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Addressing Nicotine Dependence in Psychodynamic Psychotherapy: Perspectives From Residency Training

Dr. Judith J. Prochaska, Ph.D., M.P.H.,

Department of Psychiatry, University of California, San Francisco, California

Dr. Sebastien C. Fromont, M.D.,

Department of Psychiatry, University of California, San Francisco, California. Alta Bates Summit Medical Center, Berkeley, California

Dr. Peter Banys, M.D.,

Department of Psychiatry, University of California, San Francisco, California. San Francisco Veterans Administration Medical Center, California

Dr. Stuart J. Eisendrath, M.D.,

Department of Psychiatry, University of California, San Francisco, California

Dr. Mardi J. Horowitz, M.D.,

Department of Psychiatry, University of California, San Francisco, California

Dr. Marc H. Jacobs, M.D., and

Department of Psychiatry, University of California, San Francisco, California

Dr. Sharon M. Hall, Ph.D.

Department of Psychiatry, University of California, San Francisco, California

Abstract

Objective—According to APA treatment recommendations, psychiatrists should assess and intervene in tobacco use with all of their patients who smoke. The ease with which this occurs may vary by treatment model. This study examined perspectives in residency training to identify a framework for addressing nicotine dependence within psychodynamic psychotherapy.

Method—The authors collected data from a focus group of psychiatry residents and interviews with psychiatry residency faculty with expertise in psychodynamic psychotherapy. The transcribed interviews were analyzed for key themes and synthesized.

Results—Though the residents reported hesitancy to address patients' tobacco use, specifically in psychodynamic psychotherapy, the consensus from the expert faculty consultants was that tobacco interventions can and should be incorporated. The faculty provided suggestions, consistent with a psychodynamic formulation, for assessing patients' tobacco use and their interest in quitting, providing cessation treatment and/or referrals, and following up with patients to address relapse.

Conclusions—The findings provide a useful framework, consistent with a psychodynamic model, for assessing and treating tobacco use with patients. Additional training and supervision likely are needed to increase residents' confidence and comfort with implementing these strategies.

Nicotine dependence is the most prevalent substance abuse disorder among individuals with mental illness, with rates of tobacco use two to four times that in the general population (1, 2). Tobacco use adversely affects the quantity and quality of life for patients with mental illness (3, 4), is predictive of future suicidal behavior (5, 6), and can reduce the therapeutic blood levels of psychiatric medications (7). In terms of lives saved, quality of life, and cost-efficacy, treating smoking is considered one of the most important activities a clinician can do (8). Yet few psychiatrists in practice address patients' tobacco use (9, 10), and little training is provided for treating nicotine dependence in psychiatry residency programs (11).

The current study grew out of efforts to develop a tobacco cessation curriculum for psychiatry residency training. Cognitive behavior treatments (CBT) have been developed for smoking cessation, with particular efficacy demonstrated among smokers with a history of depression (12, 13). To be successfully adopted in psychiatric practice, however, tobacco treatments need to fold into different systems of psychotherapy. Though the Accreditation Council for Graduate Medical Education (ACGME) requires training in a variety of evidence-based psychotherapies (14), psychodynamic models predominate in U.S. psychiatry training (15) and only half of psychiatry residency programs require CBT (16). Given the established position of psychodynamic therapy in training and practice, it may be particularly important to consider how tobacco treatments may be delivered within this theoretical framework.

Early psychoanalytical perspectives interpreted smoking behavior as providing "oral erotic gratification" (17), and excessive smoking as part of the "oral personality" (18). A 1951 psychotherapy handbook encouraged smoking by patients and therapists in session "as a small pleasure ... to enjoy" (19). More contemporary psychodynamic views on drug abuse treatment emphasize attention to patient deficits in regulating affects and behavior but have not specifically discussed treatment of nicotine dependence (20).

In 1996, APA published clinical guidelines for treating nicotine dependence (21). Psychiatrists are recommended to "assess the smoking status of all their patients ... discuss interest in quitting ... [and provide] explicit advice to motivate the patient to stop smoking." For patients interested in quitting, the minimal initial treatment includes written materials, brief counseling, and a follow-up visit or call 1 to 3 days after the quit date. Cessation strategies, however, are not discussed with respect to integration within different systems of psychotherapy. The U.S. Preventive Health Services recommends pharmacotherapy, such as nicotine replacement and bupropion, for use with all smokers trying to quit, except in special circumstances (22). The National Cancer Institute provides five "As" as guidelines for clinician intervention: *Ask* about tobacco use, *Advise* smokers to quit, *Assess* readiness to quit, *Assist* in quit attempts, and *Arrange* for follow up (23). The extent to which these guidelines are consistent with delivery within a psychodynamic treatment model has not been explored.

