National Behavioral Health Network

for Tobacco & Cancer Control

from NATIONAL COUNCIL FOR MENTAL WELLBEING

Supporting Tobacco Cessation with Trauma-Informed Approaches

August 11th 12:30 – 1:30 pm ET

Welcome from the NBHN Team!

Tamanna Patel, MPH
Director, Practice Improvement
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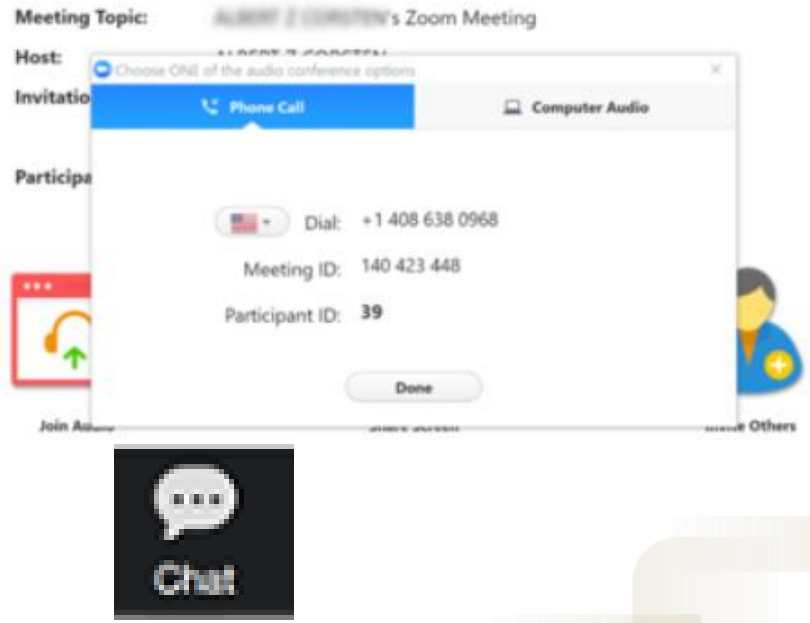

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National Behavioral Health Network for Tobacco & Cancer Control

- Jointly funded by CDC's *Office on Smoking & Health & Division of Cancer Prevention & Control*
- Provides resources and tools to help organizations reduce tobacco use and cancer among individuals experiencing mental health and substance use challenged
- 1 of 8 CDC National Networks to eliminate cancer and tobacco disparities in priority populations

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A Note on Language & Terminology

- **Mental wellbeing:** thriving regardless of a mental health or substance use challenge.

- **Commercial tobacco use/tobacco use:** The use of commercial tobacco and nicotine products (including electronic nicotine devices, otherwise known as ENDs).*

- ***All references to smoking and tobacco use is referring to commercial tobacco and not the sacred and traditional use of tobacco by some American Indian and Alaskan Native communities.**

Setting the context

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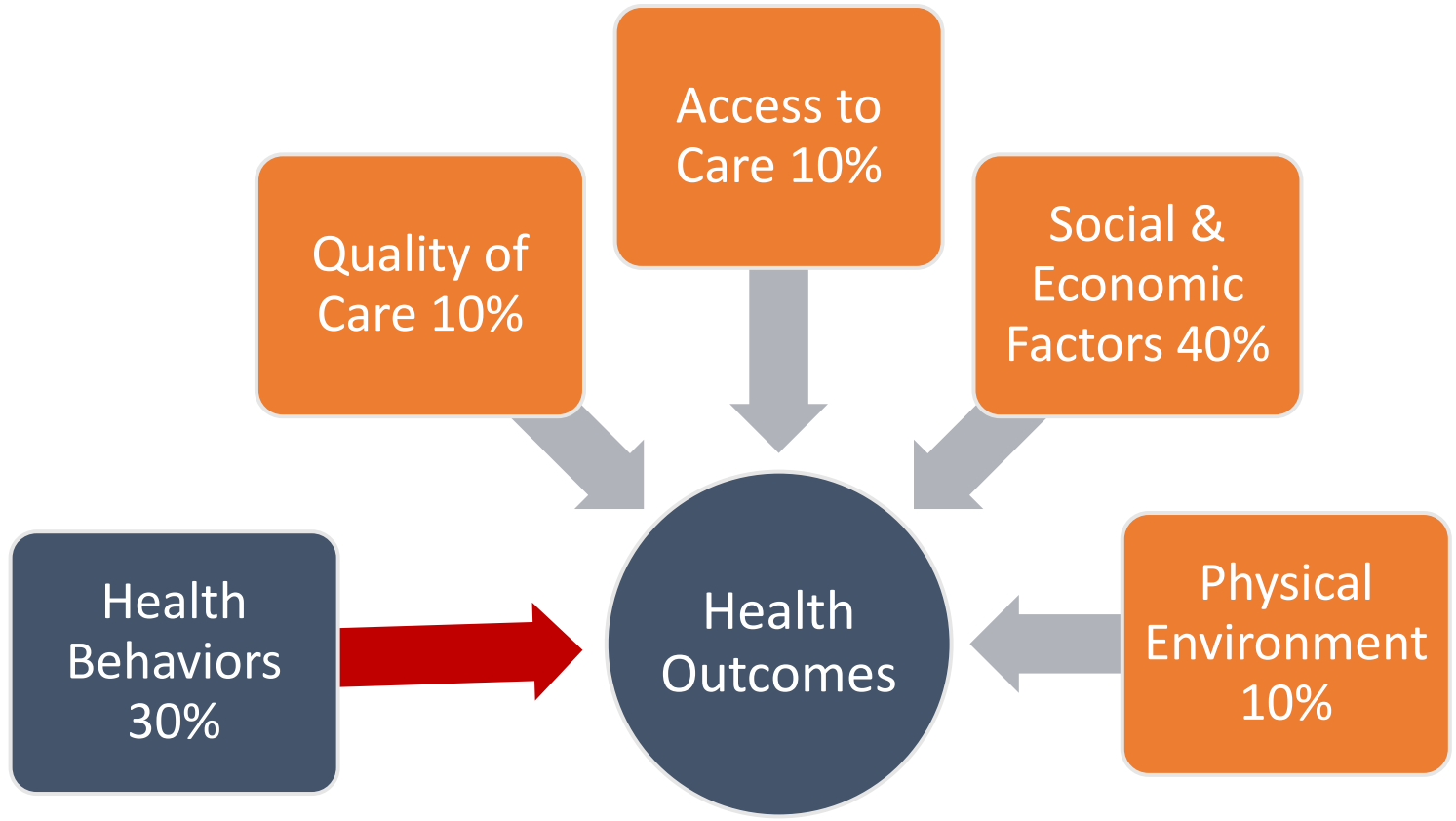
Determinants of Health



