Putting It on the Line: Telephone Counseling for Adolescent Smokers

Gary J. Tedeschi, Shu-Hong Zhu, Christopher M. Anderson, Sharon Cummins, and Neil G. Ribner

Adolescent smokers need cessation help, but the question of how best to intervene remains unanswered. This article describes the empirically validated protocol of an established, well-utilized adolescent telephone counseling program for smoking cessation, tailored to adolescent developmental needs and shown to increase clients' 6-month prolonged abstinence rate significantly. Clinical issues addressed include client assessment, motivation, self-efficacy, familial and social support, planning, coping, relapse-sensitive call scheduling, and self-image. Counselor training considerations are also discussed.

Shortly after adolescents start smoking regularly, they express a desire to quit. Studies indicate that more than half of adolescent smokers make quit attempts each year (Centers for Disease Control and Prevention, 1998). Yet only 2% to 4% of adolescents annually succeed on their own (Paavola, Vartiainen, & Puska, 2001; Stanton, McClelland, Elwood, Ferry, & Silva, 1996; Zhu, Sun, Billings, Choi, & Malarcher, 1999). Clearly, adolescents need help with quitting. However, when they enter counseling for smoking cessation, it is still unclear how best to intervene (Curry, 2003; Mermelstein, 2003). Published literature on adolescent cessation seldom provides sufficient detail on the content of counseling to allow clinicians to learn from one another or to allow researchers to assess reasons for the success or failure of interventions (McDonald, Colwell, Backinger, Husten, & Maule, 2003). The present article is one attempt to address this need. We document in detail an intervention protocol used in a large, statewide telephone program for teen smokers (Zhu, 2003).

Since 1992, when California established the first statewide telephone "quitline," this form of cessation assistance has become increasingly popular (Bailey, 2003; Stead, Lancaster, & Perera, 2003; Zhu et al., 2002). Statewide quitlines for adult smokers are currently operating in 40 states. Adolescent smokers, too, find telephone counseling attractive, as evidenced by their call rate. For example, the number of teens calling California's statewide quitline (the California Smokers' Helpline) increased from 200 in 1996 to 1,033 in 2002, even though program advertising targeted adults (Zhu, Cummins, Mills, Muesse, & Roeseler, 2005).

Five characteristics of telephone counseling for smoking cessation (Zhu, Tedeschi, Anderson, & Pierce, 1996) ensure broad appeal and suitability for adolescents. Telephone counseling is easy to access, requiring no transportation and reducing scheduling difficulties associated with traditional group programs. Telephone counseling is also semi-anonymous. Teen clients often share concerns more readily during a telephone session than in a face-to-face interview. Telephone counseling is delivered on an individual basis: Counselors can adjust to each client's readiness to take action, capitalizing on client motivation and skill level. The telephone format facilitates proactive counseling. After a teen makes the first call for service, a counselor can initiate all subsequent contact, thus creating a therapeutic level of social support and keeping the teen accountable during the quitting process. Finally, the telephone format permits use of a structured protocol. This gives counselors a written framework that ensures coverage of important topics while tailoring each session to the individual, resulting in an intervention that is brief, focused, and personalized.

In the present article we discuss an adolescent counseling intervention used by the California Smokers' Helpline and tested in one of the largest randomized trials to date. In this study, more than 1,400 teen clients were randomly assigned to an intervention group or a control group. Participants in the intervention group received telephone counseling in addition to written cessation materials, whereas participants in the control group received written cessation materials only. Preliminary analysis revealed that significantly more clients in the telephone counseling group than in the control group quit and remained abstinent for 6 months (Zhu, 2003). The results of this study show that the counseling protocol increased the 6-month prolonged abstinence rate for teens. This

Gary J. Tedeschi, Shu-Hong Zhu, Christopher M. Anderson, Sharon Cummins, Department of Family and Preventive Medicine, University of California, San Diego; **Neil G. Ribner,** California School of Professional Psychology, Alliant International University. This work was supported by the National Cancer Institute (Grant 5 PO1-CA72092) and by the California Department of Health Services, Tobacco Tax Health Protection Act of 1988, Proposition 99 (Grant 96-27049). Many contributed to the development of the protocol presented. The authors acknowledge the California Smokers' Helpline staff members, in particular, Janet Baldwin, Michael Byrd, Sean Elliott, Patricia Harris, Kendal Manning, Laura Muesse, and Denise Scott. Correspondence concerning this article should be addressed to Shu-Hong Zhu, University of California, San Diego, Mail Code 0905, 9500 Gilman Drive, La Jolla, CA 92093-0905 (e-mail: szhu@ucsd.edu).

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is a notable result given the challenging task of helping teens quit smoking and the shortage of rigorously tested interventions that have yielded statistically significant effects (McDonald et al., 2003; Mermelstein, 2003). The present article addresses our approach to adolescent cessation counseling, providing an overview of the theoretical constructs that underlie the protocol; a detailed description of the protocol itself, with special attention to developmental issues that shape the counseling intervention; and a discussion of counselor training for protocol implementation.

The Counseling Protocol

Theoretical Constructs

Three tenets about smoking behavior underlie this adolescent protocol. First, smoking is a learned behavior that can be unlearned. Second, smokers must have sufficient motivation to change and must take an active role, committing to behavior change strategies. Third, counseling can help adolescent smokers quit, whether through specific components, such as restructuring perceptions about smoking or developing concrete plans for quitting, or through nonspecific components, such as increased support and accountability (Zhu, Tedeschi, et al., 1996).

