Health at any Age – Supporting Cessation in Late Life

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Objectives

Identify health effects associated with tobacco use in older adults

Recognize barriers specific to older adults’ willingness, readiness, and ability to quit

Understand empathic approaches that help providers break through those barriers
Future State/Statistics

• By the year 2030, 20% of Americans will be 65 years of age or older

• Expected 75% increase in number of Americans ages 65 and older requiring nursing home care, from 1.3 million in 2010 to 2.3 million in 2030

• Increase in racial and ethnic diversity
  • By 2060 the share of the older population that are Caucasian is projected to decrease from 78% to 54%
  • 1 in 5 people in the US will be > 65 years old
How Many Older Adults Smoke?

Nearly 9 of every 100 adults aged 65-years and older (8.8%)

Despite the lowered rate of smoking among older adults, the aging of the baby boomers will surely spike the total number of older adult smokers in need of cessation services in the years to come.
Effects of Smoking on Late Life Physical Functioning and Quality of Life
Taking a Toll: Do they Realize?

- Older adult smokers:
  - Often demonstrate a **lack of knowledge** regarding smoking related health risks
  - Tend to **minimize the negative impacts** of smoking on their health
  - Also **minimize potential health benefits** of cessation
The Link Between Health and Older Smokers

- Smoking related deaths have their most impact during the ages of 50-70.
  - Loss of an average of at least 10 years life expectancy
- Bone mass decreases in in the elderly smoker, both in men and women
  - Increasing the risk for fractures
- Changes in endocrine system
  - Increasing the risk for diabetes
Compromises Quality of Life

- **Physical Functioning**
  - Smoking is linked to a loss of function, mobility, independence, and fire-related fatalities in the elderly

- **Cognitive Functioning**
  - Smoking is linked to a higher risk of cognitive impairment and dementia
  - Study completed in China (Chen R, et al. *Occup Environ Med* 2013) - People exposed to SHS are 30% more likely to develop dementia

- **Sensory Functioning**
  - Hearing changes
  - Macular degeneration and cataracts
  - Decreased abilities to smell and taste
Medications and Smoking

- Psychiatric medications are widely affected by smoking
  - Antipsychotics
  - Antidepressants
  - Hypnotics
- Smoking may interact with Warfarin by increasing its clearance and reducing its effect.
  - INR should be closely monitored when there is a change in patients' smoking status.
- Other meds: hypertension, diabetes management
People who stop smoking between the ages of 65 and 74 can potentially add years to their lives.

- Men who quit smoking at age 65 have proven significant health benefits and gained 1.4 to 2.0 years of life.
- Women gained 2.7 to 3.7 years of life (Cataldo, 2007)
Barriers Specific to Older Adults’ Willingness, Readiness, and Ability to Quit
Barrier #1: Being Overlooked by Providers

- Elders are often not considered for smoking cessation strategies

- Health care professionals do not tend to target elderly patients who smoke

- Every Breath counts
Missed Opportunity: They Can Quit!

• Literature highlights that elderly populations are more likely to quit smoking than the younger population.

• **Commitment rates** for smoking cessation also show that the elderly are less likely to relapse compared to the younger population.
Barrier #2: Older People’s Own Self-Limiting Beliefs

• “The sky is falling!” - In a study by Young et al (2005) older people tend to adopt “fatalistic” health beliefs around smoking cessation.

• “I can’t do anything about that now. We all have to die of something.”

• They tend to have a “perceived locus of control” that is external; they feel that the control of their behavior and its consequences lies external to themselves.

• Believing that poor health is not associated with smoking behavior, but are due to genetic factors or luck.

• Loss
Myths and Excuses

- “It is too late, the damage is done” - Resignation
- “It’s my pleasure, I quit everything else” - Justification
- “How will I go to the bathroom without smoking” – Fear of Change
- “I’ve lived a long life, and smoking helps me to cope” - Reward
Barrier #3: Holding onto the Psychological Distress Being a “Smoker” has Caused

- **GUILT** – A negative response of one’s risky behavior
- **SHAME** – Embarrassment resulting from acknowledgement of risky behavior
- **BLAME** – Ruminative thoughts of diagnosis as self-inflicted
- **REGRET** – Majority of smokers regret starting to smoke as youth
Social-Cultural Contributors to Stigma: "Exiled" in the World of the "Healthy"

Study on Patients with COPD (Halding et al, 2011)

Participants felt blame emanating from a variety of sources

- **Burdened** by negative emotions influenced by recognition of smoking as a major contributor to COPD
- **Troubled** by encounters with health care professionals that focused on smoking
  - Evaluated providers as *non-empathetic*
- **Avoided** asking for help
- **Concealed** health problems and **withdrew**
Consequences of Stigma

- Delayed diagnosis
- Poor quality of life
- Poor patient-clinician communication
- Avoidance and conceal health problems
- Reduced treatment adherence
- Increased risk for depression
- Misreporting of current smoking status
Understand Empathic Approaches that Help Providers Break Through Those Barriers
Knowing the Older Person Mindset

- Self-concept that drives behavior
  - Erickson’s- 8th stage of development
    - “self-integrity” vs. “despair”
- Life experience that informs and emboldens change
- Independence Need
  - Must show respect for elderly people’s needs, choices and desire to manage their own lives
What Works?

The older adult needs to feel respected, supported and encouraged to break through their specific barriers to quitting.

Actively and energetically promoting cessation instead of berating and chastising smokers is challenging BUT KEY to getting the older adult to “buy into” quitting smoking.
Empathic Opportunities

• **Examples**
  - The patient displays *Emotion* about smoking
  - The patient verbalizes *Challenge* in their quitting efforts
  - The patient verbalizes *Progress* or positive steps toward quitting

• **Dos**
  - Provide rationale
  - Acknowledge
  - Establish safe and open environment
Increasing Self-Efficacy

• One must believe it to achieve it!

• Improving self-efficacy in older adults can serve to improve mental health by alleviating feelings of loneliness and sadness

• Self efficacy of older people can also be improved by positive experiences in achieving goals

• Ask about prior successes in life
Sense of Responsibility to live with Integrity in their Role as an Elder in their Family

Older adults may be more responsive to the health risks of their family members and loved ones. Education on the health risks of SHS exposure may be effective tool in treating older adults with a spouse, children, grandchildren.
Success

Success means different things to different people: does not necessarily mean that you got them to quit smoking completely, but that you were able to help them achieve their goals.
In Honor of: Paul Crain

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Questions & Discussion

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