Depression, smoking and smoking cessation: a qualitative study

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Background. A high proportion of smokers suffer from mental health problems including depression. Despite many of them wanting to stop smoking, low mood adversely affects their ability to quit.

Objective. To explore the experiences of smokers with self-reported depression, the relationship of smoking with mental health problems and the experiences of smokers while trying to quit. The study also explored what help within the primary care setting could assist in quitting.

Methods. Participants were recruited from a large general-practice-based smoking cessation trial. Participants who had indicated they were suffering from depression on a self-reported baseline survey were invited to participate. Semi-structured interviews were conducted over the telephone and digitally recorded. The interviews were transcribed and analysed using a phenomenological qualitative approach.

Results. Sixteen interviews were conducted (11 females, 5 males). Mood disturbances were frequently reported as triggers for smoking and low mood was seen as a barrier to quitting. Perceived benefits of smoking when depressed were limited and for many, it was a learned response. A sense of hopelessness, lack of control over one’s life and a lack of meaningful activities all emerged as important factors contributing to continued smoking. Participants felt that their quit attempts would be aided by better mood management, increased self-confidence and motivation and additional professional support.

Conclusions. Smoking and depression were found to be strongly interconnected. Depressed smokers interested in quitting may benefit from increased psychological help to enhance self-confidence, motivation and mood management, as well as a supportive general practice environment.

Keywords. Depression, nurse practitioners, primary care, qualitative research, smoking/tobacco use.

Introduction

Depression and smoking

Both smoking and depression contribute substantially to the burden of disease among general practice patients, and mental health disorders and tobacco use frequently coexist. As smoking rates in the general population decline, a greater proportion of smokers have coexisting problems such as mental illness. The smoking rate for people with a mental health problem is ~32%, more than double the general population rate. Furthermore, ~30% of patients are suffering from probable current depression at the beginning of a quit attempt. Depressive symptoms can adversely affect a patient’s ability to succeed when attempting to quit smoking. This is also true of patients with subclinical levels of depression.

Despite this difficulty in quitting, many patients with mental illness are just as motivated to quit smoking as the general population.

Qualitative research has found that smokers with mental illness need to have a meaningful relationship with those assisting them to quit. The general practice could provide this. Previous work on depression and smoking has been based in outpatient mental health facilities and little is known about the experiences of depressed smokers in a general practice setting. The aim of this current study is to explore the experiences of depressed smokers, the relationship of smoking with mental illness, experiences of trying to quit and what help within the primary care setting could assist in smoking cessation.
Methods

Participants
This study was nested within a large cluster-randomized controlled trial that tested enhanced general practice support for smoking cessation (‘Quit in General Practice’). In total, 2393 patients were recruited in this study and 29.6% (n = 709) indicated that they were experiencing depression on a self-reported baseline survey.

Letters of invitation were sent to all participants (n = 208) who had completed the 12-month follow-up of the ‘Quit in General Practice’ study as of May 2011 and had self-reported depression in their baseline survey. Participants who agreed to participate were then contacted by telephone by one of the investigators (NC) and a time was arranged for the interview. Participants were reimbursed for the time taken to complete the interview with a $50 shopping voucher.

Procedure
In-depth semi-structured interviews were conducted over the telephone. Participants were asked to describe their experiences with depression and other mental health conditions; the relationship they perceived between their smoking and mental health; their experiences with previous quit attempts and what help within the primary care setting could assist in smoking cessation (see Table 1).

Data collection and analysis
With patient consent, the interviews were recorded and then professionally transcribed. Three interviews were purposively selected and read by three researchers and an initial framework for coding was developed. Prior to coding, each interview was listened to again and the transcript read. With the assistance of NVivo9 software, open coding of the transcripts was conducted. Qualitative thematic analysis using a phenomenological approach was performed in order to understand the participants’ lived experience. Additional questions explored their views on various models of psychological support for quitting that could be provided within the primary care setting.

Ethics
Ethical approval was obtained through the University of New South Wales and the University of Melbourne Ethics Committees.

