

# Telephone Counseling for Smoking Cessation: What's in a Call?

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*Telephone counseling for smoking cessation has been gaining popularity as studies have demonstrated its efficacy. What comprises a successful program, however, has not yet been detailed in the literature. In this article, an innovative telephone counseling intervention for smoking cessation is described, with attention to the clinical issues of client assessment, motivation, self-efficacy, planning, coping, relapse-sensitive call scheduling, and self-image. Counselor training and supervision issues, ethical and legal considerations regarding this form of service delivery, and suggestions for future direction also are outlined.*

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**M**ental health practitioners traditionally have provided the majority of counseling interventions in face-to-face settings, but with the increased emphasis in managed care on efficiency and brevity (Austad & Berman, 1991), telephone counseling has become an attractive alternative system for the delivery of counseling services in certain cases (Fish, 1990). In the field of smoking cessation, for example, telephone counseling has been tested with a variety of populations, including hospital patients (e.g., DeBusk et al., 1994; Ockene et al., 1994), HMO insurees (e.g., Orleans et al., 1991), and smokers from the community at large (e.g., Anderson, Duffy, Hallett, & Marcus, 1992; Lando, Hellerstedt, Pirie, & McGovern, 1992; Ossip-Klein et al., 1991; Zhu et al., 1996). It has been considered by many as a cost-effective approach to providing service to smokers who need help quitting. (For a recent review, see Lichtenstein, Glasgow, Lando, Ossip-Klein, & Boles, in press.)

With regard to service delivery, there are several advantages to a telephone intervention for smoking cessation. The fact that clients can avail themselves of services without leaving their homes is particularly helpful for those whose mobility is limited or who live in rural or remote areas. This aspect also appeals to many who are reluctant to seek face-to-face help, especially in group settings. Moreover, the increased accessibility of the telephone format may help to redress the longstanding underrepresentation

of the non-White population among those who seek assistance, as indicated by the active participation of ethnic minority smokers in a large telephone counseling program in California (Zhu, Rosbrook, et al., 1995).

While telephone counseling has been gaining recognition as studies demonstrate its efficacy, few details have been published on the clinical content of successful telephone interventions. Practitioners interested in starting such a program or in integrating telephone counseling into their existing practices find little information on protocols that can be used to train counselors or to guide their own practice. The issue often raised is how, from a clinical perspective, a telephone counseling session is conducted. The purpose of this article, therefore, is to describe one example of an effective telephone counseling protocol in sufficient detail so as to answer the question, "What's in a call?"

The counseling protocol described in this article is one that was tested and shown to be effective in a randomized trial with over 3,000 participants and later served as a prototype for three large-scale statewide telephone counseling services for smoking cessation (Zhu et al., 1996). The experiment tested two levels of telephone counseling against a self-help approach. One was a single counseling condition including a 50-minute session preceding the smoker's attempt to quit smoking. The other was a multiple counseling condition, with the same 50-minute pre-quit session plus five additional 20-minute sessions over a 1-month period following the quit attempt. Follow-up

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interviews 12 months later showed that both counseling conditions were effective and that there was a clear dose-response relation between counseling intensity and treatment effect. The 12-month continuous abstinence rates for the self-help, single counseling, and multiple counseling groups were 14.7%, 19.8%, and 26.7%, respectively.

On the basis of these results, the California Smokers' Helpline was established in 1992 to provide an easily accessible smoking cessation service to smokers across the state of California. Similar statewide programs using the same counseling protocol were established in Massachusetts in 1994 and Michigan in 1996.

The protocol that we describe in this article is based on the original multiple-counseling protocol tested in the above study (Zhu et al., 1991) and has been further refined through the helpline's collective experience of counseling more than 11,000 additional smokers throughout California. We first provide an overview of the general features of telephone counseling for smoking cessation and the psychological implications of its structure. We then give a detailed explanation of the counseling protocol used by the California Smokers' Helpline, followed by a review of counselor training and supervisory issues, ethical and legal considerations, and suggestions for future direction.

## CHARACTERISTICS OF TELEPHONE COUNSELING FOR SMOKING CESSATION

The telephone format has unique characteristics that affect the interactions between counselor and client. We outline four basic features of telephone counseling that differ significantly from traditional group sessions for smoking cessation.

First, telephone counseling is conducted on an individual basis. This allows the counselor to focus on the unique needs of the individual client. Although it is often true that group settings engender strong social support, it also may happen in these settings that the individual's needs are overridden by the group's needs or by the needs of the most active members of the group (Yalom, 1995).

Second, the telephone format provides a degree of anonymity because the counselor and the client never meet face-to-face. A disadvantage, of course, is that visual information relating to the client's appearance or body language does not transmit over the telephone. On the other hand, the semianonymous nature of the phone call, together with the fact that it is one-on-one, seems to facilitate frank discussion, which allows the counselor to form a detailed picture of the client's smoking situation rather quickly. Thus, the counselor can address very early on any misconceptions about smoking or quitting, which may have led the client to believe that he or she could not quit.

Third, the telephone makes it practical to conduct proactive counseling. Once a smoker has taken the step of calling for help, all subsequent contacts can be initiated by the counselor. The fact that the counselor makes an appointment for each call and then follows through by calling

at the appointed time seems to foster accountability and support (Zhu et al., 1996). The proactive approach also reduces the attrition rate, because the counselor does not share the client's possible ambivalence about following through with the sessions as planned (Zhu, Freeman, Martinez, & Anderson, 1995).

Fourth, the telephone format lends itself readily to the use of a structured counseling protocol. Such a protocol provides the minimum acceptable content for each session, to which the counselor freely adds according to the client's individual needs. It serves as a guide for the flow of each session and reminds the counselor to attend to certain important issues that become relevant at different points in the quitting process. In this way the protocol helps to ensure that each session is thorough yet focused and brief (Heather, 1989). When only a limited number of sessions can be offered to each client, use of the structured protocol helps to achieve the goal of providing the best service in the most efficient manner.

