Ageism in Gerontology

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Assignment: Ageism in Gerontology

This paper, written in satisfaction of a course requirement for Social Justice in Clinical Psychology, examines the presence of old ageism in the field of gerontology, specifically mental health care. It opens with definitions, history, and characteristics of ageism in gerontology, goes on to describe examples of ageism's persistence in this field, and ends with a discussion of psychologists as agents of oppression—and potentially agents of social justice. I write this paper from a social position of a white, cis-female, middle-aged, United States born citizen, with clinical interests in neuropsychology and geropsychology.

Definitions of Gerontology and Ageism

Gerontology, described in the inaugural issue of the *Journal of Gerontology* (Frank, 1946), is a multidisciplinary field that studies aging and applies that knowledge to the health care and well-being of older adults. It includes health care providers, researchers, policy experts, and educators. In medicine, the specialty is called geriatrics; clinical psychology has the specialty of geropsychology. It might be assumed that the field of gerontology would be relatively free of old ageism, perhaps even be a leader combating ageism, given its purpose to promote the well-being of older adults. In this paper I argue that ageism is still present, even in a field that has a leadership role advocating respect and care for older adults.

To examine ageism in gerontology, we need a working understanding of the phenomena. Any "-ism" is rooted in power and the distribution of and access to privilege and resources. Isms leverage human tendencies for automatic bias (physiological), stereotypes (cognitive), prejudice (affective), and discrimination (behavioral) on socially constructed identities to build and maintain a status quo that privileges some at the expense of others. This includes ageism.

Iversen et al. (2009) found that just within psychology there are multiple, inconsistent definitions of ageism. However, among the 27 definitions included in their review paper, one consistency does stand out: they were all focused on some facet or combination of attitude, knowledge, stereotyping, prejudice, or discrimination. A few even included positive ageist stereotypes in their definitions, introducing the confounding idea of "reverse discrimination." None of the definitions, including their own, dealt with power, privilege, or resources (Iversen et al., 2009).

More recently, Ayalong and Tesch-Römer (2018) unpacked the concept of ageism, and they too discussed bias, stereotypes, prejudice, and discrimination. They expanded Iversen et al.'s (2009) conception of the micro-, meso-, and macro-levels of ageism and explored how ageism operates within the individual, within groups, and at the systemic level. They recognized ageism as a process of depreciation of the worth of older adults, and also included considerations of intersectionality with other target ranks (Ayalon & Tesch-Römer, 2018). It is important to consider the possibilities of how intersectionality influences who even arrives at old age, as it is likely that intersections of target ranks affect life expectancy.

Two features of old ageism compared to other isms are (a) if we reach an average life expectancy we will involuntarily go from agent to target rank, and (b) there are essentially no social sanctions for expressing ageist views (Iversen et al., 2009). In fact, it is a social convention in Western cultures to express deprecation of old age, by young and old alike, and to expect older adults to behave in ways considered age-appropriate (Ayalon & Tesch-Römer, 2018).

In a rare example of discussing ageism head-on as a function of power, privilege, and resources in the gerontology literature, Ardelt and Friedman (2014) argued that older adults are at once vulnerable and privileged in the United States. Their argument that older adults are

privileged rests on older adults disproportionately benefitting from publicly funded social programs, specifically Social Security and Medicare. While it is certainly critical to examine access to and distribution of resources, in this instance Ardelt and Friedman may have conflated the *status* that some older adults have with *rank*. Furthermore, the mere presence of a social justice policy addressing a target rank identity does not flip that identity from target to agent rank and create privilege.

In this brief literature search, I could find only one other author who consistently addressed power, privilege, and resources in ageism. The psychiatrist Robert N. Butler is credited with coining the term "age-ism" in 1969, defining it as bias, prejudice, and discrimination by one age group toward another and relating it to the idea of the generation gap (Butler, 1969). While that definition proved to be a conventional one over the subsequent years, his 1969 article actually described ageism as operating from power, privilege, anxiety about resources, and existential dread. He surveyed the revulsion, distaste, and fear of growing old; age discrimination in employment; mandatory retirement policies; disproportionately low levels of health care research and services; the resentment of the middle-aged burdened by caring for old and young; exposure to violence and abuse; and discrimination in housing (Butler, 1969). In contrast to Ardelt and Friedman (2014), he called Social Security and Medicare "little more than sops to the conscience" (Butler, 1969, p. 246). Twenty years before Crenshaw published her landmark paper on intersectionality (Crenshaw, 1991), Butler gave examples of how ageism and racism intersected and claimed that ageism functions as a socially acceptable proxy for racism.

