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Gender differences in characteristics and outcomes of smokers diagnosed with psychosis participating in a smoking cessation intervention



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ABSTRACT

While research has identified gender differences in characteristics and outcomes of smokers in the general population, no studies have examined this among smokers with psychosis. This study aimed to explore gender differences among 298 smokers with psychosis (schizophrenia, schizoaffective and bipolar affective disorder) participating in a smoking intervention study. Results revealed a general lack of gender differences on a range of variables for smokers with psychosis including reasons for smoking/quitting, readiness and motivation to quit, use of nicotine replacement therapy, and smoking outcomes including point prevalence or continuous abstinence, and there were no significant predictors of smoking reduction status according to gender at any of the follow-up time-points. The current study did find that female smokers with psychosis were significantly more likely than males to report that they smoked to prevent weight gain. Furthermore, the females reported significantly more reasons for quitting smoking and were more likely to be driven by extrinsic motivators to quit such as immediate reinforcement and social influence, compared to the male smokers with psychosis. Clinical implications include specifically focussing on weight issues and enhancing intrinsic motivation to quit smoking for female smokers with psychosis; and strengthening reasons for quitting among males with psychosis.

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1. Introduction

There are differences between smokers diagnosed with psychotic disorders (e.g. schizophrenia, bipolar affective disorder and schizoaffective disorder) and smokers not experiencing mental illness in the general population. The prevalence of smoking is significantly increased in people diagnosed with psychosis compared to those without (up to 90% vs. 16%) (de Leon and Diaz, 2005; AIHW, 2010). Smokers diagnosed with psychosis smoke more cigarettes and illegally grown tobacco ("chop chop" tobacco), smoke for longer periods and have higher levels of nicotine dependence than people in the general population (Compton, 2005; Kumari and Postma, 2005; Moeller-Saxone et al., 2005; Williams et al., 2011). Smokers diagnosed with psychosis are motivated to quit (Siru et al., 2009), but their success rates are more modest than those of people without mental illness

(El-Guebaly et al., 2002; Banham and Gilbody, 2010). Every effort needs to be given to enhancing smoking cessation outcomes for people diagnosed with severe mental illness such as psychosis, as their smoking behaviour is directly contributing to the significantly increased morbidity and mortality related to cardiovascular disease evident in this population (Osby et al., 2000; Cohn et al., 2004; Hennekans et al., 2005).

Research examining gender differences in smoking variables and outcomes in the general population have found clear differences between males and females. While females are more likely to seek assistance to quit smoking and engage in more quitting strategies, they tend to have more difficulty quitting (Perkins, 2001; Reid et al., 2009) and poorer smoking cessation treatment outcomes than males (Blake et al., 1989; Perkins, 2001). Female smokers in the general population are less likely to use nicotine replacement therapy (NRT), and are more likely to report subjective distress related to nicotine withdrawal symptoms than male smokers (Perkins, 2001). Research has indicated that females are less interested, committed and confident in relation to quitting smoking (Blake et al., 1989; Perkins, 2001).

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There are also gender differences in reasons for smoking and quitting in the general population. Females were more likely than males to say they smoked to suppress their appetite, to cope with daily life, because other family members smoke, and because they enjoy smoking (Reid et al., 2009). Research has found that females, rather than males, use cigarettes to cope with negative emotions, and are more vulnerable to developing negative affective states (e.g. depression and stress) during a quit attempt (Borelli et al., 1996). Females also reported significantly lower motivation to quit smoking for reasons related to health concerns and higher motivation to quit smoking for reasons related to immediate reinforcement (e.g. save money on cigarettes, won't smell) than males (Curry et al., 1997). Research suggests that attempts to quit smoking by females are likely to be promoted by extrinsic motivators like concern for the health of others, social influences and the cost of smoking (Reid et al., 2009).

While there has been no research reported to date that describes potential gender differences in smoking behaviour, motives, experiences or cessation outcomes among people specifically diagnosed with psychosis, some literature is emerging examining such gender differences in people with mental illness more broadly, usually combining participants with mood and anxiety disorders together with those with psychosis (Johnson et al., 2010; Torchalla et al., 2011; Okoli et al., 2011). One study found no significant differences between male and female smokers diagnosed with mental illness in number of cigarettes per day, level of nicotine dependence and readiness to change (Torchalla et al., 2011). Predictors of smoking in males with severe mental illness included being less educated, separated or divorced or aged 50–59 years and in females being younger (17–29 years) and living in residential facilities (Johnson et al., 2010). Predictors of smoking cessation among both males and females with a substance use disorder and/or mental illness were baseline carbon monoxide level and greater attendance at the smoking clinic, and a history of alcohol dependence (Okoli et al., 2011). Heroin and marijuana use were predictive of unsuccessful smoking cessation only in males (Okoli et al., 2011).

Identifying potential gender differences in smokers diagnosed with psychosis is important to ensure that smoking cessation interventions are gender sensitive to enhance smoking outcomes in this population. The current study is the first to examine gender differences on a range of smoking variables among people specifically diagnosed with psychosis. The current study aims to

- examine gender differences in smoking variables for people diagnosed with psychosis before and after they participate in a smoking cessation treatment, and
- determine what factors are predictive of smoking reduction and cessation in people diagnosed with psychosis, according to gender.

