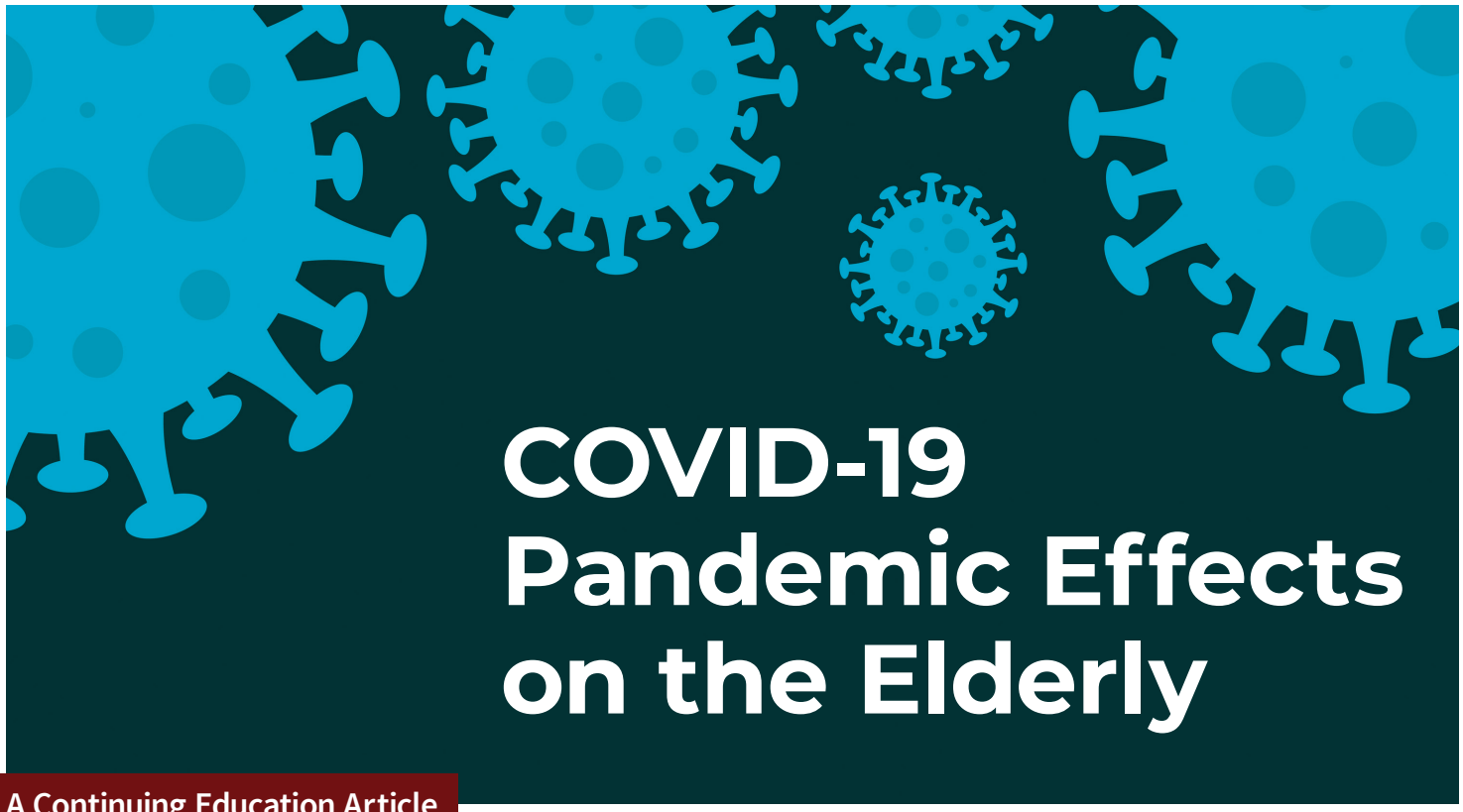

COVID-19 Pandemic Effects on the Elderly

A Continuing Education Article

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Take the continuing education quiz on page 55.

