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Title: Tobacco exposure and sleep disturbance in 498,208 UK Biobank participants

Running head: Smoking and sleep disturbance

Boakye, D (Doctoral Student)¹

Wyse, CA (Postdoctoral Researcher)²

Morales-Celis, CA (Postdoctoral Researcher)³

Biello, SM (Professor of Neuroscience and Biopsychology)⁴

Bailey, MES (Senior Lecturer)⁵

Dare, S (PhD Candidate)⁶

Ward, J (Researcher)⁶

Gill, JMR (Reader in Exercise Metabolism)³

Pell, JP (Director, Institute of Health and Wellbeing)⁶

Mackay, DF (Head, Public Health Department)⁶

¹Division of Clinical Epidemiology and Aging Research, German Cancer Research Center (DKFZ), 69120 Heidelberg, Germany

²Royal College of Surgeons in Ireland, Dublin 2, Ireland

³Institute of Cardiovascular and Medical Sciences, University of Glasgow, G12 8TA, Glasgow, UK

⁴Institute of Neuroscience and Psychology, University of Glasgow, G12 8QB, Glasgow, UK

⁵Institute of Molecular Cell and Systems Biology, University of Glasgow G12 8QQ, Glasgow, UK

⁶Institute of Health and Wellbeing, University of Glasgow, G12 8RZ, Glasgow, UK

Address for correspondence

Dr Daniel F Mackay

Head of Public Health Department

Institute of Health and Wellbeing

University of Glasgow

G12 8RZ

Glasgow, UK

Email: daniel.mackay@glasgow.ac.uk

Tel: +44(0)1413302567

ABSTRACT

Background: The prevalence of sleep disturbance is high and increasing. The study investigated whether active, former and passive smoking were associated with sleep disturbance.

Methods: This cross-sectional study used data from the UK Biobank: a cohort study of 502,655 participants, of whom 498,208 provided self-reported data on smoking and sleep characteristics. Multivariable multinomial and logistic regression models were used to examine the associations between smoking and sleep disturbance.

Results: Long sleep duration (>9hrs) was more common among current smokers [odds ratio (OR): 1.47; 95% confidence interval (CI): 1.17-1.85; $P=0.001$] than never smokers, especially heavy (>20/day) smokers (OR: 2.85; 95% CI: 1.66-4.89; $P<0.001$). Former heavy (>20/day) smokers were also more likely to report short (<6hrs) sleep duration (OR: 1.41; 95% CI: 1.25-1.60; $P<0.001$), long sleep duration (OR: 1.99; 95% CI: 1.47-2.71; $P<0.001$) and sleeplessness (OR: 1.47; 95% CI: 1.38-1.57; $P<0.001$) than never smokers. Among never smokers, those who lived with more than one smoker had higher odds of long sleep duration than those not cohabitating with a smoker (OR: 2.71; 95% CI: 1.26-5.82; $P=0.011$).

Conclusions: Active and passive exposure to high levels of tobacco smoke are associated with sleep disturbance. Existing global tobacco control interventions need to be enforced.

KEYWORDS

Passive smoking, sleep disorders, smoking cessation, tobacco

INTRODUCTION

Worldwide, sleep disturbance affects more than one-third of the adult general population,¹ and the prevalence is rising partly due to the ageing population and increasing urbanisation.^{2,3} The proportion of the English population taking sleep medication has doubled since 1983.⁴ Symptoms of sleep disturbance include sleeplessness or insomnia, short and long sleep duration, difficulty awakening in the morning and signs of daytime dysfunction, such as daytime sleepiness.⁵

Sleep disturbance predisposes to poor health, including cardiovascular diseases and mental health problems.^{6,7} Short (<6 hrs/day) and long (>9 hrs/day) sleep duration are particularly associated with increased risk of diabetes,⁸ cardiovascular diseases⁹ and memory impairment.¹⁰ Meta-analyses of cohort studies^{11,12} have consistently shown an increased mortality risk in persons reporting short or long sleep duration. Economic implications of sleep disturbance cannot be overlooked and include increased absenteeism and lost productivity,¹³ more accidents¹⁴ and increased healthcare utilisation and costs.¹³ In the United States, the annual economic burden of sleep disturbance has been estimated at \$100 billion,¹³ and the National Health Service (NHS) in England spends around £50 million on sleep medication each year.¹⁵

It is evident that nicotine can stimulate the release of neurotransmitters, such as acetylcholine and norepinephrine¹⁶ which, in turn, may inhibit gamma-aminobutyric acid (GABA) and sleep-promoting neurons located in the ventrolateral preoptic area, causing excessive arousal of the body.¹⁷ Electroencephalography (EEG) reports have also revealed marked differences in sleep waves between smokers and non-smokers, with smokers having frequent arousals.¹⁸ There is strong evidence that smoking cessation is associated with poor sleep,¹⁹ however, previous studies on active smoking and sleep characteristics have produced conflicting results. For instance, while some studies have reported positive associations between active smoking and sleep disturbance,^{20–25} others have reported no association^{26–32} or even negative associations.^{33–35} Furthermore, research is lacking into whether exposure to passive smoking is associated with sleep disturbance.

With the increasing geriatric population and increasing prevalence of sleep disturbance, understanding how exposure to tobacco smoke is associated with sleep behaviour may help strengthen the existing tobacco control interventions, which may subsequently reduce the impact of smoking on a wide range of health parameters, including sleep disturbance. We used the baseline data of a large population-based cohort study to examine the associations of active, former and passive smoking with various self-reported sleep characteristics including: total sleep duration, sleeplessness, difficulty awakening in the morning and daytime dozing.

METHODS

Study population and procedures

UK Biobank³⁶ recruited 502,655 men and women aged 40-69 years from the general population between 2006 and 2010. Participants attended one of 22 assessment centres across the United Kingdom (UK) where they completed a touch-screen questionnaire.³⁷ A validated questionnaire was used to obtain information on a number of variables such as socio-demographic characteristics (age, sex and ethnicity), lifestyle factors (smoking behaviour), occupational information (frequency of shift work) and self-reported health (stress, depression and health rating) from the participants.³⁶ Our study was cross sectional and we used the baseline data in the UK Biobank.