One specific component that Helpline counselors endeavor to work into their counseling is to help adolescents view quitting, rather than smoking, as adult behavior. Adolescence is a time of striving toward maturity, attempting to shape an emerging identity. Teens seek out behaviors that they associate with adulthood; smoking is one example (Moolchan, Ernst, & Henningfield, 2000; U.S. Department of Health and Human Services, 1994). The counseling protocol leverages adolescents' developmental process by framing quitting, rather than smoking, as the adult thing to do.

Counselors follow principles from motivational interviewing (Miller & Rollnick, 2002) to enhance motivation to change and from cognitive-behavioral therapy (Beck, Wright, Newman, & Liese, 1993) to help adolescents restructure their thinking about quitting and devise strategies to combat temptations to smoke. These approaches are well suited to teens, whose thinking is relatively malleable and for whom taking on new behaviors is the norm.

Adolescent smokers are not entirely similar to adult smokers (Singleton & Pope, 2000). Although adolescents dependent on nicotine experience the same withdrawal symptoms as adults (Colby, Tiffany, Shiffman, & Niaura, 2000a; Prokhorov et al., 2001), adolescents are in general more dependent on family, limited in life experience and maturity, strongly influenced by peers, and fluid in identity. Each of these areas presents opportunities as well as challenges for the counselor and requires special consideration in a cessation protocol for teens. Thus, we considered several key questions when devising our adolescent intervention.

Key Questions

Who is best suited to work with adolescent smokers? Popular belief holds that the best person to help a teen is another teen and that adolescents are averse to talking with adults. Although there is some support for adolescent peer counseling as a viable approach to health promotion and behavior change (Covert & Wanberg, 1992; Erhard, 1997; Mellanby, Rees, & Tripp, 2000; Sussman, Lichtman, Ritt, & Pallonen, 1999), no studies show peer counselors to be more effective than adult counselors at helping adolescents quit smoking (Erhard, 1999; Gerber & Terry-Day, 1999; Lindsey, 1997; McDonald et al., 2003; Mermelstein, 2003; Prince, 1995; Skara & Sussman, 2003). In our experience, a counselor's age is less important than skill and enthusiasm.

How involved should parents be, if at all? Despite the importance of the peer group, parents' attitudes play a substantial role in adolescent smoking (Chassin, Presson, Rose, Sherman, & Prost, 2002; O'Byrne, Haddock, & Poston, 2002; Sargent & Dalton, 2001). To engage with parents or guardians, Helpline counselors obtain consent before counseling clients under the age of 18. Far from objecting to having their parents contacted, most teens (88%) are surprisingly willing (Zhu et al., 2005). Some have even used this forum to let their parents know that they smoke. When counselors talk with a parent, the adolescent's degree of accountability to make a quit attempt increases. Parental contact also allows counselors to intervene briefly on behalf of the teen, maximizing parental support and minimizing potential sabotaging (e.g., nagging, smoking in front of the teen). If, as is often the case, the parent smokes, contact provides the added benefit of conveying implicitly that the Helpline is available to the parent for cessation assistance. This benefit gains significance in light of data from intergenerational studies showing that parental (especially maternal) smoking cessation lowers adolescents' likelihood of continuing to smoke (e.g., Chassin et al., 2002).

What keeps adolescents interested in talking? Adolescents are often more impulsive than adults in their approach to life in general and to quitting smoking in particular. Rigid adherence to a protocol with standardized questions can make them impatient. Helpline counselors, instead, use a structured but flexible protocol that specifies topics to be covered but leaves the order and emphasis to the counselor's discretion. Counselors may move beyond protocol topics to discuss topics of interest for the teen, such as music, video games, movies, or sports. This flexibility enhances responsiveness to the client and results in greater connection, increasing the likelihood that the adolescent will want to talk further with the counselor.

How directive should counselors be? Helpline counselors take into account adolescents' sometimes conflicting developmental needs. On one hand, if teens believe that they are controlling their treatment and that their input is

important, they are more likely to try new behaviors and to be available for future counseling sessions (Lawendowski, 1998). In light of this, Helpline counselors build the relationship by allowing teens plenty of room to try things their own way and to make their own choices. On the other hand, because most adolescents lack life experience, counselors must know when to offer expertise. Counselors can, in fact, lose credibility if they fail to provide adequate structure. For example, given the choice, many adolescents will not set a quit date. Giving them full control of this decision leads to a protracted quitting process that yields little change. Yet if counselors adopt a highly directive style, essentially taking over, adolescents lose their investment in the process. Teens are quick to rebel against explicit direction with no room for input. Helpline counselors steer a middle course by discussing options for a quit date. They give adolescents the choice of how to get there and what date to choose but direct the adolescents to set a date. The challenge for counselors is to strike a balance between empowering adolescent clients to take charge of their quitting and holding them accountable for taking action.

How necessary is planning? Planning is important for preventing relapse (Zhu, Tedeschi, et al., 1996), making it an essential element in the counseling protocol for teens, who are generally less inclined to plan courses of action. Teens may spontaneously go without cigarettes, for example, when they temporarily run out of money, but they seldom approach quit attempts systematically. Some even harbor a false notion that quitting is easy and they can put down their cigarettes whenever they want (Leventhal, Glynn, & Fleming, 1987). The counseling protocol, therefore, reminds counselors to guide teens in building solid plans before quitting and to help them evaluate their plans during the quitting process.

