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## *The Winning Edge*: Development and Refinement of our Program

We wrote this book to describe a cost-effective program we developed—*The Winning Edge*—to help smokers achieve their goal of lifelong abstinence from smoking. Sobering statistics bring into sharp relief the tremendous personal and societal burdens of tobacco smoking and the urgent need to find viable ways to combat the world's leading preventable cause of premature mortality and morbidity. In the pages that follow, we describe our response to addressing this imperative.

We begin with an overview of the myriad, and increasingly well-documented and compelling, health-related risks of smoking. Smoking can cause cancer in almost any organ of the body. Smoking accounts for about 90% of all lung cancer mortalities and over 80% of deaths from chronic pulmonary obstructive disease (COPD), including emphysema and chronic bronchitis (United States Department of Health and Human Services/USDHHS, 2014). Furthermore, smoking increases the risk of developing type 2 diabetes mellitus, cataracts, tooth loss and gum disease, and age-related macular degeneration, and has been linked to rheumatoid arthritis (USDHHS, 2014). Smoking causes high blood pressure, strokes, and cardiovascular disease (Centers for Disease Control and Prevention/CDCP, 2010); reduces fertility levels of men and women; and increases the risks of miscarriage and birth defects (USDHHS, 2010, 2014). Moreover, smoking nearly doubles the risk of postoperative complications and is associated with higher odds of postoperative infections, increased risk of pulmonary and neurological complications, and higher intensive care unit admission rates (Gronkjaer et al., 2014; Turan et al., 2011).

Public campaigns against smoking, education about the dangers of smoking, and numerous treatment programs have reduced smoking rates. Indeed, the American smoking rate has been halved since 1962 (USDHHS, 2010), and the US smoking rate between 2005 and 2015 has continued to decline, from 20.9% to 15.1% (CDCP, 2016). Still, 36.5 million US adults continue to smoke (CDCP, 2016). Each year, in the US alone, approximately 480,000 people die of a smoking-attributable illness (USDHHS, 2014).

Globally, the World Health Organization (WHO) estimates that tobacco has caused 100 million deaths in the 20th century (WHO, 2008). To put this into perspective, *The Guardian* (Chalabi, 2013) reported that 8.5 to 16.5 million people—soldiers and civilians—died during World War I. Another 40 to 72 million people died during World War II. Accordingly, more people have died from smoking than from both world wars combined! Current smokers in the US die, on average, roughly 10 years younger than their lifelong nonsmoker counterparts (Jha et al., 2013).

In the European Union (EU), the number of smokers and deaths attributable to smoking is even higher than in the US. In 2017, the European Commission Special Eurobarometer (ECSE) report, based on nearly 28,000 survey respondents, revealed that 28% of the population smokes and that smoking produces 700,000 annual deaths inside the EU. The report projects that about half of all EU smokers will die prematurely, on average 14 years earlier than nonsmokers. According to the EU Directorate General of Health and Human Safety, tobacco consumption is the single largest avoidable health risk in the European Union (Eurostat News, 2017).

The good news is that smoking rates in the EU are trending downward, paralleling the trend in the US. For example, between 2006 and 2017, EU smoking rates declined by about 6 percentage points, although the pattern was inconsistent across EU countries (ECSE, 2017). In the US, there are concerns that the downward trend in smoking prevalence rates may have stalled (see Fletcher, 2012). Accordingly, the remaining US smokers are more likely to be hardcore smokers who are smoking more and for longer periods of time than earlier cohorts of smokers seeking treatment for smoking cessation.