In our study, we grouped the participants into 'never smokers', 'former smokers' and 'current smokers' based on their response to the questions: "Do you smoke now?" and subsequent ones. Those who responded "Yes" were considered as 'current smokers.' Participants who responded "No" were further asked whether they had previously smoked. Those who had previously smoked were grouped as 'former smokers', and those who were neither current smokers nor had previously smoked were grouped as 'never smokers.' In addition, data on daily number of cigarettes consumed by current and former smokers, and whether never smokers lived with one or more current smoker were obtained from the participants.³⁷

Sleep duration was defined as the total number of hours a respondent reported to be sleeping in a day. The participants were asked: "About how many hours of sleep do you get in every 24 hours?" We categorised the numerical responses into short sleep duration (<6 hours per day), normal (6-9 hours per day) and long sleep duration (>9 hours per day) using the National Sleep Foundation (NSF) definition of short, long and normal sleep duration.³⁸ The questions: "Do you have trouble falling asleep at night or do you wake up in the middle of the night?" and "How likely are you to doze off or fall asleep during the daytime when you don't mean to?" were used to evaluate sleeplessness and daytime dozing, respectively.³⁷

The participants' health state was evaluated with a question that asked the participants to rate their health on a scale of 1-4: "1" equated to "excellent health" and "4" equated to "poor health." They were also asked whether they felt "stressed" or "depressed" and their responses were used to ascertain stress and depression separately.³⁷ Shift work was evaluated with a question that asked the participants to describe their current shift pattern, whether it involved a shift schedule. The responses were: "Not", "Sometimes", "Usually" and "Always" in shift work. Participants were further asked whether they considered themselves to be "Definitely a morning person", "More of a

1 morning person”, “More of an evening person” and “Definitely an evening person” based on the
2 time they were most active. This was used to assess chronotype.³⁷
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5 Postcode of residence was used to allocate the participants to general population quintiles of
6 socioeconomic status (proxy for household status), using the Townsend index which is derived
7 from area-based information on unemployment, car ownership, ownership of house and
8 overcrowding. The design of the UK Biobank has been published elsewhere.^{36,39}
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12 **Statistical analyses**

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15 In order to identify confounding factors, the Pearson Chi-square (χ^2), Chi-square test for trend and
16 Kruskal-Wallis rank tests were used to examine whether there were significant differences in
17 sleep characteristics and smoking status according to socio-demographic characteristics, lifestyle,
18 occupational and health factors. A series of logistic regression models were used to investigate
19 the associations between tobacco exposure and sleep characteristics: sleeplessness, difficulty
20 awakening in the morning and daytime dozing. We used a multinomial logistic regression model
21 to examine the association between tobacco exposure and total sleep duration (long, short and
22 normal sleep duration). The models were initially run univariately, then multivariably. The
23 multivariable models adjusted for covariates – age, sex, ethnicity, socioeconomic deprivation,
24 self-reported stress and depression, alcohol and coffee consumption, physical activity level,
25 engagement in shift work and self-identified chronotype – that were significantly associated with
26 both the exposure and the outcome. Interaction tests were conducted and the associations were
27 further stratified by covariates that had statistically significant interactions with smoking on the
28 association with sleep disturbance, as appropriate.
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38 Two-tailed test was used in all the analyses. Our study comprised a very large sample and might
39 therefore be prone to type I error. We therefore set statistically significant level at $P \leq 0.01$,
40 instead of the conventional $P < 0.05$. The assumptions underlying the validity of χ^2 and Kruskal-
41 Wallis tests were examined, and the Hosmer-Lemeshow test was further used to assess the
42 goodness-of-fit of the multivariable regression models. All analyses were undertaken using Stata
43 version 14.0. This study was conducted under the generic approval for UK Biobank from the NHS
44 National Research Ethics Service (approval letter dated 17th June 2011, ref 11/NW/0382).
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RESULTS

Characteristics of the participants

Of the 502,655 UK Biobank participants, 498,208 (99.1%) were eligible for inclusion in the study. Of these, 54.4% were women and the mean age was 56.5 years. Overall, 27,383 (5.5%) reported short total sleep duration (<6hrs), 9,234 (1.9%) long sleep duration (>9hrs), 359,722 (28.2%) sleeplessness, 378,828 (24.1%) daytime dozing and 407,251 (18.1%) difficulty awakening in the morning (Table 1).

Participants who reported short or long sleep duration, sleeplessness and daytime dozing were older, more likely to be socioeconomically deprived, more likely to report feeling stressed or depressed, more likely to report poor overall health, less physically active, consumed more coffee and were more likely to work shifts (Table 1). In addition, women were more likely than men to report short or long sleep duration (Table 1) and sleeplessness (31.9% versus 23.8%), but were less likely to report daytime dozing (22.4% versus 26.0%).

Current smokers were more likely to report short or long sleep duration (10.9%) than either never (7.1%) or former (6.7%) smokers (Table 2). The prevalence of short or long sleep duration increased with the amount currently and previously smoked among current and former smokers, respectively (Table 2). Compared with never smokers who did not live with a smoker (6.9%), the prevalence of short or long sleep duration was higher among those who lived with one smoker (9.1%) and highest among those who lived with more than one smoker in the house (11.8%).

Smoking and sleep disturbance

On univariate analysis (Table 3), current smokers were more likely than never smokers to have short or long sleep duration. However, following adjustment for potential confounders, only the association with long sleep duration remained statistically significant (adjusted OR: 1.47; 95% CI: 1.17-1.85; $P=0.001$). When we adjusted for health status, we found that 8.8% of the observed association could be explained by poor health. The odds of long sleep duration was particularly highest among those who smoked more than 20 cigarettes per day (adjusted OR: 2.85; 95% CI: 1.66-4.89; $P<0.001$). Current smokers were, however, less likely to report daytime dozing than never smokers (adjusted OR: 0.91; 95% CI: 0.86-0.96; $P=0.001$), with evidence of a dose-relationship whereby the likelihood of daytime dozing decreased with the amount smoked per day (Table 4).

