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Caitlin Monahan, Jamie Macdonald, Ashley Lytle, MaryBeth Apriceno, and Sheri R. Levy
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COVID-19 and Ageism: How Positive and Negative Responses Impact Older Adults and Society

Caitlin Monahan and Jamie Macdonald
Stony Brook University

Ashley Lytle
Stevens Institute for Technology

MaryBeth Apriceno and Sheri R. Levy
Stony Brook University

The disproportionately high rates of coronavirus disease 2019 (COVID-19) health complications and mortality among older adults prompted supportive public responses, such as special senior early shopping hours and penal programs. Simultaneously, some older adults faced neglect and blatant displays of ageism (e.g., #BoomerRemover) and were considered the lowest priority to receive health care. This article examines positive and negative responses toward older adults in the United States during the pandemic and the consequences for older adults and society using data from the pandemic in the United States (and informed by data from other countries) as well as past theorizing and empirical research on views and treatment of older adults. Specifically, positive responses can reinforce the value of older adults, improve older adults' mental and physical health, reduce ageism, and improve intergenerational relations, whereas negative responses can have the opposite effects. However, positive responses (social distancing to protect older adults from COVID-19 infection) can inadvertently increase loneliness, depression, health problems, and negative stereotyping of older adults (e.g., helpless, weak). Pressing policy issues evident from the treatment of older adults during the pandemic include health care (triaging, elder abuse), employment (layoffs, retirement), and education about ageism, as well as the intersection of ageism with other forms of prejudice (e.g., racism) that cuts across these policies.






Public Significance Statement

This article explores positive and negative responses toward older adults during the COVID-19 pandemic and the expected short- and long-term consequences such as impacting beliefs about and treatment of older adults, intergenerational relations, and individuals' mental and physical health. This article discusses policy changes to health care (triaging, elder abuse), employment (layoffs, retirement), and education about ageism.

Keywords: ageism, aging, COVID-19 pandemic, intergenerational relations, older adults

In initial reporting about the COVID-19 pandemic by China in early January 2020 and Italy by late February

2020, older adults¹ were deemed the highest risk age group for health complications and mortality, with confirmatory data from the United States by early March. These reports indicated that adults over age 60 presented worse symptoms including pneumonia, with significantly higher mortality than younger individuals (Centers for Disease Control and Prevention [CDC], 2020b; Chan et al., 2020; Zhou et al., 2020). Further, the severity of COVID-19 presentation in older adults is exacerbated by comorbid preexisting conditions (heart disease, hypertension; NY State Department of Health, 2020).

 Caitlin Monahan and  Jamie Macdonald, Department of Psychology, Stony Brook University;  Ashley Lytle, Department of College of Arts and Letters, Stevens Institute for Technology;  MaryBeth Apriceno and  Sheri R. Levy, Department of Psychology, Stony Brook University.

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Correspondence concerning this article should be addressed to Sheri R. Levy, Department of Psychology, Stony Brook University, Stony Brook, NY 11794-2500. E-mail: sheri.levy@stonybrook.edu

¹ It should be noted that “older adults” is used throughout this article to refer to a wide age range of adults ages 60 and older, consistent with how the World Health Organization (WHO) defines older adults; however, this is not to convey that older adults are a homogenous group defined by a specific age nor to challenge age as a fluid concept.

This article examines responses toward older adults in the United States during the COVID-19 pandemic including positive responses (e.g., food and other essential deliveries to older adults, penpal programs, telecommunication) and negative responses (e.g., triaging, inadequate precautions including in nursing homes, #BoomerRemover discourse). Current and expected long-term consequences of these responses are explored, using data from the pandemic in the United States (and informed by data from other countries), as well as past theorizing and empirical research on the views and treatment of older adults. Pressing policy issues evident from the treatment of older adults during the pandemic include health care, employment, and education about ageism.

Supportive and Positive Responses to Older Adults During the COVID-19 Pandemic

Protective responses in the United States emerged soon after initial news reports suggested that older adults were the most vulnerable age group for health complications and mortality from COVID-19 (CDC, 2020b; Zhou et al., 2020). Initial supportive solutions involved policies to limit older adults' exposure to COVID-19. For example, stores offered early morning hours for older adults to shop in a less crowded store that had been thoroughly disinfected (Kassraie, 2020). Supportive community responses also involved home deliveries of food, medications, and household essentials. In addition to loved ones delivering items to older adults, organizations such as Invisible Hands were launched to deliver goods to older adults (Invisible Hands, 2020). These examples align with prepandemic "senior" services in the United States such as store discounts as well as provisions in health care (Medicare), housing, and taxes (Nelson, 2009; Palmore, 1999). Such services reflect traditional cross-cultural views of older adults as cherished, respected, and valued contributors to communities (Levy & Macdonald, 2016).