## THE COUNSELING PROTOCOL

Three tenets about smoking behavior dictated the helpline's approach to treatment: (a) that smoking is first and foremost a learned behavior, and new learning can lead to new behavior; (b) that in order to quit smoking, the smoker must have sufficient motivation and must take an active role in changing his or her behavior; and (c) that counseling can help such a smoker quit, whether through its specific components, such as the development of coping skills, or through its nonspecific components, such as support and accountability (Zhu, 1993). As such, the guiding principles of this protocol fall within the general framework of social learning theory (Abrams & Niaura, 1987; Bandura, 1969, 1986; Marlatt & Gordon, 1985; Rotgers, 1996). Of particular relevance to the development of the protocol is the theory's emphasis on the individual's capacity for self-regulation and the importance of self-efficacy in effecting behavior change.

The actual conduct of counseling in the California Smokers' Helpline follows a combination of the principles of motivational interviewing for inducing behavior change (Miller & Rollnick, 1991) and those of the cognitive-behavioral approach to treating substance abuse (e.g., Beck, Wright, Newman, & Liese, 1993; Marlatt & Gordon, 1985). The motivational interviewing approach is intended to create a collaborative counselor-client relationship through which the client's motivation to change is enhanced. The cognitive-behavioral approach focuses on restructuring the client's beliefs about smoking and quitting and emphasizes the development and implementation of coping strategies (Marlatt & Gordon, 1985). The role of the counselor, then, is to promote the motivation to change and to help the client develop competence in self-management. The helpline uses a structured counseling protocol that embodies these principles.

This protocol covers two phases of smoking cessation: preparing to quit and staying off cigarettes after quitting. Only those who feel ready to quit smoking soon (i.e., in a week or so) are counseled using this protocol. (Readiness to quit is assessed during a 5-minute intake survey when the client first calls the helpline, at which time self-help quitting materials are mailed to the client. Counseling normally commences within a week.) Each client receives one session before quitting and up to five sessions afterward. The first call, which is the most comprehensive, takes about 50 minutes. Each of the follow-up calls takes about 20 minutes. Therefore, the typical client who participates in the full program receives no more than 3 hours of counseling.

During the preparatory session, the counselor assesses the client's smoking habit and addresses motivation, self-efficacy, and planning. The goals are to help clarify the client's motivation to quit, boost self-confidence, and develop realistic strategies for coping with the urge to smoke. At the end of this call, the counselor and the client agree on a quit date. In follow-up sessions, discussion focuses on behavior maintenance issues such as effective coping, relapse prevention, and self-image. To minimize relapse, the counselor schedules these sessions according to a new probabilistic method (Zhu & Pierce, 1995). These concepts as they pertain to telephone counseling for smoking cessation are discussed below.

### **The First Session**

The areas covered during the first session are outlined as follows:

1. Assessing the client's unique situation: smoking and quitting history, current smoking behavior, and environmental and social factors.
2. Enhancing motivation.
3. Boosting self-efficacy.
4. Planning: identifying difficult situations and developing coping strategies.
5. Setting a quit date.

*History and present circumstances.* The first task of the counselor is to become familiar with the client's history and present circumstances. Some of this information is already known to the counselor in the form of intake data gathered when the client first calls the helpline. The counselor inquires about the age at which the client became a regular smoker, how many times the client has tried to quit before, and for how long. If the client has never tried to quit before, the reasons are explored, whether disinterest, ambivalence, or fear. If the client has tried to quit, the specific methods that were used are identified, methods which the client may choose to use again or to adapt for the current effort. Then, the situations in which the client returned to smoking are examined. The goal in this part of the session is threefold: that the client take credit for prior successes, critically examine his or her role in prior relapses, and apply this experience to the formation of a new realistic plan for quitting. In the process of articulating

his or her experience, the client should achieve some insight about the past and also a greater sense of control over the outcome of the current quit attempt. This is crucial if the client is to make a successful break from established patterns of behavior.

The counselor ascertains the number of cigarettes the client currently smokes per day and the length of time between waking and smoking. This information provides a measure of the client's current dependence on nicotine (Fagerström, 1978; Heatherton, Kozlowski, Frecker, & Fagerström, 1991).

The counselor also assesses environmental factors, such as the presence of other smokers in the household. The availability of cigarettes from other smokers in the household is usually a much bigger challenge than clients realize before they quit. Even if the other smokers do not offer cigarettes or leave them where the client can find them, their continued smoking can strain the client's resolve not to smoke (Mermelstein, Cohen, Lichtenstein, Baer, & Kamarck, 1986; Murray, Johnston, Dolce, Lee, & O'Hara, 1995; Nides et al., 1995).

Along these lines, the counselor tries to determine what degree of support from family, friends, or professionals the client can expect during the quitting process. Because social support has been shown to have a positive effect on the outcome of behavior change interventions (Janis, 1983; Mermelstein et al., 1986), and because the counselor can provide support only in a time-limited way, the client is urged to identify other reliable sources of support that can be called upon as needed, and, if possible, to try to broaden this base. A client who has little or no social support, however, is still encouraged to quit; in fact, such a client may benefit greatly from contact with the counselor, who serves as an initial support base.

*Motivation.* Printed in large letters on a worksheet mailed by intake personnel to each client are the words, "Motivation is all that matters." The counselor and the client work on this sheet together during the first session, and the client is asked to post it for later reference. Although quitting smoking is rarely as simple as the motto may suggest, the theme of motivation is central to the counseling provided by the California Smokers' Helpline. The goals of clarifying and enhancing the client's motivation to quit are pursued both directly, through open discussion of the client's reasons for doing so (Miller & Rollnick, 1991), and indirectly, through the safe counseling environment that the counselor strives to create (Raskin & Rogers, 1989).

