Treatment Manual for Smoking Cessation Groups

A Guide for Therapists

Werner G. K. Stritzke
Joyce L. Y. Chong
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CAMBRIDGE
UNIVERSITY PRESS

CAMBRIDGE UNIVERSITY PRESS
Cambridge, New York, Melbourne, Madrid, Cape Town, Singapore, São Paulo

Cambridge University Press
The Edinburgh Building, Cambridge CB2 8RU, UK
Published in the United States of America by Cambridge University Press, New York

www.cambridge.org
Information on this title: www.cambridge.org/9780521709255

First published in print format 2008

ISBN-13 978-0-511-45143-0 eBook (Adobe Reader)

ISBN-13 978-0-521-70925-5 paperback

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Preface

Becoming smoke free is a radical lifestyle change. Assisting smokers in successfully making that change is a highly rewarding endeavor for health professionals providing smoking cessation interventions. It is rewarding to witness the transformation clients go through as they gradually extract themselves from the stranglehold nicotine has on their daily routines and embrace the fresh outlook on their lives that lies ahead on the smoke-free path. It is also gratifying to know that for each smoker who is helped to stay smoke free, there are others in that person's life who are happy and relieved to see their loved one choose health over debilitating habit. Of course, the benefits of becoming smoke free go beyond the individuals seeking treatment. Smoking cessation providers play a key role in improving public health.

The social and political context in which smoking occurs has dramatically changed over the last few decades. The numbers of daily smokers have been steadily declining in many countries (e.g., daily smoking rates for Australians aged 14 years and older have declined by 40% between 1985 and 2004 alone, with now fewer than one in five persons smoking daily [Australian Institute of Health and Welfare, 2007]). In parallel with this trend, an increasing number of nations have enacted legislation prohibiting smoking in public buildings, restaurants, pubs, and many workplaces, and restricting it to special areas segregated from the smoke-free mainstream. Importantly, smoking has become socially stigmatized, and tolerance for suffering exposure to second-hand smoke has been replaced by firm policies to protect the non-smoking public from smoking-related health risks. It is in this changed environment of stigmatization and social pressures that many smokers who have difficulty quitting on their own seek the help of trained professionals. To meet that demand, health professionals must combine compassion for the plight of these "hard-core" smokers with rigor in the application of science-informed intervention strategies.

It is little more than a decade ago that empirically supported treatment approaches for nicotine dependence became broadly available via the systematic dissemination of clinical practice guidelines. For the busy healthcare professional, it is, however, a big step from adopting practice *guidelines* to knowing how to put these guidelines into *practice*. The task is further complicated

when a group of clients is the intervention target rather than an individual client. This manual was developed to help service providers with less experience in running groups to conduct an effective group intervention for smoking cessation. The manual has two aims: (a) to translate international clinical practice guidelines into step-by-step instructions for setting up, conducting, and evaluating a group intervention for smoking cessation; and (b) to provide ready-to-use client materials and treatment tools. The core content areas and treatment strategies covered in the manual are consistent with the *Standard for Training in Smoking Cessation Treatments* for group interventions published by the Health Development Agency in the UK in 2003.

We would like to thank Bruce Campbell for sharing his dual expertise as a pharmacist and clinical psychologist on pharmacological aids to smoking cessation. We also would like to acknowledge a few colleagues whose feedback was instrumental in the development and refinement of some of the materials in this manual: Casey Ashby, Emma-Jane Barclay, Beatrice Drysdale, Nichola Forster, Rebecca Jamieson, Kristy Johnstone, Fiona Michel, Claire Nulsen, Georgie Paulik, Rikki Prott, Michael Stephens, and Leanne Wheat.