The coronavirus disease 2019 (COVID-19) pandemic has altered the lives of most individuals by changing the way in which each of us lives and the way in which 500,000+ individuals (as of this writing) in the USA has died[1]. Older adults have been disproportionately affected by the COVID-19 pandemic in a number of ways. One of the unexpected and unintentional consequences of the COVID-19 pandemic has been a rise in ageism as the virus has been identified as a geriatric health emergency with older adults being misrepresented and undervalued[1]. In addition, the virus has had deadly physical consequences and devastating mental health consequences, in part because of the necessary mitigation strategies implemented to reduce disease transmission. Regarding the psychological impact of the COVID-19 pandemic, the quarantine and social/physical distancing interventions have exacerbated the social isolation/loneliness public health crisis which already existed. Older adults are especially vulnerable as many are dependent on family members or community services for support which of course has been curtailed[2].

Berkman, et al.,[3] reasoned that social dynamics, notably social crises, exert detrimental impacts on health and well-being when the opportunity to remain connected is constrained. Specifically, living conditions and the social environment are considered social determinants of health which interact with risk behaviors or factors that impact social integration and the richness of relationships. The

repercussions of the "behavioral epidemic" of social isolation and loneliness include increases in depressive symptomotology, declines in self rated health, reductions in physical activity levels, and worsening cognition[2]. For older adults already at risk for loneliness (e.g. the subjective feeling of being alone) or social isolation (reductions in the amount and social interactions) the COVID-19 pandemic has been devastating[2,4]. The impacts of social isolation and loneliness may be amplified for already vulnerable older adults, such as persons with untreated hearing loss[2].

Until recently, scientists outside the realm of hearing healthcare rarely acknowledged that untreated hearing loss and the associated communication breakdowns actually do compromise the ability to participate and engage fully in society. When older adults with untreated hearing loss find that the quality of their interactions do not meet expectations they lose the motivation to participate and they tend to withdraw. This isolation often triggers a downward spiral which includes feelings of loneliness which may contribute to development of depressive symptoms[5,6]. It is notable that in their recent editorial on the fact that loneliness is an unaddressed health problem, Berg-Weger & Morely underscored the importance of managing loneliness and the sensory deficits that contribute to the onset. They suggested that both medical and social interventions are necessary and that "persons with decreased hearing, including those who hear poorly in noisy groups, need to be evaluated for hearing amplifiers or hearing aids," and that "persons with visual disturbances need to be provided with appropriate vision aids," and that "persons with dual sensory impairment are at particular risk for loneliness."[4]

A CALL TO ACTION

As we transition into the post-COVID-19 world, hearing care professionals should view the epidemic of social isolation and loneliness as an opportunity. We should begin to review our protocols, better tailor our interventions to meet the individual needs of each of our patients, and develop strategies and approaches to address loneliness and social isolation among the older adults we see clinically. There is much we can learn from evidence existing prior to the COVID-19 pandemic in terms of assessment, evidence-based interventions, and the impacts of ageism and stigma. The three pillars of hearing health (patient journey, and diagnosis of hearing difficulties, management, and rehabilitation), outlined by Tye-Murray[7], suggest that we must begin with a complete understanding of our patient's journey and perceived impacts of communication breakdowns associated with hearing loss. Assessing clinical concerns relating to well-being, such as the feelings of loneliness our patients may express despite the presence of multiple social contacts, is an important first step[4]. While a recent report by Bennett, Meyer, Ryan & Eikelboom[8] revealed that hearing healthcare professionals feel ill-prepared to appropriately detect and refer patients for emotional symptoms and psychological concerns they raise during the clinical encounter, we should view the post-pandemic period as our chance to adopt the necessary steps to assist our already vulnerable patients.

