



Cognitive and Behavioral Treatment Strategies

TTS – Treatment Strategies

Key Points:

- This module focuses on the use of cognitive and behavioral strategies to help people quit tobacco use.
- It will build on the counseling skills discussed in Module 3, although with a different focus.
- We will discuss the different phases of treatment, addressing treatment for priority populations and looking at group interventions.

Objectives

1. Describe the differences between cognitive and behavioral strategies
2. List specific cognitive and behavioral strategies for the pre-cessation, cessation, and relapse prevention phases of treatment
3. Describe processes to promote relapse recovery
4. Review treatment considerations for priority populations

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Key Points:

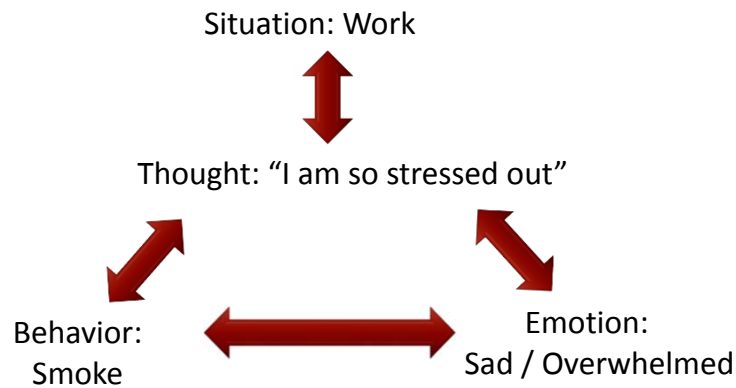
- Goal of module: to provide an overview of treatment strategies appropriate throughout the quitting process.
- The participant will inform the discussion around what works, what doesn't.
- Challenge for today: How to combine--and effectively use--MI strategies and cognitive behavioral strategies.
- These strategies may need to be more directive, due to their behavioral nature, and strongly encouraged.
- Your skill as a counselor is critical, motivating and encouraging clients to participate in these strategies whose effectiveness has been demonstrated in the the literature.
- Remember to document all strategies that your client employs. This may help with billing and will help when writing a case study.

Activity:

- Review module objectives on the slide

Remember: Thoughts, Emotions, and Smoking

Triggers of Smoking Initiation



We may be unaware of automatic thoughts, but aware of the emotions that they create within us

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NOTE – this slide was presented in Module 1 – so this is just a review.

Key Points:

- Thoughts and emotions influence behavior.
- How you think can influence how you feel and subsequently how you behave and can turn into a negative 'vicious cycle'.
- On the other hand, positive thinking and managing emotions can influence behavior positively.
- This cycle of thoughts, emotions and behaviors form the foundation of cognitive-behavioral therapy (CBT) which is often used to help a person quit smoking once they have made a commitment to stop.

Cognitive Strategies

- Focus on how thoughts influence resulting behaviors
 - The associations formed while smoking continue after physical withdrawal ceases
- Identify and “interrupt” negative thought patterns
- Introduce new ways of thinking about a situation
 - Learn new ways of coping with stress and urges to smoke

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Key Points:

- Cognitive and behavioral associations formed while smoking may persist long after physical withdrawal ceases.
- The use of cognitive and behavioral strategies to address these associations is critical to cessation.
- These strategies help by:
 - increasing client’s confidence in ability to quit;
 - exploring ambivalence about quitting;
 - learning ways of coping with stress and urges to smoke.
- A client’s physical and social environment is also critical in determining behavior and should be addressed.
- TTS role: Assist clients to use their thoughts about tobacco use and cessation as a coping skill for triggers, i.e., focusing on reasons for quitting and consequences of tobacco use.

Behavioral Strategies

- Identify actions that replace or interfere with tobacco use
- Describe behaviors that are measurable and observable by others
- Include changes in the environment - Things you can change
 - Should you buy gas, milk, etc. where you used to buy cigarettes?
 - “If you hang out in a barber shop long enough sooner or later you’ll wind up getting a haircut”

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Key Points:

- It is the combination of cognitive and behavioral strategies that are shown to be most effective.
- Behavioral strategies are the actions the client takes or does to change their tobacco use patterns.
- Specific strategies include escape, distraction or delay.

Additional Background:

You will often hear your clients refer to this as the “habit” part of their tobacco use. Many already have a sense that changing this is going to be an important part of quitting. Specific strategies that we can help our clients employ may be escaping difficult trigger moments or using distraction or delay at moments we have an urge or craving to use tobacco. Cravings to use tobacco are brief on average, if we can help our clients to cope or manage with these strategies they can face these moments down.

A Framework for Intensive Multi-component Treatment

Quitting tobacco consists of five phases:

- Building Motivation
- Pre-Cessation (Getting ready)
- Cessation (Quitting)
- Relapse Prevention (Maintenance)
- Relapse Recovery

Effective treatment planning addresses all 5!



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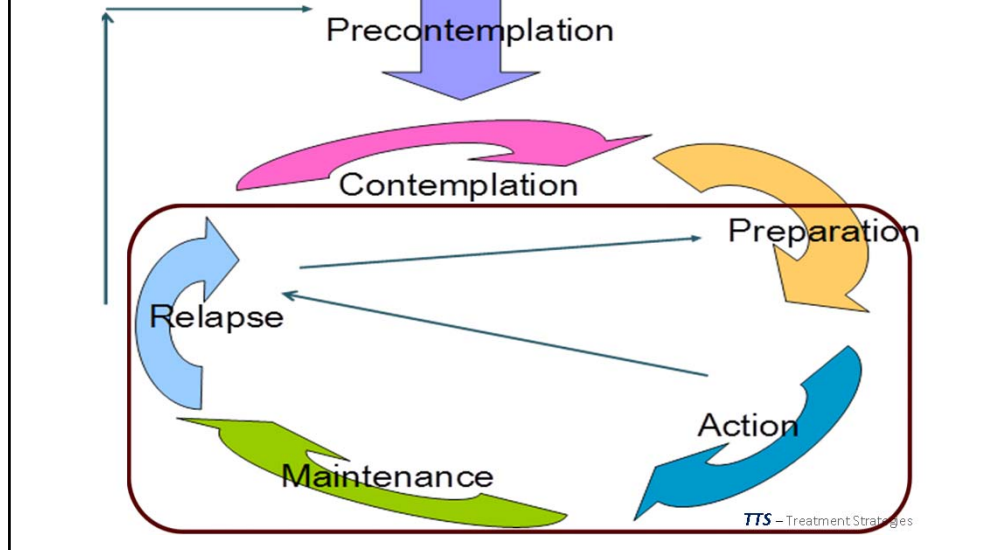
Key Points:

