

**A Review in Geriatrics and Quality of Care:
Impact of Communication Disorders on Older Adults**

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Abstract

The interaction of physical and mental health factors determines life quality and social participation levels. Many conditions and communication disorders also contribute. Three that are highly prevalent in the older adult population are age-induced hearing loss (presbycusis), dementia/aphasia, and traumatic brain injuries. A brief overview is provided on the physiology of these conditions, as well the effects they have on someone's language status. Due to the varying natures of the disorders, their comorbidity and overlapping development will be considered. The geriatric population is further examined in terms of nationality and economic background. This provides a focus on how different populations face a variety of issues because of these conditions. Health support systems that work with individuals to satisfy their needs are evaluated, in terms of the acceptance and accessibility they provide. The biases and issues resultant of healthcare disparities are expanded upon. Psychological and social systems of older adults are considered, as well as how they change when health or communication fails to function. Specific topics addressed include the development of mental illness, the effects of communication loss on social skills, and challenges with self image. The availability of support systems is vital. Understanding practices and systems that threaten life areas and quality of life for older adults enables service providers to produce better outcomes through advocacy.

Keywords: communication disorders, quality of life, older adults, geriatrics, chronic conditions, psychosocial effects, healthcare disparities, diversity

Quality of life is defined by our levels of health and stability, as well as the ability to participate in social activities and interact with others. As a person ages over time, different variables play into quality of life. To ensure a child will thrive, a high level of security and care encourages early communication. Later, an adolescent's external and internal environment will have different attributes and needs, although basic necessities might remain the same.

For the older adult, quality of life can be impacted during the process of aging. Many variables of physical and mental health determine these changes. Aspects that contribute to physical health include health status, the presence of an illness or chronic condition, diet, exercise, and mobility. All of these factors combine to influence the level of stamina one has to carry out life activities, which in turn affects daily functioning. Areas that contribute to mental health are emotional, psychological, and social well being. Specific functionalities that may be affected in old age are cognition and the level of rationale someone has. These mental and physical health areas can be compromised by chronic conditions and other wellness factors. A person may need additional support, services, or resources to obtain the same lifestyle and satisfaction they did before. In the presence of a chronic condition, physical and mental health can change dramatically, affecting all different areas of life. This paper will examine the impact of common chronic health conditions on an aging population, particularly in terms of communication, health disparities, and psychosocial state.

When mental or physical health is interrupted by a chronic condition, there are several levels of functioning that change. For example, there may be changes in personal or vocational responsibilities. An individual could be unable to participate and do tasks they once performed daily. They are no longer fulfilled by a role they have been responsible in for a lifetime.

Occupation is an area that can be affected, especially in the case of older adults. There will also be changes in lifestyle and a person's hobbies. For someone who enjoys going out and doing strenuous activities, this may become impossible when mobility is threatened by a chronic condition. This is just an example, since dexterity, flexibility, gait, and strength are other qualities that become altered in older age, regardless of the presence of a specific condition. Sensory acuity, in terms of vision and hearing, are also abilities that are affected (Osoba et al., 2019). Daily life functioning can deteriorate as the result of changes in these skills. Simple daily tasks like getting dressed, cooking dinner, and going to the bathroom are some needs that become a struggle for someone with a significant mental or physical condition. This in turn can lead to an impact on self image. The way a person views themselves when they are facing decreased physical or mental health is harsh. Many may feel embarrassed, weak, or useless when one or more of these health parameters aren't of the quality they used to be. Self perception is affected by an inability to complete tasks or be involved in activities or hobbies as well as they used to. A negative self concept is often established by older adults as a result of uncontrollable effects of health decline.

Three common health conditions that are prevalent in the older adult population are presbycusis, dementia, and traumatic brain injury (TBI). Presbycusis is age-induced hearing loss that occurs due to a variety of risk factors and biological effects. Dementia is cognitive decline that occurs as a result of mental processing in the brain degrading. Memory, cognition, and daily occupational skills deteriorate over time as this condition progresses (National Institute of Aging, 2019). Alzheimer's is a very common form of dementia caused by senility, but other forms of the condition can also be caused as the result of a stroke. Much of the time, this

condition is associated with a breakdown in language known as aphasia. Lastly, traumatic brain injury results from a penetrating concussion that disrupts typical functioning of the brain. Older adults are at a high risk of TBI due to their higher likelihood of traumatic falls (CDC, 2020b).

These three conditions interact with sensory and cognitive function on multiple levels.

Causation and biological factors of the conditions will be further discussed. When the effects are very severe, dysfunctions in communication often result for these patients.

Even in illness or uncertain circumstances, communication allows people to have input into their lives and healthcare. But what happens when that ability and freedom is taken away, and it cannot be restored in conditions that threaten cognitive well being? Communication with others is fundamental to obtaining the physical and spiritual necessities of life. How can we react when an ability we rely on disappears gradually over time?

This is an obstacle many in the older adult population face. As knowledge and wisdom increases in age, health and abilities once present will deteriorate. Some health conditions lead to what are known as communication disorders. A communication disorder is when communication is rendered atypical and stands out from the norm. It will make conversation and knowledge dissemination incoherent. This can be stressful to either the speaker or the listener (ASHA, 1993).

Hearing loss that occurs in old age, presbycusis, is one sensory disorder studied often in relation to communication disorders. This is a hearing loss that may occur gradually at fluctuating levels over a long time, eventually increasing to high levels. Statistically, about 30 - 35 percent of adults age 65 and older have hearing loss (NIDCD, 2020a). Deficits in the ear's ability to recognize and decode high frequency sounds are common. This can cause issues in

receptive communication abilities, since a large quantity of speech sounds are in this frequency area. A person may no longer be able to discern words and conversation, especially in poor light, distracting conditions, or when background noise is present.

Presbycusis usually develops through the degradation of inner ear hair cells during the process of aging, which is a type of sensorineural hearing loss. This form of the condition is categorized as sensory presbycusis. The hearing loss can also be the result of poor or absent nerve pathways functionality, which is neural presbycusis. Mechanical/ cochlear conductive presbycusis is an additional subtype that is the result of degenerative thickening and stiffening of the basilar membrane of the cochlea (Banks, 2018). Associated health problems that might occur alongside presbycusis are heart disease, high blood pressure, or circulatory issues (NIDCD, 2020a).

Once a person with presbycusis receives a diagnosis through a hearing evaluation, they will be recommended certain accommodations through therapy or rehabilitation. The person's outlook for recovery and success may be pessimistic. It will be important for them to understand that although there is a low possibility of 100% recovery with full hearing clarity, treatment and healing to bring back usable sensory functioning is possible. Working with audiologists, physicians, and related professionals is vital for the individual to receive the services and resources they need. Receiving reputable information and counseling will help the person develop a positive mindset that takes ownership over their condition.

