Busting Myths about Smoking Cessation and Mood Disorders

What does the evidence really tell us?



BACKGROUND



Smokers with depression experience greater rates of relapse and have lower long-term quit success rates compared to the general population.^[1] Despite this evidence, research has found that smokers with co-occurring mental illness are less likely to be offered treatment for smoking cessation.^[2] These inconsistencies are, in part, caused by misconceptions regarding smoking cessation among this population.^[3]

In this resource we will identify and address common myths related to smokers with mental illness, specifically individuals with mood-related disorders, and provide tips for healthcare providers when working with this population.

BUSTING MYTHS ABOUT SMOKING CESSSATION AND MOOD DISORDERS



MYTH: "Smokers with mental illness lack the motivation to quit smoking."

FACT:

Evidence suggests that individuals with mental health issues, including depression are as motivated to quit smoking as the general population.^[4] In fact, many smokers with mental illness express concern over the impact of smoking on their health and finances, and are motivated to quit or reduce their tobacco use.^[5]

- 85% of smokers with co-occurring mental illness have made a quit attempt in the past versus 78% of those without mental illness.^[3]
- A study by Haukkala (2000) found that smokers presenting depressive symptoms display reduced selfefficacy, but had higher motivation to quit smoking compared to non-depressed smokers.^[6]
 - Among female smokers, higher depression scores were associated with greater motivation to quit smoking.^[6]

TIPS FOR HEALTHCARE PROVIDERS:

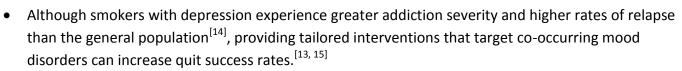


- Brief interventions (2-5 minutes) can be used to help your patient understand the relationship between their tobacco use and mood disorder, and increase their motivation to initiate positive health behaviour change.^[7]
- Incorporate **motivational interviewing** as part of **brief interventions** with your patients by using the following skills:^[8]
 - ✓ Explore your patient's ambivalence and develop discrepancies
 - ✓ Provide reflections and affirmations when appropriate
 - ✓ Establish goals that are realistic to achieve
- Self-management resources, such as the "<u>Self-Awareness: Managing Your Mood</u>" workbook, can be
 offered to patients to help reinforce techniques learned during counseling sessions and maintain
 positive mood while attempting to quit or reduce smoking.^[9, 10]

MYTH: "Smokers with mood disorders do not have the capacity to successfully quit smoking."

FACT:

Healthcare practitioners may be disinclined to providing smoking cessation interventions to individuals presenting mood disorders out of fear that this will worsen their depressive symptoms. ^[11, 12] However several bodies of evidence have shown that quit success is possible among this population. ^[13]



- Strong evidence has found that integrating a mood management component as part of standard smoking cessation treatment can increase long-term quit success rates by 12-20% in smokers with current and past depression.^[15]
- Evidence-based interventions for counselling smokers in the general population are effective for treating individuals with mood disorders, including both pharmacological ^[16-18] and psychosocial interventions.^[10, 19, 20]

TIPS FOR HEALTHCARE PROVIDERS:

- Incorporate psychosocial interventions as part of your patient's treatment plan
 - Cognitive behavioural therapy (CBT) and mindfulness/relaxation exercises can be used to help patients manage symptoms of stress, depression and anxiety as well as cope with triggers and cravings to smoke.
- Consider that individuals with mood disorders may require longer treatment plans, and adjusted doses of pharmacotherapy, including higher doses of nicotine replacement therapy.^[21]
 - Assess your patient's mental health status, including a history of mood disorders, which can influence their treatment plan and pharmacotherapy options. ^[10, 21, 22]
 - **Monitor** your patient for any changes in mood or potential adverse side effects, since quitting smoking can affect certain medications. ^[21, 22]
 - Consider potential drug interactions with medications being used to treat mood disorders and tobacco dependence and adjust doses as necessary. ^[21, 22]

Myth: "Smoking cessation should not be a top treatment priority among individuals with co-occurring mental illness."

FACT:

Evidence has found that individuals with psychiatric disorders are more likely to die from a tobacco-related disease than their mental health issues.^[3, 23]

• Smokers with mental illness have a lower life expectancy than the general population, with much of their excess mortality being attributable to smoking.^[3]







- Cardiovascular disease, respiratory illnesses and cancer are among the most common causes of premature death among this population, which is most commonly associated with tobacco use.^[3, 24]
- In individuals with mental health problems, there is a 77% increased risk of suicide attempts among those who smoke, compared to non-smokers.^[3, 25, 26]
 - \circ The risk of suicide significantly decreases following one year of smoking abstinence.^[3, 25]
 - Quitting smoking is not associated with greater risk of suicidality.^[3, 26]

TIPS FOR HEALTHCARE PROVIDERS:

- Healthcare providers should make it a priority to screen and address tobacco use when working with patients with mood disorders, in order to reduce smoking-related morbidity and mortality.^[3]
- Integrate the same evidence-based **psychosocial** and **pharmacological** treatments that are used with the general population for smoking cessation as part of treatment for smokers with mood disorders.^[21, 22]
- Agenda mapping can be used to help patients and practitioners identify and prioritize specific health behaviors they want to change in order to guide the development of treatment plans.^[10]

Myth: "Smoking alleviates symptoms of depression and anxiety, and can promote relaxation to help relieve stress and stabilize mood."

FACT:

Evidence has shown that nicotine is ineffective in treating mental illness. ^[13, 27] While nicotine may cause short-term elevation in mood due to the release of dopamine in the brain, nicotine is a stimulant and can actually exacerbate feelings of anxiety and low mood, and increase stress levels. ^[13, 27-30]



- Irritability, negative mood and anxiety are common withdrawal symptoms, and may be misinterpreted as depressive symptoms among individuals making a quit attempt.^[29, 30]
- Strong evidence has shown that smoking cessation is associated with reduced feelings of depression, anxiety and stress and improvement in psychological quality of life and positive affect. ^[29]

TIPS FOR HEALTHCARE PROVIDERS:

- Psychoeducation: Educate your patient on the connection between their mood and smoking to help address common myths and "placebo effects." ^[10, 30]
 - **Review** the differences between feelings of withdrawal and feelings of depression.^[30]
 - **Discuss** the positive impact that quitting smoking can have on their mental health. ^[30]
 - Create a list of alternative activities that patients can participate in when experiencing negative mood or withdrawal symptoms in order to reduce the risk of relapse.



Page 6-7 of the "Self-Awareness Managing Your Mood Workbook" provides a list of pleasant and healthy activities that patients can engage in when experiencing cravings and/or low mood and a daily tracking sheet where they can chart their mood, smoking and activities to help visualize the connection between their mood and smoking patterns.

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