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Management of Tobacco Smoking Employing Psychosomatic Techniques:

A Retrospective Study of the Results of Treating a Group of Tobacco Smokers for Smoking Cessation

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ABSTRACT

This paper studies to what degree of abstinence Psychosomatic Methodology [PSM], has assisted a group of smokers of tobacco, twelve months or more after receiving treatment by PSM, which was aimed at removing the smoking habit. The period of treatment was between April 1998 and April 2000. 144 subjects [54 males and 90 females]. There were no exclusions from treatment. 37, [26%] of the subjects for this study came referred by their General Practitioner, the remainder were via word-of-mouth recommendation, or direct advertisement.. 21 subjects disclosed co-morbidity with a smoking-related disorder, which was under the care of their medical attendant. 10 subjects were lactating or pregnant females. 13 subjects presented diagnosed neurological disorders for which they were taking prescribed medication. All these subjects were included in the study. At an interval in excess of twelve months from treatment, the subjects were contacted and asked to self-report their smoking status. Non responders [n=17], were included in the results as "never stopped smoking"

The application of psychosomatic modalities [PSM], helps people to stop smoking tobacco. Psychosomatic medicine is defined as that branch of medicine concerned with the interrelationships between mental and emotional reactions and somatic processes, in particular the manner in which intrapsychic conflicts influence physical symptoms. It maintains that the body and mind are one inseparable entity, and that both physiologic and psychological techniques should be applied in the study and treatment of illness. [Mosbeys, 1998]. Psychosomatic therapies are constantly being developed and extended. Among the better-known techniques are clinical hypnotherapy, analytical hypnotherapy consultative therapy and meditation. Abbott, Stead, White Barnes and Ernst [200], reviewed 3 studies from the USA, one each from Australia and the UK, and 4 from Canada, in which hypnotherapy was used in treating tobacco smoking. Thirteen other studies were excluded from the review, apparently all North American in origin. Abbott et al, [2001], consider hypnotherapy has not proven to have a greater effect on six month quit rates than other interventions, or than no intervention.

A rider is added, to the effect that:

"Since hypnotherapy is regularly suggested as a possible aid to smoking cessation, there is a need for larger trials to establish its efficacy. The type of Hypnotherapy used needs to be clearly defined, and described. Comparison needs to be made with active interventions, preferable matching for therapist contact time."

On the other hand, Sorenson, Bedar, Riolo and Pinney [1995], suggest that a large trial of hypnotherapy in the United States, during the early 1990's, involving over 2,500 subjects, resulted in a 15% quit rate. This was in conjunction with a workplace smoking ban, in one large corporation, and entailed close follow-up of each respondent. Pilot studies indicated that there were good reasons to suppose that techniques in PSM could

offer habitual smokers the opportunity to abstain long-term, given that they wished to do so, [Magrath, 1995]. These studies indicated that a wider and deeper coverage of the issues in smoking cessation might have a significant effect on the habit.

A protocol was designed for the treatment of such smokers, and offered to the smoking public by means of referral from general practitioners, advertisement, and word-of-mouth referral. The work in PSM being reviewed here, is intended and designed to be a methodology in the treatment of the tobacco smoking habit, which is:

" Effective --- the treatment should offer the smoker a reasonable percentage possibility of safely achieving total abstinence from the use of tobacco within a short period, and the ability to maintain that total abstinence for the rest of the life of the abstainer. So-called "social smoking" is a myth, since it is widely acknowledged that that an occasional single cigarette can create long-term damage to the human system [Quit, 2000].

" Economic - the "who pays?" issue is old and difficult. Receipts in the order of \$AUD 4.6 billion are taken annually by the Federal Government in tobacco excise revenue; [it is estimated that of this figure, \$AUD 64 million represents income from tobacco duty related to sales to children. (Chapman 2000)]. The only assisted payment for PSM in tobacco cessation is from those Health funds that now rebate costs of this kind of treatment. The cost of nicotine Replacement Therapy, and Bupropion Hydrochloride, may be met by the public purse, on prescription, whilst the cost of PSM will not. This study strives to demonstrate that this oversight needs careful re-consideration. These studies in PSM have no Institutional funding.