The Historical Development of Ageism in Mental Health Care

Bodner et al. (2018) suggested ageism in mental health care may go back to Freud, who believed older adults were too mentally inflexible to benefit from psychotherapy. G. Stanley

Hall, on the other hand, published *Senescence: The Last Half of Life* in 1922, when he was 76 years old, to describe his own experience with aging, reflect on the differences between his experiences and "public opinion" about older adults, and advocate for more research and care of older adults in psychology (Morse, 1922). Nevertheless, through the years of the World Wars and their aftermath, older adults were not psychology's priority, as the military was the primary driver of psychology's growth in these years (Summers, 2008), and it wasn't until 1946 that the American Psychological Association established Division 20, Adult Development and Aging. The 1960s brought greater awareness of the lack of training, research, and care for the elderly in mental health; developmental psychology began emphasizing the lifespan approach; and the Older American's Act of 1973 and the founding of the National Institute on Aging in 1974 expanded funding of health care research and services for older adults (Robb et al., 2001).

The specialty of geropsychology can be considered launched in earnest in 1981 with the Conference on Training Psychologists for Work in Aging ("Older Boulder"). From at least that time, geropsychologists have had an interest in attracting resources—research dollars, third-party payer reimbursement, new trainees—to sustain and expand the specialty. This has helped drive an attempt to explain ageism and combat it.

The resulting body of literature of the past 40 years has primarily focused on the biases and attitudes of professionals and trainees. Research uncovered biases in diagnosis and treatment recommendations using hypothetical case scenarios, usually by presenting the exact same case to two groups with only the age changed, and by examining actual case records (Wyman et al., 2018). Among mental health care providers, older patients are less likely to be perceived as candidates for therapy, more likely to receive a diagnosis of psychosis, more likely to be referred

for medical intervention only, and more likely to be considered to have a poorer prognosis than patients who are middle aged or younger (Bodner et al., 2018; Robb et al., 2001).

In addition to the implicit bias revealed in these studies, researchers have also found more explicit negative attitudes toward older adults by mental health care providers and trainees. These expressions include: older adults aren't verbal or psychologically minded enough for therapy; they are too rigid, apathetic, passive, or resistant to growth; their potential and opportunities for change are limited; and they are too close to the end of their lives. These attitudes have been explained with Butler's concept of "therapeutical nihilism," Kastenbaum's "the reluctant therapist," and Terror Management Theory, all of which locate the negative attitudes in the therapist's own fear of aging and death (Bodner et al., 2018; Robb et al., 2001).

A contrarian point of view questioned whether studies finding bias and negative attitudes toward older people among mental health care providers are valid, and hypothesized that the problem is "healthism," instead. James and Haley (1995) studied healthism and ageism among clinical psychologists and did find evidence of professional and interpersonal bias on the basis of poor health status, regardless of age. It would be interesting to see if this finding can be replicated today, especially given clinical psychology's trend toward health service psychology. However, they also found that after controlling for health status, clinical psychologists were less likely to accept older patients and considered them to have a worse prognosis than younger patients. In their discussion, they recommended focusing more on systemic issues, such as health care reform, than on provider attitudes as a way to address mental health care for older adults (James & Haley, 1995).

Advancing this debate beyond intra- and interpersonal attitudes to the macro- or systemic level is certainly important. Unfortunately, it is difficult to find literature that addresses ageism in

gerontology at this level. One exception is, Ardelt and Friedman (2014), who described the trend of medicalization of old age and how it leads to both over- and underutilization of health care by older adults. On the one hand, older adults are subject to invasive, heroic medical procedures—which Medicare reimburses—often without full understanding of their diagnosis, treatment, or prognosis, which results in a lack of agency on their part. On the other hand, preventative care, behavioral and mental health care, and palliative treatments and therapies are less likely to be reimbursed by Medicare, or are reimbursed at a lower rate. Older adults are a critical consumer base for the health care industry, including hospitals, service providers, pharmaceutical companies, and manufacturers of equipment and supplies for tests and procedures; but experience barriers to mental health care or health care that meets their needs and wishes (Ardelt & Friedman, 2014; Robb et al., 2001).

One of the most disturbing examples of this bias in mental health care for older adults was found in a study of primary care physicians treating suicidal ideation in older adults, using a hypothetical case study design. The authors found that physicians were less willing to treat suicidal ideation in older patients, less likely to refer them to psychiatric or psychological care, and more likely to consider suicidal ideation in an older person normal and even rational (Uncapher & Areán, 2000). Given that the highest rate of all suicide in the United States is found in men 65 and older, and among women the highest rate is in ages 45 to 64 (National Institute of Mental Health, 2018), ageism in gerontological mental health care can be lethally harmful.

