Practical Office Approaches*

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I am a psychiatrist particularly interested in the dynamics of cessation and large scale methods of psychotherapy for cigarette smokers. I have been trying to apply general behavioral science theory and known treatment techniques to help people stop smoking. In the face of the overwhelming medical evidence about the inevitable dangers and harmful effects of cigarettes, as a psychiatrist I would categorically say that anyone who continues smoking or begins smoking is acting in an irrational way and denying reality. I think cigarette smoking can properly be described as a kind of masochistic perversion in which people get pleasure out of hurting themselves and making themselves sick. Since in my daily clinical practice I attempt to help all kinds of psychiatric patients change various forms of symptomatic and non-adaptive behaviors, I hope to contribute this clinical orientation, as well as my research experiences and studies on smoking, to this Forum. I will extrapolate what I have learned from my own research investigation of a group of individuals who succeeded in stopping smoking, in terms of what can be generalized and made applicable to the whole smoking population. From this study, I have developed some insights into the psychology of cessation and will indicate approaches or general principles that other physicians might apply. I have ideas as to what any physician might do to create the necessary and sufficient conditions for smoking abstinence. I plan to discuss the medical problem of patients who smoke as related to the physician himself and his relationship to patients. I will try to take up some broad issues as well as specific, practical suggestions about medical interventions. In general, I see my role here as trying to translate and apply what I know about basic psychodynamics, psychotherapy, and psychiatric research to all of the discussions.

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We must focus on the physician himself. Whether he smokes or not does not seem to be nearly as important as his medical views and scientific position with regard to cigarette smoking in his patients. Since what he does in his medical practice depends upon his own scientific point of view and beliefs, he must make his own clinical decision about the harmful effects of cigarette smoking. Statistical studies and data can only indicate correlational relationships; causality has to be decided by clinical judgment. Clinical judgment must be used to decide what significance and weight to ascribe to cigarette smoking as causing or aggravating illness. Each physician must make up his own mind about the effects of cigarette smoking on the health and longevity of his patients. Only then can he act with conviction and scientific consistency in his medical practice. Once having made up his own clinical mind about the role of cigarette smoking in causing or aggravating such conditions as bronchitis, pulmonary emphysema, coronary artery disease or peptic ulcer, he can then plan a program of management and take a position with those patients who suffer from such specifically cigarette-related or aggravated conditions. From the point of view of preventive health, he will be better able to advise and make recommendations for the improvement of the health of patients who consult him for routine physical check-ups, and take advantage of other similar opportunities for prophylactic interventions.

Because of the confusion and contradictory publicity in the mass media, every physician owes it to his patients to explain his own clinical opinion about the effects of smoking on his patients' health. In cases where smoking is obviously contraindicated, such as in patients suffering from Buerger's disease, the doctor should insist and make an absolute recommendation that the patient stop smoking. Physicians must be particularly adamant about stopping where continued smoking superimposed on another condition, such as hypertension, might make a critical difference. For example, we know that for those patients already suffering from hypertension, cigarette smoking increases the risk of death from coronary artery disease by more than 200 per cent. Likewise, a post-coronary patient who persists in smoking cigarettes is not much different from a diabetic who blatantly disregards his diet by eating sweets freely. Any patient in the category of double jeopardy from a disease that is clearly aggravated and probably caused by cigarette smoking who does not stop smoking should be considered as having a serious disturbance in reality testing. Such extreme denial of illness and blatant denial of the harmful effects of smoking may well warrant the help of a psychiatrist.

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*Presented at the National Forum on Office Management of Smoking Problems, Chicago, April 11–12, 1968.
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Less dramatic, but of more generalized importance, is the larger group of patients who come to physicians for various reasons not particularly related to cigarette smoking. What should the physician do about or for patients who come for routine physical examinations and incidentally report that they also are cigarette smokers? The doctor owes it to every patient to include as part of his everyday medical practice a discussion of the effects of cigarette smoking on each of his own patients. Every individual who consults a physician should have the benefit of such an explicit expression and discussion of the doctor's own medical views about cigarette smoking. Here again, I would distinguish the doctor's scientific position from his own personal behavior. The physician's opinion and medical recommendations are much more important and are the most influential source of information because of the special nature of the patient-doctor relationship. Part of the obligation to the patient who literally entrusts his life to the physician's hands is the responsibility to take the initiative in advising and to make recommendations actively about every aspect of the patient's health. Even if the patient does not indicate a desire to stop smoking, the physician should do what he can to motivate his patients to change their smoking patterns.

