Chapter 2: Helpful Tips and Information to Help Facilitate the Change Process

This chapter is designed to complement our training by reviewing important concepts that are the foundation of the smoking cessation interventions. Some of these concepts are a review of what was presented in the training; however, this chapter provides more detail. Concepts reviewed in this chapter include:

- Fundamentals of Quitting
- Theoretical Foundation: Stages of Change, Motivational Interviewing Strategies, and Cognitive Social Learning Model
- The Working Alliance
- Pharmacotherapy

Fundamentals of Quitting:

Clients may find it helpful to understand the underlying process of smoking cessation. Highlighting the following **three important areas** for you and your client will be beneficial in starting you and your clients on the same page:

1. First, quitting smoking is a learning process. Just as smoking was learned, quitting can also be learned. This message establishes a positive tone for what is going to be covered in group.
2. Second, having mixed feelings or ambivalence about quitting is perfectly natural. Typically, clients feel that they want to quit but also that smoking has been helpful and they are afraid of letting it go.
3. And lastly, there will be ups and downs throughout the journey to becoming an ex-smoker. It is important to emphasize that while quitting is hard work, being committed to putting in the necessary effort will help clients succeed in their quit attempt. Many individuals just like them have quit.

At the start of the program, outline what will be covered so the client knows what to expect in the following sessions. For groups, it is especially important to set up ground rules and the structure of group. This will help build momentum and make the best use of a group setting to foster individual change. Ultimately, clients want to know what the quitting process looks like, how they will be supported, and what tools they will gain to improve on their previous quit attempts.

Theoretical Foundation:

There are two theoretical models used to design this smoking cessation program: the Transtheoretical Model (including the Stages of Change) and the Cognitive Social Learning Model. These theories provide the basis for understanding why the smoker continues smoking and how to use that information to help them quit. By understanding the components and basics of the theories, you can better understand the use and purpose of certain strategies within each session.

1. The Transtheoretical Model and Stages of Change:

The first theoretical model is the Transtheoretical Model of Intentional Behavior Change and the Stages of Change (Prochaska & DiClemente, 1983; 1986). The Stages of Change are based on the idea that individuals engaging in intentional behavior change follow a common pathway that can be broken down into various steps or stages (see table below). Each stage of the change process corresponds to specific tasks that must be accomplished in order to progress to the next stage of the behavioral change pathway. The client completes these tasks but the provider can help facilitate them.

Stage	A tobacco user in this stage…	Relevant Tasks
Precontemplation	Gives no thought to quitting use and has no intention to quit in the near future (i.e., within next 6 months)	Increasing Awareness, Concern, Hope, & Confidence
Contemplation	Has begun to examine their tobacco use and desire to quit; is weighing the pros and cons of quitting tobacco	Risk-Reward Analysis & Solid Decision to Change
Preparation	Has made a decision to quit (usually within the next 30 days), and has begun developing a plan for quitting	Commitment & Creating an Effective/Acceptable Plan
Action	Has put their plan for quitting tobacco into action (less than 6 months of no use)	Adequate Implementation & Revision of Plan
Maintenance	Has successfully sustained abstinence for at least 6 months	Integration of New Behavior into Lifestyle

It is important to note that this change process is not always linear. Individuals do not always move directly from earlier to later Stages of Change. People often recycle through the stages—moving from earlier to later stages and back again. Such recycling can take the form of an individual moving back to Contemplation or Preparation from the Action stage after a relapse. Regression may also occur if an individual moves from a later stage back to an earlier stage; for example, an individual may move from the Preparation stage to the Contemplation stage if they are planning for their quit attempt, then the holidays sneak up on them and they stop planning and start to debate if this is the right time for them to quit.

Determining which Stage of Change group members are in for tobacco use cessation can be very

helpful to meet an individual where they are (see appendix for Smoking Stage of Change Questionnaire). For individuals progressing through the Stages of Change for tobacco use cessation, certain techniques or strategies may be more useful at a particular stage in the process. For example, techniques to enhance motivation may be especially useful for individuals in earlier stages, since the tasks for progressing through the process include building motivation and commitment to quitting smoking.

Motivational Interviewing:

Motivational Interviewing (MI) can be defined as a "collaborative conversation style for strengthening a person's own motivation for and commitment to change" (Miller & Rollnick, 2013, p. 12).

