

2.2

Smoking & Mental Health Influences on Smoking

Overview

Given that smoking rates are significantly higher among those with mental illnesses than in the general population, it seems reasonable to assume that the factors that motivate smoking in this group are somehow different from the norm in their nature, magnitude or saliency.

A better understanding of the factors determining smoking rates among people with mental health conditions is not merely an academic pursuit. Rather, if we are to effectively address smoking in mental healthcare settings, and propose to service users the possibility of quitting, we must first understand the function that smoking plays and what 'gaps' must be filled once smoking cessation has occurred.

Like any behaviour, smoking (in any group in society) is likely to be a biopsychosocial phenomenon. That is, it not only meets physiological needs, but is also prone to influence from psychological and social factors. To seek to understand smoking in relation to only one of these domains of influence is unlikely to lead to robust explanations or effective interventions.

The 'Self-Medication' Hypothesis

Tobacco, or more specifically, nicotine is physiologically addictive. Smoking is continually, negatively reinforced by the prospect of withdrawal symptoms such as cravings, tension and low mood. Indeed, any smoker can be thought of as regularly 'self-medicating' against withdrawal – just as someone suffering from chronic pain may regularly self-medicate using analgesics.

In the context of mental health conditions, however, to view smoking simply in terms of negative reinforcement and the avoidance of withdrawal may be to underestimate the situation. For many people living with a mental illness, smoking may be particularly rewarding and serve to offset some of the adverse features of their condition (Campion et al., 2008). However, there is also contradictory evidence relating to the effectiveness of smoking as an effective medication against psychiatric symptoms, and it is likely that if there is any benefit, then it is transient and unlikely to lead to any stable advantage. Therefore, while the self-medicating function of smoking helps us understand why mental health service users may be highly motivated to smoke, it is unlikely that facilitating smoking could ever be considered an effective (or indeed ethical) way of maintaining mental health. The effects of smoking on mental health are discussed more fully in Section 2.3

The 'Cultural' Hypothesis

In recent years, and particularly over the last two decades, smoking has become less central (or even acceptable) in everyday social situations. In contrast, however, smoking represents an "entrenched process that has been central to the history of mental institutions over the past three centuries" and often remains central to the culture of mental healthcare settings (Lawn & Pols, 2005). The implication of this is that, while for most smokers in society the decision to quit will take one from a 'minority group' in society to the majority, quitting smoking for many mental health service users requires a willingness

to step outside of the majority and the prevailing social culture. This inevitably discourages or hinders quit attempts.

It would be wrong to assume that the fundamental role smoking has within mental healthcare settings is simply due to the high prevalence of smoking among service users. Within mental health settings, a large proportion of staff are smokers themselves (Trinkoff & Storr, 1998), and smoking related interventions and policy have been found to be significantly less popular among mental health staff than other health care professionals (McNally et al., 2006). It has also been observed that mental health staff may often use cigarettes in order to appease or engage patients (Mester et al. 1993) and in this way, it has been utilized as a 'clinical tool'.

It can be argued that the place of smoking in the culture of mental healthcare, and the extent to which this culture maintains smoking, is set to diminish. Research suggest that as mental healthcare settings move to smoke-free policies (which are often supported by stop smoking support programmes) staff attitudes change to a more positive view of smoke free initiatives (Lawn & Pols, 2005). The 'hub' of social interaction on a ward will cease to be the smoking room, and as more patients quit, the social pressure to smoke will lessen.

The 'Void' Hypothesis

A third and less researched explanation for the high smoking rates among people with mental health conditions can be described as a 'Void Hypothesis'. This theory is based on the idea that quitting smoking will often leave a 'bigger gap' in mental health service users lives than it does for other people in society. In short, mental health service users smoke because 'they have nothing else in life'.

The 'void' refers to a lack of both pleasurable activity and effective coping strategies. In relation to activity, people with mental health problems may be seen to smoke out of 'boredom' and because of having 'nothing else to do'. In relation to coping, smoking can be seen as having 'robbed' many people with mental health problems of more effective or sustainable ways of dealing with stress.

There may be some validity in the 'Void Hypothesis', in that many people with mental health problems can be said to lack daily activity, structure or effective coping strategies. However, it is worth noting that this theory may exist to some extent as a 'self-fulfilling prophecy' generated by healthcare staff and even family or friends. The perception by others that a person with a mental health condition will have little else in life than smoking may lead to the facilitation of smoking and the discouragement of quit attempts.

A more positive approach to a perceived 'void' in a mental health service user's life however may be not simply to accept its existence, but to directly tackle it. Smoking cessation support, because of it's person-centred and facilitative approach, can be used to empower a service user to find new activities and new ways of coping with stress. In other words, rather than using a void to justify smoking, it may be better to utilize quit smoking support to fill the void.

References

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