Successful quitting from a mental health perspective

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this presentation

- Identity
- Planning versus spontaneous change
- Will discuss 2 current theories of smoking cessation, TTM and PRIME
- Will link quitting with recovery and encourage you to do the same

Smoking cessation theories

- Think of identity in simple terms.
- Identities complex – context

Recovery

- Self and identity central to definitions of recovery
- Smoking cessation theories need to add more complexity
- Recovery theory can also explore identities, environment and behaviour change
- Offer alternatives

Justification for study

- Harms to health
- Harms to finances
- Social harms

1a. Impact of smoking - Health

- Mortality

- 2-3 fold increased mortality rate compared to the general population. Gap widening
  (European Psychiatric Association position statement 2009)

  Main cause of death is Ischaemic Heart Disease. Death rates for people with mental illness is 1.9 times that of general population

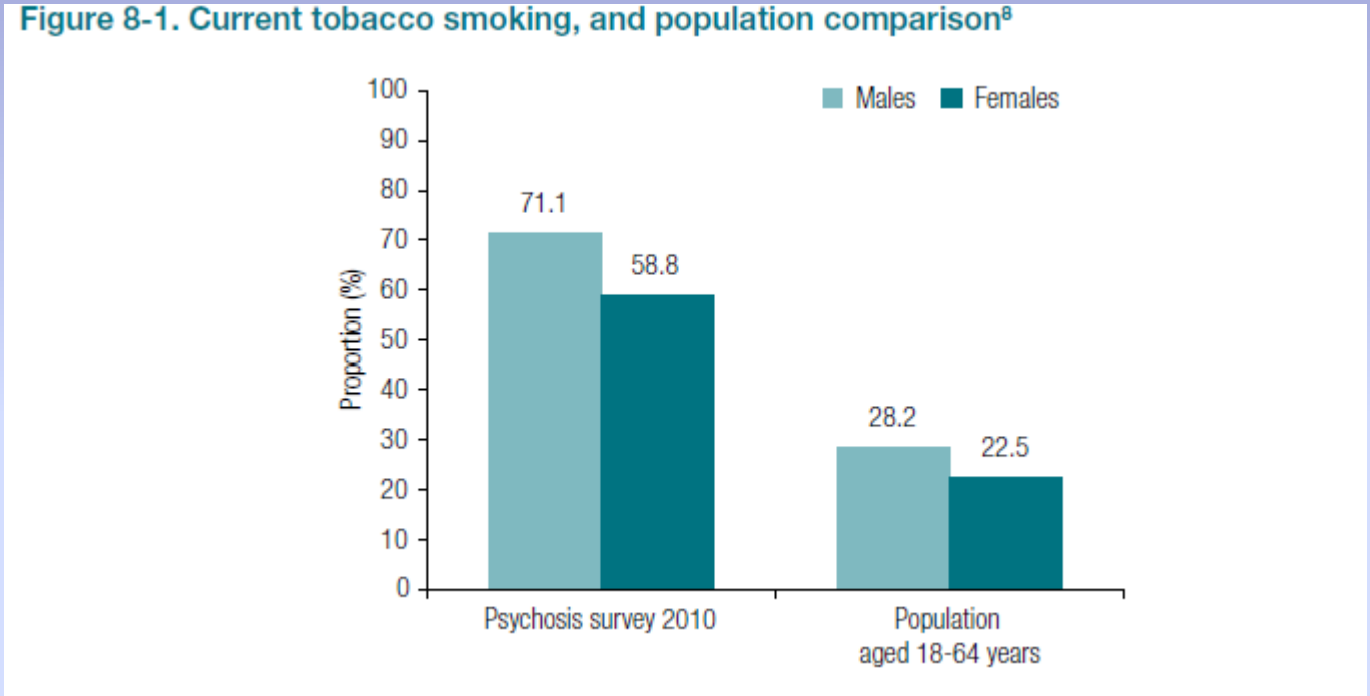
  (LAWRENCE, D.M. et al. The British Journal of Psychiatry 2003 182: 31-36)

