Integrating Religiosity into Motivational Interviewing and Nicotine Replacement Therapy for a Patient with Schizophrenia and Nicotine Addiction: Lessons from a Mental Health Service

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Abstract

Background: Patients with schizophrenia have a higher incidence of smoking relative to the general population. They are more likely to smoke high-tar cigarettes than patients of other mental health problems. Smokers with this diagnostic category are therefore more likely to be addicted to nicotine, and are at an increased risk of developing serious health complications. Despite this, they are generally unlikely to seek help to quit smoking, a function of their inability to do so. Although this is the case, patients with schizophrenia are rarely involved in smoking cessation activities. Hence, this case study of a smoking cessation programme.

Aim: The intention of this case study is to explore the effectiveness of an integrated smoking cessation programme in enabling patients to stop smoking. This paper describes the application of this programme on patients with schizophrenia and nicotine addiction. It also describes roles played by its components in smoking cessation.

Methods: The integrated programme comprised of nicotine replacement therapy and motivational interviewing. It is a 10-week programme that involved six patients. One patient was also offered an additionally 6-week tailor-made integrated programme comprised of nicotine replacement therapy and motivational interviewing that creates space for discussion of religious beliefs. This is first to include religion, nicotine replacement therapy and motivational interviewing in a smoking cessation treatment for patients with schizophrenia.

Results: Five patients quitted smoking at the end of the 10-week programme, and one stopped smoking at the end of the additional 6-week programme. In sum, the integrated programme was successful in enabling patients to stop smoking.

Conclusion: These findings indicate that stopping smoking is possible for individuals with schizophrenia, especially if the treatment is tailor-made to incorporate patients’ wishes. Quitting should not be considered impossible for individuals of this patient group. Religious beliefs do have a part to play in smoking cessation. The strength of religious identification may enable people to abstain from substance use and misuse.

Keywords: Motivational interviewing; Nicotine replacement therapy; Schizophrenia; Religion; Smoking cessation

Introduction

People with mental disorders are twice more likely to smoke than individuals with no mental illness [1]. This chance of smoking is even greater for people with severe mental health problems, such as bipolar disorder and schizophrenia [2]. Approximately 85% of people with schizophrenia smoke more cigarettes than smokers without this diagnosis [3]. Individuals of this patient group are also 13 times more likely to smoke high-tar cigarettes than patients of other diagnostic categories like anxiety and depression [4]. Certainly, such smoking characteristics lead to greater exposure to nicotine which, as reiterated in a number of studies, contributes to reduced smoking cessation rates in this population.

The choice of medication offered also contributes to smoking cessation failures. People with schizophrenia are often treated with both typical and atypical anti-psychotic medication, with the former often generating extrapyramidal side effects, such as akathisia and tardive dyskinesia [5]. Smoking or nicotine consumption ameliorates these side effects as well as some illness-related negative symptoms, like amotivation and anhedonia [6]. It is therefore not surprising to note a significantly high incidence and prevalence of smoking behaviour among patients with this diagnosis [7]. Such an elevated rate of smoking is a significant contributory factor to the high medical comorbidities in schizophrenia [8,9]. Despite this, mental health services do not often offer smoking cessation services. However, infrequent general advice to quit is noted in the literature to be provided by mental health nurses who are often not trained to do so [10]. Acknowledging this, cigarette smoking among people with schizophrenia is a serious health concern which needs to be addressed by mental health services.

Background

Cigarette smoking is a worldwide problem that increases both the morbidity and mortality of individuals. It is reported to accounts for 3 to 5 million deaths worldwide annually, an estimate that is predicted to reach 10 million in the year 2030 [11]. Individuals with schizophrenia are at a greater risk of death than those in the general population [12]. Added to this, they are generally believed to die prematurely;
Schizophrenia patients, particularly those who smoke regularly, are at an increased risk of dying from stroke, cardiovascular and respiratory disorders [14]. Despite this, individuals of this patient group are generally unlikely to seek help to quit smoking, a function of their inability to do so [15]. This appears to be the case, as many researchers stress that many individuals living with schizophrenia do want to quit smoking, but this desire is in the main impaired by loss of confidence and ability caused by their illness [4]. Yet smoking cessation activities, including counselling, are rarely provided to these patients. This is a function of healthcare professionals' assumption that members of this patient category are unlikely to quit smoking. But taking into account the high rates of cigarette smoking among people with schizophrenia and the health implications associated with this behaviour, it is critical to offer assistance with smoking cessation to this patient group.

