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Phenomenological Inquiry on Cigarette Smoking in Adults With Serious Mental Illness

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Walden University

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Pedro Gabiño

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Walden University

2015

Abstract

Phenomenological Inquiry on
Cigarette Smoking in Adults With Serious Mental Illness

by

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MA, University of Antioch Santa Barbara, 2006

BA, University of Antioch Santa Barbara, 2000

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Psychology

Walden University

March 2015

Abstract

Cigarette smoking in adults with serious mental illness (SMI) has increased even when accounting for a decrease of smoking among the general population. Most of the research has focused on the prevalence, rates, and effects of smoking in adults with SMI. Little research has examined the motivations for smoking and experiences with smoking cessation among adults with SMI. Such an understanding may facilitate a reduction in smoking in this population. To address this gap in the literature, 12 adults with SMI who live in the southern Nevada area and smoke were selected through invitations distributed at a treatment facility and the use of the snowball technique. Interviews were designed to elicit these adults' views and experiences of smoking and smoking cessation. The health belief model provided the conceptual framework for this phenomenological study. Interview data were recorded, transcribed, coded, and analyzed with emergent codes and themes. Three major themes emerged from participant stories: perceived benefits to cigarette smoking, problems related to smoking cessation, and risks related to cigarette smoking. Results indicated that participants found a sense of relaxation and means of socialization while smoking. Despite attempts to quit smoking, participants struggled with the withdrawals of nicotine which led to continuous smoking despite the negative consequences of smoking on their quality of life. This study contributes to positive social change by revealing the voices of adults with SMI, which helps illuminate a more holistic approach to treatment. Study findings may contribute in the development and implementation of smoking cessation programs for this specific population.

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Dedication

This doctoral study is dedicated to my parents Roberto and Rachel Gabiño. My father passed away recently and did not have the opportunity to see me graduate. My father was a very hard working and loving man who always reminded me to work hard and do what was best for my life. His example taught me how to do just that. My mother is also a very hard working and loving parent. My mother always looked out for her children and together with my father ensured the family was well taken care of. Both my parents taught me the true value and commitment of work and education. For all my parents have taught and gave me I am grateful.

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I acknowledge the Gabiño and Zárate family. My family has been an integral part of my educational journey. It is with family support and encouragement I obtained the strength and perseverance to reach this important milestone in my life.

I express my gratitude to the participants of my study. It is through their willingness to share their stories that made this study possible.

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Chapter 1: Introduction to the Study

Introduction

In this study I utilized a phenomenological design to analyze the motivations for smoking in adults with serious mental illness (SMI). I also utilized the health belief model (HBM) as a conceptual framework to analyze specific attitudes, beliefs, and behaviors in adults with SMI who smoke (Kinzie, 2004; U.S. Dept. of Human Services, 2005).

Approximately 45 million adults are smokers and an estimated 1 in 5 adults die from the consequences of smoking within the United States (American Heart Association, 2012; Centers for Disease Control and Prevention, 2012). Consequently, professionals dealing with public health have strived to educate the public on the consequence of smoking and tobacco related deaths (American Heart Association, 2012). For instance, educating the public on tobacco use has focused on the consequences of cigarette smoking, tobacco's effect on health, and on the billions of dollars spent for intervention and treatment of smoke related concerns (American Heart Association, 2012; Margaret, McKie, & Allen, 2003). Additionally, public health organizations have disseminated information on cigarette smoking and the risk for developing various health problems (e.g. cancer, coronary disease, and lung disease) (American Heart Association, 2012; Center for Disease Control and Prevention, 2012). These educational efforts have led to an awareness that cigarette smoking is a primary reason for unnecessary deaths (Center for Disease Control and Prevention, 2012; McClave, Rock, Thorne, & Malarcher, 2011). Due to these educational efforts, cigarette smoking, the consequences of smoking,

and smoking rates have declined (Lawrence, Mitrou, & Zubrick, 2009; Lucksted, McGuire, Postrado, Kreyenbuhl, & Dixon, 2008; Snyder, McDevitt, & Painter, 2008). However, smoking rates in adults with SMI have increased despite educational efforts to lower smoking in the general population.

Despite a noticeable decline in smoking in the overall population there remains a high incidence of cigarette smoking in adults diagnosed with SMI. This phenomenon has been extensively studied (Compton, Daumit, & Druss, 2006; Dixon et al., 2007; Lucksted et al., 2008). Therefore, new avenues for conducting research within this specific population emerged due to the increasing occurrence of smoking in adults with SMI and tobacco related comorbidities (e.g. cardiovascular disease, cancer, and respiratory disease). In order to examine the impact of cigarette smoking in adults with SMI, I investigated the personal views and experiences of adults with SMI who have a history of cigarette smoking. This will serve as a foundation for interventions for this specific population and will assist adults with SMI in smoking cessation.

Within the health community, mental illness and its personal and social implications are viewed as separate. Nevertheless, integration of these two systems due to the number of adults diagnosed with SMI and entering the mental health system were occurred. It is estimated over 57 million adults have been diagnosed with mental illness in the United States and 1 in 17 adults suffer from SMI (National Institute of Mental Health, 2011). Serious mental illness is regarded as an ailment that interferes with an individual's daily functioning. Adults suffering from SMI have an axis 1 diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, or major depressive disorder

(American Psychological Association [APA], 2000). The National Institute of Mental Health (NIMH) projected that millions of individuals suffering from severe mental issues will develop a serious disability (National Institute of Mental Health [NIMH] 2011). Additionally, the NIMH indicated adults with SMI experiencing serious disability are found to have certain characteristics that vary across diagnostic categories. For instance, these differences are related to gender, age, ethnicity, race, social class, and financial status. Furthermore, more than 26% of adults in the United States account for a current mental disorder disability while of the 26% approximately 22% of adults account for severe prevalence of mental illness (NIMH, 2011). The Center for Disease Control and Prevention (CDC) reported similar data indicating approximately 25% of adults are found to have a mental illness while more than half of adults will develop a specific mental disorder in their lifetime (Center for Disease Control and Prevention [CDC]; 2012).

Despite efforts made by public health organizations to educate the general population on the consequence of smoking, evidence has shown many adults with SMI continue to smoke regardless of their chronic health condition and gradual deterioration of their quality of life (Lasser et al., 2000). Consequently, smoking in adults with SMI continues to be a problem (Dixon et al., 2007; Lasser et al., 2000).

The incidences of smoking in adults with SMI are greater in comparison to the general population and vary among diagnostic categories (Moeller-Saxone, 2008; Siru, Hulse, & Tait, 2009). For instance, researchers have shown when compared to other SMI diagnosis prevalence of smoking is greater in adults with schizophrenia, bipolar disorder,

and major depression (Johnson et al., 2010; Tidey & Rohsenow, 2010). Researchers have suggested reasons behind this trend is the result of self-medication, substance abuse, inability to cope with social situations, and lack of education in regard to smoking (Diaz et al., 2009; Dodd et al., 2010; Johnson et al., 2010; Johnson, Moffat, & Malchy, 2010; Lasser et al., 2000). Additionally, adults with SMI receiving outpatient treatment have reported poorer health, smoke related symptoms, long term illnesses, negative interactions with medication metabolism, and functional disability due to their smoking (Dodd et al., 2010). Mental health providers have also reported high costs of treatment, physical illness, and high rates of mortality when dealing with adult smokers with SMI (Heiligenstein & Stevens, 2006; Snyder et al., 2008). Not only is there a link between mental illness and smoking but also a concern that each psychiatric diagnosis brings with it additional challenges for reducing the rates of smoking.

The minimal effect in reducing smoking in adults with SMI could be due to ineffective treatment interventions. For instance, treatment interventions do not include the following six elements: (a) a view that adults with SMI struggle to accept and engage in interventions available to them; (b) the failure to evaluate the individual's low readiness to change thus leading to minimal retention of these adults in their programs; (c) a failure to understand adults with SMI are long term smokers who are unable or unwilling to stop smoking; (d) current smoking intervention programs that do not focus on co-occurring disorders; (e) interventions that do not deal with each diagnosis individually in order to understand the various levels of motivations to quit smoking; and (f) smoking interventions that fail to deal with cognitive, social, and affective deficits

found in specific diagnoses (Rogers et al., 2001; Siru, Hulse, & Tait, 2009; Snyder et al., 2008). Consequently, the increase of smoking in adults with SMI continues to occur and the necessity to isolate and further investigate certain factors that underlie a smoking trend in adults with SMI is warranted.

Efforts have been made to isolate the root cause of smoking in adults with SMI. Much of the research on smoking and SMI has been ongoing and primarily focused on rates of smoking, effects of smoking, and possible motivations for smoking (Johnson et al., 2010; Lucksted et al., 2008; Morris, Waxmonsky, May, & Giese, 2009; Moeller-Saxone, 2008; Siru et al., 2009). Nevertheless, there is a gap in the literature regarding qualitative research that investigates the personal experiences and views of adult smokers with SMI. Therefore, further investigation on smoking among the mentally ill and their experiences with quitting smoking is essential. Consequently, there is an opportunity to further understand the seriousness of this problem and implement social change as a consequence of this phenomenological analysis.

This chapter includes the background of the research problem, problem statement, purpose and nature of the study, theoretical framework that guides the study, assumptions and limitations of the study, and the significance of the study within the scientific community.

Background of the Problem

The increase of adults diagnosed with SMI with a history of smoking has led mental health professionals and individuals within the scientific community to investigate and analyze this specific population. Researchers have searched for the means necessary

to assist this population obtain and strengthen their psychiatric treatment and eliminate smoking rates. During this endeavor certain obstacles in the treatment of the seriously mentally ill have emerged. These obstacles include but are not limited to the marginalization of adults with SMI, implications of health costs within the mentally ill population, and noticeable weaknesses in smoking cessation efforts.

Marginalization of the Mentally Ill Population

Mental health professionals and individuals within the scientific community have made an effort to investigate, analyze, and search for the means to assist adults with SMI obtain and strengthen their quality of life. Throughout this endeavor obstacles in treating the seriously mentally ill have emerged. For instance, as researchers strive to understand smoking in the mentally ill population, there is evidence adults with SMI are also confronted with an array of personal and social barriers affecting their psychiatric treatment (Dixon et al., 2007; Heiligenstein & Stevens, 2006; Teachman, Wilson, & Komarovskaya, 2006; Thompson, Noel, & Campbell, 2004). Consequently, these barriers have a negative effect on the individual and has not allowed for ongoing research of adults with SMI with a history of cigarette smoking.

The social and personal barriers confronted by adults with SMI are an additional obstacle to overcome. These particular barriers force adults with SMI to develop a belief system in which they are expected to fit into society (Corrigan, 2004a, 2004b). This belief system evokes stress which is a consequence of public stigma due to the individual's mental illness. These individuals are then confronted with prejudice, stereotypes, and discrimination, and experience fear, avoidance, and anger directed at

them by those they encounter on a regular basis (Corrigan, 2004a, 2004b). Therefore, not only does an adult with SMI have to deal with the complexity of their mental illness, they also experience public stigma as a factor that prevents these adults with a smoking history seek treatment.

Individuals with SMI gradually isolate and begin to avoid family, friends, and treatment providers. This occurrence is primarily due to the experience of public stigma (Corrigan, 2004b). This experience leads to self-stigma which negatively affects the individual's perception of self-perpetuating a sense of shame due to the person's SMI (Corrigan, 2004a). Consequently, the effect of stigma becomes a source of distress provoking the desire to self-medicate by adopting certain types of unhealthy behaviors such as smoking (Lawrence et al., 2009). In many instances, these unhealthy behaviors are attributed to the individuals' desire to self-medicate thereby avoiding their primary psychiatric treatment and in turn search for alternatives.

Though high rates of smoking have been attributed to self-medication, there are other motivating factors behind smoking. These additional factors include particular abnormalities in cognition, emotions, and/or abnormal behaviors in specific diagnosis, genetics, gender differences, and the influence of a personal rationale for smoking (Chattopadhyay, 2005; Diaz et al., 2009; Dome et al., 2010; Sachs-Ericsson et al., 2009). Though self-medication can be one primary reason for smoking, there is a need to further investigate other factors and motivations by examining the personal views and experiences of adults with SMI.

SMI and Health Costs

Reducing the high cost of psychiatric treatment is a priority for governmental entities, for profit businesses, and nonprofit organizations (American Heart Association, 2012; El-Guebaly et al., 2002; Johnson et al., 2009; Nevada Cancer Institute, 2012). These organizations have encountered additional costs when dealing with both psychiatric treatment and health considerations. High mortality rates and an array of medical conditions in individuals with SMI are attributed to the person's mental health diagnosis and psychotropic medication side effects (Compton et al., 2006; Davidson et al., 2001; Lasser et al., 2000). For instance, chronic health disorders found in the mentally ill are cardiovascular disease, respiratory diseases, digestive disease, and various types of cancers (CDC, 2012; NIMH, 2011). Additionally, adults with SMI have poorer health conditions, high rates of obesity, gastrointestinal disorder, diabetes, HIV, and pulmonary disease (Compton et al., 2006; Sebastian & Beer, 2007). Furthermore, about half of adults with SMI have high incidence of substance abuse according to epidemiological studies (Center for Substance Abuse Treatment, 2007; Weaver et al., 2003). Therefore, the cost of treating various medical conditions can range from approximately \$175 to \$4000 annually per individual (Jones et al., 2004). The consequence of a mental disorder and chronic health conditions results in a financial hardship for the individual with SMI, family members, and state and local entities that offer treatment opportunities (NIMH, 2011). In 2002 it was estimated that over \$300 billion per year was spent on the treatment of approximately 10% of adults experiencing a severe disability associated with their mental illness (NIMH, 2011). For adults contributing to their mental health

treatment, it is estimated over \$50 billion was paid for services (NIMH, 2011).

According to NIMH (2011) and reflected in research conducted by the CDC (2011) this is an average of approximately \$1500 per individual. When examining the cost of psychiatric treatment, chronic health problems in adults with SMI, and due to high rates of smoking and treatment costs, studies on smoking and smoking cessation among the mentally ill population have become a priority.

Smoking Cessation Efforts

Adults with SMI who smoke also have greater difficulty with smoking cessation. For instance, when compared to adults without a mental illness, quit rates among adults with SMI are much lower (Compton et al., 2006; Lawrence et al., 2009). Lower quit rates are also evident among adults with SMI that have an alcohol or substance abuse history (Lasser et al., 2006; Snyder et al., 2008). Additionally, with the rates of smoking and diagnostic categories, there are also differences among specific mental illness diagnosis and smoking quit rates. For instance, researchers indicated adults with schizophrenia had lower quit rates in comparison to adults with a bipolar or depression disorder (Siru et al., 2009). Furthermore, lower quit rates among adults with schizophrenia may be associated to the number of adults with this same diagnosis that smoke (Siru et al., 2009). What is also evident is a need to further investigate for other contributing factors that influence quit rates.

There have been explanations for the increase of smoking and low quit rates among adults with SMI. For instance, these explanations range from genetics,

self-medication, psychological factors; to personal trauma, social factors, and lack of education (Johnson et al., 2009; Lawn, Pols, & Barber, 2002; Lopes, et al., 2002; Morris et al., 2009). Additionally, increases in smoking have been attributed to health care providers limiting nicotine dependence as a diagnosis thus failing to include intervention or treatment considerations in the individual's treatment plan (Johnson et al., 2009; Lawn & Condon, 2006; Lucksted et al., 2008).

Problem Statement

When compared to individuals without a serious mental illness, adults with SMI are more prone to cigarette smoking (Diaz et al., 2009; Jones et al., 2004; Morris et al., 2009; Woznica & George, 2009). Additionally, there is evidence that adults with SMI continue to smoke and struggle with smoking cessation despite psychiatric treatment (Lambert, Velakoulis, & Pantelis, 2003). However, the personal experiences and views of adults with SMI who continue to smoke cigarettes despite the negative effects of tobacco on personal health have not been investigated.

The lack of research on personal experiences and awareness of smoking adults with SMI has led to poor insight into the motivations behind cigarette smoking. This limited insight leads to smoking cessation interventions and treatment considerations that focus primarily on the general population rather than adults with SMI. To enhance the understanding within the scientific community of adults with SMI who smoke, isolating the experiences of the phenomenon and allowing participants give voice to the essence of their experiences is necessary.

Purpose and Nature of the Study

I addressed existing gaps in the empirical literature by presenting the experiences and views of smoking of adults with SMI. I conducted this study within the natural setting of the participants where I examined the personal experiences and common perceptions of adults with SMI related to smoking behaviors and smoking cessation. Participants expressed their views and experiences thus allowing for a better understanding of smoking by this particular population. Through this understanding I laid a foundation for treatment considerations. I utilized the following questions to guide this research:

1. What meaning do adults with SMI ascribe to their experiences to cigarette smoking and smoking cessation?
2. What are the motivations that adults with SMI have for cigarette smoking?
3. What is the individual's personal awareness of the risks of cigarette smoking?

I obtained a deeper insight into the participant's experiences of the phenomenon as pertinent questions were explored. Additionally, as I addressed these questions I moved beyond statistical data and consequently attained insight from the participant's personal stories and shared experiences (Creswell, Hanson, Plano, & Morales, 2007).

I utilized the phenomenological tradition which is appropriate for obtaining the essence of the lived experiences of the participants (Groenewald, 2004; Starks & Trinidad, 2007). Twelve participants with SMI consisting of schizophrenia, schizoaffective, or bipolar disorder were selected to share their personal stories and provided a rich description of their experiences of cigarette smoking and smoking cessation (see Table 1). During the personal interviews for this study, participants

answered open ended questions and had the opportunity to expand on the various themes, images, ideas, and feelings that emerged regarding the phenomenon under study. I gained a foundation for the implementation of smoking cessation opportunities that can be incorporated into the participant's holistic treatment. The study occurred at a mental health facility within the southern Nevada area.

Theoretical Framework

I utilized the HBM due to the prevalence of cigarette smoking, low quit rates, health concerns, and costs related to smoking by adults with SMI. Additionally, I employed this theoretical framework to analyze and understand the personal experiences and health beliefs of adults with SMI and their motivation for smoking. The HBM was initiated in the 1950s by US public health service professionals and widely utilized to understand attitudes and beliefs regarding health behaviors. Additionally, this health model has been implemented to strengthen health related interventions (U.S. Dept. of Human Services, 2005). During the initial utilization of HBM, social psychologists strived to isolate health beliefs which influenced health behaviors of individuals. These beliefs consisted in susceptibility to certain health conditions thought to be intertwined with personal perceptions of certain benefits for engaging in health behaviors to avoid unhealthy conditions (Kinzie, 2005). Furthermore, these beliefs and perceptions influenced the individual's readiness to take action (Kinzie, 2005; U.S. Dept. of Human Services, 2005).

