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VIEWPOINT

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**Author Audio
Interview**

Older Adults and the Mental Health Effects of COVID-19

As the coronavirus disease 2019 (COVID-19) began to spread in the US in early 2020, older adults experienced disproportionately greater adverse effects from the pandemic including more severe complications, higher mortality, concerns about disruptions to their daily routines and access to care, difficulty in adapting to technologies like telemedicine, and concerns that isolation would exacerbate existing mental health conditions. Older adults tend to have lower stress reactivity, and in general, better emotional regulation and well-being than younger adults,¹ but given the scale and magnitude of the pandemic, there was concern about a mental health crisis among older adults. The concern pertained to older adults both at home and in residential care facilities, where contact with friends, family, and caregivers became limited. The early data summarizes evidence suggesting that, counter to expectation, older adults as a group may be more resilient to the anxiety, depression, and stress-related mental health disorders characteristic of younger populations during the initial phase of the COVID-19 pandemic.

Approximately 8 months into the pandemic, multiple studies have indicated that older adults may be less negatively affected by mental health outcomes than other age groups. In August 2020, the Centers for Disease Control and Prevention (CDC) published a survey, conducted June 24-30, 2020, of 5412 community-dwelling adults across the US,² noting that the 933 participants aged 65 years or older reported significantly lower percentages of anxiety disorder (6.2%), depressive disorder (5.8%), or trauma- or stress-related disorder (TSRD) (9.2%) than participants in younger age groups. According to the report, of the 731 participants aged 18 through 24 years, 49.1% reported anxiety disorder; 52.3%, depressive disorder; and 46%, TSRD. Of the 1911 participants aged 25 through 44 years, 35.3% reported anxiety disorder; 32.5%, depressive disorder; and 36% for TSRD. Of the 895 participants aged 45 through 64 years, 16.1% reported anxiety disorder; 14.4%, depressive disorder; and 17.2%, TSRD. Older adults, compared with other age groups, also reported lower rates of new or increased substance use and suicidal ideation in the preceding 30 days, with rates of 3% and 2%, respectively.

These findings are similar to other reports from high-income countries. A cross-sectional study involving 3840 community-dwelling older adults aged 18 through 80 years from Spain noted that older age (60-80 years) compared with younger age (40-59 years) was associated with lower rates of anxiety, depression, and posttraumatic stress disorder (PTSD).³ In this study, women had higher prevalence of anxiety, PTSD, and depressive symptoms than men. A study involving 776 community-dwelling US and Canadian adults who used a 7-day daily diary to track affect and stress found that older adults (>60 years; n = 193),

compared with younger adults (18-39 years; n = 330) and middle-aged adults (40-59 years; n = 253) had less negative affect and more positive affect and more often reported positive daily events than the younger groups, despite similar level of perceived stress.⁴ A longitudinal study involving 1679 community-dwelling older adults (65-102 years) in the Netherlands found that although loneliness increased after the pandemic, mental health levels remained unchanged before and after the start of the pandemic.⁵

There are several caveats to consider about these data. The findings represent the experience during the first few months of the pandemic. The longer-term effects of COVID-19, especially in countries like the US with very high rates of disease, remain unclear. Long-term population-level stressors can increase the rates of mental health conditions such as prolonged grief disorder, depression, and anxiety. Positive short-term outcomes among older adults at the population level may not necessarily capture the heterogeneity of outcomes at the level of individuals or circumscribed communities or environments (eg, nursing homes, assisted living facilities). According to the CDC report,² even though older adults may have better mental health outcomes than expected, those from underrepresented minorities or with lower household incomes or who are serving as unpaid caregivers are at disproportionately elevated risk of experiencing negative health outcomes. The currently available data also do not provide perspectives on subgroups of older adults like those with dementia, those caring for persons with dementia, or those residing in assisted living facilities or nursing homes. The effect of comorbid chronic medical or psychiatric conditions also remains unclear thus far.

