SURVEY RESULTS OF THE 'ROB KELLY METHOD®': AN APPLIED PSYCHOLOGICAL TECHNIQUE FOR SMOKING CESSATION

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ABSTRACT: *This study presents the results of an online questionnaire for a novel smoking cessation treatment utilising applied psychological techniques. Participants were 107 paying clients attending Rob Kelly's Cambridge Clinic. Post treatment 92.5% of participants reported that they had stopped smoking.*

INTRODUCTION:

Cigarette smoking has a high risk for a wide range of negative consequences for an individual (Mattson, M., Pollack, E.S. and Cullen, J.W., 1987; Freund, Belanger, D'Agostino and Kannel, 1993). As a result, smoking cessation has been widely researched and a great many treatments are available to help a person to stop smoking (See for example, Viswesvaran and Schmidt, 1992).

Smoking cessation is widely believed to be very difficult to achieve, with many giving a pessimistic outlook on obtaining abstinence, particularly without treating what is commonly believed to be an underlying nicotine addiction. One meta-analysis suggested a control group quit rate of just 6.4% (Viswesvaran and Schmidt, 1992). On the other hand Schachter (1982, as cited in Katz and Singh, 1986) found that 64% of those in a non-clinical population who tried to quit smoking on their own ultimately managed to do so - many without much difficultly.

It has been suggested the notion that 'stopping smoking is a very difficult thing to achieve', establishes an unhelpful and negative belief system that actually fuels difficulty in quitting. For example, Atrens (2001) suggested that while smoking continues to be seen as an inescapable addictive process, smoking cessation programmes will be limited by a self-fulfilling prophecy.

Eiser and Sutton (1977) proposed that the decision a smoker faces is typically not one of continuing to smoke or stopping, but one of continuing to smoke or *trying* to stop. Many smokers believe that significant willpower is required

to achieve smoking cessation (for example, Roddy, Antoniak, Britton, Molyneux and Lewis, 2006; Ingall and Cropley, 2010), and lack of willpower is often cited as a reason for failure to abstain from smoking (for example Katz and Singh, 1986; Copeland, 2003).

It is, however, proposed that willpower is not a fixed trait, but that the amount of willpower or persistence a person demonstrates in a particular situation is linked to their expectancy of success or self-efficacy. Mukhopadhyay and Johar (2005, p781) suggest that the greater the self-efficacy, *"the more vigorous and persistent are people's efforts"*.

In relation to smoking cessation, Yates and Thain (1985), found that self-efficacy in relation to cessation success was the best predictor of whether or not a person would stop smoking without relapse at both 4 months and 8 months after quitting. Research by DiClemente (1981) found that, after a cessation attempt, relapsers and maintainers did not differ on any demographic or smoking history variables. However, maintainers did show significantly higher self-efficacy scores than relapsers. Eiser, Van der Pligt, Raw and Sutton (1985) found that whether or not participants believed that they could stop smoking significantly distinguished abstainers from relapsers 1 year later. Etter, Bergman, Humair, and Perneger, (2000) found that baseline smoking self-efficacy scores predicted smoking cessation sixteen months later.

It therefore seems plausible that treatment interventions that aim to alter limiting beliefs around smoking cessation and increase self-efficacy would improve quit rates. This has already been demonstrated in weight loss research, where Weinberg, Hughes, Critelli, England and Jackson (1984) found that both manipulated and pre-existing high self-efficacy groups lost more weight over the 8 weeks than those with low pre-existing and manipulated self-efficacy.

This study examined the effectiveness of a currently available smoking cessation treatment, 'The Rob Kelly Method®', which utilises applied psychological techniques, that aim to alter detrimental beliefs surrounding smoking cessation and increase self-efficacy and willpower. The ease of quitting was also investigated.

METHOD:

Participants

107 participants took part in the treatment and completed the survey. Participants were smokers, who were paying clients that had visited Rob Kelly's Cambridge Clinic in order to undergo the smoking cessation treatment. There were 54 women and 53 men. The exact age of the participants was not determined, but two participants were within the range 18-25 years, ten were within the range 26-35 years, nineteen were within the range 36-45 years, twenty nine were within the range 46-55 years, thirty two were within the range 56-65 and fourteen were over 65 years old. One participant did not disclose his age range. The majority (87.9%) of participants had tried other smoking cessation methods prior to this treatment, including: willpower, nicotine replacement therapy, Zyban, visiting an NHS stop smoking clinic, other hypnotherapy treatments, acupuncture and laser treatment. Thirteen participants had made no previous attempts to quit, twenty four had made one previous attempt, forty had made two previous attempts, twenty one had made three previous attempts, five had made four previous attempts, one had made five previous attempts and one had made more than five attempts previously.