Still, smokers generally *wish* to stop. For example, over half (i.e., 54%) of the smokers completing the Eurobarometer survey reported that they had attempted to stop smoking at some point in the past. US surveys note that around 70% of current smokers *want* to stop, and that a majority of smokers have *attempted to quit* within the past year (USDHHS, 2014). Importantly, a majority of current smokers *believe* that they will successfully stop smoking at some point in the future (DiClemente, Delahanty, & Fiedler, 2010). Given the alarming health-related consequences of continued smoking and the public knowledge about the dangers of smoking, it's surprising that relatively few smokers *wanting to stop* seek professional help or formal treatment options for smoking cessation. Indeed, nearly three-fourths of people in the EU reported *not* using any formal treatment methods or assistance when trying to stop smoking. Astonishingly, within Spain, the percentage of current smokers trying to stop on their own was nearly 90% (ECSE, 2017). Unfortunately, only a small percentage of smokers trying to stop on their own are successful during any given attempt. US surveys and reviews estimate that less than 5–7% of smokers successfully stop smoking without assistance on any given quit attempt (e.g., Brose et al., 2011; Hughes, Keely, & Naud, 2004).

Fortunately, smoking cessation is associated with decreased mortality and morbidity across many health conditions. For example, ex-smokers reduce their excess lung cancer risk by upward of 50% within 10 years of quitting (USDHHS, 2010). After stopping smoking, cardiovascular risks, including heart attacks, decrease substantially. Following 2–5 years of smoking cessation, the risk of stroke mirrors that of a nonsmoker (USDHHS, 2010). Estimates indicate that nearly one-third of all cancer deaths would be eliminated if people didn't smoke (USDHHS, 2010, 2014). Additionally, stopping smoking is associated with increased reports of subjective happiness. Nearly 70% of adults and 72% of parents reported increased levels of happiness after stopping smoking (Drehmer, Hipple, Ossip, Nabi-Burza, & Winickoff, 2015; Shahab & West, 2009). Furthermore, at a macro-level perspective, getting patients to stop smoking prior to a surgical intervention requiring hospitalization reduces the overall costs associated with treatment and follow-up (Gaskill et al., 2017). With more than a billion people still smoking worldwide (WHO, 2018), and an estimated economic impact of 1.8% of the world's annual gross domestic product (Goodchild, Nargis, & Tursan d'Espaignet, 2018), it's imperative to develop cost-effective treatments that promote long-term abstinence (Levy et al., 2017; Raw et al., 2017).

## Responding to the Need for a Cost-effective Treatment

Our book responds to this pressing need. We present a cutting-edge treatment program for tobacco addiction that uses cognitive-behavioral approaches, including acceptance and mindfulness-based interventions, to defeat smoking behaviors. Cognitive-behavioral therapy (CBT) encompasses a broad range of approaches which share the assumption that modifying maladaptive and self-defeating cognitions, emotions, and behaviors can alleviate distress and problems in living, including those associated with tobacco addiction (Hofmann, Glombiewski, Asnaani, & Sawyer, 2011). Our program is premised on the assumption that acceptance and mindfulness of the constantly changing stream of thoughts and emotions—rather than avoidance of anxiety-arousing or painful experiences—are key to psychological and experiential flexibility, and are a pathway to breaking the grip of smoking (Bowen & Marlatt, 2009). Hypnosis, which is also an important component of our program, is fundamentally a cognitive-behavioral intervention, which involves thinking, imagining, and experiencing in response to suggestions that can target cognitive, behavioral, and affective change (Green, Barabasz, Barrett, & Montgomery, 2005; Lynn et al., 2015; Lynn, Malaktaris, Condon, Maxwell, & Cleere, 2012; Milburn, 2011; Schoenberger, 1999).

As we noted at the outset, we collectively refer to the various strategies we teach in our program—CBT, mindfulness, acceptance, and hypnosis—as *The Winning Edge.* We invite participants to employ these strategies tactically to increase their motivation and to learn skills necessary to draw on personal resources to resist smoking urges and to stop smoking for life. When appropriate, we also encourage the use of nicotine replacement therapy (NRT) as a method to reduce withdrawal symptoms and cravings to smoke, and we disseminate handouts that describe the nature and pros and cons of using NRT. We'll address NRT more specifically later on, as well as elaborate more fully all of the ingredients of our program. Our program constitutes a multifaceted approach that can be customized to leverage the strengths of participants and to respond to their individual needs.