The HBM was designed for the general population to pinpoint specific health behaviors (U.S. Dept. of Human Services, 2005). To further expand the model's core

assumptions, additional aspects were incorporated after its inception. There are six main factors thought to influence a person's decision to engage in positive health choices. These six factors involve the individual's belief system and means of processing the need to choose or not choose a specific health behavior. First, it is thought individuals have a belief about the possibility of experiencing or falling victim to an illness (perceived susceptibility). Second, if individuals believe there are serious consequences due to a particular condition (perceived severity) they will choose a healthy behavior. Third, if individuals believe a particular action will reduce their chances of falling ill (perceived benefits) they will opt for the healthy behavior. Fourth, if the individual believes the benefit of taking a positive action outweighs the cost and efforts (perceived barriers) they will choose it. Fifth, if the individual is motivated from an outside source (cue to action) they will choose the healthy behavior. Sixth, if individuals are confident they can be successful in performing the action (self-efficacy), the action will take place (Kinzie, 2005; U.S. Dept. of Human Services, 2005). Though these six assumptions assist in understanding the individual's belief system, it is also necessary to take into consideration other elements that influence health beliefs and actions such as demographics, social, and psychological variables, and cost benefits.

Definition of Key Terms

I will outline certain terms utilized in the dissertation research. I will present these terms in alphabetical order to obtain an understanding of their definitions.

Adults: Individuals 18 years and older.

Chronic health condition: Medical conditions such as hypertension, obesity, or diabetes that may or may not be treated by a health practitioner that may lead to the risk of heart, stroke, or kidney failure (Sturm, 2002).

Diagnostic categories: Set of mental disorders that are based on a particular criterion with defining features (APA, 2000).

General population: Adults with a history of smoking that do not carry a diagnosis of SMI (Diaz et al., 2009; Siru et al., 2009).

Holistic treatment: A specific treatment utilized to have an effect on the root of an illness, employs preventative efforts, adheres to treatment, and expands the person's quality of life (Lutgendorf & Costanzo, 2003).

Inpatient treatment: Twenty-four hour psychiatric care offered to patients with a mental illness. Each patient is treated on an individual basis with an individualized treatment plan (Ker & Owens, 2008; Stubbs, Haw, & Garner, 2004).

Lived experience: A participant's daily encounter with the phenomenon being studied. It is the participant's voice that is manifested in themes, images, and words during the study (Creswell et al., 2007).

Mentally ill: Adults with a mental disorder diagnosis as presented in the DSM-V (APA, 2014).

Outpatient treatment: Ongoing treatment to reduce the severity of symptoms experienced by an adult with a mental illness within a non-inpatient setting (Lawn et al., 2002; Lopes et al., 2002).

Phenomenon: A specific concept experienced by participants and examined in a research study (Creswell et al., 2007).

Prevalence: Proportion of adults within the mentally ill population that smoke cigarettes (Compton et al., 2006; Dixon et al., 2007).

Prolonged engagement: The researcher spends extensive time within a specific culture to better understand a participant's values, behaviors, and beliefs (Creswell et al., 2007).

Providers: Individuals that offer services and assist adults with mental illness. These include professionals and/or caregivers (Dickens, Stubbs, Popham, & Haw, 2005; Johnson et al., 2009).

Psychiatric treatment: Prevention, diagnosis, and treatment of a mental disorder by a psychiatrist or psychiatric nurse (Lawn & Condon, 2006; Stubbs et al., 2004).

Serious mental illness (SMI): A mental disorder impairing an individual's normal daily functioning. These are schizophrenia, bipolar disorder, major depressive disorder, and schizoaffective disorder (APA, 2000).

Smoking cessation: Behavior to discontinue cigarette smoking. Individuals quit cigarette smoking on their own or participate in a specialized program (Sachs-Ericsson et al., 2009).

Assumptions

I based this research on two assumptions. First, adults with SMI offer significant information on the motivations underlying smoking. Second, additional information will assist in understanding the individual's experiences of smoking cessation.

This study offers an opportunity for mental health practitioners to consider the findings and apply them to the population they assist. As a result, this has the potential for professionals to assist adults with SMI strive for better health by motivating them to participate in smoking interventions and cessation options designed specifically for this population. Consequently, these options may be incorporated within holistic treatment.

Significance of the Study

Awareness of smoking among adults with SMI has led to studies focused on rates of smoking, effects of smoking, and possible motivations for smoking (Compton et al., 2006; Morris et al., 2009; Tidey & Rohsenow, 2010). I addressed the existing gap in the empirical literature by presenting the personal experiences of 12 adults with SMI who smoke, are currently attending outpatient psychiatric services, and are living in the southern Nevada area. The study participants were asked to share their experiences of cigarette smoking, smoking cessation, and risks of smoking during this study.

Consequently, I obtained an enhanced knowledge of the experiences of the participants with SMI. This allows for smoking education, smoking intervention, and smoking cessation opportunities specifically geared toward the mentally ill population to be incorporated within the individual's holistic treatment. Furthermore, results from this study may motivate existing agencies and mental health professionals who deal with smoking cessation to evaluate its efforts in including all sectors of their communities in program recruitment and participation.

As a result of this study, an opportunity exists to provide a foundation for appropriate smoking cessation alternatives specifically geared to adults with SMI living

in southern Nevada. The enhanced understanding of why adults with SMI smoke allows mental health professionals to move away from smoking cessation beliefs that do not adequately serve the mentally ill population. Implementation of smoking cessation opportunities geared toward adults with SMI, will result in lower smoking rates and education on the influence of tobacco use on psychiatric treatment. It will also emphasize the importance of healthy lifestyle changes affecting physical health, will minimize chronic health conditions, and its costs, and will enhance the individual's quality of life. Consequently, these actions lead to social justice, human dignity, and appreciation of adults with SMI when appropriate mental health services are provided to this particular sector of the community.

Summary

Approximately 45 million adults have a history of smoking (American Heart Association, 2012). Despite attempts to reduce smoking through educational efforts, there still remains a high number of individuals with SMI that smoke (Compton et al., 2006; Dixon et al., 2007; Lasser et al., 2000; Lucksted et al., 2008). Consequently, researchers have sought the means to mitigate the increase of smoking in the mentally ill population (Brunero & Lamont, 2010; Sebastian & Beer, 2007). Nevertheless, difficulty in assessment exists due to social marginalization related to mental illness (Dixon et al., 2007; Teachman et al., 2006). Additionally, smoking and health concerns continue to be a dilemma in the treatment of this population (Dodd et al., 2010; Heiligenstein & Stevens, 2006).

Cigarette smoking exacerbates many health issues already confronted by adults with SMI (Davidson et al., 2001). Ongoing psychiatric treatment and tobacco related health conditions lead to financial burdens (Johnson et al., 2009; Lawn et al., 2002; Lopes, et al., 2002; Morris et al., 2009). I have brought into focus the motivations underlying cigarette smoking leading to a broader understanding why adults with SMI continue to smoke despite their chronic health conditions, poor quality of life, and high mortality rates.

In Chapter 2 I review the empirical literature. Additionally, I discuss the study's relevance to mental health providers, smoking prevalence among the mentally ill, and cigarette smoking within inpatient settings. I also present factors that may contribute to cigarette smoking, the rationale for cigarette smoking, and issues confronted by adults with SMI who smoke. In Chapter 3 I describe the rationale behind the design and method utilized for this study. I also include the research questions, participant criteria, and recruitment process, the role of the researcher as the primary instrument, study procedures, ethical considerations, means of protecting participants, data collection and analysis process, the means of ensuring trustworthiness and authenticity of the study, and methods utilized for the dissemination of the study findings. In Chapter 4 I present the study findings as well as common themes that emerged from participant interviews. Furthermore, I present a description of the participant's experiences of smoking reflected in detailed verbatim narratives. In Chapter 5 I comprise the findings of the study, social change and practice implications, and conclude with future research recommendations.

Chapter 2: Literature Review

Introduction

I established a framework for the study as a result of the literature review. I also critically evaluated the findings of additional studies regarding SMI and cigarette smoking. Furthermore, I identified particular points of view, suggestions for continuing research, and gaps in the literature. For this literature review, SMI is defined as a mental disorder impairing an individual's daily functioning and refers to a primary diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, and major depressive disorder (APA, 2000). I investigated the perceptions, views, and life experiences of adults with SMI within their natural setting allowing for an understanding of the phenomenon in question (Cresswell et al., 2007). In addition, I recognized the experiences of smokers with SMI and identified unknown subtle factors that are imperative in understanding the individual's motivations to smoke (McCaslin & Scott, 2003). As the result of the significance of these issues, I moved beyond statistical data and focused primarily on existing cases of adults diagnosed with SMI. Consequently, I attained insight from these personal life stories and individual voices related to their views and experiences of cigarette smoking and mental illness. Once I reported the study findings, I presented a social change component related to smoking cessation geared toward the mentally ill population. I underscored research highlighting smoking as a health and educational concern, relevance for mental health providers on the issue being investigated, smoking rates in the mentally ill population, smoking by adults with SMI within an inpatient

setting, neuropsychiatric disorders and smoking, gender and smoking, rationale for smoking, and issues confronting adults with SMI who smoke.

Research Strategy

I utilized for this literature review the Walden online library. I employed the following databases during the literature search: Academic Search Complete; PsychInfo; PsychArticles; PsychExtra; Medline Fulltext; Psychology: A SAGE Full Text Collection; Psychiatry Online; and SAGE Fulltext. Additional resources valuable in obtaining relevant information in researching the particular topic include, The National Institute of Mental Health (NIMH); American Heart Association; Center for Disease Control and Prevention (CDC); Substance Abuse Mental Health Services Administration (SAMHSA); National Institute of Drug Abuse (NIDA); National Institute of Alcohol Abuse and Alcoholism (NIAAA); National Alliance on Mental Illness (NAMI); International Society of Psychiatric Genetics (ISPG); United States Department of Health and Human Services (HHS); and Mental Health Foundation. I utilized the search terms “smoking and mental illness” as the primary form of inquiry. In narrowing the search additional terms such as “smoking and schizophrenia;” “smoking and bipolar;” “schizoaffective disorder and smoking;” “smoking and chronic health conditions;” “tobacco and depression;” “smoking cessation and mental illness;” “smoking and addiction;” and “smoking and caregivers/providers” were employed. I also located references in significant articles not found during the primary search in order to enhance the research. Not apparent during the literature review were studies primarily focused on the life of adult smokers with SMI

and their experiences, voices, and personal views they offered in regards to smoking and smoking cessation.

Smoking as a Health and Educational Concern

Nicotine is the most utilized product in the United States and is bought in various retail forms. In addition, nicotine is considered an addictive drug with serious social and health consequences. According to the Center for Disease Control and Prevention (CDC, 2012), tobacco use in the United States is the major reason of productivity loss averaging approximately \$900 million annually. The annual health care cost is estimated at over \$700 million, and the average cost per smoker per year is approximately \$2,395.00 (CDC, 2012). As a result of these costs, the prevalence of smoking and its consequences are a major focus and concern leading to research in this area (Forchuk et al., 2002; Lawn et al., 2002; Rogers et al., 2001).

Adults deemed smokers in the general population experience various health concerns such as coronary disease, lung cancer, cardiovascular disease, and respiratory diseases (Baker et al., 2011; Compton et al., 2006; Sachs-Ericson et al., 2009). Even after individuals stopped smoking physical ailments persisted or new health problems emerged (Sachs-Ericsson et al., 2009). Researchers comparing smokers to nonsmokers also found that adults who smoke demonstrated high rates of chronic health problems and high levels of stress (Guimaraes & Abberton, 2005). Persistent cigarette smoking in the general population is also linked to deficiencies in cognitive functioning, intellectual capacity, cognitive processing, memory, and an increase of neurodegenerative diseases (Durazzo, Meyerhoff, & Nixon, 2010). The link between smoking and high death rates

as a result of various lung diseases is of particular concern. For instance, it was projected approximately 90% of deaths in males and 80% deaths in females were attributed to lung cancer (CDC, 2012). Additionally, as a consequence of smoking chronic obstructive lung disease was the cause of 90% of deaths within the general population (CDC, 2012).

Mortality rates in the mentally ill population are linked to the individual's mental disorder and have a negative influence on psychiatric treatment. Generally, the health of adults with SMI is poor and negatively impacts the individual's quality of life decreasing their life span. For instance, adults with SMI have an increase comorbidity that leads to cardiovascular and respiratory disease, diabetes, and epilepsy (Brunero & Lamont, 2010; Chafetz, White, Collins-Bride, & Nickens, 2005; Davidson et al., 2001). In addition to mortality rates linked to SMI, there is also a connection to the effects of nicotine. For instance, according to the CDC (2012), a main result of unnecessary deaths of individuals who smoke in the general population is due to the use of nicotine. Smoking causes higher mortality in smokers even when compared to deaths associated to acquired immune deficiency syndrome (AIDS), substance abuse, automobile accidents, and suicide and homicide combined (CDC, 2012). Cigarette smoking has devastating effects on health. Therefore, these statistics on tobacco use and its consequences have led professionals in the medical, health, and scientific fields to educate the general public.

Educating the general public and implementing smoking cessation interventions have been the main tools used for decreasing smoking. These smoking cessation measures consisted in diverse levels of interventions such as dissemination of information on smoking cessation, community resources, self-help techniques; education

and brief counseling sessions on nicotine use, cigarette smoking, and smoking cessation; and long term counseling, pharmaceutical monotherapy, combined pharmacotherapy, and pharmacotherapy, and psychological therapy (CDC, 2012; Mohiuddin et al., 2007; Ranney et al., 2006). The efficiency of these interventions differs depending on their variety and length of use (CDC, 2012; Mohiuddin et al., 2007; Ranney et al., 2006).

Due to the mixed results of smoking cessation intervention effectiveness and its influence on smoking cessation, ongoing efforts by researchers in understanding the intensity of smoking have been ongoing. For example, in a quantitative study by Pierce, Messer, White, Cowling and Thomas (2011), an attempt was made to assess smoking intensity in California and in the United States. Data were obtained from two national surveys consisting of a total of 1, 662,353 participants. Researchers found heavy intensity of smoking was at its highest in 1965 in California and throughout the United States. Due to this high intensity various smoking control programs originated. For instance, these programs consisted in an increase of cigarette taxes, ordinances restricting smoking in the work place, and public areas, and smoking cessation programs geared toward the general population (Pierce et al., 2011). These smoking control programs led to a gradual decrease in smoking, a decrease of health costs related to the effects of smoking, and low mortality rates between 1987 and 2002 (Pierce et al., 2011; Rodu & Cole, 2007). Despite evidence of a gradual decline in smoking among the general population as a result of health education campaigns, taxes, ordinances, and smoking cessation programs (Pierce et al., 2011), noticeably absent in these statistics was a decline in smoking among adults diagnosed with SMI. This reality brought to the forefront the

need to further examine the reasons why these smoking reducing measures had no effect on adults with SMI. Additionally, questions remained in regard to the mental health provider's role and their influence in reducing smoking rates in adults with mental illness.

Relevance to Mental Health Providers

The number of adults diagnosed with SMI brings with it the need to focus on the individual's treatment and its cost, the responsibility of providers in this treatment, and the urgency to reexamine the consequences of tobacco use. The National Institute of Mental Health (NIMH) (2012) reported that in 2008 nearly 13.4 % of adults living in the United States obtained treatment due to various mental health problems. This encompasses individuals who received inpatient or outpatient services and/or utilized prescription medications for a specific mental or emotional difficulty. Additionally, NIMH also reported approximately 58% of adults in the United States with a diagnosis of SMI obtained psychiatric services, outpatient treatment, and psychiatric medications. Furthermore, the report of NIMH estimated the yearly cost for treating a SMI within the adult population was in excess of \$300 billion. The ongoing treatment or lack thereof continues to be a financial burden to mental health institutions. As more individuals are diagnosed with mental illness, many under resourced institutions offering mental health services seek the financial means necessary to treat these patients. In many instances this has become a challenge and the need to further educate mental health clinicians to alleviate this problem is warranted.

Mental health clinicians, such as psychiatrists and nurses, aim at providing quality of care in the treatment of adults diagnosed with SMI within both inpatient and outpatient

settings. The role of these mental health providers is essential in treating the patient's mental illness, in helping the patient deal with other ailments, and primarily to ensure positive clinical outcomes (Dickens, Stubbs, & Haw, 2004; Stubbs et al., 2004; Dwyer, Bradshaw, & Happell, 2009; Wagner et al., 2010). Consequently, these mental health professionals are given the opportunity to build rapport with patients and provide mental health services and educational opportunities (Lawn & Condon, 2006; Wagner et al., 2010).

Adults with SMI view mental health clinicians as professionals with whom they share their concerns and personal issues. Furthermore, within the individual's personal experiences the patient accepts the clinician's professional role reinforcing the image the clinician is a major participant in the patient's psychiatric treatment (Keys, 2007; O'Connor, 2003; Wagner et al., 2010). On a routine basis, mental health clinicians educate patients about their mental illness, medications, and aftercare plans. In particular, psychiatric nurses address the patient's health concerns such as hypertension, high cholesterol, and diabetes (Dwyer et al., 2009; Lawn & Condon, 2006). Nevertheless, researchers that conducted quantitative studies primarily within inpatient settings found the majority of mental health patients had not been educated on the negative consequences of cigarette smoking as a result of certain views and perceptions held by mental health providers (Dwyer et al., 2009; Stubbs et al., 2004).

To better understand mental health provider's views on smoking in adults with SMI and to explore the provider's reasons on why adults with SMI smoke, studies have been conducted in this area. For example, mental health providers indicated adults with

SMI smoke as a therapeutic means, an opportunity for interaction with peers and staff, a means to build a therapeutic relationship between patient and providers, and smoking as an individual right that should be respected (Dwyer et al., 2009). Additionally, providers viewed smoking cessation as harmful and indicated quitting smoking was a difficult task for adults with SMI to achieve (Johnson et al., 2010; Johnson et al., 2009; Morris et al., 2009). The failure in educating patients on smoking within inpatient settings further complicates the task of helping reduce the number of adults with SMI who smoke once discharged from a psychiatric inpatient setting (Dickens et al., 2004). Therefore, many of these same patients are discharged into the community where cigarette smoking and its risks continue to be a growing problem. Furthermore, it is evident that mental health providers have a particular role in providing both psychiatric treatment and smoking cessation education to mental health patients. To begin reducing smoking rates among the mentally ill, the role of mental health providers will need to move beyond solely a medical model and begin incorporating a holistic approach to treatment.

The trend of moving adults with SMI to community care instead of institutionalization has shifted the primary responsibility of mental health care to primary caregivers and consumer workers. Researchers indicated both caregivers and consumer workers have been confronted with a new responsibility (Morris et al., 2009; Pejler, 2001). Caregiver refers to a parent(s), sibling, children, friend(s), significant other, or partner engaged in the support and care of the person with SMI (Cleary, Hunt, Malins, Matheson & Escott, 2009). A consumer worker provides psychosocial options for adults with SMI as a means of peer to peer support while at the same time currently dealing

with their own mental health issues (Cleary et al., 2009). Caregivers and consumer workers have confronted unanticipated burdens in regards to the individual's psychiatric treatment, health concerns, and costs, and mental health relapse (Morris et al., 2009). Furthermore, in dealing with an individual's smoking history adds a burden to the already stressful situation.