It is noteworthy to indicate that there is currently no specific protocol available in the United Kingdom to guide smoking cessation activities for people with severe mental health problems. This is based on the view that the treatment approaches that are deemed to be effective in other clinical populations are also valuable in enabling individuals with severe mental health problems to stop or at least reduce their smoking behaviour. These views are shared by healthcare providers in other parts of the world. Taking Canada and Australia as examples, mental health services are encouraged to implement smoking cessation programmes similar to those that are effective in the general population [1,2,4]. However, taking into account that quit rates are significantly lower in people with mental health problems than the general population, it is critical to state that cessation interventions may require some degree of adjustment, for example, in treatment duration, to effectively address the needs of this patient group [16].

The standard treatments offered to smokers wanting to quit smoking include nicotine replacement therapies (NRTs) and psychological approaches [17]. NRTs are available in gum, inhaler, spray, lozenge and nicotine patch. The psychological approaches, which include motivational interviewing and cognitive behavioural therapy (CBT), can be delivered using an individual or group format. The use of a single treatment strategy, NRTs or psychological approaches, is identified in some studies to reduce smoking rates in smokers with a diagnosis of schizophrenia. Patches and inhalers are frequently used in in-patient settings as the main forms of NRTs. The use of these forms of NRTs reduced cigarette consumption among patients with schizophrenia in both in-patient and community settings [2]. However, patients with this diagnosis are often reported to experience some difficulties maintaining long-term abstinence. Similar findings were observed in studies which used single psychological approaches, such as CBT, to facilitate smoking cessation in patients living with schizophrenia [18]. Although individuals of this patient group are usually motivated to stop smoking the absolute quit rates when single approaches are used, are usually significantly lower compared with people without mental health problems [19]. Acknowledging this, combining pharmacological and psychological treatment approaches may optimise outcomes.

A combined treatment approach of NRTs, CBT and bupropion on patients with schizophrenia, indicated a significantly higher abstinence rate at six month in the treatment group relative to the controls [20]. A comparable outcome is noted in a similar study conducted three years later [21]. High quit rates were achieved in the treatment group compared with the control group, with indications of acute urges to smoke noted in some members of the former [22]. The presence of these urges indicates the possibility of relapse; meaning some patients may resume their smoking behaviour. For these patients, this may not only indicate a low readiness to quit smoking, but it may also suggest the possibility of nicotine dependence.

Nicotine dependence relates to compulsive use of tobacco product and diminished ability to abstain [23]. In addition to compulsion to smoke, people who are addicted to nicotine also frequently encounter intense motivation to continue with their behaviour [24]. It is these two factors, as repeatedly reiterated in the literature that overwhelm and undermine people's attempts at abstaining from smoking [25]. Clearly, motivation to smoke is a central feature of nicotine dependence. Accepting this, smokers' ratings of their urges or motivations to smoke could serve as a useful measure of dependence severity. Knowing the severity of nicotine dependence would enable healthcare workers to offer appropriate cessation support to patients.

The most commonly used tests of nicotine dependence are the eight-item Fagerström Tolerance Questionnaire (FTQ) [26], the six-item Fagerström Test for Nicotine Dependence (FTND) [27], and the Heaviness of Smoking Index (HSI), developed in 1989 using two questions from the FTQ and FTND measures; time to first cigarette after wake up and the number of cigarettes smoked per day [28]. These questions have not only been noted to account for most of the cessation predictive value of the Fagerström questionnaires, they have also been validated in a range of studies to provide similar results [29-31]. Simply, the HSI is a reasonably reliable and valid test of nicotine dependence [32]. Noting this, the HSI, a two-item easy to use instrument, was utilised before implementing the integrated smoking cessation programme to determine the severity of nicotine dependence of participants. It must be stressed that low motivation to quit, noted among persons with schizophrenia, is a major barrier to improved cessation outcomes [22]. Thus, it is advisable for cessation treatments to include a motivation enhancement therapy.