How motivational are health issues? The conventional wisdom has been that health concerns do not motivate adolescents. Adolescents do tend to feel invulnerable to danger, including the dangers of smoking (Milam, Sussman, Ritt-Olson, & Dent, 2000; Romer & Jamieson, 2001). However, counselors find that if a teen is already having negative health effects or seeing a friend or loved one suffer from a smoking-related illness, this more immediate experience can spark a quit attempt. In fact, a number of our teen clients identify their health issues as serious concerns and motivators. These issues include respiratory problems (e.g., asthma, chronic bronchitis), vanity-related hygiene issues (e.g., bad breath, stained teeth, clothing odor, threat of premature wrinkling), and sports performance issues (e.g., shortness of breath, lack of endurance).

Guided by the aforementioned theoretical constructs and key considerations, by the relevant research literature, and by our clinical experience with pilot studies of adolescent smokers, we developed a counseling protocol to test in a randomized trial (Zhu, 2003). The protocol includes one comprehensive counseling session to prepare the client for quitting and multiple follow-up calls to assess client progress and to refine (or, if necessary, reestablish) the quitting plan to prevent relapse. However, before counseling, there is an initial contact that establishes the relationship between the adolescent and the Helpline.

Initial Contact

When adolescents first call the Helpline, intake staff follow a written protocol to conduct a 7–10 minute interview gathering information on demographics, smoking behavior, quitting history, environmental challenges to quitting, and attitudes such as confidence and readiness to quit. Interest in counseling is assessed at this stage, and those who are not interested receive only self-help materials (which those in counseling also receive).

Counselors next obtain parental consent for minors. During this procedure, counselors provide parents with an overview of the program and with a brief psychoeducational intervention. Counselors encourage parents to (a) ask what support the teen wants, (b) provide a smoke-free environment, (c) provide healthy substitutes for cigarettes, (d) allow for bad moods, (e) support teens by recognizing their efforts, (f) understand that teens may experience withdrawal symptoms, and (g) keep in mind that relapse is common. This approach is consistent with long-term study results suggesting that parental support of cessation increases adolescents' chances of successful quitting (Chassin et al., 2002).

Once parental consent is obtained, the counseling can begin. The counseling protocol provides a written framework for each session, and, within that framework, counselors tailor the discussion to the needs of the client.

The First Counseling Session

The first session covers (a) assent and assessment of client intentions, (b) current circumstances and smoking/quitting history, (c) self-efficacy, (d) enhancing motivation, (e) familial and social support, (f) identity issues, and (g) goal setting and planning.

Assent and assessment of client intentions. In the first few minutes of the call, the counselor reviews the basics of the program, the rights of the client, and confidentiality. Attention to these details is important, because adolescents are unlikely to have any expectations regarding the kind of help they might receive. Next, the counselor assesses the teen's intentions and asks how to be most helpful (e.g., plan for a quit date, plan for tapering). Responses to this set of questions guide the counselor's choice of topics to emphasize throughout the rest of the call.

Current circumstances and smoking/quitting history. The counselor assesses the adolescent's level of nicotine dependence (e.g., how soon after waking the adolescent lights up, number of cigarettes per day; Colby, Tiffany, Shiffman, & Niaura, 2000b) and differences in weekday and weekend

smoking, which may be pronounced for teens attending weekend parties or working during weekends. The counselor then asks about other forms of tobacco use (bidis [i.e., imported cigarettes with high-tar tobacco and sweet flavorings], cloves [i.e., imported cigarettes with poor quality tobacco and shredded cloves], pipes, cigars, and chew), the teen's smoking history (some teen callers are still in the uptake phase), and previous attempts to quit. When teen clients say they have "tried to quit," they are not always referring to an intentional act. For example, a teen who ran out of cigarettes for several days or was hospitalized might say that he or she quit for that period of time, yet such episodes do not necessarily increase ability to cope with urges to smoke as true quit attempts do. Even if previous quit attempts were intentional, adolescents seldom review them to learn from them. Counseling provides a structure for slowing down the quitting process and examining elements that foster success. Reviewing prior quitting experiences facilitates analysis of what worked or didn't work and what needs to be planned for the current attempt.

Self-efficacy. Self-efficacy plays a critical role in behavior change, according to social learning theory (Bandura, 1997). Smoking cessation literature confirms the importance of self-efficacy (Baer & Lichtenstein, 1988). An analysis of a national sample of adolescent smokers in the United States found that adolescents' self-estimation of whether they will be smoking a year from the time of the survey significantly predicts future quitting (Zhu et al., 1999). This correlation does not mean that teens' self-estimation is completely accurate, but it does suggest that they possess self-knowledge that is meaningful for future quit attempts. Counselors address self-efficacy by first asking adolescents to rate their confidence level and then facilitating discussion of their ability to make the change. Overinflated confidence can lead adolescents to plan inadequately, underestimating their need for a structured approach to the challenges of quitting (Hines, 1996; Stanton, Lowe, & Gillespie, 1996), whereas insufficient confidence leaves them unlikely to make a quit attempt. Counselors help teens identify the challenges they may face and help build confidence for dealing with these challenges.

Enhancing motivation. Motivation is a key to changing smoking behavior in adolescents (Colby et al., 1998; Lawendowski, 1998; Sherman, Rose, & Koch, 2003). The counselor spends much of the first call addressing the teen's reasons for quitting, to clarify or bolster motivation. Motivational interviewing strategies (Miller & Rollnick, 2002), such as listing the pros and cons of quitting, help to highlight ambivalence that adolescents may feel. Counselors ask evocative questions such as, "What might you miss about smoking?" and "How do you think things will be better after you quit?" Acknowledging both the positive and the negative aspects of smoking helps not only to accentuate motivation to quit but also to build counselor credibility: The counselor is not just another lecturer on the evils of smoking. In addition, addressing the positive aspects of smoking helps identify potential triggers to be incorporated into a quitting plan later in the call.