As with mental health clinicians, caregivers and consumer workers tend to be aware of the harmful chemicals in cigarettes and its negative health consequences. Yet, what tends to be lacking and not reinforced is education on the risks of tobacco use (Stubbs et al., 2004). Therefore a primary question remains. What do providers and consumer workers think motivates adults with SMI to smoke? Researchers have found that caregivers and consumer worker views on smoking were similar (Johnson et al., 2009). For instance, caregivers and consumer workers believed adults with SMI smoke due to the individual's SMI diagnosis, the need for relaxation, a form of escape, a means to alleviate daily stress, a form of symptom management, and as a means to cope with adverse life circumstances (Morris et al., 2009; Pejler, 2001). Researchers also found due to the clinicians, caregivers, and consumer workers own smoking history the inability to offer smoking cessation information and practical interventions by educating adults with SMI on the consequences of cigarettes smoking was minimal (Johnson et al., 2009). As with mental health clinicians, caregivers and consumer workers also face the challenge of educating adults with SMI on the consequence of smoking. Yet, their views and beliefs on why these adults smoke limit the possibility to make a difference in

regards to smoking quit rates. It is evident the role of the caregiver and the consumer worker is changing and education in this area is needed.

Mental health clinicians, caregivers, and consumer workers have the opportunity to empower adults with SMI learn about the consequences of cigarette smoking. This task can be accomplished by mental health providers moving beyond their own perceptions and biases on cigarette smoking and begin to understand the experiences of adults with SMI (Dickens et al., 2004; Lawn & Condon, 2006). Consequently, extensive studies on cigarette smoking, smoking risks, and smoking cessation in adults with SMI, point to the urgency of this concern.

Adults With SMI and Smoking

Mental health problems affect a large portion of the United States population. Among these individuals, the most severe cases are concentrated among a number of adults experiencing more than one mental health problem at a time (Mental Health Foundation, 2007). Additionally, researchers have reported within 1 and 4 families have a member with a mental disorder (Mental Health Foundation, 2007). The National Institute of Mental Health (NIMH) (2012) indicated individuals that were diagnosed with schizophrenia, schizoaffective, bipolar disorder, and major depressive disorder had increased. Additionally, the prevalence of SMI was greater among females and adults 18 to 25 years of age (NIMH, 2012). In adults with SMI, when a mental health diagnosis is left untreated it has a negative effect on the individual. This is manifested in chronic health problems, psychosocial dysfunction, and a primary source of disability (Keyes, 2007). Therefore, the primary source of disability in the United States is mental health

disorders (Mental Health Foundation, 2007; NIMH, 2012). This particular population has been studied and researchers have focused on finding the means of implementing best practices in the treatment of adults with SMI. For example, elements that have been considered are the implementation of a holistic perspective in treatment and the urgency to deal with various health risk factors.

Researchers noted that among the general population the rate of smoking has decreased. Consequently, studies have been conducted to examine how reduction in smoking had been accomplished. For instance, in a study by Syamlal, Mazurek, and Malarcher (2011), it was reported cigarette smoking among adults decreased 42.4% since 1965 and was last reported to have decreased to 19.3% in 2010. In general, it was also reported the decrease in smoking had been attributed to smoking cessation treatment, interventions of counseling, self-help techniques, complementary and alternative treatments, and pharmaceutical approaches (Syamlal et al., 2011). Quit rates in the use of treatment interventions were substantial. For instance, a study by Levy, Graham, Mabry, Abrams, and Orleans (2010), found in utilizing smoking cessation interventions the annual population quit rate was 4.3%. Furthermore, if existing treatment policies were implemented the quit rates among adults would demonstrate the effectiveness of treatment considerations (Levy et al., 2010). Despite the utilization of mental health services, smoking has become a continuing concern in the mentally ill population. Furthermore, over 70% of adults with SMI smoke cigarettes, a rate considered triple in relation to smokers without a mental health diagnosis (Dixon et al., 2007). Moreover, severity of smoking in adults with SMI has been measured by the amount of cigarettes

smoked leading to additional health concerns (Dixon et al., 2007). A study by Lawrence et al. (2009), utilized a population wide survey in investigating the relationship of mental illness and smoking. Results similar to previous studies (Compton et al., 2006; Dixon et al., 2007; Forchuk et al., 2002; Moeller-Saxone, 2008) indicated adults with a SMI in the United States smoked twice as much than smokers in general. Noticeable in this research were participants 16 to 24 years of age, considered recent smokers, and diagnosed with anxiety disorders, affective disorders, and substance abuse (Venable, Carey, Carey, & Maisto, 2003). Researchers found these younger smokers had most recently started smoking and the severity of smoking would rise as they progressed in age (Venable et al., 2003). With the concern smoking rates in adults with SMI are not diminishing, researchers have investigated if this may be linked to the individual's psychiatric treatment or lack thereof.

Researchers conducted studies on an outpatient basis to evaluate the severity of smoking in adults with SMI and also noted the majority of adults receiving outpatient services with a history of smoking were also found inpatient. Many of these individuals who spent time inpatient received minimal or no information on the consequences of smoking.

Inpatient Setting and Smoking

Within inpatient psychiatric settings, the culture of cigarette smoking has been an ongoing occurrence. Researchers have indicated smoking within inpatient settings has occurred during the last century (Lawn & Pols, 2005; Monihan, Schacht, & Parks, 2006; Olivier, Lubman, & Fraser, 2007). Additionally, the allowance of tobacco as a form of

motivation or reward in the patient's psychiatric treatment occurred daily (Shmueli, Fletcher, Hall, Hall, & Prochaska, 2008; Lawn & Pols, 2005). Most recently, due to the consequences of cigarette smoking, tobacco policies within these specific settings have been implemented (El-Guebaly, Cathcart, Currie, Brown, & Gloster, 2002; Hollen et al., 2010; Moss et al., 2010). Nevertheless, with smoking policies emerging within inpatient settings there a need to review their success in lowering smoking rates.

Due to the history of smoking within inpatient psychiatric settings and the need to reduce smoking rates, smoking policies within these facilities in the United States emerged. Additionally, due to the influx of smokers entering both inpatient and outpatient settings the investigation of the policy's effectiveness were needed. The National Association of State Mental Health Program Directors (NASMHPD) (2008) conducted an analysis of policies and procedures related to smoking in various psychiatric inpatient settings. Researchers indicated over 40% of hospitals had zero tolerance for smoking among patients, approximately 12% had set goals to eliminate smoking within a year, and more than 16% had plans to change current smoking policies in the future (National Association of State Mental Health Program Directors [NASMHPD], 2008). In evaluating the effectiveness of nonsmoking bans, researchers found no evidence that indicated nonsmoking by patients caused violence or aggression, patients left the facility against medical advice, nonsmoking cause patient elopements, and there was no evidence of an increase in the use of medications by nonsmokers (El-Guebaly et al., 2002; Hollen et al., 2010). Smoking ban outcomes within inpatient

settings were positive and there was a need to move forward in implementing a nonsmoking environment that would ensure cost effectiveness in treating patients.

Despite efforts to move to a nonsmoking environment, two important questions remained. First, what changes, if any, take place in the patient's thought process regarding quitting smoking and second, why did the majority of patients who refrained from smoking during their inpatient stay continued to smoke upon hospital discharge. These questions led researchers to further investigate factors on the motivation to smoke by adults with SMI residing within an inpatient psychiatric setting.

During studies conducted within inpatient settings, researchers found there were certain views on smoking and motivations for patients to continue smoking. For instance, researchers found participants had a previous history of smoking before being admitted to an inpatient setting (Dickens et al., 2005; Shmueli et al., 2008; Skorpen, Anderssen, Oeye, & Bjelland, 2008). Additionally, these patients had no change in their attitudes to stop smoking or found it difficult to quit smoking. Furthermore, the motivation to smoke by patients was influenced by having the opportunity to spend time in the company of other patients and staff who smoked, an occasion to spend time in a smoking environment, and patients did not have sufficient encouragement or had limited information on quitting smoking (Dickens et al., 2005; Shmueli et al., 2008; Skorpen et al., 2008). Additionally, researchers noted patients that smoked for socialization also felt they had an opportunity to help other patients with their personal and psychiatric problems, smoking was used as a therapeutic means, smoking was viewed as a means to deal with problems, and smoking gave individuals an opportunity to fit in with the other

clients while inpatient (Dickens et al., 2005; Shmueli et al., 2008; Skorpen et al., 2008).

Smoking rates within inpatient settings are also found in outpatient settings.

Consequently, smoking continues to be a problem despite the individual's psychiatric treatment. An argument can be made that lower rates of smoking occur within inpatient settings due to the 24 hour care these individuals receive. Yet, this argument has minimal validity since patients in some psychiatric settings are permitted to smoke in designated areas or are not allowed to smoke at all due to smoking bans.

Researchers have noted even when smoking bans are implemented within inpatient settings questions arise on their effectiveness. For instance, despite the implementation of smoking bans in inpatient settings, once discharged these same patients returned to their smoking patterns. Researchers also found patients with a history of smoking who did not smoke while inpatient resorted to cigarette smoking moments after being discharged from the hospital (Prochaska, Fletcher, Hall, & Hall, 2006). For instance, some patients reverted to smoking in one month while the majority of patients resumed cigarette smoking within the first three months. Furthermore, half of these patients attempted to quit smoking within a 24 hour period without success (Prochaska et al., 2006).

Noteworthy in evaluating smoking within inpatient psychiatric settings is the failure to investigate the motivations behind smoking in these patients with a particular diagnosis. Though concern regarding the consequences of smoking is valid and therefore smoking bans are implemented, the core reason these patients smoke and how it relates to their specific diagnosis had been overlooked.

Neuropsychiatric Disorders and Smoking

Researches have conducted studies to further identify elements influencing smoking as related to the psychiatric disorders of schizophrenia, bipolar, and major depressive disorder (De Luca, Likhodi, Van Tol, Kennedy, & Wong, 2006; Diaz et al., 2009; Dixon et al., 2007; Forchuk et al., 2002). Furthermore, given a SMI diagnosis has particular abnormalities in cognition, emotions, and/or abnormal behavior (APA, 2000), each neuropsychiatric disorder has been independently studied. For instance, researchers found smoking patterns varied among psychiatric diagnosis leading to greater severity of cigarette smoking (Lopes et al., 2002). Smokers diagnosed with schizophrenia were found to have higher rates of smoking followed by bipolar disorder, major depression, and a primary diagnosis of psychosis. Researchers also reported as many as 70% to 80 % of adults with schizophrenia utilized tobacco when compared to other psychiatric diagnosis (NIMH, 2012). The decline of smoking among the various psychiatric diagnoses is minimal and underlying motivations to smoke diverse (Compton et al., 2006; Moeller-Saxone, 2008). Each of these neuropsychiatric disorders has a distinct profile and when independently studied offers unique factors underlying cigarette smoking.

Schizophrenia

Schizophrenia is a mental health diagnosis that has been studied extensively. Researchers that studied adults diagnosed with schizophrenia focused on the use of nicotine. For instance, adults carrying the diagnosis of schizophrenia have smoking rates of about 90% in contrast to the general population (Williams & Ziedonis, 2004). When researchers investigated factors influencing smoking by adults with schizophrenia as

compared to other SMI diagnosis, diverse results were presented. For example, these adults smoked primarily to control their psychiatric symptoms, sought relief from medication side effects, and did not possess basic strategies to quit smoking (Forchuck et al., 2002; Johnson et al., 2010; Mann-Wrobel, Bennett, Weiner, Buchanan, & Ball, 2011; Moeller-Saxone, 2008; Tidey & Rohsenow, 2010). Additional factors thought to influence cigarette smoking in adults with schizophrenia were also evident. For instance, smoking precedes the onset of schizophrenia and these individuals are most vulnerable to smoking after age 20 (Dome, Lazary, Kalapos, & Rihmer, 2010). Therefore, genetic vulnerability to schizophrenia and not schizophrenia itself is associated to smoking behavior (Chattopadhyay, 2005; Dome et al., 2010). Studies on schizophrenia, genetic implications, and smoking continue to be a research priority within the scientific community.

In conducting genetic studies and research with adults carrying a diagnosis of schizophrenia certain results emerged. For instance, researchers found a significant association between the cholinergic receptor, nicotinic, beta 2-neuronal (CHRNA2) gene, and high rates of cigarette smoking (Dome, et al., 2010). This is similar to other studies that isolated a dependence of nicotine due to certain interactions between genes and environmental factors (Voineskos et al., 2007; Xinag, Lou, Chen, Ma, & Elston, 2008). Though I located in the literature important findings in regards to genetics and smoking, genetic studies were presented as a first step in understanding nicotine addiction in individuals with schizophrenia. Other factors such as brain circuits and the pathophysiology of schizophrenia were also investigated (Due et al., 2002).

Research on schizophrenia has also been conducted on certain brain circuits associated with smoking behavior and addiction (Due et al., 2002). For example, researchers investigated high rates of nicotine addiction among adults with schizophrenia and neural circuits associated to smoking (Hong et al., 2010). Researchers reported there was a trait like circuitry biomarker associated with addiction severity in these adult smokers. Furthermore, this circuitry was found to be impaired thus offering an explanation for high rates of smoking (Hong et al., 2010). Additionally, the pathophysiology of schizophrenia impacts the reward system found in the brain leaving the individual open to cigarette addiction (Dome et al., 2010). Schizophrenia is only one diagnosis in which the prevalence of smoking is shown. Smoking in adults diagnosed with bipolar is also of concern.

Bipolar

The second highest rates of smoking within the SMI population are found in adults diagnosed with bipolar disorder. Subsequent to schizophrenia, much of the research on understanding the factors underlying smoking and SMI has been conducted with adults carrying a diagnosis of bipolar (Dodd et al., 2010; Moeller-Saxone, 2008). Studies on the underlying factors of smoking by adults diagnosed with bipolar have also resulted in diverse findings. For instance, researchers from a cross sectional study found the frequent use of tobacco was linked with various factors such as rapid cycling, substance use and abuse, current episodic moments, ongoing depressive and manic episodes, and episodic severity (Dodd et al., 2010). Furthermore, smoking was related to suicidal behaviors, alcohol use, caffeine, and use of illicit drugs (Dome et al., 2010).

Researchers also found excessive smoking in adults with bipolar was associated with psychosis or extreme psychosis and not necessarily related to a diagnosis of bipolar itself (Corvin et al., 2001). Therefore, the link between nicotine and bipolar is seen as a link between smoking and psychotic symptomatology.

As I conducted the literature review, it was apparent there was scarce as well as contradicting information on certain factors related to bipolar and cigarette smoking. For instance, questions arose regarding the following: relationship between smoking and depressive episodes in bipolar; vulnerability to psychosis by adults with bipolar when compared to nonsmokers; questions regarding smoking severity and its close association to the characteristics of bipolar itself; the role between cognitive function and smoking behaviors; and if the onset of smoking preceded bipolar disorder or vice-versa (Dome et al., 2010). Due to these ongoing questions, I found a gap in the literature for isolating the relationship between smoking and bipolar. On the other hand, as with schizophrenia, researchers in genetic studies reported additional information. .

As with schizophrenia, genetic studies were also conducted to determine any relationship between smoking and bipolar. For instance, researchers investigated if specific genes are manifested at diverse levels in the brain of bipolar and found no differences in gene expressions among patients with schizophrenia, bipolar, or individuals without a mental illness (De Luca et al., 2006). However, other researchers indicated there was a connection between polymorphism in the CHRNA7 gene and smoking in bipolar (De Luca et al., 2006).

Depression

Major depression is a serious health problem leading to a disability and possible mortality. As with schizophrenia and bipolar, extensive research in this area has been conducted (Curtin, Brown, & Sales, 2000; Dierker, Avenevoli, Stolar, & Merikangas, 2002; Dome et al., 2010; Douglas & Porter, 2009; Lopes et al., 2002). Despite the connection between smoking and depression, questions still remain on what factors influence this relationship. Therefore, as a result of research in this area various elements were found.

In addressing the diagnosis of depression and its relationship to smoking, researchers identified various findings. For example, adults with depression expressed their desire to smoke due to cigarettes being habit forming, the addictive elements related to smoking, and smoking utilized as a means to manage their depressive symptoms (Malpass & Higgs, 2009). Researchers also found nicotine in cigarettes contain antidepressant properties contributing to an individual's depressive disorder and inability to stop smoking (Diaz et al., 2009; Woznica & George, 2009). Nicotine's antidepressant properties were also connected to depression due to cigarette smoking being related to weak serotonin activity, smoking activities influencing the hypothalamus-pituitary-adrenal (HPA) axis related to stress and depression, and smoking inducing depression due to specific pulmonary diseases (Curtin et al., 2000; Dome et al., 2010). Furthermore, cigarette smoking caused mood disturbances due to nicotine deprivation experienced throughout the individual's day thus leading to further smoking (Dome et al., 2010). To

further understand the effects of depression on smoking and determine if a diagnosis is associated to tobacco use, genetic studies were also conducted.

Researchers conducted genetic studies on depression to investigate its connection to smoking. Researchers have shown a genetic connection among smoking and depression is primarily established in the initial start and continuation of cigarette smoking (Lyons et al., 2008; Dierker et al., 2002). Moreover, a genetic predisposition is connected to nicotine dependence and depression. Furthermore, genetic factors, which are attributed to the risk of depression, overlap with the risk of daily smoking (Lyons et al., 2008). Researchers also investigated the association among depression, active cigarette smoking, and nicotine dependence in males and reported similar results (Lyons et al., 2008). For instance, various genetic factors influenced nicotine dependence and adults with major depression were also vulnerable to smoking (Lyons et al., 2008). Furthermore, genes of the dopaminergic pathways were connected to smoking mood effects (Dierker et al; Williams & Ziedonis, 2004). Researchers also reported data indicating nicotine use throughout pregnancy increased vulnerability for developing a mood disorder and evoked salient changes during the development of the nervous system in a fetus (Dierker et al., 2002). Finally, health risks and costs associated with neuropsychiatric treatment of the particular SMI diagnosis are exacerbated with smoking further complicating treatment considerations (Lawn et al., 2002; Moss et al., 2009).

Gender and Smoking

To grasp the experiences of adults with SMI with a history of smoking implies focusing on the individual in his or her totality. Therefore, investigating gender and its relation to smoking in these adults is warranted. .

Researchers indicated there are no gender or sex differences in the overall prevalence of SMI (Sachs-Ericsson et al., 2009). Nevertheless, vital differences in the specific SMI symptoms of each gender do exist (Sachs-Ericsson et al., 2009; World Health Organization, 2002). Furthermore, gender differences exist in the individual's perception of their distress and psychiatric treatment derived from their SMI diagnosis (Bertakis et al., 2000; Sachs-Ericsson et al., 2009; World Health Organization, 2002). Concerning the differences between sex and gender in smoking, differences exist in both males and females in their rationale for cigarette smoking, the intensity of their addiction, and difficulties experienced in smoking cessation (Johnson et al., 2010). In addition, differences are attributed to social (gender) and biological factors (sex) (Johnson et al., 2010).