Continued on page 16

Continued from page 15

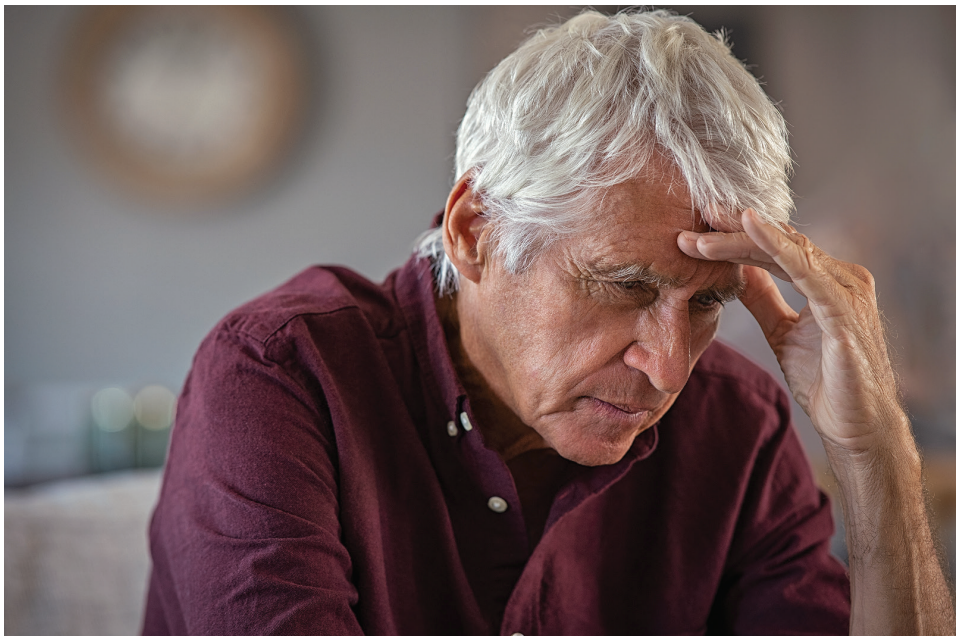
The results of a recent report by HLAA and Cochlear Limited,[9] highlight the importance of including questions on loneliness and social isolation when evaluating the needs of older adults. Remarkably, 87% of hearing health care providers responding to a survey of the impacts of face masking on communication reported that they have noted increased signs of loneliness or isolation in their patients since the pandemic began. Because hearing loss appears to be a modifiable risk factor for protecting against selected negative health outcomes, hearing health care professionals should ensure that our interventions address the emotional, physical, and social impacts of hearing difficulties on a person's life[6,10].

In fact, a recent report by the National Academy of Sciences, Engineering, and Medicine (NASEM)[11] on social isolation and loneliness challenged healthcare providers to become aware of and address the conditions contributing to the experience of isolation and loneliness among older adults[11,12]. The report specifically stated that untreated hearing loss, as quantified by both self-report or when objectively measured, is associated with reductions in social participation and higher rates of loneliness. In the NASEM report, the scientists suggested that practitioners should make appropriate referrals to a hearing health specialist if hearing loss is suspected as a contributor to the experience of isolation and loneliness. A relevant recommendation from the report is as follows:

"Healthcare providers and practices should periodically perform an assessment using one or more validated tools to identify older adults experiencing social isolation and loneliness and to initiate potential preventive interventions after having identified individuals at elevated risk due to life events (e.g., loss of someone significant, geographic move, relevant health conditions)."

The work of Laird and colleagues[10] underscores the importance of addressing and quantifying the social and emotional concerns raised by our patients as our efforts could serve to optimize outcomes. In fact, the comments of participants in a qualitative study conducted by Laird and colleagues are prescient. At least one respondent remarked that besides gaining a hearing device (i.e., hearing aid or cochlear implant), they gained increased social interaction, social inclusion, and confidence[10]. The ALONE screening questionnaire shown in Table 1 is a simple and easily administered questionnaire which can be used to assess an individual's perception of being lonely. Alternatively, the six item DeJong Gierveld Loneliness Scale[13] as shown in Table 2 is a reliable, valid, and widely used index of social well-being. The latter measure has been used as an outcome measure in documenting the benefits of intervention with hearing aids and cochlear implants[14]. It is well accepted that hearing aids are the treatment of choice for persons with hearing loss, the goal being to increase audibility of sound, reduce the effort necessary to understand communication partners, and in so optimize speech understanding, especially in noisy environments. There is considerable variability in the extent to which hearing aids achieve the aforementioned outcomes. Hence,

TABLE 1. The ALONE Scale (Berg-Weger & Morley, 2020)
A – Are you attractive (as a friend) to others?
L – Are you lonely?
O – Are you outgoing/friendly?
N – Do you feel you have no friends?
E – Are you emotionally upset (sad)?



satisfaction with our treatments is not always a given. Since hearing aid satisfaction is the north star for patients and clinicians, we must understand the factors that contribute to this important end user experience.