Given adolescents' developmental drive toward autonomy, counselors also explore the topic of control as a motivator. They ask, "Do you feel that cigarettes control your life in any way?" Often teens haven't considered that cigarettes could be controlling them. They want to believe that they control their own lives (Nichter, Nichter, Vuckovic, Quintero, & Ritenbaugh, 1997; Williams, Cox, Kouides, & Deci, 1999). Admitting that cigarettes have power over them can be so distasteful to teens that it can deepen their motivation to quit.

Adolescents may or may not report health concerns as a motivation. If adolescents don't initiate the topic, counselors do. Counselors increase the salience of long-term risks by tying them to people teens know and care about, such as parents or grandparents. Counselors also ask about immediate health consequences that may be more tangible to a young person, such as shortness of breath, asthma, or bronchitis. These discussions make both long-term and immediate health risks more real without lecturing.

Familial and social support. Counselors must understand adolescents' familial and social environment. The counselor tries to determine who is influential in the teen's life and to assess the support the teen anticipates. Most adolescents are legally, financially, and emotionally dependent on their families. This dependence can increase an adolescent's vulnerability during a quit attempt. Parents may smoke, refuse to create a smoke-free home, or otherwise undermine the teen's confidence in quitting. However, this dependence does provide a unique opportunity. As noted earlier, the process of gaining parental consent enables counselors to educate parents and guardians about how to help.

Usually, adolescents who smoke have friends who smoke (Chassin, Presson, Pitts, & Sherman, 2000). Many adolescents find it difficult to abstain around peers who smoke. Helpline counselors address this issue in several ways. First, they help teen clients identify nonsmoking peers who can provide support. In addition, because most teens choose not to avoid their smoker friends while quitting, counselors ask, "What might make it hard for you to say no to smoking when you're around your friends?" They discuss refusal skills to help adolescents cope with these challenges (Leventhal, Keeshan, Baker, & Wetter, 1991). Because direct refusal may fail, counselors may engage teens in role-playing to practice assertive yet nonalienating responses such as "Please don't give me any." Counselors also suggest responses for times when adolescents feel less assertive, such as "I just brushed my teeth," "I have a sore throat," or "My mom will smell it on me and ground me." Equipped with varied strategies, teen clients can refrain from smoking and still feel part of the group. Counselors also suggest that teens watch and learn from what nonsmokers do in these social situations.

Identity issues. Adolescents are still developing a sense of who they are and who they will become, and their identity is

more fluid than it will be later in life. Counselors encourage adolescents to assess how smoking fits with their image of themselves and their future. These discussions alert young smokers to discrepancies between what they envision for their future and the reality of a future that includes smoking.

One consequence of the incompletely formed identity is that adolescents have a desire to imitate or engage in adult behavior. This compelling desire is one of the primary reasons young people begin smoking. Helpline counselors capitalize on this desire. Without being parental or condescending, they communicate that quitting smoking is synonymous with maturity. They further incorporate identity development into counseling by making teens aware of the uptake, smoking, and quitting process for smokers. Counselors point out that teens who are quitting are much further along in the process than many adults, reinforcing the idea that these teens are mature for their age, doing something that their peers have not seriously considered and that even many adults have not attempted yet.

Goal setting and planning. The goal-setting and planning segment of the call proceeds in one of two directions. If an adolescent client is not ready to set a quit date, the counselor discusses other options for behavioral change (e.g., tapering) en route to quitting completely. If the client wants to set a quit date, the counselor guides him or her through a comprehensive plan, identifying potential triggers to their smoking and formulating a range of coping strategies for each.

Clients not ready to quit. The idea of giving up cigarettes completely soon after the initial call is unattractive to many adolescents. Teens are likely to call on impulse, not having planned to quit. Rather than asking adolescent clients to call back when they are ready to quit, counselors explore with them other options conducive to eventual cessation and set mutually agreed upon goals. Counselors ask, "What changes would you like to see over the next few weeks?" and "What do you think would be the next step?" While the teen can choose any number of tapering strategies (e.g., brand switching, smoking half a cigarette, banning cigarettes from the car and home), counselors encourage a scheduled reduction plan (e.g., Cinciripini, Wetter, & McClure, 1997). They guide adolescent clients toward setting goals for reducing their smoking over a set period, not by cutting out random cigarettes but by gradually smoking fewer cigarettes at predetermined, equal intervals (e.g., every 2 hours). This allows teen clients to experience some control over their smoking rather than responding only to cravings or other common triggers. Counselors call teen clients back to assess behavioral changes and to set additional goals for tapering or for quitting completely.

Clients ready to quit. The protocol calls for counselors to work extensively with adolescents on planning. To start them thinking of specifics, counselors begin by asking, "When you quit, what will be the most difficult situations in which you will need to overcome the urge to smoke?" Client and counselor try to identify all possible barriers to quitting. Then the counselor guides the teen in devising personalized strategies to cover each situation.

One of the most common triggers that adolescents identify is stress. Cigarettes often help regulate mood, and smoking is frequently a stress management strategy for adolescents (Koval, Pederson, Mills, McGrady, & Carvajal, 2000; Weinrich et al., 1996). Rather than accept the general term *stress*, counselors ask for specifics. Is it school pressure? Is it difficulties with a boyfriend or girlfriend? Does the adolescent use *stressed* to mean "depressed" (Patton et al., 1996)? A mutual understanding of the exact nature of each trigger allows planning of specific, effective strategies.

