Brief Motivational Interviewing (2001)

Brief motivational interviewing can be integrated into any multi-session intensive tobacco treatment program. The elements of brief motivational interviewing involve FRAMES:

- **Feedback** - personalized information
- **Responsibility** - freedom of choice; individual's responsibility for own health
- **Advice** - need for change delivered in a clear, supportive, concerned manner
- **Menu** - strategies for change offered in a varied (menu) format
- **Empathy** - empathetic, reflective, supportive style related to positive treatment outcomes
- **Self-efficacy** - client's belief in ability to change is essential

Motivational Interviewing Techniques

Assess client's readiness to change by using two questions:

"From 1-10, what is your Desire to quit?"

"From 1-10, how Confident are you in your ability to stop?"

(If someone answers a 3 to either question, you might ask, "How come you're not a 10?"

- Listen for and discuss with client **ANY** ambivalence presented. For example, if client mentions a child, try to draw out **ANY** ambivalence (regarding using tobacco in relation to the child) and get client to talk about it. This can help the client move through the stages.

- Go through Decision-making Worksheet with client, to make sure that both practitioner and client are "on the same page."

Examples of open-ended questions appropriate for motivational counseling :

1. How did you first get started smoking?

GOOD THINGS ABOUT SMOKING	NOT SO GOOD THINGS ABOUT SMOKING
NOT SO GOOD THINGS ABOUT QUITTING	GOOD THINGS ABOUT QUITTING

2.
3. What would change in your life if you stopped smoking?

4. Sometimes people decide to quit using and succeed, only later to begin again. What things do you think might influence you to start smoking again after you've already stopped?

Examples of closed-ended questions appropriate for motivational counseling:

1. I'd like to summarize what I understand so far. Would you be willing to listen, and make sure I've gotten it right?

2. Would you be interested in hearing some information about our treatment program?

Reflective Listening

The process of reflective listening involves hearing what the client says and either repeating or paraphrasing back to the client, or reflecting the feeling you believe is behind what the client says. Different levels of reflective listening can be distinguished (Ingersoll et.al, 2000).

- **Simple Reflection.** Counselor simply restates what client says.

Client: But I can't stop smoking. All of my friends smoke!
Counselor: So, all your friends smoke, so you don't think it's possible to quit.
Client: Yes, right, although maybe I should.

- **Amplified Reflection.** Counselor exaggerates the client's statement to the point client may disagree with it. Counselor must not be mocking or patronizing.

  Client: But I can't quit smoking. All of my friends smoke!
  ***Counselor*:** Oh, so you couldn't really quit smoking because then you'd be too different to fit in with your friends.
  Client: Well, that would make me different, although maybe they might not really care if I didn't try to get them to quit, too.

- **Double-Sided Reflection.**Counselor reflects both the current, resistant statement, and a previous, contradictory statement the client has made.

  Client: But I can't quit smoking. All of my friends smoke!
  Counselor: You can't imagine how you would be able to not smoke with your friends, and at the same time you're worrying how it's affecting you.
  Client: Well , yes, I guess I have mixed feelings.

- **Shifting Focus.** Sometimes counseling goals are better achieved by simply not addressing the resistant statement.

  Client: But I can't quit smoking. All of my friends smoke!
  Counselor: Well, we're not really there yet; I'm not talking about your quitting smoking here. Let's just keep to what we're doing here-talking through the issues-and later on we can worry about what, if anything, you want to do about the smoking.
  Client: Well, I just wanted you to know.

- **Rolling with Resistance.** With clients who are extremely unreceptive to any idea or suggestion, this technique can be effective. It involves a paradoxical element, which can often bring the client back into a more balanced, non-combative perspective.

  Client: But I can't quit smoking. All my friends smoke!
  Counselor: And it may be that when we're finished here, you'll decide that it's worth it to you to keep on smoking. Right now it may be too difficult to make a change. That decision is yours to make.
  Client: Okay

- **Reframing.**With this strategy, the counselor invites clients to examine their perspective in a new light,

thereby giving new meaning to what the client has said.

Client: My best friend is always bugging me to stop smoking. It's really irritating.
Counselor: Your best friend must really care a lot about you to say that, knowing you'd probably get angry with him/her.