To address the risks for negative mental and physical health outcomes posed by socially isolating, creative solutions revised existing social connections or created new ones, such as replacing in-person visits with video calls (Van Orden et al., 2020). In its first set of recommendations to long-term care facilities on March 13, 2020, the CDC recommended prohibiting visitors and canceling group activities while providing alternative methods for visitation, such as video calls (CDC, 2020c). Other organizations that were working with older adults before COVID-19 changed course as well. For example, Glamour Gals, a national nonprofit which facilitates positive intergenerational contact through makeovers, adapted their in-person approach to a letter writing program called "My dear friend" (GlamourGals, 2020). Other letter writing and penpal programs have

also emerged to connect older adults in senior living facilities with high school students or children (Zaveri, 2020).

It should be noted that social distancing is not always possible, such as for older adults who are essential workers or who cannot physically distance from household members who leave home to shop and work. According to Census data from 2010, multigenerational households, where older adults live with younger family members, tend to be of lower socioeconomic status with fewer resources (Cohn & Passel, 2018), which may make it difficult to practice physical distancing. Further, the 64 million Americans who live in multigenerational households tend to be from Asian and Latinx cultures, which raises issues of health and safety within and across communities (Cohn & Passel, 2018).

Effects of Positive and Supportive Responses

There are two key positive and interconnected consequences of supportive responses to older adults during the pandemic: (a) mental and physical benefits to older adults themselves and (b) benefits to individuals across the life span (i.e., improved views of aging and intergenerational relations). Positive responses, such as special senior shopping hours, communicate that older adults are valued members of the community, which can foster positive self-perceptions of aging. A longitudinal study over 20 years showed that the more positive self-perceptions of aging someone had, the more likely they were to engage in health promoting behaviors such as eating healthy, exercising, and limiting alcohol and tobacco use (Levy & Myers, 2004).

Intergenerational service-learning program interactions (e.g., penpal programs) can lead to more positive attitudes and perceptions of aging and older adults, increased knowledge of aging, more empathy toward older adults, and finding common interests despite age differences (Levy, 2018; Lytle, Nowacek, & Levy, 2020; Roodin, Brown, & Shedlock, 2013). Moreover, studies show that even reading about examples of positive intergenerational contact can reduce negative attitudes toward older adults and increase aging knowledge (Lytle & Levy, 2017). As such, these studies demonstrate the importance of intergenerational contact. However, if in-person contact is limited, older adults may benefit from telecommunication, as frequent use of communicative technology (e.g., Smartphones) has been shown to improve the psychological well-being (i.e., life evaluation, affect, and eudaimonia) of adults age 75 and older (Fang, Chau, Wong, Fung, & Woo, 2018).

Taken together, supportive responses to older adults through the pandemic may improve their well-being, social connectedness, feelings of worth, and can save lives, which benefits all given the continued contribution of older adults in society. Exposure to supportive responses during the pandemic also communicates a positive portrayal of older

adults and suggests a society that values older adults, challenging the youth-centered U.S. society (Nelson, 2009).

Negative Unintended Consequences of Positive Responses

Even well-intentioned positive responses can have negative, unintended consequences. For one, protecting older adults from COVID-19 exposure via social distancing creates the potential for social isolation and loneliness, which can negatively impact the mental and physical health of older adults (Van Orden et al., 2020). During the pandemic older adults have become increasingly isolated and socially detached, especially older adults who are already distant from family members (i.e., geographically distant; in assisted living, Brooke & Jackson, 2020). Many older adults who rely on social contact from community centers and places of worship, are also experiencing significant disruptions in their social networks and relationships (Armitage & Nellums, 2020). Before COVID-19, it was well-documented that social isolation and loneliness can increase mortality, risk for dementia, and impact other mental and physical health outcomes including anxiety, depression, rehospitalization, risk of cardiac heart disease, and negative health behaviors such as drinking and smoking (Kuiper et al., 2015; Nicholson, 2012). Loneliness may also exacerbate comorbid conditions that older adults face, with pre-pandemic research showing strong associations between loneliness and chronic illness, impaired mobility, and lack of socioeconomic resources (e.g., limited income; Ong, Uchino, & Wethington, 2016).