" Safe - for both patient and medical practitioner. PSM may be offered, referred and used without precaution or contra-indication, provided it is delivered by a trained person. PSM is the treatment of choice for smokers who are also lactating or pregnant females, patients with neurological disorders, or patients who have co-morbidity with some other disorder, particularly those associated with tobacco smoking, or people who choose not to take pharmaceutical medication.

Legitimacy in this study is gained from the need to examine and consider all methods of smoking cessation, in an effort to drastically reduce the cost to the Nation of tobacco smoking, not only in economic terms, but also because of the human misery and suffering which accompanies the ultimate disaster of smoking tobacco. Table 1. shows the cost to Australia of tobacco smoking.

For the purposes of this study, one "hospital bed-day" is estimated to be valued at \$AUD 2,000. This does not allow for high dependency units, or other specialised facilities. Employing this estimate, then the representative cost of hospital treatment attributable to tobacco smoking, being funded by the Australian taxpayer would be in the order of \$AUD 1.6 billion per annum. A comparison of these estimates, to those of the U.K., on a per capita basis, lends authenticity and accuracy, where a similar cost per capita of smoking-related health care is recorded. [Parrott et al., 1998].

In 1988, the cost of tobacco smoking related health costs in Australia was estimated to be \$AUD 6.8 billion, which included the cost of loss of

productivity in the workplace. [Davey, 1997]. Estimated deaths caused by active smoking of tobacco in Australia in 1992 are shown in Table 2.

Parrott et al. [1998], suggested that an estimated 687,434 "life years" are lost annually in the U.K. to smoking attributable causes, also that the average smoker sees his or her GP more often than a comparable non-smoker, receives more prescriptions, and is more likely to be referred to hospital for an out-patient appointment.

TABLE 1

Hospital Bed Days And Hospital Episodes Attributable To Tobacco Use In Australia In 1992.

Hospital Episodes NUMBER	% OF TOTAL	Hospital Bed days NUMBER	% OF TOTAL
93,373	56	812,866	51

Source: QUIT Victoria 1995

TABLE 2

Estimated Deaths Caused By Active Smoking Of Tobacco In Australia

	MALES	FEMALES	TOTAL
Number of Deaths from all conditions	66,108	57,543	123,651
Number of Deaths from tobacco smoking	13,977	5,104	19,081
Percentage of Deaths caused by tobacco	21 %	8.8 %	15.4 %

Source: QUIT Victoria 1995

The main resource in primary care is the cost of the GP's time.

Reducing the volume of tobacco smoking should improve health, and the greater the health gain, the greater should be the reduction in smoking-related health care costs, [Parrott et al., 1998], which, by inference, should result in more efficient health care for everyone.

Chapman, [2000], has stated that up to 60% of tobacco smokers aim to achieve abstinence each year, but that most smokers who try to quit, do not succeed. Hypotheses are discussed in this study, as to why such smokers fail to achieve abstinence.

There are several possibilities open to a "smoker" of tobacco, who wishes to abstain from its use or quit:

1. WILLPOWER: The so-called "cold-turkey" approach succeeds in some cases. Parrott et al, [1998], suggest that some 3% of smokers achieve abstinence by this method.

2. PLACEBO: Jorenby et al., [1999], showed that at 12 months after treatment, in a double blind, placebo controlled comparative trial, 15.6% of subjects had achieved abstinence from tobacco use, by the use of placebo and "motivational support".

3. NICOTINE REPLACEMENT THERAPY: At the end of 12 months from commencement of transdermal therapy, it has been shown, (Jorenby et al., [1999]), that just over 16% of subjects abstaining, did so by this method, in conjunction with "motivational support". Subjects who are candidates for nicotine transdermal delivery systems should be instructed to cease smoking tobacco immediately, (Thomas, (2000)].