(www.motivationalinterview.org), section adapted from NIAAA Project MATCH Motivational Enhancement Therapy manual)

- **Working with resistance.** To reduce client resistance, the counselor can use paraphrasing. Effective motivational interviewing involves a ratio of paraphrasing to questioning. The counselor should paraphrase two to three times as often as ask a question (Interview with Robert Rhode, July 2000).

Recovery-oriented Therapy

Recovery-oriented therapy is based on an addictions model. This treatment modality approaches tobacco use as a "real drug," comparable to other major addictive substances such as alcohol, cocaine, and heroine. The addictive aspects of nicotine and smoking are used in the service of quitting smoking, as opposed to viewed as obstacles to quit (Rustin, 1997). Within the scope of the addictions framework, it is imperative that treatment providers set boundaries with, and serve as role models for, their clients (Rustin, 1999; 1998).

How Addiction Recovery Principles Can Be Applied to Nicotine Dependence Treatment

Acceptance of the Problem: Stages Involved

- **Dealing with denial** (the unconscious inability to see the truth).
  Using logic is ineffective at this point. When clients are in denial, the goal is to increase their level of ambivalence.
  "Assume you can recover."
  "Your energy level (coughing, emphysema) is going to get a lot better after you quit smoking."

- **Exploring Ambivalence**
  Spend time decreasing fear, reframing fearful feelings/statements.
  A client's anxiety about losing his smoking friends if he quits using tobacco can be reframed with a questions such as, "What else do your friends like about you?"

- **Investing in the future**
  "What would be good about being a non-smoker?"
  "How's your life going to be better off after you have quit smoking?"
  Agree with whatever the client responds and prompt client to be as specific as possible.

- **Surrendering**
  Client is able to give up preconceived notions regarding the addiction.

- **Support**
  Client is able to seek support in the form of either individual or group or both.
  (Rustin, 1999; 1998).

Relapse Prevention

Action Stage
Client is not yet totally comfortable with newly adopted behavior. The cognitive process may involve wondering, "How hard do I have to work at this?"
Evaluate the specific threats with the client. Ask what has worked in the past. Offer what other clients have tried that was successful and ask if any of those options could help.

Maintenance
Encourage clients to give support to others as a way to remain committed to abstinence.
(Rustin, 1999; 1998)

How Treatment Providers Can Use Recovery-oriented Therapy with Tobacco-dependent Clients

- Frame the discussion around tobacco use by using the terms "addiction" and "dependency."
- Help clients understand that smoking is an addictive disorder that alters perception, affects thinking, and reduces choices; it is not merely a habit.
- Help clients to recognize and address defenses and to accept loss of control.
- Emphasize the "relationship" clients have with tobacco; how their behaviors and thoughts express that relationship (Rustin, 1997) Example: A client recounts how, when she was on vacation with her husband and they had unpacked and settled in for the night at the hotel, she realized she had run out of cigarettes. She had to get dressed, drive to the nearest store, and purchase cigarettes.
  The question to pose to the client would be: "What does that tell you about your relationship with cigarettes?"
- Encourage clients to use recovery programs (http://www.nicotine-anonymous.org)

Solution-Focused Brief Therapy

Solution-focused brief therapy differs from instrumental therapy, in that the practitioner is not the expert, but one who joins with the client to discover and create meaning. Client motivation is created together through conversation between client and counselor (www.brief-therapy.org). The emphasis is shifted from focusing on the problem to creating solutions in the client's life. Purposeful questioning is used to help clients construct workable solutions. Clients are encouraged to identify what they are already doing well and build upon those strengths. The client is viewed as self-resourceful, as the source of the solution (Miller, Hubble & Duncan, 1996).

Guiding Principles of Solution-Focused Brief Therapy

- The problem is reframed, using paradox and analogy as helpful tools (Dormody, 1999).
- The treatment goal has to be the client's; the cessation provider never goes further than the client is willing to go
- The emphasis is on the positive-on what works, not what does not
- Exceptions are identified (times the individual does not experience the difficulty)

- Questions are asked to promote spontaneous change
- The attention is shifted to how the client would like to live; the client is encouraged to visualize healthy behaviors and success in being tobacco free

How Solution-Focused Brief Therapy can be applied in treating tobacco dependent clients

This treatment modality can be used in both individual and group settings to identify and transfer the successes in clients' lives and create solutions for their tobacco dependency. In groups, clients benefit from the solution-focused orientation and the therapeutic factors inherent in group work (www.ezonline.com/grafton/solution).

