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Mental health challenges of the older adults during the covid-19 pandemic

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Abstract

The Coronavirus disease 2019 (COVID-19) pandemic that began in early 2020 has challenged all aspects of human life. Older adults have been affected most adversely by this virus. The difficulties this group is facing are contributing to negative mental health outcomes. The present article explored some pertinent areas of research regarding older adults and COVID-19. These areas included age discrimination, social isolation, and death anxiety.

Keywords: COVID-19, Coronavirus, Elderly, Older Adults, Seniors, Isolation, Ageism, Age Discrimination, Social Distance.

Introduction

Public health emergencies are not new for humanity. COVID-19 is one in a long history of plagues and pandemics to strike the human race. The effect it has had on the modern world is what makes this pandemic unique from others. The older adults during this pandemic have had to endure not only the disease but many other problems. This cocktail of problems has had dire results for this population. Staton and Singg [1] reported in their recent article that in August 2021, among those who were reported to have died due to COVID-19 in the United States, the largest group (79.6% deaths) was older adults age 65 and older and this group made up only about one-eighth of the total number of COVID-19 cases.

On July 27, 2021, the Centers for Disease Control and Prevention (CDC) [2] issued new guidance that everyone in areas of substantial or high transmission wear a mask in public indoor places, even if they are fully vaccinated. This was due to the alarming rise in the COVID-19 case and hospitalization rates around the country due to the emergence of the Delta variant, which causes more infections and spreads faster than early forms of SARS-CoV-2, the virus that causes COVID-19. Even though the highest percentage of people who are fully vaccinated are 65 or older (82.3%) [3], the death rate in this group is also the highest. Many of these individuals die alone in the hospital due to the COVID-19 restrictions.

Research related to COVID-19 and older adults is growing, and most of this research is divided into three common topics: age discrimination, social isolation, and death anxiety. Age discrimination refers to discrimination based on a person's age, which was a widespread problem before the outbreak. In 2003, Dittmann [4] reported that 80% of older adults are experiencing age discrimination. According to Malik et al. [5], age discrimination is thriving and worsening during the pandemic. Social distancing left many older adults in a state of social isolation that caused or worsened mental health problems, such as depression and suicidality [6,7]. COVID-19 triggered death anxiety more in older adults than younger adults [8]. Death anxiety encompasses the terms fear of death, fear of dying, and end-of-life anxiety and in this article, it refers to the exacerbated fear of death due to the serious effects of the disease.

We examined the research findings of studies addressing the above three major issues facing older adults during the pandemic. However, these issues are not just pandemic related and we believe that the information presented here would be useful even after the pandemic ends. Age discrimination existed well before COVID-19, but a virus that disproportionally affects older adults brought these beliefs to the forefront of conversations. Elderly isolation has been a topic of research for years, but a pandemic that forced many to stay at home or be secluded in nursing homes worsened this issue. COVID-19 did not create a fear of dying in older adults but perhaps made it worse. Thus, to examine these issues concerning the pandemic, an integrated literature review was conducted using the online databases available through PsycINFO, PsycARTICLES, Academic Search Complete, and SAGE Journals Online as the main databases. Interlibrary loans were used to obtain articles that were unavailable digitally through the university database subscriptions.

Origin, Nature, and Epidemiology of Covid-19

Before discussing the complex problems caused by the virus, it is important to give a good empirically supported explanation of the virus itself. This is especially important because of the amount of false information released about COVID-19 since January 2020. According to CDC [9], this disease is caused by a virus called SARS-CoV-2. Most people with COVID-19 have mild symptoms and get better within a few weeks after getting ill, but some people can become severely ill and experience long-term post-COVID conditions. Older people and those who have certain underlying medical conditions are more likely to get severely ill. Post-COVID conditions can be a wide range of new, returning, or ongoing health problems lasting more than four weeks after first being infected with the virus. According to CDC [10], the variant of the SARS-CoV-2 virus that caused the first U.S. COVID-19 cases in January 2020 is no longer detected among the variants that are infecting people in the U.S. The new variants are expected to emerge and replace previous variants. In October 2020, a new Delta variant of COVID-19 was identified in India and in March 2021 in the U.S. Currently, it is the predominant variant with several sub-variants and is more than two times as contagious as the previous variants and with more severe symptoms for some [10].

