

Ageism and health care essay sample

[Sociology](#)



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Kunda (1999) noted that people have a tendency when they perceive others in social settings, to automatically categorize them into three major dimensions: race, age and sex (as cited in Nelson, 2004, p. ix). Barrow and Smith (1979) noted that only a small proportion of theoretical and empirical research within psychology has been directed towards understanding ageism (while much of the research has focused on the other two ‘isms’: racism and sexism) (as cited in Nelson, 2004, p. ix). Butler (1969) coined the term ‘ageism’ describing it as being comparative to other examples of bigotry (e. g. sexism and racism) whereby he defined it as people systematically stereotyping and discriminating others on the basis that they are old (as cited in Angus & Reeve, 2006).

Nowadays, the concept is more loosely defined as one discriminating against or being prejudicial (in a positive or negative manner) towards any age category (Angus & Reeve, 2006). Discrimination may be defined as a set of processes which leads to another individual or group being marginalized (Thompson, 2005, p. 3). While prejudice may be defined as one having a negative attitude about other people because of the group they are a member of (Holt et al., 2012, p. 539).

One possible reason for why there has not been much attention paid to ageism is the fact that demonstrating age prejudice is probably one of the most socially common, overlooked and institutionalized types of prejudice found globally – especially in the United States (Nelson, 2004, p. ix). For e. g. think back to the last time you bought a birthday card for a friend/family member who was over the age of 50 which implied some sort of mental or physical decline or had an “over the hill” theme despite being done in a

supposedly humorous way (Thompson, 2005, p. 16; Nelson, 2004, p. ix).

Since research into ageism is sparse and that it is a common form a social prejudice, this essay will aim to identify the causes and consequences of ageism as well as putting forward some recommendations which could help to ameliorate this “ism”. The Causes of Ageism

One interesting and defining characteristic of ageism, is that age, unlike sex and race, signifies a category in which young people will most likely grow old (provided they do not die at a young age) (Nelson, 2004, p. x). As a result, it seems quiet strange that young people would demonstrate prejudice towards those who they themselves will eventually become like (Nelson, 2004, p. x). A number of explanations as to what causes ageism have been put forward and we will look at the following three: stereotypes, terror management theory and social identity theory. Stereotypes

Harding, Proshansky, Kutner, and Chein (1969, p. 4) defined a stereotype as being “ a belief that is simple, inadequately grounded, at least partially inaccurate, and held with considerable assurance by many people” (as cited in MacKie, 1973, p. 432). We use stereotypes as cognitive structures to hold our expectations and beliefs regarding the characteristics of individuals belonging to different social groups and whether or not they are accurate, our stereotypes influence our social behaviour (Nelson, 2004, p. 4). The stereotypes which have been established regarding ageism have become so ingrained in the perceptions we have about human life that they have now become unquestioned beliefs (Angus & Reeve, 2006).

Whenever you see people, you categorize these individuals into race, age and sex (Nelson, 2005). We have learned to categorize people very well and it has become a pivotal aspect to our social perception (Nelson, 2005).

Categorization can lead to stereotyping and as Ormrod (2000) stipulated, stereotypes have three defining characteristics: they are simple, rigid and inaccurate (Nelson, 2005; as cited in Bowd, 2003).

Hummert (1990) recruited 80 undergraduate students in order to identify positive and negative stereotypes associated with the elderly. Following cluster analysis of the data Hummert (1990) identified two high-level clusters, one containing 31 positive stereotypes and the other containing 57 negative stereotypes. Some of the negative stereotypes included unable to handle a job, demanding, useless, annoying, easily upset, unable to communicate and a burden to society while some positive stereotypes included understanding, interesting, happy, family orientated and wise (Hummert, 1990). Snyder and Miene (1994) proposed that stereotypes of the elderly act as a form of ego-protection, suggesting that the negative aspects of ageist stereotyping allows the individual using that stereotype to distance themselves from the older group which subsequently facilitates the belief that the young and middle-aged individuals in society are the predominant group (as cited in Bowd, 2003).