Overall, there was no statistically significant association between former smokers and short or long sleep duration: (adjusted OR: 0.96; 95% CI: 0.90-1.02) and (adjusted OR: 1.13; 95% CI: 0.97-1.33), respectively. However, on sub-group analysis, former smokers who had previously

1 smoked more than 20 cigarettes per day had statistically significantly higher odds of short
2 (adjusted OR: 1.41; 95% CI: 1.25-1.60; $P<0.001$) and long sleep duration (adjusted OR: 1.99;
3 95% CI: 1.47-2.71; $P<0.001$) than never smokers (Table 3). Former smokers were also more
4 likely to report sleeplessness (adjusted OR: 1.10; 95% CI: 1.07-1.14; $P<0.001$) and daytime
5 dozing (adjusted OR: 1.05; 95% CI: 1.02-1.08; $P=0.004$) than never smokers, with the highest risk
6 of sleeplessness apparent among those who previous smoked more than 20 cigarettes per day
7 (Table 4). Similarly, never smokers who lived with one or more smoker had an increased odds of
8 long sleep duration (adjusted OR: 2.71; 95% CI: 1.26-5.82; $P=0.011$). However, neither active nor
9 passive exposure to tobacco smoke was significantly associated with difficulty in awakening in the
10 morning in this study.

11 Sub-group analyses revealed that most of the statistically significant associations were stronger in
12 men, white participants, those aged 47-66 years and participants who were not in any shift work.
13 In addition, 'evening type' current smokers were more likely to report long sleep duration but were
14 less likely to doze off at daytime, while sleeplessness was stronger among 'morning type' former
15 smokers. However, there was no substantial difference in the effect size of the association
16 between smoking and sleep disturbance in the deprivation quintiles.

17 In the sensitivity analysis (Suppl. Table 2 & 3), current smokers still had statistically significantly
18 higher odds of long sleep duration (adjusted OR: 1.29; 95% CI: 1.04-1.60) and lower odds of
19 daytime dozing (adjusted OR: 0.87; 95% CI: 0.83-0.92) than former smokers. Additionally,
20 compared to former smokers, current smokers had lower odds of sleeplessness (adjusted OR:
21 0.95; 95% CI: 0.91-1.00).

DISCUSSION

Main findings

Active, former and passive smoking were all associated with sleep disturbance. Consistent with previous studies, we demonstrated that former heavy smokers were more likely to report short or long sleep duration and sleeplessness. Furthermore, current and never smokers exposed to high levels of passive smoke were also more likely to report long sleep duration. These associations were independent of socio-demographic, lifestyle, occupational and health confounding factors.

What is already known about the topic

Whilst previous studies have consistently shown an association between smoking cessation and sleep disturbance,^{19,40,41} the existing evidence in relation to current smoking is inconsistent.^{29-31,33-35} Some of the previous studies have been much smaller in size (range 88-498) and have varied in their definition of sleep disturbance.^{25,28,31} In addition, most previous studies have focused on sleeplessness; in comparison, sleep duration and daytime dysfunction have been relatively neglected. Some studies have also combined current and former smokers in a single group in the analyses,⁴²⁻⁴⁴ and many did not adjust for potential confounders such as engagement in shift work, chronotype and mental health.^{23,30,42,43,45}

There is some evidence to suggest that sleep disturbance may vary by ethnicity;⁴⁶ hence, it may be difficult to generalise findings from one country to another. Only one previous study has been conducted in the UK; a cross-sectional study of 1,484 men and women living in rural Oxfordshire.⁴⁷ The investigators reported that cigarette smoking was associated with shorter self-reported sleep duration in both sexes, but smoking was not associated with self-reported sleep quality.⁴⁷ The investigators stratified the analyses by sex and adjusted for age but could not control for other potential confounders.

What this study adds

Our study comprised a very large sample of the general population. We were able to examine three types of tobacco exposure (current, former and passive smoking) and five measures of sleep disturbance (short sleep duration, long sleep duration, sleeplessness, difficulty awakening in the morning and daytime dozing) in the same study population. There is strong evidence of increased morbidity and mortality risk in persons reporting long sleep duration.^{11,12} We showed that current smokers might be at increased risk of long-sleep duration and this might mediate the established harmful health effects of cigarette smoking. Importantly, short, long and normal sleep durations were defined using a standard definition.³⁸ To our knowledge, this is the first population-based study to investigate how passive smoking is associated with both long sleep duration and daytime dozing. Additionally, we were able to examine whether there was evidence of a dose-

1 response relationship with the level of tobacco exposure in all the three groups: daily number of
2 cigarettes smoked for current and former smokers and number of cohabitants who smoked for
3 never smokers. A number of other factors are known to be associated with sleep disturbance and
4 smoking including age, sex, physical illnesses,⁴⁸ socioeconomic deprivation,⁴ alcohol
5 consumption⁴⁹ and we were able to adjust for these, and other potential confounders, in the
6 analyses. Moreover, we stratified the associations by age, sex, ethnicity, chronotype and social
7 deprivation. Furthermore, we conducted a sensitivity analysis to examine whether the sleep
8 characteristics in current smokers differed from former smokers. These, in particular, have not
9 been considered in the majority of the previous studies.

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16 The mechanism underlying the association between cigarette smoking and sleep disturbance has
17 been widely explored. Nicotine is known to stimulate the release of neurotransmitters, such as
18 acetylcholine, dopamine and norepinephrine.¹⁶ It is believed that these neurotransmitters inhibit
19 GABA and sleep-promoting neurons located in the ventrolateral preoptic area, causing excessive
20 arousal of the body, which may consequently lead to sleep disturbance.¹⁷ This has also been
21 observed in EEG reports, where marked differences in the sleep waves were observed between
22 smokers and non-smokers, with smokers having frequent arousals.¹⁸ Nicotine can entrain
23 circadian timing mechanisms which strongly regulate the timing of the sleep wake cycle,⁵⁰ and
24 these might explain the increased risk of sleep disturbance and nicotine withdrawal effects such
25 as sleeplessness and daytime dozing observed in our study.