About the origin of COVID-19, the most common theory was that COVID-19 mutated from an earlier strain of the virus in animals [11]. In this case, the bat was the animal that was believed to have transmitted the disease to humans. As of the writing of this article, there are several theories about the origin of the virus. On June 17, 2021, Chow [12] of NBC News reported that most of the theories fall under three possible scenarios: (1) the virus evolved naturally from an infected animal, (2) an employee at the lab became infected from a sample and "leaked" it into the community, (3) and lab scientists were manipulating the virus samples and accidentally or intentionally released it [12]. On May 26, 2021, U.S. President Joe Biden ordered the intelligence agencies to review the information that could explain how exactly the virus originated. To everyone's disappointment, the U.S. intelligence agencies failed to reach any definitive conclusion about whether the coronavirus originated from an infected bat and the virus somehow leaked from the lab. Office of the Director of National Intelligence released the summary of the report on August 27, 2021, which stated that the intelligence community ". . . remains divided on the most likely origin of COVID-19. All agencies assess that two hypotheses are plausible: natural exposure to an infected animal and a laboratory-associated incident" [13]. President Biden's response to the report was "We all must better understand how COVID-19 came to be to prevent further pandemics." He criticized China for not cooperating and sharing "critical information" about the virus and its origin. The report further stated, "China's cooperation most likely would be needed to reach a conclusive assessment of the origins of COVID-19" [13].

COVID-19 is a respiratory disease, which travels through droplets in an infected individual's cough or sneeze, and when the person exhales, talks, or sings too close to another person. Researchers for the CDC have realized these droplets can travel farther than 6 feet. As is true about many airborne viruses, this virus most commonly spreads among people who are in close contact with one another. They also found that community spread is a significant problem, which is the primary reason that masks have been highly suggested. The CDC [14] suggests some risk factors that contribute to the severity of the illness or complications after COVID-19 infection. The risk factors include age and some medical conditions such as cancer, kidney disease, diabetes, down syndrome, heart disease, and obesity among others. The full list and other information are updated on the CDC website regularly [14].

COVID-19 affects different people differently. Some experience deadly symptoms while others experience little to no symptoms [15]. Also, one of the most difficult aspects of this disease is that some people can be asymptomatic, where they experience no symptoms with no indication they are infected with the virus. Researchers are still unsure as to what determines if a person is asymptomatic [16]. However, most symptomatic cases of coronavirus are of mild-to-moderate severity with the following symptoms; low-grade fever, cough, fatigue, and loss of taste and smell, among others. The disease feels more like a cold. The severe symptoms of COVID-19 include mild and moderate symptoms, as well as shortness of breath, chest discomfort, confusion, trouble staying awake, eye problems, and a blueish face/lips, etc. However, trouble breathing and significant shortness of breath are considered serious symptoms needing medical emergency attention. COVID-19's attack on the respiratory system in some people is extremely deadly leaving lasting damage to those that survive the disease [17]. With the emergence of the muted new Delta strain of this virus, things have become even more serious.

Mueller et al. [18] investigated why age matters while facing COVID-19 and reported that one major reason is that older people are more likely to have many of the risk factors associated with severe symptoms of this disease. Also, as humans age, their cells naturally change in ways that encourage diseases and disorders that younger people rarely see. Thus, these changes primarily come over time [18]. Some are of the opinion that one other major factor contributing to the different mortality rates between the older and other age groups is the medical field's inherent bias, prioritizing the younger patients over the older ones [19].

Age Discrimination

Age discrimination can be a foreign topic to some, and confusing to others. The literature on age discrimination primarily uses four terms to describe roughly the same phenomenon: age discrimination, ageism, age bias, and age stereotyping. In the present article, we will use the term age discrimination. The oldest definition goes back to 1969 with Butler, who introduced the term "ageism" to encourage social reform on what was becoming a growing issue in healthcare at the time [20]. He defined the term as "systematic stereotyping or discrimination against people because they are old" (p. 12). Over the years, more definitions developed. For example, Stone and McMinn [21] referred to age discrimination as "bias against older people by the (temporarily) young." Another definition calls it simply "age discrimination," which implies discrimination based upon a person's age, either young or old [22]. However, the definition being used in this article comes from the 2009 article by Iversen et al. [23] who after exploring multiple definitions of age discrimination defined the term as "negative or positive stereotypes, prejudice and/or discrimination against (or to the benefit of) aging people because

of their chronological age" (p. 4). It should also be noted that some researchers disagree with the simplicity of the definition being used here [24-26]. These researchers would prefer to distinguish between normal, nonharmful discrimination and harmful, unjust discrimination.