In their survey of attitudes towards hearing health and hearing aid use, Singh, Lau, & Pichora-Fuller[15] found that the best predictor of hearing aid satisfaction for both new and experienced hearing aid users is perceived social support. Social support was defined according to perceived confidante support, or having someone with whom to discuss important and personal matters, perceived affective support or the feeling of being cared for emotionally[15]. These findings presaged the findings of their follow-up retrospective study, which explored hearing aid adoption patterns of over 60,000 persons undergoing a hearing examination in private clinics throughout the United Kingdom[16].

Hearing aid purchasers who were accompanied by a significant other to their hearing healthcare appointments were more likely to purchase hearing aids than were persons unaccompanied by a significant other. It was notable that severity of hearing loss mediated the above relationship such that hearing aid adoption was more robust for individuals with mild hearing losses, who were accompanied to their appointments with an significant other, rather than when attending appointments alone. While qualitative in nature, the findings underscore the importance of social support in hearing healthcare. As clinicians we must recognize the role that social support serves in terms of hearing aid uptake and satisfaction and, more importantly, we must remain cognizant of the essential role hearing and communicative ability plays in helping to maintain rewarding social connections with support networks. Once again, the findings of Laird and colleagues are applicable. Many respondents to their structured interviews reported that "hearing loss is the loss of a primary sense in which most people rely upon heavily for their social participation… the loss of hearing ability precipitated further losses in their lives, especially losses related to feeling connected with people and their environment."[10] Findings from a recent study that I was involved in on hearing aid use and emotional loneliness demonstrated that hearing aids help to foster social connections and by resolving some of the communication challenges posed by hearing loss, help to address the loneliness/social isolation epidemic[14].

TABLE 2. The DeJong Gierveld Loneliness Scale (De Jong Gierveld & Tilburg, 2006)
1. – I experience a general sense of emptiness
2. – I miss having people around
3. – I often feel rejected
4. – There are plenty of people I can rely on when I have problems
5. – There are many people I can trust completely
6. – There are enough people I feel close to

Continued on page 18

Continued from page 17

Finally, as alluded to earlier, many believe that the response to the COVID-19 pandemic has been ageist and that the stigma associated with selected geriatric syndromes and impairments may serve to increase social isolation and loneliness[11]. The latter is likely true however, a recent report published by HLAA and Cochlear Ltd. showed that need for facial coverings has inhibited communication for persons with and without hearing loss should be construed as a positive[9]. Anecdotally, persons without diagnosed hearing loss now share the frustration associated with the misunderstanding and mishearing what others are saying because of the absence of visual cues to supplement hearing and because of the decrease in audibility which attends the need to socially distance. Ironically, the extra effort necessary to listen and communicate because of the mitigation strategies to curtail viral transmission is even apparent to young children who historically have been impatient with parents and grandparents with hearing difficulties.

In the past, stigma was a significant deterrent to managing one's hearing loss. Seemingly, the COVID-19 pandemic has reversed the stigma of attending to hearing loss a previously undervalued condition considered to be "a normal part of the aging process." It is apparent from data emerging from the survey conducted by HLAA and Cochlear Ltd. that people with and without hearing loss are realizing the importance of being able to hear and now appreciate the connection to quality of life. Their data are quite compelling:

- 84 % of hearing health care providers reported noticing an increase in their patients' awareness of hearing difficulties during the pandemic,
- 52% of providers said they had seen an increase in their patients' desire to explore new hearing loss solutions due to the pandemic, and
- 68% of respondents said that the pandemic-related increase use of technology has caused them to become even more aware of their hearing loss.

Broader adoption of telehealth platforms has been hailed as a way to improve access to hearing health care for hearing impaired consumers. Another paradox of the pandemic is that reliance on user-friendly tele-health technologies has exacerbated disparities and may be a barrier for many older adults who are not familiar or comfortable with this mode of healthcare delivery[2]. As the recent qualitative report by Kotwal and colleagues revealed, telehealth interventions do support

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social well-being and are critical however, excessive reliance on technology can exacerbate loneliness and accentuate divides within society.

