall process of overcoming dependence on nicotine.
- Also, much negative thinking is closely linked to nicotine use. Smoking is often a consequence (a “C”) of a negative thought.
- The client should be able to start challenging negative thoughts that lead to smoking. (e.g. *I feel stressed, the only way to cope is by smoking*).

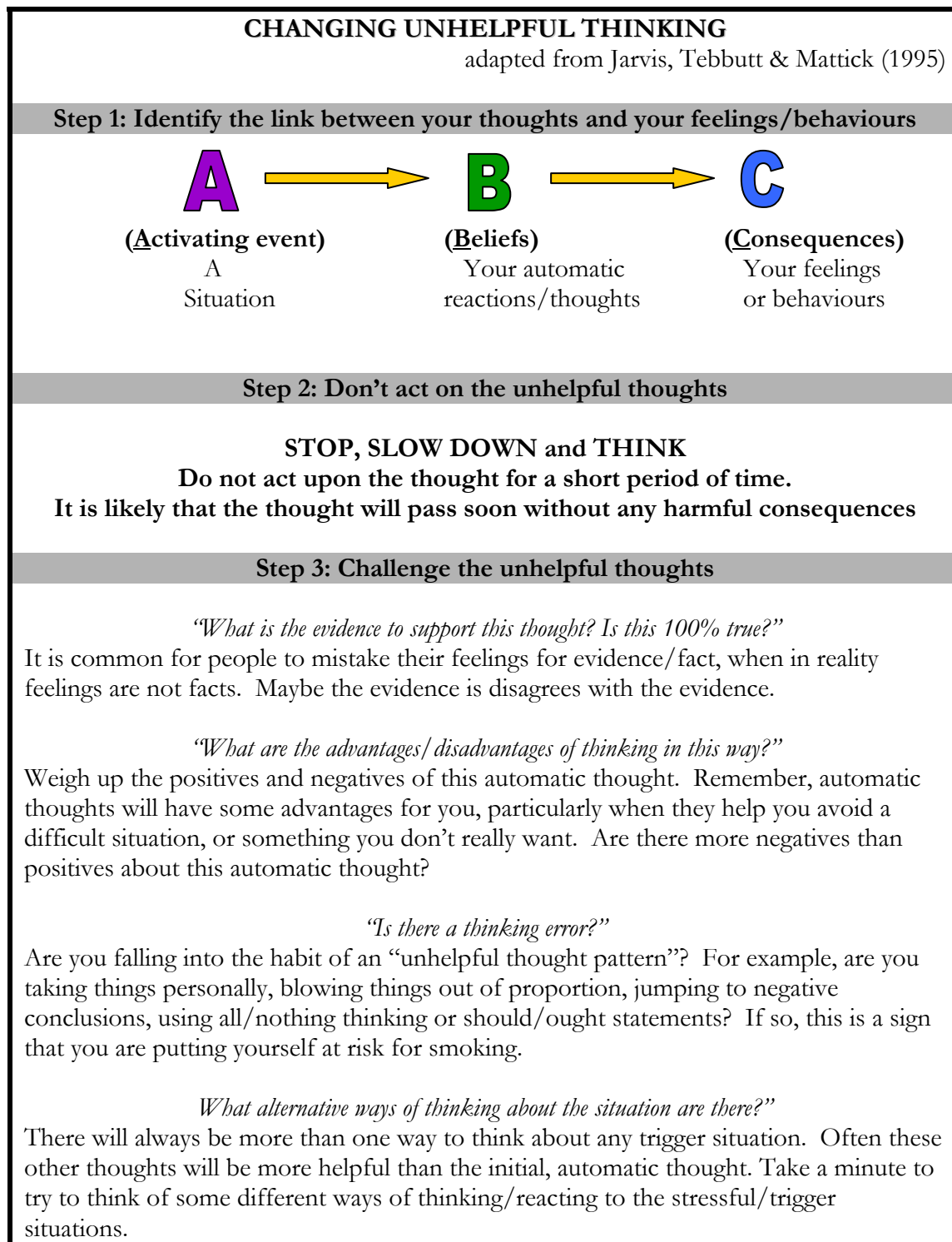


Figure 3.9 Changing Unhelpful Thinking

Discussion of the role of expectancies

- Anticipation of having a smoke is often due to the influence of expectancies.
- These expectancies may be positive, “a smoke will help me relax”; or negative, “smoking will get rid of my boredom”.
- Expectancies can be (and need to be) challenged.
- Most clients would be very surprised to learn that the main effect of smoking is due to psychological expectancies, rather than the physical effect of nicotine.

- In general, high expectancies and low confidence in resisting leads to strong urges. Encourage the client to challenge automatic expectancies, by replacing them with alternatives.

Boosting Motivation

It is at this point that the therapist boosts motivation by expressing confidence in their ability to do well in the treatment. The therapist may help the client review reasons to stop smoking, elicit examples of client's past successes and commend the client for making the current effort. Use Phase 1 and Phase 2 motivational enhancement techniques as appropriate.

Homework

- Supporter to read Supporters Booklet.
- Avoid high-risk situations.
- Maintain abstinence for every day over the next week.
- Use 1*21mg nicotine patch every day for the next seven days.
- Practice challenging unhelpful automatic thoughts.
- Use the Craving plan when necessary.
- Bring SANE Smokefree handbook to the next session.

CBT THERAPIST CHECKLIST (Adapted from NIDA, 1989)	
Client ID Number:_____	Date_____
Session Number:_____	
Please complete the following based on this session:	
1. What issues were covered this week?	
_____	Motivational Interviewing
_____	Introduction to CBT: Thought monitoring and high-risk situations
_____	Problem solving
_____	Managing unhelpful thoughts
_____	Coping with cravings/urges to use alcohol/other drugs
_____	Drink/Drug refusal skills
_____	Planning for emergencies and coping with a lapse
_____	Relapse prevention
2. Did a support person attend the session?	
Yes	No
If YES , who? _____	
(relationship to client)	
3. How much time did you spend on each of the aims of this session?	
Phase 1 motivational interviewing	_____ mins
Phase 2 motivational interviewing	_____ mins
Engage support person	_____ mins
Nicotine withdrawal & NRT	_____ mins
Abstinence/rule violation effect	_____ mins
Demonstrate link between thoughts/behaviours	_____ mins
Identify and challenge unhelpful automatic thoughts	_____ mins
Identify a support person	_____ mins
Set a quit date	_____ mins
Discuss high-risk situations	_____ mins
3. Did your client complete the homework set after the assessment session?	
_____	No attempt made
_____	Some attempt made
_____	Practice exercises completed adequately
_____	N/A; not assigned

Figure 3.10 Therapist Checklist for Session 3

SESSION 4- SEEMINGLY IRRELEVANT DECISIONS, DEVELOPMENT OF PERSONAL SKILLS

Therapist Summary Sheet

Aims:

- Discuss seemingly irrelevant decisions.
- Discuss and develop the skills the client may need to assist them in their abstinence.