- One way to conceptualize the quitting process is to break it into 5 phases: Building motivation, Pre-cessation, Cessation, Relapse Prevention, and Relapse Recovery.
- The **Building Motivation** phase includes those smokers who are not ready to make a quit attempt.
- The **Pre-cessation (or Preparation)** phase begins to prepare the smoker for quitting by strengthening motivation to quit and by helping the tobacco user learn about his unique smoking habit. Many clients overlook or shortchange this phase.
- The **Cessation (or Quitting)** phase teaches specific strategies for quitting smoking -- Period just prior to and during quit attempt.
- The **Relapse Prevention (or Maintenance)** phase helps smokers understand that maintenance of nonsmoking is the ultimate goal, while teaching specific strategies for achieving long-term maintenance of nonsmoking.
- Finally, in the **Relapse Recovery** phase the goal is to re-engage clients in treatment if they return to smoking after a quit attempt.

Additional Background:

Note that there is overlap between the phases and that quitting does not happen in the linear way it appears on paper. However, it does make it easier to develop a quit plan for a smoker if you think about in these stages.

Stages of Change



Building Motivation is appropriate for those in the Precontemplation and Contemplation stages of change – that is for those not yet ready to commit to a quit attempt. It was the focus of the module on Motivational Interviewing.

Today will focus on working with clients who are ready to commit to a quit attempt – those in the Preparation, Action and Maintenance stages

Finally we will discuss potential processes for those who have relapsed.

Shared Decision Making: a key component of patient-centered care

- Clinician & client work together to make treatment decisions based on evidence that balances risks and expected outcomes with client's preferences and values
- The client:
 - learns about & understands their health conditions
 - recognizes a decision needs to be made & are informed about different options (pros and cons)
 - is better prepared to work with their provider
- The provider:
 - feels client's gain knowledge & are better prepared
 - feels it helps client understand what we are trying to do
- Supports a needed lasting and trusting relationship

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Key Points:

- Website references include:

Objective

Describe the specific and appropriate strategies for the **pre-cessation phase** of treatment

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Key Points:

- This section will describe strategies that can be used during the pre-cessation (or preparation) phase of treatment.

Pre-Cessation Phase – Key Objectives



- Strengthen and renew patient's motivation to quit smoking or using smokeless tobacco
- Target quit date should be clearly established
- Self-monitoring of smoking/dipping behavior should be encouraged
 - Learn more about your triggers
 - You may have ones that you don't realize
- Develop a plan of action!

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Key Points:

- Motivation and Planning are the key objectives in this phase!
- There are several other important objectives during this phase:
 1. Set quit date
 2. Monitor tobacco use via pack wrap or journaling
 3. Develop a plan of action

Additional Background:

This slide (and the objective/strategy slides for the other 2 stages) is meant to be more of a **brief** summary slide. Look for opportunities for further discussion during the small group reports after the exercise

Pre-Cessation Phase - Treatment Strategies

- Cognitive Strategies: listing short & long-term benefits of quitting (not only medical)
- Personalized health feedback: CO levels, pulmonary function, oral exams for ST users
- Setting a target quit date provides time and date to mobilize resources
- Self-monitoring of smoking/dipping behavior
- Practice quit days
- Pharmacotherapy

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Key Points:

- These are some of the intervention strategies that can be used in the Pre-cessation (preparation) phase of treatment.
- Some preparation strategies (e.g., personalized feedback) are also appropriate for smokers in precontemplation and contemplation.
- Recent research shows some promise for using practice quit days – either with or without medications. This may allow client to build self-efficacy and demonstrate how helpful medications and strategies can be. Building in short-term reward – like using the money saved for something else – may build motivation.
- If there has been a forced abstinence, e.g. during hospitalization, reviewing the use of pharmacotherapy during that time may be helpful.

Additional Background: A reasonable quit date should NOT be in a day or 2 (usually need more time to prepare) but neither should it be too far in the future (such as a year off, too easy to procrastinate). A reasonable quit date will be 2-6 weeks in the future; it is often chosen to coincide with a special event, and it should not be scheduled during a particularly difficult time. Also, for a woman, her menstrual cycle should be taken into consideration, as withdrawal symptoms are similar to PMS, and she will be doubly uncomfortable. Wait until AFTER her period!

The time is not set in stone: the date needs to work for the client. Helpful for a group to work towards the same quit day.

Cognitive Strategies for Pre-Cessation Phase

- List benefits of quitting and harms of continued tobacco use (short & long term)
 - Post reasons in a visible place
- Include visual cues for reasons to quit (family photos, an activity you enjoy, etc.)
- List alternative thoughts to be used during craving
 - “I can resist this one cigarette”
 - “This craving will pass”
 - “A cigarette won’t change this situation”

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Key Points

- Help your clients explore how they currently think about tobacco use e.g. “I really need a cigarette to relax” and find phrases to replace usual thoughts
- Keep the thoughts focused on positive and self-affirming language

Activity

- Invite the group to brainstorm some positive phrases that clients may or have found helpful.

Self-Monitoring of Smoking Behavior

- Key Principle: To better change, a person must first understand their own unique “relationship” with smoking or dipping.
- Increases knowledge about factors that cue and maintain tobacco use
- Self-monitoring is reactive - may result in a reduction of smoking rate, however don't make conscious changes while self-monitoring

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Key Points:

- Keeping a written record of number of cigarettes smoked is a standard procedure for any smoking cessation program, or any behavior change program such as weight loss or exercise.
- Self-monitoring helps identify triggers and high risk situations.
- Self-monitoring helps a tobacco user to better understand his/her unique tobacco use patterns and therefore is critical in developing effective coping strategies.

Additional Background:

Key principle – in order for clients to effectively change their smoking habit, they must first gain an understanding of their own unique habit pattern. Self-monitoring serves to increase knowledge about the factors cueing and maintaining one's smoking habit. Situational notations allow patients to understand the environmental influences that trigger smoking.

How to do Self-Monitoring

- Generally called “Wrap Sheet” or “Pack Wrap”
- **Self-record each cigarette (or dip) before using**
 - Date and Time of day
 - Situation in which the cigarette was smoked
 - Place
 - Who with
 - Mood at the time of each cigarette

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Key Points:

- There are many names for this, usually called Pack Wraps or some variation.
- Clients are to self-record each cigarette prior to smoking it, and to record:
 - Time of day
 - Situation in which the cigarette was smoked (e.g., "with coffee")
 - Mood at the time of each cigarette (e.g., tense, relaxed, etc.)
- *Appropriate for chew and cigars as well, or even nicotine gum!