- Increasing concerns about diabetes
  2-4 times higher among schizophrenia

1a. Finances

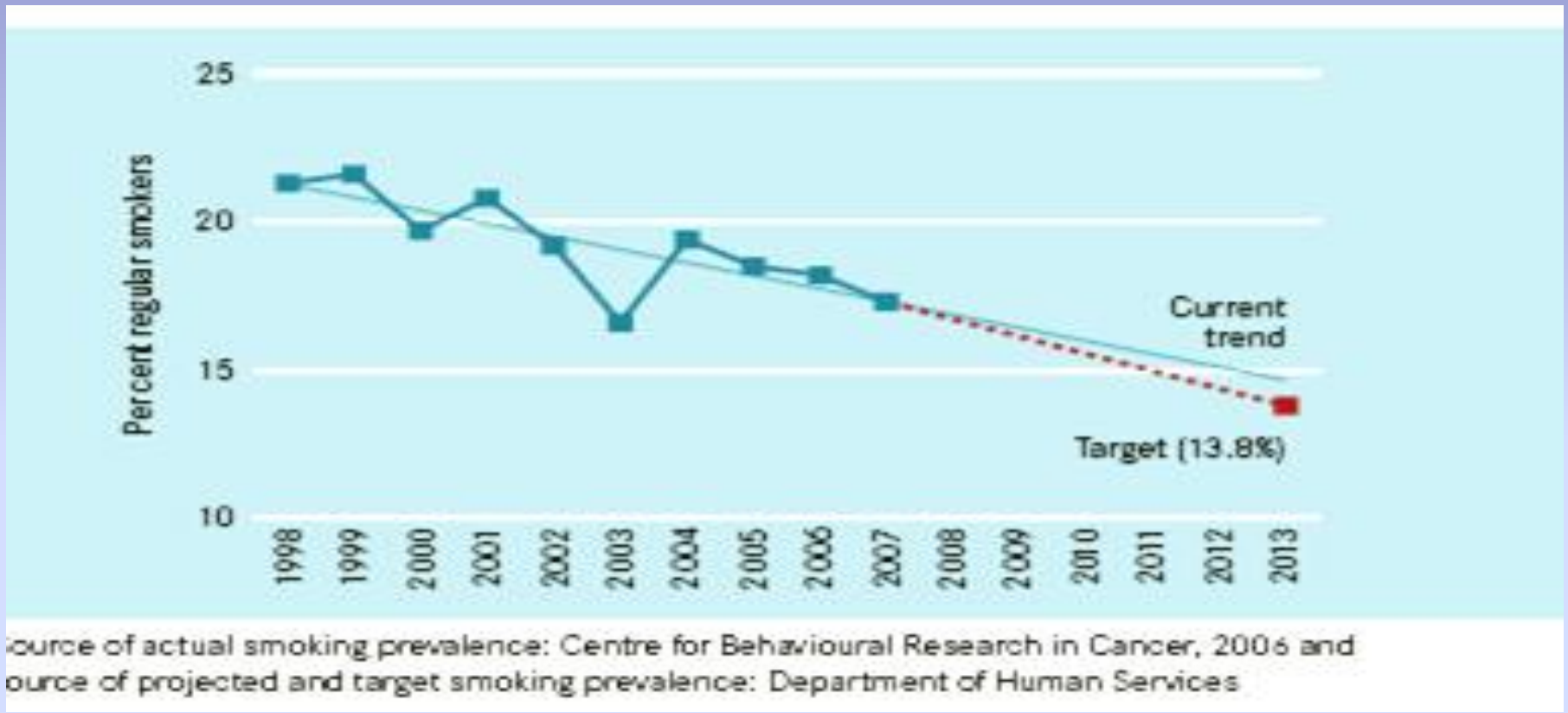
- Mental illnesses are associated with low incomes and higher levels of debt. (Jenkins et al, 2008)
- The employment rate of people with low prevalence mental illness in Australia is 28%
- 85% are recipients of a pension or disability benefit. (Jablensky et al, 2000)
- Current disability pension payment is $695 per f/n
- Cost of pack 20 cigarettes is $14-$18 ($196-$252 per f/n)
- Cost of smoking by people with (all) mental illnesses is over $3.5 billion dollars a year (health system costs, reduced productivity and money spent on drug addiction). (Access Economics Report, SANE Australia 2007)