The current investigation examined perspectives on addressing nicotine dependence in psychodynamically oriented treatments. Assessments included a focus group with psychiatry residents and expert interviews with residency faculty. This article summarizes these discussions and seeks to provide a framework for addressing patients' nicotine dependence within psychodynamic psychotherapy.

Method

Focus Group

A 2-hour focus group was held in June 2005 with four fourth-year psychiatry residents and one child psychiatry fellow from the University of California, San Francisco (UCSF). The participants were four women and one man. The 4-year UCSF psychiatry residency program trains up to 62 general psychiatry residents in clinical settings that include an academic-based psychiatric institute, a Veterans Administration (VA) Medical Center, and a county hospital. Training is provided by more than 150 full-time faculty and 600 volunteer clinical faculty drawn from the San Francisco psychiatry community.

Two of the authors (JJP and SCF) moderated the focus group discussion, which was audiotaped and transcribed for analysis. The discussion centered on attention to tobacco use in psychiatric practice, identification of tobacco treatment curriculum objectives, and considerations for residency training. All participants were active in providing feedback and received \$100 for their time. Focus group procedures were approved by the UCSF Institutional Review Board on human subjects.

Expert Faculty Interviews

Four UCSF faculty were identified who represented more than 100 years of training of residents and psychodynamically oriented clinical practice. Two were analysts, and all four had extensive experience training residents in psychodynamic psychotherapy. One-on-one structured interviews were held with each of the expert respondents during the fall of 2005. The interviews focused on potential strategies for addressing patients' tobacco use with a psychodynamic formulation and treatment approach. One of us (JJP) conducted and transcribed for analysis the 60-minute interviews.

Analyses

Two of us (JJP and SCF) analyzed the transcribed focus group and interviews for key themes and synthesized and organized the findings with respect to the National Cancer Institute's five "As" tobacco treatment framework (23). Issues relevant to clinical supervision also were identified and incorporated. The faculty respondents reviewed an initial draft of the manuscript and provided further clarification and consultation.

Addressing Tobacco Use in Psychodynamic Therapy

Focus Group Feedback

The residents acknowledged their role as psychiatrists in addressing patients' tobacco use, stating, "We are doctors. This is a very important health and societal issue. We have to take

responsibility and figure out how to do it and what's the best way to do it." Another resident added, "We see our patients a lot more than other medical providers do, and so we have the unique opportunity to impact that."

The residents' willingness to address tobacco, however, was restricted to medication management visits and CBT sessions. For psychodynamic therapy, the residents expressed concern that efforts to address tobacco might violate the therapeutic relationship: "I can see why some would be very reluctant to bring up [tobacco use] in dynamic cases. It definitely changes the relationship a lot."

To address their concerns, the residents expressed interest in learning tobacco treatment strategies consistent with a psychodynamic formulation. One resident stated, "I would love to hear how an analyst would talk about this." Another agreed, "If there's some sort of artful way of being taught how to introduce this, that would be very valuable." A third concurred, "The difficult part is knowing exactly how to say it."

Faculty Response

A seasoned residency psychotherapy supervisor, clinician, and addictions training program director identified the "ideological problem" as the fact that the residents are focused on "a caricature of psychodynamic therapy in which the psychoanalyst does not intrude, does not reveal, and does not tell people how to live. He just explores, explores, explores. It is a refuge for passivity ... it is the perfect place to hide when you do not know what to do. The residents are caught up in 'technique-ism.' They want to know, 'What do I do now ... what do I say next?' The question should be 'What's the task?' not 'What's the method?' The antidote is to think in terms of the task. If it is to explore the unconscious, then you use free association. But if it is to solve a problem, some are solved through advice and referrals. Always do what is best for the patient. Stopping smoking is certainly best for the patient."

Another faculty respondent explained, "The residents are struggling to gain mastery over different approaches and are artificially dichotomizing cognitive behavior and psychodynamic therapy." A third faculty member emphasized, "There needs to be a greater climate for integration. If the residents have too isolated a view of what psychotherapy is, they will miss this. You need to conceptualize smoking as a self-destructive behavior. Attention to substance abuse is part of psychotherapy and how we address self-defeating, self-destructive behaviors, examine resistance to change and support change, and then provide interventions to quit."