## A Bit of History

How did our program come to be? At the crux of many a good story is another story. Perhaps the history of *The Winning Edge* is such a story. Here's how it begins. Back in 1986, one of your authors (SJL) read an advertisement in a local newspaper about an itinerant hypnotist who promised, for the third time in as many months, to relieve people of the scourge of smoking (or something along those lines) with a "money back guarantee." The hypnotist boasted that he recently had filled the large room he rented in a hotel and successfully treated almost all of the attendees. Reading the latest ad was particularly irksome, and I wrote a letter to the editor of our local paper questioning the inflated claims of success (90% or more) and commenting that it isn't particularly challenging to quit smoking for a few days, even without hypnosis, and thereby attribute the short-term success to hypnosis. I questioned whether the brief induction of hypnosis, combined with no scientifically based treatment, could do the trick. I also conjectured that perhaps people didn't line up to get a refund because they "blamed themselves" for not having the hypnotic ability or the wherewithal to fulfill the promises the program offered, or perhaps it was just too much bother to complete the paperwork.

Still, I was aware, even 30 years ago, that hypnosis could be a valuable tool—a catalyst to promote treatment effectiveness—when combined with the increasingly formidable technologies for behavior change that psychological science has to offer. Interestingly, within a few months of my letter to the editor, I received a call from a representative of the American Lung Association (ALA) of Ohio, who expressed a high level of concern about the same hypnotist and offered to provide a small grant to a student I would supervise to review the psychological literature on smoking cessation and craft a treatment that incorporated hypnosis with state-of-the-science methods to assist people in quitting smoking. Victor Neufeld, a graduate student in our program at Ohio University, was quick to volunteer to be point-person, and he devoted an entire year to scouring the literature on psychological smoking cessation methods, which were mostly focused on enhancing motivation and behavioral approaches.

We strived to condense the multiple components of the ALA's *Freedom From Smoking* program into a single-session format, grounded our intervention in behavioral and cognitive-behavioral techniques, and added a component of self-hypnosis. In 1988, Victor and I published encouraging results from this single-session hypnosis-based intervention for smoking, which we'll describe more fully in the next chapter. A few years later, Lynn, Neufeld, and Rhue (1992) expanded the protocol into a two-session approach, culling various cognitive, behavioral, and hypnotic strategies in a more cohesive package (see also Lynn, Neufeld, Rhue & Matorin, 1993). Joseph (Joe) Green (your author) jumped on board in the late 1980s, and we, together, have expanded, updated, and refined the program, which we're still doing as of the time of writing. In a series of book chapters, Joe illustrated the specifics of the Lynn et al. (1993) program, as applied in individual and group formats (Green, 1996, 1999a, 2000, 2010).

## What Motivates our Program: Principles and Practices

Over the years, we have made significant modifications and refinements to the original protocol, with Joe taking the lead in these efforts (see Green, 2010; Green & Lynn, 2016, 2017; Lynn, Green, Elinoff, Baltman, & Maxwell, 2016). The latest iteration of our program revamps and restructures earlier versions in notable respects, tying interventions more closely with the current literatures on cognitive-behavioral approaches, hypnosis, motivational interviewing, and acceptance/mindfulness-based methods, and with specific interventions geared to modify potential mediators and moderators of outcome, including motivation, negative affect, self-efficacy, social support, and weight concerns, as we describe in later chapters.

Our program remains firmly grounded in cognitive-behavioral principles and practices. The treatment is now systematically organized into strategies focusing on cognition, affect, and behavior. We encourage participants to use multiple strategies (e.g., self-reward, behavioral substitution, cue exposure, social support) in order to increase the likelihood of achieving abstinence. We target irrational thinking, cognitive distortions, and erroneous beliefs regarding smoking, and adopt a step-by-step approach in which cessation is the top priority. Imagery techniques, many of which are commonly used in CBT and relapse prevention programs, are incorporated in order to promote self-efficacy and enhance motivation (Beck, 1970; Bell, Mackie & Bennett-Levy, 2014). Self-efficacy (the belief that you can succeed or accomplish a

task; Bandura, 1986) is an important ingredient to successfully kicking the smoking habit, as self-efficacy ratings predict both short-term and long-term success in smoking cessation programs (Etter, Bergman, Humair, & Perneger, 2000; Mudde, Kok, & Strecher, 1995; Stuart, Borland, & McMurray, 1994). Importantly, self-efficacy can be enhanced by providing individuals practical strategies and a detailed plan to stop smoking and by highlighting the negative consequences of smoking (Berle, 2003).