The author of this work implemented an integrated treatment programme of motivational interviewing and NRTs on smokers with schizophrenia in an in-patient setting who expressed intentions to quit. This is a case study which intends to describe the role of the programme components in smoking cessation. Although a generic approach was adopted for all patients, more attention was paid on a specific patient who was observed to have a long standing problem with cigarette smoking (Details provided below). Permission to conduct the case study was sought and gained from the Trust’s Research Ethics Service. In addition to preserving anonymity, both verbal and written consent were obtained from the patients for conducting the case study.

Case Description

A total of 6 patients took part in the integrated smoking programme. All patients were men, had a diagnosis of schizophrenia and were hospitalised on a male-only ward of a secure psychiatric hospital in the United Kingdom. On average, five of the patients were 45 years old and began smoking when they were 25 years old. This means they had been smoking for approximately 20 years. For these patients, the reported time to first cigarette was between 6 and 30 minutes, and smoked an average of 24 cigarettes per day. These patients had a mean HSI score of 4, which means they were heavily dependent on nicotine. While this was the case, they expressed a desire to quit smoking but acknowledged limited confidence in their ability to do so. According to these patients, the wish to quit smoking was in the main a function
of their health concerns. The sixth patient was noted to be different in a number of ways. It was these differences (such number of cigarettes smoked) that triggered this case study. Hence, a detailed account of the same is presented.

Thomas (a pseudonym) is a 64-year-old Caucasian male patient detained under the Mental Health Act 1983. He was diagnosed with schizophrenia at the age of 24 following referral to a local community mental health resource centre by a relative who was concerned about his behaviour. He was described at the time to be isolative with low motivation to engage with people, limited interest in his surroundings and occasional delusional expressions, which were in the main associated with religion.

Thomas had a long history of cigarette smoking. He commenced smoking when he was 16 years old and claimed to use cigarette smoking to cope with isolation. Thomas cigarette smoking increased over the years. He was reported to smoke about 40 cigarettes per day, and the time to first cigarette after waking in the morning was within five minutes. Thomas was assigned a HSI score of 6, which was noted to be higher than that of other patients (HSI=4). Thomas motivation to quit was observed to fluctuate. This was usually influenced by how he perceived his health. He had diagnoses of chronic bronchitis and emphysema, and the latter was claimed to contribute to his frequent experiences of breathlessness. Despite these health problems, Thomas continued to smoke. However, Thomas has made three attempts to quit smoking, but was unsuccessful because of reported limited skills to do so.

Components of the integrated programme

Motivational interviewing (MI): MI is a directive patient-centred counselling technique for eliciting behaviour change by helping people to explore and resolve ambivalence or uncertainties about their behaviour [22]. This approach is underpinned by the assumption that people’s motivation to engage in a behaviour is fluid, as it can change from one situation to another [22]. Consequently, counsellors using this approach are required to adopt the view that people’s motivation can be influenced to change in a specific direction. Hence, lack of motivation to engage in behaviours, often described as resistance to change, and should perhaps be perceived as something that can be changed.

The use of aggressive or confrontational styles in MI can strengthen resistance to change [22]. Noting this, MI involves the application of carefully selected sets of techniques for addressing difficulties people may experience about making behaviour changes. Examples of these include assessing patients’ readiness for change, ambivalence about changing behaviours, eliciting change talk or self-motivational statements, reflecting patients’ self-motivating statements, summarising and highlighting desire for change [33]. The implementation of these techniques within a MI process is guided by four principles; expressing empathy, developing discrepancy and rolling with resistance [22]. MI is a brief psychotherapeutic intervention, applied in this case as a multi-session course of treatment.