Materials needed for Session 4

- SANE Smokefree handbook (SANE Australia, 1998)
- Figure 3.11 – Seemingly Irrelevant Decisions
- Figure 3.12 – Worries about Weight Gain
- Figure 3.13 – Problem Solving
- Figure 3.14 – Therapist Checklist for Session 4
- 7 days supply of 21mg NRT
- Carbon Monoxide Meter

Main Areas to be Covered:

Review past week and homework activities and set agenda.

Seemingly Irrelevant Decisions

Development of personal skills

1. Managing insomnia.
2. Progressive muscle relaxation.
3. Managing weight gain.
4. Lifestyle/activity level/hobbies.
5. Coping strategies for drug resistant psychotic symptoms.

Problem solving skills

Homework

SESSION 4: SEEMINGLY IRRELEVANT DECISIONS, DEVELOPMENT OF PERSONAL SKILLS.

Detailed Intervention

Review of previous week

Review progress, discuss problems and recap on previous techniques. Pay particular attention to the “automatic unhelpful thoughts”, and how the client managed this exercise through the week. Discuss this in a “real life” sense, so that the client can actually use this technique when it is needed.

Take a carbon monoxide reading and record in the Notes pages of the SANE Smokefree handbook. Reinforce the client’s progress.

Give the client the next weeks’ supply of NRT (21mg).

Seemingly Irrelevant Decisions (SIDS) (Monti, Abrams, Kadden & Cooney, 1989).

Previous exercises have helped the client to identify situations in which they are most likely to smoke. Explain to the client that one useful way of avoiding these situations, and hence the trigger for a cigarette craving, is to become aware of the “seemingly irrelevant” decisions they make that can lead to them being in a situation of high-risk for using.

Present the following rationale to the client:

Many of our daily choices on the surface seem to have nothing to do with smoking. Although our decisions may not directly involve choosing whether to smoke, they may slowly move you closer to such behaviour. It is often through seemingly irrelevant decisions that we gradually work our way closer to entering high-risk situations that may lead to smoking.

People often fall victim to their situations (e.g. “I always end up smoking at parties and can’t help it”). Although it is difficult to recognise choices made when in the decision-making process, each small decision you make over a period of time can gradually lead you closer to your predicament. The best way to combat this is to think about each choice you make, no matter how seemingly irrelevant it is to smoking, so you anticipate potential dangers ahead.

Always choose the lowest-risk option when faced with a decision, to avoid putting yourself in a risky situation. When you become aware of seemingly irrelevant decisions, you will be better able to avoid high-risk situations. It is easier to simply avoid the high-risk situation before you are actually in the situation.

Exercise: Seemingly irrelevant decisions (Monti, Abrams, Kadden & Cooney, 1989)

- Ask the client to think about their last relapse to smoking and to describe the situation/events that preceded the relapse. What decisions led up to the relapse?
- Take the client through the reminder sheet (Figure 3.11, below), and paste onto the back cover of the SANE Smokefree handbook.

✂

SEEMINGLY IRRELEVANT DECISIONS (Monti et al., 1989).

When making any decision, whether large or small, do the following:

- ◆ Consider what options you may have.
- ◆ Think ahead to the possible outcomes of each option. What positive/negative consequences you can anticipate, and what is the risk of relapse to smoking?
- ◆ Select one of the options: Choose one that will minimise your risk of relapse. If you decide to choose a high-risk option, plan how to protect yourself while in the high-risk situation.
- ◆ *Practice Exercise:* Think about a decision you have made recently or are about to make. The decision could involve any aspect of your life (eg. friends, family). Identify low-risk options and choices that decrease your risk of relapse.

Decision to be made: _____

Low-risk option: _____

High-risk option: _____

✂

Figure 3.11 Seemingly Irrelevant Decisions

Development of personal skills

The skills appropriate to each client to assist them in maintaining their abstinence from cigarettes will probably differ according to the individual's need. It is important to discuss with the client the skills they think they need in order to help them quit smoking. The following list is a useful place to start:

Management of Insomnia

- Begin by ascertaining the presence of any sleep problems the client is experiencing.
- Explore the nature of the sleep problem. Is the insomnia sleep onset, sleep maintenance or early morning waking? These may reflect different problems, and may indicate different approaches in their management.
- Educate the client in sleep hygiene. Review issues such as the bedtime ritual (or lack of it), the sleeping environment, and the sleeping partner (time going to bed, latency of sleep, length of sleep, behaviour if unable to sleep, etc). Check the client is not exposed to light, noise or other disturbances. Encourage the client to go to bed at the same time each night, establish a ritual before bedtime (e.g. a warm decaffeinated drink), using the bathroom and checking the house is locked. All of these behaviours will become cues to sleep.
- Stimulus control treatment of sleeping problems can help re-establish a normal pattern. Remind the client that most people require 10-20 minutes to fall asleep. If they are unable to sleep, it's best to get up and go to another room, until they are ready to sleep. Encourage the client to resist the urge to sleep in, or nap during the day, as this also delays re-establishing a sound sleeping pattern. Ask them to try to avoid getting anxious and upset about sleep. Some individuals go to bed tired, but become anxious when in bed owing to sudden, intrusive

thoughts about the possibility of not being able to sleep. Also learning an appropriate relaxation technique may assist in obtaining a natural sleep.