We have added techniques that reflect recent innovations in CBT—an emphasis on experiential acceptance—underpinned by research indicating that attempts to suppress negative feelings are not as effective as accepting they will pass and acting in keeping with salient goals and values (Hayes & Levin, 2012; Lynn et al., 2016). Cravings to smoke and other negative thoughts or emotions can be reframed as being normal, transient, and subject to change over time. By not getting absorbed in cravings, self-doubt, or perceived failures, individuals often report that they become more optimistic, empowered, and better able to focus their efforts on achieving the goals of treatment. We invite participants to accept transitory discomfort (e.g., "surf the urge") and focus on reasons to quit (see Ostafin & Marlatt, 2008). A smoking cessation program based on urge management and acceptance produced better outcomes at 1-year follow-up than NRT alone (Gifford, Kohlenberg, Hayes, Antonuccio, & Piasecki, 2004).

Program development and innovation have flowed directly from the empirical literature. For example, a Cochrane Review (Stead, Carroll, & Lancaster, 2017) found that cognitive-behavioral components of group counseling produced significant improvements in smoking cessation outcome. We now incorporate techniques from motivational interviewing (MI) to facilitate readiness for change and promote smoking cessation (Burke, Arkowitz, & Menchola, 2003; Lundahl, Kunz, Bronwell, Tollefson, & Burke, 2010; Steinberg, Ziedonis, Krejci, & Brandon, 2004; Williams & Deci, 2001; Williams, Gagne, Ryan, & Deci, 2002; Williams, McGregor, Sharp, Kouides, et al., 2006; Williams, McGregor, Sharp, Levesque, et al., 2006). In a meta-analytic review of the effectiveness of MI across 31 studies and over 9,000 patients, Heckman, Egleston, and Hofmann (2010) reported a near 50% improvement in smoking cessation rates relative to control conditions. Even brief applications (i.e., 15 min) of MI may be beneficial, and repeated encounters appear to strengthen the therapeutic effect of MI (Cupertino et al., 2012).

Another Cochrane Review (Lancaster & Stead, 2004) concluded that brief advice from a physician produces a small (2.5%) yet meaningful increase in the odds of quitting. Consistent with a review indicating that motivational enhancement techniques produce gains in smoking cessation when delivered by a physician, nurse, or hospital clinician (Lindson-Hawley, Thompson, & Begh, 2015), we include a health-promotion and confidence-building message delivered via video by a medical health professional. Health education by itself appears to be an important ingredient to successful smoking cessation, especially among individuals with low motivation to stop smoking (see Catley et al., 2016).

Consistent with both Self-Determination Theory (SDT: Deci, Koestner, & Ryan, 1999; Ryan & Deci, 2000) and client-centered therapeutic approaches (e.g., Miller & Rollnick, 2002), we strive to promote participants' sense of volition and autonomous control. We present educational information about the dangers of smoking to participants, provide a detailed, step-by-step plan to assist them in achieving their goal of smoking cessation, and express optimism that our program will be helpful; however, we allow space for

participants to examine their own reasons for smoking as well as their reasons for stopping smoking, decide for themselves whether they want to stop smoking (*Do the benefits outweigh the costs?*), and determine whether the time is right for implementing a smoking cessation program. Our collaborative approach is consistent with findings that "autonomy-supportive" styles of communication (versus direct advice or more "controlling" approaches marked by statements about what a participant *should* do or *needs* to do; e.g., *You need to stop smoking!*) encourage active engagement, promote internal motivation, and facilitate lasting behavioral change (Cupertino et al., 2012; Williams, 2002, 2006; Williams & Deci, 2001).