Solution-Focused Brief Therapy Techniques

Scaling questions

Because tobacco-dependent clients often "believe" that their cigarettes (or chew, etc.) are more important than anything else, the scaling question exercise can help put into perspective the relative importance of their tobacco use (Rustin, 1998).

"On a scale of 1 to 10, how important is your home (for example) in your life?"

To client's response, the counselor asks: "In relation to your home, are your cigarettes more or less important? Then the counselor continues with questions about other aspects of the client's life (such as family, car, job, etc.).

The "Miracle Question"

The use of the Miracle Question enables clients to visualize how different their lives would be if suddenly they did not have to deal with their tobacco dependency.

"Suppose while you are sleeping tonight a miracle happens. You wake up in the morning and you have no desire to smoke. How would you know this miracle happened? How would your life be different?" (Rustin, 1997).

Working with Difficult, Resistant, or Mandated Clients

Often the motivation to quit tobacco use stems not from the client, but from someone else in the client's life, such as a family member, a friend, or an authority. In working with these clients, the counselor can ask certain questions to convey that the client is an expert on his or her own situation and that the counselor is interested in listening to the client's definition of the problem.

An effective initial question to ask might be: "So, how is your smoking too much a problem for you?" Other good questions to ask:

- Whose idea was it that you come to see me today?
- How did ___ get the idea that you need to come here today?
- So what would your family (school personnel, friend, physician) say how your smoking is a problem for you? Do you agree with their ideas?

- How will (she) know that the problem (she) thinks you have is solved?
- What will she be doing differently then?
- What will be different between the two of you then?
- How will that be helpful? (Insoo Kim Berg)

(Additional References for this treatment modality: Miller, S.D., Hubble, M.A., Duncan, B.L. (1996). Handbook of Solution-Focused Brief Therapy

Social Support

Social support is an effective component of a comprehensive program for tobacco dependence. The increase of social support in the tobacco user's environment can increase long-term cessation by 50 percent (Surgeon General's Report, 2000). Individuals participating in treatment should be educated about and offered both intra-treatment social support and extra-treatment social support. Increasing the unity among members of smoking cessation groups can enhance both types of social support (Fiore et al., 2000).

Elements of Intra-treatment Supportive Interventions (within treatment setting)

- Treatment provider offers encouragement and belief in user's ability to quit
- Provider communicates caring and concern, is open to individual's expression of fears of quitting and ambivalent feelings
- Tobacco user is encouraged to talk about the quitting process (reasons to quit, previous successes, difficulties encountered)
- The use of intra-treatment social support yields a 14.4% abstinence rate (Fiore et al., 2000)

Elements of Extra-treatment Supportive Interventions (outside treatment setting)

- Tobacco user is offered skills training in soliciting support from others (family, friends, co-workers), is helped in establishing a smoke-free home
- Information on community resources (helplines) is provided
- Tobacco user establishes a buddy system (letters, contracts, tip sheets) (www.lungusa.org)
- Extra-treatment social support shows a 16.2% abstinence rate (Fiore et al., 2000)

Behavior Modification

Along with the physiological and emotional aspects of nicotine and tobacco addiction are the related behavior patterns associated with the addictive substance. Comprehensive cessation counseling includes educating the client on how to use various behavioral techniques and strategies that will aid his or her success at quitting and staying quit.

