COGNITIVE-BEHAVIORAL THERAPY

Dr. Silvia Jakimczuk

Smoking is a complex disease and approaching it requires integrating several interacting components, that strengthen to approach this pathology.(1)

There is no doubt that psychosocial measures are essential to manage smoking, and they could be compared with pharmacological treatments in terms of significance and impact.

The cognitive-behavioral approach is one of the main techniques used for the management of smoking, since it promotes a series of changes in the lifestyle of patients, modifies beliefs, and behaviors related to the act of smoking.

The cognitive-behavioral counseling is brief and focused.

There are several studies supporting the efficacy of behavioral therapy as a treatment for smoking, since it offers the patient abilities to solve problems, provides social support as part of the treatment, and helps the smoker to get social support outside the management.(2)

Intensive approach

The intensive approach starts with a personal interview that has as its main goal to evaluate which is the proper management for each patient.

The interview should be conducted individually and it is essential to learn details of the relationship of the patient with cigarettes, so as to establish during the management, strategies to face quitting smoking. For this reason the following should be investigated:

1) *History of smoking:* it is important to know the relationship of the patient with cigarettes, when he/she started smoking, how it was this start, when did he/she start smoking regularly, and which is the pattern of use in a normal day, since some smokers display considerable variations in the consumption in a week, and especially on weekends.
2) *Prior attempts:* in general, most smokers attempted several times to quit smoking; knowing the factors or situations which led to relapses during prior

attempts is essential, investigating the ideas and expectations formed after the failure of prior attempts, which is the belief or barrier that prevents doing it.

3) *Social support:* it is essential to investigate the social and family environment of the patient; whether there is someone smoking at home; whether relatives or friends are pressuring him/her to quit smoking or whether they encourage "not smoking"; if there are restrictions to smoke at home or at the work environment.
4) *Dependence:* to evaluate the physical dependence, the Fagerstrom Test for Nicotine Dependence is used, and the needs and options of pharmacological therapy are discussed. Research which is the psychological relationship of the patient with cigarettes and which are his/her most frequent habits.
5) *Degree of motivation:* find out what is the main reason for which the patient wants to quit smoking. Each smoker has a reason of their own to quit; some are worried about their health, others about the money they spend on cigarettes, smokers who are fathers may be worried about the example given to their sons. Knowing these motivating factors is useful to promote personalized advice that may increase their motivation further. We have to take into account that the management should be appropriate to the present time of the patient.(3)
6) *Self-efficacy:* this concept is based on the capacity the person has to reach a given goal.(4) Sometimes the smoker cannot quit not because of lack of motivation, but because of a low self-efficacy.
7) *Concomitant diseases:* some diseases may be directly related to smoking, such as hypertension, strokes, cancer, diabetes.
8) *Psychiatric disorders:* some psychiatric conditions are significant, such as depression, anxiety, and they may worsen the symptoms when the smoker decides to quit.

<u>Selecting the best treatment</u>

Smokers have a unique relationship with cigarettes; they smoke for different reasons, and they do not necessarily experiment the same abstinence symptoms. They differentiate by age, the presence of clinical or psychiatric co-morbidities, education, socio-economic class.

The treatment could be individual or in groups, but guided by a professional trained in the treatment of smoking.

The efficacy of the approach is directly proportional to the time of permanence with the patient; the longer the time, the more efficient the treatment.

The treatment, individual or in groups, uses the same techniques. The first allows for a greater attention and adjustment to the specific characteristics of each patient. In groups there are some advantages; a greater social support, greater easiness to discuss risk situations.(5)

After the first interview, the patient should be referred according to what is most appropriate for him/her; for this reason all the data arising from the first interview should be considered mostly: the presence of psychiatric co-morbidities, degree of motivation, degree of self-efficacy, prior attempts to quit smoking. Besides, the professional helping the smoker should ask him/herself some of the following questions: will the patient benefit from a group treatment? Does he/she have the conditions to follow the group? Or does he/she need more explanations? Will the group benefit with the patient?