The ambivalence that is often seen in people who are thinking about changing an addictive behavior (Miller & Rollnick, 1991) indicates that such changes carry not only benefits but also costs (Janis & Mann, 1977; Velicer, DiClemente, Prochaska, & Brandenburg, 1985). A smoker who is trying to quit is unlikely to succeed if the benefits of quitting, such as improved health or financial savings, do not seem to outweigh the costs, such as withdrawal or the loss of an easy source of comfort. A smoker who has not had to articulate what the costs and benefits of quitting

smoking will be may have only a vague idea about both. When attempting to quit, however, he or she may find that the costs become tangible readily, whereas the benefits remain vague and distant. It is to help the client form a clear conception of exactly what he or she stands to gain from quitting that a counselor in the California Smokers' Helpline dedicates a major portion of the first counseling session to a comprehensive discussion of motivation.

This discussion begins with the counselor asking what it was that triggered the client's most recent decision to quit. In some cases, the client has recently had a highly motivating experience, such as being told by a cardiologist that smoking has damaged the heart muscle, or losing a relative to cancer. Others have not had such an experience but have simply decided that they are ready to make an attempt. The counselor then asks what the client's reasons for quitting are. Without attempting to introduce new reasons, the counselor first helps the client to clarify and make as concrete as possible what is already on his or her mind.

Then the counselor begins to explore other possible motivating factors that the client has not mentioned. The question, "Have you ever felt uncomfortable smoking in a public place?" may elicit the client's dissatisfaction at having what he or she perceives as a socially unacceptable habit. Questions about the client's health, such as, "Has a doctor ever told you that you have emphysema or chronic bronchitis?" and "Do you have high blood pressure or high cholesterol?" may likewise elicit concern. Whether or not any smoking-related health problems have yet arisen, these questions provide, without lecturing, an opportunity to make sure that the client has clear and accurate information about the risks of smoking. The counselor does not provide medical advice but does share pertinent facts about cigarettes and health as part of an ongoing educational approach and as a way of subtly supporting the motivation to quit smoking. After the discussion of health, the counselor asks, "Are you concerned that cigarettes control your life too much?" The feeling of being controlled by cigarettes is one that few clients have articulated before counseling but that often resonates loudly once the counselor mentions it. With the discussions that arise from questions such as these, the counselor helps the client tip the cost-benefit scale further on the side of the benefits of quitting.

Finally, the counselor asks the client to write, on the worksheet where the words, "Motivation is all that matters" appear, his or her most compelling reason to quit smoking. The client is asked to be as concrete as possible. Later, when encountering difficulties, the client can recall that "I want to stay healthy to see my children grow up" or that "I'm tired of being out of breath every time I climb a flight of stairs." In explaining the motto about motivation, the counselor urges the client to use the most compelling reason to help get through times of faltering motivation.

Besides these more or less direct ways in which the client's motivation is enhanced, the counselor works to create a counseling environment that in itself promotes motivation (Miller & Rollnick, 1991; Raskin & Rogers, 1989). For

this to happen, the counselor must foster an atmosphere of acceptance in which the client feels safe to experiment with new thoughts and behaviors and to decide for himself or herself why to quit smoking (Beck et al., 1993). Reflective listening and motivational interviewing help to create such an environment, in which the counselor's role is not to tell the client why he or she should change but to discover and promote the client's intrinsic motivation to change (Miller & Rollnick, 1991).

*Self-efficacy.* A client who has strong motivation to change a behavior may nevertheless feel unable to do so. Low self-efficacy can sabotage a quit attempt or even prevent the smoker from trying to quit. In fact, a lack of self-confidence concerning sustained abstinence from smoking is highly predictive of relapse (Baer, Holt, & Lichtenstein, 1986; Condiottie & Lichtenstein, 1981). For this reason, the counselor in the California Smoker's Helpline spends considerable effort attempting to boost the client's self-efficacy. In the first session this effort is focused on simply making a quit attempt; in later sessions the focus is on long-term abstinence. Early in the first session, the counselor asks how confident the client feels about being able to go for a week without smoking, and then for a month. These questions provide a measure of the client's initial self-efficacy.

With a client whose self-efficacy is low, the counselor helps the client to identify and challenge self-defeating thoughts about quitting smoking (Beck et al., 1993). These may arise from the client's never having tried to quit before or, more commonly, from having quit and relapsed several times. Many smokers who have quit in the past consider themselves failures for relapsing; they forget that their efforts paid off in at least partial success. With that in mind, the counselor draws attention to the client's longest previous quit attempt and asks, "What do you attribute your success to?" If the client attributes a prior success to the help of others or to circumstances, such as being pregnant, the counselor tries to shift the client's focus to the efforts he or she had to make in order to quit. This helps diminish the client's feeling of being unable to quit. The popular belief that nicotine is as addictive as hard drugs can also be self-defeating. The counselor reminds the client that although quitting smoking is difficult, thousands of people do so successfully every year despite having similar fears.

Paradoxically, while boosting self-efficacy, the counselor downplays its importance in quitting smoking. The motto, "Motivation is all that matters," conveys the idea that a strong reason to quit can compensate for low self-efficacy. For this to happen, however, the client must come to believe that a lack of self-confidence is not necessarily fatal to the quit attempt. The counselor attempts to shift the client's focus away from the issue of confidence to that of motivation. For example, the counselor may ask the client to imagine being offered \$100 as a substitute every time he or she wants a cigarette. Most likely the client can imagine taking the money and refusing the cigarette. This

illustrates for the client how a strongly felt reason to quit smoking (in this case the hypothetical money) can overcome the lack of confidence.

It also conveys the idea that quitting smoking is not one large task but a series of choices. Along these lines, the counselor encourages the client to set proximate goals. The thought of never having another cigarette is overwhelming to many smokers, so just getting through the urges of the first day without smoking is the focus of the first counseling session. With or without previous quitting experience, having clearly defined proximate goals seems to boost the client's self-efficacy (Bandura, 1986).