Traditional Addiction Discourse & Programming

Source: County Health Rankings Model, 2014

Tobacco & Behavioral Health:
What has caused the disparity?

The overall rate of cigarette smoking among adults has been falling decreasing, but individuals with mental health challenges have been neglected in prevention efforts, environmental and clinical interventions.

This disparity can be attributed in part to predatorial practices by tobacco companies which included:

- Targeted advertisements
- Providing free or cheap cigarettes to psychiatric clinics
- Blocking of smoke-free policies in behavioral health facilities
- Funding research that perpetuates the myth that cessation would be too stressful and negatively impact overall behavioral health outcomes

- **High rate of ACEs/Trauma**
- **Limited access to high quality care (delays in care, lower quality of care, and more)**

Source: Apollonio and Malone, 2005

Let's Talk About Why People Start Smoking

- Targeted and Predatorial Marketing
- High rate of ACEs/Trauma
  - High risk behaviors
- Limited access to high quality care
- Delays in care
- Lower quality of care
- *Anything else?*

Thinking About Intersectionality and Examining Community Disparities…

Race/Ethnicity

31.8% American Indians/Alaska Natives

16.6% White

Education Level

40.6% GED

4.5% Graduate degree

Poverty Status

25.3% Below poverty

14.3% At or above poverty

Health Insurance

28.4% Uninsured
25.3% Medicaid
11.8% Private

Disability/limitation

21.2% Yes

14.4% No

Sexual orientation

20.5% Lesbian/Gay/Bisexual

15.3% Heterosexual

Serious Psychological Distress

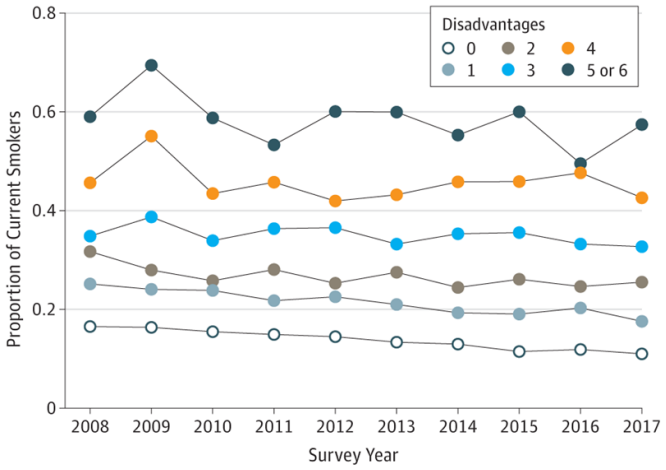
35.8% Yes

14.7% No

Source: Centers for Disease Control; Jamal et al 2016

Examining Risk:
Poverty, other disadvantages tied to higher smoking risk

Source: Association of Cumulative Socioeconomic and Health-Related Disadvantage With Disparities in Smoking Prevalence in the United States, 2008 to 2017 (Leventhal, Bello, Galstyan, et al.)