Regardless of the biological functionality and presence of the hearing loss, the loss in terms of lingual information is massive. When hearing is normal, the features of everyday speech are natural and easily discernible. Our brains are cognitively accustomed to focusing on

certain formants, fricative characteristics, and pitch changes in order to derive linguistic meaning from auditory information. Once the degree of sensory input decreases, auditory processing becomes mentally tiring and highly stressful. Especially when the loss is in higher frequencies, where much important consonant information is found, speech perception becomes nearly impossible without amplification (Pichora-Fuller et al., 2015). Less meaning is able to be found in speech, and the person becomes accustomed to using this sense less if they do not receive services.

In older adults, notable decreases in cognitive and memory ability often occur concurrently (Pichora-Fuller et al., 2015). A growing difficulty with speech perception is associated with the older patient's cognitive struggle with rapid speech. When content is missing from a speech signal, information relevant in memories of the experience will not be retained later on. Working memory and short term memory are directly affected by long term hearing loss, since the brain becomes used to this lack of information. As less and less information is relayed auditorily (and perhaps through other senses such as vision), the ability to retain information breaks down over time. Sentences that are syntactically complex are even less comprehensible than before (Wingfield et al., 2006). The aging brain is affected by its lack of neuroplasticity. A younger brain may be able to reorient itself when challenged by deteriorating sensory conditions and rely on other senses. An elderly mind is far more likely to have limited options due to cognitive decline (Pichora-Fuller et al., 2015).

Older adults enjoy many different levels of social activity. Regardless of their interests and personality, the ability to maintain a 100% optimal communication zone at *all* times with

moderate to severe hearing loss is impossible. Amplification or auditory support is a necessity for participation in the social world of spoken language.

Hobbies and social communities become even more important in old age: a time when inaction and mental health issues might arise following retirement or the death of friends and family. Concerns about other health problems are already highly stressful for older individuals. The sense of support gained through community is widely beneficial. Through hearing loss, that ease of communication that was always there and allowed access to these communities may be gone. It can be incredibly frustrating and sometimes traumatizing.

The severity of presbycusis often increases with late age and may be undiagnosed for years - that coupled with possible cognitive decline can create immense sensory and social pressure. Cognitive decline, hearing loss, and general frailty are somewhat associated, with their respective effects compounding (Pichora-Fuller, 2015). Typical and optimal communication skills provide an individual with independence, a sense of identity, and higher quality of life. But with presbycusis, everyday actions can become debilitating. This is especially true especially when the individual does not even realize their hearing is deteriorating,

Presbycusis can compound cognitive issues over time. A number of studies exist that perpetuate this connection. The brain will become used to not receiving an influx of constant information rich lingual context, contributing to an overall devaluing of linguistic information. Such an association can lead to the brain's detachment with language as a whole, a quality also present in aphasia.

Aphasia is a communication disorder also associated with cognitive decline. This is a condition acquired through brain damage to the areas that are responsible for language

recognition, reception, and expression. It often occurs suddenly, after events such as a stroke or traumatic brain injury. But it can also develop steadily or at fluctuating paces over time due to dementia, Alzheimer's disease or other progressive neurological diseases.

Aphasia is caused by blood flow to parts of the brain responsible for language becoming cut off. The blood cells are unable to obtain sufficient amounts of nutrients and oxygen, leading to brain cells dying off (NIDCD, 2020b). Language functions in these areas become severely limited. This communication disorder is most often acquired by people middle-aged or older. Aphasia is also at risk of developing after a traumatic brain injury, which will be discussed further later on. Statistically, about 1 million individuals in the U.S. have aphasia, and almost 180,000 are diagnosed with it each year. The prevalence of this disease is consistent, and since it largely occurs within the older population, this number can be expected to increase in the future with the aging of baby boomers (NIDCD, 2020b).

Fluent and nonfluent aphasia are two categories of aphasia integral to understanding the effects of the condition. Fluent aphasia, also known as Wernicke's aphasia, occurs when there is damage to the temporal lobe of the brain. Language will be fluent with complete and well paced sentences, but the arrangement of words has little to no meaning. This is known as jargon, which can be described as fluent and prosodically appropriate output. It resembles the language it is spoken in, but contains meaningless speech. Inappropriate, unnecessary, out of sequence and made up words and phrases will be present in their speech. These made up words are known as neologisms. They are non word substitutions that do not truly resemble the intended word, even when the communicative intent is still there (AphasiaBank, n.d.).

People with Wernicke's aphasia often do not even realize their speech is unintelligible, which imaginably can make conversation very difficult and cause high levels of frustration for the individual. Understanding others' speech, reading, and writing can also be quite difficult for those with this type of aphasia. Yet, this ultimately depends on the unique way it will be expressed in the individual. Deficits may be caused in certain areas and not others, and every patient will react differently.

Nonfluent aphasia is another category of aphasia. The person may still possess typical receptive communication skills, but be limited expressively. Individuals with nonfluent aphasia often have their condition classified as Broca's aphasia. Damage from either a stroke, neurological condition, or accident primarily affects the frontal lobe of the brain. Other attributes include weakness or even paralysis on the right upper and lower extremities, due to the frontal lobe's responsibility in motor movements (NIDCD, 2020b).

Individuals with receptive aphasia have good receptive language skills, meaning they understand speech well. They may be able to plan what they want to say well, but are unable to fully express it as a syntactically correct sentence. These people are much more aware of their speech difficulties, and take great effort even to produce very short utterances in order to try and get their meaning across. This can make communication a difficult undertaking, especially when the experience is new for the person and those around them.

Much of the time, the individual will be aware their communication is distorted. As difficulties persist, the person may speak even less, stagnating their speech skills further. They become increasingly isolated from others and their normal activities. These quality of life changes will be further discussed later on.

An additional category of aphasia important to note is global aphasia. This occurs when the damage described in fluent and nonfluent aphasia occurs simultaneously. For even very simple phrases, there will be a high level of difficulty with comprehension, and language expression may be limited to the repetition of very short phrases and words. All features of other types of aphasia may be expressed in global aphasia. Communication and remediation can be incredibly difficult with this condition (NIDCD, 2020b).

With all types of aphasia, support through speech pathology can make a dynamic change over time to work against the condition's effects. Depending on the severity and amount of damage, getting to a functional version of language can be quite complicated. Finding the same level of linguistic functionality and meaning that a person once had before the onset of aphasia is often unattainable. Various strategies and counseling with the family will be integrated to support the person's reentry into communication.

The elderly are unfortunately vulnerable to common diagnoses that cause aphasia. The breakdown in language that is part of aphasia is present through the stages of Alzheimer's Disease, particularly in the moderate to severe stages (Ferris & Farlow, 2013).