Although counselors encourage adolescent clients to devise their own strategies, counselors also provide examples of cognitive and behavioral strategies. Cognitive strategies might include recalling one's reasons for quitting, thinking positively about one's ability to change, visualizing successful handling of cravings, and turning toward a spiritual source for strength. Behavioral strategies might include changing one's routine (e.g., showering rather than smoking before breakfast, doing homework in a different room), using relaxation methods (e.g., deep breathing, journaling, meditation), keeping busy (e.g., listening to music, playing video games, calling a friend, exercising), and using substitutes (e.g., gum, suckers, healthy snacks). Either type of strategy (cognitive or behavioral) increases the probability of continued abstinence. Being prepared with both types gives adolescents the broadest base for coping with urges to smoke (Pallonen, 1998).

Relapse Prevention Follow-Up Calls

For follow-up sessions, counselors use a written framework that covers (a) assessing client progress and normalizing withdrawal symptoms; (b) evaluating coping strategies; (c) examining slips and relapses; (d) reviewing support, self-efficacy, and motivation; (e) developing the nonsmoker self-image; and (f) revising plans as needed.

Relapse sensitive scheduling. The purpose of follow-up counseling calls is relapse prevention. The probability of relapse is greatest during the first 2 weeks, so counselors front-load the scheduling of follow-up calls, calling clients within 24 hours of the quit day and again at 3 days, 1 week, and 2 weeks (Zhu, Stretch, et al., 1996). Calls occur further apart as the client's need for contact with a counselor decreases, with the final call 1 month after the client's quit date.

Nonattempts. Often, teens who agree to cut down their cigarette intake or who set a quit date have made no change at all by the time of the first follow-up call. A number of things may have affected them, including unexpected life circumstances (e.g., relationship breakup, bad grades, a fight at school) or a decrease in motivation or self-efficacy. Counselors try to determine what factors contributed to the nonattempts and discuss the possibility of reestablishing a

plan. Counselors continue to call teen clients who recommit to a plan and who demonstrate behavioral changes conducive to quitting. However, if teen clients show no movement toward change after three calls, counselors shift the responsibility to the teens and ask them to call back when they are ready to start the program again.

Assessing progress. For adolescents who planned to taper down, counselors use the follow-up calls to assess progress. The goal for these adolescents is to continue to change their smoking pattern until they reach a quit date. Counselors assess challenges that have come up, determine how the tapering plan is working, make adjustments as needed, and work toward having clients commit to a quit date. Many teens are content with cutting down their cigarette intake, so counselors continually address the issues of motivation and willingness to make changes. If a teen is satisfied with staying at a lower level of smoking, counselors congratulate him or her for the changes already made but also discuss the challenge of staying at the lower level. Counselors mention that many low-level smokers gradually and unconsciously increase their use. Awareness of this fact motivates some teens to stay at low levels (to prove the prediction wrong) and makes it less likely that those who do increase their use will do so unconsciously. If, after further assessment and discussion of motivation, the teen is still uninterested in quitting completely, the counselor invites him or her to call back when ready to make further steps forward.

For adolescents who set a quit date without tapering, follow-up calls follow the relapse-sensitive schedule. Follow-up calls often begin with questions to determine how the client is doing and to assess his or her smoking status. Counselors also ask about withdrawal symptoms and help to normalize them by educating the adolescent about the physical and emotional changes people experience after quitting.

Effectiveness of coping strategies. If adolescent clients have made any effort toward quitting, they will have successfully handled at least some challenges. Counselors ask them to recall the times when they were most tempted to smoke and to share strategies they used to successfully manage the situations. This discussion provides an opportunity for counselors to boost adolescent clients' self-efficacy, reinforce effective strategies, and open a discussion of slips and relapses if clients have smoked at all since quitting.

Slips and relapses. When adolescent clients slip or relapse, counselors determine how the clients are interpreting the event. Adolescents who take a negative view of themselves or of their ability due to the slip or relapse will be less inclined to maintain abstinence or to quit again (Bandura, 1997). Counselors use the topic of slips and relapses as a way to form teens' thinking about quitting. When a teen client slips and then gets back on track, the counselor reinforces the idea that the client had the internal wherewithal to push forward. Conversely, when a teen client relapses, the counselor helps him or her reframe this event as having more to do with factors like an inadequate plan than with an internal deficit. In either situation, positively reframing the smoking incident can bolster the teen's self-efficacy and increase the likelihood of sustained abstinence despite slips or of resumption of quitting behavior despite relapses.

Support, self-efficacy, and motivation. During follow-up calls, counselors revisit the topics of social support, self-efficacy, and motivation as they relate to teens' quitting plans. A supportive familial and social environment increases the odds of quitting (Chassin et al., 2000), but counselors are also aware that adolescents have less control of their family environment than adults and are susceptible to peer pressure. Moreover, some adolescents state that they do not need or want support from family or friends; they see quitting as solely their own responsibility. During these follow-up sessions, counselors explore the social support issue. If the client agrees to the benefits of social support, the counselor moves on to helping the client bolster his or her support base. This might involve the client's identifying a nonsmoking family member or friend to talk with when tempted to smoke.

Self-efficacy is another important topic for follow-up calls, because most adolescent clients have now made a quit attempt and have a better idea of what quitting involves. Counselors reassess adolescents' level of confidence and reinforce behaviors and attitudes that lead toward quitting or maintaining abstinence (e.g., reminding clients of their accomplishments) or try to bolster sagging confidence by discussing concrete coping strategies that can increase ability to deal with challenges.