Smoking prevalence



Dept. Health and Ageing: People Living with psychotic illness 2010

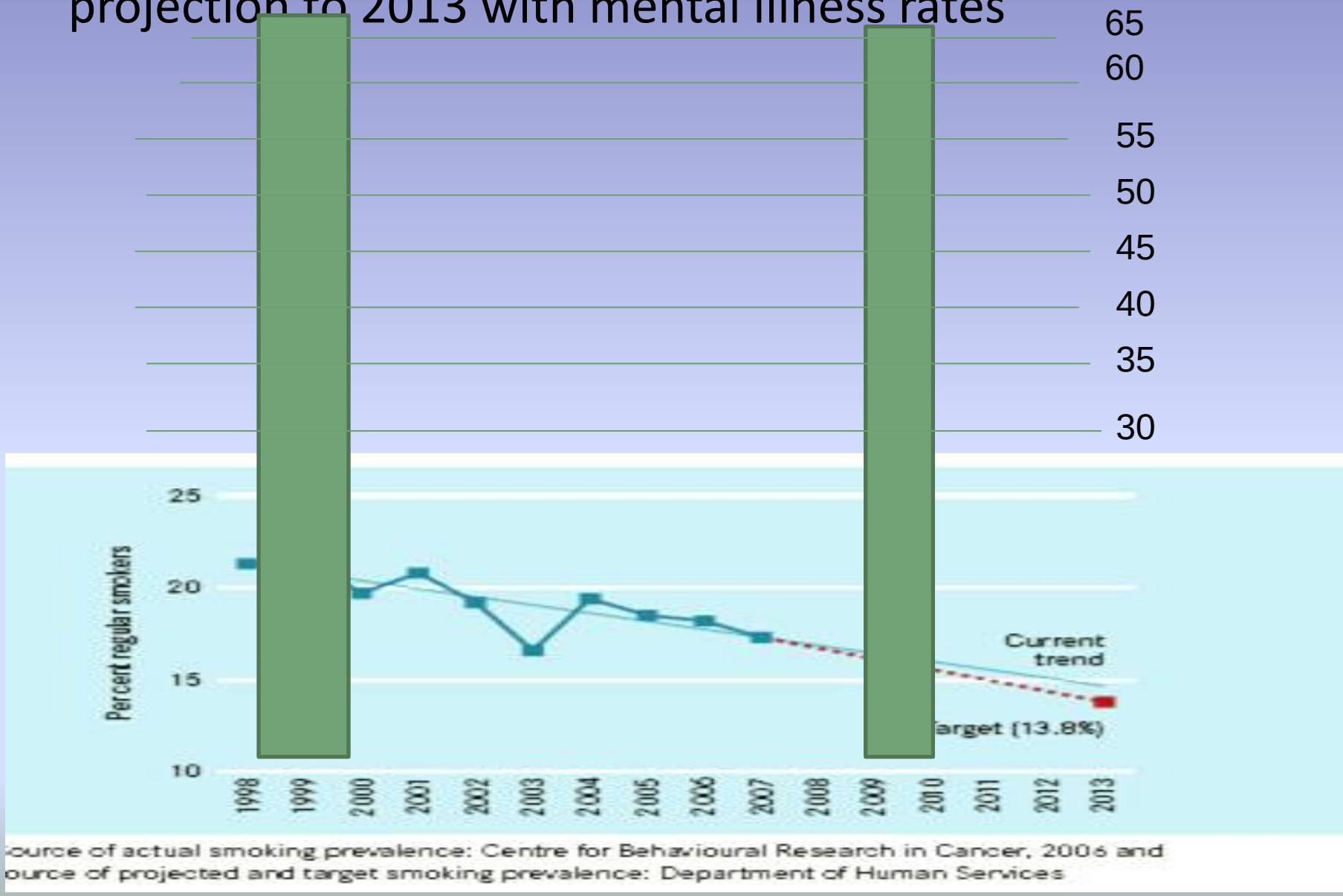
Smoking prevalence in Victoria from 1998 to 2007 and projection to 2013



ource of actual smoking prevalence: Centre for Behavioural Research in Cancer, 2006 and
ource of projected and target smoking prevalence: Department of Human Services

Ref: Victorian Tobacco Control Strategy 2008-2013
http://www.health.vic.gov.au/tobaccoreforms/downloads/vtcs0813.pdf

Smoking prevalence in Victoria from 1998 to 2007 and projection to 2013 with mental illness rates



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1a. Why no change?

- Socio-Economic Status
  lower SES smokers try to quit with the same frequency as higher SES smokers, but that high SES smokers succeed more often at quitting. (Kotz & West, 2008)

- Self-medication hypothesis (Kumari & Postma, 2005)
  - 'beneficial' effects of nicotine

- Smoking culture in mental health services (Lawn)

- Psychological factors such as low confidence, lack of motivation, skills for quitting such as planning

Stopping smoking

- Cessation studies in this group have lower success rates (RCT 10% Baker et al, 2006) vs 22% (US Surgeon Gen. 2008)

Transtheoretical Model

Prochaska & DiClemente

- Most popular model of behaviour change
- 'Stages of Change' view change as a sequential process from precontemplation to contemplation to preparation to action to maintenance or relapse