Concern about weight gain is common among individuals trying to stop smoking. Whereas women often report greater concerns about weight gain than men, increasingly it seems that men are also worried about postcessation weight gain (Bush et al., 2012). As many as 80% of smokers who successfully stop may gain weight, with increases of 6–11 lb (2.7–5 kg) over the course of a year being typical (Aubin, Farley, Lycett, Lahmek, & Aveyard, 2012; Tian et al., 2015; Williamson et al., 1991; USDHHS, 1990). Fortunately, combining a smoking cessation program with cognitive-behavioral strategies to minimize weight gain can be effective (Levine et al., 2010; Perkins et al., 2001). Our program addresses weight gain and the importance of eating a healthy diet and regularly exercising (see Chapter 9).

Learning skills to avoid high-risk situations and how to handle temporary lapses in treatment are critical components of relapse-prevention strategies (Irvin, Bowers, Dunn, & Wang, 1999) and are efficacious for treating smoking (see Collins, Witkiewitz, Kirouac, & Marlat, 2010). Relapse rates may be highest after the first 3–6 weeks following treatment (Silagy, Lancaster, Stead, Mant, & Fowler, 2004). Relatedly, it's not uncommon for participants to make multiple quit attempts before finally stopping smoking for good (Spring, King, Pagoto, Horn, & Fisher, 2015; USDHHS, 2001). Indeed, a recent study estimated that many smokers may make upwards of 30 quit attempts over their lifetime before finally stopping smoking (Chaiton et al., 2016). Accordingly, we encourage a long-term focus on healthy living, stress the importance of remaining vigilant about smoking triggers, and incorporate relapse-prevention strategies into our program.

Mindfulness refers to purposeful, nonjudgmental attention to the unfolding of experience on a moment-to-moment basis (Kabat-Zinn, 1994, 2003). The literature on the virtues of mindfulness and acceptance-based strategies suggests that such interventions may be ideally suited to address treatment barriers and limitations associated with more traditional CBT and may serve as a useful adjunct to traditional CBT featured in our program (de Souza et al., 2015). Acceptance approaches may facilitate abstinence by encouraging the ability to tolerate distressing thoughts and impulses, pivotal to achieving smoking abstinence (Hernandez-Lopez, Luciano, Bricker, Roales-Nieto, & Montesinos, 2009; Lee, An, Levin, & Twohig, 2015).

Davis and Hayes's review (2011) concluded that substantial research supports the affective, interpersonal, and intrapersonal benefits of mindfulness practice: Mindfulness elicits positive emotions, minimizes negative affect and rumination, and promotes emotion regulation. We use mindfulness, acceptance, and values-based strategies to promote greater response flexibility and decreases reactivity to thoughts and emotions (Green & Lynn, 2017; Hayes & Levin, 2012; Lynn et al., 2012).

Unlike traditional cognitive-behavioral approaches, the goal of mindfulness and acceptance-based approaches isn't to "argue with" irrational or distorted maladaptive

beliefs and counter or dispute automatic thoughts so much as to disengage from them (Lynn et al., 2016). Participants learn to not identify the "self" and their ultimate capability to resist smoking urges with demotivating thoughts and emotions. In acceptance-based and mindfulness approaches, the content isn't the central focus of treatment: What's important is the decoupling of subjective experience (i.e., smoking urges) from overt behavior (i.e., taking a puff on a cigarette). In other words, participants learn to develop strategies to be aware of and accept smoking urges while they gain confidence in their ability to resist the urge to smoke and to implement goal-directed, value-driven actions (Herbert & Forman, 2011).