About 14 percent of individuals without any of these forms of adversity smoked

With each added disadvantage, smoking rates increased, rising to 58 percent among individuals with all six forms of adversity

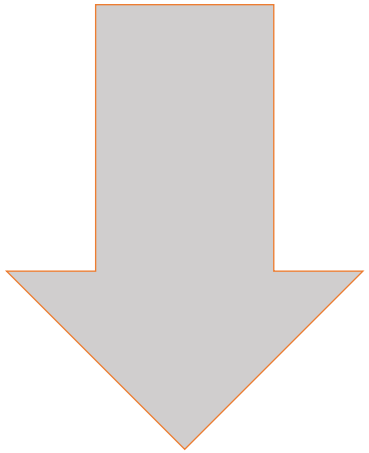
Unemployment/poverty

Low education

Disability

Serious psychological distress/heavy drinking

- *"Disadvantage is a common denominator in smoking in the U.S. today, and if you face more disadvantages, your liability to smoking increases.*
- *Disparities in smoking are explained by disadvantaged populations being more likely to start smoking and less likely to quit smoking."*



Source: Leventhal, 2019

Understanding Trauma: *taking a closer look*

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Child Trends, 2019.

Adversity, Trauma and Toxic Stress

- **Trauma** – possible outcome of exposure to adversity that occurs when a person perceives an event or set of circumstances as extremely frightening, harmful or threatening.
- **Toxic stress** – can occur when an individual experiences adversity that is extreme, long-lasting and severe without adequate support and the stress response system becomes overactivated.
- **Childhood adversity** – wide range of circumstances or events that pose a serious threat to a child's physical or psychological well-being.
- **Adverse childhood experiences** –a subset of childhood adversities included in the seminal ACEs study.

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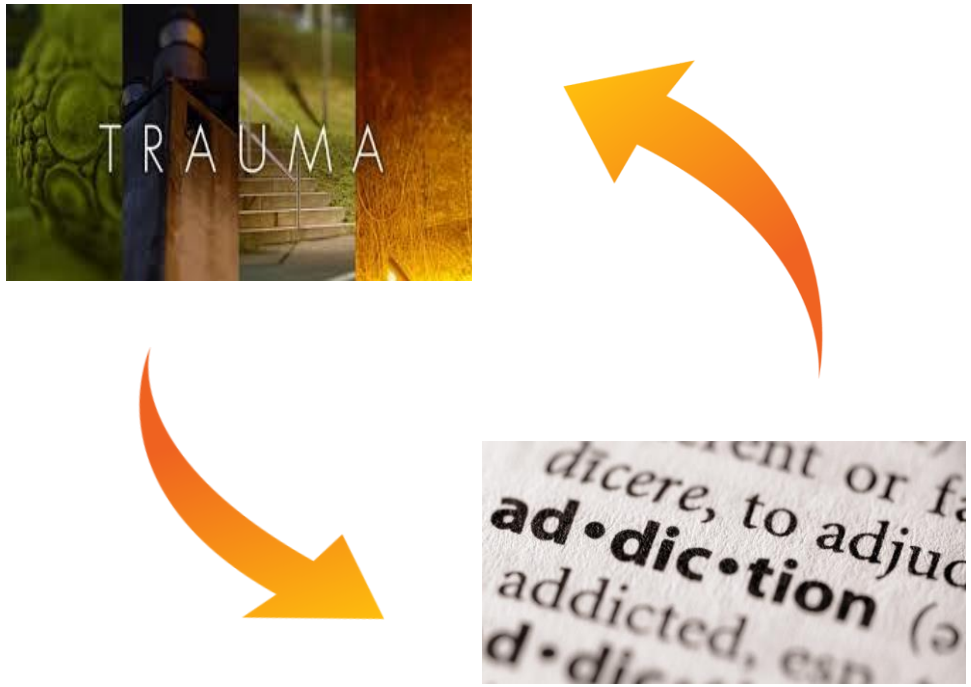
Key Elements of Trauma

1. Events
2. Experiences
3. Effects

Making Connections



- Sources estimate that 25 -75% of abuse and/or violent trauma survivors develop alcohol misuse issues
- Survivors of accidents, illness, or natural disasters have between 10 to 33% higher rates of addiction
- A diagnosis of PTSD increases the risk of developing alcohol misuse
- Male and female sexual abuse survivors experience a higher rate of addiction compared to those who have not survived such abuse

Source: *The Correlation Between Trauma and Substance Abuse*. (August 2021). The Recovery Village. https://www.palmerlakerecovery.com/blog/trauma-substance-abuse.