> *"The way in which you talk with patients about their health can substantially influence their personal motivation for behavior change."*
>
> ~Rollnick & Miller, developers of Motivational Interviewing

(Rollnick, Miller, & Butler, 2008)

This approach has been used in various treatment settings and is considered an evidence-based practice in the treatment of individuals with substance use disorders, and may be especially effective in helping individuals in earlier Stages of Change (i.e., Precontemplation, Contemplation, and Preparation) resolve their ambivalence regarding quitting tobacco use.

<u>Key Components of MI Spirit:</u>

MI spirit is the foundation of MI. To ensure that MI is done in the client's best interest, the MI spirit is considered to be most important and the MI skills should be practiced always with the spirit in mind. MI is based upon four key components:

1. Partnership
2. Acceptance
3. Evocation
4. Compassion

1. **Partnership** highlights that MI is done *for* and *with* the client not *to* or *on* them. Providers who engage in a cooperative partnership with their clients avoid taking on the role of an "expert," meaning they do not push their own views onto the client (i.e., being confrontational or judgmental).

2. **Acceptance** of what the client brings to the partnership includes four important qualities: (1) understanding the inherent and *absolute worth* of every client, (2) practicing *accurate empathy*, (3) supporting the client's *autonomy*, and (4) providing *affirmation* of the client's

strengths and efforts.

- *Absolute worth* is based on Carl Rogers' (1980) discussion of unconditional positive regard towards the client. Unconditional positive regard refers to acceptance and understanding of the client's views and behaviors regardless of what they say or do. An opposing view to absolute worth is judgment.

- *Accurate empathy* involves taking an active, genuine interest in the client's perspective. Unlike sympathy, this is an understanding of another's perspective and a respect for that perspective.

- *Autonomy* indicates that the power for making and maintaining changes in one's behavior lies within the individual making the change, not within the provider. Emphasizing the client's autonomy in the behavior change process empowers the individual and communicates that the decision to quit and how they go about quitting is ultimately their decision. With regard to smoking cessation, offering a "menu" of options for quitting (i.e., Nicotine Replacement Therapy, medication, individual counseling, support groups, etc.) can support the client's autonomy, thus promoting lasting change.

- *Affirmation* refers to recognizing a client's strengths and efforts. It is important to note that affirmation involves the counselor voicing their appreciation aloud, such as "I appreciate you being so honest with me about your fears regarding quitting smoking," or "You really care about your family and are truly concerned about the effect your smoking may have on your child."

3. **Evocation** is a fancy word for having the client make the argument for change. It involves drawing out the individual's own thoughts and ideas in order to enhance motivation and commitment to change. This approach is based upon the idea that the argument or reasons for change are much more powerful when they come from the individual than if they come from the provider. Individuals who smoke have ambivalence about their smoking and evoking their own reasons for wanting to quit will help enhance their motivation to make a quit attempt. In other words, when the reasons and methods for quitting tobacco come directly from the smoker—and not from anyone else— they will be more likely to quit smoking and stay quit.

> *"It is the patient, rather than you, who should be voicing the arguments for behavior change."*
>
> ~Rollnick, Miller, & Butler (2008)

4. **Compassion** includes actively promoting the client's welfare and putting their needs before

your own. It is important to realize that smoking is an addiction and it is incredibly difficult to quit. Remembering this when working with individuals in their quit attempt will promote compassion. It is possible to practice the other three elements of MI spirit without compassion and in the pursuit of personal interests, therefore particular attention to this element is essential.

Method of MI:

The following **four processes** form the progression of MI. These processes build upon one another, as each is necessary to begin the next process. However, it is not necessary that one process stop for another to begin; some processes will occur at the same time. For example, evoking a client's own motivation for change will not be beneficial unless the client has been engaged in a solid working relationship first. However, evoking the individual's own thoughts about change may continue throughout the planning process.