In the study of gender differences between male and female, rates of smoking differ in adults with SMI. A quantitative study by Johnson et al (2010), investigated differences between males and females and prevalence of cigarette smoking. Data was obtained through a cross sectional survey from 788 adults diagnosed with schizophrenia spectrum, mood, or anxiety disorder. In addition, researchers reported participants were known to have been receiving mental health services, more than half of participants were males with a diagnosis of schizophrenia, and were current smokers. Additionally,

researchers found gender differences consisted in the rationale to smoke, diverse levels of nicotine addiction, and diverse difficulties related to quitting smoking (Johnson et al., 2010). Despite both males and females being diagnosed with a mental disorder, each gender experienced their mental health symptoms differently. Consequently, a question remained. Do these mental health symptoms experienced diversely by males and females contribute to their desire to smoke? I took a closer look at the available literature in this area to answer this question.

In examining the differences between gender and smoking, understanding the motivation to smoke is also necessary. Consistent with other studies investigating the motivations for smoking, adults with SMI from both genders reported cigarette smoking was utilized to deal with anxiety, stress, depression, and psychosis (Forchuk et al., 2002; Siru et al., 2009). Furthermore, high rates of smoking among men were due to the following: a diagnosis of schizophrenia, being of older age (50-59 years of age), having a high propensity to smoking, having abused substances, having minimal education, being separated or divorced, and being a recipient of social financial assistance (Forchuk et al., 2002; Siru et al., 2009). Factors related to high smoking rates among women were found due to the females age (17-29 years of age), women who used cannabis and were associated with smoking, women who lived in a residential facility with a risk factor for tobacco use despite their specific diagnosis, and women of European descent (Forchuk et al., 2002; Siru et al., 2009). Researchers also reported nicotine dependence among women was higher after first use when compared to males (Forchuk et al., 2002; Siru et

al., 2009). Furthermore, it is also necessary to investigate additional factors that may influence gender difference in smoking, smoking behaviors and attitudes.

When researchers investigated environmental factors in both males and females, minimal results emerged. For instance, women were prone to relapse into smoking when confronted with drug cravings and differences in smoking due to environmental factors between male and females existed (Dome et al., 2010; Johnson et al., 2010). What I found lacking in these gender studies were the personal motivations and rationale for smoking expressed by adults with SMI.

Rationale for Smoking

The occurrence of smoking in adults with SMI manifests itself diversely within the individual's environment. Due to the high rates of mortality among the mentally ill population, emphasis on investigating this particular issue in both inpatient and outpatient settings was needed. Therefore, researchers conducting studies on smoking and adults with SMI found diverse rationale in regards to smoking (Diaz et al., 2009; Dome et al., 2010; Forchuk et al., 2002; Ker & Owens, 2008; Lawn & Condon, 2006; Lawn et al., 2002).

Adults with SMI endure stressful life events related to their mental illness and environment causing psychological distress. Within this conflicting environment severe cigarette smoking has manifested itself which has motivated researchers to further investigate this occurrence (Dome et al., 2010). Questions related to the reasons adults with SMI smoke despite experiencing chronic health problems have been ongoing (Mental Health: A Report of the Surgeon General, 2011). For instance, researchers

investigated the link between psychosocial factors and smoking (Dome et al., 2010; Diaz et al., 2009; Forchuk et al., 2002; Ker & Owens, 2008; Lawn et al., 2002; Lucksted et al., 2008). Researchers indicated adults with SMI smoked cigarettes for its calming and relaxation effect, as a stress reliever, as a means to deal with hopelessness, and for overcoming loneliness. Adults with SMI also smoked to self-medicate, to obtain a sense of control in daily living, and as a means to strengthen the individual's sense of self-worth (Dome et al., 2010; Forchuk et al., 2002; Diaz et al., 2009; Ker & Owens, 2008; Lawn et al., 2002; Lucksted et al., 2008). Cigarette smoking was also used as a coping mechanism in dealing with social influences, significant others, socioeconomic status, and interpersonal relationships. Additionally, adults with SMI utilized smoking as a faithful companion while their smoking behavior was being reinforced by family and friends. (Dome et al., 2010; Forchuk et al., 2002; Diaz et al., 2009; Ker & Owens, 2008; Lawn et al., 2002; Lucksted et al., 2008).

The rationale for smoking is diverse and a result of a stressful environment. Therefore, psychosocial factors have also been investigated as related to smoking in adults with SMI (Lucksted et al., 2008; Tidey & Rohsenow, 2010). Yet, what is unclear is if these factors are a direct result of the individual's mental health diagnosis or a consequence of the individual's environment. What is clear is adults with SMI express a certain rationale for smoking. Researchers investigated smoking within the individual's environment and found adults with SMI had varied views pertaining to cigarette smoking and smoking cessation (Ker & Owens, 2008; Lawns et al., 2002; Lucksted et al., 2008; Tidey & Rohsenow, 2010). These views influenced adults not to initiate smoking,

reduced their smoking, or influenced them to quit smoking all together. For example, adults carrying a diagnosis of schizophrenia sought to reduce or quit smoking due to social consequences and concerns with physical ailments due to smoking. Researchers also found various elements that had an influence on smoking and smoking cessation. For instance, these included SMI stabilization, the individual's knowledge on smoking consequences, their experiences with withdrawal symptoms, and the individual not being allowed to smoke in treatment facilities. Also emerging from these studies was the individual's participation and experiences in treatment for smoking. Adults with SMI rarely sought and received treatment for smoking cessation and therefore continued to have high rates of cigarette smoking (Ker & Owens, 2008; Lawns et al., 2002; Lucksted et al., 2008; Tidey & Rohsenow, 2010). Nicotine and the rationale underlying its use also influenced smoking and smoking cessation. For example, researchers reported high levels of nicotine dependence were viewed by the participants as a result of frequent smoking patterns, due to recurrent brief attempts to quit smoking, and the participant's low confidence in their personal ability to quit smoking (Mann-Wrobel et al., 2011).

As with psychosocial factors influencing the rationale for smoking, the individual's various views and experiences also contribute to the motivation to smoke. Therefore, it is vital to put in context the views of the individual and how it relates to smoking and its influence on age, ethnicity, culture, and family history.

Issues Confronting Adults With SMI who Smoke

The use of nicotine has serious consequences and researchers have investigated cigarette smoking and its negative elements. For instance, tobacco contains 43 human

carcinogens out of over 4000 chemical compounds (American Heart Association, 2012). Furthermore, the rapid absorption in the brain of nicotine results in various chemical changes and binds to certain receptors (CDC, 2012). With large amounts of nicotine sedating and smaller amounts stimulating the CNS, the cognitive processes, emotions, and reward pathways are affected (CDC, 2012). Additionally, the negative effects on health, loss of productivity, and high rates of mortality related to nicotine use have also been documented (CDC, 2012). As a result, information regarding nicotine and its consequences led researchers to investigate cigarette smoking and its influence on adults with SMI. For example, an increase in cigarette smoking was related to various chronic health conditions (e.g. hypertension, respiratory, and gum diseases) (Dixon et al, 2007); cigarette smoking led to financial and social deprivation (Lawn, Pols, & Barber); and diverse levels of smoking led to various reasons for smoking (Ker & Owens, 2008).

Research on smoking has occurred in both inpatient and outpatient psychiatric settings. Consequently, three major issues have emerged and are confronted by adults with SMI who smoke. First, smoking exacerbates chronic health conditions. For instance, these health conditions include hypertension, cardiovascular disease, and diabetes, acute respiratory and gastrointestinal disorders. Second, the effects of toxic chemicals from nicotine and its negative influence on the metabolism of individuals taking psychotropic medications. Third, smoking as related to suicidal behavior thus leading to high mortality rates. I will further expand on these three issues and its negative influence on adults with SMI who smoke.

Health

As a result of mental illness, adults with SMI are confronted with poor general health. Within their mental health treatment, adults with SMI deal with both their psychiatric diagnosis and an array of negative health consequences. Studies on this issue have been vital and ongoing (Dickerson et al., 2006). As I previously indicated, the cause of death and mortality among adults with SMI stems from various serious medical problems and risks (Brunero & Lamont, 2010; Chafetz, White, Collins-Bride, & Nickens, 2005). For example, adults with SMI have experienced hypertension, cardiovascular disease, diabetes, epilepsy, acute respiratory and gastrointestinal disorders, and skin disease (Chafetz et al., 2005; Davidson et al., 2001; Sabastian & Beer, 2007). Furthermore, these medical conditions have weakened the quality of life and shorten the individual's life span (Chafetz et al., 2005; Davidson et al., 2001; Sabastian & Beer, 2007). Many of these health conditions are dealt with on an outpatient basis. However, when left untreated these chronic health conditions have sent many adults with SMI for urgent hospital care. In addition to health conditions being related to a specific diagnosis, there are other environmental risk factors that need to be addressed.

Though certain medical conditions are attributed to the individual's mental health treatment, other conditions such as behavioral and environmental risk factors encountered throughout diagnostic categories have also been attributed. Some examples include sedentary lifestyle, poor nutrition, and strain on social relations, obesity, and cigarette smoking (Brunero & Lamont, 2010; Chafetz et al., 2005; Compton et al., 2006; Dixon et al., 2007; Sebastian & Beer; Tidey & Rohsenow, 2010). In particular, health problems

and high mortality rates related to smoking are widespread among adults diagnosed with SMI and a reduced life span of approximately 20% exists (Campion et al., 2008).

Particularly, smoking adversely impacts proper treatment of bipolar and schizophrenia disorders leading to lifetime depressive and manic episodes and enduring chronic health complications (Dodd et al., 2010). Consequences of smoking on mental health treatment have also led to the necessity for smoking cessation programs in the mentally ill population.

Adding to the most common medical health conditions of cardiovascular disease, respiratory diseases, and diabetes there are other health concerns confronted by adults with SMI. For instance, smokers with SMI can also suffer from various forms of cancer, oral and dental problems, voice problems, nose abnormalities, respiratory diseases, reflux disease, susceptibility to dehydration, and adults with SMI that smoke spend prolonged periods of time in hospitals (Dixon et al., 2007; Dodd et al., 2010; Guimaraes & Abberton, 2005). Medical issues need to be addressed when dealing with smoking especially when the individual has been prescribed psychotropic medication as part of their psychiatric treatment.

Psychotropic Medication

The management of psychotropic medications of adults with SMI is a frequent occurrence within psychiatric inpatient and outpatient settings. When psychotropic medications are prescribed to adults with a history of smoking, serious concerns emerge in the individual's treatment (Ker & Owens, 2008; Vanable et al., 2003). Within psychiatric settings, smoking as an environmental factor contributes to the diverse means

adults with SMI respond to prescribed psychotropic medications (Desai et al., 2001). In particular, the treatment with antipsychotic medications influences smoking behavior. For example, Haloperidol has been linked to an increase in smoking and clozapine to a decrease (Campion et al., 2008). Additionally, a close association of health problems and antipsychotic medications has led to weight gain, diabetes, and unexpected death, cardiac and endocrine difficulties. (Johnson et al., 2010; Morris et al., 2009; Snyder et al., 2008).

Due to side effects of various antipsychotic medications within varied mental health diagnosis, risk factors have a tendency to be higher. For instance, adults with schizophrenia and deemed heavy smokers have a less positive attitude toward a healthy lifestyle and have a negative attitude toward physical health when compared to individual's without a SMI (Baker et al., 2011). Researchers also noted adults having a primary diagnosis of bipolar and schizophrenia and deemed heavy smokers suffered from various chronic health problems leading to a less effective treatment (Baker et al., 2011). Moreover, in adults with SMI and a smoking history, and due to medication changes and medication adjustments healthcare providers may also encounter ongoing concerns in relation to drug metabolism complicating the individual's psychiatric treatment (Desai et al., 2001). This occurrence is due to the pharmacokinetics and pharmacodynamics changes that take place while taking psychotropic medications and smoking (Desai et al., 2001). Therefore, these changes can either increase or decrease the drug's concentration leading to possible toxicity or diminished potency of the drug in question (Desai et al., 2001). Consequently, there is concern psychotropic medications may have an influence on smoking habits or cause resistance for smoking cessation.

Researchers also investigated the effects of typical and atypical medications and its relation to smoking primarily with patients diagnosed with schizophrenia. For instance, patients receiving typical antipsychotics scored high on a nicotine dependence test and had higher smoking rates when compared to patients taking atypical antipsychotics (Campion et al., 2008). Researchers also reported when an antipsychotic dose is increased the desire to smoke increases giving the patient a sense of stimulation. Consequently, in treating smokers that take higher doses of antipsychotics an increase in the metabolism of these medications can occur due to the various toxic chemicals in tobacco (Campion et al., 2008; Dome et al., 2010). Finally, higher loads of anticholinergic are known to increase the motivation to smoke. In addition, participants treated with typical medication had high rates of cigarette consumption when compared to participants treated with atypical medications (Barnes et al., 2006; Barr, Procyshyn, Hui, Johnson, & Honer, 2008). Furthermore, researchers reported smoking affects psychotropic blood levels, smokers experience more tardive dyskinesia, and depressed smokers tend to have higher suicide rates when compared to depressed nonsmokers (Barnes et al., 2006; Barr et al., 2008).

Suicide

Another cause of mortality among adults with SMI is suicide. Suicide rates among adults with SMI are a primary concern, especially when these adults participate in psychiatric treatment. Ongoing observation and assessment of a client to determine if they are a danger to self or others is routine and necessary during their treatment. When dealing with adults who smoke the chances for suicide increases. Therefore, further

investigation on suicide and its relation to smoking is essential. While I reviewed the literature, I found few adults without an SMI may die prematurely while more than 50% of adults with SMI who regularly smoke will die prematurely due to smoke related illnesses (Bolton & Robinson, 2010). Add to this the 10% lifetime risk of suicide in adults with SMI who smoke (Bolton & Robinson, 2010; Campion et al., 2008; Christiansen & Jensen, 2007; Links, Eynan, Ball, Barr, & Rourke, 2005). Diligence in understanding this relationship to smoking has also been of interest within the scientific community. What remains unclear is the influence of smoking on suicide attempts and mortality (Bolton & Robinson, 2010; Campion et al., 2008; Christiansen & Jensen, 2007). Clinicians within the psychiatric community have focused on the high rates of suicide within the mentally ill population. The issue of suicide confronting adults with SMI has been of interest due to the number of individuals being admitted to a psychiatric facility and consuming a majority of mental health resources. For instance, over 90% of suicide victims and most individuals that attempted suicide carried a diagnosis of a mental disorder. This added to the already high cost of psychiatric inpatient and general health care (Doerfler, Moran, & Hannigan, 2010; Mann, 2002). When investigating smoking and mental illness, also of concern is the direct connection between smoking and suicide.

Investigating the rates of suicide among the mentally ill population, researchers and professionals in the psychiatric community identified various theories to identify the connection between smoking and elevated risks of suicide attempts, suicide ideation, successful suicides, and its impact on adults with SMI (Dome et al., 2010). Researchers

found three risk factors that make an adult with SMI with a history of smoking susceptible to suicidal behavior. First, adults who are current smokers and increase their smoking are at high risk for suicide due to the smoking effects on mood and emotions (Hemmington & Kriebel, 2003; Hughes, 2008). Therefore, the desire to self-medicate by smoking and factors such as substance abuse, alcoholism, and certain antidepressant medications contributed to suicidal behavior (Hughes, 2008; Hemmingsson & Kriebel, 2003; Malone, Wateraux, Cooper, Li, & Mann, 2003; Mann, 2002). Second, various medical conditions experienced by adults with SMI, particularly life threatening illnesses linked to either a psychiatric diagnosis or as a result of smoking, also contributes to suicidal behavior (Mann, 2002). Life threatening illnesses cause extreme anxiety, depression, and give the individual a sense of hopelessness. The ongoing deterioration of physical health exacerbated by cigarette smoking can eventually lead to suicide (Links et al., 2005). For instance, individuals with pulmonary disease have a bigger risk of experiencing changes in temperament and anxiety that contribute to the many symptoms already experienced by their current psychiatric disorder (Dome et al., 2010). Third, daily stress and life style changes due to the individual's mental illness experienced in combination with cigarette smoking also can lead to suicidal behavior (Doerfler et al., 2010; Hughes, 2008). Researchers found individuals with SMI react to adverse life events in unhealthy ways. For example, these individuals can become aggressive, impulsive, feel powerless, and find unhealthy means to self-medicate or isolate all together due to their hopelessness (Mann, 2002). The ongoing experiences of smoking on mood and emotions, the negative experiences of chronic health conditions, and the

daily stress occurrences among adults with SMI has led to self-destructive behavior such as suicide. Though researchers found cigarette smoking itself does not lead to suicide, focus is given to this issue especially in the treatment of adults carrying the diagnosis of schizophrenia, bipolar and major depression.

Summary

I focused on the rates of smoking in adults with SMI and on cigarette smoking and its negative influence on health and the individual's quality of life (Brunero & Lamont, 2010; Chafetz et al., 2005). Due to smoking which leads to health problems and the costly impact on treatment, researchers investigated what contributes to smoking behaviors in adults with SMI and what factors underlie their smoking behavior (Brunero & Lamont, 2010; Chafetz et al., 2005). What I encountered in the literature are gaps yielding certain themes. The themes found lacking in both quantitative and qualitative studies were adults with SMI and their awareness of factors influencing their smoking and smoking cessation, their personal stories on learning to live with mental illness without smoking, and their lack of knowledge on the risks of cigarette smoking. In order to reach adults with SMI and offer them valuable information on smoking prevention, intervention, and treatment, research on the perceptions views and experiences of adults with SMI is warranted.

Chapter 3: Research Method

Introduction

In Chapter 3 I present the details of the study, the qualitative method, and study design utilized to understand the meaning the participants attributed to their personal experiences of smoking. Additionally, I will outline the participant selection criteria, the researcher's role, procedures for collecting and analyzing data, and the verification of findings. In the initial section of the chapter, I will present the justification for the use of qualitative methodology and the research questions. Also, I will include in this chapter the ethical protections implemented for protecting participants from harm. In the final section of the chapter, I will discuss the study's implications and interpretation of the research findings.

Rationale for use of Qualitative Research Design and Methods

I identified various gaps in the literature. I filled these gaps with data obtained from the lived experiences of adults with SMI by presenting the participant's personal experiences of smoking and smoking cessation, motivations underlying the participant's smoking, and the participant's knowledge of the consequences of cigarette smoking. As I previously discussed, there was a potential to investigate the perceptions, views, and lived experiences of an adult with SMI (Creswell et al., 2007).

The qualitative methodology with phenomenological inquiry of this study was fitting for enhancing the understanding related to the experiences of smokers diagnosed with SMI. Unlike quantitative methodology, qualitative research implied observe and analyze a particular phenomenon within its natural setting (Creswell et al., 2007). By

utilizing this methodology, I analyzed the research problem which gradually led to the motivations and meaning adults with SMI gave to cigarette smoking (Creswell et al., 2007; McCaslin & Scott, 2003). As the primary instrument, the role of the researcher is to search for themes, common patterns, and categories emerging from the collection of data. I obtained an enhanced understanding of the person in his or her totality through this qualitative research by investigating the awareness of motivators influencing the smoking of adults diagnosed with SMI. Additionally, due to certain limitations with quantitative measures and statistical analysis (i.e. dealing with the entire complexity of the problem), qualitative research was beneficial for this study and required its own analytical objectives, specific questions, and particular collection data instruments (Whittemore, Chase, & Mandle, 2001). The topic I studied was concerned with facts, real life experiences, and the reporting of study findings given that qualitative research deals with the participants within their natural environment. Furthermore, this qualitative inquiry complements quantitative research in understanding and interpreting the complexity of the research problem (Creswell et al., 2007; McCaslin & Scott, 2003).