Trauma & Smoking in Behavioral Health Populations:

The connection

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PTSD and DSM-5 Diagnostic Criteria

- Exposure to actual or threatened death, serious injury or sexual violence
- Intrusion symptoms
- Persistent avoidance of stimuli associated with the trauma
- Negative alterations in cognitions and mood that are associated with the traumatic event
- Alterations in arousal and reactivity associated with the traumatic event
- Persistence of symptoms (B, C, D and E) for more than one month
- Significant symptom-related distress or functional impairment
- Not due to medication, substance or another medical condition

Source: Substance Abuse and Mental Health Services Administration, 2014

Post-Traumatic Stress Disorder (PTSD)

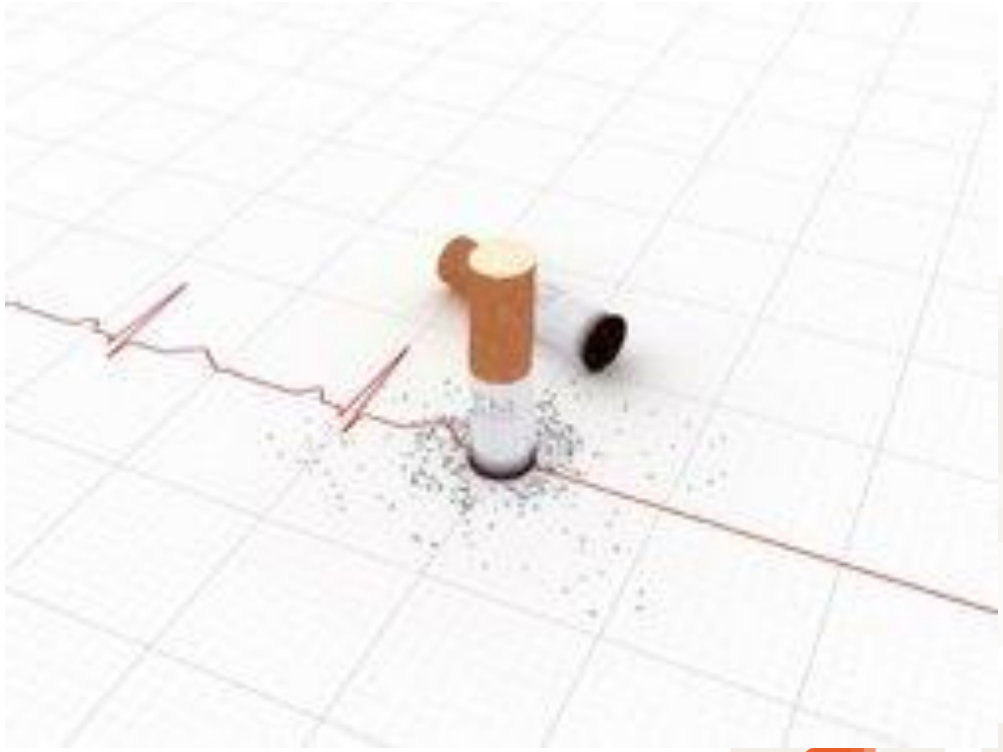
- Anyone can develop it after witnessing and/or experiencing a traumatic event
- Affects about **3.5%** of Americans at any given time (or about **11 million** people)
- About **1 in 11** people will be diagnosed with PTSD in their lifetime

Source: *What is Posttraumatic Stress Disorder(PTSD)?* (2020). American Psychiatric Association. https://www.psychiatry.org/patients-families/ptsd/what-is-ptsd

Health Risk Behaviors ➡ Long Term Health Consequences

Individuals with a history of severe trauma are **twice** as likely to develop a smoking dependence

- **45**% of adults with a PTSD diagnosis smoke
- **73%** of those smoke 1+ pack of cigarettes per day



Sources: Lasser et al, 2000; Buckley et al, 2004

The relationship between smoking and PTSD is bi-directional.

Smoking possesses three unique factors that make it a reinforcer for at-risk individuals. Due to this effect, **individuals with PTSD trying to quit may frequently relapse.**

1. Pleasure/positive affect
2. Anxiety reduction (Kassel & Unrod, 2000)
3. Distress termination (Kassel, Stroud & Paronis, 2003)

