Facilitating Tobacco Cessation through Clinician-Client Partnerships

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January 9, 2008

NYS Cessation Center Collaborative Statewide Conference Call
Objectives

- Identify evidence-based psychosocial treatments for those who are tobacco dependent

- Identify interpersonal strategies designed to enhance clients’ autonomous motivation and efficacy for stopping smoking

- Describe interpersonal barriers to building provider-client partnerships that support clients’ autonomous motivation and efficacy for stopping smoking
Outline

- Resources for best practices
  - PHS Guideline for Treating Tobacco Use and Dependence
  - APA Practice Guideline for the Treatment of Patients with Substance Use Disorders
- Integrating PHS & APA guideline recommendations
- Self-determination theory: A lens for enhancing motivation and efficacy through autonomy support
- Partnerships that support autonomy
  - Strategies for enhancing autonomous motivation & efficacy for stopping smoking
  - Barriers to building partnerships
CLINICAL PRACTICE GUIDELINE

Treating Tobacco Use And Dependence

U.S. Department of Health and Human Services
Agency for Health Care Policy and Research
Structures/types of interventions
(Fiore et al., 2000)

- **A. Brief**
  - 3-10 minutes
  - Targets smokers who are willing (5 As), unwilling (5 Rs), and those who recently quit (relapse prevention)

- **B. Intensive**
  - Total clinician-client time > 30 minutes with at least 4 sessions
  - Tend to be coordinated by tobacco dependence specialists
  - Multiple clinician types

- **Strong dose response between counseling intensity and cessation success**
Components of Counseling
(Fiore et al., 2000)

- Pharmacotherapy

- Problem solving & skills training
  - answer questions/provide information
  - educate about nicotine withdrawal/toxicity
  - identify & strategize about danger situations
  - develop coping strategies

- Interpersonal support
  - be positive, encouraging, & compassionate

- Mobilizing support from others
  - NYS Quitline at 1-866-NY-QUITS
  - family/significant others education
<table>
<thead>
<tr>
<th>FIVE KEYS FOR QUITTING</th>
<th>YOUR QUIT PLAN</th>
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<tbody>
<tr>
<td><strong>1. GET READY.</strong></td>
<td><strong>1. YOUR QUIT DATE:</strong></td>
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<tr>
<td>▶ Set a quit date and stick to it—not even a single puff!</td>
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<tr>
<td>▶ Think about past quit attempts. What worked and what didn’t?</td>
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<tr>
<td><strong>2. GET SUPPORT AND ENCOURAGEMENT.</strong></td>
<td><strong>2. WHO CAN HELP YOU:</strong></td>
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<tr>
<td>▶ Tell your family, friends, and coworkers you are quitting.</td>
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<tr>
<td>▶ Talk to your doctor or other health care provider.</td>
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<td>▶ Get group, individual, or telephone counseling.</td>
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<tr>
<td><strong>3. LEARN NEW SKILLS AND BEHAVIORS.</strong></td>
<td><strong>3. SKILLS AND BEHAVIORS YOU CAN USE:</strong></td>
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<tr>
<td>▶ When you first try to quit, change your routine.</td>
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<td>▶ Reduce stress.</td>
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<td>▶ Distract yourself from urges to smoke.</td>
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<td>▶ Plan something enjoyable to do every day.</td>
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<td>▶ Drink a lot of water and other fluids.</td>
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<tr>
<td><strong>4. GET MEDICATION AND USE IT CORRECTLY.</strong></td>
<td><strong>4. YOUR MEDICATION PLAN:</strong></td>
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<tr>
<td>▶ Talk with your health care provider about which medication will work best for you:</td>
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<tr>
<td>▶ Dyp评定 SR—available by prescription.</td>
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<tr>
<td>▶ Nicotine gum—available over-the-counter.</td>
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<tr>
<td>▶ Nicotine inhaler—available by prescription.</td>
<td></td>
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<tr>
<td>▶ Nicotine nasal spray—available by prescription.</td>
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<tr>
<td>▶ Nicotine patch—available over-the-counter.</td>
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<tr>
<td><strong>5. BE PREPARED FOR RELAPSE OR DIFFICULT SITUATIONS.</strong></td>
<td><strong>5. HOW WILL YOU PREPARE?</strong></td>
</tr>
<tr>
<td>▶ Avoid alcohol.</td>
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<tr>
<td>▶ Be careful around other smokers.</td>
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<tr>
<td>▶ Improve your mood in ways other than smoking.</td>
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<tr>
<td>▶ Eat a healthy diet and stay active.</td>
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</table>

Quitting smoking is hard. Be prepared for challenges, especially in the first few weeks.