Results

Participant characteristics
Eighteen participants replied positively to the invitation for the study; however, two of these could not be contacted on the phone numbers supplied. Sixteen (5 males and 11 females) telephone interviews were completed, with an average length of 24 minutes (range: 17–33 minutes). The mean age of participants was 51.5 years (range: 24–85 years). One participant was in full-time employment, five were in part-time/casual work, two were looking for work, three had retired and five were on a sickness/disability pension. Most (n = 10) had finished secondary school, with six of these having done some level of tertiary study.

Mental health history
The participants reported a mix of mood disorders, ranging from reactive depression to chronic dysthymia and recurrent major depression. Self-reported coexisting mental illnesses were common, including anxiety (n = 9), agoraphobia (n = 3), bipolar disorder (n = 2) and psychosis (n = 4). Most had multiple social/financial/family issues that complicated their depression and recovery. Hopelessness was a common sentiment reflected by many of the participants. Many related this to the sense of life not getting better and an inability to see a positive future for themselves.

Smoking history
All of the participants had been long-term smokers, most starting as teenagers. Many described ritualized smoking. Behaviours related to high levels of nicotine addiction were described, including not being able to stop the first morning cigarette and not being able to go long between cigarettes.

Several themes emerged in the interviews and are presented in three main groups: the varying attitudes expressed towards smoking, the complex relationship between depression and smoking and, finally, issues surrounding the quitting process (Table 2).

### Table 1 Questions asked in the semi-structured interviews

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<th>Question</th>
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<td>Can you tell me about your experience, past and present, of depression?</td>
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<tr>
<td>Have you experienced other mental health conditions? If so, could you describe these?</td>
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<td>Can you tell me about what relationship you see, if any, between your mood and your smoking?</td>
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<tr>
<td>Please tell me about your experience of any psychological symptoms when trying to quit.</td>
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<tr>
<td>What support did you receive, or would have liked to receive, to help you deal with psychological symptoms when trying to quit?</td>
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<td>What role do you see for the GP in helping people with depression quit smoking? How much do you feel your GP understands your smoking and depression?</td>
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<tr>
<td>What other supports do you see a role for in helping people with depression quit smoking? e.g. Practice nurse, telephone support, psychiatrist and psychologist.</td>
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Attitude towards smoking

Internal conflicts. All participants expressed a desire to quit smoking. The most common reasons reported were financial, health and the antisocial status of smoking. Many, however, expressed conflicting attitudes, with feelings of despair that life is not going to get better affecting their motivation to quit.

You don’t see a future, and if you don’t see a future then . . . there’s no point in doing anything that’s going to help you stay alive. (Interviewee 2)

Cutting down versus quitting. Many participants expressed the need to cut down prior to quitting as a vital step and a few viewed cutting down on smoking as their primary goal.

Relationship between smoking and depression

Low mood as a trigger. Low mood, anxiety and stress were frequently reported as triggers for smoking. Many participants described a close relationship between their mood and smoking behaviour.

The more I feel down, the more . . . you know, like you sit down and cry half the day for no reason, well, all I do is smoke that whole time . . . If I’m having a good day, then no, I don’t smoke as much. (Interviewee 5)

Lack of sense of control. Many described their lives as disorganized and a feeling that they lack control over their lives. Smoking was seen as providing a sense of purpose.

It’s just the satisfaction of doing something I want to do myself, like the control of my life that I don’t seem to have. (Interviewee 3)

Lack of meaningful activities. Many participants described an association between being bored and increased smoking. It was common for participants to report less smoking when busy or away from home.

I get back home and I sit down and there’s nobody to talk other than the TV or the radio and when it comes on my mind I grab a cigarette. (Interviewee 4)

Therapeutic effect of smoking. Most participants were ambivalent about how much it helped them when feeling depressed. Some thought it may help relax and partly relieve mental distress, whereas others felt it can also leave them feeling worse afterwards.

It’s like a comfort thing I think, even though it probably makes things worse because I know it’s so bad for me . . . so I do end up smoking more but then I kick myself. (Interviewee 15)

A common perceived benefit from smoking was that it provided an ‘escape’ or ‘time out’.

I don’t know if it helps. It just seems it’s something to do. Do you know, it’s like . . . a crutch maybe. (Interviewee 2)

Others described it as having become a habit, a learned response when they feel down or stressed.