Progressive muscle relaxation

- Explain to the client the benefits of learning how to relax, and of incorporating relaxation practice into each day. This will also potentially assist with any sleep problems, as well as provide another strategy for coping with the effects of nicotine withdrawal.
- For progressive muscle relaxation, the emphasis is on gradually relaxing skeletal muscles. Feeling physically relaxed tends to slow down mental activity and induce a peaceful feeling. Begin by having the client seated in a comfortable chair, feet flat, and arms by their side or in the lap. Outline what you will be doing, this is not hypnosis and the client will be in control at all times.
- Explain that the client simply needs to listen to what is being said. You will make some suggestions and the client will simply listen to those and gradually feel him/herself becoming more and more relaxed. The client's thoughts may wander, this is natural and OK. Ask the client to return his/her thoughts to what you are saying whenever he/she realises this has happened.
- The relaxation exercise requires the therapist to ask the client to consider tension in different muscles of the body, and imagine the tension slowly being released or melting away. Start at the top of the head, and move through the forehead and eyebrows; cheeks, lips, tongue and jaw; neck and shoulders; arms, elbows, forearms; wrists, hands, fingers; chest and stomach; thighs, knees, calves, ankles, feet and toes. Some therapists like to ask the client to first tense various muscles, and then forcibly relax them, in order to feel the difference between tension and relaxation.
- Take around 10 minutes to work through this exercise with the client. If appropriate, take an audio recording of the relaxation exercise, and give the client a copy of the tape to take home and practice with throughout the coming weeks.
- At the conclusion of the exercise, discuss the applications for relaxation practice as they are relevant to the client's situation. These may include general relaxation, assisting sleep onset, or to be encouraged when feeling anxious, upset or stressed. Encourage its use in a modified way that can be attempted anywhere and at anytime.

Managing weight gain

- Many clients will be concerned about gaining weight as a result of giving up smoking.
- Use Figure 3.12 below as a guide for discussing the concerns about gaining weight.

DEALING WITH WORRIES ABOUT WEIGHT GAIN (PAGE, ALLEN & CONSIDINE, 1999)

When you give up smoking, you are going to have more energy, breathe easier, have an improved sense of taste and smell, and feel more alert. On the other hand, you may be worried about gaining weight.

Remember, smoking is more harmful to you than being a little overweight for a little while.

In most cases, it is easy to avoid weight gain by planning ahead, by adding physical exercise (eg. walking) into your day, or by focussing on adding low calorie foods to your diet. It is also important to drink loads of water. Understanding why and how you might gain weight when you stop smoking will help you in planning ahead. Answer the following questions to help you through this process.

1. Do you feel a need to put something in your mouth to replace cigarettes?
☐ Yes ☐ No
2. Do you deliberately treat yourself by eating extra foods or sweets as a reward for stopping smoking?
☐ Yes ☐ No
3. Has your sense of taste improved since stopping smoking, and has your desire to eat increased?
☐ Yes ☐ No
4. Do you have a better appetite now you have stopped smoking, because your health has improved?
☐ Yes ☐ No
5. Have you used smoking in the past as a substitute for food, or to maintain a lower than normal weight?
☐ Yes ☐ No
6. Have you used smokes as a “pick-me-up” whenever you had a break? For example, do you now reach for a sweet biscuit every time you have coffee or tea?
☐ Yes ☐ No
7. Have you used smoking or food in the past to deal with emotions such as depression, loneliness or boredom?
☐ Yes ☐ No

If you answered YES to any of these questions, use the following tips to help reduce your risk of weight gain when you stop smoking...

- Cut your food into smaller pieces
- Drink plenty of water
- Eat slowly, avoid going for seconds
- Have set times for meals, avoid the kitchen at other times
- Keep your mind focussed & hands busy
- Leave the table as soon as you finish
- Brush your teeth as soon as you finish
- Eat your dinner later if snacks are a problem
- Stay away from coffee shops & snack bars when shopping
- Spend more time outdoors, exercising
- Only go shopping when you are feeling OK and not hungry
- Choose a non-food reward for not smoking
- Eat small, healthy meals
- Plan a range of healthy snacks to make dieting easier
- Have 3 meals a day
- Always eat breakfast
- Eat fresh fruit and vegies to give your tastebuds a lift
- Try chewing gum or cinnamon sticks instead of lollies or biscuits

Figure 3.12 Dealing with Worries about Weight Gain

Coping strategy enhancement for drug resistant psychotic symptoms (Tarrier et al., 1993)

- Identify which coping strategies have been successful in the past. Encourage the use of more than one coping strategy.
- Select from the list of cognitive, behavioural, sensory, and physiological suggested below.

- ***Cognitive strategies:*** includes only mental cognitive events not actions.
Distraction/Attention switching: the focus of attention or concentration is actively switched from one subject (i.e. symptom) to another (i.e. distracting stimulus). It may be necessary to practice forming a mental image of the distracting image before practicing the switch. This is a cognitive technique only and does not include changes in behaviour, although a behaviour change may be included at a later date to strengthen the attention switch.

Attention narrowing: attention is narrowed or restricted to exclude the pathological stimulus (e.g. symptom). This does not mean the inclusion of new material into the attention span as in attention switching. Rather, the client is directed to concentrate on something already in their attention span (just not the particular symptom). Attempts to “clear your mind” or “empty your mind” or “think of nothing” would be included here.

Positive self-instruction: here, the client identifies the pathological stimulus (symptom) as part of their illness and tells him/herself to ignore the content, as it is not based in reality. Specific statements to be used by the client should be identified and then practised initially by therapist verbalisation (outside control), then by the patient overtly verbalising (overt control) and then by the patient internally verbalising (covert control).

- ***Behavioural strategies:*** includes only behavioural actions.
Increased solitary activity: In which the patient initiates some action that they can perform alone, such as going for a long walk, reading, digging the garden, etc. Define and specify each selected activity.

Increased social activity: In which the patient actively seeks out other people or social contact, from being alone/disengaged to engaging other/s in social contact or interchange.

- ***Sensory strategies:*** These include strategies that attempt to directly modify sensory input. Examples would be to increase input by turning up the radio with the expressed desire to drown out voices (this is different from distraction) or the use of other auditory stimuli such as headphones, ear plugs etc. to reduce or modify input.
- ***Physiological strategies:*** Include strategies that attempt to modify internal physiological states. This clarification has been divided into those strategies that are thought to be desirable or undesirable.

Appropriate: In which the patient tries to modify his/her physiological state in a positive non-harmful manner. This includes the use of breathing or relaxation exercises to reduce arousal levels.

Inappropriate: In which the patient attempts to modify internal states but through actions which may have undesirable physical or social consequences either through their nature, such as abusing drugs illegally or exceeding the prescribed dose of medication without or against advice, or through excessive alcohol consumption.

Problem solving skills (Jarvis, Tebbutt & Mattick, 1995)

The aim of problem solving is to enable the client to resolve real life problems that impinge upon his/her ability to maintain a smoke free lifestyle.