Sadly, age discrimination is common, a widespread problem before the outbreak of COVID-19, with 80% of older adults experiencing one or more forms of age discrimination [22]. A meta-analysis of multiple cross-cultural studies confirmed the negative consequences of old age stereotypes and older adults being seen as less cognitively and physically competent than younger adults [27]. The researchers mentioned that these stereotypes were more prevalent in the developed nations with less collectivist cultures. According to Malik et al. [5], age discrimination is not only still in existence, but it is worsening during the pandemic. He found that social media is the biggest provider of anti-elderly sentiments and that one-fourth of a sample of 18,128 tweets consisted of harmful language with derogatory terms or wishes for death directed towards older people. Earlier studies before the pandemic had less anti-elderly language. Malik et al. concluded that the increase can be attributed to COVID-19 and how it affects young and old people differently. Also, new hashtags like "OK, Boomer" and "Boomer Remover" that contain significant anti-elder language have seen increased usage during the pandemic [28]. Research also found some areas where age discrimination is not as common as expected. When surveying the practicing doctors to find instances of preferring young over old patients or holding ageist beliefs, Wilson et al. [29] found it difficult to determine the frequency of age discrimination. They found no significant difference between doctors and the general populous on a test of age discrimination in the workplace. However, the researchers concluded that age discrimination among doctors came from their work environments and upbringings instead of their medical education.

Research shows many negative effects of age discrimination on older adults including higher anxiety and health worries [30]. Age discrimination is also negatively associated with loss of feelings of "mattering," a term used to determine life worth, which affects loneliness and physical health [31]. Ayalon [32] determined that the anti-elder language is contributing to intergenerational tension. Intergenerational tension results in increased physical and emotional attacks on the elderly. The reason there is more violence against older adults than younger adults is because of the inherent differences in the two groups' development and different levels of stress experienced by the two age groups during the pandemic. When looking through training material in the nursing field, Stone and McMinn [33] found an extensive amount of anti-elder language. Monahan et al. [34] have done work compiling evidence of both "positive" and "negative" age discrimination during the pandemic and the effects both have had on older adults. They found that "negative" age discrimination had harmful impacts on the older population and perpetuated negative stereotypes, increased social isolation, and loss of economic stability. An example given of "positive" age discrimination was the creation of elder-only shopping times along with other privileges created during COVID-19. However, the "positive" age discrimination resulted in the same negative psychological impacts as the "negative" age discrimination for older people. Older adults have suffered the most from social distancing requirements leading to the highest rate of family violence, domestic violence, and social isolation [6].

While researchers look into many different aspects of age discrimination, most of these studies have reached similar conclusions. Stone and McMinn [21] suggest that those working with older adults should make sure they do not use any anti-elderly language. Ayalon [32] pointed out another issue, referring to the older adults as one large homogenous group when discussing them. Malik et al. [5] recognized that the problem of abuse of older adults and age discrimination is difficult to combat, but psychoeducation targeting common elder stereotyping and intergenerational contact was important. They also suggested increasing funding to Adult Protective Services (APS) as the agency is under-funded. Meisner [28] also highlights the importance of advocacy and increasing awareness of this problem, while Monahan et al. [34] push for policy changes in older adults' health care, education, and employment to curb age discrimination quickly. Another conclusion made by researchers is that it is important to factor in geography and multiculturalism when discussing age discrimination since culture plays a large role in some people's opinions of older adults [27]. Also, it is suggested that counseling interventions should be used with self-worth and mattering, two issues resulting due to age discrimination of older adults [31].

Social Isolation of the Older Adults

Social isolation is one of the major challenges for older adults during the pandemic, which appears to be widely known but not understood well. The major issue researchers came across while defining the term was to explain the difference between social isolation and loneliness. Social isolation, as described by some is the act of being separated from social contacts, either physically or mentally, while loneliness is the subjective feeling of being socially isolated [6]. Another way to describe loneliness is the discrepancy between desired and perceived social relationships [35]. Social isolation might involve being forced to stay in a house without going outside and loneliness would involve the effect of staying in that house on a person's mental health. While most research on this topic discusses how COVID-19 forced social isolation on older adults, the researchers are often studying and collecting data on loneliness, the outcome of social isolation.