**Planning.** In planning for the first day of quitting, the client must first determine in what situations the desire to smoke will be strongest. For this reason the counselor asks, "After you quit, what will be the three most difficult situations in which you will have to overcome the urge to smoke?" While discussing these situations, the counselor asks the client to write them on the worksheet under the main reason to quit. If the client overlooks any relapse situations from the past, or any situations that the client expressed concern about in other parts of the session, the counselor asks whether they ought to be added to the list as well. In this way the client breaks the daunting task of quitting into manageable pieces (Goldfried & Davison, 1976).

Having identified what the most difficult situations are likely to be, the client then plans strategies for getting through each one without smoking. Before making suggestions about what to do, the counselor allows the client to propose his or her own ideas. Using these ideas as a starting point, then, the counselor offers additional possibilities. The goal is to be sure the client has a repertoire of strategies that are practical, behavioral, and specific (Morgan, 1996; Wilson, 1989). Some serve as substitutions for smoking, such as chewing gum, drinking water, eating a healthy snack, or deep breathing. Others provide distraction, such as going for a walk, reading a book, watching a movie, or calling a friend. Still others serve to break the association between the situation and smoking, such as showering as soon as one wakes up or brushing one's teeth immediately after a meal. In addition, the counselor may suggest some cognitive strategies, such as refusing to dwell on how good it would feel to smoke a cigarette, instead reflecting on how much effort one has invested in the quit attempt or remembering the main reason for quitting (Beck et al., 1993). The client is asked to write whatever strategies are selected on the worksheet next to the difficult situations and to commit to using them when the situations arise.

Besides the strategies that can be used in the midst of difficult situations, there are proactive measures that the counselor also suggests. One is to go to the store and buy whatever substitutes the coping strategies call for (e.g., carrots, pretzel sticks, or straws). Another is to change one's environment if possible, for example, by cleaning the car of all reminders of smoking or declaring the house off-limits to other smokers. Two related measures are (a) to

prepare a support network by telling friends and family of one's intention to quit and asking in advance for help and patience and (b) to make arrangements with smoking household members to reduce one's exposure to smoking. One of the best proactive measures is simply to avoid unsupportive people as well as the places where difficulties arise, such as nightclubs or smokers' lounges. The client is counseled to get rid of all cigarettes, lighters, and ashtrays the night before quitting. Finally, the counselor suggests that the client plan some kind of a reward on the first day of quitting, for positive reinforcement and to counterbalance the initial loss the client may feel upon giving up smoking.

In addition to planning for difficult situations, the client is given an idea of what to expect with regard to withdrawal symptoms. The goal is to normalize these phenomena and provide some reassurance that they will only be temporary, so that the client does not become alarmed when they occur and relapse for a lack of understanding about what is happening (Gritz, Carr, & Marcus, 1991). If the client is a heavy smoker and is very concerned about withdrawal, the counselor may recommend seeing a doctor to inquire about nicotine gum or patches, so as to minimize its intensity. If the client already plans to use them, the counselor ensures that he or she knows exactly how they are to be used.

**Setting a quit date.** When the client feels that all questions have been answered and that a suitable plan has been devised, the counselor and client agree on a quit date. The client is asked to write that date on the worksheet, below the reason to quit, the difficult situations, and the coping strategies, and to hang the worksheet in a prominent location. This puts the intention to quit in a tangible form, creating an impetus to action. The counselor then schedules an appointment to call back for a follow-up session on or immediately after the quit day. The client's expectation of this second call creates a degree of accountability, which helps to overcome the client's ambivalence about following through with the plan. In fact, evidence indicates that, even if there is no scheduled follow-up, a client who receives the first session and sets a quit date is more likely to make a quit attempt and to maintain abstinence from smoking than a smoker who receives no counseling at all (Zhu et al., 1996).

### **Relapse-Prevention Follow-Up Calls**

The areas covered during the follow-up sessions are outlined as follows:

1. Assessing the client's progress.
2. Discussing and normalizing withdrawal symptoms.
3. Evaluating the effectiveness of coping strategies.
4. Examining slip or relapse situations.
5. Revising the plan as needed.
6. Revisiting self-efficacy and motivation.
7. Developing a self-image as a nonsmoker.

The follow-up calls are designed to prevent relapse. The 2 weeks immediately following the client's last cigarette

are the period in which cravings and withdrawal symptoms are most intense (U.S. Department of Health and Human Services, 1990) and in which relapse is most likely to occur. Thereafter the cravings are normally weaker, withdrawal symptoms are either no longer experienced or less prominent, and the likelihood of relapse is lower.

*Relapse-sensitive scheduling.* Because most of the client's difficulties occur soon after quitting, the California Smokers' Helpline uses a unique method of scheduling follow-up sessions to ensure that help is given early, when it is needed the most. Traditional smoking cessation programs typically follow an equal-interval schedule; weekly sessions are most common. In contrast, the California Smokers' Helpline schedules follow-up sessions in a nonlinear fashion, according to the probability of relapse (Zhu & Pierce, 1995).

The probability of relapse is a negatively accelerated function of time. In other words, relapse is most likely right after quitting, and decreasingly so thereafter. Therefore, if the follow-up sessions are to prevent relapse, they should begin very soon after quitting and follow each other fairly rapidly. Later, when relapse is less likely, they need not occur so frequently. Accordingly, follow-up sessions provided by the California Smokers' Helpline occur 1 day, 3 days, 1 week, 2 weeks, and 1 month after quitting. In other words, the sessions are "front-loaded": three in the first week of quitting and two in the next few weeks. An earlier study that analyzed the hazard functions (statistical representations of instantaneous relapse probability) supported such a scheduling method (Zhu et al., 1996). This study compared the relapse probability of clients who quit by themselves with that of clients who received counseling on such a schedule. It showed that the first week was the most critical period for intervention. In fact, the data strongly suggest that follow-up counseling sessions must occur very soon after quitting if they are to produce any additional effect.