Phenomenology and Social Change

I utilized this qualitative phenomenology study to examine the personal experiences of adults diagnosed with SMI who confronted with chronic health conditions continued to smoke. Phenomenological inquiry gradually revealed the individuals' experiences existing in their awareness and unconsciousness (Creswell et al., 2007). Through this inquiry, I obtained an enhanced understanding of the phenomenon under study from the participant's viewpoint derived from their personal experiences

(Grownwald, 2004). Based on the participant's description of their personal awareness and experiences, phenomenological inquiry provided a description of what it means for individuals diagnosed with SMI continue to smoke despite deterioration of their quality of life. Furthermore, I was given the opportunity through this inquiry to describe and analyze the experiences within the participant's environment. Consequently, this process allowed for the emergence of new possibilities and approaches in dealing with specific associations (Creswell et al., 2007; Grownwald, 2004).

As I gained awareness and enhanced understanding of the experiences of adults with SMI who smoke and due to the study's potential to find ways to elicit holistic changes in adults with SMI, this study met Walden University's mission of positive social change.

Research Questions

I identified the personal awareness and experiences of adults with SMI that smoke. These adults have a SMI consisting of schizophrenia, schizoaffective disorder, or bipolar disorder. Additionally, these adults were current smokers, had a history of smoking, and a number of participants had a chronic medical condition that was not a SMI. I utilized specific open ended questions to understand the participant's experiences. In addition, I listened attentively to the participants and when necessary modified the questions after I explored the problem further. For instance, the more the problem was clarified the questions were restructured. I asked these questions within the participant's natural setting and was able to collect emerging themes, words, patterns, and images (McCaslin & Scott, 2003; Creswell et al., 2007). General research questions I used to

guide this study will follow. Detailed questions for participant interviews are listed in Appendix C.

Research Questions

1. What meaning do adults with SMI ascribe to their experiences to cigarette smoking and smoking cessation?
2. What are the motivations that adults with SMI have for cigarette smoking?
3. What is the individual's personal awareness of the risks of cigarette smoking?

Methodology

Context of the Study

I recruited a pool of participants from a mental health facility due to the number of adult smokers with SMI receiving psychiatric services. This facility was located in the southern Nevada area and offered comprehensive services for adults with SMI. The primary mission of this facility is to offer treatment to the individual while focusing on medical and psychosocial issues affecting mental health. The services offered to individuals are determined by a comprehensive assessment performed by mental health clinicians. These services include prescribing of medication, and medication management, outpatient therapy, and a day treatment program that allows these adults to function at the highest level. Additionally, many of these adults with SMI who receive an individualized and comprehensive approach to their treatment are offered case management where they obtain additional services.

The pool of potential participants was actively receiving mental health services. I placed emphasis on participants who were currently receiving mental health treatment within an outpatient setting, were current smokers, or had a history of smoking. I observed at the research facility a number of clients who smoked in solitude or congregated to smoke cigarettes. In addition, what I saw lacking in many of these outpatient facilities in the southern Nevada area was comprehensive smoking cessation considerations geared specifically toward the mentally ill population. Though these adults were offered the opportunity to stop smoking, many expressed difficulties in smoking cessation. Consequently, this led many clients struggling with their psychiatric treatment to experience deterioration of personal health, lack of quality of life, or to spend their time smoking with their social network.

Participant Recruitment

I had a meeting with the director of community support services at the research site. I had a discussion on the appropriate process in the selection of study participants and discussed a plan to ensure its implementation. Additionally, I included the criteria in this plan in order to implement the selection process. I also implemented guidelines to formulate the research questions presented to the participants. The guidelines had useful indicators for identifying adults that would be included or excluded as study participants. After I determined the participants for the study, I had a briefing and discussion regarding the study. I selected for the study a final group of 12 participants consisting in adults with a SMI diagnosis, received mental health services, and were mentally competent during the research, particularly during the interview. The criterion was confirmed by

mental health clinicians. Furthermore, participants were able to express their experiences of the phenomenon being studied and had the competence, knowledge, and ability to read and sign the informed consent.

Compensation for Participation

I gave participants a \$30.00 gift card from a local store. This gift card was considered a compensation for their time and inconvenience in participating in the research study. The amount of this gift card did not interfere with the participants' voluntary agreement to participate in the study (APA, 2002). I informed the participants they would receive a gift card even if they decided to withdraw from the study.

Snowball Technique

I utilized the snowball technique in addition to mental health clinicians assisting with participant recruitment by distributing the letter of invitation to clients. Once I identified the participants, they were allowed to utilize their social network within the research site in order to contact other individuals who demonstrated interest in the study. The individuals receiving services at the mental health facility are a close knit community. The majority of these adults participates in various service options throughout the campus and regularly congregates to smoke cigarettes. With the assistance of mental health clinicians and the snowball technique, I ensured a narrow range of sampling had experienced the phenomenon under study (Creswell et al., 2007; Groenewald, 2004). Furthermore, through this sampling strategy the maximum number of participants representing adults who have experienced the phenomenon offered quality assurance of the study (Curtis, Geslen, Smith, & Washburn, 2000).

Participant Selection

The sample size for the study was 12 adults comprised of four men and eight women with a SMI diagnosis. All participants I selected were receiving services in a mental health facility and had a history of cigarette smoking. Therefore, in deciding this sample size saturation was met. The 12 participants and interviews were sufficient to reach the intended goal for this study. As I implemented this qualitative study in combination with phenomenological inquiry, I obtained an enhanced knowledge of the experiences of the participants with smoking and smoking cessation. Consequently, the data from these participants refined the essence of the phenomenon under study. This occurred due to these individuals having experienced the phenomenon and having the ability to offer detailed accounts of their personal experiences (Starks & Trinidad, 2007). I assured participants who were recruited had experienced the phenomenon being investigated by using purposive sampling. This experience is the unit of analysis in which numerous concepts were generated by these individuals. Therefore, it was not necessary to have large samples to obtain rich contextual sets of data. As a result, the sample size of this study was considered reliable (Starks & Trinidad, 2007).

I obtained participant information for the potential to formulate a smoking cessation program specifically for the mentally ill population. Therefore, I also considered individuals who had failed or refused to quit smoking.

For this study, SMI refers to schizophrenia, schizoaffective disorder, and bipolar disorder (APA, 2002). In addition, chronic health problem is defined as an enduring nonlife threatening illness, in which the underlying condition is still experienced by the

individual despite being treated or not treated by medical care (i.e. asthma, diabetes, hypertension) (Sturm, 2002).

Role of the Researcher

I took on the responsibility of engaging with participants, implementing the recruitment process, data collection, data analysis, ensuring verification and trustworthiness of data, and disseminating the results. I made sound judgments throughout the study with regards to data, monitoring, documenting, and constant evaluation of the analytic process. Additionally, I ensured rigor and trustworthiness was maintained. Since I engaged in qualitative inquiry, there was a need to be open and observant about personal bias. Therefore, I attentively focused on the participant's personal views and experiences. What follows is a discussion on the intentions and reasons in regards to the study. Furthermore, I will present a description of any personal researcher bias that may have influenced the design and implementation of this study.

I currently work for Southern Nevada Adult Mental Health Services. I oversee two mental health outpatient clinics in the southern Nevada area as a clinical program manager. I have the responsibility of overseeing clinic staff consisting in two psychiatrists, five psychiatric nurses, and various support staff. These outpatient clinics currently serve approximately 400 patients with SMI. During the 10 years I have worked for the state of Nevada, I observed the majority of outpatient clients with a tendency to smoke cigarettes. This occurrence took place outside the clinic, at the client's residential facility, and/or when the client was discharged from an inpatient facility. I observed a number of these clients smoke despite receiving psychiatric services and having a chronic

health problem. On various occasions, I asked these clients about their reasons for smoking cigarettes and during the conversation I received a range of responses. What was evident in these conversations was some clients had no idea why they smoked, expressed difficulty in quitting smoking, or expressed they had no resources to help them with smoking cessation.

I sought ways to assist this population by finding the means to obtain an enhanced knowledge of the underlying reasons related to their smoking and experiences with smoking cessation while working with adults with SMI. As I searched for community based programs, it became clear many of the smoking cessation programs were not geared toward the mentally ill population nor had the capacity to serve this special clientele. I concluded there was a need for smoking cessation programs geared specifically toward the mentally ill population that can be incorporated into the individual's continuum of care.

In addition to working as a clinical program manager, I also worked and conducted counseling with adults with a dual diagnosis, homeless adults, and incarcerated adults with SMI. In addition, I was a mental health counselor and an active member of the mental health court in Las Vegas Nevada and worked with adults diagnosed with SMI on probation and parole. I also have more than ten years working in substance abuse treatment. Within these programs it was apparent the tendency for adults to smoke cigarettes was ongoing and increasing. Additionally, cigarette smoking was also acceptable in twelve step recovery programs such as alcoholic and narcotics anonymous. As an addiction specialist, the primary focus I had was offer treatment for

illicit drug and alcohol abuse and emphasize sobriety from any form of addiction.

Though I do not have a history of cigarette smoking, within my family history there is a tendency toward addictive behavior. Therefore, cigarette smoking is also to be avoided.

I was as objective as possible during this study. For instance, I was conscientious of any personal belief in addiction personalities, experiences working with the mentally ill population, and I maintained awareness of any family addiction history that could have affected the study's design, implementation, and interpretation.

Procedures

I met with the director of community support services from the research site before the selected participants were contacted. The director received pertinent information related to the study (e.g. purpose and nature of the study, means utilized to collect data, method of analyzing the data, and the process for validating the study findings). I was present at the research site and at client social gatherings. During these times I introduced myself to clients and briefly informed them I had plans to conduct a study at the mental health facility. I gave the clinicians at the research site written and detailed information on the specific criteria regarding participants for this study. In addition, the clinicians also received information this study was voluntary and participants could decide to drop out of the study at any time. After receiving written and detailed information on the specific criteria regarding participants for this study and after clinicians understood the study was on a voluntary basis and participants could drop out of the study at any time, the letter of invitation was distributed (Appendix B). In addition, after the invitation was made the clinician did not ask any client if they were

chosen for the study. The clinicians further communicated to the participants that clarification of the study or for any additional questions participants needed to contact the researcher directly. Thereafter, I had contact with each potential participant via telephone, explained in more detail the study, and set interview appointments according to the participant's schedule. I conducted the recruitment process during a three month period. I gave participants full details of the study during the initial contact via telephone and before the individual interview. Additionally, before the interview I asked the participant questions, I gave participants information on the researcher's role, and participants were given sufficient time to clarify any concerns regarding the study. Participants reviewed and signed the informed consent before the interviewed commenced (Appendix A).

Ethical Considerations

I kept the dignity of participants in the forefront by implementing ethical considerations throughout the research. The Institutional Review Board (IRB) approval ensured ethical procedures were implemented before the study proceeded (Appendix D). I ensured participants were protected from all harm. This protection initially took place when I explained the study to the director of community support services of the research site and formally requested permission to recruit participants. Before the research was initiated participants had a clear understanding of the study and were encouraged to ask questions as well as review and sign the informed consent (Appendix A). Additionally, I gave participants information concerning confidentiality, informed participants the study was voluntary and they could drop out at any time if they chose, and reminded

participants they did not have to answer any questions they felt uncomfortable with. I deemed all participants functional, self-sufficient and ensured they had no legal guardian/custodian that would need to make decisions for them. Therefore, this allowed the participant to sign the informed consent.

Participant Distress

Adults with mental illness rarely share their daily experiences with others. Even if these individuals have regular contact with their providers they tend to share minimal information. Individuals in a similar situation may experience distress in diverse ways (Corcoran, et al., 2003). For certain individuals, a stressful situation can cause strain on the person and prolonged stress may impair functioning, particularly in adults with SMI (Corcoran, et al., 2003; Jansen, Gispen-de, & Kahn, 2000). I made an effort to minimize any stress and distress that could have occurred during the interviews with the participants. For instance, I focused on the participant's present experiences and if any discomfort was evident I was prepared to address it. I also checked in with the participants during the entire study minimizing any participant distress. In addition, I put in place measures ensuring the safety of the participants before the study began. For example, I identified mental health professionals located at the research site as a resource for any participants that would have required a professional follow up. If the assigned clinician was temporarily unavailable I would have referred participants to the clinician on duty at the mental health facility. Additionally, I put safeguards in place in case of an extreme crisis. For example, as a state employee I am allowed by the State of Nevada (NRS 433.160) to place an involuntary hold on the participants in order for them to be

evaluated at the local emergency room if need be. After I conducted all interviews and due to sufficient information I gathered, participants were not asked to return for an additional interview. Finally, I ensured a positive and constructive exit of the study.

Protection of Confidentiality

Protection of client confidentiality and ethical considerations is the highest importance in any study (APA, 2002; Bersoff & Bersoff, 2002). Therefore, I put safe guards in place to ensure the privacy rights and confidentiality of the participants were safeguarded. The research site distributed the letter of invitation to clients on behalf of the researcher. I then proceeded to contact the participants. After the letter of invitation was distributed the clinician refrained from asking any client if they had been chosen for the study. Clinicians also communicated to the participant any further clarification of the study or additional questions would need to be referred to the researcher directly. I conducted the individual interviews in a private and confidential location. I had discussed suggestions for this location with the director of community support services at the research site before the study. During the recorded interviews I avoided any use of participant identifying information and didn't address any participant by their name.

I recorded all interviews and subsequently transferred all recorded information to a personal password secured computer. Once I completed the transfer, I deleted all original audio recordings to ensure unauthorized use of this particular information. I transcribed all interviews and extracted all identifying information from the transcriptions.

Means of Collecting Data

Instruments

I utilized two instruments for collecting participant data (a) demographic questionnaire and (b) semi structured interviews.

I implemented the demographic questionnaire by asking participants for their age, mental health diagnosis, years of smoking, number of cigarettes smoked on a regular basis, location where they smoked, and if they had ever attempted to quit smoking.

I utilized semi structured interviews to explore participant experiences with cigarette smoking, smoking cessation, and explored the participant knowledge on the risks of cigarette smoking. I initiated the interviews with various questions (Appendix C).

Data Collection

Data collection consisted in adults participating in an audio recorded interview. Average time length of these interviews ranged between 20 minutes to 45 minutes. The participants were open in sharing their personal experiences with smoking during the interview enhancing the data collection process. This process in turn evoked thoughts, dialogue, and action leading to validity and quality during the qualitative inquiry (Roulston, 2010). I focused on the participant's demographics (see Table 1) thus putting the individual's experiences within a contextual setting. Additionally, I strengthened the process through rapport and the participant understood and signed the consent form (Appendix A). In addition, I collected pertinent information of the participant's experiences.

I informed the participant before the interview I was a mandatory reporter under Nevada law. I explained specific information can be reported without their consent to Nevada authorities if they expressed and/or acknowledged he or she was a danger to self or others. Additionally, before the interview began the participants had an opportunity to ask questions regarding the study, had sufficient time to review the informed consent, and voluntarily sign the informed consent ensuring they fully understood the study, I informed the participants they were free to request any ongoing information regarding the study and/or obtain a synopsis of the study findings after the interview concluded. This allowed for all participants to have access to the study.

I focused on the participant's views and experiences regarding smoking. This ensured an enhancement of collaboration between researcher and participant would initiate social change (Roulston, 2010). I addressed the participant's experiences at the present moment by presenting focused questions derived from the central questions of the study during the interview. I used key questions that guided this study. What meaning do adults with SMI ascribe to their experiences to cigarette smoking and smoking cessation? What are the motivations that adults with SMI have for cigarette smoking? What is the individual's personal awareness of the risks of cigarette smoking?

In conclusion, I ensured privacy at the location where the interviews were conducted and ensured this location was void of any type of distraction. The interview time length ranged from 20 minutes to 45 minutes, was audio tape recorded, and subsequently transcribed. I ensured there was a continuous observation of participants during the interview. I took notes of the participant's answers to the research questions

and noted a description of relevant behaviors. I utilized these notes to search for meaning units which were also coded. I kept all this information in a confidential research journal that was used throughout the research. I asked participants if they had any pending questions and I reminded them I was available for further debriefing of their experiences with the study after the interviews concluded

Data Analysis

I conducted this study within a framework of transcendental phenomenology. As I utilized this framework, it was of the utmost importance to avoid any prejudgments or preconceived assumptions in regards to the phenomenon under study. Additionally, I described objects as they were and obtained an understanding of their essence. For that reason, I utilized “bracketing” as a tool in the analysis of data forgoing any personal bias while analyzing the participant’s behavior or expression of their personal experiences (Groenewald, 2004; Mack, Woodson, MacQueen, Guest, & Namey, 2011). I also utilized “structural description.” Consequently, I was able to identify common and emerging themes during the participant’s description of their experiences of smoking (Groenewald, 2004; Mack et al., 2011). I utilized a detailed procedure to further analyze the data after the interviews were transcribed. For instance, I reviewed the interview transcripts in detail and identified any statements relevant to the phenomenon under study. Additionally, I focused on the relevant information. Once the relevant information was isolated, I disseminated it into segments which reflected particular and specific thoughts related to cigarette smoking. Additionally, I grouped meaning units into specific categories that reflected aspects of the phenomenon under study experienced

by the participants. I then analyzed the range of experiences each participant had with the phenomenon. Finally, I created an overall description of the participant's views and experiences of smoking.

I developed thematic codes and code descriptor once all pertinent information was gathered. I included in this process an additional step in which code lists were compared. Once I established, reviewed, and analyzed emerging themes, I organized a compilation of themes into a specific dictionary that was utilized to begin the formulation of a report. Furthermore, I ensured that in the analysis and final result write up, the name of the research site was kept confidential and only relevant and none detailed demographics were utilized. In addition, I removed all participants identifying information and assigned to each participant a specific code. This ensured participant identities were not disclosed.

I used a personal and password secured computer to retain all documents in a sole location and were readily available. Furthermore, I organized the research information in order to trace the flow of progression from the beginning of the study to its conclusion. I organized all materials to develop a coding system that facilitated the labeling of the data and allowed for pertinent information to be organized into specific categories (Schensul & LeCompte, 1999).