Procedure

(i) Treatment Protocol

The same practitioner administered the smoking cessation treatment to all participants, largely individually to each participant. In a minority of cases the treatment was administered jointly to two participants, who were a couple. Participants were smokers, who paid for the session. Treatment consisted of one sixty to ninety minute session, which was split into two parts:

(a) *The face-to-face discussion.* This part of the session lasted approximately fifty to eighty minutes and firstly involved a discussion in which the participant's beliefs around smoking were discussed, challenged and changed, based on a training programme entitled 'Changing Limiting Beliefs' (Kelly, 2010). This included presenting the participant with evidence that suggested stopping smoking could be much easier than most people expected and showing him/her how his/her psychological processes were involved in his/her smoking habit. This was designed to boost self-efficacy, and thus willpower, as the participant was shown that he/she has far more control over his/her smoking than previously realised.

This component also included a discussion around what the participant currently gained from smoking and what they would gain if they were to quit, particularly highlighting the tangible rewards they would receive through quitting. Participants were encouraged to now see themselves as a non-smoker.

(b) *A short hypnosis session.* The second part of the session involved the use of hypnosis and lasted approximately ten minutes. This short hypnosis component involved a progressive relaxation induction, in which the participant was asked to close his/her eyes and to focus on breathing slowly and deeply. The participant was asked to focus on relaxing different muscle groups of his/her body in turn.

The relaxation induction was followed by carefully worded positive suggestions to the effect that the participant would find it easy to stay a non-smoker, suggestions for self-efficacy, and a reminder of the benefits of quitting. For example: *"This thing that you have always thought was going to be difficult, is going to prove to be remarkably easy"; "everyday you will feel more in control of your life"; "you are going to feel fitter, healthier and more full of life".*

(ii) Survey Questionnaire

Over a fourteen month period, all smoking clients who contacted Rob Kelly through his smoking cessation website (www.stopsmokingeasily.com) and later visited him for this treatment, were asked to take part in this survey. Post treatment, participants were asked if they would fill in a short online post treatment questionnaire in their own time. It was stressed that this questionnaire was optional.

The post-treatment questionnaire (appendix one) was self-administered online. The online method was used rather than a face-to-face interview or telephone survey, in order to reduce social desirability bias (see for example Tourangeau & Smith, 1996; Presser & Stinson, 1998; Tomlin *et al*, 1998; Vuillemin *et al*, 2000). Participants were given a password that enabled them to access the questionnaire, to prevent those who had not taken part in the treatment from filling it in. The online form explained the purpose of the research and detailed that participants' identifying details would not be disclosed to a third party.

The survey obtained a number of demographic details from participants, including gender and age-range. It asked what previous methods for stopping smoking the participants had used and how many attempts at stopping they had already made. The participants were asked what their reasons for quitting were.

Participants were then asked whether or not they had stopped smoking post treatment, and asked to state their beliefs as to why they had or hadn't stopped. They were also asked to comment upon how easy or hard they found the process and whether or not they suffered cravings, withdrawal or side effects.

RESULTS:

92.5% (99) of participants reported that they had stopped smoking after the treatment.

Participants filled in the questionnaire between one day and 209 days (approximately seven months) after the session. The average time at which participants completed the questionnaire was 28.1 days post-session. The average time at which those who stated that they had stopped smoking completed the questionnaire was 29.7 days post-session (approximately one month), whereas the average time at which those who stated that they had not stopped smoking completed the questionnaire was 7.9 days post-session.

When given the opportunity to state why they felt that they had or hadn't stopped smoking, as well as comment on the effects of the process, 84 participants out of 107 (78.5%) submitted answers.