4. SUSTAINED RELEASE BUPROPRION: Figures from Jorenby et al [199], suggest that the use of this form of pharmaceutical therapy, in conjunction with "motivational support", results in 30.3% of patients abstaining at 12 months from therapy. Bupropion Hydrochloride is a noradrenalin re-uptake inhibitor, [NRI], and has been used as an anti-depressant pharmaceutical. There appears to be no indication of the mode of action in tobacco abstention.

5. HYPNOSIS AND COUNSELLING: Historically, in tobacco cessation treatments, hypnosis has relied to some extent upon the use of aversion therapy, which seems to have some success, albeit in some cases for short periods, since, hypothetically, the human mind will ultimately reverse the effect of the aversive suggestion. However, it may be that some subjects could use this initial period of cessation to trigger a longer abstention. Abbott, [2001], and Sorenson et al., [1995], have reviewed the use of hypnotherapeutic methods in tobacco smoking cessation studies.

6. PSYCHOSOMATIC METHODOLOGY: Manual and electronic searches have failed to reveal quantitative or qualitative studies of therapies used in this modality. This study is the first to investigate the efficacy of PSM.

METHOD

The Original Project

This was a non-comparative, result-oriented study of one method by which the habit of smoking tobacco may be treated. Subjects were treated between April 1998, and March 2000. There was no control group, since the original work was commercial in nature, being unfunded. External validity is asserted and achieved, since the study group of subjects was by random self-selection, and self-allocation to the project. The assertion is made that the subjects are representative in sample of that part of the smoking population who wishes to quit. The motivational aspects of these subjects are different from those of non-paying volunteers. The same specialist treated each subject in this study, in one of six medical centres situated in the South West Sydney region, the medical centres being separated by approximately 110 kilometres North to South, and 70 kilometres East to West. Hence the draft of subjects is from a representative geographic and socio-economic Metropolitan and outer suburban sector of a major city. Thus it is asserted that these results could be applied to the whole smoking population, since only the motivation to quit, which is vital, and the availability of the necessary fee for treatment, discerns. Each subject received either three sessions of two hours per session, or 6 sessions at one hour per session, at one weekly interval, on a one-to-one, face-to-face basis with the same psychosomatic specialist, in return for a relevant fee.

Subjects

One hundred and forty four [144] subjects commences treatment, comprising 90 females and 54 males. They were individuals who presented the need to abstain from tobacco smoking, at any one of the medical centres at which the specialist was in practice, during the period from April 1998 to March 2000, requiring to be treated psychosomatically, in order to try to eliminate the habit of tobacco smoking, for life. The subjects were, by definition, willing to give up the smoking habit. Many had tried alternative methods to achieve the objective. Twenty-one [21] subjects disclosed co-morbidity with a smoking-related disorder. Ten [10], subjects were lactating or pregnant females. Thirteen [13], subjects revealed diagnosed neurological or mood disorders for which they were taking prescribed medication. Thirty-seven [26% of the total number of subjects], of the subjects of this study], were referred by their General Practitioner; the remainder were via word-of-mouth referral or direct advertisement.

Protocol

The treatment protocol was designed by the specialist, with the specific object of providing standardisation of content and format, so that the independent variable, [the treatment], could be assessed. At the first session, details were collected concerning the subjects':

- Personal and medical background and history, if relevant;
- Smoking habits and history;
- Motivation to quit smoking; and,
- Reasons for the choice of PSM to try to achieve the objective.

All the subjects were asked to confirm that they: "Had decided to make a self-induced decision about smoking, independently, and uncluttered by any other coercions".

It was explained to all subjects that there existed neither guarantees nor predictions as to the outcome of the treatment, and that the treatment involved no dangerous or invasive procedures, no drugs or other prescriptive remedies. Each were told that they could stop the proposed treatment, at any time, particularly if they felt that they found they were in a position to achieve abstinence at that point. It was also explained that there would be no impediment to continuing the treatment at a later period, should this incomplete treatment result in a later re-uptake of the habit.