Verification of Trustworthiness/Authenticity

The quality demonstrated in qualitative research is established in the validity and trustworthiness of the study (Creswell et al., 2007; Groenewald, 2004). I demonstrated trustworthiness when presenting the rationale for the study, detailed explanation of data

collection procedures, analytical methodology, and the interpretation of the data (Williams & Moore, 2009). In addition, I addressed two major categories of trustworthiness that consisted in the integrity of the data and the distinction between objectivity and subjectivity during the research (Williams & Moore, 2009)

I preserved integrity of the data by presenting a detailed step by step presentation of the research methods (i.e. research design and process of analysis). This in turn, allowed for a replication of this particular study (Schensul & LeCompte, 1999). Another element I put in place to preserve the integrity of data was to ensure sufficient data had been collected. The adequacy of the data consisted in the sample size, variety of demographics, and participant's viewpoints (Creswell et al., 2007; Groenewald, 2004). Triangulation also provided for integrity of data (Creswell et al., 2007). Finally, I ensured interpretation reflected the data. For instance, the presentation of data reflected the participants as individuals within a specific population. Therefore, the interpretation was reflected in data that contained direct quotes and responses of the participants and was organized into categories reflecting certain themes (Whittemore et al., 2001).

I also addressed trustworthiness by distinguishing between the statements offered by the participants and how I interpreted its meaning. In order to ensure this distinction, I utilized "bracketing" and kept an ongoing journal (Williams & Moore, 2009). Also, I fomented a sense of openness among the participants (Creswell et al., 2007; Groenewald, 2004).

I implemented "prolonged engagement" as another procedure to ensure verification of trustworthiness. This was manifested in spending a sufficient period of

time engaging with the participants during the interviews (Creswell et al., 2007; Groenewald, 2004). I was also attentive to the location the participants gathered to smoke cigarettes, with who they spent time smoking with and the quantity of cigarettes they smoked at any given time. Additionally, I utilized “persistent observation” to ensure all pertinent information was differentiated from information not linked to the purpose of the study (Creswell et al., 2007; Groenewald, 2004).

Data Interpretation

I organized and coded into a detailed dictionary emerging themes, words, patterns, and images. I interpreted the data utilizing the various elements found in this dictionary. I continued to use the HBM in interpreting data related to smoking, smoking cessation, and health behaviors.

I found a gap in the literature in regards to the specific topic of this study. Therefore, analyzing current empirical research was crucial in informing interpretation. Consequently, what was apparent in the literature was highlighted and provided meaning and significance to specific patterns that may be obscured from the reader. Additionally, I addressed various aspects of the current study. For instance, I examined if this current study built on, validated, differed, or disconfirmed what existed already in the literature in regards to the subject matter. I emphasized this current study and its contribution to the existing literature in regards to adults with SMI who smoke by using the existing research to inform interpretation.

I made certain participant perspectives were accurately reflected in data interpretation. For instance, I reviewed, analyzed, and summarized each interview in

order for emergent themes to be well defined. I also included quotes to ensure the lived experiences of the participant were accurately reflected. I included full or partial interviews as they related to the phenomenon without breaking confidentiality.

I also relied on my personal experiences as a mental health professional and an addiction specialist when interpreting the narratives of the views and experiences of the participants with smoking and smoking cessation. In particular, I focused on the participant experiences with psychiatric treatment and smoking. I also emphasized certain words and phrases that described the participant's struggle with smoking and smoking cessation, experiences with psychiatric treatment, concerns with risks associated with smoking, and concerns with chronic health issues.

Summary

I presented a discussion on the research design, sample selection, responsibility of the researcher, and the study's methodology. Additionally, I also outlined techniques used for data collection, data analysis, and data interpretation. Furthermore, I discussed the means utilized to protect the rights of the participants and efforts made to ensure confidentiality. Finally, I detailed the means to ensure verification and validity of the study. In Chapter 4, I will present a description of participant demographics as it relates to the data, collecting data procedure, the data analysis process, the study's findings, and evidence of trustworthiness of the study.

Chapter 4: Results

Introduction

I analyzed the personal experiences and perceptions related to smoking and smoking cessation of adults with SMI. I encouraged participants to share their experiences. Consequently, I obtained an enhanced awareness of why these individuals have opted for smoking. This understanding has the potential to lay a foundation for treatment considerations. I utilized three central questions that guided this research. What meaning do adults with SMI ascribe to their experiences to cigarette smoking and smoking cessation? What are the motivations that adults with SMI have for cigarette smoking? What is the individual's personal awareness of the risks of cigarette smoking?

In this chapter I will present a description of the demographics as related to the data, the procedure to collect data, the data analysis process, the study's findings, and evidence of trustworthiness of the study.

Demographics

I collected data in the southern Nevada area from November 2013 through January 2014 from 12 adults diagnosed with SMI who smoke (see Table 1). Out of the 12 participants three stated they had stopped smoking months prior to the study. I conducted participant interviews in a mental health facility that offers a variety of services to adults with mental illness. I made frequent visits to the research site prior to interviewing the participants. During these visits I introduced myself to clients and informed them I planned to conduct a study at the mental health facility. I was available to answer questions regarding the study during these visits.

Table 1

Participant Demographics

Pseudonym	Age	Diagnosis	Years Smoking	Cigarettes Smoked Daily	Smoking Occurs	Tried Quitting
Gus	29	Schizophrenia	18	1 pack	Alone	No
Larry	42	Bipolar	27	1 pack	Others	Yes
Lisa	47	Schizophrenia	12	2 packs	Others	Yes
Sue	25	Schizophrenia	10	2 packs	Alone	No
Roy	53	Schizophrenia	37	1 pack	Others	Yes
Beth	40	Bipolar	26	1 pack	Others	Yes
Doe	25	Schizophrenia	10	1 pack	Others	Yes
Paula	50	Schizophrenia	37	1 pack	Alone	Yes
Mary	38	Schizophrenia	22	1 pack	Others	Yes
Lucy	47	Schizophrenia	31	1 pack	Others	Yes
Jim	38	Bipolar	24	2 packs	Others	Yes
Patricia	60	Schizophrenia	39	1 pack	Alone	Yes

Data Collection

I selected 12 individuals that met the criteria to participate in the study after the clinicians distributed the letter of invitation. I utilized individual interviews as a means to collect data and informed participants the interview was to be recorded. I then presented the purpose of the study, initiated rapport, and reviewed with participants the informed consent (Appendix A). I proceeded to collect participant demographic information after the informed consent was signed by the participant. I then turned the recorder on, the interview was initiated, and I asked specific study questions (Appendix C). I also asked additional questions during the interview. These questions expanded on the participant's experiences and I obtained a detailed life story.

Each interview was unique in style, information, and time length. This is due to each participant's personal history with smoking, and smoking cessation, years receiving

mental health services, and each participant's mental health diagnosis. The interview room was private, comfortable, and was optimal for recording each participant.

I provided participants sufficient time to share their experiences with smoking during the interview. I expanded the research questions to obtain additional information not yet shared in previous participant interviews. After I collected the data I transcribed each recorded interview individually. I changed participant names to ensure privacy. Furthermore, I redacted the name of the research site to protect privacy and ensure confidentiality. I will present in this section participant stories verbatim. The goal is to present and enhance the readability of the material. Therefore, I removed any repeated pauses or stammers allowing for a better grasp of the participant's story.

Data Analysis

The process of coding, analysis, and interpretation was ongoing. First, I transcribed each recorded interview individually. Once transcribed I read all transcripts as a whole. I then wrote notes based on first impressions. After I reviewed the transcripts as a whole, I read each individual transcript line by line. At this point, I labeled words, sentences, phrases, and sections relevant to the study. I completed this coding process in three levels. Level one consisted in the initial coding. At this level, I focused on the entire data of each transcript and labeled it appropriately. The second level consisted in reexamining level one codes. During this second level, I used focus coding in analyzing the data. For each focused coding I wrote a set of memos for future use. During the third level, I reexamined both initial and focused coding in order to identify emerging themes. In addition, I kept in a manual under a specific assigned

number certain codes, categories, and themes that were identified in each transcript. I then integrated these codes, categories, and themes to obtain a clearer representation of the participant's stories. During this analysis, I developed a detailed depiction of participant experiences and consequently common themes emerged. I removed certain codes and categories due to their lack of consistency with the overarching themes. From the data, I identified three major themes related to smoking and reflected in participant experiences.

Findings

Three significant themes emerged from the participant's stories. Two of the themes point to underlying reasons these adults with SMI smoke and one theme points to the knowledge these individuals had regarding the risks of smoking. The stories shared by these adults illustrated they are confronted with an array of experiences and emotions related to their mental illness. In order to deal with their stressful circumstances, these adults perceived specific benefits in smoking and therefore chose smoking as a source of relief. Furthermore, these adults also viewed smoking as way to socialize with family and peers. Though these individuals used smoking as a means to deal with their stressful circumstances, they also sought ways to quit smoking at certain periods in their lives. Yet, time and again many of these adults experienced failure in quitting smoking due to the intolerable effects of nicotine withdrawals and smoking cessation strategies that failed. After experiencing the failure of smoking cessation, these adults relapsed and returned to smoking. Therefore, for these individuals smoking habituation became a common occurrence within their daily activities. Despite the perceived benefits of

smoking and the experiences of failure with smoking cessation, these adults with SMI had knowledge that cigarette smoking had negative consequences. This was particularly evident in the individuals who acknowledged smoking negatively impacted their health. Yet, the majority of these adults continued to smoke despite the risks. The following are common themes that emerged from the participant's narratives. I will present a detailed discussion of these themes in Chapter 5.

Emergent Themes

Perceived Benefits of Cigarette Smoking

Participants viewed cigarette smoking as positive that gave them certain benefits. There were three participants who had stopped smoking months prior to the research who did not share this view.

For the participants, perceived benefits of cigarette smoking were present during their early years and gradually were accepted through adulthood. Throughout the interviews participants consistently reported smoking was a significant part of life and to quit smoking was an unrealistic goal. Cigarette smoking as positive was expressed by both male and female participants. The perceived benefits of smoking communicated by participants were found in two categories. These categories are (a) relaxation and (b) socialization.

Category 1: Cigarette smoking as a means for relaxation.

The first category that emerged from this theme was smoking as a means for relaxation. In particular, for the participants relaxation was beneficial in dealing with an array of feelings and emotions. For the majority of participants, smoking was the means

to deal with stress which in turn helped the individual experience a sense of relaxation. During the interviews the participants' reiterated stress was present in their daily experiences and affected many areas of their life. Consequently, these individuals learned to cope and deal with stress by smoking cigarettes. For example, when asked what smoking meant to them a participant stated:

Gus, "To feel good, relax...I just like to smoke, I don't like to quit or none of that."

The participants indicated smoking was an important means for relaxation especially in dealing with mental health symptoms, anxiety, fear, anger, frustration, or nervousness. In dealing with negative affect by smoking, a sense of relief was obtained. One of the participants stated:

Sue, "Well, I smoke to relax myself, relax my temperament, myself, and relax my diagnosis. When I get all shaky for no reason and then like the medicine doesn't work I just smoke a cigarette."

For other participants, mental illness, smoking, and relaxation were also interconnected. For instance, one participant related her smoking to mental illness and indicated this experience led to smoking which in turn relaxed her.

Pat, "Well it makes me, when I get nervous I have to have a cigarette. And the voices, they make me have to have a cigarette too."

Out of the 12 participants there were three that had stopped smoking months prior to the study. Out of the three there were two participants that did not view smoking as a

means of relaxation. When asked what cigarette smoking meant, one participant acknowledged smoking had no meaning.

Lisa, “It didn’t really mean too much then. I thought it was doing me some good relieving the stress they say. But to me it was causing more stress and more health issues.”

Category 2: Cigarette smoking as a means for socialization.

The second category that emerged was the participant’s view of cigarette smoking as a means for socialization. The majority of participants indicated smoking gave them the opportunity to spend time with peers. This was apparent when participants gathered with others to smoke during their visits to the mental health facility where they received treatment and/or participated in structured activities. In addition, participants communicated they spent time with their peers smoking at their place of residence. One participant put it this way:

Larry, “I think it would be more social. Here I sit and read and stuff on our breaks. Communication skills are a lot better now.”

For other participants socializing while smoking offered them a sense of acceptance and support by others. Being in close proximity with their peers gave the majority of participants the sense they were not alone and smoking offered them a time to share their experiences with others who also had a SMI diagnosis.

For instance one participant stated:

Roy, “Like you feel like being around other people that smoke. Some people that smoke, that try to help you quit...everybody talks

about it.”

For other participants smoking as a means for socialization emerged when they were young. In finding the means to connect and socialize with their peers, some participants began to smoke and learned that smoking is one way to communicate with others.

For example, one participant indicated:

Mary, “Yea and this reminds me of how school days was when I used to be with my friends that smoked also cigarettes when I was in high school.”

For another participant who had stopped smoking, using smoking as a form of socialization was not desirable.

Jim, “Socializing? I don’t have to rely on something to be sociable.”

I observed throughout the mental health facility various groups of individuals congregated on a regular basis during the day. When I asked participants about these gatherings they indicated it was a time to smoke and socialize. It was rare to observe individuals smoking alone at the mental health facility.

Problems Related to Smoking Cessation

As participants viewed cigarette smoking with positive benefits, they also reported smoking cessation had become a struggle at different periods of their life. For instance, the majority of participants at one time or another opted to quit smoking. Out of the 12 participants seven smokers had quit smoking during some point in their life, three smokers had given up smoking months before the study, and two smokers reported they never tried to stop smoking.

Three categories that emerged from the second theme in regards to the problems related to smoking cessation were (a) nicotine withdrawals; (b) failed smoking cessation strategies; and (c) habituation due to smoking.

Category 1: Nicotine withdrawal from quitting smoking were intolerable.

The first category involved nicotine withdrawals experienced by participants when they attempted to quit smoking. For example, 10 participants indicated they experienced negative emotions, physical discomfort, and misguided anger when attempting to quit smoking. This in turn motivated the participant to return to frequent smoking. For example, one participant stated:

Larry, “Just get me really moody and stuff. And when I don’t have it I got moody, you know.”

Some participants acknowledged that nicotine made it difficult for them to quit smoking. One participant shared their experiences this way:

Paula, “If I don’t smoke the nicotine affects me badly. If I don’t smoke I get nervous because of the nicotine in the cigarettes. I get pissed and cranky.”

For other participants, nicotine withdrawal from smoking cessation led to smoking in order to avoid the experiences of physical discomfort and fear of hurting others. For instance one participant stated:

Mary, “I feel terrible...I’m afraid of going off the deep end. That’s something I’m afraid of doing. I will take out my anger on not having a cigarette on somebody. I’m afraid of attacking.”

All participants acknowledged nicotine withdrawals were the most difficult experiences they had while trying to quit smoking. Also expressed by some participants during the interviews, not having a cigarette at that moment caused them some anxiety. This confirmed the intolerability of nicotine withdrawals.

Category 2: Strategies to quit smoking failed.

Another category involved with failure to quit smoking was participants utilizing specific smoking cessation strategies that failed. Out of the 12 participants only two indicated they had not tried to stop smoking. For the other participants various types of smoking cessation strategies were utilized at one point. For example, one participant tried the nicotine patch, two participants used the nicotine gum, two participants tried both the nicotine patch and gum, three participants opted to stop smoking “cold turkey,” and two participants chose the nicotine patches and tried to stop smoking “cold turkey.” One participant indicated:

Doe, “When I was wearing the patch I felt it didn’t work cause I didn’t see any steps that I was taking to quit. I don’t never see me not smoking.”

There were other participants who had tried to quit smoking without any external assistance and indicated they had relapsed and immediately returned to smoking.

For example one participant stated:

Lucy, “I tried the patch and I also tried cold turkey. But I tried to quit. I almost, I couldn’t, I couldn’t do it.”

As indicated by the participants throughout the interviews after a smoking cessation attempt the quantity of smoking remained the same or increased.

For the majority of participants attempting to quit smoking was experienced as a failure. For instance one participant put it this way:

Larry, “I had 1 cigarette and 4 puffs off a cigarette and about 2 weeks ago I went back to smoking.”

For the participants, despite the failure of smoking strategies, many opted to try new interventions while others decided to give up on smoking cessation all together. For the participants who were currently not smoking the smoking cessation strategies they were using were helping them thus far.

Category 3: Cigarette smoking as a habit.

Another category related to smoking cessation involved the habit forming elements of smoking. Due to the struggle of quitting smoking, participants acknowledged another reason for smoking was due to its habitual aspect. For instance one participant stated:

Lisa, “It was just a bad habit; it was just a really bad habit to pick up.”

For other participants the habit of cigarette smoking had a devastating influence on their life. One participant put it this way:

Larry, “Yes, I mean I’m just living for that cigarette. I mean, break time here, run go smoke. Every minute I got I run and go smoke.”

For other participants smoking as a habit was viewed as a regular routine or activity that was considered a normal part of life. Two participants explained it this way:

Doe, “That’s one of my hobbies. First when I was young I just wanted to be cool and then after that once I found out I couldn’t live a day without

a cigarette.”

Paula, “Something to do with my hands. Yes, I have a cigarette I go back and forth (participant mimics smoking at this point) something to do with my hands.”

It was also reported by three participants that the habit of smoking led to an addiction. For instance, one of those participants stated:

Roy, “It’s like something to do. You get addicted to it.”

While participants shared their experiences they indicated smoking as a habit was a continuous worry and struggle. One participant stated:

Beth, “I’m trying to stop. I am really trying to stop. I really am.

I’m trying to stop, really am trying to stop real bad. I wanna stop.

I gotta have the will power to stop.”

Risks of Cigarette Smoking

The third theme emerging from the data concerned the risks of cigarette smoking. For all participants, despite particular perceived benefits they received from smoking, cigarette smoking had negative consequences.

Category 1: Cigarette smoking as detrimental to personal health.

A category that emerged from this theme was cigarette smoking was detrimental to personal health. All participants were aware and expressed smoking damaged their health. One participant put it this way:

Lisa, “They cause serious health issues, like they mess with your

breathing. You wheeze. It was just causing me more health problems.”

In addition, participants also reported other physical ailments not related to smoking or the person's SMI were negatively affected by smoking. For example, three participants indicated they were currently suffering from asthma, lung problems, and obesity. One participant indicated:

Larry, "I want to breathe you know, be able to breath... I'm tired of coughing and wheezing you know. Yea, but I got like the psych meds, I got thyroid, I got diabetes."

There were other participants that indicated they had a family member that had died of smoking related consequences. Yet, the participants continued smoking despite this family history. One participant stated:

Larry, "it's killing my family but I kept doing it. My dad died 10 days the day he quit. He died of lung cancer so I was like why should I quit I'm a die 10 years later so I kept smoking."

The majority of participants acknowledged though smoking had its risks it did not deter them from continuing to smoke. Nevertheless, three participants indicated it was due to the risks of cigarette smoking they had stopped smoking months prior to the study.

For example, one participant put it this way:

Lisa, "Once I stopped my health started getting better. I wasn't wheezing as much, I was able to walk a little longer, climb some stairs if it was possible, do a little exercises without all the breathing."

Additional Findings

I located other minor findings in the participant's stories. These additional findings were (a) the cost of cigarettes. Some participants reiterated the cost of cigarettes had a negative impact on their budget; (b) unpleasant smell of cigarette smoke. Some participants shared they did not like the smell of cigarette smoke on their clothes; (c) parents/significant others disagreed with participant's smoking. Family members and/or significant others did not tolerate and expressed disapproval of the participant's smoking; and (d) cigarette smoking odor. For other participants cigarette smoke odor in their homes was unpleasant. Since these findings were not as common throughout all the participant's stories I did not target them in this study.