Criteria for individual management

It provides greater attention to the difficulties the patient presents; it is the treatment of choice when unchecked psychiatric disorders appear, if the smoker has problems to relate to the group, auditory, cognitive, or memory deficits so that he/she cannot join the group. Also, certain characteristics of personality, such as excessive shyness or making negative references about the treatment to the group.

Criteria for group treatment

The group environment provides plenty of experience, and it mainly provides a significant network of social support to quit smoking. For a good development the following aspects should be considered: no relatives should be included in the same group, since often intimate issues related to the process of quitting are told; the age is also essential, since in general most people looking for treatment are between 35 and 60 years old, and that is why it is unlikely for a younger person to identify with such group.

It is also beneficial to avoid great socio-cultural differences between the members of the group so that it won't become an obstacle between its members. The members of the group should preferably have the same degree of motivation to avoid "contaminating" the group.

Stages of treatment

It is known that the more intensive the treatment, the greater the efficacy. In general, meetings should be weekly at the initial period of the treatment, then every two weeks, and then monthly until discharging the patient.

Most smoking programs consider that abstinence is achieved in 4 or 5 weeks. For this the following should be considered:

1) *The patient should be aware of his/her relationship to cigarettes,* what is the function fulfilling in his/her life, identify what situations or feelings trigger the desire to smoke. For this, the patient should write down every cigarette he/she smokes and what he/she was doing at the moment.

E.g.: TIME	SITUATION	FEELING
9	drinking coffee	wish to smoke
9:30	talking over the phone	joy
10:15	family argument	anger

The patient should be explained that smoking is not only related with a physical dependence, but with other forms of dependence such as the psychological, that is why when stressed or happy, the cigarette acts as a trigger for our mood. Or else, in the behavioral dependence there are routines. E.g.: smoking before going to be, smoking and drinking coffee, etc.

2) *The patient should have his/her motivations clear,* writing down the reasons why he/she wishes to quit, and what the benefits will be.

3) *The patient should have information about what will happen when he/she quits smoking,* know about the abstinence syndrome, what it is, what are the symptoms, how long does it last. Work on the idea of quitting smoking and increasing weight (it is not

advisable to quit smoking and start a strict diet simultaneously). The focus should be in "quitting smoking."

4) *The patient should develop skills to face their habits.* E.g.: waiting situations, in general are a risk for most smokers. Suggest having a book at hand or to fill in crosswords.

5) *Work on the feelings related to the idea of quitting smoking:* many patients experience a feeling of ambivalence during management, explain why this should not be considered a sign of failure, or that some smokers cannot picture themselves without cigarettes, that is why we have to ask them if there are significant people in their lives and who do not smoke.

6) *The patient should acquire abilities to face his/her feelings:* according to Albert Ellis(6) our behaviors and emotions are determined by the interpretation we make of reality, of our beliefs. E.g.: with symptoms of abstinence syndrome:

EVENT: lack of focus.
THOUGHT: I will never get a job.
FEELING: anger, concern.
REACTION: I smoke a cigarette.

Another option:

EVENT: lack of focus.
THOUGHT: this is temporary; it will last a few weeks.
FEELING: peace of mind.
REACTION: allow him/her a deficit over that period.

For this it is necessary to practice the following outline:
EVENT THOUGHT FEELING QUESTION THE THOUGHT PRODUCTIVE RESPONSE
E.g.:
EVENT: robbery

THOUGHT: I need a cigarette to solve the situation
FEELING: anger, sadness
QUESTIONING: the cigarette won't give me back my money
RESPONSE: talk to someone to calm down.