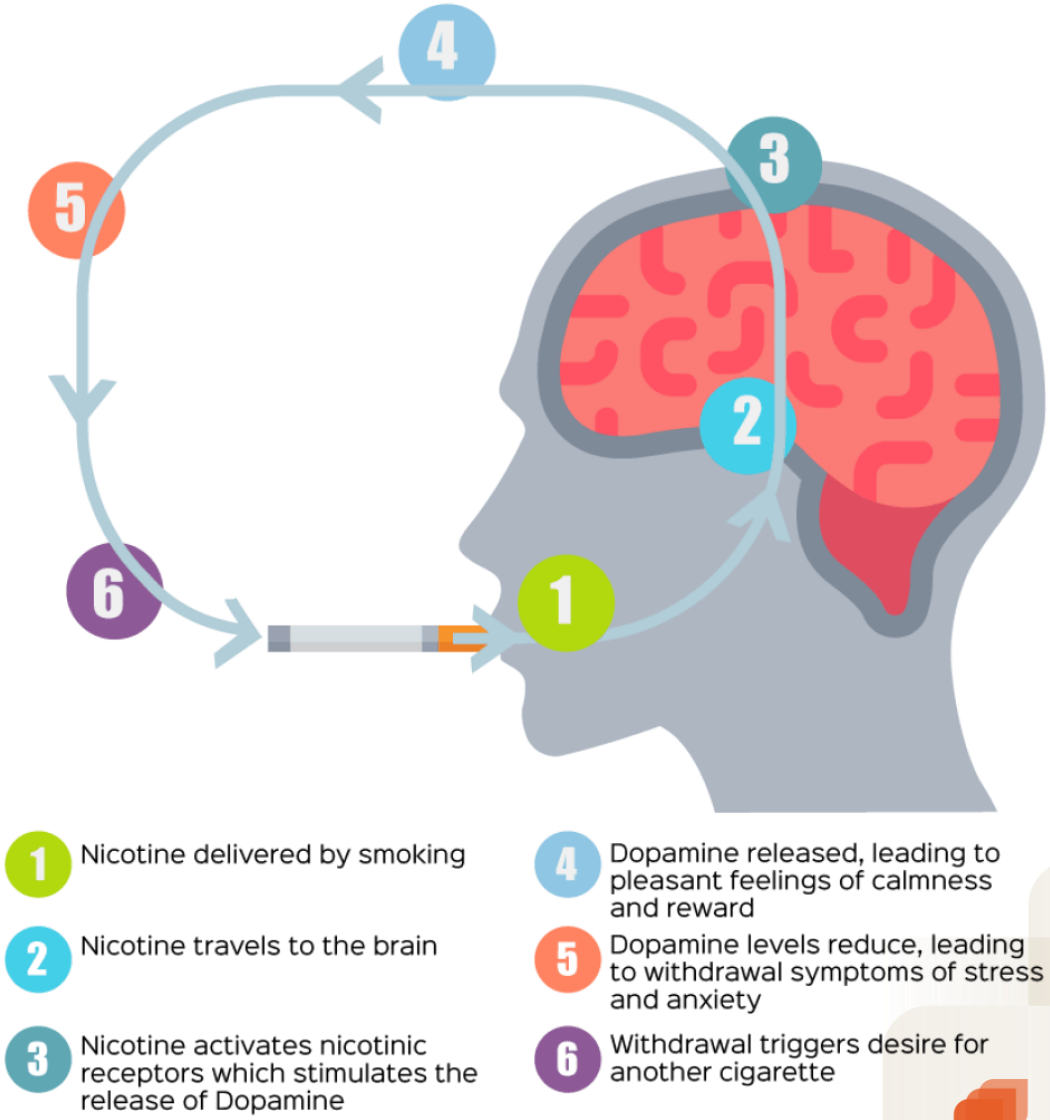


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Image Source: Action on Smoking and Health Wales Cymru

Symptomology

- People with a PTSD diagnosis who smoke are more likely to:
  - Experience exacerbated **symptoms of PTSD,** including depression and anxiety (Chou et al., 2018)
  - Have a higher trauma history, a negative affect**,** and a greater comorbid psychiatric history (Kearns et al., 2018)
  - Endure escalating **negative psychological symptoms**, such as emotional reactivity and startle responses (Chou et al., 2018)

Symptomology

- Reduction of **negative affect** is the most consistently identified smoking motive among individuals with PTSD (Kearns et al., 2018)
- Using tobacco can worsen physical symptoms of PTSD, including cardiovascular diseases and premature death (Dennis et al., 2014)

Figure 1. Theoretical model of emotion regulation related mechanisms in co-occurring nicotine addiction and PTSD.

