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 self-efficacy, 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 “Self-Awareness: Managing Your Mood” 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]
**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. However several bodies of evidence have shown that quit success is possible among this population.

- Although smokers with depression experience greater addiction severity and higher rates of relapse than the general population, providing tailored interventions that target co-occurring mood disorders can increase quit success rates.
- 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.
- Evidence-based interventions for counselling smokers in the general population are effective for treating individuals with mood disorders, including both pharmacological and psychosocial interventions.

**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.
  - Assess your patient’s mental health status, including a history of mood disorders, which can influence their treatment plan and pharmacotherapy options.
  - Monitor your patient for any changes in mood or potential adverse side effects, since quitting smoking can affect certain medications.
  - Consider potential drug interactions with medications being used to treat mood disorders and tobacco dependence and adjust doses as necessary.

**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.

- Smokers with mental illness have a lower life expectancy than the general population, with much of their excess mortality being attributable to smoking.
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.\cite{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.\cite{3, 25, 26}

- The risk of suicide significantly decreases following one year of smoking abstinence.\cite{3, 25}
- Quitting smoking is not associated with greater risk of suicidality.\cite{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.\cite{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.\cite{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.\cite{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.\cite{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.\cite{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.\cite{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.\cite{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.”\cite{10, 30}
  - Review the differences between feelings of withdrawal and feelings of depression.\cite{30}
  - Discuss the positive impact that quitting smoking can have on their mental health.\cite{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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