Permission was obtained from each of the subjects for a follow-up to be undertaken, as part of the treatment, and the results of that follow-up are the subjects of this study.

No subject was under 18 years of age, or over 75 years of age. Each subject, in the course of 6 hours of treatment, had explained and discussed with them the factors surrounding the smoking of tobacco.

These factors included:

1. The pathological risks of the habit, interwoven with brief ventures into human anatomy and physiology.
2. The marketing, economic and manufacturing facets of the tobacco industry and its relationship to Government. The reasons why government has difficulty in banning the sale and distribution of a substance widely recognised to be poisonous, dangerous and costly to the nation as a whole. A broad and simplified idea of the chemistry and pharmacological aspects involved in tobacco smoking; and overview of the botanical areas of tobacco production.

3. The psychology of the habit. Discussion centred upon the reasons why tobacco smoking is such a problem to remove; how the habitual and addictive nature of the problem reflected upon the individual's view of self, and in what ways the marketing strategies of the tobacco industry have historically used psychology in the marketing of the product.
4. Each patient received a discussion concerning distress, and its relation to the body, and smoking in particular, and all the subjects were tutored in methods of dealing with the distress syndrome. Philosophical, meditative and hypnotherapeutic treatments were delivered.
5. Using psychosomatic methodology which included analytical and clinical hypnotherapy, philosophical argument, and cognitive analytical techniques, depending upon the individual needs, attitudes and awareness of each patient, endeavours were made to disengage smoking, and smoking-related events and issues, from the self-image of each subject, and their background, up-bringing, remembrances of childhood and infant nurture.
6. Agreement was sought with each subject, that there exists no "magic button", and that each individual needs to find their own way out of the habit by decision and motivation, once having endeavoured to remove automatic and embedded counteractions to the objective.
7. Each individual was tutored to recognise that the decision whether to be a smoker or not is personal, and ought not to be subject to any imposition by any other party. Also, that the original decision to smoke was made without consideration of knowledge or information about the act of smoking, apart from a generalised belief that "this is what adults do". The average age of commencing smoking of 144 smokers was 16.8 years.

Utmost care was taken to present each session in a similar format to all others. The commencing protocol was set out in aide-memoir form, and referred to during the sessions to enable and ensure standardisation of treatment delivery as far as possible. It will be recognised that slight variations in treatment content could occur due to the interaction of specialist and patient, but it is asserted that this aspect was minimal in these sessions.

At the commencement of each session, a short induction took place, which was designed to ensure as complete as possible involvement of the sub-conscious mind of each subject. A typical suggestion series might have been as follows:

"As you are now in a position that you have decided to make a decision about tobacco smoking, the sub-conscious part of your mind which is involved in these matters, might be encouraged to store these ideas and suggestions carefully and securely, in such a way that they will be available for you to use to assist you in making a decision about smoking and keeping that decision intact in time to come. It may be that you will be able to adapt these suggestions and ideas in your way, and be interested in so doing, but they will be able to help you to achieve the things that you wish to achieve. Please bear in mind the fact that you are not asking yourself to give anything up. You are not asking yourself to deprive yourself of anything. Tobacco smoking offers not one single benefit to this your body, in any way whatsoever. The only pleasure you acquire by tobacco smoking is an illusion, which you have taught yourself by the habit. Thus all the ideas which you are about to hear will form a part of the whole process of coming to a firm unequivocal decision about tobacco smoking for yourself. Remember, only you are involved. No one else. There is no guilt or pressure upon you by virtue of this decision. It is utterly and solely your decision."

The designed intention of this treatment was to bring each of the facets of the smoking habit, to the attention, both consciously and sub-consciously, of each smoker, so that they would have a clearer and more complete understanding and knowledge of the issues involved in tobacco smoking, and hence would be able to select individual reason[s] for abstention, from these issues.

At the conclusion of the treatment, each subject was then encouraged to make a decision about smoking, based upon the evidence and information imparted and demonstrated during the sessions, and which they now possessed.