Angus (2000) mentioned that negative stereotypes of the elderly can undercut an elderly person's belief that they can still be self-reliant (as cited in Angus & Reeve, 2006). For e. g. Seale (1996) analysed the accounts given by 163 relatives, friends and others who knew elderly individuals living alone, independently during the final twelve months of their lives and found <https://assignbuster.com/ageism-and-health-care-essay-sample/>

that older people resisted help from neighbours and friends as a way to ensure that they would not be forced into a nursing home which would cause them to lose their sense of independence. Seale (1996) concluded from the narratives provided by elderly individuals living alone, that when their physical abilities began to decline this led to a feeling that they were losing control of their lives and signified the beginning of a social death. When we maintain attitudes towards the elderly which are regarded as positive this does not prevent us from for e. g. engaging with them in a manner that is mediated by the negative stereotypes that exist about the elderly (Nelson, 2005).

One form of engagement with the elderly by younger individuals is known as overaccommodation (Nelson, 2005). Giles, Fox, Harwood, and Williams (1994) explained that with overaccommodation younger adults communicate with elderly people through speaking more slowly and loudly, use simplified language or avoid words that have more than two or three syllables while Grainger, Atkinson, and Coupland (1990) said that overaccommodation can result in the downplaying of feelings, thoughts and concerns that older people express (as cited in Nelson, 2005). Terror Management Theory

Another possible explanation for what causes ageism is the Terror Management Theory (TMT). This theory, which has its foundations in the writings of Becker (1971; 1973; 1975) maintains that as humans our desire to survive, alongside our awareness that we will eventually succumb to the grim reaper, causes the potential for us to feel anxious and so we must maintain control over this anxiety (Martens, Goldenberg, & Greenberg, 2005). According to the TMT, as humans we have developed a psychological

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anxiety defence mechanism which is composed of self-esteem and a cultural worldview (CWV) and this mechanism helps us cope with our unconscious knowledge that our death is impending (Bodner, 2009).

A CWV refers to a shared perception of reality which provides stability, meaning, permanence, order and a symbolic or literal everlasting life (e. g. our lives continue through our children or belief in an afterlife) to those who maintain the standards of value imposed by the culture they belong to (Bodner, 2009). Self-esteem refers to one's assumption that they are maintaining the standards of value which are set out by the CWV (Bodner, 2009). Together the CWV and self-esteem ensure that people are invaluable members in the world and this helps them protect themselves from their fears of dying (Bodner, 2009).

Martens et al. (2005) using the TMT, identified three psychological threats which help to account for individual's negative reactions towards the elderly. The first is the Threat of Death – When young people see older people, older people remind them that they cannot outrun the inevitable end – which is to grow old and die (providing that one is not killed in a car accident, by a disease, at the hands of another etc. i. e. providing we do not die before our time) (Martens et al., 2005). As a result, from this point of view, elderly people may be the most powerful reminder that as humans we are but mortal beings (Martens et al., 2005) The second is the Threat of Animality – This threat is less associated with death itself, rather it indicates that the physical body undoubtedly becomes fallible with age (Martens et al., 2005). As we age, it may occur that we have less control over our bodily functions,

which as younger individuals we try to ensure that these functions are kept discreet (Martens et al., 2005).

To younger people, the elderly not only remind us that we will die, but due to their declining physical bodies, they remind us of our physical and animalistic nature (Martens et al., 2005). The third is the Threat of Insignificance – The elderly remind the young about the possibility that one day they may be stripped of the sense of value that they possess now. Older people may provoke fear in the young, if they witness the elderly lose the way(s) in which one maintains their symbolic sense of self-worth (for e. g. your profession which you may lose during later life because of forced/early retirement or because there has been a decline in one's functioning abilities) (Martens et al., 2005). This sense of self-worth is a main contributor to protecting ourselves from the fears that arise from knowing that we are not immortal (Martens et al., 2005).

Martens, Greenberg, Schimel, and Landau (2004) conducted a study in order to identify whether the hypothesis that older people serve as a reminder of our mortality, in which concerns about mortality can give rise to ageism by younger people towards older people. 96 students from an introductory psychology class were recruited (with an average age of 18.65 years) and divided into two groups: one group (the death group) wrote a short story detailing the emotions and thoughts they had when they thought about dying while the second group (the control group) also wrote a short story, this time not about their deaths but rather the uncomfortable experience of having a tooth ache (Martens et al., 2004). Both groups were asked to rate how well 16 statements about various behaviours (e. g. I'm a very friendly

