

Regular article

Comparison of two intensities of tobacco dependence counseling in schizophrenia and schizoaffective disorder

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Abstract

Compared to the general population, smokers with schizophrenia (SCZ) have reduced success in quitting smoking with usual approaches. This study tested two manualized behavioral counseling approaches—Treatment of Addiction to Nicotine in Schizophrenia (TANS) or Medication Management (MM)—for smokers who were motivated to quit. Individual counseling sessions were provided by mental health clinicians in mental health settings, along with nicotine patch. The two treatments varied in intensity and frequency of sessions. Eighty-seven subjects were randomized and attended at least one treatment session. Twenty-one percent ($n = 18$) of participants had continuous abstinence at 12 weeks after the target quit date, which was not significantly different between conditions (15.6% TANS vs. 26.2% MM, $\chi^2 = 1.50$, $p = .221$). Smokers in both groups significantly reduced smoking as measured by cigarettes per day and expired carbon monoxide. Findings support that mental health clinicians can be trained to effectively help smokers with SCZ maintain tobacco abstinence. © 2010 Elsevier Inc. All rights reserved.

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1. Introduction

Individuals with schizophrenia (SCZ) or schizoaffective disorder (SA) smoke at rates nearly three times that of the general population, with prevalence rates of about 60% in a variety of studies (de Leon & Diaz, 2005; Hughes, Hatsukami, Mitchell, & Dahlgren, 1986; Ziedonis et al., 2008). As with other smokers, there is now ample evidence of negative consequences from tobacco in this group with regard to poor health and poor management of finances, in

addition to the stigma and reduced quality of life suffered by smokers in general (Brown, Inskip, & Barraclough, 2000; Dalack, Healy, & Meador-Woodruff, 1998; Goff et al., 2005; Steinberg, Williams, & Ziedonis, 2004). Smokers with SCZ are often highly nicotine dependent, have higher blood nicotine levels, and have lower than expected success rates in attempts to stop smoking, compared to smokers without this disorder (Covey, Hughes, Glassman, Blazer, & George, 1994; Lasser et al., 2000; Williams et al., 2005; Williams, Gandhi, Steinberg, et al., 2007; Ziedonis, Kosten, Glazer, & Frances, 1994).

Given the continuing high rates of tobacco addiction in this population, there is a need to integrate nicotine dependence pharmacotherapy and psychosocial treatments into mental health treatment settings. Based on clinical

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experience and recent literature reviews and practice guidelines, pharmacotherapy for nicotine dependence (nicotine replacement or other Food and Drug Administration [FDA]-approved products) appears to be a necessity (Hitsman, Moss, Montoya, George, 2009; Kleber et al., 2006; Ziedonis et al., 2008). In addition, there appears to be a need to train mental health clinicians to provide behavioral therapy for this population, including how to integrate tobacco dependence treatment into their mental health treatment. This will include a role for educating clients about the use of pharmacotherapy to improve compliance.

Although psychosocial treatment is recommended as first-line evidence-based strategy for smoking cessation, less than 5% of all smokers make use of behavioral interventions to help them quit smoking (Fiore et al., 2008). There have been several studies examining the effectiveness of smoking cessation treatments in SCZ, although most have focused on pharmacological interventions such as nicotine patch (NP) or bupropion (BUP; Montoya & Vocci, 2007). These studies included counseling in the overall treatment approach; however, the counseling was not the focus of the intervention. There have been fewer studies of intensive behavioral counseling for smokers with SCZ, and reported studies of combined interventions have study designs that make it hard to disentangle the effects of the psychosocial from the pharmacological intervention (Steinberg & Williams, 2007).

Addressing the unique problems of SCZ, including persistent symptoms, low motivation, poor social skills, cognitive limitations, and difficulty forming a therapeutic alliance, may be critical in helping this population to quit smoking. Key aspects of an adapted behavioral treatment for tobacco dependence in smokers with SCZ should attempt to increase and maintain intrinsic motivation to change, improve self-efficacy to manage smoking cues that are prevalent in the environment, and include the use of personalized feedback blended with relapse prevention and social skills training. Many of the skills necessary to quit smoking involve influencing one's social environment in some way, and given deficits in social skills, enhancing this in treatment has been discussed in the literature (Addington, el-Guebaly, Campbell, Hodgins, & Addington, 1998; George et al., 2000; George et al., 2002; Ziedonis & George, 1997). Avoiding triggers such as ubiquitous peers who smoke or finding activities during leisure time that do not involve smoking is important. Poor social skills associated with negative symptoms of SCZ (these include apathy, lack of emotion, poor or nonexistent social functioning) may make this difficult.

In general, there is a dose–response relationship with better smoking abstinence rates associated with more psychosocial treatment (total minutes of contact) during the quit attempt (Fiore et al., 2008). Community-based smoking cessation services for the general population are often brief in session length and time limited (about four to six sessions; Fiore et al., 2008). Altered learning and information processing in SCZ require adaptations from traditional

smoking cessation approaches. More and longer treatment sessions are needed to adequately cover materials, review key concepts, and allow for in-session practicing of new skills. Several prior studies of smoking cessation in SCZ have included extra sessions prior to the quit date to provide more time for the use of motivational enhancement techniques (Addington et al., 1998; George et al., 2000; Ziedonis & George, 1997; Ziedonis & Trudeau, 1997). Additional time for client education is also essential with repetition of key concepts. Handouts also facilitate different learning styles and help reinforce medication information. In the delivery of motivational techniques, it is helpful to provide personalized feedback via handouts and visual displays of information via graphs (Steinberg, Ziedonis, Krejci, & Brandon, 2004).

There are currently only two published studies of smoking cessation in SCZ that emphasized the psychosocial treatment and included a quit date. George et al. (2000) found that although there were no statistically significant differences in abstinence rates at a 6-month follow-up evaluation between participants attending a standard American Lung Association group protocol and those attending a protocol focused on smokers with SCZ, those receiving the SCZ-focused protocol were significantly more likely to achieve continuous, 4-week abstinence at end of treatment than those receiving the standard protocol. Baker et al. (2006) conducted a randomized controlled trial of a smoking cessation intervention among people with a psychotic disorder. The treatment condition included eight individual 1-hour sessions of motivational interviewing (MI) and cognitive–behavior therapy plus NP, whereas the control group received treatment as usual, consisting of booklets for smoking cessation and NP. Although this study found no overall differences between the treatment and comparison groups, there was a strong dose–response relationship between treatment session attendance and smoking abstinence and reduction. Attendance at eight treatment sessions was associated with the highest continuous abstinence (CA) at 3 months, and no participants who attended fewer than five treatment sessions reported abstinence at any follow-up point (Baker et al., 2006). Building on our past clinical and research experience, we conducted a study examining two levels of intensity of individual counseling treatment for smokers with SCZ. In addition, this study trained mental health clinicians who had not done smoking cessation behavioral counseling previously in the context of a community-based mental health center.

2. Materials and methods

This study tested two different intensities of behavioral counseling approaches—Treatment of Addiction to Nicotine in Schizophrenia (TANS) or Medication Management (MM)—for smokers with SCZ or SA who were motivated to quit.

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