Progress in understanding and resisting ageism in mental health care has been slow. As recently as 2018, Wyman et al. wrote, “We believe ageism remains a powerful force within the healthcare setting” (Wyman et al., 2018, p. 207). This is at least in part because there is little consensus in how to talk about it. Few researchers and practitioners followed Butler’s lead in

1969 of connecting ageism to power, privilege, resources, and other isms. For example, the American Psychological Association released an updated resolution on ageism just a few months ago, in August 2020. This statement is firmly located in stereotypes, prejudice, and discrimination rather than power, privilege, and resources (APA, 2020).

In 2005, 36 years after he coined the word ageism, Butler wrote in a reflection, "I have come to understand that [ageism] is more than images, words, actions, or attitudes. It is deeply embedded in society in many areas" (Butler, 2005, p. 86). He went on to advocate, once again, for political, policy, and legal actions as necessary to address the power, privilege, and resource issues in ageism. It may be time for gerontology to follow the lead he set back in 1969.

Characteristics and Effects of Ageism on Older Adults and Health Care Providers

As with all isms, speaking of a socially constructed group identity as a coherent, cohesive class of people doesn't hold up well. The process of aging is no more or less determined than the process of child development; within a general developmental framework, as many unique life courses unfold as there are people. The aging experience varies based on any number of genetic and environmental factors and intersectionality with other agent and target ranks. An intuitive difference between child and geriatric development is that geriatric development ends in decline and death. However, that is also true for child development. All human development leads to senescence and death.

However, because ageism is so pervasive in Western societies, internalized ageism becomes a self-limiting and self-fulfilling factor. By the time people reach old age, they have absorbed decades of negative messages about aging, many of them explicit since ageist words, images, and jokes carry little social disapprobation. This plays out in health care. Older adults are at risk of assuming that health problems are "normal" for their age and may not always seek

treatment for their health care needs or take actions that would improve their health. Among those who do seek health care, most prefer to work with a primary care doctor; those who have mental health care needs often do not follow through on referrals to mental health care providers (Bodner et al., 2018). Some studies of older adults have found a relationship between negative attitudes about aging and poorer health care outcomes, and positive attitudes about aging and better health care outcomes (Wyman et al., 2018).

Health care providers, on the other hand, have more power in the relationship with their older patients. Eliassen (2016) described the parallel dynamics of medical paternalism as the way health care providers maintain authority and control, and health care consumerism as a source of distrust between doctors and patients. Ageism interferes with the potential for health care collaboration, in which health care providers and patients share goals and partner toward greater health and well-being. It obscures the power dynamics involved in paternalism and consumerism, which can lead to conflict, or simply the absence of care. Eliassen described the primary condition for collaborative health care relationships: awareness by patients and health care providers alike of the particular power relations in geriatric health care and a willingness by all parties to communicate openly about their needs (Eliassen, 2016).

Because systemic ageism works against this kind of collaborative relationship, both sides lose. Ageism harms the health and well-being of older adults, including the well-being that comes from being respected and valued. For health care providers in gerontology, ageism protects their position of privilege and power, but also may cost them the opportunity to experience the satisfaction of authentic, collaborative relationships with older patients, and to experience their own aging more positively.

Since many health care providers, especially those who have chosen a career in gerontology, are well-intentioned and desire the best for their patients, why does ageism in health care for older adults persist? The short answer is power and money. Creating a truly collaborative relationship in the health care system would mean listening to older patients; engaging with them; returning their agency to them; ensuring their participation in research, diagnosis, and treatment; creating feedback and quality control loops with older patients themselves; and improving recruitment and training of professionals to work with older adults. All of this equates to time and money. All service industries make deliberate choices about the level of quality service and support they provide in order for those services to be profitable. "Services" delivered in an environment of fear, vulnerability, high stakes, and disempowerment cost less to deliver and are more profitable than services delivered in an environment of choice, respect, freedom, collaboration, and mutual agency. Advocating for change is risky (discuss power).

Example of System Mechanism Preserving Ageism

Need an intro sentence here. Aging simulations have been used in gerontology specialties since the 1970s as a training method intended to increase knowledge and empathy (Greenblat, 1977; McVey et al., 1989). These simulations are still being used and may even be a trend in health care education, as evidenced by a number of articles published in 2020 (Bowden et al., 2020; Lee & Teh, 2020; Tsao et al., 2020). I raise this practice and the research literature about it as an example of a mechanism that might actually reinforce ageism.

The aging simulations described in the literature all use the same basic method. Student participants are asked to suit up in ways that are supposed to simulate sensory and functional losses of aging. These instructions vary in their sophistication but often involve wearing ear

plugs, goggles smeared with petroleum jelly, wads of cotton in their nostrils, pebbles inside their shoes, bandages to restrict joint movement, ankle and wrist weights, rubber gloves, and a back protector adjusted to create a stooped posture. So attired, they are asked to complete a few tasks of everyday campus or workplace living, such as buying a cup of coffee; sometimes on their own, sometimes with a unencumbered partner for safety. Most simulation designs include some combination of debrief, discussion, or reflection. I found one simulation design that included a debrief with an older adult, but this feature was soon dropped because of budget and logistics (Pacala et al., 2006). None of the simulation designs I reviewed mentioned any other participation of older adults in the design, development, delivery, or evaluation of the simulation.

These simulations might be reinforcing ageism in any of the following ways: emphasizing deficits and loss; excluding strengths and resources; creating an experience that is sudden, incomplete, brief, and artificial; reinforcing stereotypes; defining aging as merely the inevitable loss of sensory and motor function; reinforcing fear of aging; and reinforcing negative feelings about older adults.

Could the simulation experience lead to bypassing? In other words, participants might prematurely conclude that they have become sufficiently aware and empathetic, done the work, and no longer need to engage in further self-reflection or meaningful contacts with older adults. It is possible that the activity doesn't have to end with bypassing. It could prompt genuine engagement with older adults, and that engagement could be enhanced by a shifted concept of self as experienced and empathic toward older people. But what if instead the simulation experience provides an incentive *not* to engage with older adults in a meaningful and authentic way, if participants considers themselves to have "achieved" or "learned" empathy?

Even for those who do go on to engage more authentically, at what cost to dignity and respect — their own, as current and future professionals, and that of older adults? Some of the articles describing these simulations include photographs of the participants in their simulation attire. I am struggling with whether to include and cite these photographs in my class presentation on this topic. I would not share photographs of people costumed to simulate any other target rank. Think of the likelihood that such photographs exist in an academic setting, and the reaction that would occur if they did. What makes old age acceptable to simulate? The point of these simulations seems to be simply to teach people that it sucks to get old. That this point is being made uncritically in health care education is an example of deeply embedded ageism at work.

The literature on aging simulations is almost entirely silent on these questions, which is one of the ways research can reinforce oppression: by what is and *is not* asked and answered. Instead, most studies claim that the aging simulation was effective. There are several problems with this conclusion: most studies do not include a control group; they all focus on attitude rather than behavior as their measure of effectiveness; they all rely on self-report using attitude scales or workshop/course evaluations; and older adults play no role in providing data on how professionals trained in this way behave (Bowden et al., 2020; Douglass et al., 2008; Lee and Teh, 2020; McVey et al., 1989; Pacala et al., 2006; Tsao et al., 2020). Self-report of attitude seems to be a particularly weak way to measure the effectiveness of interventions intended to promote some aspect of social justice. This research design essentially relies on people with an agent rank to self-report about what is experienced by people with a target rank.

I found only one systematic review of studies that evaluated geriatric simulation games. All of the eight studies in this review assessed attitude, but none found a statistically significant

change in attitude. None of the studies assessed behavior change. The authors concluded that they found no evidence that geriatric simulations are effective in gerontology education. They recommended that the field instead use and evaluate experiential activities that involve meaningful contact with older adults, such as mentoring programs and service-learning projects (Alfarah et al., 2010). Likewise, Zucchero et al. (2014) recommend four experiential training methods for geropsychology: service learning, narrative therapy techniques, interprofessional training experiences, and supervised wellness outreach to older adults. Especially given that there are quality alternatives, it may be time for aging simulations to become a thing of the past.

Clinical Psychologists as an Agent of Oppression—or Change

There are a number of ways clinical psychologists function as agents of the oppression of older adults in geropsychology and geriatric health care generally. Psychologists can be called on to perform duties with overt ethical considerations, such as participating in the management of disruptive behavior by an older inpatient or resident of long-term care; or participating in competency evaluations of an older adult (Ardelt & Friedman, 2014). Decisions about whether or not to accept Medicare reimbursement affect what mental health care services are available to older adults. Assessments, diagnoses, and therapeutic interventions can be biased by age or fail to meet older adults' specific needs. Training methods can be insultingly inauthentic. Research and evaluation methods can exclude the most important source of data—older adults themselves.

Perhaps the most significant way clinical psychologists function as agents of the oppression of older adults is by a failure to be aware of ageism and interrogate it within ourselves and within our field. Psychology has not defined and operationalized the construct of ageism in a way that would allow advances in combating it through research, practice, and advocacy. The discourse of ageism in the psychological literature has focused on attitudes and

knowledge, rather than behavior; on intent, rather than impact; and on bias, stereotype, prejudice, and discrimination, without putting those mechanisms in the context of power, privilege, and resources.

In order to become agents of change, clinical psychologists will need to question the status quo of professional training, research and publishing, and clinical practice—out loud. Psychologists will also need to be willing to speak up and take action at the level of policy. By doing so, psychologists can contribute to a world that is more just for older people and might even find more meaning and peace in aging for themselves.

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