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person) were believed to be desirable (Martens et al., 2004). Martens et al. (2004) found that those who were in the death group accredited a larger amount of statements which portrayed undesirable behaviours, to older people, than participants who were in the control group. Social Identity Theory

The third possible explanation for ageism is the Social Identity Theory (SIT). The basic idea of the SIT is that the social category a person falls into (e. g. ethnicity, nationality, sports team etc.) and believes that they belong to, contributes to how they define themselves within the realm of their self-concept (Hogg, Terry & White, 1995). A person's self-concept (i. e. your sense of who you are) consists of both a personal identity (i. e. one's awareness of one's own personal attitudes and characteristics) and a social identity (Myers, 2009, p. 326). Within the SIT: (1) we categorize – we find it helpful to place others as well as ourselves into categories (2) we identify – we classify ourselves with particular groups (called the “ in-group”) which enhances our self-esteem, because the feeling of “ we-ness” which comes from belonging to an in-group helps to strengthen our self-concept and (3) we compare – we analyse our group (in-group) with groups to which we are not a member (the ‘ out-group’) and in doing so we demonstrate a favourable bias to our own group (Myers, 2009, p. 326).

How we identify ourselves socially can cause us to conform to the ideas and norms of the group we belong to (Myers, 2010, p. 326). The amount of importance we place on our social identity and the strength to which we attach ourselves to our in-group mediates how strongly we will prejudicially react to perceived threats from another group/out-group (Myers, 2009, p. <https://assignbuster.com/ageism-and-health-care-essay-sample/>

326). Butler (1975; 2009) proposed that the SIT implies that ageism facilitates younger individuals to move away and maintain a distance from older individuals whereby this may lead to the younger people very subtly failing to identify elderly people as human beings (as cited in Bodner, 2009). Bodner and Lazar (2008) demonstrated that for the most part, negative attitudes regarding older people are held by younger adults. The authors administered the Fraboni Scale of Ageism (Fraboni, Saltstone, & Hughes, 1990) to a convenience sample of 491 participants, aged between 17.5-45.5 years, recruited from a number of universities in Israel in order to identify if the findings from the structure of ageism studies conducted in the United States (an individualistic population) could be generalized to people who live in a more collectivist society, like Israel (Bodner & Lazar, 2008).

The results from the study provided a three-factor structure of ageism and was very similar to those found elsewhere, whereby the three factors identified were: (1) Avoidance – highlights one's tendency to avoid contact with the elderly and was similar to both the separation factor identified by Rupp, Vodanovich, and Crede (2005) and the avoidance factor identified by Fraboni et al. (1990) (2) Contribution – reflects the negative view that younger adults have regarding the contributions of the elderly to society, which was similar to the affective attitude factor described by Rupp et al. (2005) and the discrimination factor identified by Fraboni et al. (1990) and (3) Stereotype – reflects the number of negative stereotypes younger adults have towards the elderly, which was practically the same as the stereotype factor demonstrated by Rupp et al. (2005) and the antilocution factor identified by Fraboni et al. (1990). The Consequences of Ageism

There a number of consequences that can befall those who have experienced ageism. For e. g. older peoples self-esteem may suffer due to the feeling that they have a decreased sense of value (Kane, 2004). They may experience infantilization (i. e. being treated as if they were infants) which Arluke and Levin (1984) said leads to the development of a self-fulfilling prophecy whereby older people begin to believe that they can no longer contribute to and live independently in society and so adopt a dependent and passive role (as cited in Nelson, 2005). Grant (1996) aptly noted that when the elderly begin to believe the stereotypes and age myths associated with them and thus behave according to them; this bolsters the maintenance of such stereotypes and the subsequent behaviour which is directed towards them (as cited in Nelson, 2005). The consequences of ageism in the work place and health care services will be discussed.

Consequences of Ageism in the Workplace

Williams and Nussbaum (2001) proposed that by the year 2020, 39. 1% of those working will be over the age of 55 years while McCann and Giles (2002) said that alongside this there is an increase in the number of age-discrimination lawsuits being filed whereby the pay-outs in such lawsuits was approximately \$219, 000 between 1988 and 1995 and more recently pay-outs ranged from \$6. 2 million to \$58. 8 million (as cited in Rupp, Vodanovich, & Crede, 2006). Hassell and Perrewwe (1995) and Kite and Wagner (2002) said that these settlement figures exceed settlement figures offered in sexism and racism lawsuits (as cited in Rupp et al., 2006).