Doctors themselves need to be reminded of the tremendous importance they play in every patient's life. Too often physicians in the course of daily medical practice, year in and year out, lose sight of the highly charged, over-idealized role and position they hold vis-a-vis the patient. In the context of a long term, highly personal relationship with his doctor, the patient tends to attribute great powers, and omniscience to the doctor, seeing the physician as the all-loving and loving parent figure. It is exactly this "transference," as we in psychiatry technically refer to this phenomenon, that is our greatest healing tool and is the basis of some of our seeming magical therapeutic effectiveness. I would urge all physicians to put this readiness of patients to accept and use whatever we say to constructive use. The mere word and simple suggestion from one's personal physician that he should and can stop smoking can in many cases be enough. A number of controlled studies have already indicated that the placebo effect is very powerful among smokers; that anything a physician does or suggests to encourage the cessation of smoking will be highly effective. Some 40 to 50 per cent of all patients will be able to stop smoking simply by being told by their physician that this is what they must do. Imagine the headway we would make in the whole cigarette smoking problem if 40 per cent of the 49 million adult smokers were to suddenly and simply give it up. The potential for a physician to have such major impact on cigarette smoking in this country is staggering, if they would only see the power they have and say the word to their patients.

With regard to the other 50 to 60 per cent of patients who would not respond to the doctor's simple but definite recommendation that they stop, the problem is more difficult. The irrational persistence of smoking can only be explained by powerful underlying motivational forces. Viewing smoking as the quiet unconscious workings of self-destructive drives and aggression turned onto the self, would explain the paradoxical response of smokers in general to published medical reports, or to their doctor's medical advice. Instead of deterring smokers, factual, educational programs only seem to increase people's smoking. This all makes sense only if understood from the point of view of the masochistic smoker who seems determined to hurt himself, while he vigorously denies the realistic dangers and mounting scientific evidence. The medical reports only force him to rationalize all the more that smoking will not harm him. He maintains that he is immune, invincible, or certainly the favored one, convinced that lady luck is on his side and that in the probabilities game, he will be one of the few fortunate ones. This kind of magical thinking and fantasies of omnipotence are intrinsic parts of the irrationality of smoking behavior.

Furthermore, the socio-cultural forces, including the constant barrage of advertising encouraging smoking, is difficult to counteract. We really do not know how easily, or what percentage of the in-veterate, heavy-smoking population could change their smoking behavior if physicians were to make a concerted effort to help them with it. Until the last few years, there has been very little systematic research that would be of use to guide physicians in helping these patients overcome the habit. We know that people begin smoking for a wide variety of reasons and motivations, that they continue smoking out of some of the same and other motives, and that the problem of stopping involves even different dynamics. Because smoking is very much an individual matter, programs to help people stop smoking must be designed to meet various individual needs. People who smoke purely out of automatic habit may find it very easy to stop; while those who smoke in an attempt to handle or relieve underlying emotional tensions and problems, may find it extremely difficult, if not impossible to stop.
As yet, we have no way of predicting in advance who is likely to succeed, or who will find it easy or difficult if they try. Obviously, much more research about the practical problems and approaches to helping people stop smoking must be done. Because of the urgency and the very nature of the cigarette smoking problem physicians are in the best position to do the wide scale, action-oriented clinical trials necessary to develop a whole battery of approaches and techniques that should be used successfully on all patients.

Now, there are ways of increasing the chances of success and making what the doctor prescribes even more effective. The timing of medical intervention is particularly important. There are certain periods or key points in people's lives when they can be more readily influenced, particularly with regard to stopping smoking. I have found that many individuals spontaneously stop smoking of their own accord in connection with some illness. It does not seem to matter whether the illness is severe or as mild as a common cold, but rather that any illness itself, or illness or death of a close friend or other member of the family makes the individual more realistically concerned about his own health. These may be opportune times for a physician to intervene and discuss the things that his patient can do to improve his health. To stop smoking is one of the few guaranteed things that any person can do to prolong his own life.

Doctors must not be intimidated by a patient's illness, even if they are very seriously ill and obviously very upset about being sick. The natural tendency would be to put off or avoid adding to his current illness by not discussing or suggesting that he stop smoking. However, one of the things the patient is worried about is hurting himself more by continued smoking. Make your discussion highly personal, emphasize the particular risks or dangers that you see for your patient, expressed in terms of the particular illness or relationship between his disease and what is known about the effects of cigarette smoking. Don't make the patient excessively anxious since your talk may then have the opposite effect and actually increase his smoking. A physician is in the best position to counteract the massive denial and magic thinking that we see in our smoking patients. We physicians are familiar with the blind patient who maintains that he still sees, or the recent stroke victim who insists that he is not paralyzed. We must also be alert to and recognize the same kind of denial when our patients persist in smoking after they have had myocardial infarction, or a lobectomy for bronchogenic carcinoma.