In assisted living facilities, social distancing from family and friends additionally has unique consequences from reduced communication between staff and family members of residents. Family members who know the history of their relatives' health conditions are more likely than staff to be patient advocates (Gaugler & Kane, 2007) and provide meaningful contributions to detecting health changes of nursing home residents, ultimately leading to fewer hospital admissions (Powell et al., 2018). Such information may be particularly useful for medical staff to incorporate into treatment because data from long-term care facilities show that doctors are often unable to clearly diagnose COVID-19 (McMichael et al., 2020) as a result of overlapping, underlying conditions (Xie et al., 2020). Though telecommunication (e.g., video chat) may mitigate some communication issues, it may be especially difficult to implement for long-term care residents with serious cognitive impairment.

Social distancing may also inadvertently reduce some of the social benefits of long-term care centers due to reduced resident-staff interactions and peer interactions. The disruption of peer physical activities (e.g., group activities such as stretching, walking) is also a health concern because such activities have been found to prevent falls (Cameron et al., 2018) and ameliorate symptoms of depression (Harvey,

Chastin, & Skelton, 2015). Moreover, reduced staff-directed activities can take a toll on positive resident-staff interactions because these activities are related to residents' satisfaction with staff interactions (Holmes, Galik, & Resnick, 2017).

Social distancing and stay at home orders can also negatively impact older adults' jobs and economic stability. For example, according to the U.S. Department of Labor, Bureau of Labor Statistics (2019), five million workers aged 65 and older are unable to telework and are the least likely to be able to telework compared with younger age groups. In early April 2020, approximately 40% of U.S. workers aged 25–34 began to work from home as a result of the pandemic; however, only about 30% of older workers (aged 65+) were able to work from home (Brynjolfsson et al., 2020). Pre-pandemic data in the United States reveal that the top jobs for men aged 62 and older require manual labor (e.g., delivery, farming, janitorial services), making it difficult to transition to telework (Johnson & Wang, 2017). Internet access is another barrier to telework for older adults; 49% of adults aged 65 and older do not have broadband services and are significantly less likely to own smartphones compared with adults aged 18 to 64 (Anderson & Perrin, 2017).

Before the pandemic, older adults were projected to constitute 25% of the workforce by 2024 (U.S. Department of Labor, Bureau of Labor Statistics, 2017). However, there are reports of an increase (i.e., 7%) in early retirement (Coibion, Gorodnichenko, & Weber, 2020), which results in decreased lifetime earnings, retirement savings, and financial security. It is not clear whether older adults are retiring early because of duress, lack of opportunities to or inability to telework, health and safety concerns in the physical work environment, or expectations of future age discrimination. Unplanned retirement also can take a toll on older adults' health, as involuntary job loss preceding retirement increases older adults' likelihood of anxiety and depression (Gallo et al., 2006). The current economic conditions could also lead workers to delay retirement. During the recession of 2008, some older workers were more likely to delay retirement given financial insecurity amid the economic crisis (Johnson, 2012; Roscigno, 2010).

Yet another unintended negative consequence of seemingly positive helping behaviors toward older adults during the pandemic is the perpetuation of pre-pandemic negative stereotypes that *all* older adults are dependent, frail, sickly, weak, and a burden on society (Cherry, Blanchard, Walker, Smitherman, & Lyon, 2014; Nelson, 2009). Helping behaviors can sometimes be patronizing and communicate to older adults that they are helpless and dependent (benevolent ageism), which can in turn have a negative impact on their self-esteem and well-being (Cary, Chasteen, & Remedios, 2017). Likewise, the negative stereotype that older adults are frail can translate to insufficient and less aggres-

sive recommendations for treatment, and misdiagnosis in health care settings (Chrisler, Barney, & Palatino, 2016). Negative stereotypes have downstream negative effects on older adults themselves, and also on views of older adults, aging, and intergenerational relations.