Followup plan: ____________________________
Other information: ____________________________
Referral: ____________________________

Clinician ____________________________ Date ____________________________
American Psychiatric Association
Practice Guidelines
for the
Treatment of Psychiatric Disorders

COMPENDIUM
2006

- Psychiatric Evaluation of Adults (Second Edition)
- Delirium
- Alzheimer’s Disease and Other Dementias of Late Life
- HIV/AIDS
- Substance Use Disorders (Second Edition)
- Schizophrenia (Second Edition)
- Major Depressive Disorder (Second Edition)
- Bipolar Disorder (Second Edition)
- Panic Disorder
- Posttraumatic Stress Disorder and Acute Stress Disorder
- Eating Disorders (Third Edition)
- Borderline Personality Disorder
- Suicidal Behaviors
Clinicians play an integral role in promoting behavior change

- Establishing & maintaining therapeutic alliance
- Empathic, nonjudgmental, supportive
APA Practice Guideline
(2006)

- *Increasing readiness and motivation for smoking cessation*
  - Recognizing and respecting the patient’s beliefs and perspective
    - Identifying stage of change
  - Motivational enhancement models
    - Eliciting pros/cons of specific behaviors
    - Exploring patients goals/ambivalence about reaching goals
    - Listening reflectively in empathic manner
    - Avoid coercion, arguing, blaming
APA Practice Guideline
(2006)

- **Eliciting patient preferences about treatment**
  - Honor choices regarding:
    - Quit dates
    - Timing of cessation efforts
    - Abrupt or gradual
    - Cognitive-behavioral strategies to aid cessation
    - Pharmacotherapy

- **Aids adherence to plan**
APA Practice Guideline (2006)

- Treatment plan components:
  - Education
  - Somatic treatments
    - Pharmacotherapy: NRT; Bupropion SR; Verenicline
  - Psychosocial treatments
    - Social support
    - Brief therapies (behavioral support cessation counseling)
    - Behavioral therapies
    - Cognitive behavioral therapies
    - Self-guided therapies

**Best outcomes:**
Combination psychosocial & medication treatment
Integrating PHS & APA Guidelines

**Content**
- Pharmacotherapy,
- Problem-solving/skills building,
- Intratreatment & extratreatment social support

**Process**
- Empathic perspective with therapeutic alliance
- Support autonomy

*Bottom Line:*
Both the content **AND** process of tobacco dependence interventions are important to treatment success
Exemplar: Smoker’s Health Study
(Geoffrey Williams, MD, PhD, PI; funded by NIMH/NCI)

- Randomized Controlled Trial
- N = 1006 adults who smoked
  - Relatively disadvantaged (poor/undereducated)
  - More than half not initially ready to stop smoking
- Intervention
  - Integration of PHS guidelines/SDT
  - Targeted smoking and LDL cholesterol
- Sample recruited through newspapers & physician offices
  - Those with a history of psychosis excluded
  - People with depressive and/or anxiety disorders included
Self-determination theory
(Deci & Ryan, 1985)

- Human beings intrinsically motivated toward health

Three psychological needs:
- Autonomy
- Competence
- Relatedness
Self-determination theory
(Deci & Ryan, 1985)

- **Autonomous motivation:**
  - Sense of volition
  - Self-initiation
  - Personal endorsement of behavior

- **Controlled motivation:**
  - Pressured by interpersonal or intrapsychic force
Self-determination theory

(Deci & Ryan, 1985)

Autonomy supportive care environments:

- Understand patient’s perspective
- Acknowledge feelings
- Offer choices
- Provide relevant healthcare information
Self-determination theory
(Deci & Ryan, 1985)

Autonomy supportive environments enhance autonomous motivation
Self-determination theory
(Deci & Ryan, 1985)

- Controlling care environments:
  - Pressure patients to act in certain way
  - Threaten with information
Self-determination theory
(Deci & Ryan, 1985)

Controlling environments inhibit autonomous motivation
The clinical endpoint of the intervention was to guide the client to making a clear choice about whether he wanted to change or not (support client’s autonomy need)

If the client wanted to stop smoking or change diet then the clinician provided competence training on how to reach that goal (support client’s competence & relatedness needs)
Integrating PHS & APA Guidelines

- **Content** *(support psychological needs for competence & relatedness)*:
  - Pharmacotherapy,
  - Problem-solving/skills building,
  - Intratreatment & extratreatment social support

- **Process** *(support psychological needs for autonomy & relatedness)*:
  - Empathic perspective with therapeutic alliance
  - Support autonomy

**Bottom Line:**
Both the content AND process of tobacco dependence interventions are important to treatment success.

APA, 2006; Fiore et al., 2000
Smoker’s Health Study
(Geoffrey Williams, MD, PhD, PI; funded by NIMH/NCI)

**Results:**

- Those who received the autonomy supportive intervention (process), which also was based on the PHS guidelines for treating tobacco use and dependence (content) had significantly higher quit rates at 6 & 18 months than those in the comparison condition (who were encouraged to work with their primary care providers and community agencies).
Practitioner motivation

- Subset of SHS participants received questionnaire to assess perceptions of practitioner’s motivation
  - Interest in tobacco dependence
  - Knowledge about how to aid cessation
  - Pressure in delivering interventions