Hypnosis and mindfulness-based approaches overlap in key respects and can be used in a complementary manner (Alladin, 2014; Green, Laurence & Lynn, 2014; Lynn et al., 2012; Yapko, 2011), and we do so in our program. For example, many hypnosis therapy protocols and most mindfulness-based approaches encourage acceptance of experiences that cannot be changed, promote nonjudgmental attitudes to emotions and mental experiences, and provide quiet reflection to prioritize needs and goals (Lynn et al., 2016). Importantly, a dated review of interventions within health psychology identified multicomponent behavior therapy as the only smoking cessation intervention that met criteria to be labeled "efficacious and specific" (Compas, Haaga, Keefe, Leitenberg, & Williams, 1998). More recent work reveals that a number of behavioral approaches are effective in treating substance abuse disorders, including CBT, skills training, MI, drug counseling, and family and couples therapy (Carroll, & Onken, 2005; McHugh, Hearon, & Otto, 2010; Smedslund et al., 2011). Our program integrates many such strategies into a comprehensive, unified treatment for smoking. Our approach is novel in that it incorporates self-instructional material into a more encompassing cognitive-behavioral and hypnosis treatment (illustrated by the work of Hely, Jamieson, & Dunstan, 2011, described in Chapter 2).

We have retained and even amplified the hypnosis component of our program over the years. Hypnosis plays an important role for several reasons. First, because the public views hypnosis as effective in achieving abstinence from smoking, hypnosis can be useful in generating positive treatment expectancies (Sood, Ebbert, Sood, & Stevens, 2006). Second, hypnosis can catalyze empirically supported interventions (Elkins, 2017; Green et al., 2014; Kirsch, Montgomery, & Sapirstein, 1995; Lynn, Rhue, & Kirsch, 2010; Nash, Perez, Tasso, & Levy, 2009). Third, qualitative reviews and meta-analytic studies, which provide a quantitative summary analysis of research findings across multiple studies, consistently document the effectiveness or promise of hypnosis—used as an adjunctive method—in treating a wide variety of psychological and medical conditions, ranging from acute and chronic pain to obesity (Elkins, Jensen, & Patterson, 2007; Kirsch, 1996a; Lynn et al., 2010; Montgomery, David, Winkel, Silverstein, & Bovbjerg, 2002). Meta-analyses have shown that hypnosis enhances the effectiveness of both psychodynamic and cognitive-behavioral psychotherapies (Kirsch, 1990; Kirsch et al., 1995; Schoenberger, 1999). Because hypnosis is only one ingredient in our program, the program can be easily adapted to exclude any and all hypnotic aspects, retaining the many cognitive-behavioral elements of the treatment package. In the next chapter, we focus on the evidence for why we prominently feature hypnosis in our program.

Expectations play a key role in psychotherapy effectiveness (e.g., Constantino, Coyne, McVicar, & Ametrano, 2017). We use empirically supported procedures—developed in our laboratory and elsewhere—to optimize positive expectancies and hypnotic

suggestibility (Gfeller, Lynn, & Pribble, 1987; Gorassini & Spanos, 1999). For example, we show participants a video of a coping model who successfully uses self-hypnosis. The two video clips we use (i.e., the coping model discussing attitudes and strategies that promote change and the aforementioned clip of a healthcare professional presenting health-related information) were created to facilitate positive expectancies. Additionally, we encourage participants to identify and regularly review their reasons to quit smoking and provide a menu of change options throughout the treatment. We also encourage participants to incorporate "change statements" in their internal dialogue regarding smoking and to begin to imagine themselves as nonsmokers in a variety of situations.

Beyond these efforts to increase motivation, in keeping with MI, we acknowledge participants' ambivalence to quit smoking and the uncertainty they may entertain regarding their ability to succeed (Green & Lynn, 2017). We also address motivation through the use of implementation instructions (Gollwitzer, 1999) and "if–then" statements (e.g., *If you were to really put forth a great deal of effort and make stop smoking your highest priority, and if you were to fully commit to all aspects of this program, then wouldn't you give yourself the best chance to achieve your goal?*). "If–then" statements narrow a large-scale goal of "mere intention" into practical steps, promoting personal responsibility and enhancing self-efficacy (Gollwitzer, 1993). Gollwitzer and Sheeran (2006) showed that such instructions can be an effective means of changing behavior. Importantly, implementation instructions can help smokers overcome the smoking habit (Armitage, 2017). We use implementation instructions during group discussions about ambivalence about stopping and fear of being unsuccessful, and we tailor suggestions in our hypnosis script to reflect these types of statements.