Problems are a recurring part of everyday life, and our ability to deal with difficult issues makes a big difference in how we generally feel. Sometimes avoiding certain things, place us under more pressure later on. While everyone is different in their ability to solve problems, it can be learned and improved just like any other skill. This has a big impact in helping people to lead easier lives, and reduces the pressure which often leads to smoking.

Problem-solving is an important general skill that clients will be able to easily learn and use in a variety of situations that occur in their everyday lives. These situations include those that may pose a threat to a client remaining committed to their goals (quitting smoking). They can be tobacco specific (*eg.* being in a group where cigarettes are freely available), can arise from thoughts or feelings (*eg.* depressing/intrusive thoughts), in interactions with others (*eg.* arguments) or they can be more general (*eg.* work concerns).

Explain to the client that it is important to work through problems that occur in day-to-day life, rather than to ignore them or deal impulsively with them. Pressure from an unresolved problem could easily lead to a smoking relapse. It is important for the client to recognise situations as problems, and take time to work out and think through the most appropriate solutions.

In general, problem-solving is broken down into six steps (Jarvis, Tebbutt & Mattick, 1995):

1. Defining exactly what the problem is.
2. Brainstorming the options to deal with the problem.
3. Choosing the best option/s.
4. Generating a detailed action plan.
5. Putting the plan into action.
6. Evaluating the results.

Step 1: Define exactly what the problem is:

- The first step in problem solving is often the most difficult. It is important to assist the client to define their problem in very concrete terms (concrete behaviours that your client can modify).
- For example, simply saying, *"I don't like my life"*, defines a person's problem in very vague terms – it is almost impossible to solve this problem. Alternatively, breaking the problem down into *"I feel lonely because I don't have many friends"* and re-defining this as an achievable goal *"I'd like to work on making some friends"* more concretely identifies those aspects of the person's life with which they are unhappy about, thereby making them more easily targeted.
- Well-defined problems have the following characteristics:
 - Specific and concrete.
 - Realistic – the client needs to be able to change the behaviour/problem.
 - Adequate – the definition needs to be comprehensive, incorporating all aspects of the problem. Re-define the problem as an achievable goal.
 - Owned by the client – the client needs to feel that the definition is truly representative of what they feel the problem is. Allow the client time to work this out for themselves.

Exercise: Defining the problem (Jarvis, Tebbutt & Mattick, 1995)

- Use Figure 3.13 to work through this exercise.
- Have your client select a problem situation. If they have trouble thinking of one on their own, use the information gained from page 8 in the SANE Smokefree handbook. Alternatively, try to identify a potentially high-risk situation with the client where they either may be tempted to smoke.
- Help the client to frame the problem clearly, in concrete, specific, realistic, and adequate terms as an achievable goal. If necessary, get them to break a larger problem down into “sub-problems” which will be more manageable.
- Write the problem down in the space provided at Step 1 in Figure 3.13.

Step 2: Brainstorm possible options to deal with the problem

- Brainstorming is an effective way of helping clients to generate alternatives to a situation, or different ideas about that situation or their future. The quality and efficacy of their action plans will be better if the clients are able to choose the strategies from a large and exhaustive list of options. Use the following rules to brainstorming as a guide.
- No criticism allowed (including from the client him/herself). Leave evaluation of the options generated until Step 3.
- Encourage the wild and adventurous ideas. Remember any idea is acceptable at this stage. Also, the less impeded the client is, the more chance there is of them coming up with a good, novel idea.
- Quantity of ideas is important.
- Think about solutions that have worked before. An old solution may be a good starting point, even if it needs to be altered.
- Always make sure the client goes first. It is important that even if you come up with a suggestion for the list, it is the client who decides whether it will be added.

Exercise: Brainstorming options (Jarvis, Tebbutt & Mattick, 1995)

- Have your client generate as many alternatives/options for dealing with the problem situation they identified in the last activity, using the guidelines mentioned above.
- Write these ideas down in the space provided at Step 2 in Figure 3.13.

Step 3: Choose the best option (pros and cons of each solution)

- Every behaviour/thought will have both pros and cons associated with it. It is therefore important to encourage the client to think through both the positives and negatives associated with each option they generate. This will prevent rash decision making about a course of action to take when confronted with a problem (*e.g.* smoking to cope with social anxiety, or assuming that your partner hates you because of an argument you just had). This process will also help the client to sort out and discard any obviously impractical options.

Exercise: Choosing the best option (Jarvis, Tebbutt & Mattick, 1995)

- Have your client carefully consider each of the options they generated during the brainstorming session, and identify the pros and cons of putting that option into practice.
- Write these down at Step 3 in Figure 3.13.
- After the list is exhausted, work with the client to identify his/her most preferred option/s.
- Record the most preferred option.

PROBLEM-SOLVING (Jarvis, Tebbutt & Mattick, 1995)

Step 1: My problem is

Step 2: What are the possible solutions?

Step 3: What are the positives and negatives of each solution?

Possible Solutions	Positives	Negatives
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Circle the best solution

Step 4: What are the steps in putting the best solution into practice?

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Step 5: Putting the plan into practice

When you go home today, take this problem-solving sheet with you and take some time to go through your action plan in your head. Then, tomorrow, try it out.

Step 6: Evaluate the plan

How did your plan succeed? Do you need to go back to step 3 and try again?

Figure 3.13 Problem-Solving

Step 4: Generate a detailed action plan (what's my plan?)

- The next step in successful problem solving is to break down the preferred option into smaller, more concrete and achievable steps.
- For example, if the client decided they wanted to “*exercise more*” and thereby feel better about themselves, the action plan would need to specify which type of exercise, when/how often it would occur, how to get there, when to start, with whom *etc.*
- It is important to make the first step in any action plan something simple so that the client can easily achieve it and experience immediate success. This will increase their motivation to continue working through the plan.

Exercise: Develop an action plan (Jarvis, Tebbutt & Mattick, 1995)

- Help the client to break their preferred option down into manageable, concrete and achievable steps.
- Develop a detailed action plan to help guide the client in putting their preferred solution into practice.
- Record the plan at Step 4 in Figure 3.13.

Step 5: Put the plan into practice

- It is important for the client to mentally think through or rehearse their plan, and you may even like to conduct a role-play around their problem to help them practice putting the plan into action.