32 **Limitations of the study**

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34 UK Biobank is representative of the UK general population, within the age range recruited, in
35 terms of age, sex, ethnic and socioeconomic breakdown. However, participants are not
36 necessarily representative in terms of lifestyle. Therefore, it would be inappropriate to generalise
37 summary statistics, such as prevalence, to the general population. However, estimates of the
38 magnitude of associations, such as between tobacco and sleep, should be generalisable. In
39 common with most epidemiological studies of sleep, sleep characteristics were self-reported;
40 objective measurement of parameters such as sleep duration would, however, not be feasible
41 within such a large study. It is also important to mention that the questions used to evaluate sleep
42 disturbance were not from a validated scale such as the General Sleep Disturbance Scale
43 (GSDS). Smoking characteristics were also self-reported; reports of smoking status and level of
44 exposure could not be corroborated by objective measures such as cotinine assay. Whilst we
45 adjusted for a wide range of potential confounders, residual confounding is always possible within
46 any observational study. For instance, we used self-reported depression and stress as a proxy for
47 mental health and it is possible that these do not completely measure overall mental health.
48 Anxiety disorders are the most common mental disorders and are also associated with sleep
49 disturbance and probably initiation of cigarette smoking, but we could not adjust for anxiety in our
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1 analysis. Additionally, since this was a cross-sectional study, it was not possible to determine the
2 temporal relationship between smoking and sleep; therefore, reverse causation cannot be
3 excluded. For example, sleep disturbance might lead to mental disorders such as anxiety and
4 depression.⁵¹ There is some evidence to suggest that poor stress control and anxiety disorders
5 are among the factors that predict initiation of cigarette smoking.^{52,53}
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10 **Conclusions**

11 Tobacco exposure is known to directly increase the risk of many diseases including respiratory
12 and cardiovascular diseases and many cancers.⁵⁴ Our study suggests that there is also an
13 association between tobacco exposure and a number of sleep characteristics. If this association
14 is causal, tobacco exposure may also be impacting on health partly via an effect on sleep.
15 Smoking prevalence and exposure to passive smoking are declining in many developed
16 countries. However, these improvements are more than offset by increases in highly populated,
17 developing, and newly industrialised countries such as China. As a result, the global prevalence
18 of active smoking and passive exposure to tobacco is expected to continue increasing over the
19 next few decades.⁵⁵ Currently, about six million deaths are attributed to smoking every year, of
20 which 0.6 million are associated with passive smoke exposure.⁵⁶ It may be beneficial to enforce
21 the existing global tobacco control interventions to reduce the impact on a wide range of health
22 parameters, including sleep disturbance.
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34 **Conflicts of interests**

35 None
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43 Government and the Northwest Regional Development Agency. It has also received funding from
44 the Welsh Assembly Government and the British Heart Foundation.
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52 interest of the general public.
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Authors' contribution

DB, JPP and DFM designed the study, analysed the data and wrote the draft of the manuscript. CAW, CAM and SD contributed to the statistical analyses and review of the manuscript. SMB, MESB, JMRG and JW reviewed the final draft for submission.

REFERENCES

1. Zailinawati AH, Ariff KM, Nurjaham MI, Teng CL. Epidemiology of insomnia in Malaysian adults. *Asia-Pacific J Public Health*. 2008;20(3):224–33.
2. Edwards B, O'Driscoll D, Ali A, Jordan A, Trinder J, Malhotra A. Aging and sleep: Physiology and pathophysiology. *Semin Respir Crit Care Med*. 2010;31(5):618–33.
3. Cyril S, Oldroyd JC, Renzaho A. Urbanisation, urbanicity, and health: A systematic review of the reliability and validity of urbanicity scales. *BMC Public Health*. 2013;13:513–23.
4. Calem M, Bisla J, Begum A, Dewey M, Bebbington PE, Brugha T, et al. Increased prevalence of insomnia and changes in hypnotics use in England over 15 years: Analysis of the 1993, 2000, and 2007 National Psychiatric Morbidity Surveys. *Sleep*. 2012;35(3):377–84.
5. Walker HK, Hall WD, Hurst JW, editors. *Clinical Methods: The History, Physical, and Laboratory Examinations*. 3rd ed. Boston: Butterworths; 1990. p. 398–403.
6. Laugsand LE, Vatten LJ, Platou C, Janszky I. Insomnia and the risk of acute myocardial infarction: A population study. *Circulation*. 2011;124(19):2073–81.
7. Concepcion T, Barbosa C, Velez JC, Pepper M, Andrade A, Gelaye B. Daytime sleepiness, poor sleep quality, eveningness chronotype and common mental disorders among Chilean college students. *J Am Coll Heal*. 2014;62(7):441–8.
8. Kachi Y, Ohwaki K, Yano E. Association of sleep duration with untreated diabetes in Japanese men. *Sleep Med*. 2012;13(3):307–9.
9. Magee CA, Kritharides L, Attia J, McElduff P, Banks E. Short and long sleep duration are associated with prevalent cardiovascular disease in Australian adults. *J Sleep Res*. 2012;21(4):441–7.
10. Xu L, Jiang CQ, Lam TH, Liu B, Jin YL, Zhu T, et al. Short or long sleep duration is associated with memory impairment in older Chinese: The Guangzhou Biobank Cohort Study. *Sleep*. 2011;34(5):575–80.
11. da Silva AA, de Mello RGB, Schaan CW, Fuchs FD, Redline S, Fuchs SC. Sleep duration and mortality in the elderly: a systematic review with meta-analysis. *BMJ*. 2016;6(2):e008119.
12. Cappuccio FP, D'Elia L, Strazzullo P, Miller MA. Sleep duration and all-cause mortality: A systematic review and meta-analysis of prospective studies. *Sleep*. 2010;33(5):585–92.
13. Wickwire EM, Shaya FT, Scharf SM. Health economics of insomnia treatments: The return on investment for a good night's sleep. *Sleep Med Rev*. 2016;30(2016):72–82.