Although we encourage frank discussion about participants' ambivalence regarding stopping smoking and the pros and cons of smoking from their perspective, we empathically try to nudge participants forward to making a full commitment to smoking cessation by emphasizing "change talk" in the form of reinforcing any and all perceived benefits of stopping smoking (Rollnick & Miller, 1995). Although we allow for limited "sustain talk" (e.g., language that favors the status quo such as discussing participants' reasons not to stop), the goal is to shift the relative balance toward stopping smoking by facilitating a more positive attitudinal bias toward cessation (Krigel et al., 2017). Accordingly, we encourage participants to adopt an identity as a nonsmoker and work to increase the discrepancy between their current status as a smoker and their potential to achieve abstinence (Westra & Aviram, 2013).

Our inclusion of multitude of strategies is pegged to scientific evidence regarding what works best. For example, Michie, Churchill, and West (2011) identified 32 different "competencies" across effective interventions included in the 2005 Cochrane Review of smoking cessation treatments (Stead & Lancaster, 2005) and recommended the following nine behavioral change techniques shown to increase individual-based treatment success rates within England's national stop smoking services program (West, Walia, Hyder, Shahab & Michie, 2010):

> (1) strengthen ex-smoker identity, (2) elicit client views, (3) measure carbon monoxide, (4) give options for additional and later support, (5) provide rewards contingent on stopping smoking, (6) advise on changing routine, (7) facilitate relapse prevention and coping, (8) ask about experience of stop smoking medication being used and (9) advise on stop smoking medication. (p. 66)

The authors identified six additional competencies when administering group-based approaches, including explaining the importance of group support, encouraging discussions and group interactions, implementing a buddy system, and using a behavioral contract or making a public promise not to smoke.

Our program incorporates all of these effective strategies. Although *The Winning Edge* concentrates on smoking cessation, we'll later describe how the main ingredients of our approach can be used to treat other conditions. Indeed, our two-session program to achieve smoking cessation models the way that psychological principles and the latest technologies for promoting behavior change can be used to master longstanding habitual patterns of self-destructive behaviors.

## Overview of the Sessions

When we advertise our program, we direct prospective participants to printed and online sources that describe our program in detail, address common questions and concerns (e.g., *How much will the program cost? How many sessions? Do I have to be highly hypnotizable to benefit from the program?*), and provide logistical information (e.g., dates, times, location, parking, fees/costs). Additionally, when we collect data for research purposes, we request that participants download and read a consent form prior to the first meeting. We also provide contact information (e.g., phone number) if participants have additional questions. It's important that all members of the intervention team, including receptionists and secretaries, be knowledgeable about the program so that they can competently and courteously answer questions, offer encouragement, and frame smoking cessation as an achievable goal, without inflating claims of success.

Our program can be implemented on an individual basis and modified to address the unique needs of a single person or on a group basis with as many as 40 to 50 participants in a standardized format. From this point forward, we'll use the terms therapist, trainer, and facilitator interchangeably to describe (a) interventionists who work with clients on an individual basis and (b) group leaders who conduct smoking cessation programs.

The general protocol, typically administered in a group context, involves two sessions, spaced a week apart. The first session (approximately 2 hr) educates participants about the risks of smoking and second-hand smoke and describes cognitive, behavioral, mindfulness and acceptance-based, and hypnotic strategies to help participants become a nonsmoker. As originally designed, the therapist personally meets with an individual participant or a group of participants to discuss the information and strategies of our first session. In an effort to provide this information in a more expedient manner, we have created a 1-hr DVD (with over 100 slides and a running narrative) and a corresponding workbook detailing the informational and educational components of our first session. Clients can review the DVD and related written materials prior to coming to the first meeting, or, in the case of a group administration, participants may view the DVD as a group or the therapist may deliver the DVD information "live" in the introductory meeting. As mentioned above, we also show a video of a coping model responding to questions about the program, her experiences using hypnosis, and her interactions with program materials in an effort to emphasize treatment compliance and to shape positive expectancies. Copies of the educational DVD (and the coping model exchange) are included in the home study materials that participants receive. They are encouraged

to watch the DVD at least one more time between the first and second sessions, ideally with a supportive friend or family member. The first session ends with a brief (approximately 14 min) self-hypnosis exercise featuring relaxation, motivation to live a life consistent with values, and enhanced resolve to become a nonsmoker.