7) *The patient should get abilities to face stress:* it is important to know the causes, stress factors that may be removed from his/her life, and using breathing and relaxation techniques (diaphragmatic breathing, progressive muscular relaxation.)
8) *The patient should develop strategies to face the wish to smoke:* explain that the desire to smoke lasts a few minutes. There are four ways to face it: **distracting your will**, by drinking water, talking over the phone with someone, watch a movie, eat a low-calorie food. **Avoid risky situations**, like going to a party. **Escaping,** from risky situations. **Delaying,** saying I am not smoking now.
9) *The patient should seek pleasing activities,* explain that nonsmokers also have fun and can be happy without smoking.
10) *The patient should seek social support:* it is an important factor to get and keep abstinence(7), he/she should let his family and friends know he/she are in treatment to quit smoking until creating groups with other people in treatment.(8) The patient should be explained that quitting smoking is something he/she should do for him/herself; suggest to think about who could support him/her in this attempt, whether at home or work. Group management helps to create a support network, exchanging phone numbers, getting away from enablers or those who say "I liked you better when you smoked." In such cases talk to the patient not to decrease his/her motivation; if there are smokers at home, establish important rules for living together: not leaving cigarette packages around, not making pacts with friends or family to quit smoking together, since each smoker has a different relationship with cigarettes and they will not necessarily undergo the same situations during the quitting process.
11) *The patient should choose what method should be used to quit smoking;* explain that the most appropriate methodology is establishing a date to quit smoking,(9) who will be there with him/her, not doing it in a very stressful day, or where he/she will be with people that smoke, because he/she will be prone to failure.

12) *The patient should prepare for the day he/she will quit smoking,* talk about it with his/her closest people, keep ashtrays away, change bedclothes, explain the significance of not having cigarettes at home, making pleasing activities, since inactivity may promote relapses, a date for a medical interview should be appointed after establishing a date to quit smoking.

After achieving this goal, there should be a programming to maintain the abstinence.

The maintenance stage is based on preventing relapses;(10) most programs last a year. Over this stage it is important to differentiate a slip from a relapse.

A slip is an occasional use of the cigarette; a relapse is linked with a new pattern of smoking or returning to the previous pattern.

What to do if a slip occurs? Identify the situation the patient was in, which were his/her feelings at the time, let alternatives surface to face such situation.

What to do if a relapse occurs? Discuss the reasons why the patient ended up smoking, explain that it does not start with the act of smoking, but with risky thoughts or behaviors, emphasize the benefits obtained, generally the patients feel guilty, failures, so a new date has to be arranged and the treatment should be reassessed.

Most common situations that lead to a relapse

Negative affection: believing the cigarette eases sadness, anger, negative feelings.

Believing that cigarette-dependence is under control: explain to the patient that this is neurobiological relationship.

Weight increase: encouragement to make physical activities.

Habit situations: modifying routines, keeping busy reading magazines, books.

Alcohol consumption: avoid it the first weeks, not drinking with other smokers.

Social situations: seek social support, relaxation techniques, avoid stress factors.

BIBLIOGRAPHY

1.- Sutherland G. Smoking: can we really make a difference? Hart.89, 2003, p125-127

2.- West R.. Do social Support Interventions Aid Smoking Cessation? A Review Tobacco Control 9(4), 2000,p.415-422

3.- Miller W. R. & Rollnick S. Motivational Interviewing: Preparing people to change addictive behaviour. The GuilfordPress. New York 1991.

4.- Hurt R.D.; Eberman K.M, et. All. Treating Nicotine Addiction in Patients with other Addictive Disorders. Principles and Management. Oxford University Press, New York, 1993. p.310-326
5.- Prochaska J.O.Pocess of Smoking Cessation: implications for clinicians. Clin. Chest Med 12, 1991. p.727-735
6.- Beck J. Terapia Cognitiva: Teoría e Pratica. Porto Alegre. Artes Médicas. 1997
7.- Otead L.F.: Lancaster T. Group Behavior Therapy Programmes for Smoking Cessation: Cochrane Methodology Review. The Cochrane Library Issue $, Reino Unido. 2005
8.- Raw M. et all. Smoking Cessation Guidelines for Health Professionales: a guide to effective smoking cessation interventions for the health care system. Thorax 53. 1998. p.S1-19
9.- Marllant G.A., Gordon J.R. Prevencao de Recaida: Estratégia e Manutencao no Tratamento de Comportamento Adictivos. Porto Alegre. Artmed. 1993
10.- Gigliotti Analice de Paula, Presman Sabrina: Actualizacao no Tratamento do Tabagismo. Rio de Janeiro. 2006. p. 30-51