I know in the physical sense it’s not going to help me but it’s just an automatic type reaction I guess. (Interviewee 16)

For a few participants, smoking was seen as a crucial coping mechanism. Two reported smoking as their only way of coping with a depressed mood and another felt that when he has been suicidal, if he had not been able to smoke, it ‘probably would have tipped me over’ (Interviewee 7).

A form of self-harm. A few described their smoking as a form of self-harm, a way of physically punishing their bodies.

It becomes a thing where I guess in a way its kind of self-destructive without really, without really doing anything dramatic. (Interviewee 13)

Hopelessness. The feelings of hopelessness often extended into participants’ views on smoking cessation, with many expressing a frustration at having failed so many times previously and having ‘tried everything’ to help quit.

Quitting process

Mood state at quit attempt. All participants felt that they needed their mood to be stable to be able to quit smoking. Several had failed quit attempts during
episodes of depression, whereas some had been able to subsequently quit once when their mood had improved.

I feel like when I’m in a rough patch it’s just you know, it’s hard enough to get through basic things. Whereas when I quit . . . I did go through withdrawals and I did feel like crap . . . it would just be exacerbated if I was also depressed at the time. (Interviewee 13)

Motivation. All participants expressed the importance of having the desire to quit for the process to work. The need to want to quit for oneself rather than due to external pressure was also a common theme.

That’s why I think you have to . . . want to do it yourself, like I do this time. You know, it’s something I decided . . . Whereas before it’s always been pressure for me to do it. (Interviewee 3)

A lack of confidence was seen as a major barrier to success. Participants frequently referred to having enough knowledge about the options for quitting but just not being able to carry it through.

I think that if I sort of felt . . . or had the confidence enough to do it, then I’d succeed, but I just haven’t got that push. It’s just sort of not there. (Interviewee 2)

What additional supports would help a quit attempt. Most participants felt that they would benefit from additional psychological support in their next quit attempt. There was a preference for this to be a face-to-face process rather than over the telephone. The reasons given for this were related to negative experiences with telephone support programs or a preference for face-to-face approaches as a way of developing better rapport with the therapist. Some who had not used a telephone support system before felt that it might be useful.

Those participants who saw psychiatrists did not feel that they had a role in smoking cessation, except when needed to advise about smoking cessation pharmacotherapy in the setting of depression.

There was a positive attitude towards the role of the practice nurse in smoking cessation. Those participants who had seen the nurse as part of the ‘Quit in General Practice’ study reported finding the sessions useful and enjoyable. They found the nurses supportive during the process. However, despite the education and quitting advice given, most participants still felt unable to follow through and put the advice into practice.

Differing opinions on the role of a computer-based quitting support program were expressed. Some were interested in trying it, especially if combined with face-to-face support.

Role of the GP is variable. The attitude towards the role of the GP was variable. Most participants thought there was a role for the GP in helping people with depression to quit smoking. Having support during the quitting process was seen as important, and most felt that their GP understood the difficulties involved in quitting smoking.

Yes. He does seem to be spot on. I don’t think he would have ever been a smoker. I’m sure he wouldn’t. But psychologically, you know, he seems to understand the problem. (Interviewee 3)

However, there was a frequent sentiment of concern about “letting down” the GP when the quit attempt fails and feeling guilty about this. There were also some participants who felt harassed by their GP if their smoking was brought up at every visit.

Discussion

This study explored the experiences and perspectives of a group of general practice patients who had participated in a smoking cessation trial and had self-reported depression. The major themes that emerged during the interviews were as follows: (i) attitudes towards smoking are varied; (ii) smoking and depression are closely interconnected in a complex relationship; (iii) a view that more is needed to successfully quit, including enhanced internal factors such as motivation, self-confidence and increased professional support. Important novel findings from this study were the limited perceived benefit received from smoking, the use of smoking as a form of self-harm by some depressed smokers and the strong desire for face-to-face support during the quitting process.