MI has enjoyed strong empirical evidence over the years in treating addictive behaviours, particularly alcohol and substance abuse [22]. It has demonstrated efficacy in treating medication adherence, safe sex and exercise practices, and treatment engagement [34]. In relation to nicotine addiction, a recent meta-analysis, using 31 control trials, illustrates the efficacy of MI as a treatment option for this behaviour [35]. These studies demonstrate that MI is an effective approach for treating nicotine dependence among pregnant and non-pregnant populations. Whilst MI has been extensively and successful applied in smoking cessation programmes for a wide range of clinical populations, there is a dearth of literature of its use on smokers with schizophrenia. To the author’s knowledge there is only one control trial on the use of smoking cessation programme for people living with schizophrenia. The study in question relates to the application of MI with personalised feedback to enable patients with schizophrenia to seek treatment for nicotine dependence [36]. MI emerged from this study as both an effective and superior strategy over psychoeducation for motivating patients to quit smoking [36]. MI is therefore used by this author as part of a smoking cessation programme, as it is well suited to motivate, engage and enable people to change health-risk behaviours [37]. Although substantial progress has been made in the treatment of smoking behaviour and nicotine dependence, treatments that combine psychological and pharmacological approaches have shown the greatest efficacy.

Nicotine replacement therapy: This therapy uses nicotine as a drug to minimise nicotine withdrawal symptoms in people making attempts to quit smoking [38]. There are different forms of NRTs, and the types used in the integrated programme were nicotine patches or patches. This form of NRTs, sometimes referred to as transdermal nicotine systems, provides a measured dose of nicotine through the skin. Patches have different strengths or doses of nicotine. The general trend is that individuals, particularly heavy smokers are commenced on high doses of patches (e.g. 22mg of nicotine) and subsequently weaned of nicotine by gradually changing, over a course of treatment, to lower dose patches (e.g. 5–14 mg nicotine) [10]. Although such approach has been reported to be successful in reducing smoking rates, it has been highlighted that individuals using nicotine patches occasionally get addicted to them, and may experience serious side effects, such as cardiovascular diseases [39]. As a result of this, the use of NRTs should be carefully monitored to prevent the possibility of health problems. Another problem that relates to nicotine patches is that using the same over a prolonged period of time could result in another addiction.

Religiosity: religious activities: Religion refers to an organised system of beliefs, rituals and practices intended to mediate an individual’s relationship to the community, and to the sacred [40]. Some of these practices, which include church attendance and personal devotion, provide some social structures that may prevent humans from engaging in self-destructive behaviours, such as drug and alcohol abuse [41]. Religion is a form of social control and most traditional practices discourage the use and abuse of substances that may jeopardise people’s health [42]. For example, Muslim and Mormon faiths totally proscribes the use of alcohol, an action referred to in the literature as religious injunction [43]. This injunction has also been extended to some Christians, such as the Seven-Day Adventists [44], it is critical to note that most religions have conservative views about alcohol and substance use, prohibit the use of the same [45]. This protective function of religion is a well-known phenomenon in mental health services. Besides offering protection from alcohol and substance use and abuse, religion can help people recover from addictions and mental disorders [43].

Starting with psychiatric conditions, patients receiving mental health services often use religion to cope with their distress and other life difficulties. It is repeatedly mentioned in the literature that people with schizophrenia consider engagement in religious activities, such as church attendance, the most beneficial alternative to health practice [46]. Perhaps, this is a function of the view that religion is available to anyone at anytime, irrespective of people’s experiences. It can therefore be relied upon to offer resilience, coupled with a sense of meaning and purpose even during adverse life circumstances [42]. In relation to
depression and anxiety disorders, a large number of studies revealed an inverse relationship between religious involvement and experiences of symptoms [47]. Simply, this means that people with these disorders may experience symptom improvement when actively engage in religious activities.

A similar relationship exists between religion and addictive behaviour. It is claimed that the strength of religious identification and the frequency of attendance to religious services predict lower substance use [44]. Such a relationship is usually clearer in religious traditions with stronger norms against substance use. Thus, incorporating patients’ religious themes into a cessation treatment may significantly increase its efficacy. For these reasons, it is assumed that most users of substances, including cigarette, would welcome the integration of religious beliefs into their attempts to quit their health-risk behaviours. Yet, there has been little attention given by researchers on the incorporation of religion in the treatment of addiction. This study is among the few that incorporated religion into a smoking cessation programme. It is the first to include religion, NRTs and MI in a smoking cessation treatment for patients with schizophrenia.