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14. Helbig AK, Döring A, Heier M, Emeny RT, Zimmermann A-K, Autenrieth CS, et al. Association between sleep disturbances and falls among the elderly: Results from the German Cooperative Health Research in the Region of Augsburg-Age study. *Sleep Med.* 2013 Dec;14(12):1356–63.
15. Adams S. Sleeping pill cost to NHS almost £50m - Telegraph [Internet]. The Telegraph. 2012 [cited 2016 May 25]. Available from: <http://www.telegraph.co.uk/news/health/news/9257191/Sleeping-pill-cost-to-NHS-almost-50m.html>
16. Benowitz NL. Pharmacology of nicotine: Addiction, amoking-induced disease, and therapeutics. *Annu Rev Pharmacol Toxicol.* 2009;(49):57–71.
17. Saint-Mleux B, Eggermann E, Bisetti A, Bayer L, Machard D, Jones BE, et al. Nicotinic enhancement of the noradrenergic inhibition of sleep-promoting neurons in the ventrolateral preoptic area. *J Neurosci.* 2004;24(1):63–7.
18. Zhang L, Samet J, Caffo B, Bankman I, Punjabi NM. Power spectral analysis of EEG activity during sleep in cigarette smokers. *Chest.* 2008;133(2):427–32.
19. Jaehne A, Loessl B, Bárkai Z, Riemann D, Hornyak M. Effects of nicotine on sleep during consumption, withdrawal and replacement therapy. *Sleep Med Rev.* 2009;13(5):363–77.
20. McNamara JPH, Wang J, Holiday DB, Warren JY, Paradoa M. Sleep disturbances associated with cigarette smoking. *Pschol, Health Med.* 2014;19(4):410–9.
21. Riedel B, Durrence H, Lichstein K, Taylor D, Bush J. The relation between smoking and sleep: The influence of smoking level, health and psychological variables. *Behav Sleep Med.* 2004;2(1):63–78.
22. Zhang L, Samet J, Caffo B, Punjabi NM. Cigarette smoking and nocturnal sleep architecture. *Am J Epidemiol.* 2006;164(6):529–37.
23. Brook DW, Rubenstone E, Zhang C, Brook JS. Trajectories of cigarette smoking in adulthood predict insomnia among women in late mid-life. *Sleep Med.* 2012;13(9):1130–7.
24. Brook JS, Zhang C, Seltzer BA, Brook DW. Insomnia in adults: The impact of earlier cigarette smoking from adolescents to adulthood. *J Addict Med.* 2015;9(1):40–5.
25. Cohrs S, Rodenbeck A, Riemann D, Szagun B, Jaehne A, Brinkmeyer J, et al. Impaired sleep quality and sleep duration in smokers-results from the German Multicenter Study on Nicotine Dependence. *Addict Biol.* 2012;(May):1–12.
26. Jaehne A, Unbehaun T, Feige B, Lutz UC, Batra A, Riemann D. How smoking affects sleep: A polysomnographical analysis. *Sleep Med.* 2012;13(10):1286–92.

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27. Masood S, Cappelli C, Li Y, Tanenbaum H, Donna CC, Palmer PH, et al. Cigarette smoking is associated with unhealthy patterns of food consumption, physical activity, sleep impairment, and alcohol drinking in Chinese male adults. *Int J Public Health*. 2015;60(8):891–9.
28. Haario P, Rahkonen O, Laaksonen M, Lahelma E, Lallukka T. Bidirectional associations between insomnia symptoms and unhealthy behaviours. *J Sleep Res*. 2013;22(1):89–95.
29. Cheek RE, Shaver JL, Lentz MJ. Lifestyle practices and nocturnal sleep in midlife women with and without insomnia. *Biol Res Nurs*. 2004;6(1):46–58.
30. Kim K, Uchiyama M, Okawa M, Doi Y, Oida T, Minowa M, et al. Lifestyles and sleep disorders among the Japanese adult population. *Psychiatry Clin Neurosci*. 1999;53(2):269–70.
31. Kageyama T, Kobayashi T, Nishikido N, Oga J, Kawashima M. Associations of sleep problems and recent life events with smoking behaviors among female staff nurses in Japanese hospitals. *Ind Health*. 2005;43(1):133–41.
32. Asghari A, Kamrava SK, Rezaee Hemami M, Jalessi M, Yazdanifard P, Farhadi M, et al. Cigarette smoking habit and subjective quality of sleep. *Scimetr*. 2015;3(1):3–6.
33. Fabsitz RR, Sholinsky P, Goldberg J. Correlates of sleep problems among men: The Vietnam Era Twin Registry. *J Sleep Res*. 1997;6(1):50–6.
34. Wang Y-M, Chen H-G, Song M, Xu S-J, Yu L-L, Wang L, et al. Prevalence of insomnia and its risk factors in older individuals: A community-based study in four cities of Hebei Province, China. *Sleep Med*. 2015;10(18):4–18.
35. Xiang Y-T, Ma X, Cai Z-J, Li S-R, Xiang Y-Q, Guo H-L, et al. The prevalence of insomnia, its sociodemographic and clinical correlates, and treatment in rural and urban regions of Beijing, China: A general population-based survey. *Sleep*. 2008;31(12):1655–62.
36. UK Biobank Coordinating Centre. UK Biobank: Protocol for a large-scale prospective epidemiological resource UK Biobank Coordinating Centre Stockport. *Design*. 2007;06(March):1–112.
37. UK Biobank. UK Biobank Touchscreen Questionnaire [Internet]. [Accessed 7 June 2017]. p. 1–78. Available from: https://www.ukbiobank.ac.uk/wp-content/uploads/2011/06/Touch_screen_questionnaire.pdf?phpMyAdmin=trmKQIYdjjnQlgJ%2CfAzikMhEnx6

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38. The National Sleep Foundation. National Sleep Foundation Recommends New Sleep Times [Internet]. [Accessed 27 May 2016]. p. 12–4. Available from: <http://sleepfoundation.org/media-center/press-release/national-sleep-foundation-recommends-new-sleep-times>
 39. Sudlow C, Gallacher J, Allen N, Beral V, Burton P, Danesh J, et al. UK Biobank: An open access resource for identifying the causes of a wide range of complex diseases of middle and old age. *PLoS Med.* 2015;12(3):1–10.
 40. Hu L, Sekine M, Gaina A, Kagamimori S. Association between sleep quality and smoking in Japanese civil servants. *Sleep Biol Rythm.* 2007;5(3):196–203.
 41. Benbir G, Demir AU, Aksu M, Ardic S, Firat H, Itil O, et al. Prevalence of insomnia and its clinical correlates in a general population in Turkey. *Psychiatry Clin Neurosci.* 2015;69(9):543–52.
 42. Aslan S, Gulcat Z, Albayrak FS, Maral I, Yetkin S, Sutcgil L, et al. Prevalence of insomnia symptoms: Results from an urban district in Ankara, Turkey. *Int J Psychiatry Clin Pract.* 2006;10(1):52–8.
 43. Allavena C, Guimard T, Billaud E, De la Tullaye S, Reliquet V, Pineau S, et al. Prevalence and risk factors of sleep disturbance in a large HIV-infected adult population. *AIDS Behav.* 2015;20:339–44.
 44. Abe Y, Mishima K, Kaneita Y, Li L, Ohida T, Nishikawa T, et al. Stress coping behaviors and sleep hygiene practices in a sample of Japanese adults with insomnia. *Sleep Biol Rhythms.* 2011;9(1):35–45.
 45. Philips BA, Danner FJ. Cigarette smoking and sleep disturbance. *Arch Intern Med.* 1995;155:734–7.
 46. Baldwin CM, Ervin AM, Mays MZ, Robbins J, Shafazand S, Walsieben J, et al. Sleep disturbances, quality of life, and ethnicity: The Sleep Heart Health Study. *J Clin Sleep Med.* 2010;6(2):176–83.
 47. Palmer CD, Harrison GA, Hiorns RW. Association between smoking and drinking and sleep duration. *Ann Hum Biol.* 1980;7(2):103–7.
 48. Tsou M-T. Prevalence and risk factors for insomnia in community-dwelling elderly in northern Taiwan. *J Clin Gerontol Geriatr.* 2013;4(3):75–9.
 49. Canham SL, Kaufmann CN, Mauro PM, Mojtabai R, Spira AP. Binge drinking and insomnia in middle-aged and older adults: The Health and Retirement Study. *Int J Geriatr Psychiatry.* 2015;30(3):284–91.