Traumatic brain injury is also an event that can cause extensive communication breakdown. Further defined as a mild traumatic brain injury, the effects of concussions can be dynamic and wide spanning. As referenced by the CDC, many problems are indiscernible with no outer effects in mild TBI - which leads to further problems later. This occurs in about 75% of more than 1.7 million traumatic brain injuries that occur in the U.S. annually (Vander Werff & Rieger, 2019).

Symptoms are unpredictable. Some common issues in the first few weeks after a concussion are headaches, insomnia, and lessened tolerance in certain senses. This is due to temporary changes in the brain's chemistry. A number of individuals deal with issues that are more long term. Changes may persist for several weeks, months, or even years. This is because certain areas of the brain are able to heal more easily than others following injury. The brainstem, temporal lobe, and frontal lobe are much more vulnerable and face the possibility of irreversible damage (Vander Werff & Rieger, 2019).

The higher level of vulnerability for older adults is due to their increased lack of plasticity in these areas. Once a person reaches late adulthood, functionality and maturity of these sections of the brain will be capped at a maximum; they are likely declining at this point. A TBI will further set back and stagnate them in terms of cognitive functioning. This can sometimes be very detrimental, as these severe concussions can persistently affect a person's emotions, senses, cognition, and behavior (Vander Werff & Rieger, 2019). People's feelings about their life and personality can be described as "changed." The effects of TBI are extensively variable and unpredictable, making the evolution and progression of the condition when it does not go away very stressful.

When comparing TBIs in the elderly to younger individuals, it is suggested that negative effects will be exacerbated due to slow recovery times and higher need for hospital services (Peters, 2016). The longer time period spent in a hospital, the greater the strain on the person's sense of independence and normalcy. This will not allow for a return to conditions that would facilitate cognition function.

Statistically, falls are the most common etiology of TBI's for older adults. That being said, after one fall occurs, it becomes a risk factor for it happening again - which could lead to multiple TBIs. For this to occur subsequently can make the already detrimental effects of the condition multiply. This is especially relevant since this population notably has more complex TBIs than younger individuals, with a high incidence of intracranial bleed even in non-severe cases (Peters, 2016).

When areas of the brain that are responsible for language are damaged, such as Broca's and Wernicke's areas, highly specialized lingual functions will be altered or even lost. This can happen not only due to the development of dementia or stroke, but also due to a TBI.

The interconnectedness between these different communication disorders must be considered. New research has uncovered possible associations between the mechanisms of hearing loss and cognitive impairment. There is no proven causation between the two, although one study concludes through extensive research that older people with baseline hearing loss develop dementia at a higher and faster rate than those without hearing impairment (Devere, 2017). White brain matter has been shown to decrease alongside presbycusis development. Some researchers have stated this suggests this type of hearing loss isn't because of age alone - but also because of the sense deprivation that occurs through the auditory channel. Once these passageways through central auditory processing are used less and less, the brain becomes unaccustomed to using them at all. This happens even if hearing was able to be restored through rehabilitation, ALDs, or a hearing aid. Since the clarity and details of the auditory signal are going to decrease, the information coming to the brain will degrade as well. The brain's anatomy itself changes through this process (Devere, 2017).

The effects of less auditory information coming to the brain are associated with cognitive decline. Cognitive decline is an advent of Alzheimer's disease and other forms of dementia, with aphasia occurring in this neurological condition's late stages. Presbycusis and aphasia are interconnected. Although many people have one and not the other, their biological relation and the effects of them occurring concurrently is vital to consider. Doing so might lead us to make more connections between communication and hearing in the future, leading to more productive therapeutic revelations.

Analysis of the relationships between TBI, presbycusis, and cognitive decline can be done through research studies. The location of the auditory center in the temporal lobe is highly vulnerable. Even more, the frontal and temporal lobes, essential for cognition, emotions, memory, and behavior, are the most common areas affected by a concussion (Vander Werff & Rieger, 2019). For the older adult who is already at risk for hearing loss due to noise exposure and other lifestyle factors, an accidental and rapidly occurring TBI could change their communication status and brain function drastically. This is a dangerous risk, especially coupled with the risk these individuals have for falls - 36 million adults fall in the United States every year, with serious injuries occurring one of five times (CDC, 2020a.) Since the risk of older adults enduring cognitive and sensory loss due to TBI is so high, it would be productive to examine how combining factors of these other disorders can affect their lives.

The science and physiology of these conditions in the communication disorder centric sphere is deeply connected. Understanding the origin of these disorders and why they are so prevalent in the older adult population lets us vividly see the multiple areas in which these

individuals face challenges. With the support of caretakers, doctors, therapists, and families in their lives - these conditions are surely surmountable.

Following the diagnosis of a communication disorder, the perspective adopted by the individual in terms of their abilities, level of acceptance, and overall prognosis is crucial to their treatment in speech pathology and other services. The support system and society that surrounds the person also plays an immense role in their ability to deal with the disorder. This will dynamically affect their outcomes. The interaction of these psychosocial factors is complex.

But how differently are older adults with these communication disorders received by their respective societies and communities? No person or those they surround themselves with will be knowledgeable about these topics in the same way. Much more, the emotions and unpredictability that arises out of such conditions is life changing. This is true due to the impacts and disabilities created by the condition, but also because of how support and bureaucratic systems treat the person. Even for organizations inclined to help older adults, biases based on nationality, economic background, and gender can cause a significant gap in the quality of care received. How does this affect a patient and their condition, and why?

Chronic health conditions and coexisting communication disorders can determine quality of life and social well being. An additional factor that affects these outcomes is accessibility to treatment via health care. Communication deficits and various areas of diversity play a role in not only obtaining treatment, but also understanding important information that can directly affect a prognosis. Truly receiving quality services means the client will have ample opportunity to understand their rights to the best of their ability. Without the resources quality

health care provides, a treatment's rate of success will be much lower for disadvantaged older adults.

Inequity in terms of bias is not merely present in communication therapy and remediation. It plays a role in the very foundation of the health care system. Health disparities exist as differences in health outcomes for people of minorities that lead to "social, economic, and environmental disadvantages" (Department of Health and Human Services, 2011). Systematic bias and ingrained prejudice create oppressive limitations on the financial gains that are accessible to minority populations. Opportunities in higher quality education and higher paying occupations are affected by these systems that are part of Western society. These same disadvantages impact the level of health accessibility available. Level of health literacy and monetary ability to consistently access care are some examples. Factors like these often determine the quality of medical care received long term, and they can even create barriers in terms of the possibility of diagnosis and availability of care in the first place. Reasons for such disparities include differences in religion, race/ethnicity, socioeconomic status, sexual orientation, etc. (Department of Health and Human Services, 2011).

The relationship between a patient and their provider can be negatively affected by these disparities and biases, which in turn impacts quality of care. Often, the reason there is a lack of understanding in professional rapport is because the provider fails to understand the patient's experiences, cultures, values, etc. Their own experiences are too far removed from the client's. Potential conflicts created by cultural differences can be remedied by keeping up with current research and getting to know patients realistically and personally over time. An additional recommendation to gain more cultural understanding is to attend diversity and

sensitivity training, which is sometimes deemed mandatory by employers. This is not always the case or possible for a variety of reasons.