The attitudes expressed towards their smoking were varied and the same individual often expressed conflicting thoughts. Although all expressed desire to stop smoking, the level of motivation and reasons for this varied. Many ascribed this to a lack of ‘internal drive’. This is consistent with evidence that motivational enhancement therapy is important when addressing nicotine use in smokers who are depressed and can help increase abstinence outcomes.10

Mood disturbances and smoking behaviours were found to be strongly interconnected, supporting a well-recognized relationship between the two.25,9 Apart from depression, anxiety, stress and anger were all cited as triggers for smoking. It was common for smoking to be described as a learned reaction to mood disturbances, though it provided little relief. Smoking was described as a way of having some sense of control and was used to fill a void created by a lack of meaningful activities. These themes echo those found in previous qualitative research of depressed smokers in outpatient
mental health services, where cigarettes were described as being a ‘symbol of control’ and ‘a friend who gave security and companionship’.

For some participants, ambivalence towards quitting related to the perceived benefit gained from smoking, whereas others expressed a sense of hopelessness about their life situation and a lack of confidence in their ability to quit based on past failed attempts. Self-efficacy has been identified as an important mediator of willingness to accept treatment for smoking cessation among depressed smokers and low levels of self-efficacy have been associated with increased smoking and relapse in the first few weeks after quitting in depressed smokers. Interestingly, previous qualitative research has found that one mediator of continual smoking among depressed people is the role smoking plays in facilitating social connection, however, this current group of participants cited the antisocial status of smoking as being one of their motivations to quit, possibly reflecting the change in society’s acceptability of smoking.

A positive mood at the time of making a quit attempt was perceived by participants as important to success. This belief is consistent with the known association between elevated depressive scores at the start of or early into a quit attempt and decreased abstinence rates. It highlights the need to address mood management when assisting depressed smokers to quit. Typically, patients with current or recent depression have been excluded from many smoking cessation trials, resulting in limited literature regarding the most appropriate approach to smoking cessation in depressed patients. More recent studies have shown that concurrent treatment of both conditions is possible without jeopardizing an increase in depressive symptoms; in fact, depressive scores often improved after the intervention.

The need for greater professional support during a quit attempt was frequently expressed. There was a preference for face-to-face therapy, although use of the Internet (and to a lesser degree, the telephone) was also considered an option. Although previous work has found that depressed smokers would benefit from help from a health professional with a close relationship with the patient, some of the participants raised concerns about the role of their GP in smoking cessation. They were afraid of ‘letting down’ the GP if their quit attempt failed and this may affect one’s willingness to return to the GP in the event of a relapse of smoking.

This was a qualitative study with a small sample size and the results may not be generalizable across other populations of smokers. The original process of selection was by self-report of depression rather than a validated measure, but the interview information confirms that the participants suffered from depression and a range of other mental health problems. The group interviewed may represent depressed smokers who are more motivated to quit than others as selection criteria relied upon having completed the 12-month follow-up of the ‘Quit in General Practice’ study. Furthermore, the decision to participate may have been influenced by the use of a financial incentive. However, we did feel that saturation of views expressed was achieved, with no new themes emerging in the past few interviews performed.

**Future directions**

The findings of this study will help guide the development of a general-practice-based smoking cessation intervention for depressed smokers. Based on this study, important issues to address in such an intervention include the following: addressing mood management either before or concurrently; including the option to cut down cigarette numbers prior to quitting; motivational enhancement; and support to help people with depression improve their self-efficacy prior to and during a quit attempt. There is evidence to support the use and acceptability of computer-based programs in depression management. However, only a small number of computer-based interventions have addressed co-morbid mental illness and drug dependence. Clinician-assisted computerized interventions targeting co-morbid depression and alcohol use have been found to be equally effective as therapist-delivered therapy. The findings of the current study suggest that a computer-based intervention may be suitable for treating co-morbid depression and smoking cessation; however, this should include an element of face-to-face support to help increase patient acceptability and engagement.

**Conclusions**

A strong interconnection and complex relationship between smoking and depression exists. Mood disturbances, a sense of hopelessness, poor control over one’s life and a lack of meaningful activities appear to contribute to the maintenance of smoking among depressed smokers. Smoking may provide some immediate relief when distressed and allow ‘time out’, but it does not appear to help with long-term depression management. Depressed smokers interested in quitting may benefit from increased psychological help and a supportive general practice environment.

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Declaration

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Conflict of interest: none.

References