

Grand Rounds

A Multidisciplinary Approach to Counseling a 65-Year Old Woman on Smoking Cessation

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Abstract

Smoking is a leading cause of premature death worldwide and a common co-morbidity with patients with chronic spine-related complaints. This case report presents a multidisciplinary approach to smoking cessation with a patient suffering from the consequences of tobacco use. Methods for promoting patient behavior change, typical drug therapies, hypnosis and acupuncture are among the approaches discussed. Resources that may assist the clinician in helping move their patients toward successful tobacco cessation are also provided.

Case Presentation: A 65-Year-Old Woman Smoker

Robert A. Leach, DC, MS, FICC, CHES

Robert Leach has been active in private practice for 31 years and is the author of *The Chiropractic Theories: A Textbook of Scientific Research*. His primary research interests include the study of potential subluxation mediator variables, and chiropractic as a wellness approach.

History

This 65 year old retired insurance collector first mentioned that she was trying to quit smoking cigarettes during a consultation on 09/02/09, when she presented to the office for an annual exam. The patient had a long history of episodic severe back and leg pain that had been significantly ameliorated with chiropractic care that included monthly supportive care adjustments, lumbar isometric exercise, and a daily walking program. Presently she complained of only mild infrequent low back pain and very infrequent neck pain.

The patient reported that she began smoking cigarettes when she was in 3rd grade in Mississippi, stealing cigarettes from her mother's café and smoking up to a pack a day. At the time of the consultation, she stated that she had quit smoking one week ago, and she was confident that she would be able to remain smoke-free, using only CigArrest without any counseling or support group. She had previously been counseled at our office on the value of smoking cessation for slowing the rate of aging of her spinal discs, as well for increasing her longevity and improving her health. Her primary care physician had counseled her on smoking cessation as well.

She first tried to quit smoking in 1980, and was successful for two months. Prior to that attempt, she had smoked approximately 1 ½ packs per day for 27 years. Since 1980 she reports at least four additional quit attempts, which were never successful for more than two months each time. She had used aids, CigArrest gum and mints, and even an electric cigarette smoke stick filter. She stated that she "could smoke that with one hand and a cigarette in the other." She also tried nicotine patches but said, "they just made me want a cigarette."

At the time of her consultation, she reported using no medications, and only nonprescription vitamins for her eyesight. She reported using a treadmill for 30 minutes daily, or walking outdoors when weather permitted.

Physical Findings

Physical examination revealed the following vital signs: 120/62 L blood pressure, 66 L pulse, 5'2" height, 116 lb weight (21.2 Body Mass Index), and 14 respiratory rate. Pressure pain thresholds (PPTs) were

assessed at various points along the paraspinal muscles by use of the Fischer method at a rate of 1 kg/cm²/sec and revealed abnormal PPTs at axis, C5, and L5/S1. Oswestry Disability Index for low back pain and the Neck Disability Index showed mild disability (12% and 10% respectively).

Diagnosis

1. L5 segmental dysfunction
2. Myalgia
3. L5/S1 degenerative disc disease, based on prior imaging studies

Plan

The patient was advised that her prognosis regarding spine-related pain and disability was good. She was advised to continue supportive care monthly since repeated prior withdrawal of care had resulted in severe exacerbation and worsening of her back problems. She was advised to continue walking and/or use of the treadmill daily, and was encouraged to continue smoking cessation.

Treatment

Passive treatment during monthly or PRN sessions included PulStar light mobilizing adjustments targeting areas of computer-detected loss of compliance in the cervical, dorsal and lumbopelvic regions, as well as light high-velocity, low-amplitude manual chiropractic spinal adjustments directed to apparent areas of joint fixation (based on end range motion tests, PulStar compliance, and the presence of abnormal PPTs), primarily in the lower cervical and lumbopelvic areas.