Discrimination against older members in the workplace may occur because those who discriminate believe that as you age your work performance

ability decreases (e. g. Faley, Kleiman, & Lengnick-Hall, 1984; Issacharoff & Harris, 1997) however Cleveland and Landy (1983) said that so far the chronological age of individuals has not yet been found to act as a predictor of performance for any particular individual in any given job type (Rupp et al., 2006).

Laczko and Philipson (1991) identified that older individuals are often reported as having lower performance scores in spite of the fact that older workers have high levels of flexibility, willingness to learn and energy and are as productive as younger employees (as cited in Rupp et al., 2006).

Segrave (2001) identified that older workers are less prone to turnover, are more dependable and are more productive than younger workers (as cited in Rupp et al., 2006). Segrave (2001) found that from a sample of organizations which exclusively employed individuals who were aged at least 50 years, these organizations experienced 60% less inventory loss, 16% less turnover, 40% less absenteeism and had 18% higher profits, compared to similar organizations which employed younger individuals (as cited in Rupp et al., 2006). Older people can be as or more productive in the workforce than their younger counterparts, and so it makes one wonder in what ways are older employees or potential older employees discriminated against.

Take for e. g. a study carried out by Bendick, Jnr., Brown and Wall (1999) which used pairs of testers, one aged 57 years and the other aged 32 years, who applied for 102 entry-level management or sales jobs in Washington, DC. Bendick, Jnr. et al. (1999) found that: (1) applicants who were older had an advantage over their younger counterparts 1% of the time compared to younger applicants who received an advantage over the older applicants 42.

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2% of the time (2) those who were older when applying for a job were treated differently (in a negative way) to younger applicants. For e. g. one older applicant applying for a job tried to make contact with the employer four times, leaving a telephone message three times and faxing a copy of their CV once but never spoke to anyone directly.

One day after the older applicant made their first attempt at contact; the younger applicant telephoned and was provided with the name of the manager overseeing the hiring process. That same day, the manager contacted the younger applicant to organize an interview. At the end of the interview, the manager offered the younger applicant the job and (3) identified negative stereotypes associated with older employees held by employers including: absence of motivation, rigid, limited in their physical capabilities, lack of energy, and technological obsolescence.

Consequences of Ageism in the Health Care Service

It may be reasonable to assume that of all people who would be the least likely to stereotype and be prejudicial towards older people; it would be those whose job it is to help others (Nelson, 2005). Unfortunately, this is not the case as those who work as health care professionals are just as likely to be prejudicial against the elderly as anyone else (Nelson, 2005). Many physicians may hold a negative or stereotypical view of elderly patients mediated by a mixture of general cultural biases or the fact that more often than not older patients tend to remain for longer periods of time in hospital and therefore use more resources than younger patients (Reyes-Ortiz, 1997). Physicians may hold several ageist attitudes towards elderly patients, for e. g. (1) they may feel that these patients are “untreatable,” or “senile,” (2) <https://assignbuster.com/ageism-and-health-care-essay-sample/>

may become frustrated when they have to deal with the cognitive and/or physical limitations of older patients or (3) believe treatment is pointless (Reyes-Ortiz, 1997, p. 831).

The attitudes which Reyes-Ortiz (1997) elucidated to appears evident in a study carried out by Minichiello, Browne, and Kendig (2000) who qualitatively examined what ageism meant and how it was experienced by older Australians. The participants highlighted several negative experiences they had with health care professionals including being neglected or treated as if they were not important, they were not sufficiently informed as to why certain medical tests were being carried out or feeling like they had lost their autonomy when doctors did not consult them about important decisions that were being made with respect to their treatment or health (Minichiello et al., 2000). The following two extracts highlight some of the negative experiences: “ My husband had a very high sugar rating, and the doctor said he’d have to go into hospital for a couple days to have it brought down... They just put him in a corner and forgot about him for a week.

I always felt that hospital killed him...They weren’t doing anything about his diabetes. But they were doing...other tests...for prostate cancer and this and that.” (Mrs Evans) (Minichiello et al., 2000, p. 271). “ The doctor was talking to the charge nurse about nursing homes, and I said ‘ Excuse me doctor, don’t talk about nursing homes, you’ve seen me at my worst here’ ...They weren’t thinking of me. He didn’t see me here at home.” (Mr Hall)

(Minichiello et al., 2000, p. 271). The participants in the study knew that how they were being treated was wrong but they believed that for the most part, they couldn’t change or challenge this treatment (Minichiello et al., 2000).