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Introduction and overview of program

Smoking is a leading cause of preventable disease and deaths in developed countries such as Australia, the USA, and the UK. Like other addictions, it has proved difficult to treat and is associated with high relapse rates. Abstinence rates have been reported to be as low as 22% six months after treatment (Fiore *et al.*, 1994) and are even lower after unaided quit attempts (Garvey *et al.*, 1992). Although there is no shortage of self-help materials designed to reach a large proportion of smokers, available evidence suggests that self-administered treatments are only effective when combined with supportive interventions (Curry, Ludman, & McClure, 2003). In recent years, significant progress has been made in the development and dissemination of clinical practice guidelines on the basis of systematic reviews of empirically supported treatment approaches (Fiore *et al.*, 2000; Miller & Wood, 2002; Raw, McNeill, & West, 1998; West, McNeill, & Raw, 2000). In addition, many governments and health authorities maintain web-based resources for health professionals that inform about current developments in evidence-based smoking cessation services and products (e.g., an excellent website

UK; www.scsrn.org). There are also some treatment handbooks and manuals available (e.g., Abrams *et al.*, 2003; McEwen *et al.*, 2006) that convey essential background information on smoking-related issues and offer practical guidance for those involved in smoking cessation. These manuals, however, focus primarily on providing cessation services to individuals and typically devote only a single chapter to group interventions.

Group-based formats have success rates that are comparable to individual treatments, but they have the advantage that they reach more people. Hence, group programs are particularly well suited for the cost-effective delivery of intense multicomponent treatments that guide smokers through the phases of preparing for change, quitting, and maintaining a smoke-free lifestyle. However, group interventions present broader conceptual and practical challenges to health professionals who deliver them than interventions that

are tailored to only one client. This *Treatment Manual for Smoking Cessation Groups* describes how to meet these challenges successfully. It provides detailed guidance on how to run an evidence-based smoking cessation program in a group format.

This manual has been designed with the busy professional in mind. It is meant for use by healthcare professionals who want to offer group-based smoking cessation programs but may be limited in their time and resources to translate and adapt recommendations from best practice guidelines and comprehensive treatment handbooks into a succinct manual that is ready to use, incorporates up-to-date practice guidelines, and can be administered to clients with a great degree of flexibility. The flexible administration allows the treatment to be tailored towards the concerns and needs of the current group members on a session-by-session basis. Because smoking cessation programs tend to be offered in a variety of settings by a broad spectrum of health professionals with diverse training backgrounds, each of the modules in the program provides the therapist with brief background information and easy to follow guidelines regarding the treatment aims and principles relevant to that module. The *Therapist guidelines* section of each module is followed by a complementary section with *Client materials*, containing handouts and worksheets to be used with the clients. These materials facilitate the introduction of program elements and strategies in a client-focused, easy-to-understand format during sessions, and also serve as "self-help" materials for initiating, monitoring, and sustaining clients' change processes between sessions. The program elements and strategies reflect the core elements of intense multicomponent smoking cessation interventions recommended by international best practice guidelines, as well as by general principles underlying evidence-based treatments for addictive behaviors (e.g., Miller & Heather, 1998).

Core elements of the multicomponent smoking cessation program

Combining behavioral and pharmacological approaches

Nicotine addiction is not only maintained by the reinforcing pharmacological effects of the drug, but it is also powerfully reinforced by the behavioral aspects of the addiction. Consequently, both the pharmacological and behavioral components of this addiction need to be addressed in treatment. The behavioral addiction is so powerful because smoking incidents typically occur very frequently over the course of a day. Each incident involves a number of puffs – each of which can be thought of as a learning trial (O'Brien, 1997). For a regular smoker, this results in thousands of learning trials every month that

strongly link smoking with many everyday activities such as eating, drinking, and driving. Cues associated with these links can produce and maintain a strong desire to smoke (Droungas *et al.*, 1995). To break the behavioral addiction, these associations between everyday cues and smoking must be disrupted. At the same time, new associations need to be learned that link these everyday cues with smoke-free activities. Therefore, from day one of the program, clients are encouraged to engage in a process of "re-wiring" the connections between routine behaviors and smoke-free cues.