In addition, the patient was encouraged regarding continuing use of cervical and lumbar isometric exercise, walking, and other dietary and lifestyle modifications. She had previously attended a spinal care class when first presenting to our office in 2006, where the risk factors for chronic disease were compared with risk factors for back problems including: smoking, weight gain, sedentary lifestyle, and any disorder or risk factor that impairs circulation to the spine such as alcohol, diabetes, stress, or illicit drug use. At that time we explained that controlling these variables involved: a) gradually and safely improving activity levels, b) monitoring diet (the patient was provided with handouts and other resources such as www.mypyramid.gov as well as www.cdc.gov where she could learn about the

benefits of healthy diet as well as smoking cessation), and c) managing stress (such as good coping behaviors and skills to help with smoking cessation).

Progress

After 6 monthly treatment sessions, on April 7, 2010, during a routine monthly treatment the patient reported that she had seen her primary care physician who had diagnosed her with osteopenia, prescribed vitamin D and advised her again of the need to quit smoking. At that time she admitted that she began smoking 2 packs a day again less than one week after quitting in the fall of 2009. She stated that every time she has tried to quit she went back to smoking more than before she had quit. She reaffirmed that she did want to quit smoking, and had just begun taking Chantix. She stated that within three days she would quit smoking. We provided her with handouts on stress management techniques to aid in smoking cessation, including use of a stress diary as coping aids. We again discussed potential pitfalls such as social considerations and how this might affect smoking cessation. On follow up visits on May 5 and June 2, 2010, she reported remaining smoke-free since April 10, despite discontinuing Chantix after 6 weeks due to the side effect of stomach distress. She gives Chantix credit for helping her initially with her smoking cessation, however. On her most recent visit in early June 2010 she reported no problem or urge whatsoever to return to smoking, and continues her exercise on the treadmill.

Addendum

During a follow-up telephone consult in late June 2010 to check on her current status, the patient stated that she had had difficulty breathing for three-four months, which she had only reported to her PCP the previous week. Subsequent x-rays and a CT scan revealed bilateral lung carcinoma in the upper lobes. She was scheduled for additional examination at a regional medical center. She has not smoked since April 2010. Since her diagnosis she has discontinued using the treadmill as she does not feel the “breath” for this anymore. Advice was given to attempt walking for briefer periods on the treadmill several times per day, rather than 30 minutes done previously, to attempt to preserve her aerobic capacity as much as possible.

Discussant 1: Marion Willard Evans, Jr., DC, PhD, CHES, CWP

Dr. Evans practiced chiropractic for almost 20 years before pursuing a career in research. He has published and presented in the area of health promotion, primary prevention and chiropractic and has an interest in physician and intern behavior modification, tobacco cessation research, and infection control in chiropractic practice.

The case of a female senior attempting smoking cessation and under care for a chronic spine condition is an excellent case for presentation of a preventive health care opportunity. In this case the level of prevention opportunity is tertiary. According to Leavell and Clark¹ primary prevention actions are those that keep the healthy, healthy. Secondary is reversal of conditions that can lead to permanent changes in health status prior to that end, and tertiary is simply damage control. However, a 2010 systematic review found preliminary evidence that smoking cessation instituted even after diagnosis of early stage lung cancer improves outcomes.² Smoking is the most preventable cause of death in America with a current prevalence of about 20%.³ Smoking is also highly co-morbid with chronic spine conditions^{4,5} and leads to poorer surgical outcomes for spine surgery patients.⁶

In this patient's case, smoking began at an early age. In fact, for most smokers, they took up the habit prior to age 18, and studies indicate that if one does not start prior to 18 years, they likely never will.⁷ It is reasonable to discuss smoking cessation with patients who enter the office with chronic spine conditions as it is strongly associated with negative spinal health outcomes and a cause of early morbidity and disability as well. Not every smoker will appreciate a message on cessation but studies indicate that most have tried to quit in the past. On average, smokers state they have attempted cessation 7-11 times before they are successful.⁷ The doctor's report of findings should state this is a habit that may delay results and at least broach the subject with patients at that time.