**Application of integrated programme**

The initial phase of this 10-week programme commenced with a comprehensive assessment of all patients involved (n=6). This was carried out by the patients’ responsible clinician (psychiatrist) two weeks before starting the cessation treatment. The intention was to develop an understanding of their medical and psychiatric histories, including smoking behaviour, dependency and motivation to quit. All patients were observed to be severely addicted to cigarette, in other words dependent on nicotine, a chemical (alkaloid) in cigarette that causes dependency. Given the severity of nicotine dependence observed among the patients, they were commenced on NRTs (patches), part of the second phase of the programme. Patients were carefully instructed on how to use the patches and used the same on a daily basis. A reducing regime in the context of nicotine patch strength was adopted over the course of the programme. Dosing began at 22 mg/day for six weeks and was then switched to lower doses of 14 mg/day and 7 mg/day for two weeks each. NRTs (nicotine patches) were provided in conjunction with group motivational interviewing.

Group motivational interviewing was offered to all patients on a weekly basis for a period of 10 weeks. Each MI session lasted for approximately 70 minutes. The sessions were facilitated by the author of this report, a certified facilitator in smoking cessation programmes, also a mental health practitioner experienced in group work. The sessions focused on enhancing patients’ motivation and commitment to change, identifying triggers to smoke and developing coping strategies to manage identified triggers. Patients’ motivations were assessed by exploring their perceptions of confidence and importance of change. This was achieved by asking questions using a scale with graduations from 0 to 10 for each of the dimensions. The patients were asked, for example, the following questions on importance: on a scale of 0 to 10, how important do you think it is for you to quit smoking? On this scale, 0 is not at all important and 10 is extremely important, where would you say you are? Similar questions were asked about confidence: on a scale of 0 to 10, how confident do you think that you can quit smoking? On the same scale, 0 is not at all confident and 10 is extremely confident, where would you say you are? This strategy enabled the patients to verbalise and process their ambivalence further.

Motivation for change was further explored by examining patients’ perceptions of the advantages and disadvantages of smoking. In this context, they were initially asked to make a list of their likes and dislikes about smoking, as a preface to listing and talking about the likes and dislikes of abstaining from smoking. This strategy enabled the patients to clarify both sides of their ambivalence. This was generally followed by the use of double reflections on the benefits and costs of smoking with the view of strengthening change discussions. For example, it is important for you to smoke in order to deal with the stresses of the ward, but you also wish you could quit in the interest of your health. This approach helps patients to focus discussions on their need for change, stop smoking. Discussions relating to coping with stress were held. In this context, patients were asked to make a list of factors on the ward that cause them stress and how they cope with them. This strategy generated discussions of situations, such as feelings of boredom, patients perceived to be stressful and alternative ways of coping without the use of cigarette.

At the end of the 10-week programme, one patient, Thomas, experienced some difficulties with quitting smoking. As a result, this patient was provided an additional 6-week integrated programme that included NRTs (patches) and individual MI. Thomas was on 7 mg/day nicotine patch.

Individual MI sessions were offered to Thomas, and each of the sessions ran for about 60 minutes. In addition to the elements of the group MI, the individual sessions focused on eliciting Thomas’ own self-motivational statements and affirming that change is always possible but can sometimes be difficult to achieve. The sessions also concentrated on enabling Thomas to consider the advantages and disadvantages of continued smoking versus smoking cessation and to formulate an individualised change plan that was realistic and acceptable to him. Thomas requested for regular church attendance and occasional religious discussions during MI sessions to be part of the change plan. The issue of church attendance was addressed, as he commenced attendance to a non-catholic church. Religious beliefs were discussed during MI sessions only when raised by Thomas. For example, he mentioned in three of sessions that his faith discourages cigarette smoking, illicit substances and alcohol use. Thomas understanding of this and impact on his smoking behaviour was explored when ever raised.