*Nonattempts.* Despite the accountability engendered in the counseling relationship, many clients who receive the preparatory session and set a quit date do not actually attempt to quit on that date. Because rapport may be fragile in these cases, the counselor is careful to be nonjudgmental when the client has not made an attempt. Reasons for the change of plans are examined. Unforeseen difficulties may have arisen or motivation may have waned. Ambivalence about making the necessary but difficult behavioral changes also usually plays a part (Miller & Rollnick, 1991). If the client wishes to set a new quit date, the counselor helps to refine strategy, boost motivation, and overcome the ambivalence about implementing the plan. An appointment is set, and the follow-up call schedule starts over.

If the client lets a second quit date pass without making an attempt, the counselor again assesses the reasons and helps the client to understand the obstacles to quitting. There is a danger at this point that the client will view continued participation in counseling, without actually following through with a plan, as sufficient effort toward

quitting, and so become "stuck" at an early phase of the quitting process. For these reasons, and to avoid the risk of harming the client's self-efficacy by scheduling a likely third nonattempt, the counseling is usually terminated at this point. The counselor invites the client to call back after going without smoking for a day for help with the next step in the process. Besides assuring the client of future support, this subtly conveys the message that quitting requires active engagement by the one who wants to stop smoking.

*Difficult situations.* More commonly, the client does attempt to quit. However, he or she may have smoked by the time of the next session. In this case the counselor reframes the smoking event as a learning experience, so that when the situation arises again the client will be more prepared. Also, the counselor cautions the client about the abstinence violation effect (Marlatt, 1985), an attributional construct that may be activated when a person who has modified an addictive behavior has a slip. In smoking cessation, the "abstinence violator" may consider the whole quit attempt to be ruined by that slip and simply give up and relapse altogether. The client is encouraged not to consider a slip in itself as a failure or to look at relapse as the inevitable outcome of a slip. In fact, the client who has slipped has a unique opportunity for success by refusing at that point to stop quitting.

Regardless of whether the client ever has a slip, he or she almost certainly experiences some difficulties in quitting. These may be either physical withdrawal symptoms or situational triggers for smoking, or more likely a combination of the two. Possible withdrawal symptoms are many and varied, and despite having been discussed with the counselor beforehand, they may be confusing to the client and weaken his or her motivation to continue quitting. The counselor assesses exactly what symptoms the client has experienced since the last call and addresses the client's concerns about them, making sure that he or she understands the physiological processes behind the symptoms. The client also is told how long each symptom usually lasts. The goal in this part of the counseling is to bolster the client's self-efficacy for quitting by conveying the idea that the discomfort of withdrawal is normal, harmless, and passing, and by giving positive feedback for the client's having withstood them. Occasionally, a client using nicotine gum or patches experiences symptoms that are more likely side-effects of the medication than withdrawal from nicotine (e.g., a racing heart or overvivid dreams). In these cases, or if there are other troubling symptoms not normally associated with withdrawal, the counselor refers the client to his or her doctor.

Whether the client's difficulties stem more from the experience of nicotine withdrawal or from situational triggers, relapse is likely unless he or she uses effective coping strategies (Shiffman, 1982). With this in mind, the counselor asks the client to name the situations since quitting that have been difficult and to say exactly how each was handled. The approach the client took in each situation

is carefully evaluated for effectiveness and, if necessary, modified for future use. If a situation is among those that were predicted before quitting, the counselor determines whether the client used the planned coping strategy. If the client smoked a cigarette instead of using the strategy, the counselor ascertains the cause to which the client attributes the lapse. Without conveying disapproval, the counselor tries to ensure that the lapse is attributed less to the difficulty of the situation than to the failure to use an effective coping strategy, an omission that can be corrected the next time the situation arises. This reinforces the idea that the client must take action in order to succeed at quitting smoking. It is better to implement some form of coping than to do nothing at all (Shiffman, 1982). The counselor also asks the client to identify any new situations that may arise before the next follow-up session and helps the client to develop coping strategies for them.

Besides helping the client with immediate difficulties, this approach is intended to equip the client with long-term behavior modification skills (Wilson, 1989). In every session the client anticipates obstacles and develops a plan to surmount them. In every follow-up session the client reports to what extent he or she has implemented the plan, evaluates its effectiveness, and modifies it accordingly, taking into account any new situations coming up. By leading the client through several repetitions of this cycle, the counselor provides the training necessary for the client to continue the process independently after the counseling relationship is over. This is important training not only for clients who want to avoid a later relapse but also for those who, having relapsed, will want to quit again on their own.

With time, most of the situations in which it was initially very difficult to refrain from smoking become easier to manage. This may be due in part to the abatement of withdrawal symptoms and in part to the client's having learned to refrain from smoking in similar situations. The counselor ensures not only that the client does realize this, but also that success is attributed to the client's own actions rather than to external forces such as the counselor's guidance or help from friends. In attributing the success of the quit attempt to his or her use of coping strategies in difficult situations, the client gradually gains a feeling of mastery over the smoking habit (Harackiewicz, Sansone, Blair, Epstein, & Manderlink, 1987).

Some situations become easier within days, whereas others remain difficult for weeks. For example, after having quit for one week, the client may find that the first cigarette of the morning is no longer difficult to avoid, but that seeing someone else smoke still elicits a strong craving. The counselor helps the client see that the situations that are lingering as difficulties most likely have a strong psychological component. Seeing another smoker may make the client want to smoke out of a feeling of envy, or a desire for camaraderie, or because of pleasant memories associated with the smell of smoke. The client must realize that such cravings are not necessarily evidence of a continuing physiological addiction. For this reason, as counseling proceeds,

increased emphasis is placed on overcoming the psychological barriers to quitting.