Negative and Ageist Responses to Older Adults During the COVID-19 Pandemic

One of the most concerning negative responses to older adults during the pandemic has been potentially discriminatory health care practices. There has been support from some health care professionals and the general public for the use of triaging with provisions that older adults are the lowest priority for life-saving treatment regardless of other factors such as functional health (Rosenbaum, 2020). China and Italy, who were faced with overcapacity and shortages of supplies in hospitals before the United States, implemented medical triaging where older adults were considered the lowest priority for care and access to life-saving resources (Arya, Buchman, Gagnon, & Downar, 2020; Xie et al., 2020). In Italy, health care providers lamented, “We have to decide who must die and whom we shall keep alive,” and a patient’s age is often one of the key factors in such decisions (Rosenbaum, 2020). Protocols in the United States seem to disadvantage older adults with one outlined proposal to maximize benefits by saving the most life-years and giving priority to those expected to live longest (Emanuel et al., 2020).

Older adults living in care facilities are also facing worsening health care and increased mortality due in part to unsupportive and potentially discriminatory practices. On June 1, 2020, the Centers for Medicare and Medicaid Services (CMMS, 2020) reported that there were approximately 26,000 deaths attributable to COVID-19 in long-term care facilities, representing nearly a quarter of overall pandemic-related deaths in the United States (CDC, 2020d). Did delays in actions and sufficient recommendations contribute to these high rates? In the United States COVID-19 outbreaks in many senior living centers were reported as early as February 28, 2020 (Kimball et al., 2020). It was not until March 13, 2020, that the CDC (2020c) report was released recommending that long-term care facilities and nursing homes restrict visitors and limit recreational activities to protect both residents and staff. The CDC (2020c) and CMMS did not release more stringent recommendations, including screening of all individuals entering these facilities, daily temperature checks, and the use of personal protective equipment, until April 2, 2020, which was weeks after several reports of high rates of mortality in long-term care facilities (Chidambaram, 2020). The alarming number of deaths among older adults including those living in nursing homes and other U.S. facilities prompted questions about ageism such as: “why are we OK with old people

dying?” (Aronson, 2020). Prepandemic data in the United States indicate that care facilities are hotbeds for the spread of infections. For example, seasonal flu and illness are common in nursing homes, with a CDC (2014) report showing that 80% of nonfoodborne outbreaks of norovirus occurred in long-term care facilities such as nursing homes between 2009 and 2012. There is reason to be concerned about the 1.3 million Americans who currently live in nursing homes and an additional 800,000 who live in residential care facilities (CDC, 2019). Further, this population is at greater risk for mortality, as data from New York State found that approximately 90% of COVID-19 deaths had at least one comorbidity (NY State Department of Health, 2020).

In addition to triaging and the slow and inadequate response to older adults in care facilities, there are other indicators that the COVID-19 pandemic exacerbated the negative consequences of the institutionalization and acceptance of ageism (Levy & Macdonald, 2016; WHO, 2017). Social exchanges in the United States have included the hashtag #BoomerRemover, as a nickname for the COVID-19 pandemic reflecting a lack of empathy toward the high death rate among older adults (Aronson, 2020). Although the majority of deaths reported to be attributable to COVID-19 in the United States are among those 65 and older (CDC, 2020b), as of March 15, 2020 two of the most prominent medical journals published articles about COVID-19 in children but none discussed older adults (Aronson, 2020). Ageism has been discussed as a possible contributing factor to individuals not taking the COVID-19 pandemic seriously enough, exemplified by individuals’ continuation to congregate despite reports that such behavior could put the lives of older adults at risk (CDC, 2020b; Zhou et al., 2020). Early examples included college students taking spring break trips in March despite increasing warnings about the threat of COVID-19 (Montgomery & Fernandez, 2020). In May 2020, public defiance and protests of protective measures (social distancing, wearing face masks) and stay at home orders may be fueled in part by the ageist view that older adults are a burden and to blame for societal problems (in this case, continued economic hardship on society as a whole to reduce their chances of infection and death).

Effects of Negative Responses

A major effect of negative responses (e.g., triaging, inadequate protections in care facilities) to older adults is increased risk of infection and mortality during the pandemic. A related concern is inadequate care for older adults’ chronic conditions (e.g., diabetes, heart disease) that are unrelated to COVID-19 given unprecedented shortages of health care and a history of age discrimination in health care in nonpandemic situations (Chrisler et al., 2016). There is

also the impact on the longer-term health of older adults who are potentially receiving worse care for COVID-19 and conditions unrelated to COVID-19. The loss of older adults and their worsening health due to COVID-19 has profound rippling effects on loved ones and society at large, including health care professionals who are also risking their own lives to treat COVID-19.