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50. Gillman A, Leffel J, Kosobud A, Timberlake A. Behavioural characteristics and pharmacological manipulations of a nicotine-entrainable circadian oscillator. *Chronobiol Int.* 2013;30(7):855–69.
51. Alvaro PK, Roberts RM, Harris JK. A systematic review assessing bidirectionality between sleep disturbances, anxiety and depression. *Sleep.* 2013;36(7):1059–68.
52. Choi D, Ota S, Watanuki S. Does cigarette smoking relieve stress? Evidence from event-related potential (ERP). *Int J Psychophysiol.* 2015;98(2015):470–6.
53. Ah DV, Ebert S, Ngamvitroj A, Park N, Kang D-H. Factors related to cigarette smoking initiation and use among college students. *Tob Induc Dis.* 2005;3(1):27–40.
54. U.S. Department of Health and Human Services. Executive Summary (The Health Consequences of Smoking - 50 Years of Progress: A Report of the Surgeon General). Atlanta, GA; 2014.
55. Han J, Chen X. A Meta-Analysis of Cigarette Smoking Prevalence among Adolescents in China : 1981 – 2010. *Int J Environ Res Public Health.* 2015;12:4617–30.
56. World Health Organization. WHO global report on trends in prevalence of tobacco smoking 2015. Geneva, Switzerland: World Health Organization; 2015. 1 p.

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List of Abbreviations

CI	Confidence interval
DD	Daytime dozing
DMA	Difficulty in morning awakening
EEG	Electroencephalography
GABA	Gamma-aminobutyric acid
GSDS	General Sleep Disturbance Scale
NHS	National Health Service
OR	Odds ratio
P	Probability value
UK	United Kingdom
VLPO	Ventrolateral preoptic area
χ^2	Chi-square test

Table 1: Participants' Characteristics by Sleep Characteristics

	<6 hours n=27,383 %	6-9 hours n=461,591 %	>9 hours n=9,234 %	Sleeplessness n=141,427 %	DMA n=89,723 %	DD n=120,047 %
Sex						
Male	43.6	45.8	44.5	61.6	45.6	49.2
Female	56.4	54.2	55.5	38.4	54.4	50.8
Age (years)						
<47	13.1	15.5	12.7	11.3	15.3	10.8
47-56	32.0	30.1	24.8	29.5	30.2	26.0
57-66	43.9	43.8	46.5	47.4	43.8	48.4
>66	10.7	10.6	16.0	11.8	10.7	14.9
Ethnicity						
White	89.6	95.0	92.0	95.7	94.5	91.6
Black	4.7	1.4	2.6	1.2	1.7	2.8
Asian	2.8	1.9	2.8	1.6	2.0	3.1
Chinese	0.3	0.3	0.4	0.2	0.3	0.5
Other	1.6	0.9	1.5	0.8	0.9	1.4
Mixed	1.0	0.7	0.8	0.6	0.6	0.6
Deprivation quintile						
1 (least deprived)	14.4	20.6	13.8	19.0	20.7	17.8
2	15.5	20.4	16.3	19.2	20.0	18.4
3	17.6	20.3	17.7	19.6	19.9	19.2
4	21.1	19.9	21.5	20.2	20.0	20.3
5 (most deprived)	31.4	18.9	30.7	21.9	20.1	24.3
Alcohol consumption (glasses/day)						
0	43.4	32.9	46.1	24.1	33.4	35.0
1-4	30.9	36.8	28.4	22.1	36.4	37.1
5-9	15.0	18.5	13.9	11.5	18.3	17.2
>9	10.7	11.9	11.7	8.0	11.9	10.7
Physical activity (minutes/day)						
0	0.1	0.1	0.3	0.1	0.1	0.2
1-30	45.3	48.2	48.2	47.5	47.5	48.1
31-60	27.1	28.4	27.3	27.9	28.3	27.9
61-90	4.5	4.2	4.3	4.4	4.4	4.3
>90	23.0	19.1	19.9	20.1	19.6	19.7
Engagement in shift work						
Never	72.6	83.4	73.0	82.4	82.6	77.9
Sometimes	10.3	7.3	8.8	7.4	7.5	8.6
Usually	3.3	2.1	3.1	2.1	2.1	2.8
Always	13.8	7.3	15.1	8.0	7.9	10.6
Self-identified chronotype						
Definitely morning	34.8	26.7	24.7	27.7	27.2	28.9
More morning	29.3	36.0	27.0	34.3	35.4	34.1
More evening	24.5	28.6	32.5	27.8	28.5	27.4
Definitely evening	11.3	8.7	15.8	10.2	8.9	9.6
Self-reported stress						
No	69.5	77.1	66.4	69.3	76.5	71.1
Yes	30.5	22.9	33.6	30.7	23.5	28.9
Self-reported depression						
No	43.0	60.8	43.6	46.9	59.5	50.9
Yes	57.0	39.2	56.4	53.1	40.5	49.1
Self-reported health state						
Excellent	8.9	17.1	8.0	11.2	16.4	12.0
Good	45.6	59.2	37.7	52.1	57.9	53.0
Fair	31.8	20.2	32.4	27.7	21.2	26.7
Poor	13.7	3.6	21.9	9.0	4.6	8.3

n, Number of participants; DMA, Self-reported Difficulty in morning awakening; DD, Self-reported daytime dozing