Exercise: Putting the plan into action (Jarvis, Tebbutt & Mattick, 1995)

- If appropriate, carry out a role play with the client that involves their problem situation. Have them practice carrying out their action plan (and even voice/rehearse what they will say to themselves when confronted with that situation.
- Set some homework for the following week – carry out the action plan.

Step 6: Evaluate the results

- Talk with your client in session about how the action plan succeeded and/or failed when it was put into practice in the role-play. How does the client predict the plan will translate into practice?

Homework

- Maintain abstinence.
- Use 1*21mg patch per day for the next seven days.
- Identify SIDS, practice relaxation, use coping strategies, modify diet, and adjust lifestyle as targeted.
- Practice problem solving skills through the week and implement action plan discussed in today's session.
- Bring SANE Smokefree handbook to next session.

CBT THERAPIST CHECKLIST (Adapted from NIDA, 1989)	
Client ID Number:_____	Date_____
Session Number:_____	
<i>Please complete the following based on this session:</i>	
1. What issues were covered this week?	
_____	Motivational Interviewing
_____	Introduction to CBT: Thought monitoring and high-risk situations
_____	Problem solving
_____	Managing unhelpful thoughts
_____	Coping with cravings/urges to use alcohol/other drugs
_____	Drink/Drug refusal skills
_____	Planning for emergencies and coping with a lapse
_____	Relapse prevention
2. How much time did you spend on each of the aims of this session?	
Phase 1 motivational interviewing	_____ mins
Phase 2 motivational interviewing	_____ mins
Seemingly Irrelevant Decisions	_____ mins
Development of personal skills	_____ mins
Managing insomnia	_____ mins
Progressive muscle relaxation	_____ mins
Cognitive strategies	_____ mins
Behavioural strategies	_____ mins
Sensory strategies	_____ mins
Physiological strategies	_____ mins
Problem-solving skills	_____ mins
3. Did your client complete the homework set after the assessment session?	
_____	No attempt made
_____	Some attempt made
_____	Practice exercises completed adequately
_____	N/A; not assigned

Figure 3.14 Therapist Checklist for Session 4

SESSION 5 - DEVELOP COPING SKILLS, REVIEW AND CONSOLIDATE.

Therapist Summary Sheet

Aims:

- Identify any coping skills the client perceives they still require.
- Teach cigarette refusal skills.
- Discuss assertiveness, communication and stress/anger management skills.

Materials needed for Session 3

- SANE Smokefree handbook (SANE Australia, 1998; pages 12, 13, 20 and 21)
- Figure 3.15 – Summary of Refusal Skills
- Figure 3.16 – Summary of Assertiveness Skills
- Figure 3.17 – Communication Skills
- Figure 3.18 – Therapist Checklist for Session 5
- 7 days supply of 21mg NRT
- Carbon Monoxide Meter

Main Areas to be Covered:

Review past week and homework activities and set agenda.

Discuss coping skills training including:

1. Cigarette refusal
2. Assertiveness training
3. Communication skills
4. Stress/anger management

Homework

SESSION 5 - DEVELOP COPING SKILLS, REVIEW AND CONSOLIDATE

Detailed Intervention

Review of previous week

Review client's overall progress. Any slips or lapses? Any specific problems or issues? Address these problems in the framework of any of the previous outlined strategies if appropriate.

In addition, ask the client whether or not they put into action the Action Plan they developed during the session last week. Ask the following questions, and process with the client how successful the plan was:

- Was the plan implemented in full or only in part? Why?
- If the plan was partly or not at all successful discuss with the client the reasons for this. Does the plan need improving? Is a new strategy needed?
- If necessary, revisit the problem-solving exercise from last week.

Check other homework (coping strategies, weight, exercise, lifestyle, etc.)

Take a carbon monoxide reading and record in the Notes section of the SANE Smokefree handbook. Reinforce progress made.

Give the client the next week's supply of NRT.

Coping skills training

Talk to the client about the previous strategies introduced to them over the course of therapy (cognitive restructuring, SIDS, problem solving, coping skills *etc.*). If the client seems to have a good grasp of these strategies, go on to the following section.

Alternatively, revisit those skills/sessions required.

Refer to pages 20 and 21 in the SANE Smokefree handbook for some additional ideas about coping.

Learn and practice drug refusal skills

In the early stages of quitting smoking, it is important to consider avoiding high-risk situation completely. However, it is acknowledged that avoidance is not a long-term solution, nor is it always a practical one. It is inevitable that the client will encounter a situation where cigarettes are freely available, or even offered to them. There are a number of strategies that can make saying NO easier:

Non-verbal measures for refusing cigarettes (Monti et al., 1989)

- Use a clear, firm, confident and unhesitating tone of voice.
- Make direct eye contact with the other person to increase the effectiveness of your message. Stand/sit straight to create a confident air.
- Do not feel guilty about the refusal and remember, you will not hurt anyone by not smoking.

Verbal measures for refusing cigarettes (Monti et al., 1989)

- "NO" should be the first word out of your mouth. A direct statement is more effective when refusing the offer.
- Suggest an alternative (*e.g.* something else to do/eat/drink).

- Request a behaviour change so that the other person stops asking (e.g. ask the person not to offer cigarettes anymore).
- Change the subject to something else to avoid getting involved in a drawn out debate about smoking.
- Avoid using excuses and avoid vague answers, which will imply that at a later date you may accept an offer of a cigarette.

Exercise: Rehearsing cigarette refusal (Monti et al., 1989; NIDA, 1998)

- Select a concrete situation in the recent past, where the client was offered a cigarette.
- Ask client to provide some background on the person involved in the situation (the “offerer”).
- For the first role-play, have the client take the part of the “offerer”, so they can convey a clear picture of the style of that person, and the therapist shall model the cigarette refusal skills outlined above.
- Discuss the role-play. Therapist should say, *“That was good, how did it feel to you?”* Be sure to praise any effective behaviours and offer clear constructive criticism.
- Repeat the role-play, with the therapist playing the role of the “offerer” and the client playing themselves.
- Discuss the second role-play using the same guidelines as above.

As a reminder to the client, paste the Summary of Refusal Skills (Figure 3.15, below) into the SANE Smokefree handbook on one of the Notes pages.



SUMMARY OF REFUSAL SKILLS (NIDA, 1989)

Tips for responding to offers of cigarettes:

- Say no first.
- Make direct eye contact.
- Ask the person to stop offering cigarettes.
- Don’t be afraid to set limits.
- Don’t leave the door open to future offers.
- Remember the difference between assertive, passive and aggressive responses.