Activity:

- Refer to Pack Wrap in handout section

Additional Background:

A 2000 review of the literature on relapse and maintenance issues by Judy Ockene et al found that higher use of self-monitoring was related to both long and short term maintenance of nonsmoking. (Other cognitive factors included higher confidence and self-efficacy.)

Pack Wrap Example

	Time	Food &/or Alcohol	Relaxation	Work	Social/ Recreational	Driving	Other (please describe)	Angry	Bored	Depressed	Frustrated	Happy	Relaxed	Tense/anxious	Tired	Need Rating		
																Most	Least	
1																1	2	3
2																1	2	3
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Courtesy of the University of Massachusetts Medical School

Clinical Vignettes



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Key Points:

- These vignettes illustrate the issues that people addicted to nicotine face.
- They will be part of small group activities throughout the module.

Activity:

- Vignettes are found in the Handout section of the manual. Assign one vignette to each table/small group.
- During brief breakout sessions, each table will develop a strategy for each phase of treatment for their specific vignette
- Ask a representative from each table to read the story labeled: Share with Everyone

Small Group Activity

- Review the vignette and additional facts provided
- Recommend specific goals and strategies for this client

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Key Point:

- To apply treatment ideas for each group's specific client.

Activity:

- Each small group brainstorms ideas ONLY for the pre-cessation phase of treatment for their client
- Each small group then reports back to the larger group, describing one strategy they would employ and why they would recommend this strategy.
- Once all groups have reported, elicit additional ideas or suggest strategies that may have been missed.

Discussion points:

- *What did you take into consideration when discussing a potential quit date?*
- *What is the purpose of self-monitoring? Why is it important to keep a record?*
- *How might you present the benefits of self-monitoring to a client?*

Objective

Describe specific and appropriate strategies for the **cessation (quitting) phase** of treatment – the period just prior to and during the quit attempt

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Key Points:

- This section will describe strategies that can be used during the cessation (or quitting) phase of treatment.
- This phase can be thought of as the time around the actual quitting and there are a number of strategies that are appropriate at this stage.
- Somewhat arbitrary classification, but useful.

Cessation Phase Treatment Strategies

- Coping with triggers
- Altering smoking/tobacco use patterns
- Integration of pharmacotherapy
- Maximizing social support
- Self-help interventions
- Urge coping strategies
- Tapering



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Key Points:

- These are the strategies recommended by treatment experts.
- We will take a few minutes to discuss each one. At the end of this section you will discuss how to apply strategies to your client's situation.

Self-Management – Coping with Triggers

- Involves **cognitive and behavioral strategies** that rearrange environmental cues or triggers
- **Trigger** — situation, behavior, thought or mood commonly associated with smoking or dipping.
- **Goal of self-management:**
 - For patients to systematically practice using coping strategies to not smoke or dip in identified trigger situations

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Key Points:

- The goal of self-management is for clients to systematically practice using coping strategies to not smoke or dip in their identified trigger situations.
- Self-management can be considered those strategies intended to rearrange environmental cues that trigger smoking or that change the consequences of smoking.
- A critical concept to quitting is that of the **trigger** --which is any situation, behavior, thought or mood that is commonly associated with smoking a cigarette – sometimes referred to as “**People, places, & things**”. Remember to include other substance use.

Activity:

- **Ask: What are some common triggers?** (Refer to **trigger worksheet** in members only section of website)

Additional Background:

Smoking is strengthened through its association with environmental cues, as well as by the immediate positive consequences of smoking. Triggers represent classical conditioning! Phone rings, light a cigarette. Get in the car, light a cigarette. Finish a meal, light a cigarette. Get angry, light a cigarette!

Self-Management Process

- **First step** - patients use information from self-monitoring to develop list of triggers
- **Second step** - patients intervene to break up behavior chain (situation → urge → smoke) using one (or more) of 3 general strategies:
 - **Avoid** the trigger situation
 - **Alter** or change the trigger situation
 - Use an **alternative or substitute** in place of the cigarette or smokeless tobacco

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Key Points:

- Review the behavioral chain of events which is repeated countless times in the life of a smoker:

Situation (trigger)---Urge---Smoke

- As smoking is a learned behavior, *not smoking* must also be learned.
- First step - patients use information from their wrap sheets to develop a list of their various trigger situations.
- Second step - patients begin to intervene actively in their natural environment to break up the smoking behavior chain by utilizing one of three general strategies:
 - **avoid the trigger situation**- Examples: skip coffee, avoid social situations w/ alcohol (at least temporarily), avoid former smoking "hang-outs", leave table after meals instead of lingering over coffee or dessert, don't go to the convenience store etc.
 - **alter or change the trigger situation** - Examples: *Changing behavior* - drink juice in morning instead of coffee, go for walk or jog instead of watch TV, pay for gas at the pump, not inside the station. *Changing thoughts* - Tell yourself "A cigarette won't change this difficult situation" or "I don't need a cigarette" rather than "I need a cigarette to cope".
 - **use an alternative or substitute in place of the cigarette** - Examples: *Alternate behavior* - use of relaxation technique rather than a cigarette in stressful situation; use of gum, sugarless candy, fruit, plan health snacks as a reward rather than cigarette; call a friend, do needlework or something to keep hands busy. "

How might this be a triggering situation?
What would you do?



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Added for a few laughs – at this point in the day and week you have to keep interest up!

Altering Patterns of Tobacco Use May Help

- Alter smoking patterns, rates & brand of cigarettes or other tobacco
 - No longer smoke in car, inside house, garage
 - Switch your cigarettes – brand, non-menthol, etc.
 - Only smoke alone (eliminate social factor)
 - What are some that you can think of?

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Integration of Pharmacotherapy

- Combination of CBT and pharmacotherapy is more effective than either alone
- Combination of pharmacological treatments advised for heavy smokers and dippers
 - e.g., patch + (gum or lozenge), NRT + bupropion
 - Method must be consistent with patient's preferences & beliefs
- Remember: E-Cigs/Vaping are often banned at hospitals, planes, trains, etc....a good reason to consider NRT use.

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Key Points:

- Nicotine replacement, bupropion and varenicline have been shown to be effective pharmacological smoking cessation treatments that can more than double quit rates.
- However, intensive psychosocial interventions in combination with pharmacotherapy significantly increase abstinence rates and have been shown to be more effective than either alone.
- In selecting medications be sure to base the decision on consideration of the three components covered in the module on pharmacotherapy: Agent, Patient and Medical factors.