The Follow-Up Study

The follow-up study was completed in April 2001. At the end of a period in excess of twelve [12] months from the completion of the treatment, the subjects were questioned by telephone, and asked to supply a self-report as to their current smoking status. The questioning was conducted independently of the treating specialist. Each subject was asked:

"You received treatment for smoking cessation during.....[month], in.....[year]. Do you now smoke tobacco?"

If the response was that the subject had successfully quit, then the answer was noted electronically. The actual elapsed time since the end of treatment to the enquiry was noted, as were any additional voluntary comments from the subject. Enquiry was made concerning the subsequent use of any other aid to smoking cessation. Any subject having employed some other aid was recorded as "still smoking". Whether or not they had quit.

If the answer to the original query was in the affirmative, then enquiry was made as to whether there had been any abstinence post-treatment, and how long, if at all the abstinence had lasted. These answers were recorded electronically.

RESULTS

Measures of Outcome

The original project was conducted with ninety [90] females, and fifty-four [54] males, a total of one hundred and forty four [144] subjects, who presented the need to quit smoking. The rates of abstinence at twelve [12] months or more were fifty-six percent [56%] in the male group, fifty-one percent [51%] in the female group.

Fifty-three percent [53%] of the total number of subjects responded that they had not, from the date of their treatment to the date of study enquiry, continued to smoke tobacco.

Subjects were considered to be abstinent if they reported that they were not smoking at the time of reporting, and had not employed any other method or intervention to achieve this status.

No expired carbon monoxide or other bio-chemical validations were conducted. All subjects lost to follow-up were classified as "still smoking". All one hundred and forty four [144] subjects were included in the outcome analysis.

Analysis

Sixteen [16] subjects did not complete the proposed treatment, for undisclosed reasons, but of these, it was self reported that three [3] males and five [5] females had achieved abstinence for a period in excess of twelve [12] months, whilst the remainder never stopped. They are included in the study as such.

All non-respondents, {total seventeen [17], eleven [11] females and six [6] males}, are assumed to still be smoking, and are included in the statistics as such. Any respondents who had used some other form of aid to cessation, post treatment, are included as "still smoking" whether or not they have succeeded in cessation.

One [1] male subject used packet tobacco and rolled his own cigarettes; one [1] male smoked small cigars; one [1] female had acquired an addiction to nicotine gum as the result of previous attempts to quit, and still smoked tobacco; the remainder smoked "tailor-made" cigarettes. All are included in the results. {The female with the addiction to gum, quit both habits after treatment}.

Of the ten [10] pregnant or lactating females who completed the course of treatment, two [2] failed to quit.

Nine [9] females and four [4] males presented a co-morbid neurological or mood disorder, [ND], for which prescribed pharmaceuticals were being used. Of these subjects, eight [8] of the females and two [2] of the males abstained from smoking in excess of 12 months from treatment.

Sixteen [16] males and five [5] females presented a co-morbid pulmonary, cardiac or hypertensive disorder, [CMD], and of these, thirteen [13] males and two [2] females have abstained.

Forty-one [41] females, {45.5% of all females}, and nine [9] males, {16.7% of all males}, admitted that their partner smokes. From these subject totals, twenty-three [23] females {56.1%}, abstained, whilst seven [7] males, {77.8%}, succeeded in twelve months' abstinence.

One [1] male subject and one [1] female subject made a positive decision to continue with the smoking habit, when called upon for their decision about the habit. Both are still smoking.

The self-declared average consumption of cigarettes in all the subjects of this study, was, in the case of the females: 25.4 per day [upper 50 lower 10], and in the case of the males, 28.4 per day, [upper 50 and lower 10].

Of The 144 subjects commencing treatment, 117 [81.2% of the total], 43 males, [79.6% of total males], and 74 females, [82.2% of all females], declared that to the best of their knowledge and belief, at least one of their parents had smoked during the subjects' infancy, from birth to age six [6].

In the case of the females, all the subjects presenting CMD's or ND's at the outset, are in this group, whilst in the male group, three [3] CMD's are outside this group. There does not seem to be any particular significance in these figures. The composition of the group in age and gender terms is presented and tabulated in Table 3.