61 participants' responses indicated that they found the process of stopping smoking **easy or very easy** (72.6% of those that gave answers to this part of the questionnaire). Responses were categorised as indicative of this if they explicitly stated the words 'simple', 'easy', 'very easy', 'not hard at all', or stated that it was 'painless', involved 'no effort', they had not had any cravings, withdrawal symptoms or side effects, or that they did not miss smoking at all. Examples of such comments included:

"I stopped easily, and with no cravings at all"

"very simple and easy process"

"really easy - piece of cake"

"I can't belive [sic] it was so simple"

"don't miss smoking at all"

A further 12 participants indicated that they found the process of quitting smoking post-treatment **quite easy** (14.3% of those that gave answers to this part of the questionnaire). Responses were categorised as such if the participant stated that stopping was quite easy, easier than expected, easier or not as hard as before, or involved only a few cravings or withdrawal. For example:

"few cravings but basically simple"

"quite easy and only a few cravings"

"was so easy compared to previous attempts"

"very few withdrawal feelings - just for three days"

"not as hard as when I stopped before"

Overall a total of 73 participants (86.9% of those that gave answers to this part of the questionnaire) indicated that they found the process either quite easy, easy or very easy.

Another theme that reoccurred was that the process was quick, which was mentioned by four participants. Four participants, also, indicated that it was the fact that their beliefs around smoking that had changed which had enabled them to quit.

For the 8 participants who did not stop smoking, some of the reasons they gave included that they were stressed, had a row, had put on weight, they felt no different and that they did not know why they had not stopped smoking. One participant did not give a reason for why they felt that they had not quit smoking.

One participant stated that they had not stopped smoking, but then left a very positive comment regarding the treatment, suggesting that it was lifesaving. It is not known why this discrepancy occurred.

DISCUSSION:

The results suggested that the 'The Rob Kelly Method®' treatment for smoking cessation is highly promising; with 92.5% of participants reporting that they had quit smoking post-treatment. This rate of quitting appears

greater than that of many other currently available smoking cessation treatments (for example an average of 7% abstinence with physician advice, and average of 16% abstinence with nicotine replacement gum, an average of 18% with medication, an average of 26% with group withdrawal clinics, and an average of 36% with hypnosis, Viswesvaran and Schmidt, 1992; 81% abstinence immediately post hypnosis treatment, Elkins and Rajab, 2004). These results should, however, be interpreted with caution due to the lack of consistent long-term follow up in this study. Further research will aim to address this.

It is perhaps interesting to note that the self-reported quit rate at four week follow up for those attending NHS Stop Smoking Services in England between April and December 2010 was 48% for those that set a quit date (The NHS Information Centre, 2011). The most popular treatments offered through NHS services were Nicotine Replacement Therapy (62%) and varenicline (Champix) (27%). This quit rate for the NHS Stop Smoking Services may provide a useful comparison for this study since the follow up was four weeks. This is comparable to the average time at which the participants completed the questionnaire in this study: 28.1 days (four weeks) post-session.

Of the 78.5% of participants who provided comments about the treatment, 86.9% indicated that they found the process either quite easy, easy or very easy. This supports the results of Schachter (1982, as cited in Katz and Singh, 1986) who found that smoking cessation was not necessarily particularly difficult.

Although the results are very promising and suggest a high success rate for this particular intervention there were a number of limitations to the study. Due to the fact that the study took place in a clinical setting with paying clients there was no control group for comparison. The results of this study could be compared with the quit rates in other studies of those attempting to stop smoking with no intervention: for example 6% (Viswesvaran and Schmidt, 1992) and 64% (Katz and Singh, 1986). These results for smoking cessation without treatment are diverse and additionally may not be suitable for comparison with the treatment group in this study, as sample populations may differ.

As only paying clients took part in the treatment and survey, the results may only be generalisable to other clients willing and able to pay for this smoking cessation treatment. Paying for a session is likely to be one of the factors

involved in increasing motivation to stop smoking. However, this is unlikely to be the sole or even main reason participants stopped smoking as many had tried previous expensive smoking cessation treatments in the past and failed to quit on these earlier occasions. The fact that the participants in this study were people who had actively sought out treatment for smoking cessation does, however, suggest that they wanted to stop smoking and were likely to be motivated to do so. This may mean that the results of this study would not be transferable to those who did not wish to stop smoking or were not at all motivated to do so.

The questionnaire did not gather information about the participants' smoking history, so it is not known whether smoking related variables affected the outcome of the treatment. Further research will assess the number of cigarettes smoked per day and the number of years for which the participants have smoked.