Figure 3.15 Summary of Refusal Skills

Assertiveness skills

Every person has a set of rights e.g. to be respected, to be heard, to express feelings and opinions. Also, they have the right to make mistakes, to say without feeling guilty and to change their mind. Having these rights are important for every person to express themselves, to be understood by others and to have their personal needs met.

The aim of assertiveness training is to develop ways of expressing oneself in a rational, appropriate manner that ensures the maintenance of one’s individual rights and the respect of others.

Figure 3.16 displays a summary of assertiveness techniques for clients to bear in mind when communicating with others. As a reminder to the client, paste the summary into the SANE Smokefree handbook on one of the Notes pages.

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SUMMARY OF ASSERTIVENESS SKILLS (NIDA, 1989)

Tips for being assertive:

- Take a moment to think before you speak;
- Be specific and direct in what you say;
- Pay attention to your body language;
- Be willing to compromise; restate your assertion if you feel that you're not being heard.

-----✂-----
Figure 3.16 Summary of Assertiveness Skills

Communication skills

The following tips will make it easier for clients to start a conversation. Refer to Figure 3.17 for techniques for clients to bear in mind when communicating with others. As a reminder to the client, paste the summary into the SANE Smokefree handbook on one of the Notes pages.

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COMMUNICATION SKILLS (NIDA, 1989)

Tips for conversations:

- it's OK to start with simple topics; or to talk about yourself
- listen and observe;
- speak up;
- use open-ended questions to prompt a response;
- check your reception; end the conversation gracefully.

Nonverbal communication:

- use body language to help get your point across;
- remember to stand up straight, make direct eye contact, and pay attention to your facial expression, tone of voice, head nods, hand movements and gestures, and personal space.

-----✂-----
Figure 3.17 Summary of Communication Skills

Stress/anger management

The relationship between negative thoughts and anger is a direct one, and feelings of anger, irritation or frustration can be effectively managed by modifying the cognitive processes that underlie these feelings.

Discuss the nature of anger with the client, *e.g. Anger is a normal human emotion. Increased awareness of angry feelings will make it possible for you to cope with them so that they don't get out of hand.*

Then, cover the following general issues:

- *events that trigger anger* (direct attack on you; inability to reach a goal; unfair treatment; seeing an attack on someone else; excessive demands on you);
- *internal reactions that signal anger* (feelings: frustration, annoyance, irritation, feeling on edge or wound up; physical reactions: muscle tension, headache, sweating, rapid breathing; difficulty falling asleep; depression or feelings of helplessness.)

Encourage client to identify specific triggers of anger and work through an example of restructuring to focus on more positive thoughts.

Relaxation exercises may also help if the client can identify the onset of anger.

In addition, pages 12 and 13 in the SANE Smokefree handbook offer some useful ideas for dealing with stress.

Homework

- Practice cigarette refusal and other coping strategies discussed in session.
- Revisit pages 20 and 21 of the Smokefree handbook.
- Use 1*21mg patch per day for the next seven days.
- Maintain abstinence from cigarettes.
- Bring SANE Smokefree handbook to next session.

CBT THERAPIST CHECKLIST (Adapted from NIDA, 1989)	
Client ID Number:_____	Date_____
Session Number:_____	
Please complete the following based on this session:	
1. What issues were covered this week?	
_____	Motivational Interviewing
_____	Introduction to CBT: Thought monitoring and high-risk situations
_____	Problem solving
_____	Managing unhelpful thoughts
_____	Coping with cravings/urges to use alcohol/other drugs
_____	Drink/Drug refusal skills
_____	Planning for emergencies and coping with a lapse
_____	Relapse prevention
2. How much time did you spend on each of the aims of this session?	
Phase 1 motivational interviewing	_____ mins
Phase 2 motivational interviewing	_____ mins
Coping skills training	_____ mins
Cigarette refusal	_____ mins
Assertiveness	_____ mins
Communication	_____ mins
Stress/anger management	_____ mins
Identify a support person	_____ mins
Set a quit date	_____ mins
Discuss high-risk situations	_____ mins
3. Did your client complete the homework set after the assessment session?	
_____	No attempt made
_____	Some attempt made
_____	Practice exercises completed adequately
_____	N/A; not assigned

Figure 3.18 Therapist Checklist for Session 5

SESSION 6 - RELAPSE PREVENTION, RELAPSE MANAGEMENT, TERMINATION

Therapist Summary Sheet

Aims:

- Identify potential high-risk situations that may occur in the future.
- Develop a specific relapse prevention/relapse management plan for anticipated high-risk situations.
- Encourage use of relapse prevention/relapse management plan to prevent use of cigarette.

Materials Required for Session 6:

- SANE Smokefree handbook (SANE Australia, 1998)
- Figure 3.19 – Relapse Prevention Plan
- Figure 3.20 – Therapist Checklist for Session 6
- 2 weeks supply of 21mg NRT
- Carbon Monoxide Monitor

Main Areas to be Covered:

Review homework

Rationale for relapse prevention

1. Fire drill
2. Willpower vs. Skillpower
3. High-risk situations
4. Correct beliefs
5. Learn from lapses
6. Lifestyle change needed

Identification of high-risk situations

Preparation for high-risk situations

1. Useful strategies
2. Who can help?
3. Additional skills

Regulating the consequences of behaviour

Using the relapse prevention plan

1. When to refer to it
2. Monitor early warning signs
3. Update the plan

Termination

SESSION 6 - RELAPSE PREVENTION/RELAPSE MANAGEMENT, TERMINATION.

Detailed Intervention

Review homework

Review with the client how well they were able to implement the strategies discussed during the last session, namely cigarette refusal skills.

Take a carbon monoxide reading and record in the Notes pages of the SANE Smokefree handbook.

Discuss with client that this will be the last session for two weeks, and supply him/her with 2*seven day supplies of 21mg NRT.

Rationale for Relapse Prevention (Wilson, 1992)

Once clients have learned the skills and behaviours to help them quit smoking, they are ready to begin preparing for life after therapy where they must manage on their own. This session is concerned with anticipating situations in the future that pose risks to the client in terms of relapsing into smoking. This session can be a way of increasing the client's self-efficacy about how they will cope in these high-risk situations, perhaps circumventing a relapse in the process (Wilson, 1992).