All four faculty members rejected the notion that adoption of a psychodynamic treatment model precludes attention to patients' tobacco use. Rather, they viewed attention to patients' tobacco use as part of attending to the larger issues with which a patient presents.

Assessing Patients' Tobacco Use

Focus Group Feedback

The residents reported assessing patients' tobacco use at the initial intake interview, but rarely reassessing it later in treatment. One resident noted, "At the VA, there are reminders

to do the tobacco cessation counseling. So, it is just another thing you go over with patients. In our last years of training, you get more focused on therapy, which clouds how we look at this.” The VA Health Care system has a national mandate that all patients be screened for tobacco use at intake and then reassessed at least once every 3 months with ongoing offers for cessation treatment. The residents reported asking about tobacco use when required but may stop doing so later on when it is no longer required nor rewarded.

Faculty Response

The faculty recommended that tobacco use be assessed with all patients early in treatment. “Tobacco use should be assessed at intake, along with everything else, any substances a person is taking.” Deciding how to prioritize tobacco treatments once it is determined the patient is a smoker may depend on the patient’s receptiveness as well as other presenting clinical issues. One faculty respondent suggested, “If you find out that they are smoking, think about coming back to it when the acute crisis has calmed down.” At the same time, a faculty respondent challenged the myth that stopping smoking is such a stressor that one must not undertake it if under stress or in recovery. “The data show that smoking cessation in early alcohol recovery, for example, does not lead to relapse or depression. There are techniques to make quitting comfortable—the nicotine replacement therapies.”

Advising Patients on the Health Risks of Smoking

Focus Group Feedback

In general medicine, a key aspect of tobacco cessation treatment involves educating patients on the negative health effects of smoking. U.S. treatment guidelines encourage delivery of “clear, strong, and personalized” advice on the importance of quitting smoking (22). Yet in psychotherapy, such directive advice may seem antithetical to the collaborative nature of the relationship. One resident reflected on her psychodynamic training and stated, “This model where you are not supposed to advise your patient—that you should listen but not necessarily recommend—advising patients to quit feels in some ways counter to what we’re taught.”

The residents acknowledged viewing tobacco use differently from other drugs of abuse, stating, “With drugs other than nicotine, you can play a more active role because you can take the stance of it interfering with therapy and that is not seen to be the case with nicotine.” The residents resisted the idea of providing written materials on the negative health effects of smoking to patients. Instead they suggested placing the materials in the waiting room, stating, “then it is not like you are imposing.”

Faculty Response

One of the faculty respondents explained, “The residents do not want to criticize their patients and the patients are expecting to be criticized. This needs to be done within the therapeutic alliance. Tell the patients why you are asking about their tobacco use. It may seem like criticism, but it is help. It is one thing to follow the medical model and tell them it is bad for you. They have heard this before. Instead, explore with the patient what the

obstacles are. Do they perceive this as bad advice? Are they feeling criticized? As the therapist, you are unpacking the issues. You challenge through interpretation.”

To increase the relevance of tobacco interventions, the faculty emphasized linking tobacco use to the presenting clinical issues as you would with any risky behavior. A faculty respondent explained, “Ideally, you would link it to the central pathology—‘When people are depressed they do not take very good care of themselves. I want to help you take as good care of yourself as possible.’”

A variety of materials have been developed to educate patients on the negative health effects of smoking. Faculty, however, also discouraged use of such props in psychotherapy. Instead, they suggested exploring why the patients have not accessed the information themselves. As one faculty member described, “I’d ask, ‘How come you are not getting information on the health effects of tobacco? You are on the Internet all the time. Why haven’t you explored this?’ Or I would tell them, ‘You are afraid ... afraid to see the truth about the risks. You try to cut down the fear by telling yourself that it does not apply to you. That is irrational.’” A collaborative approach for eliciting the patient’s personal limitations due to smoking also was described. For example, ask the patient, “How is it climbing stairs these days? Do you notice a difference? What do you think that is due to?”

Assessing Readiness to Quit

Focus Group Feedback

Though the residents reported asking most of their patients about tobacco, they reported rarely, if ever, going further to assess their patients’ readiness or resistance to quitting. As one resident explained, “Most of my patients did not want to quit. I ask and they say, ‘Well, no, not right now.’ And that is the end of it.”

