Smoking kills more than 430,000 people each year in the United States and is currently estimated to be responsible for 30.5% of all cancer-related deaths in our society. The majority of these deaths could be prevented.

Drs. Cinciripini and McClure provide an informative, comprehensive overview of the current status of smoking cessation treatment. In addition, they briefly summarize the recent Agency for Health Care Policy and Research (AHCPR) findings and recommendations about smoking cessation that should become basic knowledge for all of us. I would like to highlight some of the authors’ recommendations and take issue with their overly negative view of what have been called “self-help” approaches to smoking cessation.

Although most medical and behavioral scientists have been frustrated by the intransigence of nicotine dependence, smoking cessation represents one of the most significant, successful individual health behavioral changes that have occurred among Americans. Prevalence rates of smoking, which reached over 40% of the population in 1962, have dropped to 23% of the total population in about 35 years, despite population growth and continued smoking initiation. This reduction is due only partially to the premature death of many smokers from smoking-related diseases. Currently, there are over 40 million living Americans who have successfully quit smoking.[1] Physicians and smokers need a positive message about smoking cessation. True, it is a process that takes significant time and effort on the part of the smoker, and most often, initial attempts to quit provide only brief periods of cessation, after which the person resumes smoking. However, successful cessation is achieved by many smokers, and this happens one smoker at a time. Increasing the Efficiency of Cessation Efforts

Since most smokers have been exposed to serious social restrictions, many media messages, advice from medical and other health-care providers, and reminders by family and friends, “unaided” cessation and “self-help” are not completely accurate labels. Epidemiologic data confirm, however, that most smokers quit without significant treatment. This fact does not mean that current smokers do not need any encouragement, support, or assistance. Quitting on one’s own, although effective, can be a rather inefficient way to stop smoking. The authors point out that the natural quit rate yields successful long-term cessation in only 4% to 6% of the smokers who attempt to quit in any one year. We need to continue to understand the process of smoking cessation in various subgroups of smokers, find ways to reach out to smokers with relevant, personalized messages, and increase the efficiency of the cessation process.[2,3] Recurring advice and encouragement, particularly from medical personnel, pharmacologic aids, and behavioral treatments can all increase the efficiency of cessation efforts. For some who find it very difficult to quit, these interventions can make it possible for them to stop smoking. However, the more formal and intensive the treatment, the fewer the numbers of smokers who are willing to engage in it. Thus, caregivers are best advised to offer continued, caring support for cessation. Hopefully, such support will facilitate the natural process of change, as well as provide opportunities for recommending the smoking cessation aids and behavioral treatments described in the review to patients who are more prepared and motivated to quit.

Key Points

I would also like to highlight several points made in the article that are worth repeating: 1) For smokers who have had little success on their own after a number of quit attempts and who may represent particularly problematic cases, nicotine replacement and other newer nonreplacement types of pharmacologic treatment may be particularly appropriate. Although there is no magic bullet, smokers who are heavily addicted or who are “negative affect” smokers (ie, who use cigarettes to manage their moods) may be able to take advantage of the assisted period of
cessation to develop alternative coping mechanisms.
2) Pharmacologic interventions must be accompanied by behavioral strategies in order to ensure long-term success. None of the pharmacologic interventions is considered appropriate for chronic administration, and all of these aids provide only temporary relief from physiologic withdrawal and dependence symptoms. Therefore, smokers using these interventions will, at some point, have to cease the medicinal aids and continue to not smoke. If they have not created an alternative abstinence lifestyle, the power of the smoking habit and the well-established psychological dependence will continue to urge a return to smoking.
3) As the AHCPR guidelines state, all smokers who enter any health-care setting should receive a clear message, given in an authoritative but not authoritarian manner, about the benefits of quitting smoking. When this type of brief, minimal intervention has actually been implemented, data from studies support its long-term efficacy. However, getting doctors and nurses to implement this type of intervention in health-care settings has been difficult. We need to continue to find the right mix of incentives, awareness, and training to make this type of intervention standard care.
4) Cessation is a process, and individuals appear to move through a series of stages of change on their way to success.[4] Recycling through the stages is part of the process. Health-care providers should see themselves as facilitators of the process and should measure their success by realistic standards. If providers are able to help smokers move forward toward cessation, even if these smokers are not completely successful in quitting for good, they should consider this movement as significant. Health-care providers may not be around for the final, successful attempt at cessation for an individual smoker, but they should feel satisfaction in knowing that they have contributed to movement along the path that led to this success.

As Americans reduce their prevalence of smoking, it is true that we are left with a group of smokers who may find it more difficult to quit. It is terrific that the armamentarium of smoking cessation treatments is becoming more sophisticated and more potent in order to be able to reach these smokers. However, motivation to change is also critical for success. We need to continue to find ways of talking to and influencing smokers, ways of reaching out proactively to smokers, and respectful ways to empower these smokers to quit smoking with and without formal smoking cessation treatments.

References:

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