At this stage, both therapist and client have the benefit of hindsight to assist in collaboratively preparing for future high-risk situations. That is, you both know how the client has responded to the different skills/techniques taught in previous sessions, as well as how they relate events, thoughts and behaviours. In addition, the client has hopefully incorporated some of the skills/techniques into their coping strategies, and will have a greater understanding of their problem (Wilson, 1992).

Identification of high-risk situations

It is inevitable that negative events will occur in the client's life that poses threats to maintaining abstinence. Indeed Wilson (1992) reports that the average person will experience at least one adverse event in a 12-month period. This is even more so for people with a mental illness.

A vital first step in preventing relapse is to identify those high-risk situations in advance and allow the client time to prepare how they will deal with them when they occur. Take time in the session to revisit the self-monitoring record the client completed previously (page 8 in the SANE Smokefree handbook) as a guide to the types of situations that have posed problems for them in the past. In addition, probe for life events the client can anticipate posing difficulties for them, for example, loss events (social, financial, failure, loss of status).

Exercise: Identify/anticipate high-risk situations (Wilson, 1992)

- Ask the client to brainstorm high-risk situations or changes that they can anticipate in the future (e.g. adjustment to new situations, financial changes, and social separation).
- Use the following questions to assist the client generate the list: *What kinds of people/places/things will make it difficult for you to stay on top of things/feel good about yourself? What situations do you consider to be high-risk for relapsing? How will you know when a slip occurs?* Alternatively, use the client's self-monitoring form completed in previous sessions as a prompt.
- Write these situations down on the "Relapse Prevention Plan" handout (Figure 3.19, below).

Preparation for high-risk situations

In preparing for the high-risk situations that will inevitably occur, it is useful for the client to take stock of everything he or she has learned during the therapy. This will also help the client to generalise the lessons learned in therapy to real life situations.

Documenting **which strategies are most useful** in dealing with specific high-risk situations can also be useful, and can serve as a reference for the client at a later stage.

At this point it is also important to ask the client: *Who can help you to maintain these skills you have learned?* And *Are there any **additional skills** you think you need so you can maintain your current mood/level of use and level of coping?*

There will be some situations that cannot be predicted. Therefore, generate some general strategies for dealing with adverse events.

Exercise: Preparing for High-Risk Situations (Wilson, 1992)

- Look at the list made in the previous activity that will detail his/her anticipated high-risk situations.
- Ask the client to think back about all the **different skills** they have learned during the therapy sessions, and nominate which ones are appropriate to use in each of the high-risk situations. Examples may include: cigarette refusal, problem solving, coping with cravings, challenging unhelpful automatic thoughts, relaxation *etc.*
- Write these coping behaviours down on the "Relapse Prevention Plan" (Figure 3.19).
- Explain to the client that not all situations can be anticipated in advance. Therefore, it is useful to think about some **generic** coping strategies that the client can employ regardless of the situation. Write these down in the space provided on the handout.
- Also, ask the client whether there are any additional skills they think they may need to assist them in future situations. Record these on the form and discuss options for referral with the client to ensure he/she receives the necessary intervention.

Regulate the consequences

Finally, discuss with the client how they intend to **reward** themselves for remaining abstinent. It is important for the client to create their own rewards as reinforcement for their behaviour, as this may not always come from other sources (*e.g.* family, friends).

Ask the client what it is that they enjoy doing. By planning time/criteria for participation in these activities, the client can learn to regulate the consequences of their behaviour/thoughts for themselves.

RELAPSE PREVENTION PLAN		
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Anticipated High-Risk Situations	Coping Strategies	Reward
General coping strategies for any situation:		
Additional skills required		

Figure 3.19 Relapse Prevention Plan

Exercise: Regulate consequences (Wilson, 1992).

- Refer back to the “Relapse Prevention” handout (Figure 3.19).
- Ask the client the following questions: *How will you know that you are successfully maintaining your behaviours? How can you reward yourself for a job well done?*
- Write these “rewards” down on the handout.

Using the relapse prevention plan

Now that you have collaboratively worked out a relapse prevention plan for high-risk situations with the client, you need to ensure the client uses his/her plan effectively (Graham, 2000).

To do this, Graham (2000) suggests you talk with the client about the following things:

- When to use his/her plan
- Regularly monitoring their early warning signs
- Refining and updating the plan as necessary (i.e. coping strategies, forms of intervention and supports) and as circumstances change

If necessary, document this information on the “Relapse Management” handout provided.

Termination

Formal termination should be acknowledged and discussed at the end of this session. Recapitulate the client’s progress and situation through the sessions and include:

- Reconfirmation of the most important factors motivating the client
- Summarise the commitments and changes made so far
- Affirm and reinforce changes already made
- Explore additional areas of change
- Elicit self-motivational statements for maintenance of change and further change
- Support self-efficacy
- Deal with any special problems
- Remind the client about continuing follow-up session in two-weeks time

CBT THERAPIST CHECKLIST (Adapted from NIDA, 1989)	
Client ID Number:_____	Date_____
Session Number:_____	
<i>Please complete the following based on this session:</i>	
1. What issues were covered this week?	
_____	Motivational Interviewing
_____	Introduction to CBT: Thought monitoring and high-risk situations
_____	Problem solving
_____	Managing unhelpful thoughts
_____	Coping with cravings/urges to use alcohol/other drugs
_____	Drink/Drug refusal skills
_____	Planning for emergencies and coping with a lapse
_____	Relapse prevention
2. How much time did you spend on each of the aims of this session?	
Phase 1 motivational interviewing	_____ mins
Phase 2 motivational interviewing	_____ mins
Rationale for relapse prevention	_____ mins
Identification of high-risk situations	_____ mins
Preparation for high-risk situations	_____ mins
Regulate the consequences	_____ mins
Using the relapse prevention plan	_____ mins
Termination	_____ mins
3. Did your client complete the homework set after the assessment session?	
_____	No attempt made
_____	Some attempt made
_____	Practice exercises completed adequately
_____	N/A; not assigned

Figure 3.20 Therapist Checklist for Session 6

SESSION 7 - (BOOSTER SESSION 1) RELAPSE PREVENTION/RELAPSE MANAGEMENT, DISCUSS STEPPING DOWN TO 14MG PATCHES.

Therapist Summary Sheet

Aims:

- Discuss relapse prevention plans and how client is managing their abstinence
- Discuss stepping down to next level of NRT

Materials Required for Session 7:

- SANE Smokefree handbook (SANE Australia, 1998)
- Figure 3.21 – Therapist Checklist for Session 7 (booster session 1)
- 1 weeks supply of 21mg NRT + 1 weeks supply of 14mg NRT
- Carbon Monoxide Monitor

Main Areas to be Covered:

Review relapse prevention/management plan.