Faculty Response

In assessing patients’ readiness to quit smoking, one faculty respondent recommended a combined directive-non-directive approach. He explained, “If the patient told me he was smoking, I would ask, ‘Is that something that you want help with in stopping?’ This uses a combined directive (I’m telling you I’m aware of your smoking) with a nondirective (asking if you are interested in quitting) approach. If the patient is not interested in quitting, this is worth an inquiry such as, ‘Given that tobacco use is not healthy, I am interested in why you are not interested in quitting.’ This would be an issue to explore ... that they are knowingly pursuing a self-destructive activity and do not want to stop. This is a common intervention in psychotherapy. The process would be to identify the resistance in treatment and the externalization of control.”

The faculty respondent also emphasized “the need to differentiate between wanting and being able to quit. Nicotine is addictive—there is a component that is less voluntary. If the patient wants to, but cannot, focus on the special help available through medications. If the patient says he needs to smoke to deal with psychiatric symptoms I would respond, ‘Wow, you must have a lot of stress and anxiety if you need to take a cancer-causing agent to deal with it. I think we really need to look at your level of stress. It should be a real priority.’”

Another faculty respondent stated, “I’m interested in knowing what it all means. I make a distinction between the addiction and the habit. The addiction is easy. We have nicotine replacement therapies that can help. The habit—whether tobacco is a comfort, a friend, something to have with coffee, after sex, when bored—that part is much more insidious, and we need to work on it. Psychodynamic treatment is well-designed to collaboratively study the emotional ways in which patients rely on cigarettes.”

Assisting Patients With Quitting and Arranging Follow-Up

Focus Group Feedback

In assisting patients with quitting smoking, the residents again expressed differences in receptiveness based upon the model of treatment being provided. When topics of quit dates and cessation plans were raised, the residents responded, “It is very CBT-ish. I can see that in the medication management clinic or CBT it would fit in, but not in psychodynamic [therapy].” Another resident raised the concern that “This is sort of blurring the boundaries. You are requiring them to do something for you outside of the office.” The residents seemed to be more comfortable with arranging referrals for tobacco treatment, stating, “Organizationally, you would have a system in place where we could refer people.”

Faculty Response

Working with patients interested in quitting smoking seemed far more straightforward for the faculty, although they varied in their perspectives on whether treatment should be integrated within ongoing care or referred out for treatment. One faculty respondent commented, “If the patient is interested and engaged, it is kind of bizarre to think that it could interfere with the alliance. Deciding to treat within the ongoing psychotherapy relationship works unless the patient wants the focus to remain on another issue.” Another faculty member stated, “While smoking may be easier to address in a specialized clinic, you can treat tobacco use within psychodynamic therapy. I would like to see the residents patching their patients. If the patient is doing well, it takes only a few minutes to check in. It does not derail psychotherapeutic work. I do it in my own independent practice.” A third faculty member commented, “If there is any place you can get a positive change, go for it. So, focus a few sessions on tobacco.”

The fourth faculty respondent provided an alternative perspective “to refer the patient who is interested in quitting to a trained colleague rather than treating within the current therapy relationship. The residents could cross-cover in this way. The purpose of the psychotherapy would be to address resistance to and garner interest in a referral for treatment. You do not want to add layers. Tobacco treatment would be its own treatment, so have it done by someone else, but with the issue raised by the psychotherapist. The residents are comfortable with that model for substance abuse treatment.”

A major concern with treating nicotine dependence, as with other substances of abuse, is relapse. Most individuals quit smoking multiple times before successfully achieving long-term abstinence (22), so it is an issue likely to be faced in therapy. One faculty respondent stated, “You handle relapse as you would address any shame or guilt issues. You normalize

it. It could tie into depressive cognitions and the stages of change cycle. You would educate them.” Another faculty member explained, “I try to take the shame out of it. Smoking cessation is hard work. It is not hard because of the suffering, but because cigarettes are such a deeply rooted part of their life. I tell patients it is a 6-month long job and I discourage premature declarations of victory. Acute situational relapse is just par for the course.” A third faculty member stated, “I would try to understand what happened. Is there an anxiety disorder not being addressed? Is there a need for other supports? If the tobacco treatment has been referred out, this frees the psychotherapist to explore it, rather than the relapse not fulfilling some expectation of the therapist.”