2. Methods

2.1. Sample

A total of 298 people diagnosed with psychosis (including schizophrenia, schizoaffective disorder, bipolar affective disorder, severe depression with psychosis and other psychotic disorders) were recruited from Sydney and the Newcastle region of NSW, Australia to participate in a randomised controlled trial of a smoking intervention among individuals diagnosed with psychosis (see Baker et al., 2006, 2007). This paper presents the results of a gender analysis of these data. Inclusion criteria included: aged ≥ 18 years; smoking at least 15 cigarettes per day; and an ICD-10 diagnosis of psychosis as described above (International Classification of Diseases, 10th Revision). Exclusion criteria included having a medical condition that would preclude the use of NRT; being currently acutely psychotic (if this was the case, these potential participants were screened 1 month later to reassess study suitability), and having an acquired cognitive impairment.

2.2. Procedure

All participants were in a non-acute phase of psychosis when they commenced in this study, and provided written informed consent. A baseline assessment was completed and then participants were randomly allocated to either: (1) treatment group: received eight individual sessions of 1 h duration consisting of motivational interviewing and cognitive behavioural therapy (CBT) plus NRT and smoking cessation self-help booklets or (2) comparison group: received the same smoking cessation self-help booklets together with treatment as usual. Further information about the procedure and therapeutic interventions delivered in this study are described in Baker et al. (2006), but briefly, participants in the treatment group received NRT as follows: 21 mg nicotine patches for 6 weeks; 14 mg nicotine patches for 2 weeks and 7 mg nicotine patches for 2 weeks. All participants completed follow-up assessments at 3 months (15 weeks after baseline), 6 months and 12 months. These follow-up assessments were conducted by a researcher blinded to the treatment condition. The research was approved by relevant regional and university ethics committees.

2.3. Measures

2.3.1. Demographic and clinical variables

The Diagnostic Interview for Psychosis (DIP) (Castle et al., 2006) provided a psychiatric diagnosis according to ICD-10. The DIP also provided information regarding demographics, illness course and service use. Current symptoms of psychosis were assessed using the 24-item Brief Psychiatric Rating Scale (BPRS-24) (Ventura et al., 1993), a clinician administered and rated tool that is scored based on a semi-structured interview, with higher scores indicating greater severity of symptoms (range: 24–68). Current symptoms of depression were assessed using the self-report Beck Depression Inventory II (BDI-II) (Beck et al., 1998) with higher scores indicating more severe depression (range: 0–63). Anxiety symptoms were measured using the State-Trait Anxiety Inventory (STAI) (Spielberger, 1983), with higher scores indicating more severe anxiety (range: 20–80). The STAI differentiates anxiety as a state, based on responses to 20 statements about how the person feels “right at this moment” and as a trait, based on responses to statements about how they feel “in general.” The 12-item Short Form Survey (SF-12) (Ware et al., 1996) was used to assess general health functioning, producing a physical health component score and a mental health component score with lower scores indicating greater disability. Substance use over the previous month was assessed using the Drug Use domain of the Opiate Treatment Index (OTI) (Darke et al., 1991), and this was specifically completed for cannabis and alcohol use.

2.3.2. Smoking variables

The number of cigarettes smoked per day was calculated using the Drug Use domain of the OTI. Participants were asked when their 3 most recent days of smoking occurred and how many cigarettes they smoked on each occasion. A simple calculation then provided an average daily number of cigarettes smoked based over a 28 day period. Nicotine dependence was assessed using the Fagerstrom Test for Nicotine Dependence (Fagerstrom et al., 1996), with higher scores indicative of greater nicotine dependence (range: 0–10). A Micro 11 Smokerlyser was used to assess breath levels of carbon monoxide. A carbon monoxide reading of < 10 suggests that the person was unlikely to have smoked in the previous 8 h. Participants were asked about changes to their smoking in the previous 12 months, any changes to their mental state with prior quit attempts and what advice they had received about their smoking from health professionals. The raw data in Table 2 for the following smoking variables, age first cigarette, cigarettes per day, level of nicotine dependence, has been previously reported in Baker et al. (2007) and has been reproduced here for completeness.

Participants completed the Reasons for Smoking Questionnaire (RSQ) (Pederson et al., 1996), by responding “yes” or “no” to statements providing reasons for smoking. Five subscale scores were then calculated: addiction (habit, craving; range 0–2); stress reduction (relaxation, to take a break, reduce stress; range 0–3); arousal (peps me up, weight control, enjoyment, to help concentration; range 0–4); mental illness (symptoms of mental illness, medication side-effects; range 0–2) and partner smoking (range 0–1).

Motivations to quit smoking were captured using the Reasons for Quitting scale (RFQ) (Curry et al., 1990). The RFQ scale includes 10 intrinsic motivation items (five items each relating to health concerns and self-control) and 10 extrinsic motivation items (five items each relating to immediate reinforcement and social influence). Participants responded to each reason for quitting according to 0=not at all; 1=slightly true; 2=somewhat true; 3=mostly true; and 4=extremely true. The raw data in Table 2 relating to gender differences in RFQ has been reported previously (Baker et al., 2007) and has been reproduced here for completeness.

Level of motivation to quit smoking was evaluated using the 11-item Readiness and Motivation to Quit Smoking Questionnaire (RMQ) (Crittenden et al., 1994). Participants responded to a series of statements by selecting yes or no for some questions (e.g. Are you thinking of quitting smoking?) and by selecting 1=not at all determined; 2=a little determined; 3=somewhat determined and 4=very determined for other questions (e.g. How much do you want to quit smoking?). A scoring algorithm was applied and participants were categorised into the

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