The negative treatment of older adults (e.g., media messages that older adults' lives are less valuable such as #BoomerRemover) can hurt their self-esteem and cognitive functioning, exacerbate day-to-day stress, and place them at greater risk for poor health outcomes including hospitalization and mortality. Research before the COVID-19 pandemic detailed how negative age stereotypes, including the same ones being reinforced during the pandemic (i.e., burdensome, dependent, frail, senile, sickly, slow, weak), influence older adults cognitively, emotionally, and physically (Levy, 2009). Research has focused on age-based stereotype threat, or how awareness of stereotypes threatens the application of those stereotypes to oneself, resulting in older adults' impaired cognitions, memory, and balance when primed with negative stereotypes regarding aging (Lamont, Swift, & Abrams, 2015). Additionally, stereotype embodiment theory (SET) posits that chronic lifetime exposure to ageism leads to internalization of ageist beliefs and may result in unconscious endorsement of negative age stereotypes, thereby setting in motion a self-fulfilling prophecy (Levy, 2009). Indeed, the impact of negative age stereotypes is chronic and long-lasting, increasing stress for older adults (Levy, Slade, Kunkel, & Kasl, 2002) and increasing the likelihood of hospitalization by 50% (Levy, Slade, Chung, & Gill, 2015). Perceptions of aging also influence longevity, with research showing that adults ages 50 and older who held more negative (vs. positive) self-perceptions of aging on average lived 7.5 fewer years even when controlling for possible confounding factors such as gender, race/ethnicity, and functional health (Levy et al., 2002). Recent research amid the COVID-19 pandemic found that negative self-perceptions of aging were strongly associated with distress and loneliness (Losada-Baltar et al., 2020). Moreover, past research has shown that negative age-stereotypes are particularly salient after two of the most stressful life events for older adults—hospitalization and death of a family member or friend (Levy et al., 2015). Both of these events are more likely to occur during the COVID-19 pandemic; thus, potentially putting older adults at a heightened risk for developing negative attitudes toward aging.

Ageism also has a profound impact on how younger and middle-aged adults feel about their own aging and older adults, potentially influencing their career trajectories as well. Widespread reinforcement of ageist stereotypes of older adults as burdensome, dependent, and sickly can elicit avoidance and neglect, which can undermine the possibility

of positive intergenerational interactions (Cuddy, Fiske, & Glick, 2007). Exposure to negative views and treatment of older adults has been linked to aging anxiety even in younger adults and adults across the life span. In one study, college students' negative feelings about their own aging correlated significantly with their negative beliefs about older adults and reduced willingness to interact with them (Chonody & Teater, 2016). As such, aging anxiety may also be an important factor in understanding social avoidance of older adults, including low interest in joining the geriatrics workforce (Boswell, 2012).

Implications and Policy Considerations

The COVID-19 pandemic has exposed some severe consequences of socially condoned and institutionalized ageism. Long-standing issues concerning (a) inadequate health care, (b) discriminatory employment practices, and (c) lack of education about ageism have been exacerbated by the pandemic and necessitate short-term and long-term policy remedies.

Health Care

The COVID-19 pandemic has overwhelmed health care facilities and highlighted the lack of clear and fair health care policies that are ideally already ingrained and well-practiced in health care facilities. Some health care workers are explicitly making ad hoc decisions that discriminate against older adults regardless of other factors such as functional health (Rosenbaum, 2020) and/or others may have unconsciously factored age into triage decisions (O'Laughlin and Hick, 2008). The previously mentioned triage protocol by Emanuel et al. (2020) prioritizes those expected to live longest. An alternative is a more detailed scoring system such as Daugherty Biddison et al.'s (2019) framework with two key ethical considerations: (a) likelihood of short-term survival (i.e., based on available resources) and (b) likelihood of long-term survival (i.e., based on presence of comorbid conditions) and includes age as a secondary consideration if two patients have the same triage score. This framework was developed by health care practitioners, ethicists, and legal experts for hospitals and public health agencies in the case of a novel respiratory pathogen that would require intensive care unit capacity and overwhelm ventilator capacities. A framework specific to COVID-19 should address the nuances of mortality risk and specific challenges in risk assessment in light of data showing the majority of older adults who die from COVID-19 have one or more preexisting conditions (NY State Department of Health, 2020; Xie et al., 2020).