Components of Behavior Treatment

- Maintaining an inventory of smoking behavior
- Recognizing cues to smoke (Fiore et al., 2000)
- Identifying events, internal states, or activities that can trigger tobacco use (examples: negative mood, being around other tobacco users, alcohol, coffee, experiencing urges and withdrawal
- Developing coping skills (Fiore et al., 2000)
    - Anticipating and avoiding temptation
    - Learning cognitive strategies to reduce negative mood
    - Implementing lifestyle changes to reduce stress and improve quality of life

      Assertiveness training (American Lung Association, 1996);

      Vigorous exercise can boost quit rates (Fiore et al., 2000);

      Post-cessation weight gain can be managed (Fiore et al., 2000)
      Nutrition: Withdrawal Diet Plans (Waltz, 1996);

      High-fiber, low-fat diet encouraged to limit weight gain during cessation
      Alkaline diet can slow nicotine metabolism and ease withdrawal: a diet high in raw fruits and vegetables (www.healthy.net)
    - Learning strategies to cope with urges and cravings

      Four D's: Delay, Drink water, Deep breathe, Distract
      Imagery
      Relaxation
      Positive affirmations
    - Provide basic information (Fiore et al., 2000)
      Inform about harmful effects and addictive nature of tobacco; withdrawal symptoms and cycles
    - Relapse prevention skills
- Aversive smoking has shown effective outcomes (Fiore et al., 2000), but is currently not often used.

Relapse Prevention/Management

Due to the chronic relapsing nature of tobacco dependence, relapse prevention should be included in any tobacco cessation treatment program (Fiore et al. 2000). The primary goal of relapse management is to prevent the client's setback from escalating, and to help the client develop competent coping strategies for present and possible future problems.

Major Contributing Factors to Relapse

- Withdrawal discomfort
- Dependence level
- Social environment
- Stressful situations
- Loneliness and boredom
- Depression
- Postpartum
- Alcohol
- Weight gain
- Lack of social support
  (Lisa Cox, Mayo Clinic Nicotine Dependence Seminar, 1999)

Relapse Prevention Methods

- Systematic follow-up is critical to relapse prevention/management. (See SCA; Fiore 2000)
- All clients who receive tobacco dependence intervention should be assessed for abstinence upon completion of the intervention program and during subsequent contacts.
- Assessment within the first week after a quit attempt is encouraged.
- For abstinent clients, relapse prevention treatment should be provided.
- Clients who have relapsed should be assessed for their willingness to make another quit attempt. Additional treatment or an intervention to promote motivation to quit should be provided.
- Client should be offered information on more intensive treatment and support groups (www.nicotine-anonymous.org)
- Pharmacotherapy should again be offered to the client.
- Follow-up methods can include in-person visits, telephone, mail, e-mail
  (Fiore, 2000)

Strategies for Relapse Intervention

"The goal is not just to prevent relapse; it is to gain the positive dimensions of recovery" (Fisher, 2000).

Strategies for Preventing Relapse to Tobacco Use (adapted from Fiore et al., 2000)

Minimal Strategies

To all former tobacco users, offer congratulations and encouragement to remain tobacco free. Using open-ended questions, engage clients in open discussions on the following:

- The benefits of quitting
- Any successes client has had
- Any problems encountered or anticipated threats to remaining abstinent

Individualized Strategies

The following guide is suggested for responding to clients' particular issues:

Problems	Responses
Lack of support for cessation	• Schedule follow up visits or telephone calls with the patient. • Help the patient identify sources of support within his or her environment. • Refer the patient to an appropriate organization that offers cessation counseling or support.
Negative mood or depression	• If significant, provide counseling, prescribe appropriate medications, or refer the patient to a specialist.
Strong or prolonged withdrawal symptoms	• If the patient reports prolonged craving or other withdrawal symptoms, consider extending the use of an approved pharmocotherapy or adding/combining pharmacologic medications to reduce strong withdrawal symptoms.
Weight gain	• Recommend starting or increasing physical activity; discourage strict dieting. • Reassure the patient that some weight gain after quitting is common and appears to be self-limiting. • Emphasize the importance of a healthy diet. • Maintain the patient on pharmacotherapy known to delay weight gain (e.g., bupropion SR, NRTs, particularly nicotine gum). • Refer the patient to a specialist or program.
Flagging motivation/ feeling deprived	• Reassure the patient that these feelings are common. • Recommend rewarding activities. • Probe to ensure that the patient is not engaged in periodic tobacco use. • Emphasize that beginning to smoke (even a puff) will increase urges and make quitting more difficult.

(Fiore et al., 2000)

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