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Similarly the bias that seems evident with health care physicians also seems evident among those who work as mental health professionals too. Ford and Sbordone (1986) administered one of two questionnaires to 179 psychiatrists, which contained four clinical vignettes which were all identical to each other, except for one factor, age (as cited in Robb, Chen, & Haley, 2002). The results indicated that patients who were younger more commonly received encouraging prognoses and were more inclined to be viewed as the “ideal patient” by psychiatrists compared to older patients (as cited in Robb et al., 2002, p. 5). Ford and Sbordone (1986) argued that the most likely cause of this was that the psychiatrists in the study were displaying prejudicial attitudes towards older patients (as cited in Robb et al., 2002).

It has been suggested that the bias that is observed in those who provide psychological or psychiatric services does not represent ageism but rather indicates healthism (the stereotypes people hold regarding individuals who are in a state of poor physical health) (Nelson, 2005). James and Haley (1995) examined health bias as a different explanation to ageism, as the “barrier-to-treatment” in mental health care provision, and found that despite the fact that therapists still perceived older patients as being less suitable for their help and continued to provide prognoses which were less positive compared to younger patients, the authors found that “healthism” was much more prevalent in the service provided by therapists (as cited in Robb et al., 2002, p. 5).

Gatz and Pearson (1988) suggested that the concept of ageism used by the mental health service may require some significant revision, as they argued that: (1) studies which utilized vignettes did not focus on biases directed

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towards older adults in general, but rather addressed biases aimed at particular hypothetical clients (2) age in itself is a “ weak” stereotype, and that people maintain numerous stereotypes of the elderly simultaneously and (3) even though certain particular biases may be directed towards the elderly, negative attitudes aimed at the elderly does not exist on a global scale (as cited in Robb et al., 2002, p. 5). Taken together, Robb et al. (2002) concluded that what had once been extensively accepted ten years ago is now open to speculation.

Recommendations for Ameliorating Ageism

Ageism changes our society and culture, even if we do not realise this, as it can instil unnecessary misery and fear among the older members of our society (Palmore, 2005). It can be considered a social disease like sexism and racism but luckily for us, ageism can be reduced through contact, civil suits, amending current legislations, provision of personal examples of “ successful aging” and education, which together can help challenge the negative stereotypes which are associated with ageism (Palmore, 2005, p. 90). We will take a look at how social contact and education may be used as means to ameliorate the effects of ageism. Social Contact

For decades, social psychologists have been interested in the idea that when individuals who are members of the “ in-group” (in this case younger people) are in contact with those who belong to the “ out-group” (i. e. elderly people) this can help change the in-group members’ attitudes about the out-group members (Harwood, Hewstone, Paolini & Voci, 2005). Making social contacts as a younger person with an older person can occur within the family context as well as other social contexts (Bodner, 2009). Harwood et al. (2005)

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demonstrated that when older members of a family maintain long-lasting relationships with the other members (in particular younger members) then the older members will be viewed more positively and less stereotypically, than older strangers.

It would seem that the first step to help prevent ageism begins within the family since Clavan and Vatter (1972) noted that when grandparents interact with their grandchildren, this provides them with a chance of gaining affection as well as interpersonal satisfaction, while Bengtson and Robertson (1985) noted that this interaction helps to improve grandparents sense of self-worth (as cited in Bodner, 2009). Timberlake (1980) mentioned a number of ways in which elderly grandparents can benefit from interacting with their grandchildren including : (1) it helps them feel like they are needed or wanted (2) gives their life stability and structure (3) allows them to experience new things and (4) allows them to have close and physical contact with others (as cited in Bodner, 2009).

A study conducted in Norway, using participants aged 40 to 79 years, norLAG (<http://www.nova.no/subnet/lag/index.htm>), identified whether or not those with grandchildren were more productive than those who had no grandchildren (as cited in Hagestad and Uhlenberg, 2006). Out of a total sample of 5, 600 participants, a smaller subsample consisting of 1, 600 participants aged 60 to 79 years were utilized for the purpose of the study, in which 70% to 80% of these were both parents and grandparents (as cited in Hagestad and Uhlenberg, 2006). However, some of the subsample members had neither children nor grandchildren: for those in their 60's, 14% of men and 16% of women did not have children/grandchildren, while those

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in their 70's, 11% of men and 18% of women had no children/grandchildren (as cited in Hagestad and Uhlenberg, 2006).