Despite these caveats, the early findings suggest higher resilience to the mental health effects of COVID-19 at least in a proportion of community-dwelling older adults. This resilience may reflect an interaction among internal factors (eg, biological stress response, cognitive capacity, personality traits, physical health) and external resources (eg, social status, financial stability).⁶

Much of the initial concern related to how older adults would respond to COVID-19 was based on how loneliness and isolation would be exacerbated as lockdown measures were implemented. The negative influence of loneliness among older adults has been well documented. However, this reaction might have been partially countered by a range of coping mechanisms. In a mixed-methods study involving 73 older adults⁷ (mean age, 69.2 years) with known depression or anxiety who had demonstrated resilience (ie, no worsening of symptoms) 2 months after the start of the pandemic, investigators noted that study participants appeared to withstand the influence of isolation, especially with social connectedness and access to mental health care.

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However, despite this early resilience, older adults expressed concerns about their longer-term physical and financial well-being.

A cross-sectional study of 515 community-dwelling adults (20-79 years) in the US noted that the use of proactive precautionary measures such as avoiding people who cough, unnecessary travel, and use of public transportation or public places⁸ was associated with lower COVID-related anxiety among older adults. The quality rather than the number of social connections may also be a factor. Thus, for older adults experiencing isolation, having more close or meaningful relationships may be protective, rather than just having more interactions with others.⁵ Maintaining these connections during the pandemic may require better ability to use technology to connect with loved ones.

An additional factor to consider is wisdom, a complex personality trait comprised of specific components, including prosocial behaviors like empathy and compassion, emotional regulation, the ability to self-reflect, decisiveness while accepting uncertainty and diversity of perspectives, social advising, and spirituality.⁹ Several recent studies involving various groups of people across the adult lifespan (25–100 years) have shown a significant inverse correlation between loneliness and wisdom, based on validated scales for measuring these constructs. The component of wisdom that is correlated most strongly (and inversely) with loneliness is compassion. Other data also suggest that enhancing compassion may reduce loneliness and promote greater well-being.¹⁰ Cross-sectional studies show higher levels of wisdom, especially the compassion component, in older than in younger adults. Additional studies are needed to shed more light on risk and protective factors as well as the nature of mediating and moderating relationships among these factors with respect to the mental health consequences of COVID-19 among older adults. There should also be more longitudinal studies on mental health trajectories among specific high-risk populations like older individuals in assisted living facilities and nursing homes.

The data from various studies contrast the numerous personal stories about how difficult the pandemic has been for the older population. This divergence likely represents the heterogeneity that is a hallmark of aging. Also, resilience captured at the population level may not translate to individuals in specific circumstances. Thus far,

there is not a clear understanding of which risk factors and protective factors are the strongest determinants of mental health outcomes, although these may vary from person to person.

Many older adults do not have the resources required to deal with the stress of COVID-19. This may include material (eg, lack of access to smart technology), social (eg, few family members or friends), or cognitive or biological (eg, inability to engage in physical exercise or participate in activities or routines) resources. Clinicians and caregivers must estimate resource availability and consider how the absence of resources can be mitigated for a given individual and family. Of particular importance is the role of technology, which has emerged as an important factor for maintaining social connection as well as accessing mental health services.

Moreover, clinicians must recognize the importance of non-pharmacological approaches, which are more effective than pharmacotherapy in the treatment of chronic stress, anxiety, and prolonged grief. Such approaches include manualized therapies such as cognitive behavior therapy, as well as promoting physical activity, greater connectedness, compassion training, and engaging in spirituality as appropriate. These approaches have also been shown to enhance coping, promote resilience, and reduce loneliness.⁹

The great pandemic of 2020 has been a unique stressor that has affected communities all around the world. Yet it is noteworthy that some individual studies from different countries have shown that at least some older adults are not experiencing disproportionately increased negative mental health consequences commensurate with the elevated risks they faced during the first few months of the COVID-19 pandemic. Understanding the factors and mechanisms that drive this resilience can guide intervention approaches for other older people and for other groups whose mental health may be more severely affected—eg, increasing components of wisdom like emotional regulation, empathy, and compassion.¹⁰ It would also be useful to consider how technology may be leveraged to this end. However, it is critical to recognize that these apparently positive early findings notwithstanding, careful monitoring and additional research will be needed to understand the psychological and mental health effects of the ongoing COVID-19 pandemic among the older population.

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