1. **Engaging** [*The process of establishing a helpful connection and mutually trusting and respectful working relationship with the client.*] To avoid some of the "traps" that can interfere with the development of a strong relationship, the provider can refrain from…
    - taking on the role as an expert (e.g., telling the client which NRT they should try instead of having an open conversation about the pros and cons of each option and exploring which NRT the client is most comfortable trying);
    - focusing too early on a goal or problem behavior (e.g., discussing how the client can change their smoking behavior before exploring the client's readiness to address or cut back on his/her smoking);
    - labeling the client as their problem behavior (e.g., referring to the client as a smoker instead of an individual who smokes);
    - blaming the client for their problem behavior (e.g., telling a client that they have not been successful in their quit attempts in the past because they have not come to counseling instead of exploring what was successful and unsuccessful in their past quit attempts);
    - or chatting without direction to the conversation (e.g., allowing the client to talk about whatever problem comes to their mind in group).

2. **Focusing** [*The process of developing and maintaining a specific direction in the*

conversation about change.] The provider and client may have a number of goals in therapy and since it is difficult to address them all at once, the provider and client must reach an agreement on which goals to address. If there is clear direction, i.e., the client wants to address their smoking, then the provider should help define what the client means by addressing smoking (cutting back, quitting sometime in the next year, or quitting immediately), explore the client's ambivalence surrounding quitting smoking, then move to evoking the client's own motivation to quit and planning their quit attempt. If there are multiple choices of direction, the provider should work on making a plan with the client about what to discuss first. For example, a client may present in group with multiple problems they want to address (e.g., craving for other substances, sleep problems, and a partner bugging him/her about quitting smoking). The provider may need to identify and validate all these problems and then work with the client to first discuss his/her smoking and address how the other problems may factor into his/her continued smoking.

3. **Evoking** [*The process of eliciting the client's own motivations for change.*] A provider can help the client talk themselves into a decision about change. If a client hears him/herself voice reasons for change it is more impactful than to hear a provider list reasons why they should change. A client may have heard about the negative health consequences of smoking from multiple people, and hearing a counselor list those health consequences will go in one ear and out the other; however, the client identifying that s/he has been having more and more trouble walking upstairs without getting winded and s/he has been coughing much more frequently will resonate more with the client, serving to bolster their motivation to make a change. There are ways a provider can talk to their client to influence them to talk more about change and less about maintaining their current behavior (See section below on principles of MI).

4. **Planning** [*The process of developing commitment to change and creating a plan for the action of change.*] It is a provider's judgment call to decide when to start planning, but it can be based on signs observed in the client: more discussion about cutting back or quitting smoking, taking small steps towards change such as researching NRT options, less talk about continuing smoking, resolution of some ambivalence and stating that they want to quit, envisioning what their life might look like if they were to quit smoking, and asking questions about how to quit smoking. Planning involves working with the client to develop a change plan that is specific to them. The change plan can include specifics about how the client is going to quit smoking (e.g., setting a quit date, decision on which NRT to use, what the client is going to do instead of smoking), obstacles they anticipate along the way (e.g. high-risk situations), social support they will have in the process, and what they might do in a lapse to smoking. The change plan can be modified with the client as unanticipated obstacles arise. The manual includes a change plan template and the group includes time dedicated to creating a change plan for clients in the group.

Principles of MI:

There are several principles within MI that can help facilitate progress for group members. As a group facilitator, eliciting "change talk" from clients and exploring their ambivalence is key.

- **Elicit Change Talk**:

  Change talk is any client utterance that indicates thinking about, motivation for, or decision to change. Eliciting change talk is an important aspect of the evoking process and getting the client to discuss their own motivations for change. The more an individual uses this language, the more likely they are to take action with regard to changing their behavior. (Hint: Remember the acronym DARN):

  - **D**esire
  - **A**bility
  - **R**easons
  - **N**eed

  Desire to make a change: Statements that reflect that the individual ***wants*** to quit smoking

  Examples: "I would love to quit smoking" or "I wish I had tried quitting smoking sooner."

  Ability to make change: Statements that reflect the belief that the individual ***can*** quit smoking or make small changes in the process of quitting smoking

  Examples: "I can cut out the cigarette after breakfast" or "I think I can quit smoking if I had enough support to deal with the triggers."

  Reasons for considering change: Statements that reflect why quitting smoking is ***important*** to the individual

  Examples: "I know I would feel better if I quit smoking" or "I would worry less about what my doctor is going to say the next time I go in to see her."