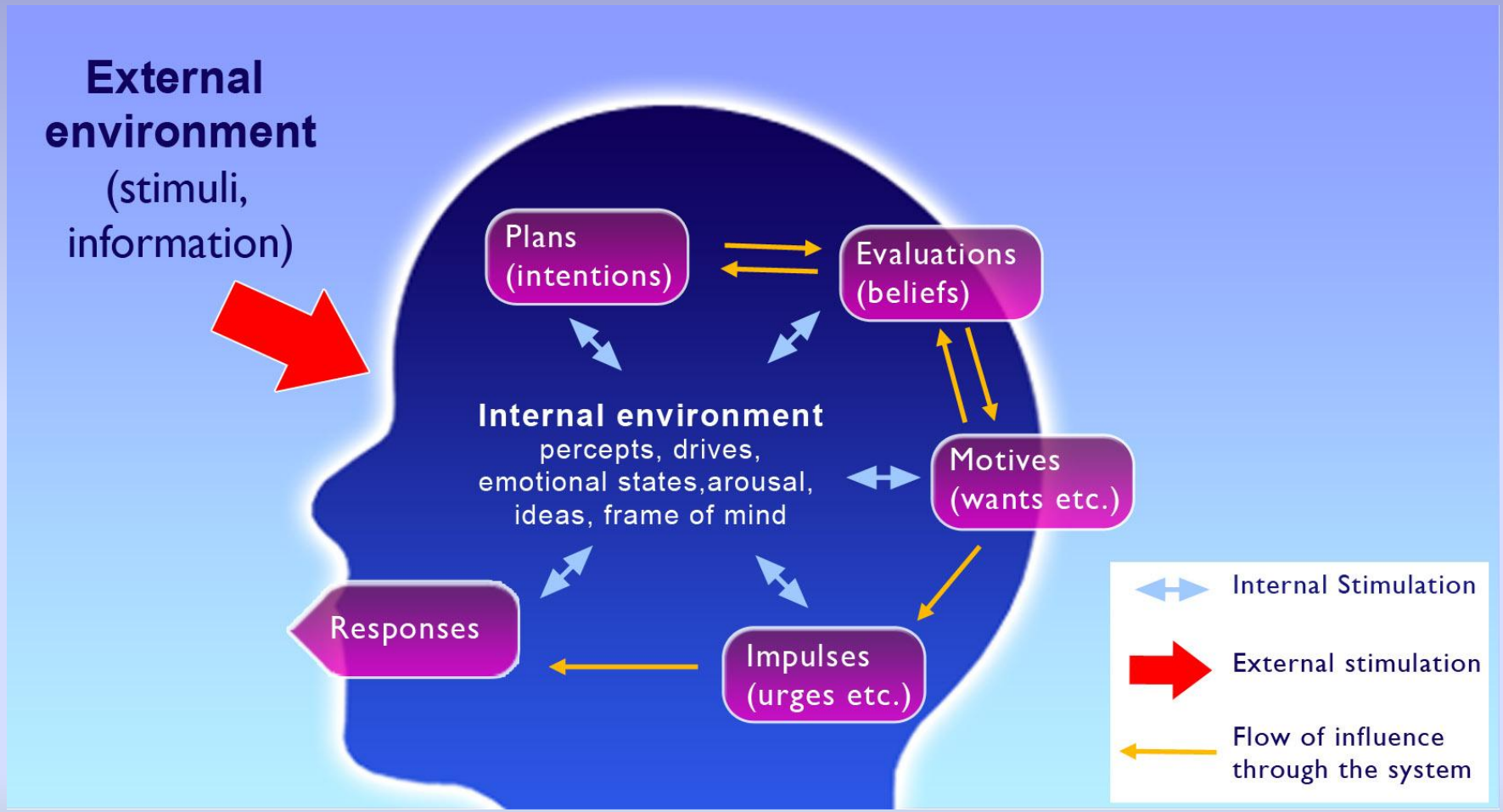
Transtheoretical Model

- Problems with TTM – “white middle class”
- Stages not exclusive, accurate, boundaries arbitrary
- Approx. half of smokers quit spontaneously

PRIME theory - 3 central ideas

- Our behaviour is driven in any given moment by wants and needs, “I want a cigarette now”
- Beliefs about what is good or bad and intentions to act are highly influenced by wants and needs in the moment, “Smoking is bad for me, but I want a cigarette now!”
- A powerful motivator of wants and needs is our identity