Maximizing Support for Nonsmoking

- Clinician support increases quit rates.
- Social support is also a key factor in smoking cessation
- Social support from family, friends and co-workers increases quit rates
 - Social support from romantic partners led to more quit attempts and more successful quits at 3 months.
 - How can family and friends who smoke support quitting?
 - Consider on-line social support
 - Build on whatever social support you can!

Burns RJ, et al, 2014

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Key Points:

- Interventions which incorporate a supportive component by the clinician during the course of treatment (intra-treatment support) have been shown to increase quit rates.
- Support from the patient's environment has been associated with an increased likelihood of successful quitting. **Ask even those who smoke for ways they want to help support quitting**
- **The more support, the more likely to succeed.** However, interventions designed to help patients' arrange to increase extra-treatment support have not been particularly effective. We don't know how to help smokers engineer this.

Nonetheless, it is important to help patients problem-solve how to deal with non-supportive individuals in their environment, as well as how to minimize exposure to others' smoking in their environment.

Self-Help Interventions

- Printed non-tailored self-help materials may increase quit rates but the effect is small
- Many have moved to websites and apps
- Materials tailored for specific individuals are more effective than non-tailored materials
- Interactive and tailored internet programs were more effective than written self-help at six months or longer.
- Look for evidenced-based interventions

Fiore M et al, 2008; Hartmann-Boyce J et al, 2014; Taylor et al, 2013;

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Key Points:

- These recommendations are from a recent Cochrane Review about the efficacy of self-help interventions.
- Self-help materials aren't very effective by themselves.
- Tailored materials may be somewhat more effective.

Urge Coping Strategies

Educate clients:

- Urges are time-limited; not one continuous urge
- Urges are stronger and more frequent upon initial quitting, but gradually diminish in intensity

Urge coping strategies:

- Behavioral:
 - 4Ds: Delay, Drink water, Deep breathe, Distract (do something else)
 - Drinking water gives you something to do with your hands
 - Mindfulness apps help with deep breathing
- Cognitive:
 - "Urge-surfing" - imagery (urge peaks, then diminishes)
 - "One day (hour, urge) at a time"

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Key Points:

- Can't always avoid trigger situation, so must teach urge-coping strategies.
- Combination of behavioral and cognitive strategies may be useful in dealing with urges to smoke.
- **Psycho-education** is important: Urges are time-limited; they will pass. They are stronger and more frequent upon initial quitting, but will gradually diminish in intensity and frequency.
- **Distraction** can be an effective behavioral strategy – get busy and **do** something to take one's mind off the urge.
- **"Urge-surfing"** – "go with the urge"; notice it, be a detached observer. Notice that it reaches a peak and then diminishes.
- Think about quitting "**one day at a time**" or even "**one hour at a time**". Thoughts about "quitting forever" can increase anxiety and intensify urges to smoke.

Activity: Review the 4Ds:

Delay, Drink water, Deep breathe, Do something else.

Tapering/Gradual Cessation

Rationale: Gradually reducing nicotine intake reduces intensity of withdrawal symptoms at quit date, so quitting may be less difficult

- Reduce smoking by about 25% per week
- ST users: switch to brand with less nicotine (Copenhagen > Skoal)
- Avoid unrealistically high goals (success builds self-efficacy)
- Do not compensate by smoking harder/longer/deeper
- Use self-management strategies to reduce cpd
- Below 10 cpd or over 2 hours between smoking could introduce withdrawal
 - ½ life of nicotine is about 2 hours. Consider switch to NRT
 - Don't want to accidentally reinforce smoking to relieve withdrawal!
- As effective as abrupt cessation ("cold-turkey") - Hughes, 2008

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Key Points:

- Clients work toward a target quit date by reducing number of cigarettes smoked by about 25% per week over 3 weeks as they work towards their quit date.
- Clients should be cautioned about the possibility of compensation (smoking longer, harder, deeper), and advised to keep such compensation changes to a minimum during the tapering process. When this happens CO test scores may remain high or even go up.
- Clients frequently report mild withdrawal symptoms. While these withdrawal symptoms are more "spread out" over the course of quitting, they will be less intense at quit date.
- Clients may also switch to different, lower nicotine brands in order to disrupt the taste and pattern of smoking.

Additional Background:

If client's regular brand is already at the lowest possible nicotine yield, they may change to another brand of equal nicotine yield in order to disrupt the taste and "comfort" associated with smoking their regular brand.

- John Hughes (2008, Jr of Sub Abuse Tx) on gradual vs. abrupt quitting:
 - Meta analyses, guidelines, Tx programs and regulatory agencies vary widely in whether they include gradual quitting as an option
 - More rigorous RCTs have found gradual as effective as abrupt cessation
 - NRT before quitting increases quit rates
 - There is good rationale for gradual reduction of nicotine

What about Hypnosis and Acupuncture?

- The efficacy of hypnosis and acupuncture has **not** been supported by empirical research
- Acupuncture and related therapies (laser therapy, electrical stimulation) – no consistent evidence that they are effective
 - hypnosis and/or acupuncture should not be utilized as a **primary form or major component** of smoking cessation treatment
 - they can be included as part of a comprehensive program

PHS Guideline, 2008; Barnes et al, 2010; White et al, 2014

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Key Points:

- The efficacy of hypnosis has not been supported by empirical data. That is - there is no research to support that this is an effective method of smoking cessation.
- Similarly, there is no empirical research to suggest that acupuncture is an effective method of quitting smoking. However, the latest Cochrane review notes "... some techniques may be better than doing nothing, at least in the short term, and there is not enough evidence to dismiss the possibility that they might have an effect greater than placebo. They are likely to be less effective than current evidence-based interventions."
- Therefore, hypnosis and/or acupuncture should not be utilized as a primary form of smoking cessation treatment. They can be considered adjunctive to behavioral therapy approaches with demonstrated efficacy, but should never be the primary or major component of a tobacco treatment program.

Additional Background:

Any potential benefits of hypnosis may be as a means of helping patients to learn relaxation skills, although more established means of teaching relaxation skills are discussed under Lifestyle Change strategies.