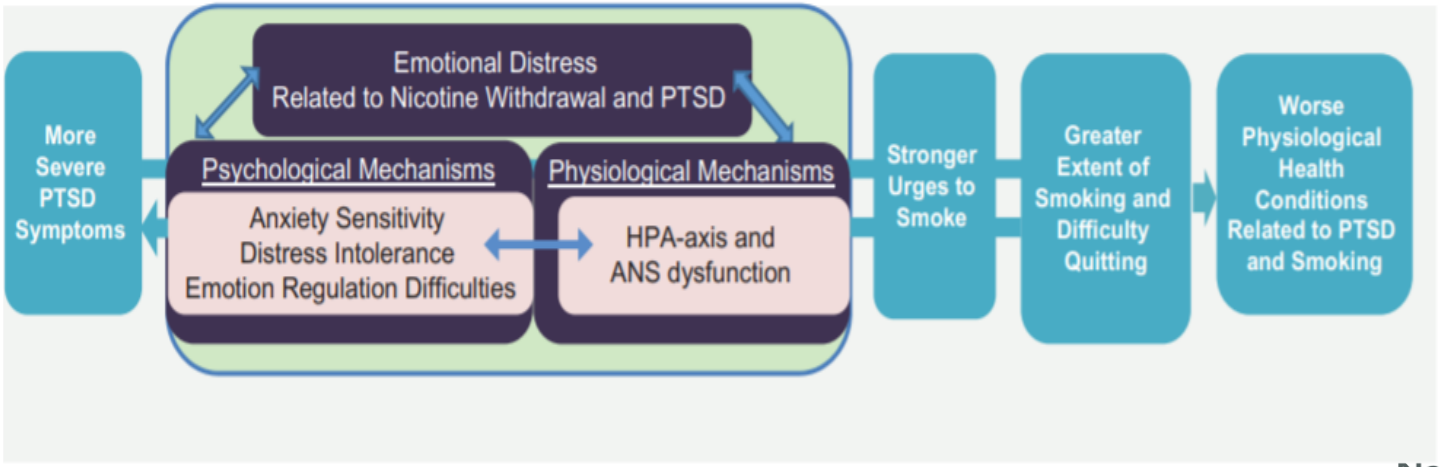


Image Source: Chou et al., 2018 (Full article: An emotion regulation-focused theoretical framework for co-occurring nicotine addiction and PTSD: Comments on existing treatments and future directions (tandfonline.com)

Special Populations

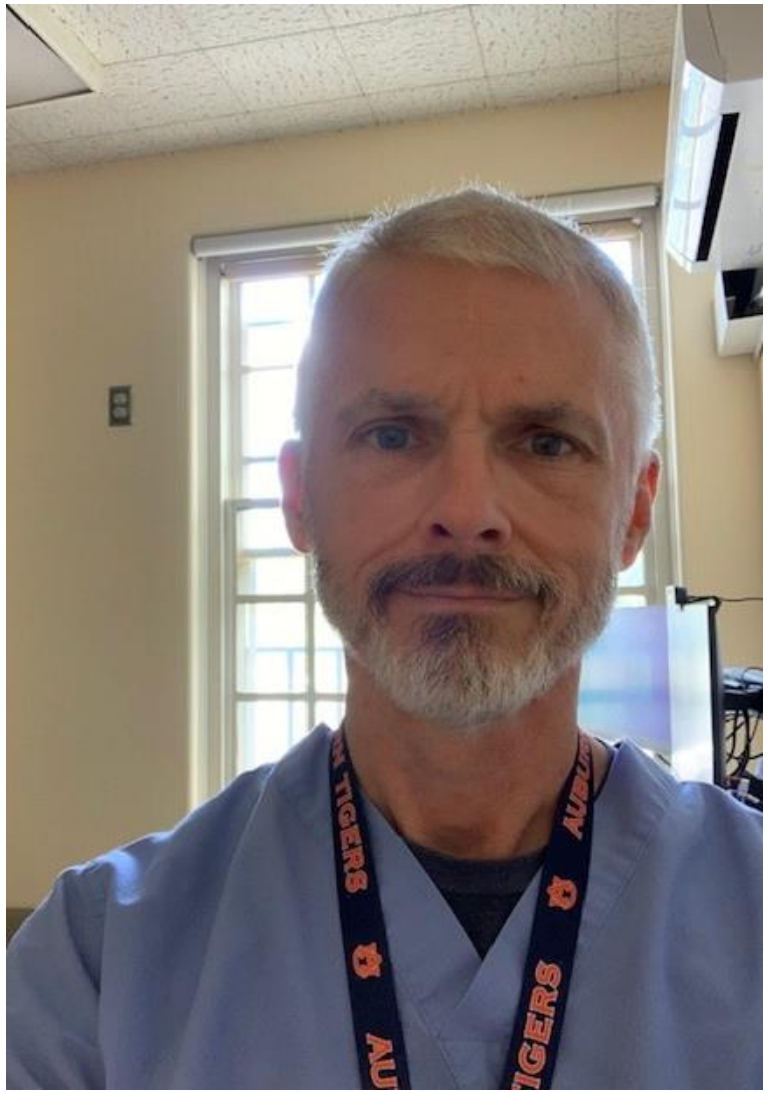
- Nearly **20 percent** of returning veterans from Iraq and Afghanistan (or 300,000 people) have symptoms of PTSD or major depression (Tanielian and Jaycox, 2008).
- Among a sample of military veterans, 47% of smokers screened positive for PTSD, compared to 33% of the nonsmokers in the sample
- 6 out of 10 veterans with PTSD smoke
- Females who have experienced traumatic event(s) are more likely to smoke if they become pregnant
  - Females who are pregnant and smoke have 10% higher rates of current and lifetime PTSD than females who quit smoking while pregnant (Kornfield et al., 2017)

Source: Substance Abuse in Veterans - PTSD: National Center for PTSD (va.gov)

Cessation in Special Populations

- Individuals with a PTSD diagnosis experience **less successful quit attempts** than people without mental health conditions (Kelly, Jensen, & Sofuoglu, 2015)
  - Treatment failure is often **directly related** to PTSD symptoms