Focusing too much on ability, though, can be counterproductive for adolescent clients. Many give up too soon because they think they lack the ability to quit. When counselors detect this attitude, they attempt to shift the teen's mental focus, communicating that this is a question not of ability (everyone has the ability to maintain abstinence) but rather of motivation. Motivation to stay off cigarettes can fluctuate dramatically for adolescents. Adults also experience shifts in motivation but can compensate more readily, offsetting ambivalence and maintaining abstinence by reminding themselves of their reasons to quit and of health risks that increase with age. Adolescents, on the other hand, can feel one way about quitting one moment and another way the next. Their ambivalence is complicated by common uptake pressure as well as by their often-reported lack of a sense of urgency. Counselors must adjust to adolescents' impulsiveness and changing priorities and to motivation levels that spike and dip. To address this, counselors ask questions such as, "Do you still think about why you quit?" "How strongly do you feel about staying quit?" "What do you miss about smoking?" and "What good things have you noticed since you quit smoking?" These establish a focus on commitment to quitting despite teens' natural fluctuations in motivation.

The nonsmoker self-image. For many adults who maintain abstinence, success is linked to a change in self-image. They shift from a view of themselves as smokers temporarily abstaining to a view of themselves as nonsmokers, no longer considering cigarettes an option (Zhu, Tedeschi, et al., 1996). By the time adults decide to quit, the smoker self-image is likely an unconscious part of their identity. For adolescents, however, the smoker self-image is much more conscious. For example, some teens report spending time in front of a mirror to practice different ways of holding a cigarette. Teens who have consciously made the smoker self-image part of their emerging identity are often less willing than adults might be to let go of this self-image. Their desire to maintain the self-image, together with pressure from smoking peers, poses a challenge to continued abstinence. To help teens face this challenge, counselors reinforce the idea, addressed in the initial call, of a new self-image. Counselors convey that the teen client is a young person on the cutting edge, tackling the difficult issue of smoking cessation. While counselors encourage teens in forming this new identity, they are careful to avoid casting them as antismoking vigilantes, a role that teen clients find offensive because it alienates peers who smoke.

Revising the plan. Follow-up calls often end with adjustment of and recommitment to the quitting plan. Counselors ask adolescents to identify challenging situations not addressed during the call but that might come up within the next few days or week. Then counselor and client work together at devising strategies.

Counselor Training Issues

Training and Supervision

Regardless of education and clinical experience, all Helpline counselors begin with thorough training in the adult telephone counseling protocol for smoking cessation. Counselors work with adults for approximately 4 months before expanding their work to include adolescents. Not all counselors are well suited to counsel adolescents or have the needed enthusiasm for the work. Counselors who do best with adolescent smokers are those who enjoy this clientele, develop rapport easily with young clients, implement the protocol with skill and creativity, and have a high tolerance for inconsistency in client behaviors. Before taking on an adolescent caseload, counselors participate in an orientation covering the background of the adolescent program, theoretical considerations for adolescent smoking cessation, and the adolescent counseling protocol itself.

Counselors on the adolescent project consult with a licensed psychologist experienced in telephone counseling for adolescent clients. The counselors also meet weekly in supervision groups to address client issues, topics relevant to smoking cessation, and other developments in the field. Periodically, with client consent, counselors record calls or participate in call monitoring sessions for supervisory purposes.

Ethical and Legal Considerations

Ethical and legal guidelines under which the Helpline functions include informed consent and confidentiality, scope of practice, crisis intervention, and clinical supervision (Zhu, Tedeschi, et al., 1996). In addition, as part of the protocol to include parents in adolescents' quitting process, our counselors obtain parental consent for service before adolescents receive any counseling. At the beginning of the first counseling session, counselors share with adolescent clients points about parental consent and about the limits of confidentiality (e.g., imminent risk to self or others or reasonable suspicion of child or elder abuse).

Another ethical consideration involves professional boundaries. Because counselors who fail to establish rapport are likely to find teens unavailable for follow-up calls, Helpline counselors address many topics of interest to teens (e.g., boyfriends and girlfriends, after-school activities, video games, music). As rapport increases, other counseling issues sometimes arise. Counselors must be vigilant about keeping the relationship boundaries clear. If necessary, even when counselors have expertise and experience counseling for other mental health issues, they reiterate to clients that smoking cessation is the limit of the counseling they can provide. Counselors continually assess client psychiatric health needs and the appropriateness of the counseling for smoking cessation. If a client is in crisis or in need of service beyond the scope of the program, counselors address the client's need for immediate help and then provide appropriate referrals once any immediate risk has been managed.

Conclusion

Adolescents need help to quit smoking, but little is known about how best to help them. Telephone counseling for smoking cessation has shown promise with adolescents (Hollis et al., 2002; Zhu, 2003). Telephone counseling is easy for adolescents to access, focuses on their individual needs, is semianonymous in nature, allows counselors to be proactive, and lends itself readily to the use of a structured counseling protocol. The teen protocol described in this article has its roots in an adult intervention but emphasizes adolescent developmental issues, such as identity formation, sense of invulnerability, need for accountability, dependence on family, identification with peers, inexperience with quitting, and desire for autonomy. The protocol advocates the idea that adolescents can be well served by adult, as opposed to peer, counselors and by the involvement of parents or guardians in the quitting process. This comprehensive approach for teen smoking cessation has implications for other teen behavior changes as well. Elements of this protocol may be transferable to other addictive behaviors, such as drug and alcohol dependency. The basic principles of addictive behavior change, such as focusing on self-efficacy, motivation, support, planning, and self-image, apply. As in the case

of smoking cessation, counselors can address these areas in combination with relevant developmental issues when treating other adolescent addictive behaviors.

