Stubbing out smoking in schizophrenia

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While I was working as a mental health recovery worker in London, my service users came from a variety of social, cultural and ethnic backgrounds. Almost invariably, though, they had one thing in common: smoking.

Given my experience, I welcomed the 2013 publication of the Lethal Discrimination report by the charity Rethink Mental Illness (see tinyurl.com/mw328h4). According to the report, one in three of the 100,000 ‘avoidable deaths’ every year have a mental illness. The Royal College of Psychiatrists has called it ‘one of the biggest health scandals of our time’. Its then president, Professor Sue Bailey, criticised Health Secretary Jeremy Hunt in the foreword to the report, writing that ‘his recent “call to action” on addressing avoidable premature mortality barely touches on the physical health of people with mental illness’.

For those working in the field, this is an unfortunate yet everyday reality. Many of the problems are related to or exacerbated by smoking, including diabetes, coronary heart disease and respiratory disease. Astonishingly, ‘more than 40 per cent of all tobacco is smoked by people with mental illness, but they are less likely to be given support to quit’ (Rethink Mental Illness, 2013).

I certainly do not include myself among those who ‘do not help patients give up smoking because they believe it is the “last pleasure they have”’ (Rethink Mental Illness, 2013; Schizophrenia Commission, 2012). But that doesn’t mean that it’s easy to persuade someone that giving up cigarettes could make a real difference in their lives. As a professional (and a non-smoker) visiting people in their own homes, smoking could be the most awkward issue to discuss. I might find myself in the difficult position of wanting to ensure my client felt at ease in their own home – and so in a better frame of mind to discuss their support needs – while also not wanting to experience the ill effects of passive smoking.

Where relevant, addiction always played a part in support planning for my clients and when a service user smoked it was always addressed. Frequently they would tell me that they had tried to quit but failed, or that they simply were not interested in giving up. The role of the mental health recovery worker is to offer practical and emotional support, and at times our only option is to signpost people to more appropriate services.

But when someone has already tried and failed with traditional smoking cessation programmes, a reminder that such things exist is hardly going to be a revelation. For those struggling to pay their bills, or tormented by voices, smoking can seem like the least of their problems.

One worldwide meta-analysis study has estimated that 62 per cent of those with a diagnosis of schizophrenia are smokers – nearly three times more than the general population (de Leon & Diaz, 2005). No one theory definitively explains the relationship, although many exist. Broadly speaking, these fall into one of three categories: (a) some aspect of schizophrenia may lead more people with the illness to smoke; (b) tobacco smoking is itself a risk factor for schizophrenia; or (c) genetic and/or environmental factors might lead to an addiction to nicotine and also to schizophrenia (Kelly & McCreadie, 2000). Within this, hypotheses range from psychological, social and biological in nature, with some evidence to support them all as plausible explanations.

Environmental and social factors certainly play some role in the excessively high smoking rates. Unemployment, poverty, limited education, peer influence and even the mental health treatment system all increase the risk of smoking of mind to discuss their support needs – while also not wanting to experience the ill effects of passive smoking.

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Iasevoli, F., Balletta, R., Gilardi, V. et al. [2013]. Tobacco smoking in treatment-resistant schizophrenia patients is associated with impaired cognitive functioning, more severe negative symptoms, and poorer social adjustment. Neuropsychiatric Disease and Treatment, 9, 1113–1120.


References
for people with schizophrenia (Ziedonis et al., 2008). Add to this the lowered motivation caused by the disorder, as well as the fact that they are less likely to be offered support with quitting, it is easy to see why people may find it harder to find the motivation to give up (Steinberg et al., 2004). Nonetheless, taken by themselves these factors do not explain the extent of the association.