- **Rates of smoking abstinence** for 30 days or more among people with a PTSD diagnosis are 50% lower than the rate among adults who use tobacco and do not have a psychiatric diagnosis (Kearns et al., 2018)



Douglas W. Lane, PhD, ABPP, CPsychol

- Dr Lane is geropsychologist in the Geriatrics and Extended Care Service of the VA Puget Sound Healthcare System. He is also a Clinical Professor in the Department of Psychiatry and Behavioral Sciences of the University of Washington School of Medicine and a Faculty Fellow in the School of Nursing of Pacific Lutheran University. He completed a PhD in Clinical Psychology through the University of Kansas, internship training in the United States Army Medical Department, and a fellowship in psychology through the Yale University School of Medicine. He has also completed post-graduate training in Health Professions Education through the University of Glasgow School of Medicine, Scotland. He is board-certified in Geropsychology and Clinical Psychology by the American Board of Professional Psychology (ABPP).

By the Numbers

- According to the CDC , older people have the highest percentage of people who smoke.
- About 18% of people between the ages of 45 and 64 smoke (the highest of all age groups).
- Around 9 % of people between 65 years old and older smoke.
- Approximately 70 % of all deaths related to smoking occur in people over 60 years old.
- In sum: millions of people across all ages smoke, but it is primarily older people who suffer the consequences.
- According to the VA, Veterans who have PTSD are more likely to smoke than those who do not. Co-morbidity rates are high.
- People with mental illnesses have a harder time quitting.
- Especially in the context of PTSD, reduced ability to tolerate stress can make quitting harder.

Sources: aginginplace.org/how-smoking-can-affect-the-elderly (22 JUL 22) Pericot-Valverdea, Elliott, Millerd, Tideyd, & Gaalemaa (2018) *Addict Behav.*

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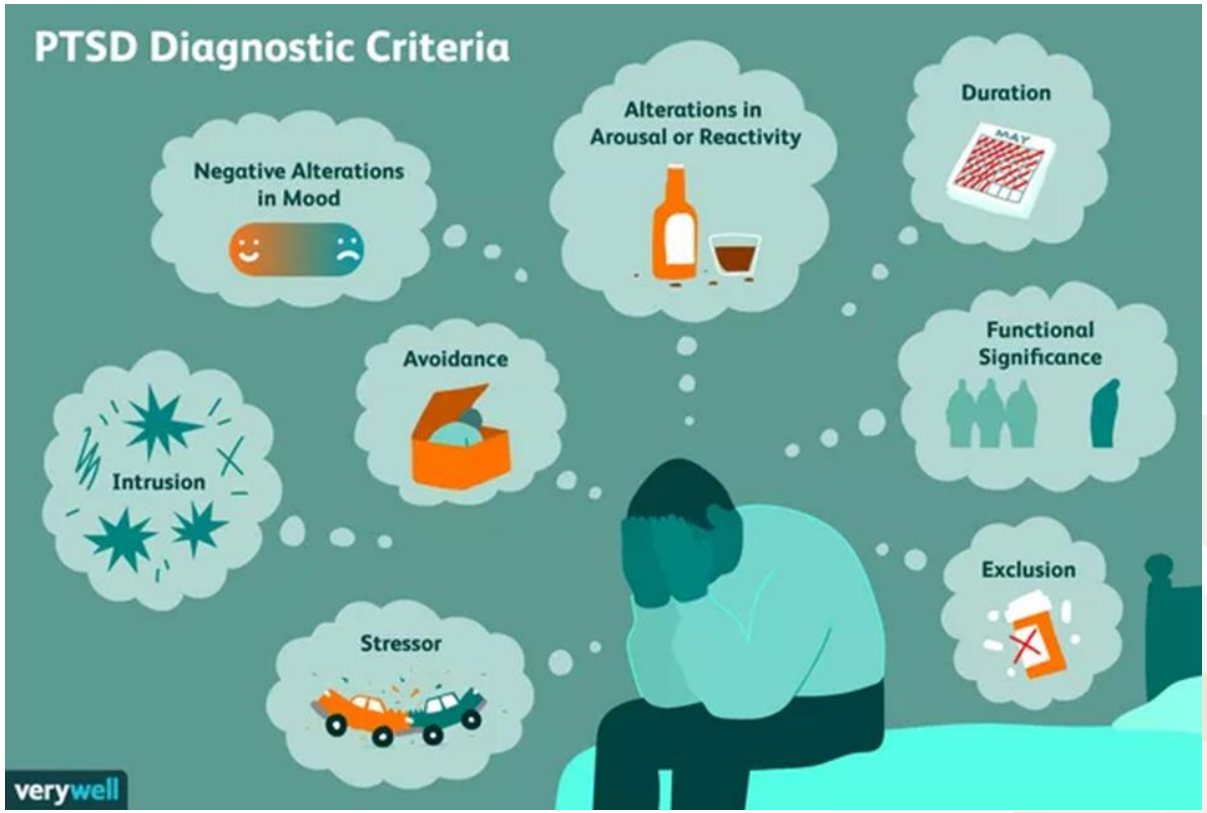
PTSD Symptom Categories