Now, some suggested approaches for the office practitioner: Make a contract with the patient. Insist that the patient commit himself to whatever program you work out together with him to stop smoking. You can say without any hesitancy that you know he can stop smoking. Any deficiency or doubts that he has about himself you will make up for with your help. You can make these positive suggestions with greater conviction if you are convinced yourself that people can change and relearn behavior patterns such as smoking. The belief that people can successfully stop smoking will only come from your own efforts and repeated successes in getting patients to stop. This requires a serious commitment and determination on the part of the physician to throw all of his weight into these efforts. Above all, be firm about having your patient progressively decrease and hopefully eventually stop smoking, but at the same time be reasonable. Do not be overly ambitious and demand too much, too soon. Make some assessment and evaluation of the individual's tolerance for discomfort and plan a modest but definite schedule for him to follow. The patient himself can be very helpful. Many people know themselves well enough to be able to tell you whether it would be best for them to stop suddenly, "cold turkey," or to taper off gradually. Make it a cooperative venture, in which you and the patient work together to get him to stop smoking. You have important ingredients to add in the form of your interest, encouragement, outright enthusiasm and applause for every step of success. You can also prescribe drugs that will help take the edge off the initial, difficult period, prescribing sedatives or stimulants depending on the individual's needs for the first three to four weeks. Once over the most difficult period and as the patient gains confidence in his own abilities to cope with or get along without cigarettes, then you can begin tapering off the medication. Work out a concrete schedule, with target dates and check points that you can use to reinforce and bolster the patient until he is well enough along to not need your attention. Phone calls, postal cards, or even a three month congratulatory certificate may be useful devices that take less time than the earlier brief office visits.

I found that some people are reluctant to try to stop smoking out of fear they might fail. Many people are very concerned about their own sense of mastery and are very reluctant to take the chance that they might not be able to overcome this habit. Thus, they would rather not try than risk failure. At the same time, continued smoking gives them the feeling of being a slave to cigarettes and chron-
ically decreases their self-esteem. Their conflicts then have more to do with concerns about being able to stop or not, rather than about any pleasure or satisfaction from smoking itself.

Have a plan in mind for the patient who stops smoking for some period of time, but who then resumes the habit. Make it possible for them to return for your further help if they need it. Tell all of your patients who stop smoking that you are very pleased, hope they will not need it, but should they find themselves smoking again that you want them to come back to see you immediately. Because of shame and their own disappointment if they do fail, most will not come back unless you actively pursue them. Encourage them to try again, since some people need at least two or three tries before they can maintain complete abstinence from smoking. It is definitely easier once having established that they can get along better than they had imagined without cigarettes. Thus, so called "failures," are really a special group for whom stopping is a series of trials. Encourage them to build on the positive aspect of their experience for however many hours or days they did stop smoking. Emphasize the fact that they did stop and hence you now know it can be done. Then work to increase the period of abstinence each time.

Now I would like to discuss some of the concrete, specific things that physicians might use, mainly to introduce them for our discussion. Help patients pick an optimal time to quit smoking, as when they are sufficiently concerned about themselves, but not too frightened or anxious and when no unusual stress or pressure is coming up that might make it too difficult to stay off smoking. Breaking up the habit patterns and associative links to smoking are very important. Advise patients to avoid the places, people and things that they usually connect with smoking. Initially they should avoid the activities or things that go hand in hand with smoking, such as alcohol, or the cup of coffee after meals. Suggest substitutions, encourage them to find different things to do with their hands, take up new hobbies or activities, such as chew gum, take walks, deep breathing exercises, showers or baths, work puzzles, and light reading. Also consider recommending frequent brushing of teeth, mouth washes, lozenges, and astringents or anti-cholergic medications. Some people have to be told the most obvious things such as that they should stop carrying cigarettes and matches, or to give away their lighters. Encourage them to talk about smoking, and to tell other people that they have decided to stop smoking. This helps to hold them to their commitment, and get encouragement from others, especially others who have successfully stopped too. We should discuss the AA type of approach, the buddy system, or having a former smoker available to help in moments of temptation. The group approach for mental support during the period of withdrawal needs to be considered. Drinking large amounts of fluids, such as water or fruit juices, may be helpful in flushing the system by increasing urinary excretion of toxic alkaloids from smoking, or perhaps it works purely as another non-specific placebo suggestion.

The universal problem of gaining weight should be anticipated and dealt with in any smoking cessation program, with discussions about eating low calorie chewy foods such as celery and salads. Or one might suggest taking first things first, and deal with the weight problem after smoking is well out of the way. Patients need to be forewarned about the increased irritability and feelings of tension that often appear following the cessation of smoking. Helping people to raise their frustration tolerance and ability to live with their chronic feelings of anxiety and hostility may be the most crucial and important part of maintaining successful cessation. Another important psychologic aspect of the program must include a discussion of how to help patients revise their self image from smokers to non-smokers. Just as dieters must learn how to think thin, so we must help the non-smoker build a new identity and develop a new mental picture of himself. Prescribed rehearsals or mental exercises of picturing himself in various situations with different people as a non-smoker might be very useful.

The role that drugs should play to help patients stop smoking is still ambiguous. They seem to help, but whether this is a specific pharmacologic action or again a placebo benefit is unclear. Aversive conditioning, with electro-stimulation, and hypnosis have also been used, but are such specialized procedures that they do not offer much promise for wide scale application.

Just as I have called attention to the possibilities for getting patients to stop smoking merely by the physician's powerful suggestions, I want to emphasize the temporariness of all approaches or cessation programs. Follow-up studies have shown how few heavy smokers are successfully withdrawn for any long period of time. This points to the need for extended programs, with continued longterm sustained efforts. Physicians have the necessary kind of relationship to their patients that might make their efforts more successful than the one week type of cessation clinics.