References

Baer, J. A., & Lichtenstein, E. (1988). Cognitive assessment. In D. M. Donovan & G. A. Marlatt (Eds.), *Assessment of addictive behaviors* (pp. 189–213). New York: Guilford Press.

Bailey, L. (2003, February). *The alliance for tobacco cessation: Lessons learned about expanding coverage for evidence-based tobacco dependence treatment*. Paper presented at the ninth annual meeting of the Society for Research in Nicotine and Tobacco, New Orleans, LA.

Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: Freeman.

Beck, A. T., Wright, F., Newman, C. F., & Liese, B. (1993). *Cognitive therapy of substance abuse*. New York: Guilford Press.

Centers for Disease Control & Prevention. (1998). Selected cigarette smoking initiation and quitting behaviors among high-school students. *U.S. Morbidity and Mortality Weekly Report, 47*(19), 386–389.

Chassin, L., Presson, C. C., Pitts, S. C., & Sherman, S. J. (2000). The natural history of tobacco smoking from adolescence to adulthood in a midwestern community sample: Multiple trajectories and their psychosocial correlates. *Health Psychology, 19,* 223–231.

Chassin, L., Presson, C. C., Rose, J., Sherman, S. J., & Prost, J. (2002). Parental smoking cessation and adolescent smoking. *Journal of Pediatric Psychology, 27,* 485–496.

Cinciripini, P. M., Wetter, D. W., & McClure, J. B. (1997). Scheduled reduced smoking: Effects on smoking abstinence and potential mechanisms of action. *Addictive Behaviors, 22,* 759–767.

Colby, S. M., Monti, P. M., Barnett, N. P., Rohsenow, D. J., Weissman, K., Spirito, A., et al. (1998). Brief motivational interviewing in a hospital setting for adolescent smoking: A preliminary study. *Journal of Consulting and Clinical Psychology, 66,* 574–578.

Colby, S. M., Tiffany, S. T., Shiffman, S., & Niaura, R. S. (2000a). Are adolescent smokers dependent on nicotine? A review of the evidence. *Drug and Alcohol Dependence, 59,* S83–S95.

Colby, S. M., Tiffany, S. T., Shiffman, S., & Niaura, R. S. (2000b). Measuring nicotine dependence among youth: A review of available approaches and instruments. *Drug and Alcohol Dependence, 59,* S23–S39.

Covert, J., & Wanberg, D. (1992). Peer counseling: Positive peer pressure. In G. W. Lawson & A. W. Lawson (Eds.), *Adolescent substance abuse: Etiology, treatment, and prevention*. Gaithersburg, MD: Aspen.

Curry, S. J. (Ed.). (2003). Youth and tobacco cessation [Special issue]. *American Journal of Health Behavior, 27*(Suppl 2).

Erhard, R. (1997). Adolescent peer facilitators—myth and reality. *International Journal for the Advancement of Counseling, 21,* 97–109.

Erhard, R. (1999). Peer-led and adult-led programs: Student perceptions. *Journal of Drug Education, 29,* 295–308.

Gerber, S., & Terry-Day, B. (1999). Does peer mediation really work*? Professional School Counseling, 2,* 169–171.

Hines, D. (1996). Young smokers' attitudes about methods for quitting smoking: Barriers and benefits to using assisted methods. *Addictive Behaviors, 21,* 531–535.

Hollis, J., Polen, M., Whitlock, E., Velicer, W., Redding, C., & Lichtenstein, E. (2002, June). *Efficacy of a brief tobacco prevention and cessation program for teens seen in routine medical care (Teen REACH)*. Paper presented at the National Cancer Institute Youth Tobacco Research Meeting, Palm Harbor, FL.

Koval, J. J., Pederson, L. L., Mills, C. A., McGrady, G. A., & Carvajal, S. C. (2000). Models of the relationship of stress, depression, and other psychosocial factors to smoking behavior: A comparison of a cohort of students in Grades 6 and 8. *Preventive Medicine, 30,* 463–477.

Lawendowski, L. A. (1998). A motivational intervention for adolescent smokers. *Preventive Medicine, 27,* A39–A46.

Leventhal, H., Glynn, K., & Fleming, R. (1987). Is the smoking decision an informed choice? Effect of smoking risk factors on smoking beliefs. *Journal of the American Medical Association, 257,* 3373–3376.

Leventhal, H., Keeshan, P., Baker, T., & Wetter, D. (1991). Smoking prevention: Towards a process approach. *British Journal of Adolescence, 86,* 583–587.

Lindsey, B. (1997). Peer education: A viewpoint and critique. *Journal of American College Health, 45,* 187–189.

McDonald, P., Colwell, B., Backinger, C. L., Husten, C., & Maule, C. O. (2003). Better practices for youth tobacco cessation: Evidence of review panel. *American Journal of Health Behavior, 27*(Suppl. 2), S170–S184.

Mellanby, A. R., Rees, J. B., & Tripp, J. H. (2000). Peer-led and adult-led school health education: A critical review of available comparative research. *Health Education Research, 15,* 533–545.

Mermelstein, R. (2003). Teen smoking cessation. *Tobacco Control, 12*(Suppl. 1), I25–I34.

Milam, J., Sussman, S., Ritt-Olson, A., & Dent, C. (2000). Perceived invulnerability and cigarette smoking among adolescents. *Addictive Behaviors, 25,* 71–80.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people to change addictive behavior* (2nd ed.). New York: Guilford Press.