The Surgeon General's 5 A's⁸ can be used to keep the clinician on track in the advising process. **Ask** about smoking status; **Advise** they should quit; **Assess** willingness to make a quit attempt; **Assist** in this process; and **Arrange** for follow up. It is important to mention this need with some authority. State that, "As your doctor, this is one of the most important things you can do to help me get you better." If one chooses to take a less direct approach, ask, "How open are you to us discussing smoking cessation?" The patient will be open to it or not. If not, it is still important to advise them it is a hazard for not only

overall health but directly related to spinal health as well.

If patients show interest in cessation, they may be better off to wait until their pain is better. However, they can consider setting a “quit-date” right away. This is a target for the day they will begin the process of cessation. They should start preparation for that date. In the scheme of things, typical patients fall into varying stages of susceptibility to hear a change-oriented message.⁹ The “stages model” suggests that one of the following will fit most people: *pre-contemplation*—not considering a change in behavior over the next 6 months; *contemplation*—considering a change; *preparation*—making plans for action; *action*—having made a step toward new changes; and *maintenance*—having successfully adopted a new behavior for 6 months. Asking how interested one is in cessation may “stage” the patient in one of these categories and even using a scale of 1-10 regarding readiness for change can be utilized. “On a scale from 1-10, 1 being not at all likely to make a quit attempt, 10 very likely, how likely are you to try quitting smoking?”

Table 1. Steps in advising smoking patients on cessation.

- Mention the need for cessation in the **report of findings** and the link to chronic spine problems with your authority as their doctor
- Have sources of information appropriate for what “**stage**” the patient is in. The **Texas Yes You Can** program has free, downloadable brochures appropriate for each stage (<http://www.dshs.state.tx.us/tobacco/toolkit.shtm>)
- Consider working directly with the patient’s **primary care physician** so medication may be used if appropriate
- Help them set a hard **quit date**
- Ask them to **notify friends** and family they are trying and help them reduce chances for relapse like preparing for not smoking if they go to a bar
- **Emphasize the positive** changes that will occur with behavior change rather than the negatives of not changing—accentuate the positive
- **Let patients know you support them** and you understand it is difficult and may take more than one attempt
- **Refer them to a local cessation program** if available such as the **American Lung Association** or **Nicotine Anonymous**
- **Follow-up** with the patient and keep encouraging them and in addition, reward their success

Once a patient has been “staged” the doctor can determine whether to move into a cessation education program or make a note to bring this up again later. With staging, the goal is to assist them when they are in a stage of readiness to make a change and not force them to change now. **Table 1** outlines some specific steps that can assist the doctor in helping the patient make a successful quit attempt.

Identification of smoking cessation resources in the community where patients can be routed is very important since many have never been provided with resources to assist in the cessation efforts.

With any patient making an attempt at behavior change, remember: change is difficult and addictive habits are more so. For chiropractors, the ABC’S of health promotion¹⁰ may help the doctor in the process. **Assess** the patient’s health risks; extol the **benefits** of changing rather than the negatives of not changing; use **chiropractic maintenance visits** to start one’s advising efforts if more comfortable there; and provide **stay-the-course** messaging to patients who are trying to change since the doctor and his or her staff may be the only source of positive reinforcement. Don’t forget opportunities with young patients to praise them for being non-smokers! It is never too early for that. In all, helping a patient change a negative habit is very rewarding and in this case, although the outcome was not good, at least an effort was made to point the patient in the right direction. Patients should expect no less from any doctor they choose.

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Discussant 2: Irving A. Cohen, MD, MPH, FACPM, FASAM

Dr. Cohen directs Preventive Medicine Associates in Kansas. He is board-certified in Preventive Medicine and Public Health as well as in Addiction Medicine. In the past, he has served as the Deputy Director of the New York State Research Institute on Addiction as well as the Chief Resident of Preventive Medicine at the Johns Hopkins University Bloomberg School of Public Health. He is the author of *Addiction: The High-Low Trap* and *Dr. Cohen's Guide to the New Hippocratic Diet: How to Really Lose Weight and Beat the Obesity Epidemic*.

