"A Way to Relate to Others"

Review of *Smoking Privileges: Psychiatry, the Mentally Ill, and the Tobacco Industry in America*

By Laura D. Hirshbein

Thomas E. Novotny MD, MPH, DSc (Hon)

Professor Emeritus, Epidemiology and Biostatistics

Graduate School of Public Health

San Diego State University

tnovotny@mail.sdsu.edu

619-206-3656

5500 Campanile Drive

Hardy Tower 119

San Diego, CA 92182

United States of America

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One is impressed by a fact cited early in this very well-written book, asserting that almost half of all smokers in the United States suffer from a mental health disorder.[1] The reference is to a 2000 report in the *Journal of the American Medical Association,* which analyzed data on 4411 respondents to the National Comorbidity Survey, a nationally representative study of persons aged 15 to 54 years that was conducted in 1991-92.[2] Adjusted odds ratios for both current and lifetime smoking were 2.7 among respondents reporting mental illness in the past month vs respondents without mental illness. In order words, people with a history of mental illness were more than twice as likely to be smokers. Even though this report is somewhat dated, the implication is clear: smoking is a special problem for those with mental illness, and subsequently for those who are tasked with treating it.

Today, smoking is prohibited in most mental health and drug treatment facilities. Still, there is controversy as to how smoking differentially affects those with mental health problems at both behavioral and neurobiological levels; similarly, there is also uncertainty as to how to best treat smoking in the mental health context. Perhaps it is the powerful chemistry of nicotine in tobacco and the powerful influence of its purveyors (the tobacco industry as well as the pharmaceutical industry) that have created these controversies?

Laura Hirshbein reviews the history of the special relationship between persons with mental illness and their cigarette smoking; not only is a high prevalence of smoking the norm among mental health patients, but it was, until the 1990s, also normative among mental health providers. In fact, it was commonplace to use cigarettes as a tool with which to build rapport between providers and patients. It was also a critical part of the power dynamics between providers and patients such that the privilege to smoke was tied to improved behavior and

therapeutic success. Providers controlled the autonomy of hospitalized mental health patients, and the awarding of smoking privileges became symbolic of their lost autonomy.

Our understanding of nicotine's pharmacology and addictiveness, along with the designation of smoking as a *disease* (beginning with the 1980 *Diagnostic and Statistical Manual of Mental Disorders* [DSM-3]), began to medicalize the approach to cigarette smoking. It became a co-morbid condition, both in terms of its physical health impacts but also in terms of new drug treatment possibilities. Along with the expansion of pharmacologic treatment for mental illness, pharmacologic approaches to nicotine addiction expanded dramatically, with nicotine replacement at first, and later with the application of an anti-depressant (bupropion) to treat nicotine addiction. Most recently, the use of varenicline, which is a partial nicotinic receptor agonist, blocking nicotine cravings and masking its pleasurable effects, has expanded dramatically. Altogether, the medicalization of tobacco use has been an enormous economic boon to pharmaceutical companies, which have become the main competitor against the tobacco industry for the mental health smoker market. The public health benefit of this bonanza, however, is unclear, with low rates of long-term cessation attributable to such treatments.[3] Still, the complexities around the relationship between mental health and smoking often get in the way of effective cessation treatments for them.[4]

Whether the tobacco industry has played a direct role in targeting mental health sufferers or not, it has certainly paid attention to the psychological profiles of smokers and to the flurry of research on neuro-biological determinants of smoking. With almost half of all smokers having mental health problems, it is clear that the tobacco industry understands this market segment and patients' needs for self-medication using cigarettes. It is highly unlikely that this population, however, appreciates the benefits of the growing denormalization of smoking nor does it fully

understand the mental health implications of their own smoking. Rather, smoking is seen as an *external* problem for these patients, over which they have little control; further, the most commonly accepted public health approaches to tobacco use may not be very effective or appropriate for them. For example, Hirshbein asserts that higher taxes and cigarette prices may not affect the behavior of smokers with mental illness, nor will product labels, public education messages, and smoking restrictions be as effective in reducing smoking as they have been for the general population. Instead, these efforts may serve to further isolate patients with mental illness and to divert attention from more contextual approaches needed for this special population. Hirshbein further emphasizes that,

> "Among individuals with mental illness, smoking has been a way to relate to others, a relationship with an object (when interpersonal relationships are too hard), and just one behavior amid a host of other difficulties. It is perhaps not surprising, then, that smoking cessation looks different from this perspective" (Page 134).