Similarities and Differences

From the 12 participants in the study two distinct groups emerged. One group consisted in participants that were currently smoking. The second group consisted in participants that had stopped smoking prior to the study. I discovered in the findings major similarities and differences among the two groups.

Major similarities I found among the two groups were (a) participants had a diagnosis of SMI; (b) participants received mental health services; (c) participants initiated smoking at an early age; (d) participants had an extensive smoking history; and (e) participants were daily smokers.

Major differences I found in the group that had stopped smoking that were not evident in the group of current smokers were as follows. (a) participants were currently not smoking; (b) participants quit smoking due to personal health concerns; (c)

participants utilized smoking cessation strategies that help them stop smoking and considered them effective; (d) participants expressed the benefits of not smoking; and (e) participants had extensive knowledge of the risks of smoking.

Evidence of Trustworthiness

I implemented two effective means to maintain trustworthiness of the study (a) prolonged engagement and (b) progressive validation.

Prolonged Engagement

I engaged with participants in building trust, rapport, and confidence. I also paid attention to the location where the participants spent time smoking and socializing (Creswell et al., 2007; Groenewald, 2004). I expanded personal knowledge of the phenomenon under study through prolonged engagement. Through this knowledge, I developed appropriate research questions, the means for analyzing the data, and in reaching appropriate conclusions. The experiences I had working within various types of mental health settings also allowed for prolonged engagement. In addition, ongoing participation in activities, trainings, and mental health agency committees strengthened this engagement. Continuous communication and interfacing with community organizations and constant visits to the research site before and during the study enhanced the engagement. Utilizing a prolonged engagement throughout the study also ensured all information observed and gathered was related to the purpose of the study (Creswell et al., 2007; Groenewald, 2004).

Progressive Validation

I focused on ensuring and verifying the quality of data. The participants were asked to share their story on an ongoing basis. I initiated this process by asking open ended questions in regards to their views of cigarette smoking, their views on smoking cessation, and their knowledge on the risks of cigarette smoking. In addition, I asked additional questions to enhance and further expand on the experiences of the participant. I was also attentive to the participant's story and utilized the skills necessary to prompt the individual at appropriate moments for additional information. These prompts for further information continued to enrich the participant's story.

I established ongoing validity by viewing the participant as the essential story teller. For example, I asked the participant to share their story and evaluate if what the participant stated was congruent with what I understood. This verification ensured the accuracy of the participant's story. Furthermore, I asked the participant to correct any perceived errors in the interpretation of the data. After I gave feedback on statements made during the interviews, study participants also had the opportunity to offer any additional information (Creswell et al., 2007; Groenewald, 2004).

I implemented additional steps to continuously maintain data quality and validity throughout the study. For instance, I chose the appropriate number of participants based on the study criteria and developed specific research questions based on the appropriate methodology. I used "Triangulation" to evaluate the outcomes and common themes as a result of the participate data. This ensured data interpretation was credible indicating the participant's views, story, and words were accurate (Creswell et al., 2007). Furthermore,

as I analyzed data an effort was made to eliminate any research bias that might have hindered objectivity of the participant's personal story (Groenewald, 2004; Mack, Woodsong, MacQueen, Guest, & Namey, 2011). As I examined the participant's experiences, common themes emerged related to smoking and smoking cessation due to progressive validation (Groenewald, 2004; Mack et al., 2011).

Summary

I presented three themes that emerged from the interviews conducted with 12 adults diagnosed with SMI who smoke. I recorded, transcribed, and analyzed these interviews. From this analysis three common themes emerged. These themes were (a) cigarette smoking had perceived benefits; (b) problems with smoking cessation existed; and (c) cigarette smoking had risks.

I will present in Chapter 5 the findings of the study, its interpretation, and recommendations for future research. Furthermore, I will present the social implications of the study and its positive impact. I will conclude this chapter by presenting personal reflections on the research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

Problem

There exists a high rate of smoking among adults with SMI leading to morbidity and mortality due to smoking related conditions. Despite this occurrence, adults with SMI continue to smoke and struggle with smoking cessation. Though gaps in the literature exist, researchers attempted to understand the underlying motivations for smoking in adults with SMI. For example, researchers focused on the reasons for smoking in adults with SMI based on the views of professionals within the mental health and medical fields. Researchers also focused on the reasons for smoking in adults with a specific mental diagnosis and residing within inpatient settings. What has been lacking is research on the views and experiences of smoking in adults with SMI expressed in personal stories within the individual's natural setting.

Purpose

I investigated the personal experiences, insight, and views of smoking, and smoking cessation of adults with SMI. I obtained an enhanced knowledge related to the reasons for smoking and the difficulties with smoking cessation in adults with SMI. The findings of the study may lay the foundation for community agencies and mental health professionals to evaluate their services as they relate to adults with SMI who smoke.

Questions

I invited adults with SMI to share their views and experiences of smoking and smoking cessation during recorded interviews. I used the following central questions to

guide this study. What meaning do adults with SMI ascribe to their experiences of cigarette smoking and smoking cessation? What are the motivations that adults with SMI have for cigarette smoking? What is the individual's personal awareness of the risks of cigarette smoking? I also asked specific questions in order to obtain rich narratives of the participant's experiences of smoking (Appendix C).

These questions were as follows.

- 1) Please describe what smoking means to you.
- 2) Please describe your experience in attempting to quit smoking.
- 3) Please describe what you get from cigarette smoking.
- 4) Please describe what you do not like from cigarette smoking.
- 5) Describe how your life would be if you did not smoke.

Methodology

I utilized a qualitative methodology with a phenomenological framework. This methodology gave adults with SMI the opportunity to share their experiences with cigarette smoking and smoking cessation. In addition, I listened to the participant stories within its natural setting. This in turn enhanced the knowledge regarding the underlying motivations for smoking (Creswell et al., 2007; McCaslin & Scott, 2003).

I collected data from 12 adults with SMI who smoke and received mental health services (see Table 1). Interviews were unstructured and I encouraged participants to share their personal stories. I chose interviews that were recorded as a primary data collection method. Interviews are an effective means to obtain rich and descriptive

experiences that are both vital to the participant and associated to the study's main questions (Roulston, 2010).

I implemented methods of integrity and validation of the study due to the collection of data of a vulnerable population. For instance, there was an adequacy of data derived from the participant sample size, demographics, and participant perspectives. In addition, participant's involvement throughout the study and particularly during the interviews ensured a true representation of the person's experiences. The integrity and validation of the study was ongoing (Creswell et al., 2007; Groenewald, 2004; Whitemore et al., 2001; Williams & Moore, 2009).

Interpretation of the Findings

I will present the following in this section (a) summary of study findings as related to the research questions; (b) literature associated to the current topic and; (c) conceptual framework I utilized to guide this study.

I examined the motivations for smoking in adults with SMI. I used the HBM to guide this study and isolate the participant's health beliefs and reasons for smoking. (U.S. Dept. of Human Services, 2005). Consequently, I asked each participant about their personal views on cigarette smoking and smoking cessation. I obtained rich information regarding their history of smoking, their current experiences with smoking, the individual's struggle with smoking cessation, and the participant's knowledge on the risks of smoking. Each participant story was unique and provided insight on their motivations to smoke and the reasons quitting smoking was not a priority. In addition, participants indicated their views of smoking originated in their early years and despite

various life circumstances these views were still relevant. Though aware of the health risks of smoking, participants indicated this did not change their inclination to continue smoking.

As I described in Chapter 3, as researcher I was the main instrument that recruited the study's participants, maintained the data collection process, conducted data analysis, ensured verification and trustworthiness of data, presented the study findings, and disseminated the results related to the study. I also had a number of interests for this study related to (a) topic of the study; (b) methodology of the study; (c) research questions that guided the study; (d) data analysis process; and (e) study findings.

Perceived Benefits of Cigarette Smoking

Adults with SMI perceived benefits to cigarette smoking. The two categories that emerged from the first theme and found in the participant stories were (a) smoking as a means for relaxation and (b) smoking as a means for socialization.

Smoking as a Means for Relaxation

The occurrence of smoking is high among adults with SMI. This high incidence of smoking is a result of the individual's belief system. This is consistent with the HBM. For instance, a significant belief expressed by adults with SMI is smoking has specific benefits. One particular benefit expressed and described in the participant's stories was the view that smoking was a means for relaxation.

Adults with SMI confront varied circumstances, emotions, and feelings (Dome et al., 2010). For these adults stress is a major occurrence. This is consistent with the research. For instance, adults with SMI who smoke have shown higher levels of stress

when compared to nonsmokers (Guimaraes & Abberton, 2005). Therefore, one means for adults with SMI to deal, manage, and cope with these experiences is to use smoking for relaxation (Dome, et al., 2010; Forchuk et al., 2002). Additionally, smoking is used by adults with SMI as a therapeutic means to alleviate stress, as a form of symptom management, and a means to deal with adverse circumstances (Morris et al., 2009). Researchers also found smoking by adults with SMI was used for the calming and relaxation effects especially in dealing with stress, hopelessness, loneliness, and lack of self-worth (Dome et al., 2010; Forchuk et al., 2002; Diaz et al., 2009).

Motivation for smoking to obtain stress relief and relaxation are also consistent with the views held by mental health providers (Dickens et al., 2006; Dwyer et al., 2009; Morris et al., 2009; Pejler, 2001). Though these views of smoking are held by providers, failures exist to supporting adults with SMI find alternative means to deal with smoking (Stubbs et al., 2004). Consequently, lack of treatment considerations was expressed and reflected in participant stories.

Smoking as a Means for Socialization

Participants actively engaged in their treatment at the mental health facility. In addition, the majority of these adults with SMI sought other activities that offered the opportunity to engage and socialize with their peers. One means of socialization the participants engaged in was congregating throughout the mental health facility with their peers to smoke. As part of their belief system adults with SMI had chosen smoking as a means for socialization that took place in both inpatient and outpatient settings (Lawn & Pols, 2005).

Smoking as means for socialization within inpatient settings offered adults with SMI an opportunity to interact with peers, staff, and psychiatric providers (Dwyer et al., 2009). Furthermore, adults with SMI utilized smoking for socialization in order to help their peers and to experience a sense of belonging (Dickens et al., 2005). These opportunities were also sought within an outpatient setting as was reflected in the participant's stories.

Also consistent with the research was smoking as a form of socialization is a venue for the adult with SMI to deal with significant others, with socioeconomic status, and a means to deal with interpersonal relationships (Dome et al., 2010; Forchuk et al., 2002).

For some participants smoking as a means for socialization began during their early years. It was during this period where acceptance and the need for support by their peers and family members were most important. However, due to smoking during their earlier years led to an increase of smoking as adults. This is consistent with research in that adults with SMI who smoke at an early age experience the severity of smoking as they get older (Venable et al., 2003).

Problems Related to Smoking Cessation

In the participant's stories, the motivation to smoke was also related to difficulties with smoking cessation. These problems consisted in (a) nicotine withdrawal from quitting smoking; (b) failed strategies to quit smoking; and (c) cigarette smoking as a habit.

Despite the view that cigarette smoking had specific benefits, the majority of adults with SMI also believed there was a positive aspect to smoking cessation. This is consistent with HBM. In addition, adults with SMI also indicated quitting smoking reduced negative smoking consequences (U.S. Dept. of Human Services, 2005). However, once the positive aspect of smoking cessation was diminished the individual returned to smoking. Therefore, found in the participant stories were the struggles and challenges these adults with SMI faced with smoking cessation.

Nicotine Withdrawals Were Intolerable

As indicated in the literature, the array of chemicals found in nicotine and its absorption in the brain leads to various chemical changes while binding to certain brain receptors (American Heart Association, 2012; CDC, 2012). Furthermore, nicotine affects the individual's cognitive ability, emotional state of being, and in particular the individual's health (CDC, 2012). Therefore, nicotine use influences smoking and smoking cessation which has caused individuals to experience negative side effects when attempting to quit smoking (Mann-Wrobel et al., 2011).

As reflected in the participant's stories, nicotine side effects were intolerable and therefore had been an obstacle for adults with SMI to quit smoking. This is consistent with research in that high levels of nicotine influence an individual's confidence and ability when trying to quit smoking (Mann-Wrobel et al., 2011).

Strategies to Quit Smoking Failed

As referenced in HBM, adults believe utilizing strategies to quit an unhealthy behavior such as smoking despite the difficulties outweighed the cost and efforts.

Nevertheless, the second problem expressed by adults with SMI to quit smoking was the failure of smoking strategies. For example, certain strategies that were used were nicotine patches, nicotine gum, smoking cessation medication, and efforts to stop smoking “cold turkey.”

With a focus on the general population, studies on the effectiveness of smoking cessation strategies were conducted (CDC, 2012; Mohiuddin et al., 2007; Ranney et al., 2006). Researchers conveyed smoking strategies as well as other smoking control programs were effective in lowering smoking in general (Pierce et al., 2011). Nevertheless, what the researchers also found were due to failed smoking cessation strategies as related to adults with SMI motivated these adults to continue smoking.

Cigarette Smoking as a Habit

The habitual components of cigarette smoking has been well documented (CDC; 2012). Adults with SMI also experienced the habitual element of smoking as another problem encountered during smoking cessation efforts (Corvin et al., 2001; Malpass & Higgs, 2009; Voineskos et al., 2007).

Researchers that conducted studies on neuropsychiatric disorders reported cigarette smoking was habit forming. For example, researchers found there was a dependence of nicotine due to specific interactions between genes and environmental factors in adults diagnosed with schizophrenia (Voineskos et al., 2007; Xinag, Lou, Chen, Ma, & Elston, 2008). In adults with bipolar, there is a link between the habitual elements of nicotine and psychotic symptoms (Dome et al., 2010). In adults diagnosed with depression, reasons for smoking was a result of cigarettes being habit forming, the

addictive elements of smoking, and smoking utilized to manage depressive symptoms (Malpass & Higgs, 2009).

In the present study, adults with SMI expressed the habit forming components of cigarette smoking was another common activity. This mindset is a reflection on how the habit forming component of cigarette smoking can be misplaced.

Risks of Cigarette Smoking

As referenced in the HBM, there are factors that are part of an individual's belief system that influence a decision to participate in positive health choices (U.S. Dept. of Human Services, 2005). For adults with SMI, the knowledge of the risks of smoking should have led to a particular action which reduced the chances of developing negative health conditions. Yet, as a failure of not choosing a healthy behavior adults with SMI have experienced an array of personal health problems due to the risks of smoking.

Cigarette Smoking as Detrimental to Personal Health

Adults with SMI have knowledge and experiences of the negative consequences of smoking. These adults viewed their experiences of the risks of smoking as it relates to the negative effects of nicotine on their personal health. Additionally, for some adults with SMI smoking further complicates a current medical condition. This is consistent with the literature. For instance, adults with SMI already confronted with poor health due to their mental illness, exacerbate this condition by cigarette smoking (Dickerson et al., 2006). Researchers found adults with SMI who had quit smoking acknowledged that by quitting smoking positive results on health were apparent, especially if they had current medical conditions.

Researchers point to the negative consequences of smoking and its impact on personal health (CDC, 2012; Dixon et al., 2007; Forchuk et al., 2002; Lawn et al., 2002; Rogerris et al., 2001). Yet, what are lacking are studies indicating adults with SMI have knowledge of these risks yet continue to smoke. In this study adults with SMI had knowledge of the risks related to cigarette smoking and yet failed to stop smoking.

The knowledge of the risks of smoking is more palpable in adults with SMI that have a period of time not smoking. Yet, as indicated in the HBM, for some adults with SMI there is a need for an outside source to encourage these individuals to choose healthy behaviors. This helps to void their life of the risks of cigarette smoking.

Recommendations for Future Research

I recruited participants from one mental health facility. Recruiting adults with SMI from additional mental health facilities would offer a varied view regarding smoking and smoking cessation of this particular population.

The pool of participants in this study consisted in adults with SMI who were currently smoking and participants who had quit smoking some time prior to the study. In order to obtain a richer perspective on smoking and smoking cessation, another recommendation is to solely recruit adults with SMI who are currently smoking or solely recruit adults with SMI who had quit smoking. Consequently, a distinct perspective on smoking and smoking cessation between two unique groups can be obtained. As a consequence of this study's results, there are differences in participants that were currently smoking and participants that had stopped smoking months prior to the study.

For this study there were only three participants that had quit smoking therefore future research with this particular group is necessary.

I recommend that continuous research be done in both outpatient and inpatient settings as evident in the literature. This allows for professionals in both mental health settings to educate adults with SMI who have a history of smoking obtain the knowledge and skills necessary to quit smoking.

As an outcome of this study, another recommendation is to conduct research on a smoking cessation program designed for the general population or with adults with SMI. This allows for an evaluation of the effectiveness of smoking cessation interventions among adults with SMI.

Finally, as reflected in the literature utilizing quantitative research is also recommended to continue examining smoking in adults with SMI. Quantitative methodologies facilitates pinpointing specific characteristics of an observed phenomenon or investigating a correlation between more than one phenomena (Groenewald, T., 2004).

Implications for Social Change

Findings derived from this study offers opportunities for social change as the means to implement ideas and actions leading to dignity and progress of persons, specific populations, and organizations (Walden University, 2014). To establish and implement a foundation for social change, participants shared their individual views and experiences with smoking and smoking cessation. In addition, by sharing their individual stories participants offered an enhanced understanding on the reasons and motivations for smoking and their experiences with smoking cessation within the mentally ill population.

With this awareness, clinicians, professionals, and organizations working within the mental health field will gain and expand their aptitude for developing and implementing best practices and consequently better serve adults with SMI who smoke.

Practice Implications

As it relates to the treatment of the mentally ill population, professionals and clinicians have a primary role to assist patients in dealing with their mental illness. Despite awareness smoking among the mentally ill population continues to be a problem, education and interventions as related to tobacco use have been overlooked within mental health treatment settings (Williams & Ziedonis, 2004). Though ongoing mental health treatment allows for certain stability in the life of adults with SMI, these individuals continue to lack education, prevention, and intervention as it relates to smoking and smoking cessation.

In addressing tobacco use and to enhance the quality of care afforded to adults with SMI, the following practice implications are to be considered (a) interventions as it relates to smoking and smoking cessation and (b) a holistic approach as it relates to treatment considerations.

In addressing treatment for adults with SMI that smoke clinicians must be required to initiate and complete a structured level of care assessment that ensures the optimum use of services. This assessment will occur when the individual with SMI enters into service, significant life changes emerge, and during ongoing mental health treatment. The assessment will be used to recommend a level of resource intensity of care which will incorporate education and interventions related to smoking and smoking

cessation within the treatment care plan. Consequently, during their ongoing mental health treatment adults with SMI that smoke are to receive education on the components of tobacco, risks of cigarette smoking, tobacco interactions with psychotropic medications, and the habitual elements of smoking. Furthermore, this type of education can also extend to the individual's family or significant other that is willing to assist the adult with SMI in their endeavor to quit smoking. This involvement will then ensure greater success rates related to smoking cessation. Similar ongoing and consistent education has been successful in other types of health programs (Olivier, Lubman, & Fraser, 2007; Williams & Ziedonis, 2004).