Quitting Smokeless Tobacco: Special Considerations

- Behavioral strategies are critical
- Oral health exam may increase/strengthen motivation to quit
- Replacement products such as mint chew found to be helpful
- PHS Guideline reports insufficient evidence for pharmacotherapy recommendations
 - It would not hurt - harm reduction at least.
 - Consider Mayo Clinic protocol

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Key Points:

- Not as much to guide us when it come to helping people quit smokeless tobacco.
- Herb Severson in Oregon and the Mayo Clinic in MN have done the most work in this area. They have found that one of the most effective strategies with smokeless tobacco users is having **an oral health exam** from their dentist.
- Some programs report that the use of mint snuff (non-nicotine) can be helpful, as is switching to brands with lower nicotine contents or tapering schedule of use.
- Mayo Clinic treats their ST users with aggressive pharmacotherapy (refer back to slide in Pharmacotherapy section)
- What we know is that the same type of behavior modification strategies used for cigarettes is just as important with smokeless, if not more so.

Quitting E-cigarettes/Vaping: Special Considerations

- Little evidence available for specific vaping strategies; currently being studied
 - “Nobody is quite sure what to do with those wanting to quit, as this is all so new.”*
- Methods for quitting cigarettes may not readily apply to vaping
 - Amount of nicotine inhaled/absorbed varies greatly
 - Formula for tapering may differ
- Suggestion: use strategies that are evidence-based for nicotine dependence

* www.nytimes.com/2018/12/18/health/vaping-nicotine-teenagers.html

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Key Points:

- Little evidence is available for specific vaping strategies; currently being studied.
- What we know about nicotine dependence in youth has been based on cigarette use. How does Vaping technology and chemistry impact that?
- Try using CBT strategies can help with cravings, triggers, etc.: prepare by leaving your e-cigarette at home during the day, identify triggers, identify strategies to use for cravings and triggers, ask for support from family and friends.

Quitting E-cigarettes/Vaping: Special Considerations for Youth

- Special considerations for youth: responsiveness of adolescent brain to nicotine; misperceptions regarding nicotine content, dependence, and possible risks; acceptability, culture of vaping
- The US Food and Drug Administration considering the role of drug therapies for youth dependence
- The Truth Initiative has expanded its quit-smoking resources to include an e-cigarette quit program: text “QUIT” to (202) 804-9884

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Key Points:

- Adolescent brain is more responsive to nicotine’s rewarding effects than adults’.
- Focus groups found that youth reported the perception that parents had positive or neutral feelings toward their use of e-cigarettes.
- Youth also reported the appeal of flavorings and doing “tricks” while vaping (Alexander et al, 2019)
- January 2018 – Truth Initiative released a first-of-its kind e-cigarette cessation program: <http://www.truthinitiative.org/quitecigarettes>. The program is tailored by age group to give teens and young adults appropriate recommendations about quitting.

Sources:

- Amrock et al, 2016
- https://truthinitiative.org/news/how-quit-juul?utm_source=Truth+Initiative+Mailing+List&utm_campaign=8f5c949435-Newsletter_136_2019_02_08&utm_medium=email&utm_term=0_c91fd8a5c5-8f5c949435-82382157
- FDA: <https://www.cnn.com/2019/01/18/health/fda-hearing-vaping-ecigarette-cessation-kids/index.html>

Small Group Activity

- Recommend specific strategies for this client in the Cessation Phase

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Key Point:

- To begin brainstorming treatment ideas for each group's specific client.

Activity:

- Each small group brainstorms ideas ONLY for the cessation phase of treatment for their client
- Each small group then reports back to the larger group, describing one strategy they would employ and why they would recommend this strategy.
- Once all groups have reported, elicit additional ideas or suggest strategies that may have been missed.

Discussion points:

- *What are examples of matching strategies to triggers?*
- *How can you help clients choose the strategies that will work best for them?*
- *How will you and your client monitor the effectiveness of strategies?*

Objective

Describe specific and appropriate strategies for the **relapse prevention phase** of treatment (achieving maintenance)

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Key Points:

- This phase of treatment deals with KEEPING the smoker quit from quit day on! Ideally, strategies for staying quit are part of the treatment plan and have been discussed and rehearsed long before quit day actually arrives.

Relapse Prevention Phase

- **Key Objective:** To teach life-long skills that will sustain abstinence
- Critical issue for intervention programs
- Majority of treated smokers or dippers will quit initially, but resume tobacco use within several months of treatment termination
- “Majority” is not the same as “everyone”
 - You don’t have to resume smoking!



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Key Points:

Goal of this section:

- To teach specific treatment strategies for maintaining long-term abstinence from tobacco use, including both relapse prevention and lifestyle change strategies.
- The majority of treated smokers/dippers will quit initially, but resume smoking within several months of treatment termination, thus developing effective relapse prevention strategies is a critical part of tobacco dependence treatment.

Relapse Prevention

- Ability to cope with “high risk situations” determines person’s probability of maintaining abstinence :
- Successful coping → increased self-efficacy → increased probability of abstinence
- Poor coping → decreased self-efficacy → increased probability of slip or relapse

TTS – Treatment Strategies

Key Points

- Marlatt and Gordon (1985) have proposed a cognitive-behavioral model of relapse that has played a major role in current thinking on tobacco treatment techniques and has stimulated a considerable amount of research.
- *Relapse prevention theory suggests that both **situational factors** (high risk situations, poor coping skills,) and **lifestyle factors** (stress, poor nutrition, lack of physical activity) contribute to relapse.
- The theory also proposes that the ability to cope with "high-risk" situations determines an individual's probability of maintaining abstinence. High risk situations frequently serve as the immediate precipitator of relapse.
- Successful coping in high-risk situations leads to an increased sense of self-efficacy, but failure to cope initiates a chain of events in which diminished self-efficacy may lead to a slip, and perhaps to a full-blown relapse.
- In these instances, patients are taught to avoid self-defeating negative emotional reactions (i.e., the abstinence violation effect) which could trigger continued smoking.

Predictors of Relapse

- Having a **prior slip** is the strongest predictor of relapse, particularly stress-triggered slips
- Increased and more intense urges
- Lowered motivation
- Seemingly irrelevant decisions (choices that lead us to higher risk of smoking)
 - What situations & decisions in the past led to the slip/relapse?
 - What stopped me from recognizing these signs?
 - What would have been a more low-risk option (lowest chance of relapse)?
 - Next - plan to manage those high-risk situations
- Decrease in abstinence self-efficacy and increase in positive smoking outcomes

Ockene et al, 2000; Gwaltney et al, 2009

TTS – Treatment Strategies

Key Points:

Factors predictive of relapse (Ockene, 2000):

- ANY smoking within 2 weeks of quitting is highly predictive of smoking 6 months later.
- She found an average of 19-41 days between slip and full blown relapse.

Additional Background:

Who is not as at much risk?