First, let me comment that, tragically, this is a case of prevention coming forty years too late. Secondary prevention at age 65, with a smoking history of over four decades, came too late to prevent this woman's carcinoma. However, the practitioner has no crystal ball. Therefore, all patients, young and old, should be treated alike. Ask and advise about smoking at every encounter.

Second, do not put off smoking cessation until a more convenient time. It was once common practice in alcohol and drug treatment facilities, where most patients smoked, to put off challenging patients regarding smoking cessation for a later date. This common practice was based upon the belief that their plate was full, just dealing with one set of problems. Therefore, it was felt that waiting for a more convenient time was appropriate. This all changed after the Olmstead County (Minnesota) study¹, published in 1996. That study looked at people previously treated for alcohol and drug addiction and found that excess mortality due to tobacco use was a greater problem than death attributed to either alcohol or drug related causes.

Third, use every tool available to motivate the patient. In this case, there is no mention of the patient's respiratory status until her carcinoma was discovered. Simply asking the patient whether his or her respiratory status has deteriorated due to smoking will often elicit a positive answer. Focusing on physical consequences of smoking already observable in this particular patient might have served as a powerful motivator in her many cessation efforts. The practitioner who has any form of testing available will reinforce this. Testing for carboxyhemoglobin, expired carbon monoxide, peak flow or complete pulmonary function testing will provide concrete data that adds to the authority of the practitioner. Although you may not have this available yourself, the patient may have already had these done through his or her PCP. Your obtaining these reports and reviewing them with the patient, discussing the

deterioration that has already taken place, can be an important motivating factor.

Fourth, the patient quit independently. Although there are formal treatment programs, they are not always available due to circumstances of timing, location or finances. Surprisingly, the reported success rate is greater for those who attempt to quit independently than for those enrolled in formal programs². This may reflect a selection bias, where those joining formal programs are those having greater difficulty quitting.

Fifth, consider adjunct pharmacotherapy. This particular patient has used several products in her previous attempts to quit. Some of these were over-the-counter remedies of no particular value. On the other hand, nicotine replacement therapy (NRT), which she also tried unsuccessfully, does help some people. The controversy over the value of NRT is that it replaces tobacco smoke with another delivery system (gum, lozenge, or patch) which delivers the same addictive nicotine. As is the case with her, many patients have failed to overcome their nicotine addiction because they continued to use NRT and eventually returned to cigarette use. If NRT is used, my recommendation is using it as one would use a detoxification medication, to wean the patient with a reduction to non-use over a short period. However, some would argue that even with the continued addiction to nicotine, there is harm reduction, simply because NRT reduces the exposure to the harmful tobacco smoke.³ Nicotine replacement products have been available over the counter for many years.

In this case, the patient was able to successfully quit only after she obtained a prescription for varenicline (CHANTIX[®]), presumably from her PCP. This medication has helped some smokers successfully quit. It is not without some danger, including psychiatric side-effects. Another medication that has been useful for some smokers has been bupropion hydrochloride (ZYBAN[®]), an older anti-depressant that was subsequently demonstrated to be effective in smoking cessation. Either of these medications can be prescribed by the patient's PCP. That practitioner may have been just as frustrated as you may be in getting this smoker to quit. Your reaching out to work with the PCP should be accepted positively.

Keep in mind that the psychological and physiological aspects of addiction are often tied closely together and difficult to tease apart. For many years, it was believed that nicotine was the only addictive substance in cigarette smoke. That did not explain the difficulty that some patients seem to have when

nicotine replacement therapy was not enough. The remaining problems were solely attributed to psychological and behavioral issues. However, in the 1990's, it was discovered that other chemicals within tobacco smoke directly affected levels smokers' levels of monoamine oxidase (MAO)-B, an important neurotransmitter involved with mood and behavior.⁴ This discovery came about when researchers were evaluating the value of anti-depressant medication. It may explain why some cigarette smokers seem to be self-medicating. The self-medication hypothesis gains credibility⁵ when one looks at the higher percentage of smokers among those with mental health issues.

Finally, do not be discouraged at your unsuccessful attempts to get patients to quit. Most smokers attempt to quit many times before being successful. You cannot know when your action or intervention will trigger action or aid a patient in successfully quitting. Never give up, never give up, and never give up.

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Discussant 3: Christena Nicholson, DC, Certified Hypnotherapist

Integration of Hypnotherapy into an Intensive Smoking Cessation Program

Tobacco use is the single most preventable cause of death in the United States. Each year in the United States, cigarette smoking and exposure to secondhand smoke causes 443,000—or 1 in 5 deaths. Economic losses are also staggering. Smoking-caused diseases result in \$96 billion in health care costs annually.¹

Treating tobacco dependence on an individual basis using multiple treatment methods increases long-term cessation. A therapy that is a useful reinforcement tool is hypnotherapy. Hypnosis communicates directly to the subconscious mind, the state of mind that resembles the sleeping state, while confounding the conscious mind, the awake state that reasons, questions, debates and debunks. Hypnotherapy provides the subconscious mind with suggestions for smoking cessation, healthy eating behavior, regular exercise and stress control/coping mechanisms. Results from a small study of hospitalized cardiac patients showed a higher quit rate with hypnotherapy than with nicotine replacement alone.² Hypnosis is most effective when included as an integral part of an intensive treatment regime.

Integrating hypnotherapy into the program is most effective when scheduling multiple visits with single goals addressed at each session. It is important to make small changes rather than trying to achieve too much too fast.³ The initial visit for hypnotherapy typically consists of an in-depth interview with the patient in order to identify the underlying psychological and physical connections to smoking. Important first visit components include: 1) determining a quit date 2) developing coping mechanisms to use as self-care for reinforcement between hypnotherapy sessions and 3) providing positive reinforcement. When the patient decides on the quit date it is necessary to identify all of the smoking cessation therapies the patient is utilizing or planning to use. The integrated approach to quitting smoking often includes the use of prescription drugs. If the drug bupropion SR is prescribed by the patient's primary care physician, it is necessary that the patient set a quit date after the initial administration of the drug for 1-2 weeks while the patient is still smoking cigarettes.

Also during the initial visit, it is important to teach the patient how to create one or two positive affirmations. The theory in support of positive affirmations is the effectiveness of “self-talk” to the subconscious mind. For example, a smoker might design a positive affirmation that reinforces the idea of being a non-smoker, such as, “I (state your name) am smoke-free and I feel great!” or “I (state your name) enjoy being a non-smoker and I am healthy.” These affirmations are repeated ten times twice or three times a day—morning, noon, and before retiring. The affirmation identifies the *person*, the *desire* and the *reward*.

The second visit initiates the quit-smoking hypnotherapy along with relaxation. The quit-smoking hypnosis sessions should take place weekly or every other week for at least four visits. This will provide adjunctive support to the patient during the worst of the physiological and physical/emotional withdrawal symptoms. Follow-up visits for hypnotherapy include positive reinforcement through suggestions for weight control and coping with stress and triggers that often cause relapses during smoking cessation.

The self-care portion of hypnotherapy involves the patient reading a self-help book such as, *How to Stop Smoking in 3 Hours* by Sidney Petrie and David Petrie.⁴ This book offers a complete process for quitting smoking with a self-hypnosis script that the patient reads into a recording device and plays back as often as necessary for reinforcement in between scheduled counseling and hypnotherapy appointments. The theory behind the effectiveness of self-hypnosis is based upon the subconscious mind hearing its “self” give suggestions for quitting smoking and healthy behavior changes. Unlike the conscious mind, the subconscious functions without filters, open to the suggestions made through hypnosis; therefore it is important to promote positive suggestions and avoid reference to negative language. It is also important to understand that the subconscious operates in the present, not the past nor the future. Not only must the suggestions be positive but also in the present, for example, “I am a non-smoker,” not, “I will quit smoking.”

A review funded by the National Institute on Drug Abuse found that nicotine replacement therapy is not as effective for women, and that women are more fearful about gaining weight after quitting. The authors urge that smoking cessation research focus on developing methods targeted to women.⁵

Weight control must be a large part of the therapy regime as current statistics on obesity indicate that the negative effect on the health of the U.S. population will overtake the benefits gained from declining smoking rates.⁶

The following activities are examples of positive reinforcements for hypnotherapy sessions.

- Positive affirmations
- Self-hypnosis recording
- Go where you cannot smoke
- Make your home a smoke-free environment (launder curtains, paint walls, throw out ashtrays)
- Imagine what your reward for not smoking will be
 - Long and healthy life
- Plan on spending the money saved by not buying cigarettes
 - Exotic vacation
 - Membership to a fitness center
 - New car
 - Relaxing massage
 - New clothes
 - Go to the theater
- More time (time not spent finding a place to smoke and smoking)
- Look in the mirror, see the healthy glow and color return to your face

Every session must include encouragement for the patient to continue life as a non-smoker. If the patient relapses, encourage him or her to make another quit attempt as quickly as possible.

An intervention review on hypnotherapy for smoking cessation indicated a wide variety of methods and treatment frequency with a great variability in quit rates. The conclusion of this review was that “hypnotherapy has not been proven to have a greater effect on six-month quit rates than other intervention, or than no intervention.” The authors recommended the need for large trials to establish efficacy for the use of hypnosis in smoking cessation.⁷

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Discussant 4: Shelly Bobbins, RN, L.Ac, Dipl. CH

Shelly Bobbins, RN, L.Ac, Dipl. CH has worked within the behavioral health field in Los Angeles for over 25 years. Initially she started out as an RN and since 1996 has worked as a Licensed Acupuncturist. She is a prior Qualified Medical Evaluator, specializing in industrial related injury and pain management. As an acupuncturist Shelly has been affiliated with Daniel Freeman Marina Hospital and continues her work for the last 10 years with the Pflieger Center also known as Cri-Help, a 120- bed treatment program for drug and alcohol addiction. In addition, she works with Harmony Place, a 12 bed drug and alcohol treatment program for dual diagnosis women. Over the years Shelly has been a consultant, developed and implemented programs within hospitals, as well as taught seminars on addiction.

Acupuncture for Smoking Cessation

Addiction can be extremely baffling and complex. As many healthcare practitioners have observed, addicts may refuse life-saving treatment, sometimes choosing to die rather than recover. It is not uncommon for smokers diagnosed with lung conditions caused by smoking, such as in Chronic Obstructive Pulmonary Disease (COPD) and lung cancer, to continue to smoke. Each year approximately 30% of tobacco smokers make an attempt to quit, but less than 10% are successful.¹ In the case presented here the patient eventually did quit smoking, only to be diagnosed shortly after with carcinoma of the lung. The description of her attempts to quit is typical of many smokers. Relapse, which is a return to an addictive substance or activity after a period of abstinence, is extremely common especially so with cigarette smoking.

There are many approaches to smoking cessation. Acupuncture can be an excellent option for treatment. In a randomized, single-blind, placebo-controlled trial of 78 currently smoking volunteers treated with acupuncture, a total of 12.5% of the active treatment group compared with 0% of the placebo group ceased smoking at six months.¹ Acupuncture can be used either specifically for smoking cessation or may include treatment for multiple problems at the same time. This is particularly helpful for patients who, like the patient under discussion, also suffer from chronic pain syndromes.