- Intrusive memories
- Avoidance
- Negative changes in thinking and mood
- Changes in physical and emotional reactions

Proposed Role of Smoking in PTSD

- Self Medication Hypothesis: Mitigate PTSD symptoms
  - Negative emotional states
  - Anxiety sensitivity
  - Reduced stress tolerance
  - Distraction from intrusive thoughts and memories
- Reciprocal Relationship: Attempts at mitigation of Symptoms -> Increase in Symptoms ->Further efforts to mitigate, and so on



Source: verywellmind.com (22 JUL 22) J.R.Bee

Source: Pericot-Valverdea, Elliott, Millerd, Tideyd, & Gaalemaa (2018) *Addict Behav.*

Challenges for Older Smokers

- Smoking can mean different things based on many factors of diversity. Age is just one. The intersectionality can be complex and can be missed without taking a patient-centered approach. It can be an important asset in cessation that is lost.
- May have been smoking 20, 30, 40 years or more before deciding to stop
- A belief that the damage is done, “What’s the point now?”
- Past failed efforts to stop
- Many other health issues to navigate
- New relationship with time
- Shame and stigma
- Nature of the “relationship” with the substance, which may be quite positive to the person
- Medical comorbidities such that medication intervention may be limited

Interventions

- Education about the role of nicotine/smoking in their overall health status and addressing myths

  -EX: Nicotine makes it even harder to sleep than chronic pain already does.

- Education about the role of smoking (like drinking, eating, etc.) in facilitating avoidance and/or paradoxically increasing or complicating PTSD symptoms
- General stress management/coping skills training (ACT, CBT)
- Acute self calming/soothing training
- Developing strong, healthy social support networks
- Harm Reduction

  -Vaping

  -Low nicotine cigarettes

  -Just the act of smoking has calming effects, independent of nicotine, and lower nicotine leads to reduced somatic carousal (breaks the cycle).

Source:Pericot-Valverdea, Elliott, Millerd, Tideyd, & Gaalemaa (2018) *Addict Behav.*Ha Bui (2020) *Subst Abuse & Misuse*

Clinical Tip #1

- Honor the person's history with smoking.
- If we take a disrespectful or youth-centric stance, we may defeat our own goal.
- Be aware that society's views have changed within the person's lifetime.
- The person may feel "double-crossed" by the medical field and larger society.
- Don't push: They have been doing this for a long time.

"I got through Korea with my M-1 rifle and a pack of Lucky Strikes."

"Back then, if you didn't smoke you were considered a sissy".

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Clinical Tip #2

In older age, we tend to become less focused on long term outcomes and more focused on immediate term outcomes. So, emphasize the benefits for chronic medical issues in the current term.

- Have the person think through ways day-to-day life could be better, based on individual interests and values, by quitting.

  -Be Concrete and Specific
  -Ex: More money available to do other things (especially on a fixed income).
  -Make a list
  -Share it with important others or even have them help create It

- Some benefits may be less obvious but just as important to highlight.

  Ex: Cough Less -> Reduced Jarring and Muscular Exertion -> Reduced Back Pain

- Older adulthood can bring an increased emphasis on relationships, so have important others share how their relationship with the person may benefit.

  Ex: "Dad, we can spend more time together because you are breathing better and have more energy."

  Ex: Setting a good Example for grandchildren, *"I love you enough to take care of myself and be with you as long as I can be."*

  Ex: Honor the health of those the person loves

Clinical Tip #3

Use the same materials, programs, and strategies as used for younger people.

But **. . .**

- Use a Slower Pace.
- Cover One Topic at A Time.
- Use Regular Breaks.
- Stop After Each Topic to Check Understanding.
- Use Concrete, Clear language.
- Use Written or Recorded Materials to Augment.
- Accommodate for Hearing, Visual, or Other Physical Limits.

  Ex: A person with COPD may not be able to use relaxation breathing as an alternate stress management strategy (vs. smoking).

Clinical Tip #4

- Relapses are an opportunity for learning. We are never “too old”.
- The person has many years of coping with challenges by this point in life. This experience can help inform cessation treatment.

  *This is especially important for those whose alternate coping options are limited by physical, environmental, or financial factors.
- If we don’t really believe the person can quit, then that can be detected by the person (“Stereotype Threat”; Ageism).

  * It is important to reflect on our own beliefs and stereotypes of aging, including our own aging.

Resources

- “SmokeFree60+” (mobile app); National Cancer Institute

  www.60plus.smokefree.gov
- National Institute on Aging: Quitting Smoking for Older Adults
- Quit Lines:
  - 877-448-7848 (National Cancer Institute)
  - 800-784-8669 (Smokefree.gov)
  - 855-784-8838 (VA Quit Line)

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Questions?

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