Mental health patients are also in what she describes as a "corporate squeeze," between the profit motives of the tobacco industry and the profit motives of the pharmaceutical industry (Page 142). The cessation drug industry is very lucrative, including for many in the anti-tobacco community who benefit as representatives and researchers of these therapies.

Because smoking among psychiatric patients has been shaped by social, cultural, and professional factors, "Tobacco Use Disorder" is now even more broadly defined as an illness in the 2013 *DSM-5* (Page 143). This designation provides a more comprehensive set of criteria with which to categorize the "illness" of smoking. This categorization is a marked change from when smoking was considered, as Hirshbein points out, "understandable for those with a psychiatric illness because of their emotional, social, occupational, and financial issues" (Page 145).

Hirshbein contends that an externalized and medicalized concept of smoking may further limit psychiatric patients' success in quitting smoking and may simply add another difficult diagnosis to their problem list. Will that designation actually help them quit? Are the pharmacologic treatments that have been tested only in non-psychiatric patients also safe for those taking multiple psychiatric drugs? Do we need to better understand the power dynamics around smoking restrictions in psychiatric hospitals?

Hirshbein is right in calling for more contextualized approaches to psychiatric patients who smoke, but nonetheless, there is increased attention being paid by public health advocates to the "end game" for tobacco,[5] an absolutist approach that would include complete prohibition of smoking in psychiatric hospitals. Whether psychiatric patients will benefit from such approaches is a serious question; they do indeed have more complex behavioral, pharmacological, economic, and social challenges to quitting than the general population. They are indeed caught in a "corporate squeeze" between the tobacco and pharmaceutical industries that compete for their limited resources. This competition may also influence the objectivity of scientific research involving cessation treatment and even policy approaches in psychiatric facilities. The highly-vulnerable mental health patient population needs more empowerment, understanding, and consideration in order to be served by existing public health efforts against tobacco use. The evidence shows, however, that they can benefit from cessation treatment, even with current behavioral approaches.[4] This book contributes significantly to our understanding of the historical context of smoking among mental health patients and to the difficulties faced by both providers and policy makers in treating these patients. It is a scholarly take on a complex and recalcitrant problem, and it should be required reading for both tobacco control advocates and mental health providers.

[1]Laura D. Hirshbein, *Smoking Privileges: Psychiatry, the Mentally Ill, and the Tobacco Industry in America*, (Rutgers New Jersey: Rutgers University Press, 2015).
[2]Karen Lasser, J. Boyd, S. Woolhandler, et al., "Smoking and Mental Illness: A Population-Based Prevalence Study," *Journal of the American Medical Association,* 284, no. 20 (2000):2606-2610. doi:10.1001/jama.284.20.2606.
[3]Shu-Hong Zhu and Cummins S.E., Garnst A.C., et al., "Quitting smoking before and after varenicline: a population study based on two representative samples of US smokers," *Tobacco Control Online First*, published on August 17, 2015 as 10.1136/tobaccocontrol-2015-052332.
[4] Judith J. Prochaska, "Smoking and Mental Illness — Breaking the Link," *The New England Journal of Medicine* 365 (2011), no. 3:196–198.
[5]Thomas E. Novotny, "The Tobacco Endgame: Is It Possible?" *PLoS Medicine* 12 (2015), no. 5: e1001832. doi:10.1371/journal.pmed.1001832.