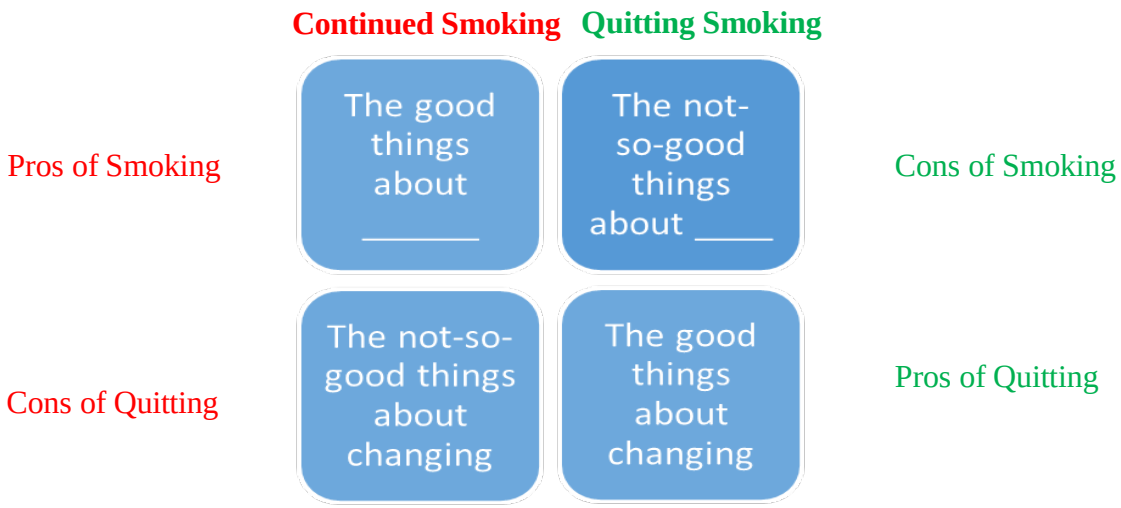
  Need to change: Statements that reflect why the individual thinks they ***should*** quit smoking (or an obligation to quit)

  Examples: "I need to stop smoking around my children" or "I have to quit smoking if I want my asthma to get better.

- **Explore Ambivalence**:

Ambivalence—having "mixed feelings" about behavior change—is a natural component of the change process. For example, a person may express that on the one hand they recently have been having trouble breathing when going up and down the stairs which makes them nervous but on the other hand smoking helps them relax. Explore the "Pros and Cons" of both Smoking and Quitting Smoking:

As a provider for smoking cessation, it is important to know that your clients have a lot of different reasons for continuing to smoke. You can assist your clients in making the decision to quit by asking them to explore what they see as the good things about quitting, as well as what they see as some of the not-so-good things about quitting. (See figure below).



Getting this information from the client will allow you to reflect on the "good things" about quitting (e.g., improved health, saved money, etc.) and the "not-so-good things" about continuing smoking (e.g., shortness of breath, concerns about costs, etc.)-- reinforcing their commitment to quit. This process will also allow you to assist the client in addressing some of the "not-so-good" things about quitting (e.g., suggesting nicotine replacement therapy to address withdrawal symptoms), and addressing some of the "good" things about continuing smoking (e.g., suggesting relaxation techniques to cope with stress, rather than smoking to reduce stress). Focus on identifying underlying values so that you can highlight discrepancies with values in their reasons. Try to consistently emphasize change talk over sustain talk in your reflections.

Note: Refer below to Reflective Listening for more specifics about how to reflect effectively.

Core Skills for MI:

There are a few core skills that can be useful in eliciting change talk and exploring ambivalence. These skills can be used across all stages, although there are certain skills that might be most beneficial for a particular stage (refer to chart below). For example, open-ended questions and reflective listening are both very helpful in *engaging* the client. Remember the acronym OARS-I:

- **O**pen-ended Questions
- **A**ffirmation
- **R**eflective Listening
- **S**ummary Statements
- **I**nforming and Advising

OARS-I: **Open-ended questions** (in contrast to yes/no questions) allow the client to give full, complete responses. When used in the context of smoking cessation interventions, asking questions in an open manner allows the client to elaborate on their reasons or plans for quitting.

Examples: "What are some not-so-good aspects of smoking?" "How might you go about quitting smoking?"

O**A**RS-I: **Affirmations** are statements that acknowledge the client's strengths or positive behaviors. Making use of such statements in the context of smoking cessation interventions can be helpful in building the client's confidence in their ability to quit smoking.

Examples: "You are definitely capable of making this change, as you know you were able to quit smoking in the past."