In conjunction with education on smoking and smoking cessation established within the individual's treatment care plan, incorporating smoking cessation opportunities geared specifically to adults with SMI ensures the person becomes successful in their attempts of smoking cessation. Prior to incorporating smoking cessation options into the treatment plan, the clinician must ensure specific elements are addressed in these options (a) an understanding of nicotine effects and its influence on mental health diagnosis symptoms. Nicotine influence on a mental health diagnosis leads to different struggles in the individual's attempt to quit smoking; (b) stress coping skills. Adults with SMI will acquire positive means to deal with stress without smoking; (c) interpersonal relationship building. Forming meaningful relationships within positive social settings will open up new avenues of socialization where cigarette smoking is no longer needed; and (d) smoking cessation strategies. Education on the various smoking cessation opportunities

and the ability to learn how to deal with possible failures with these strategies will strengthen the individual's resolve to quit smoking

To ensure adults with SMI who smoke continue to receive optimal care, smoking and smoking cessation education together with opportunities to help quit smoking incorporated in the individual's care plan are essential. Furthermore, incorporating a holistic approach to treatment is also vital when considering practice implications.

Adults with SMI confront wide ranging stressful experiences which are viewed as negative and a result of mental illness. Since the meaning of coping resides in the thoughts and actions of the individual in dealing with stress (Cooper & Dewe, 2004), this has led adults with SMI opt for smoking to acquire a sense of relief.

With an enhanced understanding of the reasons for smoking in adults with SMI, mental health professionals can gain the knowledge and skills necessary to better assist this specific population. Additionally, knowledge of the motivations, reasons, and experiences of smoking and smoking cessation from the patient's perspective allows for a holistic approach to treatment in working with the mentally ill population.

In dealing with smoking in the mentally ill population, a holistic approach to treatment can be realized when mental health providers and adults with SMI collaborate in treatment considerations. It is within this holistic approach a more balanced and productive life for adults with SMI is achieved.

As a result of study findings related to the perceived benefits of smoking viewed by the participants, adults with SMI that smoke may benefit from three specific interventions that can become an alternative to smoking (a) stress management

techniques. The individual's view on stress is modified as a result of the person discovering and implementing new ways of coping. Some examples include but are not limited to muscle relaxation, guided imagery, yoga, and meditation; (b) relaxation techniques. These techniques can alleviate stress that leads adults with SMI to smoke. Therefore, learning new relaxation skills will help in reducing negative emotions. Some examples include but are not limited to deep breathing, mind body relaxation, listening to soothing music, and finding a quiet place to relax; (c) disclosure of personal thoughts and feelings. This offers the individual the possibility of sharing their experiences, views, feelings, and emotions with a trusted individual or within a group setting. This technique will help the individual avoid repression which can lead to unhealthy behaviors. These three techniques as essential elements of a holistic treatment have also been beneficial within specific health programs (Lutgendorf & Costanzo, 2003; Miller & Cohen, 2000).

Incorporating the holistic approach to treatment can address daily stress, diagnosis symptomology, and the effects of psychotropic medication, interpersonal relationships, smoking and smoking cessation, in the treatment of adults with SMI who smoke. While addressing these elements, the provider will utilize essentials such as acceptance, empathy, mind body unity, and will work with the individual's uniqueness. Additionally, the social, psychological, spiritual, and physical dimensions of the individual's health are taken into consideration by giving the adult with SMI the tools necessary to begin the process of quitting smoking thus allowing for social change to occur (Kunitz, 2002; O'Conner, 2003).

Policy Implications

As referenced by the Nevada Cancer Institute (2014), a smoking cessation program for the general population offers broad education related to smoking and implements a course to help individuals make decisions on quitting smoking. This occurs by helping them understand how to cope with changes as a result of smoking cessation. Nevertheless, where these interventions fail is in addressing the experiences of adults with SMI who smoke.

Many of the smoking cessation programs offered to adults with SMI are not incorporated as a vital element of the individual's treatment and do not offer a holistic approach. For example, these programs offer the more traditional biological, psychological, social, and cultural interventions. Also offered through these programs are medication therapy, counseling, goal setting, behavioral therapy, and smoke free environments for quitting smoking. Many of these types of interventions have been offered individually and have also been suggested in previous research studies (Campion, Checinski, Nurse, & McNeill, 2008; Lawn, Pols, & Barber, 2002; Mann-Wrobel et al., 2011; Moeller-Saxone, 2008; Schorr et al., 2009; Snyder, McDevitt, & Painter, 2008).

Reflected in the study findings, smoking in the mentally ill population requires services and program options that deal with smoking and smoking cessation specifically tailored to adults with SMI within a holistic approach. The implementation of smoking cessation programs geared toward adults with SMI will take into account the person as a whole in dealing with both serious mental illness and smoking.

Programs for adults with SMI that assist with quitting smoking when successfully implemented will impact the individual in a positive manner thus allowing for social change to occur. Therefore, policy makers, state, and local organizations, mental health outpatient and inpatient facilities, and others involved in providing services to adults with SMI are required to begin assessing the need for and begin implementing smoking cessation programs geared specifically to adults with SMI. In particular, agencies that currently offer smoking cessation programs need to reexamine their services and acquire the means to target the mentally ill population. This implies seeking additional resources, evaluating existing policies, and searching for best practices as it relates to smoking education, prevention, and intervention for the mentally ill population. The lack of services in this area will continue to impact adults with SMI and the cost to treat this population will continue to increase.

Reflections on the Research

Researcher Reflections

With over ten years working with the mentally ill population, the one question I continued to ask was why adults with SMI smoke. This was a concern as a result of the struggles and illnesses I witnessed on a regular basis while working with this specific population.

I began the quest to find answers to this question by asking mental health practitioners what they thought the reasons adults with SMI smoked. These were clinicians who treated these adults on a regular basis and would most likely have the answer to this problem. Yet, as time went on there appeared to be a variety of reasons

given by mental health professionals on why adults with SMI smoked. Though these answers were important, there was still a need to delve further in to this problem.

During the period I attended Walden University, the high rates of smoking among the mentally population once again peaked my interest. As I began searching for a dissertation topic, understanding the reasons and motivations for smoking in adults with SMI became a priority. I concluded the optimal manner to study this phenomenon was by directly asking these adults why they smoked.

Before beginning the research, I encountered many doubts along the way. Many questions began to surface. For example, would a site to conduct this research be available? How will it be possible to balance family life, work, and school during this process? Would I be allowed by Walden University to study this vulnerable population? Will these adults with SMI even be willing to share their views and experiences on smoking and smoking cessation? As the research was initiated, many of these questions were answered and opportunities to conduct this study was possible. I became aware this study was promising during the participant recruitment and the favorable response from these individuals. Through this qualitative study, I had the opportunity to listen to the participant's stories and obtain a better understanding why adults with SMI smoke despite the struggles and health problems they faced. With this understanding I gained an enhanced awareness that can contribute to the wellbeing of adults with SMI, can reduce costs associated to their smoke related illness, and can continue to promote the dignity of adults with SMI within a mental health profession.

This study contributed to my personal growth as a doctoral student and researcher after I listened to the participant's stories and confirmed this was a reflection of their experiences reflected in the research findings.

What the Future Holds

As a result of this study, I enhanced the productive manner I interact with the mentally ill population and collaborate with professionals in the field of mental health and addictions. Additionally, I have been motivated by this study to pursue further research opportunities related to serious mental illness and health psychology.

As I began this journey, I was encouraged by colleagues to find other opportunities for promotion within the field of psychology. As a result of this study, I gained an enhanced viewpoint on the personal experiences of adults with SMI and their personal experiences with mental illness and their struggles with smoking. In addition, I feel a greater urgency to begin looking for opportunities to incorporate all that was learned through this study by implementing a smoking cessation program geared specifically to the mentally ill population. This will begin within my current employment and by expanding this knowledge to other agencies and organizations that work with this population.

Conclusion

I explored the motivations, reasons, and experiences of smoking and smoking cessation in adults with SMI. This qualitative research with a phenomenological design incorporated individual interviews with 12 adults diagnosed with SMI who currently smoked and had a history of smoking. I identified three themes related to the motivations

of smoking and smoking cessation in adults with SMI (a) perceived benefits of smoking; (b) problems related to smoking cessation; and (c) risks of cigarette smoking.

Due to the lack of research on the views and experiences of smoking in adults with SMI, the study findings are significant. With this enhanced understanding on the reasons adults with SMI smoke and their experiences with smoking cessation, clinicians, professionals, agencies, organizations, and others who work with the mentally ill population are now able to implement education, prevention, and intervention in treatment planning and smoking cessation programs to benefit this population.

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Appendix A: Informed Consent

You are invited to take part in a research study of Smoking and Mental Illness.

You were chosen for the study because you are currently receiving mental health services and have a history of smoking. This form called “informed consent” will let you understand this study before deciding to participate. This study is being done by a researcher named Pedro Gabino, who is a doctoral student at Walden University and does not work at Mojave Mental Health.

Reason for this Study:

The reason for this study is to get information on why people with mental illness smoke cigarettes.

You will do the following in the Study:

If you agree to be in this study, you will be asked to:

Be interviewed by the researcher. Individual interviews will last 60 minutes and will be tape recorded. If needed, you will be asked for a follow-up interview (approx. 30 min).

You will be asked if you want to receive ongoing information on the study and if you wish to receive a report after the study.

This Study is Voluntary:

Your participation in this study is voluntary. This means that everyone will respect your decision to participate or not participate in the study. No one at Mojave Mental Health will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind during the study. If you feel stressed during

the study you may stop at any time. You may skip any questions that make you feel uncomfortable.

Risks and Benefits of participating in the Study:

During the interview you will discuss your experience with smoking and trying to stop smoking. Sometimes you will experience certain feelings. Even though this study is not a danger to your safety; however, if you become stressful because of this study, the Mojave Mental Health staff will provide any help you may need.

Your participation in this study will give information to professionals so they can better understand how to help adults with a mental illness who smoke.

Compensation:

\$30.00 Wal-Mart gift card for each participant.

Privacy:

Any information you share will be kept private. The researcher will not use or share your information outside of the study. There is one exception to this rule. If you are a danger to self or others the researcher will have to report this to the authorities so you can receive help.

Also, the researcher will not include your name or anything else that could identify you in any reports of the study.

Contacts and Questions:

You may ask any questions you have now. Or if you have questions later, you may contact the researcher by phone (702) 217-3373 or email at pedro.gabino@waldenu.edu.

If you want to talk privately about your rights as a participant, you can call Dr. Leilani

Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 1-800-925-3368, extension 3121210. Walden University's approval number for this study is **06-28-13-0136100** and it expires on June 27, 2014.

The researcher will give you a copy of this form to keep.

Statement of Consent:

I have read the above information and I feel I understand the study well enough. By signing below, I am agreeing to the information described above.

Printed Name of Participant

Date of consent

Participant's Written or Electronic* Signature

Researcher's Written or Electronic* Signature

Electronic signatures are regulated by the Uniform Electronic Transactions Act. Legally, an "electronic signature" can be the person's typed name, their email address, or any other identifying marker. An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically.

Appendix B: Letter of Invitation

SMOKING AND MENTAL ILLNESS

RESEARCH**STUDY**

To be eligible you must be 18 years and older, primarily English speaking, have a diagnosis of schizophrenia, bipolar disorder, major depressive disorder, or schizoaffective disorder, and be a current cigarette smoker or have a history of smoking.

Participants will be asked to be available for a tape recorded interview that will take approx. 60 minutes and will be compensated with a \$30.00 gift card from Wal-Mart. In addition, a follow-up interview may be necessary. The interviews will take place at Mojave Mental Health.

Contact Pedro at (702) 217-3373 or (702) 486-5751 if you are interested or would like additional information.

IRB approval # 06-28-13-0136100

Appendix C: Interview Questions

Date: _____

Location: _____

Name of Interviewer:

_____Number assigned to Interviewee:

- 1) Please describe what smoking means to you.

- 2) Please describe your experience in attempting to quit smoking.

- 3) Please describe what you get from cigarette smoking.

- 4) Please describe what you do not like from cigarette smoking.

- 5) Describe how your life would be if you did not smoke.

Appendix D: IRB Approval

Received by electronic mail on June 28, 2013

Dear Mr. Gabino,

This email is to notify you that the Institutional Review Board (IRB) has approved your application for the study entitled, "A Phenomenological Inquiry on Cigarette Smoking in Adults with Serious Mental Illness."

Your approval # is 06-28-13-0136100. You will need to reference this number in your doctoral study and in any future funding or publication submissions. Also attached to this e-mail is the IRB approved consent form. Please note, if this is already in an on-line format, you will need to update that consent document to include the IRB approval number and expiration date.

Your IRB approval expires on June 27, 2014. One month before this expiration date, you will be sent a Continuing Review Form, which must be submitted if you wish to collect data beyond the approval expiration date.

Your IRB approval is contingent upon your adherence to the exact procedures described in the final version of the IRB application document that has been submitted as of this date. If you need to make any changes to your research staff or procedures, you must obtain IRB approval by submitting the IRB Request for Change in Procedures Form. You will receive confirmation with a status update of the request within 1 week of submitting the change request form and are not permitted to implement changes prior to receiving approval. Please note that Walden University does not accept responsibility or liability for research activities conducted without the IRB's approval, and the University will not accept or grant credit for student work that fails to comply with the policies and procedures related to ethical standards in research.

When you submitted your IRB application, you made a commitment to communicate both discrete adverse events and general problems to the IRB within 1 week of their occurrence/realization. Failure to do so may result in invalidation of data, loss of academic credit, and/or loss of legal protections otherwise available to the researcher. Both the Adverse Event Reporting form and Request for Change in Procedures form can be obtained at the IRB section of the Walden web site or by emailing irb@waldenu.edu:

<http://researchcenter.waldenu.edu/Application-and-General-Materials.htm>

Researchers are expected to keep detailed records of their research activities (i.e., participant log sheets, completed consent forms, etc.) for the same period of time they retain the original data. If, in the future, you require copies of the originally submitted IRB materials, you may request them from Institutional Review Board.

Please note that this letter indicates that the IRB has approved your research. You may not begin the research phase of your dissertation, however, until you have received the

Notification of Approval to Conduct Research e-mail. Once you have received this notification by email, you may begin your data collection.

Alex Dohm

Research Service Specialist
Center for Research Quality
Walden University

100 Washington Avenue South, Suite 900
Minneapolis, MN 55401

Received by electronic mail on June 28, 2013

Dear Mr. Gabino,

This email is to serve as your notification that Walden University has approved BOTH your dissertation proposal and your application to the Institutional Review Board. As such, you are approved by Walden University to conduct research.

Please contact the Office of Student Research Administration at research@waldenu.edu if you have any questions.

Congratulations!

Alex Dohm

Research Service Specialist, Office of Student Research Administration

Jenny Sherer

Associate Director, Office of Research Ethics and Compliance

Leilani Endicott

IRB Chair, Walden University

Curriculum Vitae

Pedro R Gabino

ACADEMIC EXPERIENCE

- | | |
|------|--|
| 2015 | Doctor of Philosophy- Psychology
Walden University, Minneapolis, Minnesota |
| 2006 | Master of Arts – Psychology
Antioch University, Santa Barbara, California |
| 2000 | Bachelor of Arts – Liberal Arts
Antioch University, Santa Barbara, California |

RELEVANT PROFESSIONAL EXPERIENCE

2001-Present Clinical Program Manager
Southern Nevada Adult Mental Health Services
Las Vegas, Nevada

Supervise clinical and administrative staff for community service programs and service coordination medication clinic. Manage, plan, organize, implement, and direct mental health service delivery programs. Establish and implement admission/discharge criteria and waiting list priorities. Enforce appropriate standards for client's rights and grievances. Investigate statewide incident grievances; file required reports, represent agency as needed and take appropriate corrective action. Jointly work with business office to ensure compliance with budgets. Oversee and ensure the maintenance of required clinical records. Manage SNAMHS residential programs. Manage Ryan White Care Act grant.

2004-2007 Mental Health Counselor
Southern Nevada Adult mental Health Services
Las Vegas, Nevada

Provide counseling, direct clinical services, community and home based services and behavioral and human services to mentally ill, and emotionally challenged clients in an outpatient, forensic, residential, and community setting. Assist in coordination of case management for adults with serious mental illness within the criminal justice system and mental health clinics. Provide direct mental health services including individual, family and group counseling with clients who carry a diagnosis of severe mental illness within the criminal justice system. Conduct screening for services, intake evaluations, using

DSM criteria to develop individual treatment plans and provide treatment according to the plan. Primarily for clients released from incarceration. Providing 24/7 crisis intervention services and work closely with other service provider systems in the community and the state. Provide psychosocial (skill building) services to clients as necessary. Interface and participate as a member of an interagency team consisting in mental health providers, judges, public defenders, District Attorney, and Parole and Probation. Maintain proper case notes and confidential files.

2003-2004 Mental Health Intervention Specialist
 Juvenile Justice Center
 Las Vegas, Nevada

Conduct screening for services, intake evaluations, develop individual treatment plans and provide treatment according to the plan. Primarily for youth incarcerated. Provide direct mental health services including individual, family and group. On-call crisis intervention in detention facilities. Interpret and translate for Spanish speaking youth and their families. Maintain proper case notes and confidential files. Prepare reports for juvenile court judge, and district attorney.

2001-2002 Substance Abuse Counselor
 Salvation Army Rehabilitation Center
 Goleta, California

Conduct substance abuse assessments, treatment plans and case management for clients referred by criminal justice system. Conduct individual counseling sessions for adults with dual diagnosis. Conduct individual counseling and coordination of process groups. Administer substance abuse screening instruments. Responsible for client process in rehabilitation program by writing quarterly evaluations. Maintain proper case notes and confidential files.

1997-2000 Substance Abuse Counselor
 Ventura County Behavioral Health
 Ventura, California

Individual counseling for adolescent clients on probation. Responsible for substance abuse assessments and treatment plans. Conduct individual counseling of youth and families and coordination of process groups. Administer substance abuse screening instruments. Interagency collaboration in order to assess and refer clients to community resources and prevent recidivism of criminal activities. Mediation services between victim and offenders and between peers. Implement and coordinate gang intervention peer groups and parent educational groups. Maintain proper case notes and confidential files.

1994-1997 Mental Health Counselor
 Commission on Human Concerns
 Oxnard, California

Individual counseling, assessments, interview, of homeless individuals with mental health problems. Assist in referring homeless individuals and families to community resources such as housing, medical necessities, mental health professionals and employment. Active outreach to homeless individuals, homeless families, and low-income families. Supervise and assist with intensive case management, development of volunteer program, and supervision of volunteers. Intake and supervise homeless clients with mental illness in shelter. Provide psychosocial (skill building) services to clients as necessary. Maintain proper case notes and confidential files. Supervise administrative staff

CERTIFICATES

Counseling Skills Certificate

Personality Disorders certificate of specialization: