

Contemporary Issues in Gerontology

Promoting Positive Ageing

V. MINICHELLO AND I. COULSON
EDITORS


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Allen & Unwin
83 Alexander Street
Crows Nest NSW 2065
Australia
Phone: (61 2) 8425 0100
Fax: (61 2) 9906 2218
Email: info@allenandunwin.com
Web: www.allenandunwin.com

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Foreword

Human ageing is a global phenomenon, linking north, south, east and west. Indeed, while the more developed countries aged substantially in the last century, it is the less developed ones that will see the greatest and most rapid increase in the number of people aged 60 years and over during the first half of this century. The global increase in this age group will be from 10 per cent of the total population in 1998 to 21 per cent in 2050 (from around 600 to almost 2000 million) and, in the less developed countries, the absolute numbers are expected to quadruple.

In the face of this demographic revolution, which presents major challenges to families and communities as well as governments, a strategy is required to ensure that the extra years added to life are quality years rather than being spent in poverty, ill-health, disability and isolation. To paraphrase the World Health Organisation: 'Years have been added to life—now we must ensure that life is added to those years'. Instead of the 'apocalyptic demography' and alarmist newspaper headlines that often greet new data on the scale of population ageing with negative images, what is required is a positive perspective that sees ageing as a lifelong process and older people as significant contributors to family, community and economic life; whose potential is not realised.

That is where this book scores handsomely. As its subtitle suggests, this collection is orientated towards positive ageing and this theme is pursued consistently from chapter to chapter. While its positive focus on active life expectancy is more than sufficient for me to commend this collection to students of gerontology everywhere, it also has an admirably practical dimension alongside its scientific core. Each chapter includes case studies and proposed activities, policy prescriptions and guidance for practitioners. This will make it invaluable as a textbook for practitioners—such as nurses and care workers who are training to work with older people. The chapters themselves are substantially literature reviews covering the key issues under each topic and these issues range widely across the gerontology field. Victor Minichiello and Irene Coulson have assembled a talented cast and, therefore, each contribution is of a very high quality.

The book begins with a powerful argument against ageism (labelled in the United Kingdom as the last unrecognised discrimination) as the basis for positive ageing. In Chapter 2 the centrality of health to positive or active ageing is demonstrated. The increasingly important topic of mental health is discussed in Chapter 3. While recognising the multiple determinants of well-

being in old age the importance of social networks and social support are highlighted. Minichiello is one of the pioneers in the field of sexuality and ageing and Chapter 4 dispels some of the grossly ageist stereotypes on this topic, especially the myth of the asexual older person. This Chapter challenges the commonplace ageist assumptions behind how society views the sexuality of older people. Chapter 5 provides a valuable guide to the prevention of dementia, pointing to the key roles of self-actualisation or spiritual growth and healthy lifestyles. The need for a new policy paradigm on work and retirement is demonstrated in Chapter 6. Then Catherine Bridge and Hal Kendig, in their consideration of housing and the built environment in Chapter 7, argue for an environmental approach to supporting older people. Again there are plenty of practical interventions that aim to promote wellbeing. Chapter 8 is an extensive review of gerontological research on caregiving. Among many other topics Neena Chappell and Glenda Parmenter refer to the trend across the more developed countries to concentrate care resources on those in greatest need, a policy which undermines the preventative potential of supportive services. The following chapter on service delivery complements nicely this account of informal care. Chapter 10 concentrates on the promotion of positive ageing and looks at interventions and lifestyle choices not commonly found in gerontology textbooks, but used increasingly by older people themselves to achieve active ageing and a positive outlook. These include natural therapies, such as acupuncture and massage, spirituality, music and wellbeing. Health professionals are given clear guidance in these novel areas. The final chapter examines the role of technology in independent living and relates gerontechnology to a broad-based health promotion model. The central message here is the need to involve older people in shaping the technology that affects their lives.

As this foreword indicates, the scope of the book is wide while the analysis achieves depth as well. Having been, for the last five years, director of the largest social science research programme ever mounted in the United Kingdom, the Growing Older (GO) Programme on Extending Quality Life, I am struck by the similarities between that research and this volume, emphasising again the universal nature of ageing. Comparative material can be downloaded from the GO website (<http://www.shef.ac.uk/uni/projects/gop/index.htm>). I have no doubt that this textbook will be a much sought after reference for students and professionals in gerontology for years to come and, because of its laudable emphasis on promoting positive ageing, also has the potential to help to make active life expectancy a reality.

Professor Alan Walker

Department of Sociological Studies, University of Sheffield, United Kingdom

Contents

Foreword	iii
Figures and tables	vii
Contributors	viii
Acknowledgments	x
Preface: The context of promoting positive ageing	xi
1 The challenges of ageism	1
<i>Victor Minichiello, Margaret Somerville, Cathryn McConaghy, Jenny McParlane, Alan Scott</i>	
2 The role of health promotion in healthy ageing	34
<i>Rafat Hussain, Rodrigo Mariño, Irene Coulson</i>	
3 The experience of ageing: Influences on mental health and well-being	53
<i>Colette Browning, Yvonne Wells, Andrew Joyce</i>	
4 Sexuality, sexual intimacy and sexual health in later life	78
<i>Victor Minichiello, Samantha Ackling, Chris Bourne, David Plummer</i>	
5 Considerations and challenges in the prevention of dementia	105
<i>Irene Coulson, Rodrigo Mariño, Vicki Strang</i>	
6 Work and retirement later in life: Is retirement a relevant concept for the 21st century?	120
<i>Linda Rosenman</i>	
7 Housing and older people: Environments, professionals and positive ageing	144
<i>Catherine Bridge, Hal Kendig</i>	

vi	Contemporary issues in gerontology	
8	The challenge of caregiving <i>Neena L. Chappell, Glenda Parmenter</i>	167
9	Delivery of care for older people <i>Lyndall Spencer</i>	190
10	Vehicles to promote positive ageing: Natural therapies, counselling, music and the creative arts <i>Judy Harris, Terrence Hays, Jeffrey Kottler, Victor Minichiello, Ina Olohan, Peter Wright</i>	215
11	Gerontechnology: Optimising relationships between ageing people and changing technology <i>James L. Fozard</i>	241
	References	269
	Index	314

Figures and tables

Figure 2.1	The ORHIS development process	47
Figure 6.1	Older men: Labour force participation over time by age cohort (Australia)	124
Figure 6.2	Older women: Labour force participation over time by age cohort (Australia)	124
Figure 6.3	Males: Average age of labour force withdrawal	125
Figure 6.4	Females: Average age of labour force withdrawal	126
Figure 7.1	Maintaining functional capacity over the lifecourse	145
Figure 7.2	The intersection of accommodation, disability and care	159
Figure 11.1	Person–environment interface and its changes over time	249
Figure 11.2	Marshall's social ecology model of person–environment relationships (left) and its relationship to gerontechnology (right)	264
Figure 11.3	Detail of the Healthy People 2010 model of the factors that influence health status and its relationship to gerontechnology	265
Figure 11.4	Health promotion model by Marshall (2002) relating well-being at any age to ever more remote factors that impact current well-being and the relationship of determiners of well-being to the person–environment model of gerontechnology	267
Table 2.1	Suggestions for improving communication with participants who have hearing and visual impairments	42
Table 2.2	Health-promoting lifestyle profile: Six healthy lifestyle dimensions	50
Table 5.1	Hachinski Ischemic Scale (1992)	108
Table 6.1	Employment status of older Australian workers, 2001	129
Table 10.1	Knowledge areas in counselling the older person for health professionals	225

Contributors

- Samantha Ackling** Doctoral student in the School of Health at the University of New England in Armidale, Australia, undertaking studies on sexual intimacy in later life.
- Chris Bourne FACSHF** Staff Specialist and Medical Unit Manager at the Sydney School of Health Centre, Sydney Hospital.
- Catherine Bridge PhD** Director of the Home Maintenance and Modification Clearing House in the School of Occupation and Leisure Studies at the University of Sydney, Australia.
- Colette Browning PhD** Associate Professor in the School of Public Health at La Trobe University in Melbourne, Australia.
- Neena L. Chappell PhD** Professor in the Department of Sociology and a Canada Research Chair in Social Gerontology in the Center on Aging at the University of Victoria in Victoria, Canada.
- Irene Coulson PhD** Professor and Dean of the Faculty of Nursing at the University of Prince Edward Island in Charlottetown, Canada.
- James L. Fozard PhD** President of the Florida Gerontological Research and Training Services, Florida, USA, and serves on the adjunct Faculty of Saint Leo University, Florida, USA.
- Judy Harris PhD** Lecturer in the School of Health at the University of New England in Armidale, Australia.
- Terrence Hays PhD** Lecturer in the School of Education at the University of New England in Armidale, Australia.
- Rafat Hussain PhD** Senior Lecturer in the School of Health at the University of New England in Armidale, Australia.
- Andrew Joyce** Former doctoral student in the School of Psychological Sciences at LaTrobe University in Melbourne, Australia, who recently completed his studies on social activity in older people.
- Hal Kendig PhD** Professor and Dean of the Faculty of Health Sciences at the University of Sydney, Australia.
- Jeffrey Kottler PhD** Professor and Head of the Department of Counseling at California State University in Fullerton, California, USA.

- Rodrigo Mariño PhD** Senior Lecturer in the School of Health at the University of New England in Armidale, Australia.
- Cathryn McConaghy PhD** Senior Lecturer in the School of Education at the University of New England in Armidale, Australia.
- Jenny McParlane** Associate Professor in Nursing in the School of Health and Associate Dean in the Faculty of Education, Health and Professional Studies at the University of New England in Armidale, Australia.
- Victor Minichiello PhD** Professor of Health and Dean of the Faculty of Education, Health and Professional Studies at the University of New England in Armidale, Australia.
- Ina Olohan** Lecturer in the School of Health at the University of New England in Armidale, Australia.
- Glenda Parmenter** Lecturer and Nurse Practitioner in the School of Health at the University of New England in Armidale, Australia.
- David Plummer PhD** Associate Professor in Community and Public Health in the School of Health at the University of New England in Armidale, Australia.
- Linda Rosenman PhD** Professor and Executive Dean of the Faculty of Social and Behavioural Sciences at the University of Queensland in Brisbane, Australia.
- Alan Scott** Doctoral student in the School of Professional Development and Leadership at the University of New England in Armidale, Australia, undertaking his studies on ageism and society.
- Margaret Somerville PhD** Associate Professor in the School of Professional Development and Leadership at the University of New England in Armidale, Australia.
- Lyndall Spencer PhD** Research Fellow in the Department of Medicine at the University of Queensland in Brisbane, Australia.
- Vicki Strang PhD** Professor in the Faculty of Nursing at the University of Alberta in Edmonton, Canada.
- Yvonne Wells PhD** Research Fellow in Lincoln Gerontology Centre in the Faculty of Health Sciences at La Trobe University in Melbourne, Australia.
- Peter Wright PhD** Senior Lecturer in the School of Education at Murdoch University in Western Australia.

Acknowledgments

The inspiration for writing this edited collection has come from talking with older persons about their lives and learning that there is nothing to fear from growing old. In fact, we have been enriched by the many positive stories and experiences that accompany the journey of people as they grow old, despite the many challenges they face.

The book attempts to value growing old and to support older people in their campaign to combat ageism in our society. We also hope that the younger reader will rethink his or her misconceptions about older people and respect the human right of older persons to experience the same rich opportunities for social, cultural and productive roles and not be subject to selective discrimination because they are 'older'.

This book reflects a collaboration between many people. First, we are indebted to the many older persons we spoke to, and particularly our senior postgraduate research students at the University of New England in Armidale, Australia. Second, we are grateful to Jeanette Tan and Gloria Davidson for assisting us with typesetting the manuscript, chasing reference details, and providing excellent support. Third, the contributors have been most patient with us. We want to thank them for participating in this project. And finally we want to acknowledge the support we have received from Emma Cant and Jeanmarie Morosin at Allen & Unwin.

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Professor Victor Minichiello

Professor Irene Coulson

Preface: The context of promoting positive ageing

Victor Minichiello, Irene Coulson

The challenge

The past century saw astronauts landing on the moon, medicine mastering human organ transplant, people communicating across the globe using email, mobile phones, faxes and instant Internet connections—but, alas, finding no antidote to stop the ageing process, the so-called ‘fountain of youth’. In our view, however, we should not be disappointed that such a remedy has not been found, because there is nothing inherently bad or abnormal in growing old.

We age from the moment we are born. But somehow western societies want to put a stop to the ageing process at about the time a person reaches the age of 21 or so. Why? So that they can retain and preserve the physical appearance and attractiveness associated with those so heavily featured by fashion, advertising and youth-preserving technologies and lifestyle industries. Perhaps our problem is not so much with ageing, but with our lust for youthfulness.

The new millennium has, however, brought what might appear to be longer life expectancy and better health for older citizens. ‘Successful ageing’ is no longer an oxymoron but a reality. We will leave the subsequent chapters to argue the impressive statistics associated with life expectancy these days and the health status of ageing populations in western societies, although it is important to make two

points. One is that some groups do better than others. For example, minority groups such as Indigenous people experience risks in their lives that adversely influence life expectancy (Thomson 2003). The life expectancy for Indigenous Australians is much lower than for white Australians; similarly, the life expectancy for people living in Australia, the United States, Canada and the United Kingdom is far higher than for people living in Rwanda, Uganda or Sierre Leone, three countries amongst those with the lowest life expectancy rates. Second, Fries (1986) studied the life expectancy of humans in general and documented that average life expectancy can expect to remain at around 85 years, plus or minus seven years, depending on how well disease and other influencing lifestyle factors can be controlled. The theory put forward by Fries, however, is that human life is finite. What has been occurring over time is not the extension of life per se, but rather that the onset of disease has been delayed to produce what he refers to as a 'rectangular survival curve'. This curve is represented by a decline in infant mortality and in the number of deaths from accident and violence during the middle years of life, together with a decline in the number of deaths from acute and chronic diseases in the later years, thus allowing more people to reach the life span of the species. Zimbabwe, however, presents a stark reminder of how quickly improvements in life expectancy can be eroded, for over the past few decades it has dropped in that country from 67.5 years to about 33 years due to HIV/AIDS (Tirrito 2003).

The new millennium has also brought general improvement in the health status of older people. Take, for example, the results of the longest study of ageing in the world, the Study of Adult Development at Harvard University that includes three separate cohorts of people born in 1911, 1921 and 1930 (Vaillant 2002). It documents overall improvements in health over the span of the study, although the argument about differences between groups made above also holds true here. Some groups show much better health outcomes than others. This American study reveals findings duplicated in many other studies across western nations. Increasingly, people in developed nations are growing old without brain disease, are not depressed and maintain a modest well-being until the final months before they die. This picture reflects our own experiences with our grandparents. For example, both grandparents of one of the authors lived independently and grew old relatively illness free until a heart attack (a few minutes) or

cancer (a few weeks) quickly terminated their lives. The authors still have their parents living independent and active lives and in good health.

Of course, we recognise that some older people do experience prolonged loss, poor health and dependency in later life. This too is a part of the reality of the ageing experience. Do we believe Robert Browning, who urges us to ‘grow old along with me! The best is yet to be . . .’, and accept this related view:

Contrary to all expectations, I seem to grow happier as I grow older. I think that America has been sold on the theory that youth is marvellous but old age is terror. On the contrary, it's taken my sixty years to learn how to live reasonably well, to do my work and cope with my inadequacies.

For me youth was a woeful time—sick parents, war, relative poverty, the miseries of learning a profession, a mistake of a marriage, self-doubts, booze and blundering around. Old age is knowing what I'm doing, the respect of others, a relatively sane financial base, a loving wife and the realisation that what I can't beat I can endure (quoted in Vaillant 2002, p. 14).

Or do we accept William Shakespeare's assertion that old age ‘is second childishness and mere oblivion; Sans teeth, sans eyes, sans taste, sans everything’. We concur that both scenarios can be someone's reality and lived experience.

The new gerontology

Holstein and Minkler (2003) describe the ‘new gerontology’ movement that is replacing the study of disease and disability. The popular discourse found in the gerontology literature and at conferences these days is that which ‘seeks to counteract and replace the old decline and loss paradigm’ (Holstein & Minkler 2003, p. 787). What is emerging is a ‘successful ageing’ agenda that uses a preventative discourse model to provide insights that avoid or delay losses and physical and mental decrements. This book welcomes this shift in emphasis—let us be clear about this point. Like our colleagues Holstein and Minkler, who make their argument so convincingly, we believe that successful ageing as defined by Rowe and Kahn (1998) to include the avoidance of disease and disability,

the maintenance of high physical and cognitive functional capacity, and active engagement in life, is much too limiting.

Good health is only one of the issues on a much larger social agenda that includes the attainment of happiness, wellness, fulfilment, respect and equality in later life. We cannot simply assume that every individual can take sole responsibility and control over their life and make autonomous and informed choices to achieve the above outcomes. To do so would assume that everything else is equal and that every person has the same means and resources made available to them by their society. Eating well, not smoking, having safe sex, exercising (all of the good health promotion messages we constantly hear) are important. But if we are to change how people think and experience ageing and later life, we need to consider the contexts and constraining factors that influence access to, for example, affordable housing, adequate income, clean environments and quality health care. Policies are required to support the equitable distribution of resources to poor and disadvantaged older persons and reverse the ageist attitudes formed over many decades, if not centuries. And we would need to recognise and address the fact that society privileges some groups over others. Holstein and Minkler (2003, p. 792) make a good point when they argue:

[An] individualistic analysis doesn't ask if the 80-year-old skier had county club privileges and a winter home in Colorado, or the 80-year-old in the wheelchair had cleaned houses for a living while holding down a second job as a nurses' aide on the graveyard shift in a nursing home. Nor does this analysis inquire about the inner or family life of our 80-year-old in the wheelchair. These contextual features, at a minimum, shape the conditions of possibility for individuals and determine how they choose what to value. If the ideal is not practically feasible for all, or even most, people—even with the best intentions—then it serves to further privilege the already privileged, a danger that a feminist perspective identifies.

Positive ageing

This book shows that we are experiencing a notable departure from the narrow focus on disability in later life and a movement towards a broader approach using wellness and primary health care concepts. Primary health care is defined by the World Health Organization

(1998) as essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community can afford. In order to promote positive ageing, health care policies and practices need to take a life course perspective that focuses on health promotion, disease prevention and equitable access to resources. Positive ageing policies need to focus on improving the life experiences of older people as a group and create an environment that offers opportunities for continuing participation in society, and an understanding of how cultural factors, gender, economic status and geography, for example, influence life chances. Definitions of health for older people must also include health and wellness as being inseparable from identities and experiences accumulated throughout the life span (Kendig 1996b).

This book invites the reader to examine the challenges we face this century, in terms of an ageing population and the diversity of issues we need to re-evaluate, including housing, technology, ageism, sexual health and intimacy, the role of health promotion, work and retirement, social support, the cost of care, and alternative ways to empower and promote positive ageing. We describe the challenges of ageism in a society that still discriminates against older people merely because of their age. We predict that in the decades to come an unprecedented number of baby boomers and future generations of older citizens will and must exert social and political influence to change the current discourses about ageing.

How quality of life will be experienced in later life will become of paramount importance to all of us. Quality of life is defined as an individual's perception of their position in life in the context of their culture and value system, and in relation to how society allows its citizens to achieve their aspirations and goals, as well as address their concerns. It is a broad-ranging context, incorporating in a complex way a person's physical health, psychological state, social status in that society, social networks and relationships to salient features in the socio-political environment.

The chapters that follow shed light on how ageing can be better understood and affirmed and spoken about in more empowering and humane ways, and not, to use a sociological term, as the 'other'. This edited collection attempts to address the questions: How can later life be enjoyed with all its strengths and complexities in more meaningful ways? and: How can older people be liberated to change the ageist fears that are internalised by so

many of us? Without a doubt the basic structures of our societies will need to be re-examined and redefined to meet the expectation by older people for a better and different life to what we currently know as 'old age'. Failure to fulfil this expectation will give rise to opposition and conflict.

1

The challenges of ageism

**Victor Minichiello, Margaret Somerville,
Cathryn McConaghy, Jenny McParlane,
Alan Scott**

No one can doubt that sexism and racism revolutionised the way people and institutions in our society had to rethink relations between dominant groups and women, black and Indigenous people. Women are now found, for example, in large numbers in medical schools and general practitioner (GP) practices, businesses and government. They hold key positions of power such as vice chancellors of universities, chief executive officers of large multi-national corporations, ministerial cabinet positions and so on. Legislation makes it illegal to discriminate on the basis of gender, race/ethnicity and sexual orientation (see Chapter 4). Forms of oppressions, such as domestic violence and segregation, have been given public exposure and both legal and political measures have been put in place to reduce the effects of such oppressions on the lives of social minority groups.

Without a doubt the 21st century will see a revolution in terms of the relationship between older people and other age groups and the way society views the status and position of older people. Why is this? Older people are devalued and discriminated against. They will not tolerate this treatment for much longer, especially given that they are growing in numbers and have the potential to be an influential activist group.

2 Contemporary issues in gerontology

Ageism is a current reality in the lives of older people and we will come back to discussing the research that supports this statement later in the chapter. Ageism reflects a deep-seated uneasiness on the part of the young and middle aged and is frequently internalised by older people themselves. Ageism is a personal revulsion towards and distaste for growing old, disease and disability, and a fear of powerlessness, uselessness and death (Butler 1975). Bytheway reminds us that we find being 'old' in western society difficult or undesirable:

So are we all sensitive to revealing our age? How self-conscious do we feel when asked outright how old we are? Do we shriek? Do we feel our energy ebbing? Do we feel uncomfortable as we stutter over the answer? Do we find ourselves elaborating it with comment about how we feel and what we do? (Bytheway 1995, p. 7).

This chapter discusses the concept of 'ageism', how it is manifested and its consequences. It documents how widespread ageism is in our society, including in the health and aged care sectors. Current discourses about older people and ageing are presented to highlight the assumptions that are underpinning such discourses. The role older people will play to reverse the impact of ageism on their lives is discussed.

What is ageism?

Before discussing ageism in more depth, let us briefly explain how ageism is created. Bytheway (1995) argues that ageism is the creation of values in society that have developed over centuries. Many of the ingrained ideas that western culture holds about ageing have come to us from ancient Greece and Rome. Amongst them was the idea that the state of youthfulness, being slim and having no defect, was most desirable, and that being 'old' was offensive. Euripides in the *Suppliants* (c.423 BC) tell us: 'Old age, that irresistible foe, how I loath your presence. I also hate those who desire to lengthen their span of life, seeking to turn the tide of death by foods and drinks, drugs and magic spells; people that death should take away when they cease to benefit the world, leaving the young their place.' Pythagoras, Hippocrates, Plato and Aristotle all found the idea of becoming old offensive, yet they were 80, 90, 82 and 62 respectively when they

died. Gossip (1952, p. 593), commenting on Aristotle's views, makes the point that: 'Few pages in literature are more depressing than that in Aristotle, who, casting aside his customary calm, savagely depicts old men as "human nature fallen into ruin, selfish and unenthusiastic, knowing and mean".'

Cicero (1971), amongst his other writings, has left us the earliest substantive work we have on ageing, in the essay 'Concerning Old Age' (44 BC). In it, he condemns the fallacies, myths and stereotypes of ageing that were rife in Roman society and identifies the four stereotypes used to identify older people. These were: 'they find life wearisome', 'they move away from active work', 'they are deficient in sensual pleasures' and 'they are worried about the nearness of death'. It is now more than 20 centuries since Cicero penned his efforts to try to dispel these myths and stereotypes, yet today we still have to argue the same case. As Perdue and Gurtman point out:

It is commonly accepted that the elderly in our society find themselves viewed in predominantly negative fashion, victims of a pervasive form of discrimination and disparagement sometimes referred to as 'ageism'. The attitudinal basis of ageism appears to be systematically negative evaluations of older persons, including (generally inaccurate) stereotypes of their character and capability. The aged are often described as more ill, tired, slow, forgetful, withdrawn, self pitying, defensive and unhappy (1990, p. 199).

Such deep-seated beliefs are widely reflected in the media, the health care system, the workplace, and in interpersonal relations. These beliefs place high emphasis on reproduction, production, consumption and youthfulness (see Chapter 4), and shape access to power and resources in ways that disadvantage older people. Consider, for example, how it is that in a youth-dominant culture the body is an important signifier to others and to the self of the 'passing of time, qualified by the socially constricted definitions associated with that image' (Briggs 1993, p. 52). The cosmetics and fashion industries constantly remind older people that their bodies are undesirable, unattractive, unwanted and devalued. When was the last time you saw a fashion event using an older woman or man as a model?

So what is ageism? Bytheway (1995, p. 14) states:

1. Ageism is a set of beliefs originating in the biological variation between people and relating to the ageing process.

4 Contemporary issues in gerontology

2. It is in the actions of corporate bodies, what is said and done by their representatives, and the resulting views that are held by ordinary ageing people, that ageism is made manifest.

The term 'ageism' was coined in the early 1960s by Robert Butler (1975), a psychiatrist living in the United States. Butler was involved with the civil rights movement at the time and was offended by the systematic stereotyping and discrimination of older people simply because they were old. As the term gained greater acceptance it was introduced, for example, in the *American Dictionary of the English Language* in 1979 and became the subject of gerontological research and debate.

The biomedicalised view of later life at the time—focusing on the less healthy, the frail and the problems of ageing persons—helped to further reinforce many of the common stereotypes held by both younger and older people. In a study that examined the impact of an educational intervention program on the attitudes and knowledge of students aged 17–18 years, Scott et al (1998) found that students held negative attitudes towards older people and that the intervention program did little to change their attitudes, largely because the curriculum focused on the biological losses associated with ageing. It is interesting to note that psychologists have also made negative assumptions about later life. For example, Shield and Aronson (2003, p. 67) critically comment that the inherent logic of self-esteem studies is to test the hypothesis 'that a decline in self-esteem is responsible for many of the overt symptoms of aging'. However, this explanation, offered by an older person, provides an alternative view as to why they may have low self-esteem:

Who was ever in any doubt that the self-esteem of the elderly declines in this society which indicates in every possible way that it does not value the old in the slightest, finds them an expense and an embarrassment, laughs at their experience, evades their problems, isolates them in hospitals and Sunshine Cities, and generally ignores them except when soliciting their votes or ripping off their handbags and their Social Security checks? And which has a chilling capacity to look straight at them and never see them. The poor old senior citizen has two choices, assuming he is well enough off to have any choices at all. He can retire from that hostile climate, or he can shrink in his self-esteem and gradually become the person he is constantly reminded he is (*The Spectator Bird* 1976, p. 116).

Even sociological theories, such as the disengagement theory put forward by Cummings and Henry in the 1960s, in which they theorised a disengagement from life as a person ages, influenced policy and social planning in such a way that it reinforced the view of the dependency status of older persons. Barrow (1996) termed this 'compassionate stereotyping'. As another example, Estes (1979) shows that the social policies of the 20th century were formulated to 'help' older people by creating what she refers to as 'an ageing enterprise'. These ageing enterprises, as she points out, have not eradicated poverty, discrimination and social ills. Instead, their establishment 'paradoxically has created their own problems and inadvertently perpetuated some of the other problems' (1979, p. 2). Carol Estes' critique

was one of the first to demonstrate how the programs and policies created an industry of helping organizations that had, and still have, a vested interest in understanding the elderly as needy and problematic. This stilted way of looking at the elderly has become its own industry. As programs and policies are created to fix the ills, and people are trained and hired to fill the positions to help clients get services, an environment of entitlement and dependency begins. Rather than solving the problems, the problems perpetuate. The people hired to fill the positions do not want to see their programs eliminated (Shield and Aronson 2003, p. 93).

These notions of need and dependency may explain why one of the frequently cited myths that young people have of older people is that they live in nursing homes, when the truth is that the vast majority live independently in the community as neighbours (see Chapter 8).

As the concept of ageism was subjected to academic and public scrutiny, social scientists challenged the 'disengagement discourse' of ageing, and the work of feminists and writers such as Simone de Beauvoir in France highlighted the social, economic and psychological roots of ageism. De Beauvoir (1970, p. 7) wrote these powerful words, which made a remarkable contribution to the establishment of a popular anti-ageist consciousness in Europe:

When their economic status is decided upon, society appears to think that they belong to an entirely different species: for if all that is needed to feel that one has done one's duty by them is to grant

6 Contemporary issues in gerontology

them a wretched pittance, then they have neither the same needs nor the same feelings as other [people].

So we now know what ageism is, even though we know it less well than sexism and racism. But what are the consequences of ageism? Bytheway (1995, p. 14) offers some insights:

- (a) Ageism generates and reinforces a fear and denigration of the ageing process, and stereotyping presumptions regarding competence and the need for protection.
- (b) In particular, ageism legitimates the use of chronological age to mark out classes of people who are systematically denied resources and opportunities that others enjoy, and who suffer the consequences of such denigration, ranging from well-meaning patronage to unambiguous vilification.

Evidence for ageism

Research shows that older people are viewed as a problem—a financial and health care burden at least. Interestingly, women had to overcome a similar situation. For example, Shield and Aronson (2003) show how women have been medicalised and pathologised by western biomedicine. Feminists have raised serious questions about how childbirth was treated by physicians and fought to re-establish the normalcy of such uniquely female physiological experiences as menarche, pregnancy, childbirth and menopause.

Viewed as a helpless problem group, older people (like women) are similarly subjected to all kinds of intervention, often couched in paternalistic terms and seen as well-intentioned. Whether past western societies viewed older people differently is debatable. Shield and Aronson (2003) argue that perhaps older persons were still seen as ‘different’ but because their numbers were so low in proportion to the rest of the population, they were tolerated by dominant groups. As they also note, ‘when the numbers go higher, tolerance tends to recede. Do people feel threatened by the proximity of these “others”? When the numbers increase, so do comments about greedy geezers, old fogey drivers, and the like’ (2003, p. 104). As in previous centuries, more festivity accompanies the birth of a child than the celebration of retirement or the beginning of the senior years!

Shield and Aronson (2002) provide a simple but common example to illustrate the point of the well-intentioned carer acting to protect the helpless older relative, something one of the authors experienced himself when his grandfather died and the family considered the risk of his grandmother living 'alone', making the decision to move her to be with a daughter. Demographic statistics about living arrangements reveal that many older widowed women live alone (frequently with pets, although this is not counted in the census). The majority of these women will not re-marry and for some this decision is a preference, an alternative to having lived with a spouse for most of their lives. Many express freedom in such new living arrangements and resist attempts by the family or health care providers who may view them as isolated, frail, lonely, vulnerable and in need of help. Many refuse such offers of help. As Shield and Aronson (2002, p. 76) argue:

Is this a bad thing? Is this a catastrophe waiting to happen? Or is not intervening a sign of respect for their individuality, their autonomy? Maybe we need to tolerate our own uneasiness when people prefer to live in ways that we judge unsafe or unsound.

Research shows that such women are not without support and often create their own sense of community and coping strategies (see Chapter 8). For example, Hochschild's classic study, conducted back in 1973, found that such older women living alone often create their own community of support and level of cohesiveness and cooperation. For example, they would let each other know that 'they were all right by opening their curtains in the morning. Closed blinds alerted the others that something was awry and needed immediate attention' (Shield and Aronson 2003, p. 77).

Sociologists have long argued that older people have been given a 'spoiled identity'. What does this mean? Like other marginalised groups in society, we believe that older people are not quite human like us and, on this assumption, we tend to impute to them, to use Goffman's (1969) own words, 'a range of imperfections' and exercise various forms of discrimination. At the popular cultural level we can easily interpret that ageing is not viewed as desirable. Consider the following advertisements: the anti-ageing cream label of Estée Lauder, Christian Dior's 'age-defense renewal serum', the slogan of Kelloggs—'the food that fights ageing', and *Marie Claire* magazine (no. 71, July 2001), which featured an 'anti-ageing special' with the

title, 'The A-Z of anti-ageing', and carried the message 'how to win the war against [lines and wrinkles]'. Or consider the message contained in Erica Brealey's (2003) book, *Ten Minute Anti-Ageing*, with the accompanying statement 'want to beat the ageing process and turn back the clock? Take just ten minutes out of your day to recapture vitality and youth!' Contrast this with recent health promotion messages about promoting good health and fitness in later life which contains no 'anti-ageing' vocabulary and uses the concept of fitness as being healthy for the body, regardless of age.

Gerontological research provides ample evidence of the wide and varied levels of negative attitudes and treatment showed by young people, and older people themselves, towards ageing. Studies related to ageism have generally examined how the attitudes and beliefs of younger people contribute to denying older people opportunities and equitable treatment. For example, Giles et al (1992) demonstrate how young people process and respond to the speech of older people in stereotypical ways. In another study, Ryan et al (1995) show how younger people at an interactional level use patronising verbal and nonverbal communication towards older carers. Sawchuk (1995), who undertook an extensive analysis of advertisement campaigns and other marketing strategies, concludes that at a public level many marketing discourses perpetuate and reinforce negative stereotypes of old age. Studies that have focused on older workers have consistently found that they often face ageist stereotypes that define them as increasingly marginal in the workforce (Maule et al 1996). The most significant barriers and deterrents are managerial biases that construct older workers are too costly, too inflexible and too difficult to train (Imel 1996). Such findings are emerging not only from western countries but also from former communist states. For example, Gerasimova (1996), who interviewed older women from St Petersburg, found that the major difficulties reported by her sample were age-discriminatory social policy and gerontophobic stereotypes. Reports of discrimination against older workers appear to be related to employers' interest in 'downsizing' their workforce (Encel 1995).

Health researchers have also examined how misconceptions about the ageing process can have a detrimental effect on the health of older persons (Grant 1996). Walker et al (1996) argue that ageist stereotypes underlie many of the services designed for older people with a disability, with the focus centred mostly on care and less on support of the older person to fulfil their potential. Numerous

studies have also reported how therapists accept socially validated negative stereotypes of later life. For example, Woolfe and Biggs (1997) found that some counsellors were less likely to use a psychodynamic approach with older persons, and this decision could result in the underestimation of later-life potential. Social workers were reported to spend less time and had fewer contacts with older oncology patients than younger patients, with the result that social workers may not be effectively assisting older patients to cope with important health and social issues (Rohan et al 1994). Examining audiotaped interactions between physicians and young and older patients, Greene and her colleagues (1996) found that there was greater disparity between the goals of the doctor and older patients, and less joint decision making with older patients. Doctors tended to be less egalitarian, patient, respectful, engaged and optimistic with the older patients. What these studies perhaps show is how easy it is for social arrangements in society to make it possible for ageism to be so prevalent, yet for the behaviour to be seen as obscure and non-intentional (Bytheway 1995).

Language, as we will further argue later, also provides us with evidence that older people are socially constructed as 'different'. For example, the vocabulary of physicians has come under some scrutiny. It has been found that physicians use the word 'gomer' (acronym for Get Out of My Emergency Room), to describe an older patient who is an unresolvable admission to the emergency room; 'lolonad' (acronym for Little Old Lady in No Acute Distress), to describe an older woman brought to the emergency room late at night with chronic conditions made worse by a failing memory; and 'Haldol Manor' (Haldol is a sedative agent) a phrase assigned to disruptive older patients and incontinent patients living in nursing homes. Konner (1987) observed in his study that doctors see death embodied in older people, and their use of humour serves to compensate for the failure of modern medicine to save older people. Konner (1987, p. 287) made this observation:

At the end of the discussions one senior physician shook his gray head, sighed, and smiled. 'As George Burns says,' he mused aloud, 'not many people die after ninety.' This was to become a favorite remark during morning rounds for the rest of the month, uttered ritually by the residents in chorus, whenever we left the bedside of a patient over ninety. The more hopeless the patient, the funnier the line.