The research shows that loneliness and social isolation for older adults was an enormous problem even before COVID-19. One study by Cudjoe et al. [36] in 2011 found 24% of individuals 65 years or older were socially isolated, with the socially isolated group consistently being lonelier than those not socially isolated. Another study in 2012 using a similar methodology as did Cudjoe et al. found 43% of people over the age of 60 experienced loneliness at least sometimes [37]. Recently, in 2018, a nationwide survey of people over the age of 45 reported 35% feeling lonely [38]. Although the rates of loneliness and social isolation among older adults were high before COVID-19, they have increased during the pandemic. Tyrrell and Williams [6] state that COVID-19 caused a "pervasive impact of increased loneliness and social isolation" (p. 215). They support this conclusion by pointing to how older individuals are separated from family members, friends, caregivers, and other social resources while being under quarantine. Older adults belonging to other vulnerable groups such

as veterans are even more at risk of experiencing social isolation and loneliness [39].

Shuja et al. [40] found that stay-at-home orders have caused older adults not to leave their homes and often not be able to contact the outside world. It is more difficult for this population to have access to the technology necessary for virtual contact. Shuja et al. claim that since there is a rapid increase in social isolation due to COVID-19, there is a rapid increase in loneliness among older adults. However, Palgi et al. [35] found that social distancing does not affect every older person in the same way. Some can be resilient to the feeling of loneliness that social distancing can bring. These researchers reported that while the number of people qualifying as socially isolated increased, the rate of people claiming loneliness did not increase as dramatically. In their sample, 634 of the 1059 participants were socially isolated after being quarantined due to contracting COVID-19, but comparing the loneliness of the socially isolated sample from the non-social isolated sample revealed no significant differences in the two groups. However, they did report that being socially isolated increased the likelihood of having severe psychiatric problems associated with social isolation.

Several psychiatric symptoms have been associated with social isolation and loneliness in the older population. According to Tyrrell and Williams [6], "salient risk factor for loneliness is age," due to losing friends and family as time goes on (p. 214] and loneliness is also a risk factor for depression, anxiety, suicide, cardiovascular disease, and cancer, among other things. Many of these risk factors increase an older person's susceptibility to COVID-19 [7]. One doctor working with older patients in long-term care stated, "these people are like prisoners in the one-room homes, isolated from each other and the outside world" [41, p.949].

Besides loneliness, social isolation has other side effects. The primary problem that arises from being forced to stay indoors is a lack of exercise. Roschel et al. [43] focused on how social distancing measures can lead to a dramatic loss of physical activity for older adults since they do not leave their houses as often. This physical inactivity is a cause of the deaths of millions of people each year, especially those 65 years or older, because of fragility, sarcopenia, or other chronic diseases.

The consensus of the research is that social isolation, through various risk factors, leads to higher mortality rates in multiple samples [6]. Several suggestions to combat social isolation and loneliness are presented. Jawaid [7] suggested elders could be put on a call list manned by volunteers who would talk to them to help maintain a semblance of a connection with others. This idea was tested by van Dyck et al. [43], who set up a call list and as a result, reported less loneliness experienced by older adults in the program. Roschel et al. [42] suggested that policymakers and medical personnel should prescribe resistance exercises as "medicine" to their older clients. Other researchers encouraged safe social interactions with proper safety measures in place, like masks and social distancing to safely get older adults out of their houses [35]. However, the most common suggestion was to use video conferencing as teletherapy and virtual communication to help older adults maintain social contact during COVID-19 by allowing them to communicate with their counselors and loved ones [39]. Eghtesadi [41] suggested the same, but also added the importance of providing tech support for older adults that have difficulty using certain technology. Eghtesadi also suggested that nursing homes and other long-term care facilities need more funding to pay for facility improvements to help curb social isolation, such as increased access to technology and expanded facilities.

Death Anxiety

Death anxiety can be a dark or difficult topic to approach for some. Feifel [44] was the first to use the term death anxiety, defining the phenomenon as "when a person views death as the end and not the beginning of a new life" (p. 130). Since then, death anxiety has been heavily researched and has multiple conceptualizations, for example, persistent and abnormal fear of dying [44], intense fear and distress about personal mortality [45], and fear of death due to uncontrollable health worries [46]. Ishikawa's [19] definition is used in the present article as a fear response to the awareness of real or perceived impending death.

