How to Help Patients Stop Smoking

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Counseling against smoking is an important aspect of preventive health care. The physician must be acutely conscious of the need for this type of intervention. Awareness of the available facilities and an understanding of the various techniques permit the physician to tailor the treatment to the patient. Social support, behavior modification, self-help and hypnotic techniques are generally more effective than drugs.

In February 1980, the Council on Scientific Affairs of the American Medical Association recommended that physicians expand their efforts to reduce cigarette smoking in the United States. This article provides some practical suggestions to help family physicians attain the council's objectives.

The physician's role in smoking prevention and treatment has been criticized for many years. Many physicians have considered smoking a matter of personal lifestyle, meriting intervention only when cigarette smoking exacerbated a medical condition. While it is not logical to assume that physician warnings are singularly effective, some success has been reported when family physicians have counseled patients against smoking.

Family physicians have an obligation both to cure and to prevent disease in their patients. The trust and cooperation that develops between patient and physician can be used to influence smoking behavior. Family physicians should consider the ways in which they can contribute to the prevention and elimination of cigarette smoking. Family practice offers special opportunities to combat this serious health hazard.

Family physicians fulfill five professional roles. Two of these—therapist and consultant/referral agent—are primary roles. The other three roles—exemplar, educator and community leader—complement the primary functions. By expanding their two primary roles, family physicians may have considerable success in discouraging cigarette usage among their patients.

The Physician as a Therapist

As a provider of therapeutic services, the family physician can use routine office visits as an opportunity to express concern about smoking behavior and to provide information about the hazards of smoking. The physician should inquire about each patient's smoking habits during every examination. Such inquiries can help patients to view smoking as a major medical concern.

Discussions of smoking have additional impact if they are initiated during "teachable moments," when patients are known to be more responsive to physician advice regarding cigarette abstinence. Office visits related to coronary symptoms, lung disease, pregnancy, upper respiratory infection and other illness are an opportune time to encourage patients to quit smoking. Patients cannot easily dissociate themselves from the adverse effects of smoking when they have symptoms of disease or pregnancy. Dissociation becomes easier, however, as symptoms subside.

When a patient seeks treatment for an upper respiratory infection that makes cigarette smoking painful or impossible, the physician might suggest that the patient use the first few days of disease-enforced abstinence as a steppingstone toward breaking the habit. Another opportunity may arise when a patient complains of frequent sinus problems. The physician can explain that smoking is a major contributor to the symptoms. Certainly, maternal instincts should make pregnant women quite receptive to the suggestion to stop smoking for the sake of their own health and that of their infants.

Once a patient is persuaded to try to stop smoking, the physician can assist with a treatment referral.

The Physician as a Consultant/Referral Agent

In nearly every study of stop-smoking programs, treatment is assigned randomly, even in studies relating personality and other individual variables to the outcome. The family physician, of course, does not randomly prescribe treatment. Rather, therapy is carefully selected on the basis of each patient's characteristics and the nature of the disease being treated. Nevertheless, this same approach is seldom used in referring patients to stop-smoking programs, which may be one reason for their limited success.

Knowledge of each patient's personality places the family physician in a position to suggest the stop-smoking strategy that is most likely to be accepted by the patient. However, in determining the best technique for a particular patient, the physician should know what stop-smoking programs are available, how they work, the competence of their staffs and the type of commitment required to achieve initial abstinence.

Stop-smoking Programs

There are innumerable stop-smoking programs, which is fortunate considering the variety of people with different levels of motivation and capacity for self-change. This myriad of programs, however, can be sorted out on the basis of a few general psychologic models.

SOCIAL SUPPORT

Social support strategies acknowledge that the cause and the continuance of smoking involve social stimuli. Therefore, programs such as the Five-Day Plan (which may actually extend for several weeks) and other self-help groups provide a social support system that encourages smoking abstinence. An individual who participates in this type of program can learn how to socially interact without cigarettes, to develop pride in the healthful image of a nonsmoker and to derive sustained encouragement from fellow participants to remain tobacco-free. Social support strategies are typically offered by church and civic groups, as well as by some hospitals.