TABLE 3 shows the number of subjects who have quit smoking and the duration of their abstinence. The number who have not quit, are shown by periods of abstinence before re-commencing smoking. Of the total entering the study and treatment, sixteen [16] males, [29.6% of all males], and twenty-five [25] females, [27.8% of all females], in total, forty-one [41] subjects, [28.5% of total subjects] did not achieve any post treatment abstinence

Seventy-six [76], subjects [52.8% of all subjects], comprising thirty [30] males, [56% of all males], and forty-six [46], females, [51% of all females], declared that they had abstained from smoking for a period of over twelve [12] months. Six [6] smokers who abstained following completion of treatment, then subsequently re-started, declared that a "stressful event" had triggered the re-uptake of the habit.

There were no adverse events following treatment conclusion, either serious or non-serious.

A number of conclusions can be drawn from the results:

- One hundred and seventeen [117] smokers, [81.2% of total subjects], whose parents appeared to have passed on to them the smoking concept within the infants' formative years, leads to an hypothesis that there exists a link between parental "teaching" in the use of tobacco, and its continued use by smokers, despite powerful and widely disseminated evidence of its dangers in disabilities and premature death.
- Human distress appears to have a part in the maintenance of the smoking habit, evidenced by those smokers who quoted a "stressful event" as the reason for their having re-started the habit, in cases, after long periods of abstinence, post treatment. It should be remembered that smoking tobacco is undertaken, in a majority of situations, amidst "relaxing" circumstances. For example; during a "smoko" or smoking break, when seated etc.
- Trials in the use of invasive aids to smoking cessation, [Jorenby et al., 1999], confirm that properly organised counselling and/or motivational support is a required adjunct to those treatments. The contact with a counsellor or interested party lends weight to the view that such contact improves and/or alters the individuals' critique of his or her self-worth, and hence self-confidence.

All these aspects of smoking tobacco appear to be important factors and must be addressed in any treatment for tobacco smoking.

TABLE 3

Subjects Who Quit Smoking and the Duration of that Abstinence

After Treatment: Total in ages	20-30	31-40	41-50	51-60	60+	TOTAL
Number in Each Age Group:	39	38	33	23	11	144
Number of Subjects who Never Stopped Smoking:	10	13	7	5	6	41
Number of Subjects who Stopped Smoking then restarted After a Period of:						
Up to One Month:	3	2	5	1	2	13
Over One Month and Up to Six Months:	2	2	3	0	0	7
Over Six Months and up to Twelve Months:	1	1	1	2	0	5
In Excess of Twelve Months:	1	1	0	0	0	2
Total Number Who Did Not Quit Smoking:	17	19	16	8	8	68
Number Who Quit Smoking for Periods of:						
12-18 Months:	11	11	7	5	1	35
19-24 Months:	9	4	4	2	1	20
In Excess of 24 Months:	2	4	6	8	1	21
Total Number Who Had Successfully Quit Smoking:	22	19	17	15	3	76
Percentage of Subjects Who Successfully Quit Smoking:	56%	50%	52%	65%	27%	53%

DISCUSSION:

Hypothetically, many people who smoke tobacco are wishing to quit. Each year, many smokers attempt to cease smoking tobacco.

Therefore it is probable that a need exists to identify a method which is efficient, effective and non-selective, to assist as many people as possible to achieve their goal.

The need to establish such a method could be extended to the broader issues of tobacco smoking globally. It would seem to be no answer to call upon Governments to introduce prohibition upon the sale or use of tobacco, which has always been one of the options available to the Legislature. History teaches us that this type of measure used in other areas of consumption, has a dismal record of failure, and is unlikely to be more successful in the case of tobacco. The smoking population continues in the habit, despite being regularly presented with incontrovertible and demonstrated evidence of the dangers to life and health of tobacco smoking, not only to themselves but also to those around them.