- Personal: male, older, more educated, little alcohol use, employed, white
- Physiological: lighter smoker, fewer years smoked, longer quit attempts
- Cognitive: greater self confidence and self efficacy, higher use of self- monitoring
- Social: married, lower levels of stress

Relapse Prevention Strategies

- Identification of high-risk situations
- Development of coping strategies for high-risk situations
- Coping rehearsal
- Coping with a possible slip
- Lifestyle balance
- Nicotine Anonymous (Nic-A)



TTS – Treatment Strategies

Key Points:

- These are the strategies recommended by treatment experts.
- Over the next few slides we will discuss these strategies.

Identification of High-Risk Situations

- A **high-risk situation** is any situation that could lead to resumption of smoking
 - If client did “pack-wraps” they might learn more
- Coping will be easier if you can:
 - **accept** that you have high-risk situations
 - **anticipate** the circumstances
 - **plan specific strategies** to deal with those situations
- Underlying assumption – it is difficult to deal with potential relapse at the last moment



TTS – Treatment Strategies

Key Points:

- Identifying and developing coping strategies in response to high risk situations is critical in maintaining abstinence.
- Patients are asked to identify as many high-risk situations as possible. Look to former triggers.
- Clients can then **anticipate the circumstances** and **plan specific strategies** to help deal with those situations.
- Advise clients to be aware of *Seemingly Irrelevant Decisions (SIDS)*: “A series of covert decisions or choices, each of them seemingly inconsequential, which in combination set the person up for situations with overwhelmingly high risk” (see below for examples).

Additional Background:

Clients sometimes make decisions that may seem to them to be irrelevant to the goal of continued abstinence, but actually turn out to create high-risk situations for relapse. Examples: (1) leaving one cigarette in the last pack before going to sleep the night before quit date, or (2) stopping to buy a newspaper at the local convenience store on quit date morning, where the owner knows your brand of cigarette and typically has the pack out on the counter waiting for you. Can you think of others?

Common Situations Leading to Slips

- Negative mood situations
- Positive mood situations especially social situations involving alcohol, marijuana, or other drug use
- Social situations where others are using any type of tobacco



TTS – Treatment Strategies

Key Points:

- Treatment focuses on helping clients to foresee situations that might lead to a slip. The three most common situations leading to slips are:
 1. *Negative mood* situations, such as anger, anxiety, depression, frustration, boredom both inter- and intrapersonal conflict; associated with highest rates of relapse.
 2. *Positive mood* situations, especially social situations involving alcohol
 3. *Social situations* where others are smoking
- In Marlatt's 1996 study of relapse back to alcohol, intrapersonal negative emotional states and interpersonal conflict situations served as triggers for **more than 1/2** of all relapse episodes.
- The vast majority of quitters relapse within 3 months of quitting
- Several studies have that any smoking within first 2 weeks of quitting is highly predictive of relapse at 6 months!

Develop Coping Strategies in High-Risk Situations

- Client should develop set of coping strategies for each high-risk situation identified
- High-risk situations are functionally similar (if not identical) to triggers
- Same self-management strategies (avoid, alter, alternative) can be applied to coping with high-risk situations

TTS – Treatment Strategies

Key Points:

- Although a high risk situation is the immediate relapse trigger, it is actually the person's **response** to the situation that determines whether he/she will experience a lapse.
- A person's coping behavior in a high risk situation is a particularly critical determinant of the likely outcome.
- For each high-risk situation identified, patients are encouraged to fully develop a set of coping strategies for successfully dealing with the high-risk situation without smoking.
- High-risk situations are functionally similar (if not identical) to the trigger situations patients have previously addressed.
- The same self-management strategies (i.e., avoid, alter, or use an alternative/substitute) can be applied to coping with high-risk situations.
- People who cope successfully with high risk situation experience increased self efficacy, which then decreases possibility of relapse.

Coping Rehearsal

- After identifying high-risk situations, practice coping responses. Be intentional
- Start with highest risk situation; rehearse at least top two or three if you can
- Encourage intervening early in a high-risk situation, using specific coping skills
- Effective use of coping rehearsal will increase self-efficacy
- Try this with each high-risk situation if you can

TTS – Treatment Strategies

Key Points:

- Some clients find it helpful to role-play or practice their response to high risk situations.
- This can easily be done in an individual, group or telephonic setting.
- Encourage clients to intervene early, it gets much harder to resist the longer they wait!

Dealing with Slips

- It is important for clients to distinguish between a **slip and a relapse**
- **Slip** - one (or several) instances of smoking after quit date.
- **Relapse** - a return to the usual smoking pattern
- Prevent a slip from becoming a relapse
 - Empathize & then elicit change talk about maintenance
 - Explore discrepancy between goals and slips
 - The slip can become a tool to move forward – why not use it to your advantage?

TTS – Treatment Strategies

Key Points:

- It is important for clients to understand the difference between a slip and full blown relapse:
 - A **slip** is one (or several) instances of smoking after quit date. If left unchecked it could lead to self-doubt, guilt, feelings of personal failure, so that the client gives up > full relapse
 - A **relapse** involves a return to one's usual pattern of smoking.
- Role of TTS: To help client frame a slip as a mistake, not a failure, and a normal part of the quitting process.
- The goal of discussing this with patients is to prevent a possible slip from becoming a relapse AND to ensure the client comes back after a slip!

Lifestyle Balance

- Stress management can include:
 - Deep breathing, meditation, relaxation exercises
- Balanced nutrition:
 - Emphasize balanced, healthy diet, not dieting
- Increase physical activity:
 - Helps with managing stress and avoiding weight gain
 - Start with small, manageable goals and increase gradually.



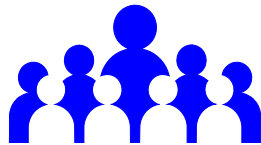
TTS – Treatment Strategies

Key Points:

- Quitting smoking is more than just changing specific behaviors; it is part of a larger constellation of lifestyle changes, such as stress management, better eating, and increase in exercise.
- It is suggested that clients set aside time (45-60 minutes) as often as possible (ideally, on a daily basis), in order to engage in a relaxing, enjoyable, noncompetitive activity.
- The use of *relaxation techniques*, in the form of deep breathing, meditation or progressive muscular relaxation, can be an ideal choice. There are many classes, books and tapes where you can learn effective techniques. See the handout in the handout section which describes an easy deep breathing exercise you can use with clients. These techniques are great alternatives to smoking but they must be practiced regularly. They are also portable! One of the 4Ds!
Stress the importance of deep breathing when quitting!
- *Eating a healthy, balanced diet* should be stressed, de-emphasizing “dieting”. Refer to nutritionist if thought to be a major barrier to quitting. Average weight gain is between 5 and 15 pounds. Don’t allow weight concerns to undermine efforts to quit smoking. **Use of NRT/Bupropion delays weight gain!**
- *Engaging in aerobic exercise* is also an effective smoking cessation strategy, especially with women. Has the added benefit of helping with weight gain and reducing stress. Start with small, manageable goals and increase gradually. Like with any behavior change, client must make a commitment to exercise, develop a plan and set aside time.