**Results and Discussion**

This case study adopted an integrated approach that mainly utilised NRTs and motivational interviewing, but also used religious discussions on one patient who experienced some difficulties with quitting smoking. Given that all the patients were heavy smokers, as revealed by high HSI scores (≥4), their need for nicotine replacement was expected. They were therefore commenced on high doses of nicotine patches, which were gradually reduced as treatment progressed. People, who are heavily dependent on nicotine, as noted in the patients of this case study, may find it difficult to abstain from smoking [19]. Generally, such difficulties are a function of high nicotine dependence, caused by long duration of smoking and heavy daily cigarette consumption [4]. This is the case for the patients of this report, and it was reported that the heavy and frequent cigarette smoking observed was attributable to boredom and stresses associated with institutionalisation.

Experiences of feelings of boredom and being controlled and loss of control of some activities of daily living, such as when to retire to bed, were acknowledged by patients to generate stress that led to anger and frustration. In such a heightened emotional state, patients asserted, customary ways of coping, which include social interaction, were ineffective in restoring emotional calmness. These patients employed cigarette smoking as an approach to regain emotional control. Despite
there, it is consistently reiterated in the literature that group or individual
counselling can facilitate cessation and improve rates of abstinence
even in heavily nicotine dependent patients [18]. It is believed that
abstinence rates can be improved when patients are offered integrated
treatment approaches of psychological and pharmacological therapies
[20]. On the basis of this, the patients were also offered weekly group
MI sessions that facilitated discussions of smoking cessation, which in
turn offered support to group members.

All the patients (n=6) completed a 10-week programme. Five patients (83%)
quit smoking and remained completely abstinent (verified using carbon monoxide technique) when followed-up at six
months after the programme. The motivation for these patients to quit
smoking was in the main intrinsic, as their commitment and desire
to engage in the programme was influenced by health concerns. In
addition to experiences of urges to smoke, particularly in the morning,
the patients expressed limited confidence and ability to stop smoking.
Clearly, they had low self-efficacy to quit. Hence, one of the key tasks
during the application of motivational interviewing was to enhance
patients` confidence, motivation and coping skills that would enable
them to engage in behaviour change.

Motivation for change was enhanced by enabling patients to
explore the advantages and disadvantages of quitting smoking. In
addition to saving money, all patients reported that quitting would help
minimise the risk of developing health problems like cardiovascular
diseases. After the fifth group session, patients repeatedly stated that they disliked tobacco odour. In addition to the health concerns, this
was a significant motivational factor noted among this patient group
to engage in attempts to quit smoking. Although this was the case, the
patients expressed a lack of confidence to do so.

Feedback was used to address the issue of confidence. Provision
of personalised feedback using normative data, such as time to first
cigarette in the morning and amount of cigarettes smoked per day, was
significant in raising patients` confidence and motivation to quit. Other
MI strategies were used to strengthen patients` need to quit smoking.
Examples of these include eliciting patients` own self-motivating
statements, and eliciting and strengthening patients` confidence. With
regard to the latter, this was achieved by exploring with patients their
personal strengths and support for change. These refer to personal
characteristics, such as being optimistic, that may help patients achieve
behaviour change. So, questions, such as the examples that follows,
were asked to elicit the same. What is there about you that would help
you quit smoking? Are there others that could help you to make this
happen?

One patient out of the six patients failed to quit smoking. This shows
that people with schizophrenia also have the ability to quit smoking.
Therefore, quitting should not be considered impossible for individuals
suffering from this disorder. However, it is critical to note that some
patients may find it difficult to stop smoking.

The patient who failed to stop smoking reduced the number of
 cigarettes smoked per day from 40 to 20 as observed at the end of the
programme. Given the fluctuated nature of the patient`s intention on
entrance into and during the programme, the reduction in smoking rate
noted was not surprising. This finding indicated the chronicity of the
patient`s smoking behaviour as well as the need to offer more
support and hope that change is possible. Patients with chronic
smoking behaviour can be enabled to quit by engaging them in
extended treatment regimes. Simply, the efficacy of interventions for
some patients can be increased by extending their duration [22]. This
is apparently the case for individuals with long histories of smoking.
As Thomas fitted well into this category, it was necessary to offer him
an extra 6-week integrated programme, which included elements of
religious discussions.