Discuss tapering of NRT.

Make appointment for two week's time.

***SESSION 7 - (BOOSTER SESSION 1) RELAPSE PREVENTION/RELAPSE
MANAGEMENT, DISCUSS STEPPING DOWN TO 14MG PATCHES.***

Detailed Intervention

Review of previous fortnight

Discuss with the client how they have managed over the previous two weeks. Review how successful they have been at maintaining abstinence, and the difficulties they have encountered in adhering to this goal.

Check application of newly developed skills. Establish whether the client feels confident in continuing to use these skills.

Take a carbon monoxide reading from the client and record in the SANE Smokefree handbook. Reinforce progress.

Relapse prevention: main ideas to be checked for application

Ask the client to take out his/her relapse preparation sheet, developed in the previous session. Go through each high-risk situation with the client and discuss whether this has occurred, how successful the strategies were that they nominated for use in that situation, and whether they rewarded themselves for managing the situation.

Discuss the difficulties the client has experienced in relation to the relapse preparation sheet, including the need for new skills to be developed, or adding additional high-risk situations to the plan.

Revise the relapse preparation plan as in Session 6 as required.

Discuss reduction in NRT.

Explain to the client that in one week's time, they will need to reduce the strength of their nicotine patches from 21 to 14mg. Talk with them about their thoughts/feelings/anxieties about stepping down to the next level as required.

Make time for next appointment

You will need to see the client for the final booster session in two week's time, so make an appointment day/time during this session for that to occur.

CBT THERAPIST CHECKLIST (Adapted from NIDA, 1989)	
Client ID Number:_____	Date_____
Session Number:_____	
<i>Please complete the following based on this session:</i>	
1. What issues were covered this week?	
_____	Motivational Interviewing
_____	Introduction to CBT: Thought monitoring and high-risk situations
_____	Problem solving
_____	Managing unhelpful thoughts
_____	Coping with cravings/urges to use alcohol/other drugs
_____	Drink/Drug refusal skills
_____	Planning for emergencies and coping with a lapse
_____	Relapse prevention
2. How much time did you spend on each of the aims of this session?	
Phase 1 motivational interviewing	_____ mins
Phase 2 motivational interviewing	_____ mins
Review relapse prevention plan	_____ mins
Alter relapse prevention plan	_____ mins
Discuss tapering NRT	_____ mins
3. Did your client complete the homework set after the assessment session?	
_____	No attempt made
_____	Some attempt made
_____	Practice exercises completed adequately
_____	N/A; not assigned

Figure 3.21 Therapist Checklist for Session 7 (booster session1)

SESSION 8 - (BOOSTER SESSION 2) RELAPSE PREVENTION/RELAPSE MANAGEMENT, DISCUSS STEPPING DOWN TO 7MG PATCHES.

Therapist Summary Sheet

Aims:

- Discuss relapse prevention plans and how client is managing their abstinence.
- Discuss stepping down to next level of NRT

Materials Required for Session:

- SANE Smokefree handbook (SANE Australia, 1998)
- Figure 3.22 – Therapist Checklist for Session 8 (booster session2)
- 1 week's supply of 14mg NRT + 2 week's supply of 7mg NRT.
- Carbon Monoxide Monitor.

Main Areas to be Covered:

Review relapse prevention/management plan.

Discuss tapering of NRT.

Make appointment for the post-treatment assessment.

SESSION 8 - (BOOSTER SESSION 2) RELAPSE PREVENTION/RELAPSE MANAGEMENT, DISCUSS STEPPING DOWN TO 7MG PATCHES.

Detailed Intervention

Review of previous fortnight

Discuss with the client how they have managed over the previous two weeks. Review how successful they have been at maintaining abstinence, and the difficulties they have encountered in adhering to this goal.

Check application of newly developed skills. Establish whether the client feel confident in continuing to use these skills.

Take a carbon monoxide reading from the client and record in the SANE Smokefree handbook. Reinforce progress.

Relapse prevention: main ideas to be checked for application.

Ask the client to take out his/her relapse preparation sheet. Go through each high-risk situation with the client and discuss whether this has occurred, how successful the strategies were that they nominated for use in that situation, and whether they rewarded themselves for managing the situation.

Discuss the difficulties the client has experienced in relation to the relapse preparation sheet, including the need for new skills to be developed, or adding additional high-risk situations to the plan.

Revise the relapse preparation plan as in Session 6 as required.

Discuss reduction in NRT.

Explain to the client that in one week's time, they will need to reduce the strength of their nicotine patches from 14 to 7mg for two weeks, after which they will step down to zero. Talk with them about their thoughts/feelings/anxieties about stepping down to the next level as required. Talk with the client about how they think they will go once the therapy has finished. Explore with them what their threats and weaknesses will be.

Make time for next appointment

You will need to make an appointment during this session for the post-treatment assessment to take place (if relevant).

CBT THERAPIST CHECKLIST (Adapted from NIDA, 1989)	
Client ID Number: _____	Date _____
Session Number: _____	
<i>Please complete the following based on this session:</i>	
1. What issues were covered this week? <div style="margin-left: 20px;"> <input type="checkbox"/> Motivational Interviewing <input type="checkbox"/> Introduction to CBT: Thought monitoring and high-risk situations <input type="checkbox"/> Problem solving <input type="checkbox"/> Managing unhelpful thoughts <input type="checkbox"/> Coping with cravings/urges to use alcohol/other drugs <input type="checkbox"/> Drink/Drug refusal skills <input type="checkbox"/> Planning for emergencies and coping with a lapse <input type="checkbox"/> Relapse prevention </div>	
2. How much time did you spend on each of the aims of this session? <div style="margin-left: 20px;"> Phase 1 motivational interviewing _____ mins Phase 2 motivational interviewing _____ mins Review relapse prevention plan _____ mins Alter relapse prevention plan _____ mins Discuss tapering NRT' _____ mins </div>	
3. Did your client complete the homework set after the assessment session? <div style="margin-left: 20px;"> <input type="checkbox"/> No attempt made <input type="checkbox"/> Some attempt made <input type="checkbox"/> Practice exercises completed adequately <input type="checkbox"/> N/A; not assigned </div>	

Figure 3.22 Therapist Checklist for Session 8 (booster session 2)

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