Health care policies also need to include clear and fair recommendations for treating older adults' health care issues unrelated to triaging and COVID-19. Adults 65 and

older see doctors more often, are admitted to the emergency department more frequently, and experience more chronic illnesses than younger adults (Chrisler et al., 2016; Pham & Lim, 2020). Prepandemic findings point to age discrimination in health care in general such that older adults received less sufficient treatment recommendations and their symptoms are downplayed as normal aspects of aging (Chrisler et al., 2016). In line with this, a 2020 prepandemic meta-analysis including more than 400 studies across 45 countries found that in 84.6% of the studies included, age was a deciding factor in the procedure and treatments patients received including withholding life-sustaining procedures for hospitalized older patients in some instances (Chang et al., 2020). Likewise, clear guidelines on avoiding and identifying elder abuse need to be included in health care policies (Pillemer, Connolly, Breckman, Spreng, & Lachs, 2015; World Health Organization, 2018). For example, only 25% of emergency room physicians are trained in the detection of elder abuse compared with 87% who receive training for child abuse and 63% for spousal abuse (Jones, Veenstra, Seamon, & Krohmer, 1997). As noted earlier, the tragic deaths of nursing home residents reveal the urgent need for clear and supportive policies for handling infectious diseases in care facilities.

Employment

Employment policies are needed to balance and address the relevant COVID-19 related health issues of older workers, while also protecting employment rights. First, COVID-19 employment policies need to address the continuity of all workers' employment including addressing potential barriers for older adults, such as their ability to telework given the nature of their job, as well as enforcing safety protections in the physical workplace to meet health guidelines (e.g., erecting barriers, providing protective gear, implementing adequate cleaning). At the same time, there needs to be consideration of accommodations for older workers (and others) who are at increased risk for COVID-19 complications and mortality.

Second, employment policies must address potential age discrimination in the application of furloughs, reduced pay, layoffs, rehiring, and retirement as the pandemic has already resulted in enormous job losses (Coibion et al., 2020). Without the implementation of specific guidelines, the age discrimination apparent during the last U.S. recession of 2008 (or global financial crisis) could be repeated. During the 2008 recession, for adults aged 55 and older between 2007 and 2009, unemployment rates doubled, rising from 3.1% to 7% and the duration of unemployment dramatically increased from 20.2 to nearly 30 weeks (PPI's Economics Team, 2008), which likely stemmed in part from employers reluctance to hire or rehire older workers (Johnson, 2012). During the COVID-19 pandemic, by April 2020, 15.7% of adults aged 65 and older were unemployed, representing a

substantial increase from 2.9% in April 2019 (U.S. Department of Labor, Bureau of Labor Statistics, 2020). Research shows that older age can disadvantage workers in the hiring process in general (see Baert, 2018 for a review). Following job loss, adults over 50 are significantly less likely to be reemployed compared to their younger counterparts (Wanberg, Kanfer, Hamann, & Zhang, 2016). Furthermore, older workers are often more likely to be rehired into lower paying, and/or part time positions (Roscigno, 2010). Protecting older adults from forced retirement or retirement under duress or uncertainty is also paramount as data indicates an increase in early retirement during the pandemic (Coibion et al., 2020), which is in contrast to prepandemic reports of an increasing delay of retirement among older workers (Johnson, 2018).

Third, health care in the United States is often tied to employment (Kaiser Family Foundation, 2018), which presents unique challenges in the midst of a pandemic and unprecedented job loss. Older adult workers who are not yet of age for Medicare may be especially vulnerable in the current situation. In light of a history of ageism in the workplace, employment policies need to clearly protect older workers during the pandemic.

Education About Ageism

The COVID-19 pandemic has perpetuated ageism, highlighting the need for swift policy action to remedy the effects but also to address the roots of ageism. Raising public awareness of institutionalized ageism in health care, workplace, and other settings is a crucial starting point. As the WHO (2017) pointed out, ageism "is everywhere, yet it is the most socially 'normalized' of any prejudice" and may now be "more pervasive than sexism or racism" (p. 1). Lack of education about aging in the United States allows pervasive media mischaracterizations of older adults as burdensome, dependent, incompetent, senile, and sickly to go unchallenged, while also reducing interest in interacting with older adults (Levy, 2018). Past research and theorizing such as the PEACE (Positive Education about Aging and Contact Experiences) model points to the need for policies to address two interrelated factors essential to ageism reduction: (a) providing education about aging and (b) positive intergenerational contact experiences with older adults (Levy, 2018). Addressing these two factors led to successful ageism reduction in brief interventions (Lytle & Levy, 2017), as well as longer interventions involving learning about aging and both online (i.e., Instagram) and in-person intergenerational contact (Lytle et al., 2020), and in service-learning programs (including penpal programs; Roodin et al., 2013). The penpal and letter writing programs emerging from the COVID-19 pandemic seem promising to foster positive intergenerational relations because they involve positive one-to-one contact that is socially sanctioned and

involves cooperation as well as the exchange of personal information (Levy, 2018). At the same time, the positive interactions fostered by these programs have the potential to debunk negative stereotypes of older adults as senile, helpless, and boring.