"Not smoking in your new car is an excellent start!"

OA**R**S-I: **Reflective listening** demonstrates understanding through rephrasing, paraphrasing, or reflecting the client's thoughts/feelings in a way that enhances the interaction. It involves listening to both what the client says and what the client means and reflecting it back to them.

Examples: After client says, "I've tried quitting smoking numerous times and have always gone back," you reply, "You've found it difficult to quit smoking in the

past."

After client says, "I need a cigarette when I'm stressed," you reply, "So, smoking helps you relax."

OAR**S**-I: **Summary statements** tie together pieces of information from various points in the interaction through the use of two or more reflections, in a way that enhances the interaction.

Example: "Let me see if I understand so far: It sounds like your life has been more stressful over the past few months, and you've been smoking more than usual and this is troubling you."

OARS-**I**: **Informing and advising** can be appropriate in certain situations in MI. This is different than giving unsolicited advice in a directive style; in MI, information or advice is only offered with permission from the client, and it is not given to simply unload information, but also as an effort to inform and guide the client to their own conclusion.

Example: "May I tell you some things that I've noticed from working with other people who were quitting smoking?"

"Would it be all right if I told you some things that have worked for other people?"

"I could tell you a bit about managing your stress while quitting smoking if you're interested. May I?"

The following table outlines the Stages of Change and the overlap with the processes of MI, the tasks to be accomplished in each stage, and the specific use of the skills for each stage.

Stage of Change	**Appropriate Motivational Strategies for the Provider**	**MI *Process* and specific Provider *Skills***
Precontemplation Client is not yet considering change, or is unwilling or unable to change.	• Establish rapport, build trust, and support client's autonomy to make decisions. • Raise doubts or concerns in the client about the current situation and behaviors: o Elicit the client's perspectives of the problem o Offer factual information about risks of current behavior, with permission o Examine discrepancies between the client's perceptions of the problem behavior and his/her other life goals and values	Processes: Engaging, Focusing Skills: Open-ended questions, Reflective listening, Summaries

Contemplation
 	
Client acknowledges concerns and is considering the possibility of change but is ambivalent or uncertain.
	• Normalize ambivalence
	• Help the patient "tip the Decisional Balance" toward change:
	  o Elicit and weigh the pros and cons of current behavior AND change
	  o Examine the patient's personal values in relation to change
	  o Emphasize the patient's autonomy and responsibility for change
	• Elicit self-motivational statements of intent and commitment from the client
	• Elicit ideas regarding the client's perceived self-efficacy
	• Summarize self-motivational statements
		Processes: Engaging, Focusing, Evoking
		
		Skills: OARS

Preparation Client is committed to and planning to make a change in the near future and is considering how.	• Clarify the client's own goals and strategies for change • Offer a menu of options for change or treatment • With permission, offer expertise and advice • Negotiate a change or treatment plan • Consider and lower barriers to change • Help the client enlist social support	Processes: Focusing, Evoking, Planning Skills: Affirmations, Summaries, Reflective listening
Action Client has made a commitment to change and has begun to do so.	• Help the client implement the plan • Help them problem solve and revise the plan as necessary to address any unanticipated barriers • Help the client identify and develop skills to cope with change and temptation to return to old barriers • Support client self-efficacy to continue to make successful change	Processes: Planning Skills: Reflective listening, Summaries
Maintenance Change has been maintained and integrated with life.	• Help the client identify and use strategies to prevent relapse to old behaviors • Resolve associated problem • Support client's integration of new behavior with lifestyle changes • Help the client engage in necessary social support	Processes: Planning Skills: OARS-I

Using MI Skills in Groups:

> *"While the MI approach with individuals has been described as waltzing, we think that using MI in groups is more like conducting a symphony. Each member plays an individual instrument and contributes to the collective melody of the group, and at the same time responds to the conductor. The conductor, in turn, gently guides the instrumental interactions, as well as the overall orchestral composition."*
>
> ~ Velasquez, Stephens, & Drenner (2013; p. 281)

In addition to the key components of MI spirit mentioned earlier, there are a few additional factors to consider when using motivational enhancement in groups (Wagner & Ingersoll, 2013). These factors are not relevant when using motivational enhancement with individuals. These factors—which are critical to the success of enhancing motivation within a group—include the

following:

- **Altruism**
  - Members often see that the support and help they provide result in benefits to other members

- **Universality**
  - Can increase disclosure, bonding, and mutual support among members
  - Powerful force for change in MI groups

- **Vicarious Learning**
  - Essential to group MI, in which group facilitators have less time to evoke change talk from each individual client
  - Linking members together in the process of making changes can facilitate vicarious learning

Wagner and Ingersoll (2013) also provide several key tips for using motivational enhancement effectively in groups:

- **Keep moving forward as a group**
  - Try not to run ahead with the member who is in the earliest stage of the change process (e.g., in Precontemplation);
  - Also try not to hold back with the member who is furthest along in the change process (e.g., in Action)

- **Avoid conducting consecutive individual mini-sessions**
  - Instead, aim to connect moments that focus on individuals with those that focus on the group as a whole

- **With vicarious learning, progress depends less on overt change talk by each member in group MI than it does in individual MI**
  - Members often think about their own situations and make progress even when others are doing the talking

2. Cognitive Social Learning Model

The second theoretical model incorporated into our smoking cessation program is the Cognitive Social Learning Theory (Bandura, 1997). The Cognitive Social Learning approach uses learning principles (classical and operant conditioning) to help understand smoking behavior. Important to this theory are concepts such as modeling the behavior of others, self-control mechanisms, cognitive beliefs, self-efficacy, and outcome expectations. Self-control is a significant component and involves goal setting, self-monitoring, self-evaluation, and self-correction.

This theory outlines how various environmental and cognitive cues trigger cravings or the desire to smoke, leading to smoking and ultimately reduction of withdrawal symptoms or a " high" feeling. The environmental and cognitive cues are called the "antecedents." The smoking after those cues is the "behavior" which is then followed by rewarding "consequences" (reduced withdrawal or a high). Thoughts, feelings, emotions, expectations are all associated with each part of this process and are typically unique to the individual smoker. However, there are generally some common patterns, thoughts, or emotions that are involved in maintaining the smoking process. The rationale for using this theory in smoking cessation is to break down this activating event, beliefs, and consequences. The client and provider can work to identify the antecedents to smoking and replace the smoking behavior with a healthier behavior; the client can unlearn smoking and put new behaviors in its place.

One important concept of this theory is self-efficacy, an individual's perceived ability to meet a challenge or perform a particular task. In the case of smoking cessation, it is the smoker's confidence in his/her ability to quit smoking. A number of factors can contribute to building a smoker's self-efficacy to quit during the cessation program. Setting goals, implementing new problem solving coping skills, evaluating how the skills are working, and incorporating self- correcting feedback, can all increase self-efficacy. As self-efficacy increases, the likelihood of maintaining abstinence increases. Self-efficacy is repeatedly highlighted throughout the intervention as it is thought to assist the smoker in going from thinking they cannot quit to believing it is possible.

Consider aspects of the Therapeutic or Working Alliance:

In addition to understanding the theoretical framework that this cessation program is built on, there are also things you can do as a provider to assist your clients through the process, which goes beyond just imparting the knowledge of the content. In addition to following the session guides, implementing the strategies, and giving out the homework, another very important element that can facilitate your clients achieving their quit goal is the working relationship you build with the client. This is called the working alliance and consists of three parts (Bordin, 1979):

Working Alliance

1. Tasks: refer to the agreement on tasks to be accomplished.
2. Goals: agree on goals that are mutually endorsed and valued by provider and client and characterize a strong working alliance.
3. Bond: create a positive personal attachment between the client and the provider.

These three components are important to engage the client in the cessation program. No matter what your theoretical orientation or your background as a provider, the working alliance has been found to be a significant predictor of treatment outcomes. The more positively the client rates the alliance, the better their general post-treatment outcomes. As a provider, do your best to think about how clear the tasks and goals are for your client, not just at the onset of the cessation program, but throughout. Consider what you can do to foster the bond between yourself and your client(s). Using motivational enhancement skills has been found to foster an alliance through client centered, empathic means. Boardman and colleagues (2006) specifically examined the use of motivational enhancement techniques as predictors of the alliance and engagement for smokers in treatment. They found that increased use of the MI principles and skills, like open ended questions, was predictive of a higher alliance. In this study, a positive alliance was associated with increased engagement and increased likelihood of smoking reduction or abstinence.