The pharmacological component of the addiction has an equally strong grip on the smoker's life. This is because the pharmacological actions of nicotine produce their reinforcing effects in the brain within seconds of smoking a cigarette (Benowitz, 1996). Tolerance to these desired effects tends to develop quickly, and hence more cigarettes are needed to achieve the same effects. Moreover, following cessation of smoking, many smokers experience unpleasant nicotine withdrawal symptoms (Hughes, 2007; Shiffman *et al.*, 2006). To break the chemical addiction, pharmacotherapy can assist in gradually weaning off the clients from the chemical rewards associated with nicotine, while attenuating the impact of any withdrawal distress. The evidence shows that pharmacological treatments approximately double quitting rates when compared with a placebo, and that there can be added benefits of combining pharmacotherapy with behavioral interventions (Mooney & Hatsukami, 2001).

Setting a low threshold for initiating the process of behavior change

One of the benefits of combining pharmacological and behavioral approaches stems from the ability to select from a range of evidence-based strategies. This provides a menu of options allowing clients to engage first in those strategies they find most appealing and easiest to maintain. Hence, the threshold for taking the first steps on the arduous journey of becoming smoke free is deliberately set low. The most important aim at this stage is to get the change process going. Once under way, promoting clients' self-efficacy regarding their ability to make progressive changes to their smoking behaviors becomes an integral part of the process. The emphasis throughout the treatment program is on becoming smoke free for good, rather than on quitting as the immediate goal.

Part of this process is to develop an understanding of the quitting process. The initial focus is on weakening the strength of the behavioral addiction. This is based on the simple rationale that behavior change occurs from doing things differently. Of the many everyday things that a client can start doing differently to disrupt the established behavior–smoking associations, the one or two that present as the least challenging are targeted first. Given the relatively

low difficulty of achieving these targets, the likelihood of experiencing success is high. This will, in turn, boost the clients' motivation and confidence for tackling the more difficult step of quitting smoking altogether. Because these behavioral changes disrupt typical smoking routines, some reduction – however small – in the amount of cigarettes smoked per day is almost inevitable. It is empowering for clients to become aware of how these subtle changes in the amount and pattern of their smoking are the result of their own efforts at doing things differently. Therefore, a simple behavioral monitoring exercise is introduced from day one of the treatment program. This method enables smokers to begin to develop some sense of control over their addiction before quitting. An added benefit for those smokers who reduce their cigarette use during this period by more than 50% is that it increases their chances of becoming smoke free (Hughes, 2000). Once the threshold for continued efforts to engage in behaviors that are uncoupled from smoking has been crossed, clients are encouraged to set a quit date for a time when they will feel ready. At this time, they will also be coached in pharmacological treatment options. With this dual approach, the need for the chemical nicotine fix can then be gradually weakened, while new behaviors associated with a smoke-free lifestyle become more and more established.

Personalizing treatment: providing a menu of options

Most smokers quit on their own without the support of formal intervention programs. Not every former smoker has used the same strategy for becoming smoke free. Likewise, within the range of evidence-based strategies recommended by clinical practice guidelines, there is much scope for flexibility and choice. For example, there now exists a variety of effective nicotine-replacement therapies such as nicotine patches, gum, nasal spray, inhalers, and lozenges. What type to chose may be influenced by contraindications such as pregnancy, breastfeeding, or allergies, but for the most part can be left to smoker preferences (Goldstein, 2003). Similarly, among the behavioral strategies available for disrupting the automaticity of daily smoking routines, there is an even greater selection to choose from. The key here is to match each client with a personalized set of behavior change tools that will work for the client. After all, it is the client who must wield the tools and do the changing.

The principle of providing a menu of options has a firm basis in the general literature on motivational interventions for substance misuse (Bien, Miller, & Tonigan, 1993). One critical element common to effective motivational interventions is an emphasis on communicating that change is the client's responsibility and choice (Miller, 1995). For smokers to embrace that responsibility and perceive that they have a choice, it is essential to offer them a menu of alternative strategies from which to choose. The chances of becoming smoke free on a particular attempt without the aid of formal

treatments are no higher than about 3% (Jarvis & Sutherland, 1998). This low success rate attests to the difficulty of the struggle faced by smokers who wish to become smoke free. A menu of options increases the likelihood that every smoker will find some strategies that they are comfortable with and ready to give a try. This also provides hope in the face of previous failures to quit, which, in turn, can provide an energizing boost to the motivation to become smoke free.

Enhancing motivation to become smoke free

There are many reasons why people want to kick their smoking habit. Some want to change because they value the benefits that a smoke-free life can bring. Others are prompted by external factors. They may be jolted into action by the worried pleas of their children and loved ones, a stern warning by a doctor, an alarming prognosis after a recent medical check-up, a close brush with death following a smoking-related emergency hospitalization, or the guilt stemming from exposing others to the hazards of environmental tobacco smoke. In recent years, external pressures to quit have even further intensified, as bans on smoking in public places are becoming the norm, and being a smoker carries an increasingly negative stigma. But ultimately, none of these "good" reasons will lead someone to become smoke free unless that person believes that these reasons outweigh the perceived benefits of smoking, as well as make up for the perceived negative consequences of quitting. Reaching that decision point, making a commitment to change, and sustaining that commitment through the tribulations of lapses and relapses require smokers to be highly motivated. Moreover, the motives that lead smokers to initiate change may be different from the motives that help them to maintain that change (Rothman, 2000). Therefore, monitoring and enhancing motivation to become smoke free is an integral part of this treatment program.

Accounting for progress and rewarding every successful step

Once smokers have crossed the threshold for initiating change and have begun to tackle some behavioral strategies from a menu of options, it is critical that these efforts and their effects are accurately monitored, and that clients receive continuous feedback on their progress. This is important for two reasons. First, involving clients in self-monitoring helps them to become aware of specific aspects of their routine behaviors that challenge current assumptions about their behavior. This information is instrumental in promoting self-evaluation and decision making in the change process (DiClemente, 2003). Second, because the ultimate goal of long-term abstinence

is a dichotomous outcome, this poses too high a hurdle to serve as a sensitive measure to evaluate treatment success (Hughes, 2002). If treatment success is solely evaluated against the gold standard of long-term abstinence, clients may experience any delays in progressing toward that goal as failure. In contrast, accounting for progress on intermediate measures (e.g., fewer numbers of cigarettes smoked each week) allows clients to experience success. This will be instrumental in enhancing motivation to persist with efforts to reach the more difficult and distal goal of maintaining a smoke-free lifestyle. Moreover, there is evidence that a reduction in the number of cigarettes smoked per day can improve health if it is not accompanied by increases in the intensity of smoking of the remaining cigarettes (Godtfredsen *et al.*, 2002). The impact of compensatory smoking on net health benefits achieved by cigarette fading can be assessed by monitoring changes in a biomarker of toxin exposure such as carbon monoxide. Receiving feedback on reductions in average carbon monoxide level is a tangible indicator of progress and can be a powerful motivator for clients along the way to long-term abstinence.

For clients to benefit fully from the gradual changes that occur because of their successful implementation of behavior change strategies, they must be aware of these changes. Some of these changes will be subtle at first and become obvious only when viewed as a trend over repeated measurements. Hence, progress is best communicated to the client by illustrating their successful steps in the change process through graphing (Page & Stritzke, 2006; Woody *et al.*, 2003). Visual representations of whether the things that a client attempts to "do differently" result in a change in smoking behavior, or whether things stay the same, will be illuminating for the individual. Thus, inspection of progress with the help of clear graphs is a routine component of each session in this treatment program. It also provides opportunities for vicarious learning by observing the progress patterns of other group members, and the graphical feedback feels like a reward for the time spent recording the data (Woody *et al.*, 2003).

Delivering treatment at a high level of intensity

There is a strong dose–response relation between intensity of treatment delivery and cessation success (Fiore *et al.*, 2000). Greater cessation rates are achieved with longer session length and a higher number of sessions. Treatments lasting more than eight sessions have the highest abstinence rates. Only a minority of smokers achieve permanent abstinence in an initial quit attempt, and most will experience a relapse within two weeks after quitting (Garvey *et al.*, 1992). Therefore, the treatment program consists of 10 weekly sessions to allow for a period of continued support following individual quit dates, which are typically set around half-way through the program. In addition, because tobacco dependence shows many features of a chronic

disease, a follow-up session is recommended (Fiore *et al.*, 2000). This will provide an opportunity to congratulate sustained success or, if tobacco use has occurred, to review circumstances and encourage recommitment to the goal of becoming smoke free.

Promoting lifestyle change

Quitting is one thing, becoming smoke free is quite another, and remaining smoke free involves a fairly dramatic lifestyle change. Promoting lifestyle change as a successful aid to remaining smoke free is an important focus of the program. This aspect of the program acknowledges the grief process and far-reaching changes that often occur in a person's life as a result of giving up smoking. The language used within the modules of this manual and in conducting the treatment program is carefully chosen to help smokers to see the changes they are making as something positive rather than negative. That is, instead of describing the change they are undertaking as "quitting" smoking, with its negative connotations of losing something, it is instead described as "becoming smoke free." Becoming smoke free signals a process of gaining something. Participants are gaining the freedom to make lifestyle choices unfettered by the demands of nicotine dependence.

Incorporating the idea of lifestyle change in this program also acknowledges that smoking has played a significant role in the life of a smoker and that new activities, beliefs, and coping strategies are going to be needed to take the place of the "smoking lifestyle." The module on lifestyle change helps participants to reduce the risk of relapse through, first, developing an awareness of how imbalances in lifestyle and some aspects of a person's previous lifestyle choices (before becoming smoke free) can threaten their attempts to remain abstinent (Marlatt & Gordon, 1985), and, second, adopting ways to address these imbalances in order to promote a smoke-free lifestyle.

Integrating individual treatment planning with facilitation of group processes

Treatment planning is an essential element of accountable practice. In group-based interventions, treatment planning involves two aspects. One is the individual case conceptualization that follows from the synthesis and integration of the assessment information regarding each individual smoker's history and circumstances. The other aspect is a "group conceptualization." That is, treatment planning takes into account the unique constellation of characteristics and circumstances for individual group members. The aim is to anticipate and plan for likely patterns of group interactions and processes that can either hinder or facilitate individual client's treatment goals. The group format has the additional benefit of securing social support as part of treatment.

Treatments for smoking cessation that incorporate supportive interventions are associated with superior outcomes (Fiore *et al.*, 2000). Hence, the purposive integration of individual treatment plans with the supportive elements arising from the dynamics within a particular group is an important task throughout the program.

Communicating caring and empathy

With the implementation of smoking bans in public places such as restaurants, airports, and workplaces, smoking has become an increasingly stigmatized behavior. Health promotion campaigns often use in-your-face strategies to portray smokers as unattractive, not smart, uncool, and plagued by bad smell and poor health. The image of sophistication, sex appeal, fun, and adventure traditionally associated with smoking has been largely replaced by connotations of disgust or pity. Many smokers joining a smoking cessation program report of their feelings of frustration and shame stemming from other people's negative reactions to their smoking habit. These can run the gamut from openly expressed hostility to more subtle reactions perceived as resentment, rejection, or disappointment. It is against the backdrop of this climate of disapproval that smokers encounter the staff conducting the smoking cessation program. From the outset, it will be very important that treatment staff are sensitive to these issues and foster supportive and caring interactions (Fiore *et al.*, 2000). There is strong evidence that skillful communication of empathic understanding improves success rates in treatment for addictive behaviors (Miller, 1998). The emphasis is on a collaborative approach, where the smoker is encouraged to be a full partner in the development of the treatment plan (Abrams & Niaura, 2003). The role of the therapist in this collaboration is similar to a "coach" (Greenberg, 2002), using language that is valuing and appreciative to help clients to progress toward their goal of becoming smoke free. There is evidence that such a collaborative "group-oriented" approach, rather than a more didactic "therapist-oriented" approach, facilitates better long-term outcomes for smokers (Hajek, Belcher, & Stapleton, 1985). Consequently, it is important that the language therapists use conveys this collaborative, caring, and empathic approach.

Incorporating humor

Smoking is a serious health risk. Overcoming the dual stranglehold of instant chemical gratification and strong behavioral habit requires a serious commitment. Hence, becoming smoke free poses a serious challenge, and failing to meet this challenge successfully can have serious consequences. Despite the anxiety, guilt, shame, and high stakes that prompt smokers to seek help from a smoking cessation program, the journey of becoming smoke free must not be drudgery. Therapists are encouraged to incorporate a healthy dose of

humor throughout the treatment program. This can go a long way in helping clients to cope with this difficult lifestyle transition and maintain a positive outlook in the face of temporary setbacks.

Overview of the program

The program is designed to run for 10 weekly sessions, each of two hours' duration, plus a follow-up session one month after treatment. Prior to the group commencing, an individual assessment session for each group member is scheduled (Figure 1.1).

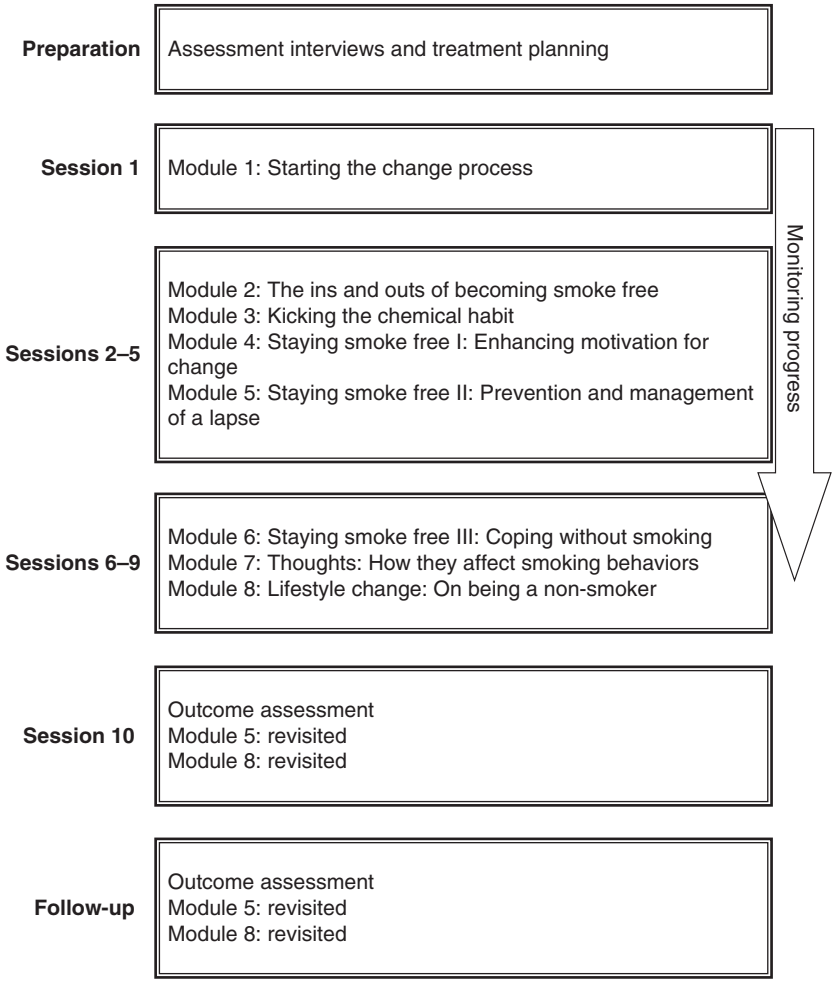

Figure 1.1 Overview of program and approximate timing of modules.