Nicotine Anonymous

- Based on the 12-steps, like AA, NA, MA, GA, FA
- Need for ongoing support from recovering peers
- May be particularly useful for patients who have successfully used other 12-step programs
- If you work with clients check out Nic-A: both the website and even a phone meeting
- www.nicotine-anonymous.org



TTS – Treatment Strategies

Key Points:

- Nicotine Anonymous may be a useful adjunct in the maintenance phase.
- Based upon the 12-step principles of AA and NA (Narcotics Anonymous).
- Acknowledges the need for ongoing support in quitting smoking.
- May be particularly useful for patients who have been successful through the use of other 12-step recovery programs.
- There are not many in-person programs available, but there are daily phone and internet meetings available. Schedule is on the website.

Activity:

Ask: ***Any active programs in your area?***

***Prior to presentation see if there is a phone meeting during the presentation and consider calling in to listen with phone on mute:
<http://nicotine-anonymous.org/telephone-meetings.html>***

Self-Management and Recovery Training (SMART Recovery Program)

Program based on 4 points:

1. Enhancing motivation
2. Refusing to act on urges to use
3. Managing life's problems in a sensible and effective way without substances
4. Developing a positive, balanced, and healthy lifestyle

How to Quit Smoking:

Behavior change, cost-benefit analysis, hierarchy of values, map out changes you want to make, put a plan in place to make those changes

www.smartrecovery.org

TTS – Treatment Strategies

- The SMART Recovery program is a community-based self-help program, which can be an alternative to, or complement to, 12 step programs such as Nicotine Anonymous. Purpose is to help participants gain independence from any addictive behavior.

Monitor Strategies

- Check in periodically with client on strategies being used: Don't assume!
 - What types of cognitive and behavioral strategies are they using?
 - Which have been helping? What hasn't been working?
 - If using pharmacotherapy, how is it working for them?
- Work with client to adjust as needed

Remember: What you learn from your client could help you help others in the future

TTS – Treatment Strategies

Key Points

- Helping your clients monitor the strategies they are using gives you information on what is working for them and models how they can adjust as need and continue to draw upon successful strategies

MI Integration with Maintenance Strategies

CBT Strategy	MI Integration
Managing the “abstinence violation effect”. Feelings of guilt & failure may lead to believing they will never stay quit (versus thinking that it was a slip due to inability to cope to a high- risk trigger)	<ul style="list-style-type: none"> • Avoid the term “relapse” • Empathize with slips • Elicit change talk about maintenance • Explore discrepancy between goals and slips
Identify triggers/develop coping skills	<ul style="list-style-type: none"> • Ask permission before engaging • Use Elicit-Provide-Elicit strategy
Supporting self-efficacy	<ul style="list-style-type: none"> • Use of affirmations • Open-ended questions to elicit confidence statements

Adapted from Naar-King et al, 2013

TTS – Treatment Strategies

Key Points

- It may be helpful to emphasize change talk about maintaining new behaviors.
- Other motivational interviewing strategies that may be helpful include the importance ruler, expressing empathy about the difficulties of maintaining behavior change, evoking the client’s perspective on slips, and supporting autonomy with regard to returning to behavior change.
- Also remember DARN-C (desire, ability, reasons, needs, commitment) when discussing this phase.
- Abstinence violation effect may influence whether a slip leads to relapse. This refers to tobacco users’ emotional response to a slip, such as feelings of guilt or failure. This may lead to feeling that they will never be able to stay quit (versus thinking that it was a slip due to inability to cope to a high risk trigger).

Reference

Larimer M et al, 1999

Relapse Recovery

- Establish system of longitudinal care to allow easy access to renewed treatment when ready
- Normalize feelings of discouragement
- Implement motivational interviewing strategies to re-build motivation
- Support possibility of time needed before next quit attempt – have an honest discussion
- Consider medication use during relapse phase and before next quit attempt

TTS – Treatment Strategies

Key Points

- From the beginning of treatment set the stage for ongoing support. While we do not want to encourage relapse it is a reality.
- Have an honest discussion about how to proceed after a relapse. Not all will be ready to begin a new quit attempt.
- Help the client identify how they will know that they are ready to try again.

Small Group Activity

- Recommend specific strategies for this client for Relapse Prevention
- Describe a process for Relapse Recovery if necessary

TTS – Treatment Strategies

Key Point:

- To begin brainstorming treatment ideas for each group's specific client.

Activity:

- Each small group brainstorms ideas ONLY for the relapse prevention phase of treatment for their client.
- Each small group then discusses ideas for how they would engage the client in relapse recovery if necessary.
- Each small group then reports back to the larger group, describing one strategy they would employ for relapse prevention and why they would recommend this strategy. They will also offer one suggestion about how they would address relapse recovery with their client.
- Once all groups have reported, elicit additional ideas or suggest strategies that may have been missed.

Discussion points:

- *How will you help this client deal with a slip?*
- *What additional resources might be helpful for this client?*



Treatment considerations for priority populations

Key Points:

- There remain several priority populations whose rates of tobacco use are still considerably higher than the general population.
- It is essential that tobacco treatment services reach these at-risk groups.
- Our services must be adapted and tailored to meet the unique needs of these populations.
- No matter what treatment setting we work in, it is highly likely that we will encounter clients that belong to one or more of these groups.

Cultural Considerations

- Know your population and tailor your interventions culturally as best as possible
- Involve community members in planning and guiding your program
 - Be transparent, build communication and buy-in
- Provide a welcoming environment
- Have materials available in relevant languages
 - <https://youtu.be/0WT8KKlmtBs> Arabic example
 - https://youtu.be/2cXrjg_mlpY Spanish example
 - See resources listed in Module 2
 - Many materials are low cost or even free
 - Nic-A has on-line materials in 17 languages

TTS – Treatment Strategies

Key Points:

- It is essential to take a person's or a group's culture into consideration when developing a treatment program.
- If you can involve community members when designing a program that is even better.
- Take an objective look at your setting to make sure it is welcoming to people of different cultures and ethnic groups.
- The list of materials in the appendix may be helpful and many can be ordered at no cost.