The second session (approximately 2 hr) begins with a discussion of smoking triggers, social support, and generating a plan to engage in alternative behaviors rather than smoking. The centerpiece of the second session is a "longer and stronger" (approximately 32 min) hypnosis exercise that presents hypnotic suggestions to achieve smoking abstinence during which the facilitator reviews the major educational components of the program.

Whether administered in a group or individual format, we encourage participants to develop detailed, personalized plans to cope with smoking urges by substituting healthier alternatives to smoking behavior. We provide participants with a menu of approaches, and we encourage participants to experiment with each recommended intervention to increase the likelihood of achieving abstinence (Brandon, Tiffany, Obremski, & Baker, 1990; Carmody et al., 2008). In our experience, different elements of the program are more effective with some participants than others. Employing multiple treatment methods targets a broad range of impediments to smoking cessation (Tonnesen, 2009).

## Latest Revisions and Updates to our *Winning Edge* Program

In recent years, we have revised the program substantially, as briefly summarized in our foregoing discussion. We have restructured our protocol in significant respects, aligning interventions more closely with the current literature on CBT and hypnosis, and incorporating mindfulness-based and acceptance strategies, as well as incorporating NRT as an adjunctive intervention. Because our program has evolved considerably over the past few years, earlier evaluations of our program (e.g., Carmody et al., 2008; Carmody, Duncan, Solkowitz, Huggins, & Simon, 2017; Hely et al., 2011) are limited and outdated. Indeed, the hypnosis intervention we now use has been enhanced significantly and is supplemented with a DVD and CDs that recapitulate the training and are intended to reinforce and generalize treatment gains. Importantly, we frame the procedures as self-hypnosis to further enhance the likelihood of transfer and maintenance of gains apart from the original treatment context (Lynn & Kirsch, 2006).

Other books purport to help people to stop smoking with hypnosis. However, to our knowledge, this is the only volume that combines hypnosis and mindfulness-based strategies with empirically supported cognitive-behavioral principles and NRT. Because the interventions we describe can be administered in a group as well as on an individual basis, the treatment is potentially highly cost-effective and can be used in schools, hospitals, industrial, and medical settings, as well as in the consulting room. Clinicians will therefore have at their disposal the means to conduct a manualized, empirically grounded intervention with a wide range of smokers seeking to "kick the habit."

Although the hypnotic techniques we present are highly scripted and require no special expertise regarding hypnosis, we do recommend that individuals receive scientific training in widely available hypnosis workshops (e.g., Australian Society of Hypnosis; Society of Clinical and Experimental Hypnosis; American Society of Clinical Hypnosis; British Society of Clinical and Academic Hypnosis; the Association for the Advance of

Experimental and Applied Hypnosis (Spain); Indian Society of Clinical and Experimental Hypnosis; and other regional societies; see the "constituent societies" link of the International Society of Hypnosis (ISH) for a worldwide listing of professional affiliations), and that facilitators possess adequate mental health training to address the needs of individuals with serious anxiety or depression-related issues that might co-occur with tobacco smoking (see Chapter 9) and to contend with any issues that emerge during the program in a competent, ethical, and professional manner.

Although our approach doesn't necessitate lengthy training in hypnosis, facilitators should have a basic understanding of what hypnosis is and is not. In terms of hypnosis training, we caution against Internet-based or stand-alone hypnosis guilds, as there are few quality controls on many of these outlets and resources. Our maxim is never to use hypnosis for treating conditions or problems that you are not trained and competent to treat without hypnosis. We're regularly asked for recommendations of "hypnotists" for treating a wide range of problems and advise that prospective clients first screen for psychologists, psychiatrists, physicians, nurses, counselors, and social workers who hold professional licenses, have expertise in a given area, and then also have some background in applying hypnosis as a supplement to their professional approach.