PRIME Theory: the structure of human motivation



www.primetheory.com

2. Method

- In this study, I asked how people with severe mental illness experienced the process of smoking cessation.
- Smoking cessation is an interpreted phenomenon
  - important in the context of the recovery model
- Interpretative Phenomenological Analysis
  - developed by U.K. psychologists (Smith, Larkin)
  - focus on phenomena as they are experienced by people
  - layers of interpretation ‘double hermeneutic’

- Semi-structured interviews

Participants - PDRS

- 10 men, 6 women
- Age range 30 to 64
- Self-reported diagnoses – schizophrenia & other psychotic disorders, depression, anxiety, personality disorder, bipolar disorder
- Previous no. cigs smoked per day 10 – 120
- Length of abstinence at interview from 1 week to 7 years
- 5 lived with smokers

Spontaneous quitting – health crisis

- “I didn’t really think about it. It was just a spur of the moment thing…I was having trouble breathing. I just said I had to give up so…I gave up because I thought I had a cardiac arrest”
  (Gary, quit 1 year ago)

Health crisis – Impact of identity

- “the woman next door to me came in after I came onto the ward and she was older, she was probably in her 80s. She turned off the oxygen herself and they found her in the morning and she was blue. She was what they call, I think hypoxic….And she said ‘I just want it over and done with I just want to die. If I can’t smoke I don’t want to live’, and I thought ‘I don’t want ever to be that person’.” *(Lorna, quit 8 weeks ago)*

Negative self-identity

- “even before the pneumonia, but I was not succeeding, so the more I would not succeed, the more I would smoke because I would **see myself as a failure** anyway. I’d say to my mum I’m going to try and give up smoking at the end of this packet and she’d say yeah right. And she’d be right, I wasn’t able to, I couldn’t do it.” (Lorna. *Bold added*)

Negative self-identity and self-awareness

- I think when I was smoking, ‘oh its too hard to quit I cant do it’. But actually it’s a lot easier than I thought it would be for me both times. I had my cravings, the ‘cringey ooh god I want a cigarette’, they’re about 5% of the time. And then the other 5% is when I see my mum’s smokes on the kitchen table and my hand starts to reach for them and I pull back and think, ‘No I don’t smoke. Don’t be stupid’.

Losing your smoking identity

- “It wasn’t even a strong thought in my mind to quit, I just did it. It wasn’t so hard for me to do. I can’t explain it but it just never occurred to me to smoke again”
- “Well some would think its strong will but I don’t think its that necessarily. That would be a plus for me. I don’t think its necessarily so that I’ve got a strong will.” *(David, quit 5 years)*

TTM and Spontaneous Quitting

- Smokers unconsciously make unplanned attempts to prove that quitting is too hard or they are incapable of quitting and this is designed to “relieve guilt and social pressure”
- Undermined by studies of spontaneous quitting

Planned quitting and identity

- “And when they started stopping you in restaurants and whatever smoking that really annoyed me! That really did get under my skin. I was angry I had to go and stand out the front on show and have a cigarette that really annoyed me. That was when I seriously thought now you’re going to be 60 soon and you’re going to Queensland so I thought if you go and get Nicabate tablets, I’ll try those.”
(Melanie, quit 4 years ago)

Planned quitting and identity

- my GP like he's a professional. Very unprofessional to say to me – have a smoke, it'll make you feel better. And I said, no I won't and I'm not smoking. But Therese you've got so much on your plate. And I go, but what's a cigarette going to do?
- (Therese, quit for 3 years)

Masculine identity

- “Some days will be alright but you have to keep fighting because you know your quality of life and your health is going to be very bad if you keep smoking. So that’s basically what I do, I’ve had this sort of you know I say to myself that I had to stop, so I’ve just had to fight along with it” *(Wasim, quit 3 months)*

Masculine identity

- “When you give up you’ve got to be ready yourself. You’ve got to be focused – that’s what I’m going to do, I’m going to give up smoking”
- “I thought I was invincible when I gave up for that time. It was too good to be true, it was too easy…I was really strong-headed about it” *(James, quit 6 months ago)*

Discussion

- PRIME - Identity as a central feature of motivation helpful in understanding the experiences of these participants
- Mental illness factors do not necessarily inhibit quitting
- TTM - Participants' spontaneous quitting was successful and not an attempt to sabotage self

Limitations

- Only spoke to successful quitters
- Using interviews to support quitting
- My own identity as someone pro-quitting
- Recording interviews – privacy, paranoia/trust, censoring
- Idiographic nature of IPA

Implications for practice

- Move away from single model
  - appreciate different styles
- Focus on adequacy rather than deficits
- The environment needs to support goals to cut down and stop