At a biological level, it has been suggested that aberrant functioning of nicotinic cholinergic transmission may increase both a person’s likelihood of becoming a smoker and also their risk of experiencing psychosis (Wing et al., 2011). This shared vulnerability may help to explain why those with schizophrenia are more likely to smoke and to smoke more cigarettes than other psychiatric populations. Alternatively, the self-medication hypothesis claims that nicotine is used by patients to counteract the cognitive deficits caused by the condition and/or the side-effects of antipsychotic medication (Kumari & Postma, 2005). This may indeed be supported by the theory that, in remedying the deficiency of dopamine in the prefrontal cortex, nicotine helps to alleviate positive and negative symptoms (Lavin et al., 1996). Schizophrenia patients who smoke have also been shown to perform better on certain cognitive tasks (testing attention, working memory, etc.) than those who do not smoke (Wing et al., 2011).

Nevertheless, patients with severe nicotine dependence have been reported to experience more severe positive and negative symptoms and to be prescribed higher doses of antipsychotics than those who do not smoke (Krishnadas et al., 2012). What is more, a recent Italian study found that those with treatment resistant schizophrenia (TRS) who smoked performed worse than non-smoker TRS patients on cognitive-functioning tasks, had more severe negative symptoms and poorer social adjustment, perhaps lending support to the theory of ‘a tobacco-smoking-induced worsening of abnormal dopamine dysfunction’ (lasevoli et al., 2013).

It’s also possible that other, more unexpected, factors are at play. In the United States, analysis of previously secret documents from 1955 to 2004 indicated that the tobacco industry ‘monitored or directly funded research supporting the idea that individuals with schizophrenia were less susceptible to the harms of tobacco and that they needed tobacco as self-medication’ (Prochaska et al., 2008). Seeing some of the advertisements allegedly targeted at those with schizophrenia, it is difficult to suppress a shudder of revulsion and shame that this was allowed to happen. Incredibly, until the late 1980s it was still accepted by some practitioners that those with chronic schizophrenia were in some way biologically resistant to cancer (Prochaska et al., 2008). What, then, can mental health professionals do to help those people with schizophrenia who smoke? In my view, and that of Kreyenbuhl et al. (2009), all should be offered support to help stop smoking altogether, including nicotine replacement products or a suitable prescription, in conjunction with psychosocial interventions and smoking education programmes.

Thankfully, such interventions are detailed in the new NICE guideline on the treatment and management of psychosis and schizophrenia in adults (NICE, 2014: see tinyurl.com/mr4ay9zp). These encourage professionals to offer people with psychosis or schizophrenia who smoke help to stop smoking, even if previous attempts have been unsuccessful.

However, the guidelines are noticeably silent on the subject of e-cigarettes, an increasingly popular alternative for those trying to stop smoking (see also tinyurl.com/nqrgyhc). Smokers of the devices (or ‘vapers’ as some call them) inhale a dose of nicotine without the tar and carbon monoxide that comes with tobacco smoking; they then breath out a colourless and odourless vapour. Until more is understood about why smoking and schizophrenia seem to go hand-in-hand, could e-cigarettes be the lifestyle change that serves as an important step in a person’s recovery?

Alternatively, would suggesting the continued use of nicotine simply provide implicit support to the self-medication model? This continuing focus may perpetuate the feeling amongst some professionals that there is no use offering people with schizophrenia support with smoking cessation. Moreover, for those individuals with TRS it may not be appropriate to suggest its continued use – in whatever form – as the substance itself may be exacerbating their symptoms (lasevoli et al., 2013). Concerns have also been raised about e-cigarettes’ effect on psychopharmacological treatments although, in most cases, it is the tobacco smoke, not the nicotine, that causes negative interactions with medication (Zevin & Benowitz, 1999).

I am not proposing – as some do – that e-cigarettes are the final solution to this global problem. I am also very conscious of the past actions of the tobacco industry in trying to sell harmful products to people at their most vulnerable; I have no interest in furthering the sales of e-cigarettes or making them the brand of choice for those who are mentally ill. Clearly cessation is more desirable than replacement therapy. But particularly for those living with a serious mental illness like schizophrenia, who face so many more challenges in day-to-day living than the general population, electronic cigarettes could offer them the chance to enjoy the health benefits and freedom that come with giving up smoking.

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