The manual is structured in a flexible manner that enables the therapists to determine which module is most appropriate to cover each week. The exception to this is that the first session should cover the module *Starting the change process*. This module provides an outline of the rationale on which the program is based and is designed to engage group members in active change from the outset. It is also recommended that the following modules be covered in the earlier sessions: *The ins and outs of becoming smoke free, Kicking the chemical habit*, and *Staying smoke free I: enhancing the motivation*. Note that some sections in later modules build on progress achieved in previous sessions. For example, the section *What to do when a lapse occurs* in Module 5 becomes most relevant around the time (usually around week 4 or 5 into the program) when most clients have set a firm date for their "becoming smoke-free day." Of course, if one or more clients are ahead of schedule in their readiness to quit, Module 5 or part thereof can be moved forward in the sequencing of modules. Refer to the therapist guidelines in each module for recommendations regarding when the module may be presented. These guidelines also contain tips on when and under what circumstances presentation order of a module, or parts thereof, may be varied. Modules 1–8 are discussed in more detail in Chapters 3–10.

Because the program emphasizes the distinction between motivation to become smoke free and an individual's perceived ability to become smoke free, it is recommended that there is a delay of at least two weeks between commitment to change and actual quitting to allow the individual to prepare for such a change (Marlatt & Gordon, 1985). The rationale for this approach is that the more prepared an individual is to quit, the greater the likelihood of success. Hence, there is no set quit day in this program: each individual sets a date when he or she feels ready. This takes the emphasis off quitting as the end goal and helps clients to see becoming and remaining smoke free as a process for which they take ultimate responsibility. Although the personalized timing of the individual quit day allows for some choice, group members will be encouraged to aim for the period around week 4 of the program as a good time for which to schedule their "becoming smoke-free day." This is because the skills required in remaining smoke free differ in some respects from those skills required in becoming smoke free. By allowing a period of time between quit day and the end of the program, it ensures that each client will be able to draw on support from the group and from the therapists for maintaining their resolve and for troubleshooting their way through the temptations and tribulations of initial abstinence.

Preparation for the day each group member has chosen for becoming smoke free involves adoption of the "mantra" of behavioral change: *change comes from doing things differently*. This includes, for example, varying the "when, how, where" for each smoking behavior. Group members are coached to use these

behavioral strategies to decrease the amount of cigarettes smoked continually. A checklist for some of these strategies is included in the *Starting the change process* module. It is strongly recommended that these be introduced in the first session and revisited weekly throughout the program. Group members should endeavor to adopt at least two strategies each week, and to keep a tally of the number of days that these strategies were used and the number of cigarettes they smoked during each day. This process of self-monitoring is an important aspect of the change process. It allows group members to observe changes over time, and the process of monitoring often itself leads to behavioral changes. Another benefit of self-monitoring is that it allows the therapists and the group to reinforce *any* changes – however small – in the right direction.

The end of the program should be marked with recognition of the group members' progress along the journey to be smoke free. It is suggested that a certificate be awarded to each member indicating that they have come to possess skills that will help them on their journey as a non-smoker (see the final module: *Lifestyle change: on being a non-smoker*).

Structure of sessions

The first half of each session should begin with a discussion of the self-monitoring of strategies and events related to smoking over the previous week. The second half of the session should then focus on one of the skill-acquisition modules. The idea is to select the module (or parts of modules) that best addresses those issues emerging from the personalized discussion during the first half of the sessions. There may be occasions when it is best to revisit parts of modules already covered before introducing new modules, depending on the pattern of individual and group progress. Finally, try to end each session with an imagery exercise to facilitate group members' ability to develop a new self-image as a non-smoker. There are a few such exercises included in the manual and others can be developed based on the preferences of group members (i.e., what personal changes and benefits they envisage as a result of being smoke free). It is recommended to end the first session with the imagery exercise contrasting life before and after smoking (*Smoke City versus Fresh Hills*).

Tips for working with individuals

Although this manual is specifically designed for delivering a smoking cessation program in a group format, the program can also be used one on one when working with individuals. The client materials are client centered, but where they do make references to a group context, clients in individual treatment can be instructed to ignore those. With respect to the therapist guidelines, they will be simplified as there is no need to accommodate

simultaneously the diverse characteristics and change trajectories of multiple group members. To help users of this manual to make the relevant adjustments when applying it in a one-on-one treatment context, each chapter has at the end of the guidelines a textbox of tips for working with individuals. These textboxes highlight how certain elements of the treatment modules can be adapted from the group format so they are readily applicable to a single client.