Death anxiety among older individuals is of great concern. Worcester [47] makes an important point that even if the pandemic was not happening, some older persons would still experience death anxiety because they wrestle with their mortality for reasons unrelated to COVID-19, but the pandemic and many restrictions imposed have only made things worse. An experiment by Ferreira et al. [48] involving 904 quarantined individuals compared the quarantined population to the general population in Portugal. The study found that those in quarantine had higher anxiety and loneliness, and health-related quality of life problems than the general population. Those over 65 had the highest anxiety levels out of all age groups in the study. According to Ring et al. [46], since older adults are at a higher risk of having a significant adverse effect when infected with COVID-19, they also tend to be the ones with the highest level of death anxiety. Rababa et al. [45] added another dimension to this phenomenon by saying that COVID-19 has forced many older individuals to face their mortality before they were ready.

Experiencing death anxiety has many adverse effects on a person's well-being [45]. Ring et al. [46] discussed this theoretically using Terror Management Theory (TMT). They state that humans can avoid confronting their mortality by developing unconscious protective mechanisms. An example of such a mechanism is remembering how far away death is when a person is young. Because of these mechanisms, theoretically, a person cannot directly confront their mortality, which is good because if any person would be completely subjected directly to their mortality, they might experience intense distress. Ring et al. further explain that as people age, their protective mechanisms begin to fail, leading to higher levels of death anxiety. Death anxiety is associated with decreases in physical functions, psychological stress, weakening religious beliefs, life dissatisfaction, and poor resilience [45]. Excessive death anxiety harms people's psychological well-being and personal self-image [50]. Death anxiety is also found to be associated with higher rates of suicide in all age groups [19] because suicide acts as a means to ending extreme fear or regaining control. Death anxiety is worsened during the pandemic because

of the fears of not being given a proper funeral or dying alone in a hospital [47].

Several suggestions are offered to deal with the rising problem of death anxiety during the pandemic. Medical personnel should recognize this potential hazard and work with mental health professionals to combat the problem, especially in older people [48]. Rababa et al. [45] state that if the option is available, the involvement of the older adults in a religious institution and increasing belief in their religious teachings are negatively associated with death anxiety because lower levels of death anxiety are found among those with religious involvement. They further recommend helping the older adults access online or through radio religious congregations to help promote their faith. Ishikawa [19] has made suggestions specifically for mental health professionals to use crisis response training to prevent suicide. She recommends offering telehealth options during the pandemic to make it easier and safer for older clients to attend therapy. She suggests therapy to encourage connectedness with friends, family, religious organizations, and community organizations. She also advises encouraging activities such as mindfulness exercises, physical exercise, routine writing, and self-care planning to increase the sense of personal control for those who feel they have lost control over their life. Finally, she emphasizes the importance of risk assessment as she states that suicide, elder abuse, isolation, self-care deficits, and substance abuse should be assessed as the risk factors for older clients [19].

Therapeutic Intervention

We are still dealing with COVID-19 even after almost two years since it first entered the United States. It appears that this virus is not going away any time soon [51] and neither are the issues faced by the older adults. Taking what we know about the major issues faced by older adults during the pandemic and combining it for the goal of practical clinical application would be helpful for therapists and clients. Because there was no comprehensive therapeutic intervention plan for older adults that dealt with their special issues during the pandemic, Staton and Singg [1] developed a science-based treatment protocol for the older adults needed during the COVID-19 pandemic. They conducted an integrated review of existing counseling techniques for older adults and created a generic and detailed treatment protocol that would also be suitable for any future pandemics or similar situations. This generic protocol focuses on what needs to be kept in mind about this segment of the population that will lead to the best outcomes for the older clients.

Conclusion

It is clear that the problems that older adults experience have been made worse by COVID-19. Age discrimination has expanded as the public sees COVID-19 as a virus that mainly kills older adults complicating further the lives of older adults. Little to no social interaction due to self-imposed isolation out of fear or forced social isolation by authorities and hospitals has led to the deterioration of the mental health of older adults. The death of family members and friends, as well as the fear of their death, has led to a rise in death anxiety in this segment of the population further harming their health and well-being.

Research about the mental health challenges of older adults during the pandemic is a topic with a large assortment of information. There are numerous articles about older adults and their mental health going back decades. When COVID-19 started spreading, a relatively large volume of literature resulted quickly about the effects of this disease on older adults, making it a “hot topic”. While this is good in the short term, the research needs to continue even after COVID-19 is under control because of the unique problems of the older adults that need to be addressed by therapists, government, communities, and society as a whole.

In sum, it is important to remember that much of the present article is focused on the challenges during the COVID-19 pandemic. Older adults experience age discrimination, social isolation, death anxiety, depression, and abuse even when a global pandemic is not raging. This population should not be forgotten when COVID-19 is finally defeated.

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