*Self-image.* One of the most challenging psychological barriers facing a client who is trying to quit smoking is the experience of dissonance between the old self-image as a smoker, which is slow to change, and the new nonsmoking behaviors (Pederson, Strickland, & DesLauriers, 1991). The unpleasantness of feeling that one's behavior and self-image do not match can be handled in at least two ways. One is to consider oneself as a recovering addict who could relapse at any moment. In this approach, the client adopts the self-image of a vigilant ex-smoker and accepts the tension of not smoking as a more or less permanent condition. A contrasting approach is to cultivate the self-image of a nonsmoker and to view the discomfort of not smoking as a temporary inconvenience. Although neither approach has been proven to be more effective than the other, clients who receive counseling from the California Smokers' Helpline are encouraged to take the latter approach, on the theory that a passing psychological discomfort is less likely to lead to relapse than a permanent one. However, if the client demonstrates a strong preference for the former approach, the counselor works with the client to use that in the quit attempt.

The means by which the counselor encourages the client to adopt a nonsmoker's self-image are fairly direct. As early as the pre-quit session, the counselor asks whether the client felt like a nonsmoker on previous quit attempts or just a smoker who was not smoking. This may be the first time the client has thought of the distinction. The counselor makes clear that the program's goal in the current quit attempt is to help the client see himself or herself as a real nonsmoker, that is, as a person to whom smoking is not an option and who is not bothered by that fact. The words, "I am becoming a nonsmoker" appear at the top of the worksheet that the client uses as a reminder of his or her quitting plan. Two weeks into the quit attempt, by which time the physical withdrawal symptoms have diminished or perhaps even stopped, the counselor asks whether the client has begun to feel like a nonsmoker. The topic is broached as well in the final call. Thus, the client's progress is discussed in terms not only of abstinence from smoking, but also of acquiring a new self-image.

Like first-time parents who stumble through the early tasks of child rearing before they feel natural as mothers or fathers, clients who quit smoking initially feel awkward behaving as nonsmokers. This is particularly true of clients who have smoked for many years or who cannot remember how they felt before they acquired the habit. The counselor helps the client over this hurdle by positively reinforcing new behaviors, normalizing the feeling of awkwardness, giving reassurance that the feeling will fade, and emphasizing that being smoke-free is the client's natural state. Ideally, the client comes to feel like a member of the nonsmoking group and to view the period in which he or she smoked as an anomaly.

## COUNSELOR TRAINING AND SUPERVISION

With thorough training in smoking cessation counseling, professional and paraprofessional counselors alike can implement the protocol we have described earlier. The counseling staff of the California Smokers' Helpline includes paraprofessionals holding bachelor's degrees in psychology and related fields, graduate students in counseling and social work, and master's-level counselors, some of whom are working toward licensure. Regardless of educational background, each counselor must successfully complete a 60-hour in-house training course before accepting clients. Although it is not possible to give here a full description of this course, we outline its components.

The course includes lecture, discussion, role-play, and a written examination, as well as assigned outside reading. The course provides an overview of counseling for the modification of addictive behaviors, in-depth education on counseling for smoking cessation, and thorough training on the protocol of the California Smokers' Helpline. General topics include traditional theoretical approaches to counseling; the fundamentals of motivational interviewing; matching counseling style and technique to client variables; the process of habit formation, maintenance, and extinction; self-regulation theory; and current models of addiction. Smoking-specific topics include the health effects of smoking and quitting; the physiology of nicotine dependence and nicotine replacement therapy; the role of self-image in smoking initiation, maintenance, and cessation; self-efficacy; self-monitoring skills; situational analysis of relapse; coping; positive expectancy; and the process of attribution for success and failure. The training also covers other special topics as they pertain to smoking, such as pregnancy, weight change, HIV and AIDS, alcohol, and substance abuse. The clinical implications of the use of the telephone as a medium for behavior modification counseling also are addressed. As part of the course, the trainee observes veteran counselors at work and engages in intensive role-playing and feedback sessions with them. At the conclusion of the course, the trainee must successfully complete a written examination and a final role-play with the clinical supervisor.

The California Smokers' Helpline is currently supervised by a licensed psychologist with previous experience in telephone counseling for smoking cessation. The supervisor is responsible for counselor training and for monitoring sessions, conducting individual conferences with counselors, facilitating group supervision meetings, and ensuring that the service provided by counselors is clinically sound and in compliance both with state laws regarding counseling practice and with ethical guidelines established for the counseling profession.

## ETHICAL AND LEGAL CONSIDERATIONS

The ethical and legal guidelines under which the California Smokers' Helpline operates have mainly to do with

informed consent and confidentiality, scope of competence, crisis intervention, and clinical supervision. Although the scope of this article does not allow for a detailed discussion of the ethical and legal aspects of telephone counseling, we outline the basic issues as a general guide for professionals who may be considering this kind of counseling service.

Every client of the California Smokers' Helpline is informed before the first session begins that the counselor will be taking notes, but that what is discussed will be kept confidential, with the exception of information indicating a clear danger to the client or to someone else. The counselor also informs the client that in order to ensure a high level of service, a supervisor may monitor the call. This allows the client to make an informed decision about whether to continue with the session. Only if these terms are acceptable to the client does counseling proceed. With the rare exception of such information as must be reported to the appropriate authorities (e.g., child or elder abuse), personal information about the client never leaves the program's office.

Although telephone counseling for smoking cessation is fairly specialized work, it is sometimes a challenge for the counselor to keep the discussion focused on quitting smoking. The client may wish to discuss issues that fall outside the purview of a smoking cessation helpline. The counselor has been thoroughly trained in smoking cessation counseling but is not necessarily qualified to provide counseling outside of this specialty, which at any rate is beyond the scope of the program's purpose. For these reasons, the counselor strives to be clear with the client about what services can and cannot be provided in the context of a helpline call. When issues arise that are outside the scope of either the counselor's competence or the helpline's purpose, the counselor must work to keep the discussion focused on quitting smoking. If the client shares information that indicates a need for services beyond counseling for smoking cessation, the counselor has referral sources readily available so as to provide the client with appropriate contacts.