Since this patient's presentation with chronic musculoskeletal symptoms along with tobacco use is common, I would recommend acupuncture for cessation 3 times a week for the first 2 weeks. Then

once a week for 2 weeks and assess for the necessity of further treatment. For this patient, who has recently ceased smoking and been diagnosed with lung cancer, acupuncture can be of great help to aid in reducing the side effects of chemotherapy. Treatment with acupuncture can also decrease anxiety while reducing pain and decreasing chances of relapse with smoking. Many patients, after the initial phase of treatment, are able to sustain their status without additional acupuncture. However, due to the difficulty of quitting cigarette smoking, some patients may find that additional weekly acupuncture treatments may be helpful to maintain their smoke-free status, until they feel that they are stabilized.

After cessation, nicotine leaves the body within days; the physical withdrawal period from cigarettes lasting an average of 72 to 96 hours.² However, psychological symptoms, including cravings, may continue for weeks, months or even longer. Acupuncture can help with abstinence during the various stages. Auricular acupuncture is especially effective in the early withdrawal phase. Various acupuncture treatment approaches can also address any continuation of symptoms.

Studies show when treatment for addiction is combined with education and a support system this increases the chance of long term abstinence. In a randomized study using acupuncture, sham acupuncture and education, all groups showed reductions in smoking and post-treatment cigarette consumption, with the combined acupuncture and education group showing the greatest effect from treatment.³ Such evidence, combined with my clinical experience, lead me to be a strong advocate of using auricular acupuncture for substance withdrawal in combination where both education and a support system are utilized.

Many studies describe the effects of acupuncture in the levels of neurotransmitters such as an increase in the levels of b-endorphins, enkephalin, serotonin and dopamine. This may also explain the effect of acupuncture on reducing pain, as well as the cravings, anxiety, agitation, restlessness and mood swings that can often be a part of the withdrawal syndrome. Due to these changes in neurotransmitters this may cause a change in the perception of tobacco smoke and a decreased desire to smoke.³

Studies measuring neurochemical responses to acupuncture have provided evidence for the biological effects that ultimately may help to understand how acupuncture can be used to treat disease.⁴ Moreover, these results suggest that acupuncture may correct reversible malfunctions of the body by direct activation of brain pathways and thus contribute to the biochemical balance in the central

nervous system by regulating neurotransmitters that control health and disease.⁴ Quitting smoking is a significant psychological and emotional stressor that can affect multiple parts of the body, including the immune system.⁵ In addition, with cessation of smoking, weight gain can become an issue and the fear of this prevents many people, especially women, from quitting. Acupuncture can help with these multiple issues, thus easing the transition periods with abstinence.

The actual process of auricular acupuncture consists of a series of very fine needles placed in specific points in the pinna and left for approximately 45 minutes. Application of the needle feels like a little pinch, and once the needle is in place, it is painless. During the time the needles are in place, the patient either sits in a chair or relaxes on an examination table. Many find it so relaxing that they fall asleep. The effects of the acupuncture are often felt before the session ends. Relief is usually experienced the same day and increases with each treatment. When body points are utilized an average session can range from 20-60 minutes or longer depending upon the individual patient and upon the acupuncturist. Auricular acupuncture is considered to be an independent system within Chinese medicine. This can either be used alone or in combination with the body points. However, auricular acupuncture is most well known for use in treating withdrawal from addictive substances.

With nicotine addiction, like other substance addictions, the user tends to rationalize his or her need to smoke. They find reasons why “now is not a good time to stop,” and to deny the consequences of smoking. Consequently, when a smoker does express an interest or desire to stop smoking, this is an important window of opportunity for a practitioner to intervene and offer assistance. The practitioner must arm the patient who smokes with education in effective approaches to quitting. It is important to acknowledge how hard it is to quit, and assure the patient that when he or she is ready to quit, that you can help.

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