Clearly, such an approach is an acknowledgement of the notion of
“harm reduction”, which stresses that a reduction in the amounts
of cigarettes smoked per day is an acceptable phase toward complete
cessation [48]. Thomas smoked less during the 10-week programme
and achieved cessation when committed and ready to do so. Thomas
stopped smoking towards the end of the programme and was abstinent
at six-month follow-up. This outcome suggests that smoking cessation
is possible for individuals with schizophrenia when treatment is tailormade to incorporate their wishes. Thomas motivation to stop smoking
was significantly influenced by extrinsic factors, which were in the main
related to his religious beliefs and practices, such as church attendance.
The church which Thomas attended discouraged the use of substances,
including cigarette [46].

It is clear from the discussions thus far that religious involvement
is protective against substance abuse as well as promotes people`s
recovery from the same and mental disorders [43]. Noting this, it is
critical for healthcare professionals to be committed and prepared to
enable patients explore religious factors relevant to their substance
use. Although health professionals may not be experts in patients` religious traditions, they occupy a unique position to generate religious
discussions. Not engaging with patients does not only indicate disrespect for this important aspect of diversity, but it may also prevent
assessment and identification of religious needs. Thus, it is critical for assessments during admissions and even during in-patient stay
to include discussions of patients` religious beliefs. Doing so could
result in referral to appropriate religious leaders for in-depth in-faith
discussions. Hence, it is helpful for mental health professionals to
have knowledge of local religious leaders for referral and consultation
purposes, and to encourage the same to make regular visits to clinical
areas. It is also help for all mental health services to create special multi-
fait environment for religious meetings.

The author acknowledges that there are some limitations to this
case study, affecting its applicability to smokers with schizophrenia
across secure settings as a whole. It was carried in a single Trust and
utilised a small sample size of patients who expressed a desire to quit
smoking. These patients may be different from those in other Trusts in
the context of their demographic characteristics, smoking histories and
clinical presentations. The findings can therefore not be generalised to
smokers with schizophrenia across secure settings. However, they are
transferable across these settings, as they provide valuable insights and
context for understanding smoking cessation with this patient group.

Conclusion
Nicotine dependence is one of the most common co-morbidity
for individuals with schizophrenia. Because of the possibility of high
nicotine dependence, smoking cessation can be challenging for this
patient group. However, integrated smoking cessation programmes
can be effective for treating people with high nicotine addiction. The
effectiveness of such programmes can be enhanced by healthcare
professionals` willingness and commitment to engage with patients.
These professional attributes are essential as the duration of programmes
may extended to accommodate the chronicity of smoking behaviour,
severity of dependence of this patient population and institutional
barriers, such as boredom and feelings of loss of control, to cessation.
Taking these issues into account, progress along the path of cessation must be determined by patients’ ability and readiness to change. Patients should therefore not be coerced to stop smoking as taking this stance may generate resistance from the same, which can be manifested in a number of ways, such as unwillingness to change and reluctance to engage. Although this was not indicated in this case study, religion was discussed by one patient who stressed that it helped him to recover from nicotine addiction.

It has been noted that strong religious identification tends to predict lower substance use. This assertion has implication for practice. Healthcare professionals should identify at the outset during admission whether patients embrace the norms of abstinence or have negative reactions against them. In instances of the latter, the advice is not to confront but to roll with resistance, as shifting focus in this case may be perceived as disrespectful [22]. Acknowledging this, healthcare professionals may encounter some difficulties to commence religious discussions with patients. To overcome such difficulties, the recommendation is to use open questions; they are a good place to start. An example could be what do you believe in or have faith in? In sum, healthcare professionals need to be aware of the religious beliefs of their patients, appreciate their value as a resource for addressing problems of addiction.

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References