Although the rule is that the counselor does not address mental health issues beyond those that normally arise when a client quits smoking, except to refer the client elsewhere for treatment, it sometimes happens that the counselor reaches a client in crisis. For this reason, the counselor is trained in the basic elements of crisis intervention and in the program's emergency procedures for such situations. For example, the counselor may need to keep a suicidal client engaged in conversation while securing assistance from a coworker to notify local authorities on another line. To ensure that the staff is prepared for such emergencies, ongoing education is provided.

It is our view that, to maintain a high level of clinical professionalism, including preparedness for crises, a large telephone counseling program like the California Smokers' Helpline should be staffed by professional counselors or thoroughly trained paraprofessionals and should be supervised by a qualified mental health practitioner. Ideally, the

supervisor would have graduate training in counseling or a related field, a clinical license, counseling experience with the targeted clientele, counselor supervision training and experience, and familiarity with telephone counseling interventions.

## CONSIDERATIONS FOR FUTURE DIRECTION

Several potential applications of the telephone counseling protocol developed by the California Smokers' Helpline are as yet untested. The protocol currently is used only with the adult population. Its appropriateness for minors who also want help quitting smoking should be investigated, or a separate counseling protocol for minors should be developed. Also, the protocol is currently used only with smokers who say at the point of screening that they are ready to quit soon. There is a need to learn how to work with those who are open to receiving counseling but do not feel as ready to quit. Likewise, there is a need to learn whether anything more can be done for those who receive counseling but do not make a quit attempt, to help them take the next step. The adaptability of this protocol to telephone counseling for the modification of other behaviors besides smoking also might be investigated. It has already been used as the basis for a new dietary intervention in a study on preventing breast cancer recurrence, centered at the University of California, San Diego Cancer Center.

Other more theoretical questions about the protocol of the California Smokers' Helpline remain to be investigated. The protocol as a whole has proved effective, but which of its components are necessary to ensure this effect? Are the components individually efficacious? How big a role does accountability play? Does counseling on self-image actually help clients change their self-image, and if so, does cultivating a self-image as a nonsmoker help prevent relapse? Are the basic elements of this intervention sufficiently universal to be used effectively in other kinds of telephone interventions? Is telephone counseling suitable as a cotreatment with existing face-to-face counseling? The effectiveness and evident attractiveness of telephone counseling would seem to argue for the improvement and wider application of this mode of service delivery.

## REFERENCES

- Abrams, D. B., & Niaura, R. S. (1987). Social learning theory. In H. T. Blane & K. E. Leonard (Eds.), *Psychological theory of drinking and alcoholism* (pp. 131-175). New York: Guilford Press.
- Anderson, D. M., Duffy, K., Hallet, C. D., & Marcus, A. C. (1992). Cancer prevention counseling on telephone helplines. *Public Health Report*, 107, 278-283.
- Austad, C. S., & Berman, W. H. (Eds.). (1991). *Psychotherapy in managed health care*. Washington, DC: American Psychological Association.
- Baer, J. S., Holt, C. S., & Lichtenstein, E. (1986). Self-efficacy and smoking reexamined: Construct validity and clinical utility. *Journal of Consulting and Clinical Psychology*, 6, 846-852.
- Bandura, A. (1969). *Principles of behavior modification*. New York: Holt, Rinehart & Winston.
- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice Hall.
- Beck, A. T., Wright, F. D., Newman, C. F., & Liese, B. S. (1993). *Cognitive therapy of substance abuse*. New York: Guilford Press.
- Condiottie, M. M., & Lichtenstein, E. (1981). Self-efficacy and relapse in smoking cessation programs. *Journal of Consulting and Clinical Psychology*, 49, 648-658.
- DeBusk, R. F., Miller, N. H., Superko, R., Dennis, C. A., Thomas, R. J., Lew, H. T., Berger, W. E., Heller, R. S., Rompf, J., Gee, D., Kraemer, H. C., Bandura, A., Ghandour, G., Clark, M., Shah, R., Fisher, L., & Taylor, C. B. (1994). A case-management system for coronary risk factor modification after acute myocardial infarction. *Annals of Internal Medicine*, 120, 721-729.
- Fagerström, K. O. (1978). Measuring degree of physical dependence to tobacco smoking with reference to individualization of treatment. *Addictive Behaviors*, 3, 235-241.
- Fish, S. L. (1990). Therapeutic uses of the telephone: Crisis intervention vs. traditional therapy. In G. Gumpert & S. Fish (Eds.), *Talking to strangers: Mediated therapeutic communication* (pp. 154-167). Norwood, NJ: Ablex.
- Goldfried, M. R., & Davison, G. C. (1976). *Clinical behavior therapy*. New York: Holt, Rinehart & Winston.
- Gritz, E. R., Carr, C. R., & Marcus, A. C. (1991). The tobacco withdrawal syndrome in unaided quitters. *British Journal of Addiction*, 86, 57-69.
- Harackiewicz, J. M., Sansone, C., Blair, L. W., Epstein, J. A., & Manderlink, G. (1987). Attributional processes in behavioral change and maintenance: Smoking cessation and continued abstinence. *Journal of Consulting and Clinical Psychology*, 3, 372-378.
- Heather, N. (1989). Psychology and brief intervention. *British Journal of Addiction*, 84, 367-370.
- Heatherton, T. F., Kozlowski, L. T., Frecker, R. C., & Fagerström, K. O. (1991). The Fagerström test for nicotine dependence: A revision of the Fagerström Tolerance Questionnaire. *British Journal of Addiction*, 86, 1119-1127.
- Janis, I. L. (1983). The role of social support in adherence to stressful decisions. *American Psychologist*, 38, 143-160.
- Janis, I. L., & Mann, L. (1977). *Decision-making: A psychological analysis of conflict, choice, and commitment*. New York: Free Press.
- Lando, H. A., Hellerstedt, W. L., Pirie, P. L., & McGovern, P. G. (1992). Brief supportive telephone outreach as a recruitment and intervention strategy for smoking cessation. *American Journal of Public Health*, 82, 41-46.
- Lichtenstein, E., Glasgow, R. E., Lando, H. A., Ossip-Klein, D. J., & Boles, S. M. (in press). Telephone counseling for smoking cessation: Rationales and meta-analytic review of evidence. *Health Education Quarterly*.
- Marlatt, G. A. (1985). Relapse prevention: Theoretical rationale and overview of the model. In G. A. Marlatt & J. R. Gordon (Eds.), *Relapse prevention: Maintenance strategies in the treatment of addictive behavior* (pp. 3-67). New York: Guilford Press.
- Marlatt, G. A., & Gordon, J. R. (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behavior*. New York: Guilford Press.
- Mermelstein, R., Cohen, S., Lichtenstein, E., Baer, J. S., & Kamarck, T. (1986). Social support and smoking cessation and maintenance. *Journal of Consulting and Clinical Psychology*, 54, 447-453.
- Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York: Guilford Press.
- Morgan, T. J. (1996). Behavioral treatment techniques for psychoactive substance use disorders. In F. Rotgers, D. S. Keller, & J. Morgenstern (Eds.), *Treating substance abuse: Theory and technique* (pp. 202-240). New York: Guilford Press.
- Murray, R. P., Johnston, J. J., Dolce, J. J., Lee, W. W., & O'Hara, P. (1995). Social support for smoking cessation and abstinence: The Lung Health Study. *Addictive Behaviors*, 20(2), 159-170.
- Nides, M. A., Rakos, R. F., Gonzales, D., Murray, R. P., Tashkin, D. P., Bjornson-Benson, W. M., Lindgren, P., & Connett, J. E. (1995). Predictors of initial smoking cessation and relapse through the first 2 years of the Lung Health Study. *Journal of Consulting and Clinical Psychology*, 63, 60-69.