Table 2: Prevalence of Sleep Characteristics

	<6 hours n=27,383 %	6-9 hours n=461,591 %	>9 hours n=9,234 %	Sleeplessness n=141,427 %	DMA n=89,723 %	DD n=120,047 %
Smoking status						
Never	39.6	40.1	36.7	37.5	39.9	39.2
Former	44.5	49.4	46.6	50.7	48.9	49.7
Current	15.9	10.5	16.7	11.8	11.1	11.1
Live with a smoker (never smokers)						
No	88.5	91.6	89.4	91.7	91.3	90.8
Yes (1)	9.9	7.5	9.4	7.4	7.8	8.2
Yes (>1)	1.6	0.9	9.4	0.9	1.0	1.1

n, Number of participants; DMA, Difficulty in morning awakening; DD, Daytime dozing

Table 3: Multinomial Logistic Regression Analyses of Smoking and Sleep Duration

	Univariate					Multivariable				
	<6 hours		6-9 hours	>9 hours		<6 hours		6-9 hours	>9 hours	
	OR (95% CI)	P value	OR	OR (95% CI)	P value	OR (95% CI)	P value	OR	OR (95% CI)	P value
Smoking status										
Never	1.00		1.00	1.00		1.00		1.00	1.00	
Former	0.91 (0.89-0.94)	<0.001	1.00	1.03 (0.98-1.08)	0.197	0.96 (0.90-1.02)	0.154	1.00	1.13 (0.97-1.33)	0.122
Current	1.54 (1.49-1.60)	<0.001	1.00	1.74 (1.64-1.85)	<0.001	1.03 (0.94-1.13)	0.534	1.00	1.47 (1.17-1.85)	0.001
Cigarettes/day (current smokers)										
0	1.00		1.00	1.00		1.00		1.00	1.00	
1-10	1.43 (1.34-1.53)	<0.001	1.00	1.60 (1.43-1.80)	<0.001	1.08 (0.91-1.29)	0.351	1.00	1.47 (1.00-2.18)	0.052
11-20	1.77 (1.67-1.87)	<0.001	1.00	1.96 (1.79-2.15)	<0.001	0.99 (0.85-1.17)	0.947	1.00	1.11 (0.73-1.69)	0.626
>20	2.55 (2.34-2.77)	<0.001	1.00	2.78 (2.41-3.19)	<0.001	1.46 (1.15-1.87)	0.002	1.00	2.85 (1.66-4.89)	<0.001
Cigarettes/day (former smokers)										
0	1.00		1.00	1.00		1.00		1.00	1.00	
1-10	0.85 (0.80-0.90)	<0.001	1.00	0.85 (0.77-0.94)	0.002	0.88 (0.77-1.01)	0.062	1.00	0.98 (0.71-1.37)	0.917
11-20	0.96 (0.92-1.00)	0.070	1.00	1.24 (1.16-1.33)	<0.001	0.96 (0.87-1.06)	0.395	1.00	1.23 (0.97-1.56)	0.085
>20	1.44 (1.37-1.52)	<0.001	1.00	1.90 (1.75-2.06)	<0.001	1.41 (1.25-1.60)	<0.001	1.00	1.99 (1.47-2.71)	<0.001
Live with a smoker (never smokers)										
No	1.00		1.00	1.00		1.00		1.00	1.00	
Yes (1)	1.37 (1.28-1.46)	<0.001	1.00	1.28 (1.14-1.44)	<0.001	1.02 (0.87-1.20)	0.792	1.00	0.86 (0.54-1.38)	0.402
Yes (>1)	1.91 (1.63-2.24)	<0.001	1.00	1.46 (1.07-1.99)	0.018	1.47 (0.99-2.15)	0.051	1.00	2.71 (1.26-5.82)	0.011

OR, Odds ratio; CI, Confidence interval

Multivariable adjusted for age, sex, ethnicity, social deprivation quintile, self-reported stress, self-reported depression, alcohol and coffee consumption, physical activity level, shift work and self-identified chronotype

Table 4: Logistic Regression Analysis of Smoking and Sleeplessness, Difficulty in Morning Awakening and Daytime Dozing

	Sleeplessness				Difficulty in morning awakening				Daytime dozing			
	Univariate		Multivariable		Univariate		Multivariable		Univariate		Multivariable	
	OR (95% CI)	P value	OR (95% CI)	P value	OR (95% CI)	P value	OR (95% CI)	P value	OR (95% CI)	P value	OR (95% CI)	P value
Smoking status												
Never	1.00		1.00		1.00		1.00		1.00		1.00	
Former	1.14 (1.13-1.16)	<0.001	1.10 (1.07-1.14)	<0.001	1.00 (0.99-1.02)	0.745	1.01 (0.98-1.05)	0.392	1.04 (1.03-1.06)	<0.001	1.05 (1.02-1.08)	0.004
Current	1.22 (1.19-1.24)	<0.001	1.05 (1.00-1.10)	0.041	1.00 (0.98-1.03)	0.641	1.03 (0.98-1.08)	0.269	1.05 (1.03-1.07)	<0.001	0.91 (0.86-0.96)	0.001
Cigarettes/day (current smokers)												
0	1.00		1.00		1.00		1.00		1.00		1.00	
1-10	1.20 (1.15-1.24)	<0.001	1.07 (0.98-1.16)	0.728	0.97 (0.93-1.02)	0.273	0.92 (0.84-1.02)	0.109	0.96 (0.92-1.00)	0.036	0.87 (0.79-0.96)	0.007
11-20	1.34 (1.29-1.38)	<0.001	1.01 (0.93-1.10)	0.783	1.01 (0.97-1.05)	0.542	1.11 (1.01-1.21)	0.023	1.05 (1.02-1.09)	0.003	0.83 (0.75-0.91)	<0.001
>20	1.70 (1.60-1.80)	<0.001	1.15 (0.99-1.36)	0.072	0.99 (0.92-1.06)	0.694	1.04 (0.88-1.23)	0.664	1.17 (1.10-1.25)	<0.001	0.74 (0.62-0.89)	0.001
Cigarettes/day (former smokers)												
0	1.00		1.00		1.00		1.00		1.00		1.00	
1-10	1.23 (1.20-1.27)	<0.001	1.14 (1.08-1.21)	<0.001	1.00 (0.96-1.03)	0.768	0.98 (0.92-1.04)	0.440	1.03 (1.00-1.06)	0.053	1.08 (1.01-1.15)	0.016
11-20	1.25 (1.23-1.28)	<0.001	1.18 (1.13-1.23)	<0.001	1.02 (0.99-1.04)	0.201	1.02 (0.97-1.07)	0.358	1.04 (1.02-1.07)	<0.001	0.97 (0.92-1.02)	0.215
>20	1.50 (1.46-1.55)	<0.001	1.47 (1.38-1.57)	<0.001	1.02 (0.99-1.06)	0.210	1.03 (0.95-1.11)	0.479	1.32 (1.28-1.36)	<0.001	1.05 (0.97-1.13)	0.230
Live with a smoker (never smokers)												
No	1.00		1.00		1.00		1.00		1.00		1.00	
Yes (1)	1.15 (1.11-1.20)	<0.001	1.05 (0.97-1.13)	0.261	1.01 (0.97-1.06)	0.507	1.10 (1.01-1.20)	0.025	1.09 (1.05-1.14)	<0.001	1.08 (0.99-1.17)	0.104
Yes (>1)	1.21 (1.10-1.34)	<0.001	1.03 (0.83-1.29)	0.785	1.10 (0.98-1.24)	0.113	1.17 (0.93-1.47)	0.186	1.30 (1.17-1.44)	<0.001	1.23 (0.97-1.55)	0.153