Policies, then, in educational settings as well as in health care and employment settings that provide accurate education about aging and provide positive intergenerational interaction opportunities show promise for addressing the roots of ageism. In addition, such policies could increase interest and help to fill the large and growing pre-COVID-19 shortage of workers across fields (e.g., health care, psychology, and social work) in positions at every level in gerontology, who primarily work with older adults (Hoge, Karel, Zeiss, Alegria, & Moye, 2015). Limited positive contact with older adults, inaccurate information on aging, aging anxiety, and ageism were deemed significant barriers to interest in and pursuit of a specialization in gerontology in the helping professions (e.g., Boswell, 2012). Policies, at the same time, would need to address the institutional ageism in health care, such as a lack of training in geriatrics for health care professionals (Wyman, Shiovitz-Ezra, & Bengel, 2018) and lower pay of nursing home staff relative to other nonprofessional health care workers with similar levels of educational attainment (Glieb, Ma, & Pearlstein, 2015).

In health care, employment, and education, it is also crucial to consider how ageism is intertwined with other systems of bias including ableism, classism, heterosexism, racism, sexism, and more (Lytle, Apriceno, Dyar, & Levy, 2018). Nursing homes with a significant portion of Black and Latinx individuals were twice as likely to have COVID-19 cases compared with nursing homes that were disproportionately white (Gebeloff et al., 2020). Further, racial minority older adults are more likely to receive inadequate health care and are disproportionately underinsured compared with older white adults (Rhee, Marottoli, Van Ness, & Levy, 2019), thus contributing to significant pre-existing health disparities. Indeed, communities of color appear to be especially vulnerable to COVID-19 complications and death, with data showing disproportionately high hospitalization and death rates among Latinx and Black individuals (CDC 2020a). In New York City, for example, 75% of front-line workers (e.g., grocery store employees, transit employees, janitors) are racial minorities (Valentino-DeVries, Lu, & Dance, 2020). Further, members of affluent communities were able to practice social distancing earlier such as by working from home, thus reducing their potential exposure to COVID-19 (Valentino-DeVries et al., 2020). Lastly, the virus is more deadly within intergenerational households (Bayer & Kuhn, 2020), potentially putting older adults of color at greater risk (Cohn & Passel, 2018). Attention and action, then, must be given to the intersection of multiple identities including age given significant and

deadly consequences for some of the most vulnerable and marginalized groups in society.

Conclusion

The COVID-19 pandemic has resulted in positive and negative reactions to older adults. Positive responses to protect older adults can reinforce the value of older adults, foster positive views of older adults, improve older adults' mental health, improve intergenerational relations, and save lives. Although social distancing and stay at home orders protect older adults, they can inadvertently lead to loneliness, the perpetuation of negative stereotypes of older adults (helpless, weak), and impact older workers' jobs and financial security. There is accumulating evidence that ageism at a broader level accounts for the sluggish and inadequate responses to the pandemic. Negative stereotyping, prejudice, and discrimination toward older adults during the pandemic (including triaging, inadequate protections in care facilities and the larger community) can translate into worse health care, and increased, tragic loss of older adults, with rippling effects on family members, friends and society at large. Ageism during the pandemic negatively affects older adults' mental health as they face being devalued, viewed as a burden, and discriminated against. Ultimately, ageism influences how all age groups view their own aging and older adults, how and whether they positively interact with older adults, and their career choices such as to enter the geriatric workforce. COVID-19 is a crisis and threat to the health, well-being, and livelihood of society as a whole. Older adults appear to be disproportionately vulnerable both to the virus itself and its social and behavioral ramifications in health care and employment. Older adults are vital, valuable contributors to society, and now is the time for research to detail the short- and long-term consequences of positive and negative responses toward older adults during the pandemic and take swift policy action.

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