CONCLUSION

The COVID-19 pandemic has focused increased attention on the physical and social vulnerability of older adults which seems to arise in part from interference with engagement with family and friends[3]. In short, engagement provides a sense of value, belonging, and attachment yet when people perceive a discrepancy between actual and desired social contacts social/emotional loneliness often sets in[12,13]. Social distancing and masking as mitigation practices to combat the pandemic have ironically had dramatic unintended consequences for already vulnerable older adults especially those with communication challenges associated with hearing loss. As Cosetti, a neurotologist in the COVID-19 epicenter so eloquently urged[17]… we should use this opportunity to shine a light on the invisible disability synonymous with hearing loss, and support and disseminate solutions for members of the hearing-impaired community. The COVID-19 pandemic seems to have unmasked the invisible disability of hearing loss perhaps reducing the stigma. Let us not miss the opportunity to improve the well-being of the people we serve. ■

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IHS Continuing Education Test

COVID-19 Pandemic Effects on the Elderly, article on page 14.

1. The COVID-19 Pandemic may have inadvertently reduced the stigma of hearing loss.
   a. true
   b. false

2. The best predictor of hearing aid satisfaction for hearing aid users is
   a. perceived social support
   b. having someone to discuss personal matters with
   c. the feeling of being cared for emotionally
   d. None of the above
   e. a, b, and c

3. According to the HLAA & Cochlear Ltd survey, most hearing health care providers experienced
   a. a decrease in their clients' desire to explore new hearing loss solutions.
   b. an increase in their patients' openness to consider new hearing loss solutions.
   c. a decrease in their patients' awareness of hearing difficulties.
   d. None of the above.

4. With the elderly population, the quarantine and social distancing measures has
   a. had negligible effect on the levels of loneliness.
   b. brought about a new phenomenon of social isolation and loneliness.
   c. exacerbated the pre-existing condition of social isolation and loneliness.
   d. None of the above.

5. The ALONE screening questionnaire
   a. shows the patient journey through the hearing healthcare process.
   b. provides an accepted measure of social well-being.
   c. assesses a client's level of perceived loneliness.
   d. None of the above.

6. Hearing healthcare professionals should view the quarantine effect of social isolation and loneliness as a/an
   a. serious threat to their profession.
   b. opportunity to review protocols and interventions.
   c. chance to develop strategies to address clients' loneliness.
   d. All of the above
   e. b and c

7. According to the HLAA/Cochlear survey, __% of hearing healthcare providers noted increased signs of loneliness in their patients since the pandemic began.
   a. 45
   b. 52
   c. 76
   d. 87

8. According to a recent United Kingdom Study, hearing aid purchasers who were accompanied by a significant other to their hearing aid appointment were less likely to purchase a hearing aid than those who came to the appointment unaccompanied.
   a. true
   b. false

9. Telehealth interventions do support social well-being and are critical, however excessive reliance on technology can exacerbate loneliness.
   a. true
   b. false

10. One side effect of COVID-19 on society is that persons without diagnosed hearing loss now share the frustration associated mishearing what others are saying because of the absence of visual cues and the decrease of audibility due to mask usage and social distancing.
    a. true
    b. false

For continuing education credit, complete this test and send the answer section to:

International Hearing Society • 16880 Middlebelt Rd., Ste. 4 • Livonia, MI 48154
or professionaldevelopment@ihsinfo.org

- After your test has been graded, you will receive a certificate of completion.
- All questions regarding the examination must be in writing and directed to IHS.
- Credit: IHS designates this professional development activity for one (1) continuing education credit.
- Fees: $29.00 IHS member, $59.00 non-member. (Payment in U.S. funds only.)

COVID-19 PANDEMIC EFFECTS ON THE ELDERLY QUIZ

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Office Telephone _____

Last Four Digits of SS/SI # _____

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Please check one: ❑ $29.00 (IHS member) ❑ $59.00 (non-member)

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Answer Section

(Circle the correct response from the test questions above.)

1.	a	b			6.	a	b	c	d	e
2.	a	b	c	d	e	7.	a	b	c	d	
3.	a	b	c	d		8.	a	b			
4.	a	b	c	d		9.	a	b			
5.	a	b	c	d		10.	a	b			