Supervision Issues

Focus Group Feedback

The residents voiced concerns that psychodynamic supervisors may not be supportive of their efforts to treat tobacco. One resident explained, “Your supervisor may want you to follow much more strictly a psychodynamic approach. You may get very mixed signals about doing something like this. So I think that might make it hard as a trainee to know what you are doing and how to evaluate it.” Another resident agreed, stating, “I think you get a wide variety of reactions from the community supervisors regarding how strict you are in your therapies, so having a clear message from all your supervisors would help a lot.”

Faculty Response

The faculty respondents acknowledged that at UCSF and similar psychiatry residency training programs, a variety of community supervisors work with the residents and some may not support residents’ efforts to address tobacco use in psychodynamic therapy. A training session for the supervisors was deemed impractical due to off-site practices and conflicting schedules. Instead, the faculty respondents encouraged sending written information to the supervisors explaining the importance of new initiatives to treat tobacco and encouraging their support. Attending to the different levels of residency training and the clinical care system was seen as essential for supporting initiatives to address patients’ tobacco use.

Discussion

The consensus from the expert faculty consultants was that tobacco use can and should be addressed within psychodynamic psychotherapy. Taking a holistic view, the faculty suggested addressing tobacco use within the full context of patients’ risky behavior patterns. The faculty perspectives for addressing nicotine dependence in psychodynamic psychotherapy fit fairly consistently within the National Cancer Institute’s five “As” framework:

1. Ask: Psychiatrists ought to ask about tobacco use in the initial phase of therapy, when getting to know patients. Nicotine use would be part of a thorough history-taking that includes questions about substance use and other self-destructive behaviors.

2. Advise: Advising patients to quit may take on a different life in a psychodynamic framework. Rather than adopting the traditional educational role, the psychotherapist may pose open-ended questions and use interpretation and other more complex psychological strategies to raise patient awareness of the personal consequences of their tobacco use.
3. Assess: Assessing patients' thoughts about smoking acknowledges that not all patients will be ready to quit and informs the next steps in addressing their tobacco use. Importantly, a patient not being ready does not have to mean the end of the conversation and can, in fact, provide a wealth of material worthy of exploration in session. The faculty provided skilled suggestions for examining a patient's resistance to and ambivalence and concerns about quitting this highly addictive substance.
4. Assist: For assisting patients with quitting, the faculty provided different perspectives ranging from integration within the ongoing psychotherapy to referring out to a colleague or cessation program. Both are valid approaches, and the decision may be patient- and/or therapist-driven. Of interest, a recent study with patients diagnosed with posttraumatic stress disorder indicated a fivefold increase in quitting smoking when tobacco treatment was integrated within therapy rather than referred to a cessation clinic (24).
5. Arrange: In terms of follow-up, the psychotherapist is encouraged to foster an environment that allows for ongoing attention to the patient's tobacco use. Even if the patient is referred out for cessation treatment, the therapist may monitor changes in psychiatric symptoms, provide support, and reassure and normalize difficulties and lapses in the quitting process. For patients not ready to quit, the therapist may ask permission to reassess again in 3 to 6 months and, as appropriate, raise attention to life issues that appear to tie into the patient's smoking behavior.

Though the framework appears rather simple and straightforward, a broader issue that appeared to contribute to the residents' hesitancy to address patients' tobacco use was their limited perspectives on the breadth of psychodynamic interventions. Doing nothing may feel safer than taking an active position in addressing patients' tobacco use yet will serve to perpetuate this deadly addiction. Further training and supervision is needed to help residents appreciate the similarities across the different systems of psychotherapy (25). It is positive that the residents recognized their role in addressing tobacco use with patients with mental illness. We need to work, however, to expand their willingness and comfort in addressing tobacco use in psychodynamic psychotherapy.

The current study is limited to one site and a small group of residents and faculty. The absence of any article identified in the literature discussing tobacco treatment in psychodynamic psychotherapy, the elevated rates of tobacco use among the mentally ill (1, 2), and the reported low rates of attention to tobacco use in psychiatry training and practice (9–11) all suggest the issue may be widely relevant. Psychodynamic therapy remains a

predominant orientation in residency training, and the current article provides a framework for incorporating tobacco cessation within this treatment model.

Clinical application of integrated care will require additional training in residency programs. Residents need to be familiar with the clinical features of nicotine dependence and withdrawal, psychological strategies for promoting and supporting cessation, and the use of nicotine replacement, bupropion, and emerging new treatments. Importantly, recent research indicates strong support for such training in psychiatry residency programs nationally (11).

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