Moolchan, E. T., Ernst, M., & Henningfield, J. E. (2000). A review of tobacco smoking in adolescents: Treatment implications. *Journal of the American Academy of Child and Adolescent Psychiatry, 39,* 692–693.

Nichter, M., Nichter, M., Vuckovic, N., Quintero, G., & Ritenbaugh, C. (1997). Smoking experimentation and initiation among adolescent girls: Qualitative and quantitative findings. *Tobacco Control, 6,* 285–295.

O'Byrne, K. K., Haddock, C. K., & Poston, W. S. (2002). Parenting style and adolescent smoking. *Journal of Adolescent Health, 30,* 418–425.

Paavola, M., Vartiainen, E., & Puska, P. (2001). Smoking cessation between teenage years and adulthood. *Health Education Research, 16*(1), 49–57.

Pallonen, U. E. (1998). Transtheoretical measures for adolescent and adult smokers: Similarities and differences. *Preventive Medicine, 27,* A29–A38.

Patton, G. C., Hibbert, M., Rosier, M. J., Carlin, J. B., Caust, J., & Bowes, G. (1996). Is smoking associated with depression and anxiety in teenagers? *American Journal of Public Health, 86,* 225–230.

Prince, F. (1995). The relative effectiveness of a peer-led and adult-led smoking intervention program. *Adolescence, 30,* 187–194.

Prokhorov, A. V., Hudmon, K. S., de Moor, C. A., Kelder, S. H., Conroy, J. L., & Ordway, N. (2001). Nicotine dependence, withdrawal symptoms, and adolescents' readiness to quit smoking. *Nicotine & Tobacco Research, 3,* 151–155.

Romer, D., & Jamieson, P. (2001). Do adolescents appreciate the risks of smoking? Evidence from a national survey. *Journal of Adolescent Health, 29,* 12–21.

Sargent, J. D., & Dalton, M. (2001). Does parental disapproval of smoking prevent adolescents from becoming established smokers? *Pediatrics, 108,* 1256–1262.

Sherman, S. J., Rose, J. S., & Koch, K. (2003). Implicit and explicit attitudes toward cigarette smoking: The effects of context and motivation. *Journal of Social and Clinical Psychology, 22,* 13–39.

Singleton, M. G., & Pope, M. (2000). A comparison of successful smoking cessation interventions for adults and adolescents. *Journal of Counseling & Development, 78,* 448–453.

Skara, S., & Sussman, S. (2003). A review of 25 long-term adolescent tobacco and other drug use prevention program evaluations. *Preventive Medicine, 37,* 451–474.

Stanton, W. R., Lowe, J. B., & Gillespie, A. M. (1996). Adolescents' experiences of smoking cessation. *Drug and Alcohol Dependence, 43,* 63–70.

Stanton, W. R., McClelland, M., Elwood, C., Ferry, D., & Silva, P. A. (1996). Prevalence, reliability and bias of adolescents' reports of smoking and quitting. *Addiction, 91,* 1705–1714.

Stead, L. F., Lancaster, T., & Perera, R. (2003). Telephone counselling for smoking cessation. *Cochrane Review*. Retrieved April 1, 2004, from http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD002850/frame.html

Sussman, S., Lichtman, K., Ritt, A., & Pallonen, U. (1999). Effects of thirty-four adolescent tobacco use cessation and prevention trials on regular users of tobacco products. *Substance Use and Misuse, 34,* 1469–1503.

U.S. Department of Health and Human Services. (1994). *Preventing tobacco use among young people: A report of the Surgeon General*. Atlanta, GA: USDHHS, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

Weinrich, S., Hardin, S., Valois, R. F., Gleaton, J., Weinrich, M., & Garrison, C. Z. (1996). Psychological correlates of adolescent smoking in response to stress. *American Journal of Health Behavior, 20,* 52–60.

Williams, G. C., Cox, E. M., Kouides, R., & Deci, E. L. (1999). Presenting the facts about smoking to adolescents: Effects of an autonomy-supportive style. *Archives of Pediatric and Adolescent Medicine, 153,* 959–964.

Zhu, S.-H. (2003, June). *A quitline for teen smokers*. Paper presented at the conference of the National Cancer Institute, Tobacco Control Research Branch, Youth Tobacco Use meeting, Washington, DC.

Zhu, S.-H., Anderson, C. M., Tedeschi, G. J., Rosbrook, B., Johnson, C. E., Byrd, M., et al. (2002). Evidence of real-world effectiveness of a telephone quitline for smokers. *New England Journal of Medicine, 347,* 1087–1093.

Zhu, S.-H., Cummins, S., Mills, J., Muesse, L., & Roeseler, A. (2005). Participation of teen smokers in an established state quitline. Manuscript submitted for publication.

Zhu, S.-H., Stretch, V., Balabanis, M., Rosbrook, B., Sadler, G., & Pierce, J. P. (1996). Telephone counseling for smoking cessation: Effects of a single-session and multiple session intervention. *Journal of Consulting and Clinical Psychology, 64,* 202–211.

Zhu, S.-H., Sun, J., Billings, S. C., Choi, W. S., & Malarcher, A. (1999). Predictors of smoking cessation in U.S. adolescents. *American Journal of Preventive Medicine, 16,* 202–207.

Zhu, S.-H., Tedeschi, G. J., Anderson, C. M., & Pierce, J. P. (1996). Telephone counseling for smoking cessation: What's in a call? *Journal of Counseling & Development, 75,* 93–102.