The "reasons why" humans may cling to what appears to be a suicidal lottery, [smoking], are the subject of many and varied hypotheses. An hypothetical profile of a smoker might be drawn from a person who received inculcation of the notion of tobacco smoking from parental sources,

through a period from birth to the conclusion of infant nurture. The first post-partum smell such a person may have taken up might have been tobacco smoke, and from that moment the interweaving of tobacco use with cognitive developments of "home", "parental love", "care" etcetera, would provide a solid basis upon which a smoker might build their own smoking habits, and the consideration of the rejection of one part of this closely woven fabric of those nurtured years, may prove too hard a task, if not impossible, unless the smoking element in this weave can be unhooked from the rest, leaving an whole sub-conscious picture, undamaged by the departure of the notions of smoking.

Were state legislature to insist in a draconian fashion that smoking must be banished, it would be simple so to do. For example, a government may pass an Act which, whilst avoiding the absolute prohibition of tobacco, makes illegal, the sale or consumption of tobacco in any place where, for example, people under the age of 18 have access. Ninety-one percent [91%], of the subjects in this study, [n = 131], when asked what would be their reaction to such an Act, responded that they would not bother to smoke again. This response, however, should be regarded as coming from the conscious mind, since if the internal and sub-conscious pressures of the "infant nurture" aspects of tobacco consumption, to which allusion was made earlier, were to be attacked by such Laws, then the prospects may well be unacceptable to the smoking population at large.

A significant number of subjects in this study, [> 10%], upon learning of the facts in tobacco smoking, rhetorically asked the question, "Why doesn't the government stop the sale of tobacco?" This is of course, an oft-repeated responsibility-shedding question, posed by tobacco smokers.

A publicly reported example exists, [Brown, 1999], of a female who at the age of 38 has emphysema attributable to smoking, and blames the Government.

Present revenue, paid weekly, from tobacco duty, represents a short-term cash flow in the order of \$80 million per week. [Davey,1997]. This is desirable income, in the sense that it enables weekly payments to be made to government creditors, such as pensioners, etcetera. Subjects in this study [> 90%], claimed that that they would be unlikely to set aside as savings, the money not being spent on tobacco after quitting; hence it is probable that tax revenue would flow back in equivalent quantity, except, rather more slowly.

It is generally understood that the revenue from raw tobacco duty, plus the GST recovered from the sale of tobacco products, approximately balances the cost to the Australian nation of tobacco-related health care. However, this does not take into consideration the cost to society in terms of workplace and family loss in coping with disability and untimely death.

Gradual pressure to abstain is probably the right way to go, yet it must be borne in mind that if the burden of smoking banishment falls upon smokers unprepared for the trial of enforced abstinence, then widespread behavioural and/or psychological problems may result, within the population who presently "smoke". Draconian measures to ban smoking could lead to considerable anxieties in the smoking population.

This study hopes to lend some weight to the view that the most important facets of the tobacco-smoking habit, not necessarily in this order of importance to the individual, are:

- The embedded idea of smoking acquired in early infancy, from parents who smoke; and,
- Self responsibility for the decision to smoke.

The hypothesis is that if these factors can be removed from the equation, then the smoker may be more readily willing to jettison the habit, in a safe, comfortable fashion, from which event everyone may benefit.

Psychosomatic techniques have the advantage that they are non-invasive, involve no drugs, and present no dangers to the patient when delivered professionally. Whilst not only dealing with what appear to be very important obstacles to tobacco smoking cessation, PSM appears to be the most attractive option available, in terms of probable outcome, and scope of candidates for treatment.

The major disadvantage of this modality is that, at present, the patient has to pay individually for the requisite specialist attendance, rather than rely upon national funding measures.

This study demonstrates that psychosomatic modalities can result in significantly high rates of abstinence, and should be regarded as being among the most effective treatments available to quit smoking, for any smoker wishing to quit the habit

It is certainly the treatment of choice for any patient who cannot or will not be prescribed pharmaceutical medication. PSM has no contraindications, nor precautions, and only requires that the intended subject be voluntarily wishing to abstain from the habit of tobacco smoking.

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