In addition to the key behavioral theories just reviewed, smoking cessation treatment often includes using some pharmacological aids. Medications can support and enhance your efforts to help clients quit.

Pharmacotherapy

Often your role as a provider may focus more on the behavioral components of tobacco dependence; it is important that you are also aware of the physical component of tobacco dependence. Research on cessation interventions suggests that the most effective cessation methods incorporate methods to address the habit (behavioral) as well as the addiction (physical). In training we covered some basic information about how nicotine in tobacco physically affects the smoker and how it creates withdrawal symptoms when they make a quit attempt. To address the physical component of tobacco dependence, the recommended treatment is pharmacotherapy. Pharmacotherapy for the physical dependence on tobacco includes two different types of treatment: Nicotine Replacement Therapy (NRT) and non-nicotine medications. It is important to understand the differences in use for both treatments, how they can be tailored for special populations, and what "guided use" looks like for these options as well.

Nicotine Replacement Therapy (NRT)

NRT has several different functions. The primary purpose for treatment is to provide the

individual who smokes with a more manageable and safer form of nicotine. It is typically used to help reduce the severity of withdrawal symptoms and gradually wean the smoker off of nicotine altogether. When withdrawal symptoms are more bearable, clients can give a more concerted effort to developing strategies to deal with the behavioral or learned components of tobacco dependence. Another benefit of using NRT is that its route of administration can be very different from the smoking behavior that delivers the nicotine to the smoker (e.g., a patch rather than inhalation via smoking). This administration discrepancy can help break the learned associations between behavioral cues and the physiological effects of the nicotine, and thus reduce the physiological response to triggers.

There are multiple NRT options available, including gum, patch, inhaler, nasal spray, and lozenges. NRT gum, patches, and lozenges are available over the counter, while inhalers and nasal spray require a prescription. The dosage of these medications should be consistent with the smoking pattern of the client. Smokers with higher levels of nicotine dependence (e.g., smoke within 30 minutes of waking; smoke 20+ cigarettes per day) should consider using higher dosages (e.g., 21 mg for patch; 4 mg for gum) of NRT to initially better match their nicotine intake. This will help reduce withdrawal symptoms and therefore decrease the likelihood of a relapse to smoking. "Guided use" is very important to the use of NRT; the best choice for NRT will be unique to each individual and should be guided by a counselor or medical professional. In general, each NRT has some associated side effects; these may vary by individual. Preferences for using NRT should be taken into account and may be based on an individual's previous NRT experience, ease/convenience of use, number and severity of side effects, and the effects on craving and weight gain. Guided use implies that there is direct feedback on these types of issues with a health care professional to ensure the NRT is being used properly or to assist them in finding the most appropriate NRT for each individual.

Treatment	Product	Dosages	Special Notes
Gum	Nicorette®, Generic	• 2mg • 4mg	• Fast onset of delivery • Available OTC, without prescription
Lozenge	Nicorette® Lozenge, Nicorette® Mini Lozenge, Generic	• 2mg • 4mg	• Available OTC, without prescription

Transdermal Patch	NicoDerm CQ®, Generic	• 7mg • 14mg • 21mg	• Available OTC, without prescription • Few side effects
Nasal Spray	Nicotrol® NS Metered Spray	• 0.5mg nicotine in 50 mcL	• Prescription required • Fastest delivery of nicotine of currently available products
Oral Inhaler	Nicotrol® Inhaler	• 10mg Cartridge • 4mg	• Prescription required • Fast onset of delivery • Frequent use during the day required to obtain adequate nicotine levels

Non-Nicotine Medications

Non-nicotine medications are prescription medications that act on neurotransmitters in the brain to reduce the cravings or other effects of dependence on nicotine. As their name implies, they do not contain nicotine. There are two recommended medications approved by the FDA: Zyban® (bupropion) and Chantix® (varenicline). Wellbutrin® is an anti-depressant that works to decrease nicotine cravings, while Chantix® reduces the positive feelings of the nicotine when consumed. Some research suggests that Chantix® is associated with the worsening of some symptoms of mental illness. Encourage clients who try this medication and who also have mental illness symptoms, including depression, to be mindful of any side effects and to speak to their health care professional if they notice a worsening of symptoms. Treatment recommendations suggest that these types of medication are similar to NRT in that they are most effective when used in combination with counseling.