OR, Odds ratio; CI, Confidence interval

Multivariable adjusted for age, sex, ethnicity, social deprivation quintile, self-reported stress, self-reported depression, alcohol and coffee consumption, physical activity level, shift work and self-identified chronotype

Suppl. Table 1: Participants' characteristics by smoking status

	Never smokers n=200,940 %	Former smokers n=245,874 %	Current smokers n=55,841 %	P-value
Sex				
Female	60.7	51.2	46.3	
Male	39.3	48.9	53.7	<0.001
Age (Years)				
37-46	16.9	12.9	20.7	
47-56	32.5	27.3	34.1	
57-66	40.7	47.8	37.9	
67-73	10.0	12.0	7.4	<0.001
Ethnicity				
White	92.3	96.7	93.7	
Mixed	0.5	0.6	1.1	
Asian	3.3	0.9	1.9	
Black	2.3	1.0	1.9	
Chinese	0.5	0.2	0.2	
Other	1.1	0.7	1.2	<0.001
Deprivation quintile				
1 (least deprived)	21.8	20.5	11.8	
2	21.0	20.5	13.5	
3	20.4	20.5	16.4	
4	19.3	20.1	22.0	
5 (most deprived)	17.4	18.4	36.3	<0.001
Self-reported health state				
Excellent	18.7	16.2	9.0	
Good	58.8	58.8	50.4	
Fair	18.8	20.8	31.1	
Poor	3.6	4.2	9.5	<0.001
Alcohol (glasses/day)				
Don't take alcohol	33.5	31.1	46.7	
1-4	41.4	35.5	23.6	
5-9	17.0	19.8	14.6	
>9 glass a day	8.1	13.7	15.1	<0.001
Physical activity (minutes/day)				
0	0.1	0.1	26.2	
1-30mins	48.4	48.0	0.1	
31-60mins	28.8	28.3	47.0	
61-90mins	4.2	4.3	4.0	
>90mins	18.5	19.3	22.8	<0.001
Self-reported stress				
No	75.7	77.1	75.7	
Yes	24.3	22.9	24.3	<0.001
Self-reported depression				
No	61.9	60.0	47.1	
Yes	38.1	40.0	52.9	<0.001
Engagement in shift work				
Never	83.4	83.8	75.3	
Sometimes	7.0	7.2	10.1	
Usually	2.1	2.0	3.1	
Always	7.6	7.0	11.5	<0.001
Self-identified chronotype				
Definitely morning	29.8	25.8	23.0	
More of morning	36.8	36.2	27.2	
More of evening	26.0	29.1	34.2	
Definitely evening	7.4	8.9	15.7	<0.001

n, Number of participants

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Suppl. Table 2: Multinomial Logistic Regression Analyses of Smoking and Sleep Duration

	Univariate					Multivariable				
	<6 hours		6-9 hours		>9 hours	<6 hours		6-9 hours	>9 hours	
	OR (95% CI)	P value	OR	OR (95% CI)	P value	OR (95% CI)	P value	OR	OR (95% CI)	P value
Smoking status										
Former	1.00		1.00	1.00		1.00		1.00	1.00	
Never	1.09 (1.07-1.12)	<0.001	1.00	0.97 (0.93-1.02)	0.197	1.05 (0.98-1.11)	0.154	1.00	0.88 (0.75-1.03)	0.122
Current	1.69 (1.63-1.75)	<0.001	1.00	1.69 (1.60-1.80)	<0.001	1.08 (0.98-1.18)	0.104	1.00	1.29 (1.04-1.60)	0.019

OR, Odds ratio; CI, Confidence interval

Multivariable adjusted for age, sex, ethnicity, social deprivation quintile, self-reported stress, self-reported depression, alcohol and coffee consumption, physical activity level, shift work and self-identified chronotype

Suppl. Table 3: Logistic Regression Analysis of Smoking and Sleeplessness, Difficulty in Morning Awakening and Daytime Dozing

	Sleeplessness				Difficulty in morning awakening				Daytime dozing			
	Univariate		Multivariable		Univariate		Multivariable		Univariate		Multivariable	
	OR (95% CI)	P value	OR (95% CI)	P value	OR (95% CI)	P value	OR (95% CI)	P value	OR (95% CI)	P value	OR (95% CI)	P value
Smoking status												
Former	1.00		1.00		1.00		1.00		1.00		1.00	
Never	0.87 (0.86-0.88)	<0.001	0.91 (0.88-0.93)	<0.001	1.00 (0.98-1.01)	0.745	0.97 (0.96-1.02)	0.392	0.96 (0.95-0.97)	<0.001	0.95 (0.92-0.99)	0.004
Current	1.06 (1.04-1.08)	<0.001	0.95 (0.91-1.00)	0.035	1.00 (0.98-1.03)	0.789	1.02 (0.97-1.07)	0.543	1.01 (0.99-1.03)	0.332	0.87(0.83-0.92)	<0.001

OR, Odds ratio; CI, Confidence interval

Multivariable adjusted for age, sex, ethnicity, social deprivation quintile, self-reported stress, self-reported depression, alcohol and coffee consumption, physical activity level, shift work and self-identified chronotype