All of the participants answered questionnaires which contained two items which were used as indicators of social productivity: expected more funding for day care and took part in volunteer work whereby it was found that among those who had neither children/grandchildren, these individuals were the least likely to volunteer while those who were grandparents took part in volunteering activities the most and thus were more productive (as cited in Hagestad and Uhlenberg, 2006).

It has been suggested that maintaining and strengthening family connections may be a pivotal first step towards providing affection and developing interpersonal satisfaction in elderly people and this can as a result help to alleviate the possibility that these individuals will be a target for ageism (Bodner, 2009). Within the realm of social contact, the first place we can look to, to help prevent ageism is in the home and perhaps in the future we can move beyond there. Education

The second way that can help reduce the occurrence of ageism is to educate people. As we saw earlier health care professions as well as policy makers, academics and advocates bring with them to their workplace stereotypical attitudes (often negative) about older people (Angus and Reeve, 2006).

Stereotypes are tenacious and can be difficult to alter given that the processes which give rise to the development of such stereotypes tends to begin at a young age and are usually unconscious (Henkens, 2005). Angus and Reeve (2006) suggested that combatting ageism is not an easy task

while Pickering (2001) proposed that since ageist stereotypes are rigid and play a part in reinforcing existing power relations, taken together this facilitates the maintenance and production of behavioural norms which incite ageist behaviour (as cited in Angus & Reeve, 2006). Despite this Palmore (2005) noted that education is the primary variable that makes a consistent and significant difference to scores obtained from the Facts on Aging Quiz (a quiz used to measure pro-age and anti-age bias indirectly) whereby for the most part results from the quiz favour anti-age bias rather than pro-age bias.

Peterson, Wendt, and Douglas (1994) mentioned that higher education institutions (HEI) during the last two decades have acknowledged that gerontology education is very much an area of study that needs to be expanded (as cited in Anderson, 1999). Ferraro and Chan (1998) identified that now more than 500 HEI offer more than 1, 000 gerontology programs in the United States (as cited in Anderson, 1999). In spite of this, HEI which offer gerontology programs still face several challenges (Anderson, 1999). One challenge is to educate the general public about the realities and myths about aging so as to help reduce ageist behaviour (Anderson, 1999). The general public need to be informed about how older individuals can and do contribute to society as well as making them aware of the numerous hardships that the elderly face (Anderson, 1999).

Another challenge involves educating non-professionals, technical staff and paraprofessionals who are responsible for providing services and programs to the elderly since Wendt and Peterson (1993) noted that many such individuals have very little if any training in gerontology while Weaver, Dunn, Ingman, and Lusky (1998) and Wendt and Peterson (1993) suggested that <https://assignbuster.com/ageism-and-health-care-essay-sample/>

those who are formally trained in gerontology provide much more sensitive, effective and appropriate care to the elderly (as cited in Anderson, 1999). This would suggest that HEI need to introduce a non-credit standardized curriculum on a full-time basis (Anderson, 1999).

Ferrario, Freeman, Nellett and Scheel (2008) followed up a study carried out by Freeman (2003) (who surveyed 117 nursing students and found that these students held negative attitudes towards the elderly) in order to determine if changes were made to the nursing program's curriculum would this cause changes in nursing students' attitudes. The changes made to the curriculum, which were hoped would cause nursing students to hold more positive attitudes towards the elderly, before the second set of students were surveyed, but which had not been implemented when the first set of 117 nursing students were surveyed, included: (1) learning about the positive factors associated with aging (2) obtaining experience early in the curriculum by working with healthy elderly adults and (3) gaining clinical experience with both acutely, chronically and seriously ill elderly adults and health elderly adults living in the community (Ferrario et al., 2008). After amending the nursing curriculum, 17 nursing students were surveyed whereby this time the results demonstrated that these participants held more positive views about the elderly compared to the first set of students (N= 117) surveyed, before the curriculum changes (Ferrario et al., 2008).

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