Even statistically, there is a lack of proportionality in terms of diversity of health professionals versus the patient population. For example, less than 6 percent of physicians in the United States are Hispanic, even though the Hispanic population makes up 16.7 percent of citizens overall. Using concrete numbers, this is a ratio of approximately 50,000 Hispanic physicians compared to the 60 million citizens of the nationality in the country (Noe-Bustamante et al., 2020). The same statistical trend is evident in communication disorders fields like Speech-Language Pathology. A report from the American–Speech–Language–Hearing Association in 2019 stated that 92% of the practicing SLPs surveyed were white (ASHA, 2019). It's clearly unrealistic to expect patients to receive 1:1 care of someone who shares their race the majority of the time, nor is it sensible or ethical. But there are particular benefits to having a clinician who shares or has first hand experience with the patient's culture. These benefits are very valuable in areas as personal as healthcare or communication disorders. In these fields, clinicians provide services for medical conditions and changes that impact many levels of an individual's personal and professional life.

Shared values between these providers and their patients can be very valuable for immigrant populations in particular. Much of the time, these people may not be fluent in English or even a legalized citizen. Their clinician may lack knowledge of the values, rights, and concerns that will be most relevant to them. Medical professionals and therapists may not always be aware of the challenges that face distinct populations, as well their mindsets. People of lower socioeconomic status are also more prone to illness, obesity, and even morbidity

(Department of Health and Human Services, 2011). This is because their resources in comparison to what is available for their more affluent (and often white) counterparts are not identical depending on their circumstances.

The accessibility of quality healthcare for individuals under private services versus public services is different. Private healthcare and insurance are often provided alongside higher paying occupations, while public services are offered to minimum wage workers or the unemployed under programs such as Medicaid. Higher quality services are much less affordable, meaning that those at a lower economic status may not even pursue areas of care in the first place. This often happens when mental health care is not prioritized when compared to more physical needs. In terms of speech-language pathology, certain conditions and developments that interact with communication are not always noticeable, or do not have a visible impact in terms of life functioning. Mental illnesses and speech disorders are similar in that the individual or family members will not always perceive a need for assessment or evaluation. General physicians and doctors may not either. Even when there are signs of an life functioning/impact issue, clinicians may fail to make a referral due to lack of time, knowledge about the issue at hand, etc. Unfortunately, public insurance plans can also coincide with poorer quality of care and stigma on the clinicians' part. Certain referrals (such as one to a psychologist or SLP) might be considered unnecessary and therefore undoable depending on monetary needs and budget considerations. Therefore, these types of services might be last on the priority list for not only the patient, but also their caregiver.

The projected costs of health care in general are expected to rise 8-9 percent annually in the upcoming years (Yamada et al., 2015). Certain services and referrals are often too expensive

for many people to consider. In addition to monetary concerns, social stigma also creates differences in qualities of treatment. Stigma is the result of differences in power dynamics within interpersonal relationships. In this case, the authority of the health provider presides over the patient as they develop a stigma about them based on their race, language difference, socioeconomic status, etc. This stigma on the physician's part is expressed through exclusion and even rejection of common treatment methods used for patients with higher level insurance plans (Martinez-hume, 2017).

The United States' mixed system of public and private health care inherently leads to inequities. Providers may even unknowingly give in to stigmatization. At times, the complex responsibilities and social life of a patient on Medicaid may be misunderstood as them being "troublesome" or "non-compliant" by the provider (Martinez-hume, 2017). Realistically, the individual may have a unique situation or particular cultural reason they react differently than other patients in their region. One example of this could be a lower-income single mother who, from the clinician's perspective, is closed off and rude as she refuses to give information about her child. The clinician's immediate assumptions are indeed false in this case, the reasons for this miscommunication could be due to privacy concerns in the woman's culture that make her uncomfortable to reveal certain information. The clinician has not taken the time to understand this cultural difference and work through it, perhaps they are even less inclined to because they know this family is on Medicaid. A language barrier or the mother's lack of presence at home due to work can also cause this conflict. Quick judgements are simple to make on the clinician's part, especially when they fail to understand the differences that might occur between the lower class and more affluent populations. The consequences of these stigmas and perceptions

are highly detrimental to the care of the patient and remediation of the issue. Such experiences can also lower their likelihood of seeking out medical care or therapy in the future.

Descriptive medical experiences from interviews state many patients under Medicaid felt like “they were just another number to get out the door” and “getting little attention” as they endured long wait times in private and public health care settings. On a more personal level, some individuals felt they were treated rudely, lowly, or even dismissively because of their health care status. In terms of the treatments and prescriptions offered, some patients recalled lack of explanation or advice as to the best options to pursue. Some providers were “reluctant to provide treatment” at all (Martinez-hume, 2017). Such harsh and non-productive treatment of those with lower level public health plans is prevalent through many communities in the United States, especially those where immigrants are the majority.

A final concept to consider is the differences that lack of a shared language between the patient and provider can create. If the clinician has preconceived, biased notions about their patient before treatment even begins, this will impact their relationship and the patient’s development of self-advocacy. When simple communication is an issue, the patient may feel isolated or looked down upon. This is especially problematic when the clinician is unable to obtain outside resources like a translating service. Even in areas of clinical research and study, many populations are not sufficiently representative of the true population’s diversity level in data collection. This statistical lack of representation carries over into the fields of Communication Disorders, geriatrics, and mental wellness. Greater ethical access into minority populations would make headway into these fields, leading to more effective treatments that will apply better to these populations’ distinct characteristics and lives.

One of the services vulnerable minority populations may lack access to is mental health treatment and resources, particularly for older patients. Common obstacles that face those who are 60 and older are isolation, stigma, and the stresses of possibly facing multiple diagnoses and conditions at once. It would seem to be of priority for these individuals to have access to services and programs that counteract these obstacles. Yet, the loss of sensory abilities like hearing and speech means the disappearance of valuable communication avenues that can make this possible.

Veterans are a population that faces high risks of hearing loss and mental disorder comorbidity. The presence of hearing loss and/or tinnitus is classified as a disability. It creates adverse mental effects that impact sleep, heighten emotions, and cause losses in concentration. Due to the potential these conditions have to create grief, shame, and communication difficulties, the likelihood and ability to seek out treatment decreases. In one study of 300 veterans who had attempted to find tinnitus treatment, posttraumatic stress disorder was present in 34% of the participants. Researchers have hypothesized this could be due to similar neural mechanisms in areas of the brain being affected by the conditions. (Kendall & Rosenheck, 2008, p. 2). There is a strong correlation between the two conditions, statistically due to the blast exposure and trauma risks soldiers face, as well as internally through biological connections. It is understandable that the life impacts of each condition will compound, yet many individuals still do not take part in psychological support that would benefit them. Life impact surveys and psychological research indicate veterans deal differently with these symptoms depending on personality and the resources available. For a population that is clearly in need, much of the time providers tell clients nothing can be done to help their tinnitus. Even

mental health services are not as readily utilized because of the ignorance that tinnitus can cause socioemotional and lifestyle changes. Veterans and other older adults are affected by a lack of support services. These individuals may not independently seek out mental health services without recommendations from a clinician. When this fails to happen, the person may not even consider it on their own. The use of questionnaires and case history interviews can make the status of the patient known, determining if they would benefit from additional support.

An additional survey done with a general sample of elderly patients found that those with hearing loss may seek out health services initially, but fail to follow up a second time (Kendall & Rosenheck, 2008, p. 2). Audiological treatments and training sessions must be consistently scheduled if the goal is any form of rehabilitation. Irregularity of appointments and lack of connection with the clinician would make this impossible. It is clear that there are resources and facilities available that are simply not being used by these vulnerable populations.

Another study done in Rochester demonstrates the Deaf and Hard of Hearing Community's lack of utilization of mental health services. There is a large percentage of these individuals in the region. It was found that only 0.64% of people utilizing mental health services were Deaf or Hard of Hearing. This is vastly unrepresentative of the entire population, especially with many of these people being 65 or older. It can be assumed the population did not take advantage of the services available, but it is also important to realize that mental health diagnoses and services were often done less for these individuals than they were for those without hearing loss. Medical physicians do not always have a complete understanding of

hearing loss and the commonly attributed psychological effects (Kendall & Rosenheck, 2008, p. 3). This is especially true for hearing clinicians who have no experiences in the Deaf community. In a cultural context, they are unaware of issues relevant to the community and how they might be nonverbally represented. All these compounding interactions and misunderstandings can lead to a lower number of referrals to other services that could be helpful to life quality.

These language and cultural barriers may limit a patient's desire and/or ability to initiate seeking care at all. This lack of initiation is only furthered when you consider the geriatric population and their understanding of mental health services. Many people in younger generations today are focused on inwardly developing positive mental health practices for oneself. They advocate for the normalization of mental illness symptoms and services. This mindset is not as common in the older population, which might believe that seeking out mental health support is a sign of weakness and such issues should be handled privately. In subpopulations of older adults with disabilities, even less research and dissemination of shared information may be accessible. The older patient is experiencing and working through a series of challenges and responsibilities everyday. They will likely not have the time, motivation, confidence, or the ability to navigate an unfamiliar system to deal with mental health challenges. It is the responsibility of the provider to support the patient positively and fairly with all the resources and tools they have. But with a lack of understanding or sense of care on the clinician's part, this becomes very difficult, if not borderline impossible.

In the past, the mindset regarding aging was quite different in geriatrics compared to today. It was a process associated with the inevitable loss of ability and health decline that

occurs alongside. Over time, experts John Rowe and Robert Louis Kahn developed a widely accepted theory to define the factors that promote greater quality of life and health in old age. The theory was known as “successful aging”, and could hypothetically be achieved by any person of any social class. Rowe and Kahn believed the choices made in a person’s lifetime have the potential to generate this optimum state later on (Minkler & Fadem, 2002, p. 1).

The loss of physical abilities and mental facilities render important areas of functioning inaccessible to the elderly. This furthers health difficulties and other forms of decline. To counteract this, Rowe and Kahn proposed a positive viewpoint that emphasizes the individual’s ability to counteract the issues associated with “normal aging.” It was believed that these factors are consequent to lifestyle choices and other health factors that are ultimately preventable. Attributes that cause decline are avoidable if people “plan ahead” and make productive choices for their bodies and lifestyles. The characteristics proposed in the experts’ paradigm for successful aging are the following: low probability of disease and disease-related disability, high cognitive and physical functioning, and active engagement with life (Minkler & Fadem, 2002, p. 1).

In reality, critics have come to understand in modern research how a maintenance of these qualities is not possible for all groups of people. One characteristic of successful aging is avoiding health conditions that cause disease-related disabilities (these include cancers, chronic conditions, diabetes, heart issues, etc.) It may be true that the probability of acquiring the disease will be higher depending on certain lifestyle choices. But the reasons that largely determine the condition’s presence are not in the patient’s control.

Structural communities available to promote socialization, information on health and welfare, and educational opportunities are not identical. The presence of these systems depend on the person's location, family structure, or socioeconomic status. For example, facilities and resources in "schools, offices...and society at large" are not present in certain rural communities, or for someone whose income level requires them to work full time at excessive hours in order to earn a liveable wage (Minkler & Fadem, 2002, p. 4). Perhaps the nature of their job is one that does not allow them to enjoy "extracurricular" and more healthy activities that are mentally stimulating and fulfilling. This is the case much of the time for those in economically disadvantaged neighborhoods, where even taking a mentally engaging walk is challenging due to high crime levels in the area.

Community non-engagement and environmental limitations are just some impacts of an inequitable society that can increase older adults' risk of one or more health problems. Prevention of diseases intertwines with the benefits of preserving mental and physical health - another aspect of so-called "successful aging." An additional primary factor is the ability to actively engage with life through social interaction, but once again this depends on the presence of disability.

Different aspects of an individual's life may be considered "active engagement" by doctors or medical professionals. This type of engagement is traditionally recognized as being able to work with others socially and occupationally through interpersonal relationships or a career. The main goal stated by Rowe and Kahn in their aging paradigm was to keep "productivity levels" high through a traditional career that lasts the person's lifetime (Minkler & Fadem, 2002, p. 4). To lose this form of work and purpose in old age leads to low productivity

and living stagnantly. Therefore, if someone's physical condition is deteriorating as a result of the conditions they acquire in old age, they will be forced to retire, which in turn will break down their mental health and emotional stability.

But what about those who never had quality physical health that allowed them to work traditionally, much less hold a long term career? Rowe and Kahn's paradigm excludes not only the economically disadvantaged, but also disabled populations. The differences between able-bodied and disabled older adults are too polarized. They are almost viewed as being a "before and after," and a representation of how drastically life can change if you age the "wrong" way.

In reality, an elderly individual's experience is multifaceted. It is a mixture of different activities they have always enjoyed, as well as the potential new roles and responsibilities they might take on in the absence of abilities they once had. For disabled individuals, specifically those who develop life altering physical, cognitive, or intellectual disabilities, the formerly acclaimed successful aging paradigm would determine they have already failed. But this is because their environment has not provided them with resources that are equivalent to that of their more affluent or privileged peers. Older adults' internal environments are also going to differ depending on their personality and abilities. There is truly no "one size fits all" categorization that is going to ensure success in geratology. People endure challenges and changing dynamics differently throughout their lives. One situation that works well for an individual may be the exact opposite for another.

For example, less social interaction as one approaches older age, although traditionally seen as negative and isolative, does not mean the individual is engaging less with others.

Understanding how this works involves the composition of a social web. This includes the quality and kinds of social relationships that an individual has with family members, friends, neighbors, coworkers, and other important people in their life. Common theories in the past on aging conceptualized that the loss of numerous social connections in life leads to a downgrade in quality of life and a loss of substantial social interaction. More recent studies and research state the opposite, utilizing the concept of the “socioemotional theory” (Palmer et al, 2019).

This theory states that older adults will seek to maintain social relationships that are very rewarding, while gradually distancing from relationships where there are little positive impacts or other benefits. This leads to older adults putting time, effort, and energy into relationships that matter most to them. In this way, it speaks more to “quality” rather than “quantity” of these connections. Having the ability to keep these important relationships intact through a means of communication will increase self-efficacy and independence. Risks due to loneliness and depression will also be lowered when these secure attachments are in place.

As clearly as the progression of these social networks seems to be defined, they will obviously have different qualities depending on the personality and lifestyle of the person (as is true for an individual in any age group). Different qualities of older adults’ social networks may involve age, gender, educational status, income level, and occupation (Palmer et al, 2019). Adults will experience and benefit from their social realities in a variety of ways. This depends on their needs and what they are acclimated to.

The established successful aging model discussed prior suggests that if someone *is* living with a disability, they cannot live well. Other studies refute this mindset, proving that even individuals with severe disabilities can achieve high levels of productivity and interpersonal

engagement through various activities. One example is providing mentorship to young individuals with disabilities. Both people partaking in this partnership will build a relationship person or virtually through phone calls and other technology. A weekly phone call meeting makes the experience highly accessible for those with physical disabilities or chronic conditions that make travel difficult. In this way, people of various ages within the subpopulation are contributing to each others' lives (Minkler & Fadem, 2002, p. 4).

The development of disability during old age should not cause others to instinctively assume there is a negative prognosis. Individuals are still able to lead very successful and fulfilling lives, regardless of their circumstances. Research and the health care environment should encourage the sustainability and possibility of this quality of life. This would be instead of viewing individuals with chronic conditions or disabilities as a "lost cause." A more positive outlook for this population has been developed in the past twenty years, advocating for greater freedom, autonomy, and more positive outlooks for older adults. This same mindset can apply to adults who develop communication disorders as the result of cognitive disabilities, hearing loss, or TBIs. The outreach done to support these individuals is expanding in Western-style caretaking and medical science - even though such opportunities are not always available at an equal rate.

Many communication disorders are often comorbid with disabilities that have a higher incidence in older age. Impacts on language, cognitive or sensory dysfunction can be difficult to separate from other factors of disability or illness that occur alongside. But there is a definite relationship between accessibility of support, communication ability, and social participation.

Social self-efficacy is implicitly part of these life attributes and how they function. This is defined as someone's ability to make an effortful attempt to take an action and achieve the desired result (Palmer et al., 2019). Social relationships and their consistency directly affect the level of self-efficacy someone has. As someone becomes older, they may find themselves efficient in some tasks, but still needing assistance in other areas. This can be highly demoralizing when the desired outcome is not met, evidently demonstrating the level of independence the person once had no longer exists.

In terms of the development of a communication disorder, limitations on language expression and comprehension will only add to the obstacles created by limited self-efficacy. Deterioration of self image is highly possible, which is concerning in terms of the individual's mental health and quality of life. Even in circumstances when an older adult has typically functioning communication and conversational skills, there is a perpetuated fear of appearing "weak" or "needy" to friends or family members. They fear they will no longer be viewed as self-sufficient, and perhaps the self- autonomy they currently have is going to be taken away. This is a common feeling even for people whose physical health is intact, allowing them to be largely independent. The relationship between the self and social environments determines the ability to achieve what is needed. This has a huge impact on independence, which can be a defining trait of a person's mental health and life.

Some studies state that decreased self-efficacy can even increase depressive symptoms (Antonucci, 2006). This is due to a lessened ability to demonstrate negotiation skills on their own behalf. For someone who is dealing with the loss of language due to a recent stroke or TBI that has caused aphasia, this is a prominent concern. Many other health and life concerns

caused by the condition as a whole may be prioritized by the person and their family. Mental health status may be the last objective considered when physical differences caused by the condition are far more prominent. This is a difficult reality that many older adults face as their communication and pragmatic skills deteriorate, even when there are possible support systems and mechanisms available.

Social support is intertwined with factors that can contribute to or limit physical and psychological conditions. Having intact and high quality support systems can improve mental health and cause reductions in the risks of physical disabilities and mortality (Palmer et al., 2019). Communication contributes to several levels of support that can be defined through different levels of attachment. Robert Weiss, a psychologist therapist, cites some of these as emotional support attachment, social integration, reassurance of worth, reliable alliance, guidance, and the ability to provide active support for others (Palmer et al., 2019). All these levels and qualities of attachment are beneficial in that they provide context to:

- establish connections with others
- be established in a community
- know one is valued and useful to others when working with them
- to assist others and be supported in return

When considering sensory deficits that are common in old age, hearing loss in particular is a contributing factor to the degradation of these social and supportive attachments. Older individuals with progressive hearing loss often need greater emotional and social support. This is understandable, since they will deal with career and life altering changes as a result. Family members and friends may not always have the capabilities to respond in ways that are helpful

or productive to the person in this scenario. There is a decreased level of satisfaction with the levels of formal and informal social support received by older adults with hearing loss (Dobson, 2008). In addition to social degradation due to hearing loss, these same conditions and needs will be present for those affected by dementia, aphasia, or a TBI. For someone who is genetically predisposed to acquire one of these conditions, a lack of social and stimulatory interaction may be the reason they develop the condition and even express it symptomatically. Sensory deficit, poor social support, and a proneness to severe concussions combine to exacerbate symptoms of cognitive decline. This comes full circle, since the probability of each of these aspects increases once a condition like dementia is diagnosed. The presence of strong social support is vital. It can play a role before a pathology occurs to help prevent it from happening, or diminish it during its course. With any of these conditions, treatment has a greater probability of success when mental health is benefitted by strong social attachments.

Much of the time the responsibility lies on an audiologist, medical practitioner, or related clinician to note these emotional changes in a client. They are able to provide them with resources and opportunities to help them react and respond to the dramatic life changes they are experiencing.

The clinician's involvement while counselling the patient on such a personal level might not be easily established due to a number of reasons. The patient may have a low level of comfort or familiarity with the idea of counseling, especially while grappling with life and other family concerns. It may even be a mindset influenced by sociability, personality, personal standards, or culture that does not incline them to participate in therapy. Even if they do participate in therapy or a similar support group, the focus might be on internal strength and

well being. The external factors of the individual's support system and social environment are equally important when the diagnosis of a communication disorder is made. Such an environment and its effects are not always easily manipulable in therapy.

Family counseling and evaluation of the patient's environment at home and work are highly important for non professional counseling on an Audiologist or SLP's behalf. These factors also should be taken into account for formal counseling by social workers or professional psychologists. However, these services are at a costly rate much of the time. Due to the gap in income equality and differences in coverage under public versus private insurance, many older adults likely cannot make use of these services.

A lot of the counseling on an audiologist's part to ensure the client handles things well is only done when they are being fitted for an amplification device. This may not even happen for a person with age-related hearing loss, also known as presbycusis. The National Institute of Deafness and Other Communication Disorders states one in three people in the U.S. between 65 and 64 have hearing loss, and nearly half of those older than 75 years old have difficulty hearing. Yet, in 2018 as per market data, only one third of people with hearing loss wear hearing aids. Less than half of adults who reportedly had issues have even seen a healthcare provider for hearing in the past five years (Victory, 2021). (Note these statistics are not only focused on older adults with presbycusis.) A widening use of hearing aid and other amplification device technology has been prevalent in recent years, although hearing aids sales have fallen by 18% in 2020 due to the pandemic (Strom, 2021).

A clear variety of factors contribute to the scarcity of those receiving treatment or amplification devices. This is especially true in recent times. Economic status, cultural concern,

and personal comfort affect the ability, or even the desire, to receive care. Much of the time, information on hearing loss and possible treatments are not easily accessible. This is sometimes the result of bilingual language barriers or differences, but also because of a lack of health literacy.

A highly dense document or fact-sheet with jargon and scientific terms will be meaningless for a patient. And if it is legible or understandable for one person, it may not be for others, such as someone who speaks English as a second language or has lower than average cognitive abilities. Information written at too high a reading level can potentially be incomprehensible. Direct senses like eyesight and hearing play a role in the ability to obtain information from written documents and interactions with professionals and doctors. For example, if a speech-language pathologist presents information in a way that is not very clear to the client, there is a high chance nothing will be gained from the interaction. This could be because of too complex language being used, too high a rate of speech, or simply too much information at once.

Clients may feel like the clinician is belittling them or sees them as inferior. Even if the clinician realizes this disconnect exists and attempts to remedy it after the fact, they may have already lost the patient's patience, respect, attention, or willingness to cooperate. Understandably so, since time has been wasted for the client. A sense of rapport and a productive start to this professional relationship is pivotal in enacting treatment. This is the case for most all communication disorders. In this period where the client is getting to know their clinician, such misunderstandings can compromise the relationship, which will ultimately hinder positive outcomes from treatment.

It is for this reason information in interviews, counseling, and treatment discussion should be clear, slowly dictated, and patiently given. Enough time should remain in sessions to create opportunities for repetition by the clinician. This will hopefully help clarify any information the patient was unclear on, with the clinician using reinterpreting their words into more understandable verbiage if necessary (Federico, 2015). This is a highly valuable method to ensure health literacy and quality dissemination of information with elderly patients. It should be prioritized for those with communication disorders, neurological issues, or cognitive limitations that result from old age or a distinct condition's progression.

When applicable, It is recommended for patients to be involved with and understand the purpose of treatment, as well as the progression of their condition. This contributes to their levels of self autonomy and independence, in addition to the maintenance of a realistic view of a future with the communication disorder or disease. Not only the client, but also their family will adjust better to changes as a result of these practices.

Dementia is one condition where it is important to make the individual aware of changes and complications to expect and how their condition will progress over time. There is no treatment that currently serves as a cure for dementia. Therefore, many individuals survive to old age with the condition as it reaches its later and most devastating stages (Volicer, 2007). This is a painful process for the individual and their loved ones, especially as they become aware of their autonomy and sense of cognitive reasoning slowly being over time. Self advocacy is an important goal of counseling that SLPs provide to their clients with dementia. But this becomes increasingly difficult as cognitive abilities are threatened through a condition like this, as well as when a traumatic brain injury occurs. Aphasia, the language and speech disorder discussed

previously, is often expressed in these patients. This furthers the complications to be had, especially as they occur alongside memory loss and the declination of physical mobility and function.

At this time, there will be a greater focus on providing the family with information on the client's clinical and communication prognosis. Since the individual's cognitive skills have changed or regressed, the family or caretakers will take on this responsibility. The clinician will expand on what to expect and strategies to deal with symptomatology. This can be an increasingly stressful and heavy mental burden for relatives who may have a close relationship with the client. Greater rates of strain, depression and a variety of emotions are common for family members and caregivers of those with dementia and/or chronic cognitive impairment (Lu & Haase, 2009). Attention by physicians and other professionals should be given to the state of the family, and mental health and support resources can be provided as options.

Dementia is considered to be a terminal illness at its most severe stage, since it usually is part of the patient's life until their death. There are some aggressive forms of treatment available that aim to alleviate the disease's detrimental symptomatology. But these are not always in the best interest of the patient and their desired quality of life, especially in a time where their current functioning may already be limited. In more advanced stages of dementia, palliative care is seen as a more appropriate strategy to maintain dignity, life comfort, and as high a quality of life as possible (Volicer, 2007). This can be done with support and care in a positive environment.

The setting should evoke emotions of comfort and happiness when possible for the patient, along with the consistency of a caregiver's presence. A respectful caregiver, who is

possibly trained and may be a relative of the client, will help maintain functioning during day to day activities. The alternative to this warm and nurturing caretaking is an environment that is much less mentally and physically engaging in comparison. There is a lack of personal connection to the patient in this setting, where they may be sitting immobile in an institution or hospital.

There are several situations where an acute care setting with more intensive medical intervention would be necessary. Unfortunately, this is where orientation of care that does not concern the patient's dignity may be put into practice. By definition, dignity oriented care views a client as an individual with values, pride, needs, and wants (Volicer, 2007).

Perhaps the most medically sound definition of treatment is not what will truly benefit the patient when they are already in the late stages of their life. In a time where former functional and communication skills the person has had all their life are threatened or completely absent, the person deserves the right to maintain these comforts and smaller forms of dignity. An example of this is tube feeding in an acute care setting, and whether or not this is justifiable. Such situations and decisions are tremendously stressful, difficult, and even traumatizing to the patient and their family. There may be differences of opinion and desire, and the individual awaiting treatment may not be able to verbalize their preference. The option of palliative care in situations such as these is vital to understand. It should be considered not only by the family, but also workers and professionals in medical health care and group home settings.

Some practitioners and clinicians may already have more progressive leaning ideologies in terms of their intentions and methodologies for older patients. The question of what

treatment would best serve someone's quality of life when they have an incurable communication disorder or condition depends highly on the situation. Some care settings and types of professionals will hold different opinions and values that compete with one another. The patient's family member may even have to advocate for them on their behalf, and the decision may not be easy no matter what is decided.

The consideration of the older adult's right to dignity, quality of life, and hope should be prioritized. This is even in circumstances that traditionally require medical care to prolong the life span. Current forms of assistance for older adults to sustain their social skills, self-autonomy, and quality of life are valuable to consider and evaluate. Doing so will provide insight on current and future care models for individuals with and without communication disorders. Analysis of these models will further not only the effectiveness of care in speech-pathology and audiology, but the entire medical field.

Communication and the potential it creates for human connection is a driving force of our lifestyles. The health of our minds and bodies determines the quality of our lives. Through making decisions on how to manage stress, dealing positively with conflict, and taking time to relax, we care for mental health. By maximizing medical resources, eating well, and exercising, we maintain physical strength. This is no easy feat for practically anyone - the day to day dynamics of life lead to all of us facing deficits in one or two of these lifestyle areas. This is inevitable since no one's life is perfect. Many of the support systems and opportunities we have are framed by inequity. A variety of health conditions and illnesses will interact with our mental and physical health throughout our life times. Many obstacles will face us, and every individual

deals with these trials differently. It is compelling to consider the different environments and individuals that support us all through life and its challenges.

A person may acquire a condition that impacts them for the rest of their lifetime - like hearing loss or the loss of language skills. What activities that they love will they still be able to do? Who will be there for them in this crisis; who will they lose? Besides the biologically profound impact the condition will have on their physical health, their identity and well being is at stake. It is important to find meaning in this new version of normal, especially when everything else in life becomes so unpredictable.

Special attention has been given to research of older populations with chronic conditions and disabilities. Many individuals affected may attempt to look into online resources to understand themselves and their condition. They might seek connections with doctors, specialists, and other members of their community to share empathy through healing together. This is common for all sorts of disease and conditions; our current technological world makes the potential for knowledge and empowered connections greater than ever. But this cannot truly solve the problems created by a condition or illness. When there is no true cure, these resources serve as a sense of comfort and strength when our will and hope wanes.

More medical professionals and people who work with geriatric populations should serve with care methods geared towards preserving quality of life. The process of aging is incredibly complex and something we will all hopefully have the privilege and opportunity to experience. People are living to reach older age on average than they have ever before, but this does not come without a series of communication and life changes. The medical issues that arise are immense, and they cannot be treated or understood in the same way they are in

younger populations. Older adults deserve a holistic focus in scientific and medical research.

This will contribute to the development of treatment and counseling techniques that help them obtain the best life outcomes possible.

An awareness of the challenges that face the elderly is not only important to upcoming professionals, but seasoned ones as well. All professionals can benefit from making their clientele aware of the changes in quality that might result from one or more of these common conditions. Keeping an optimistic tone and thought process while understanding the parameters of aging can make an incredible difference. Not all treatments are equally accessible, so there are several obstacles patients need to be made aware of. Even in the current times that the pandemic has created, communication has become limited for people of all ages. In a therapeutic sense, one can imagine how difficult things must be. There is growing research on teletherapy research in speech and other modalities for children, but the next next step is understanding how things can be made easier for older adults in this context. Individuals are living to be older and older, but if we can't find it in ourselves as a society to care and do work for their well being , their quality of life will not be high.

In terms of promoting self advocacy and psychosocial assistance for older adults, a lot of successful measures have been established. Researchers and advocates are paying close attention to what matters in this stage of life - and the results are evident from the growing research in geriatrics and the changing structures and quality of adult care homes. Yet even as new solutions are discovered and developed, it is very hard to distribute benefits evenly across economic boundaries that interact with multiple areas of diversity. Professionals are being trained more on diversity approaches through academics and continuing education units. But to

actually apply these ideals is a skill that demands extensive experiences and personal involvement. Some clinicians are not as committed to creating room for this modality of thinking as others - even those who work with diverse or older populations. There are many other options available for distinct groups of people who need services, especially when traditional ones are not feasible. For example, for a low income family, there are other forms of funding, like university clinics and community centers. There are a series of resources growing all the time, but how can we most effectively apply strategies and resources in real time? Are there any official answers, or does it truly depend on the unique situation presented and the effects of the condition?

An additional topic to consider in future research is the morality of rehabilitation and care services in the past compared to today. Some treatments used in the past for older adults with these conditions and communication issues are unethical by today's standards. Even practices used presently with good intentions can contribute to negative impacts, almost becoming neglective or abusive. Although most scientific and medical practices must be attempted and done wrong before they are done right, the cost should not be the integrity of a human being already in vulnerable circumstances. It seems important to understand the research of the past and its fallacies by today's standards. Also, although Western medical rhetoric and science is not the golden standard, it would be useful to compare its evolution of care to systems in other countries. Which countries have information and treatment that enables them to advocate well for older adults' quality of life? How does this compare to Western protections and the accessibility of health care systems? Which countries that claim to uphold these rights are not doing so? Before immediately assuming the morality of one kind of

treatment over another, one should take an acquisitive eye - to both the past and the present - to eliminate bias. This mentality seems valuable to ensure mistakes are not repeated and inventive solutions are prioritized.

Another area to expand on is intersectionality, especially in terms of the challenges faced by older adults of diverse populations. This was discussed briefly in the health disparities focused section of this paper. Further research and analysis of what affects quality of life in these circumstances would be fascinating to explore. Older adults who have LGBTQ+ identities, are part of the homeless population, or have addiction issues may be more difficult to gather information on. Although, if done well, analysis and understanding of these groups would lead to greater therapeutic outcomes and understandings. This is important because it would help reach people who are often underrepresented and disenfranchised throughout their lifetimes. They may not even realize they have the right or the means to access health services specific to issues they may be dealing with. These attributes of life and unique challenges for older adults intertwine with general quality of life concerns that are discussed throughout the paper. By learning more about the values and concerns of these communities, clinicians of all kinds will be able to advocate for them and achieve greater care outreach over time.

There is always more to learn and consider in the aging adult population. Gaps between communication loss, chronic conditions, and economic inequality should be further narrowed down through future analysis and work. These conflicts and barriers will always exist, and it is important to realize how these concepts directly affect real people. It is beyond data, statistics, and scientific analysis. I anticipate continuing to learn more in the field, not only through a

communication disordered lens, but also one that provides insight on people's way of life and thinking. This will encourage me and others to be empathetic in working as clinicians and understanding how to be supportive to people from all walks of life. A disabled or chronically ill person being referred to as a "lost cause" is common. Such phrases are ableist and ageist. Our ways of thinking in society and the medical field have assuredly improved over time in these areas, but there is more work to be done. People's self perception affects their chance at successful treatment and improvement. When the world hands you a view of yourself that says all is lost, it's hard not to internalize it. We as clinicians and fellow human beings need to persevere against that mindset, for the good of the older adults in the present, as well as for the needs all of us will have in the future.

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