- Ockene, J. K., Kristeller, J., Pbert, L., Hebert, J. R., Luippold, R., Goldberg, R. J., Landon, J., & Kalan, K. (1994). The physician-delivered smoking intervention project: Can short-term interventions produce long-term effects for a general outpatient population? *Health Psychology, 13*, 278-281.
- Orleans, C. T., Schoenbach, V. J., Wagner, E. H., Quade, D., Salmon, M. A., Pearson, D. C., Fielder, J., Porter, C. Q., & Kaplan, B. H. (1991). Self-help quit smoking intervention: Effects of self-help materials, social support intervention, and telephone counseling. *Journal of Consulting and Clinical Psychology, 59*, 439-448.
- Ossip-Klein, D. J., Giovino, G. A., Megahed, N., Black, P. M., Emont, S. L., Stiggins, J., Shulman, E., & Moore, L. (1991). Effects of a smokers' hotline: Results of a 10-county self-help trial. *Journal of Consulting and Clinical Psychology, 59*, 325-332.
- Pederson, L. L., Strickland, C., & DesLauriers, A. (1991). Self-efficacy related to smoking cessation in general practice patients. *International Journal of the Addictions, 26*, 467-485.
- Raskin, N. J., & Rogers, C. R. (1989). Person-centered therapy. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (pp. 155-194). Itasca, IL: Peacock.
- Rotgers, F. (1996). Behavioral theory of substance abuse treatment: Bringing science to bear on practice. In F. Rotgers, D. S. Keller, & J. Morgenstern (Eds.), *Treating substance abuse: Theory and technique* (pp. 174-201). New York: Guilford Press.
- Shiffman, S. (1982). Relapse following smoking cessation: A situational analysis. *Journal of Consulting and Clinical Psychology, 50*, 71-86.
- U.S. Department of Health and Human Services. (1990). *The health benefits of smoking cessation: A report of the Surgeon General* (DHHS Publication No. CDC 90-8416). Washington, DC: U.S. Government Printing Office.
- Velicer, W. F., DiClemente, C. C., Prochaska, J. O., & Brandenburg, N. (1985). A decisional balance measure for assessing and predicting smoking status. *Journal of Personality and Social Psychology, 48*, 1279-1289.
- Wilson, G. T. (1989). Behavior therapy. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (pp. 241-282). Itasca, IL: Peacock.
- Yalom, I. D. (1995). *The theory and practice of group psychotherapy* (4th ed.). New York: Basic Books.
- Zhu S.-H. (1993, November). *Basic tenets of telephone counseling for smoking cessation*. Workshop conducted at the Sixth National Conference on Nicotine Dependence, American Society of Addictive Medicine, Atlanta, GA.
- Zhu, S.-H., Freeman, D., Martinez, E., & Anderson, C. M. (1995, March). *Help-seeking and active helping in smoking cessation*. Poster presented at the 16th Annual Scientific Sessions of the Society of Behavioral Medicine, San Diego, CA.
- Zhu, S.-H., & Pierce, J. P. (1995). A new scheduling method for time-limited counseling. *Professional Psychology: Research and Practice, 26*, 624-625.
- Zhu, S.-H., Rosbrook, B., Anderson, C., Gilpin, E., Sadler, G., & Pierce, J. P. (1995). The demographics of help-seeking for smoking cessation in California and the role of the California Smokers' Helpline. *Tobacco Control, 4* (Suppl. 1), S5-S15.
- Zhu, S.-H., Stretch, V., Balabanis, M., Martinez, E., Munguia, M., & Pierce, J. P. (1991). [Unpublished counselors' training manual for the UCSD Smokers' Helpline]. La Jolla, CA: Cancer Center, University of California, San Diego.
- Zhu, S.-H., Stretch, V., Balabanis, M., Rosbrook, B., Sadler, G., & Pierce, J. P. (1996). Telephone counseling for smoking cessation: Effects of single-session and multiple-session intervention. *Journal of Consulting and Clinical Psychology, 64*, 202-211.