- Results:
  - Practitioners perceived as both highly motivated and autonomy supportive
    - Patients reported highest autonomous motivation & competence (efficacy) for stopping smoking
  - Practitioners perceived as highly motivated but controlling
    - Patients reported lowest autonomous motivation & competence (efficacy) for stopping smoking

Sharp Minicucci, et al., 2003
Implications

- **Our interpersonal approach to caring for our clients influences their efforts to stop smoking**
  - Good interpersonal care (i.e. autonomy support) enhances autonomous and competence motivations thereby improving cessation rates

- **And it’s not simply about good “techniques”**
  - Genuine clinician interest in helping people stop smoking along with knowledge of the best evidence-based intervention strategies are likely to maximally support clients’ cessation efforts
Interpersonal strategies that support autonomous motivation & efficacy

- Recognize at the outset that the clinician-client relationship is a partnership (versus an expert/recipient model)
  - It is a privilege to work with people on health-related goals
  - Clinician and client learn from one another
  - Maintain a curious position about your client’s perspectives/experiences

- Stay mindful of importance of psychological need satisfaction:
  - Autonomy
  - Competence
  - Relatedness

Friedman, 1991; Napodano, 1986; Williams et al., 2006
Interpersonal strategies that support autonomous motivation & efficacy

- Elicit and acknowledge the client’s perspective
  - Listen well and use reflective skills
  - “It sounds like you are worrying about how smoking is affecting your health?”

- Strive to understand and reflect both sides of ambivalence if it arises
  - “On one hand I want to stop smoking & on the other hand I don’t want to stop smoking”; “Tell me about that.”

- Stay curious!
Interpersonal strategies that support autonomous motivation & efficacy

- Advise client about the importance of stopping smoking to health in a clear but non-controlling manner
  - Do not use information as a weapon/threatening manner

- Provide health risks/benefits information; pharmacotherapy & quit plan options when invited/client signals readiness
  - Ask permission
  - Check in with clients about how they are hearing the information
  - Provide rationale for suggestions you offer
Using Information Helpfully: Managing Triangles

Health Care Information

Clinician

Patient

Friedman, 1991; 1996
Interpersonal strategies that support autonomous motivation & efficacy

- Whenever possible, offer your clients options
  - “You could use any of 5 different types of NRT”
  - “When you think about setting a quit date, is there a particular time that you think would be best?”

- Support client initiatives for change

Miller & Rollnick, 2002; Williams et al., 2002
Interpersonal strategies that support autonomous motivation & efficacy

- Stay mindful of how very difficult it is to stop smoking and use this knowledge to maintain a compassionate perspective with your client

- Stay hopeful!
Barriers to building clinician-client partnerships

- **Feeling willful?**
  - Ask yourself what’s driving that in you?
  - Willfulness is your problem (not the client’s resistance)

- **Feeling invested in a particular outcome?**
  - Try not to get on either side of the issue (stay neutral)
  - Getting invested in an outcome potentially reflects overfunctioning

Friedman, 1991; Miller & Rollnick, 2002; Williams et al., 2006)
Barriers to building clinician-client partnerships

- **Pressuring or persuading?**
  - If you find yourself pressuring or persuading (e.g. “Why don’t you try stopping smoking?” when the client expresses no interest in doing so):
    - Back off and regain a neutral position
    - Remind yourself of the importance of staying curious as a way of finding a more neutral place

Friedman, 1991; Miller & Rollnick, 2002; Williams et al., 2006
Barriers to building clinician-client partnerships

- **Talking too much?**
  - Take a breath
  - Check in with the client to see what he or she is thinking and/or feeling
Barriers to building clinician-client partnerships

• **Giving advice?**
  - Avoid unless invited
    - People are most likely to use strategies they themselves think of and/or develop
    - More consistent with perspective that humans have propensity for growth
  - **If client needs help generating quit plan ideas or any other part of process**
    - Let them know what others have found useful
    - Don’t get invested in clients using your suggestions
    - Check in with him/her to hear how they have heard any suggestions you have offered

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Miller & Rollnick, 2002; Williams et al., 2006
Barriers to building clinician-client partnerships

- Recognition of these barriers requires a capacity for self-reflection on the part of the clinician and an ability to stay present to the client in the midst of that self-reflection.
  - *Skillful use of clinical supervision helps one to develop these abilities*
Linking SDT & Motivational Interviewing

- Both assume humans have an innate propensity for personal growth toward cohesion & integration

- This integrative tendency enhanced or thwarted through social environment/supports for autonomy, competence, relatedness

- Autonomy support: unique to both

- SDT helps offset the risk of using MI simply as a set of techniques by underscoring importance of freedom from pressure and control (in external environment &/or within the person’s psyche)

Markland, Ryan, Tobin, & Rollnick, 2005
Both the self of the practitioner and that of the client are vitally important to the health behavior change process: 

*It’s a partnership!*
References


References