Additional Background:

Research and obtain materials for these various cultural and linguistic groups. Put up posters that let folks know you welcome persons of color, persons in recovery from alcohol and other drugs, and persons from the GLBT community.

Cultural Tailoring of Interventions

What do we know?

- Compared to non-Hispanic whites (Trinidad et al, 2010):
 - Smaller % of African Americans, Asian Americans/Pacific Islanders and Hispanic /Latinos have ever smoked
 - Fewer African Americans report long-term quitting
 - Racial/ethnic minorities are more likely to be light and intermittent smokers but are less likely to successfully quit smoking.
- All groups express interest in quitting
(Sanderson Cox et al, 2011)

TTS – Treatment Strategies

Key Points:

- Studies have shown that that minority smokers tend to smoke less and more intermittently and also have less success in quitting (Trinidad).
- Specific treatment needs vary across racial and ethnic groups.
- We may to revise our perceptions of addiction and the quitting process among these groups.
- Minority groups are underrepresented in research, despite evidence of interest in quitting.

Cultural Tailoring of Interventions

What Works?:

- Research is limited
- PHS 2008 update recommends use of defined interventions for all population groups
 - Counseling *plus* medications recommended
- Review of treatments supports PHS recommendation
 - Highlights need to consider individual variability
 - Recommends further evaluation of efficacy of cultural adaptations

(Sanderson Cox et al, 2011)

TTS – Treatment Strategies

Key Points:

- There is limited research in this area.
- Counseling PLUS medication is recommended by the PHS for ALL groups.
- Reinforces need to assess and treat each person individually.

Addressing Tobacco in Substance Use Disorder Treatment Increases Long-Term Abstinence

- Clients *are* interested in quitting
- Tobacco use negatively impacts psychosocial issues that challenge clients in recovery (housing, employment, finances, relationships, etc.)
- Cigarette smoking increases the likelihood of drug use relapse (Weinburger, 2017)
- Quitting advice should be offered, without hesitation, to smokers who report substance use and those in treatment for SUD (McKelvey 2017) .

TTS – Treatment Strategies

Key Points:

- The majority of individuals in addiction treatment ARE interested in quitting smoking (Prochaska et al, 2004, Williams et al 2005)
- Alcoholism makes abstinence more challenging but it is possible (Martin et al, 1997; Prochaska et al, 2004).
- Participation in smoking cessation efforts while engaged in other substance abuse treatment has been associated with a 25 percent greater likelihood of long-term abstinence from alcohol and other drugs (Prochaska et al. 2004)
- Cigarette smokers relapsed to their primary drugs of choice more frequently and sooner than did nonsmokers (Sees & Clark, 1993; follow-up study of patients from the Betty Ford Center).
- The role of the Tobacco Treatment Specialist is to make connections between smoking and other addiction, health and psychosocial issues.

Additional Background:

There was no evidence that participants who were either successful or unsuccessful at smoking cessation relapsed to other substances in any significant numbers (Campbell et al., 1995).

Many alcohol-dependent patients spontaneously noted that it would be easier and better for them not to smoke after achieving alcohol sobriety - since drinking and smoking were so strongly linked for them (Orleans & Hutchinson, 1993; survey of 118 residential patients).

The stress of quitting smoking does not appear to prompt relapses to alcohol and drug abuse (Martin et al., 1997; 205 recovering alcohol and drug abusers with 3 mos. continuous abstinence).

Continued smoking generally was associated with a higher relapse risk for alcohol abuse (Sobell & Sobell, 1996; Canadian National Alcohol & Drug Survey of 11,634 people and a five year study of 120).

Non-tobacco users maintain longer periods of sobriety after inpatient treatment for alcohol/drug dependence than tobacco users (Stuyt, 1997; 12-month recovery rates compared after SA inpatient treatment).

The benefits of quitting smoking extend to many areas of a person's life, including but not exclusively, health.

Addressing Tobacco in MH Treatment

- Quitting smoking is associated with mental health benefits
- Meta-analysis (2014) comparing studies of participants found those who quit had:
 - Decreased anxiety, depression and stress
 - Improvement in psychological quality of life
- The effect of quitting smoking is equal to or larger than that of antidepressant treatment

Taylor G., et al, 2014

TTS – Treatment Strategies

Key Points:

- A literature review (Taylor G., et al, 2014) looked at assessments of mental health before smoking cessation and at least six weeks after cessation or baseline in healthy and clinical populations.
- The review found that smoking cessation is associated with reduced depression, anxiety, and stress and improved positive mood and quality of life compared with continuing to smoke.
- The effect size seems as large for those with psychiatric disorders as those without.
- The effect sizes are equal or larger than those of antidepressant treatment for mood and anxiety disorders.
- More recent studies find similar benefits to mental health:
 - Smoking Cessation is associated with improved mental health (Skov-Ettrup, Nordestgaard, Petersen, & Tolstrup, 2017)
- Smoking was associated with poorer cognitive performance in patients with schizophrenia (Vermeulin, 2018)

Substance Abuse and Mental Health Services Administration. *Implementing Tobacco Cessation Programs in Substance Use Disorder Treatment Settings: A Quick Guide for Program Directors and Clinicians*. HHS Publication No. SMA18-5069QG. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.

Treatment in Individuals with Depression

Meta-analysis (2013) of smokers with current or past depression found that they were more likely to be quit at 6 -12 months if psychosocial mood management was included in treatment

- Almost all used cognitive behavioral therapy, either in groups or individual counseling
- Some included self-help materials (website)
- Outcome was not influenced by anti-depressant use

van der Meer et al., 2013

TTS – Treatment Strategies

Key Points:

- A meta-analysis of studies of smokers with current or past depression found that adding psychosocial mood management to a standard treatment intervention increased the likelihood that they would be quit at 6 months or longer.
- Talk with your clients with a current or past diagnosis of depression about the benefits of including CBT or other treatment in conjunction with tobacco treatment.

Summary

- Tobacco Treatment planning consists of 5 phases:
 - Building Motivation (pre-contemplation/contemplation SOC)
 - Pre-cessation, Cessation, and Maintenance (preparation, action and maintenance SOC)
 - Relapse Recovery (relapse SOC)
- Assist clients in the development of cognitive and behavioral strategies
- Monitor and adjust strategies in all phases
- Tailor treatment accordingly to meet the needs of your population

TTS – Treatment Strategies

Key Points:

- This concludes the Cognitive and Behavioral Treatment Strategies module.
- Summarize the above points.