It could be argued that the only way to accurately verify abstinence from smoking is through biochemical analysis. This study, however, relied upon the participants self-report of whether or not they had stopped smoking. As the study involved participants who were genuine paying clients in a clinical setting, it would have been impractical and potentially unethical to attempt to implement biochemical methods of abstinence verification. It is, thus, possible that the self-report of smoking cessation contained some inaccuracies, as some participants may have produced answers that they felt were socially or personally desirable. The post-treatment questionnaire was, however, self-administered online, rather than in a face-to-face interview or telephone survey, which is likely to have reduced social desirability bias (see for example Tourangeau & Smith, 1996; Presser & Stinson, 1998; Tomlin *et al*, 1998; Vuillemin *et al*, 2000). Furthermore, it is postulated that since participants were paying clients they may have had a greater desire to make it known if the procedure had not helped them to quit smoking, than recruited participants in an experimental setting, further reducing social desirability bias.

A further limitation of the survey was that participants did not complete the questionnaire at a particular time post treatment (most participants completed the study between one day and six months after their session), so long term follow up was not consistently conducted. Further research will address this by assessing participants' smoking status at six months and one year post treatment.

Finally, the treatment session consisted of two different parts: a face-to-face discussion component and a hypnosis component. As such it could not be conclusively determined from the study exactly which factors contributed to the success of those participants who stopped smoking. In order to assess the contributions of the two components of the 'The Rob Kelly Method®' treatment, further research could compare the efficacy of each individual component with the combined treatment. This was impossible in the current study as participants were paying clients, who could therefore ethically only be offered the full programme.

From clinical experience and previous client feedback, the researchers propose that the face-to-face discussion part of the treatment played a greater role in assisting the participants to stop smoking than the hypnosis part. Four participants explicitly mentioned in their feedback that the fact that their beliefs had changed had contributed to their stopping smoking, which was a key part of the face-to-face discussion. These belief changes could, nevertheless, potentially have occurred in either part of the session. Twenty seven participants (25.2%) had, however, previously visited a hypnotherapist for smoking cessation and it can be deduced that this did not work for them long term since they were attending further treatment. This could potentially indicate that the face-to-face discussion component is a key part of the success of the treatment. Additionally the proportion of participants who reported quitting appeared greater than that of many other smoking cessation treatments utilizing hypnosis (see for example: Viswesvaran and Schmidt, 1992; Green and Lynn, 2000; Elkins and Rajab, 2004). This should, however, again be interpreted with caution, due to the lack of consistent long-term assessment of smoking status in this study. Once further research has addressed some of the methodological issues in this study, this can be better evaluated.

This study has provided some useful preliminary results, which suggest that 'The Rob Kelly Method®' treatment for smoking cessation is promising. These may indicate that changing the beliefs of smokers and increasing self-efficacy, along with the use of hypnosis can aid cessation success. Further research will help to clarify and evaluate the long-term effectiveness of this programme.

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APPENDICES

Appendix 1: *Online questionnaire*

Date of session:
Name:

Question 1:
Are you:

- ☐ Male
- ☐ Female

Question 2:
Which of the following identifies your age group?

- ☐ 18-25
- ☐ 26-35
- ☐ 36-45
- ☐ 46-55
- ☐ 56-65
- ☐ 66+

Question 3:
What methods had you tried in the past to stop?

- ☐ Willpower or 'cold turkey'
- ☐ Nicotine replacement (either patches, gum or other)
- ☐ Zyban or other prescription drug
- ☐ NHS Stop smoking clinic
- ☐ Other visit to hypnotherapist

Other (Please Specify)

Question 4:
Please indicate, by 'ticking' the boxes below, how many attempts you had made previously to quit - whether successful or not:

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ More than 5 times

Question 5:
Please indicate, by 'ticking' the boxes below, what your reasons were for wanting to quit:

- ☐ The financial cost
- ☐ To achieve better health generally
- ☐ To alleviate a specific health problem
- ☐ Social stigma - pressure from friends or society
- ☐ Pressure from G.P or other medical professional
- ☐ The smell
- ☐ The wasted time - the hours or minutes each day
- ☐ To 'live longer'
- ☐ In an attempt to avoid getting cancer
- ☐ Not feeling powerless, or a 'slave to the addiction'
- ☐ To boost your self-esteem

Other (Please Specify)

Question 6:
After your visit to a 'Stop smoking easily - with the Rob Kelly Method' practitioner, did you stop smoking?

- ☐ Yes
- ☐ No

Question 7:
If you DIDN'T stop, why do you think that was?

Question 8:
If you DID stop, why? If you had tried to stop before, what was different this time? Please give details:

Question 9:
Could you sum-up your experience of this method - in just a few words. Comment on how easy (or hard!) you found the process, and whether you suffered from cravings, withdrawal or side effects.