BEHAVIOR MODIFICATION

Behavior modification can involve either actual or imagined aversive stimulation. Surprisingly, the two strategies are similar in effectiveness. Actual aversive reinforcement may entail a light electric shock to a finger, a puff of smoke in the eye, smoking in a closed smoky room until satiated, rapidly smoking to the verge of nausea and several other maneuvers. Imagined negative reinforcement, often called covert sensitization, consists of imagining oneself as nauseated by smoking or as coughing uncontrollably in public. With either real or imagined aversive therapy, smokers learn to associate these negative experiences with smoking, to the extent that the association of smoking with discomfort becomes stronger than the association with pleasant experiences. Aversive therapy is commercially available and is also offered by some colleges and universities in connection with research projects.

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SELF-HELP

Self-help methods focus on the cognitive awareness of smokers. This model assumes that physical, temporal and social stimuli in daily life act as learned cues that trigger smoking. To help the smoker become more aware of his habit, the frequency with which he smokes in certain settings may need to be monitored, so that the links between environmental cues and smoking behavior can be recognized and perhaps broken. A frequently used method involves separating the day into segments and then striving to establish one smoke-free period at a time. This can be aided by self-control techniques such as smoking "legal" cigarettes cued by a random signaler, or smoking only in out-of-the-way places that present minimal social stimulation. Self-help programs are often sponsored by colleges and universities and sometimes by church and civic organizations.

ALTERED STATES OF CONSCIOUSNESS

Altered states of consciousness, primarily hypnotic and meditative states, are utilized in some stop-smoking programs. They operate according to one of two models. The first focuses on the heightened suggestibility associated with hypnotic trance; a stop-smoking message is interjected during this state. The second model makes use of the mind-body integration obtained from periodic meditative "time-outs." Theoretically, this technique purges the body and mind of the need to rely on cigarettes for relief of tension. Most licensed hypnotists can perform autosuggestive techniques. Consciousness-altering programs employing yoga or transcendental meditation are prevalent in university towns and most large cities. The majority of these techniques reportedly have success rates comparable to those of most other strategies.

MEDICAL INTERVENTIONS

Medical interventions include drug therapy, psychotherapy and surgery in the form of acupuncture. The drug therapy model operates on the assumption that nicotine and its withdrawal symptoms are responsible for cigarette addiction and, therefore, that smokers can be treated by introducing nicotine or nicotine-like chemicals directly into the bloodstream, without recourse to smoking. However, the use of nicotine chewing gum and drugs such as lobeline has had a low level of success in research studies. Tranquilizers and amphetamines have also been employed, but without success.

Psychotherapy has been moderately successful for smokers with a psychologic disturbance. In such cases, smoking is considered a symptom or a nervous habit. Therapeutic intervention of this type is generally provided by psychiatrists and clinical psychologists.

Acupuncture has been shown in several studies to be an effective stop-smoking technique. However, it has yet to receive broad medical endorsement.

Principles of Patient Referral

When considering a patient for referral to a stop-smoking program, each physician must

take into account the strategies and models employed by the programs in the community. With the exception of drug therapy, which is generally ineffective, most strategies for stopping cigarette usage are equal in their rates of success – approximately 30 percent.

Patients with a low tolerance for discomfort should usually be steered away from programs employing aversive reinforcement. They might find hypnosis or social support groups more appealing. Patients who are not highly self-reliant or self-disciplined are poor candidates for self-help programs, but might fare well in a social support group. Patients who pride themselves on being independent might respond to self-help procedures or programs using altered states of consciousness. Meditation and yoga are popular with highly educated young people, whereas they are viewed skeptically by many older people.

Determining what programs are available in the community may be a rather difficult task. The telephone book will typically list only the more costly commercial programs, which may consist of a mere half-dozen or so even in large metropolitan areas. Numerous inexpensive programs are sponsored by charitable and other community organizations, but they are not highly publicized because of lack of funds for advertising. Physicians may learn about programs of this type from patients who have participated in them and found them effective.

In cooperation with their local medical association, physicians might want to establish a clearing house for available stop-smoking techniques. In addition, the medical association might occasionally sponsor a symposium or lectures in which representatives from the various stop-smoking programs in the community present information about their methods.

Ultimately, matching the stop-smoking strategy to the patient's personality is likely to afford the best chance for cigarette abstinence. ■

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