

Aging and Ageism: Cultural Influences



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Learning Objectives

By the end of this chapter, you should be able to do the following:

- Define ageism and identify positive and negative aging myths.
- Explain the ways in which ageism impacts older adults and everyone.
- Discuss three theoretical approaches that help explain ageism.
- Identify the ways that ageism intersects with other personal characteristics.
- List ways in which you can reduce ageism.

INTRODUCTION

Cultural beliefs shape social norms and values surrounding the aging process and the role of older people. These beliefs about aging are not static—they shift and change as society evolves. Like other social groups, such as women or African Americans, myths have emerged and, over time, have become part of the social fabric. These aging myths, which form the basis for stereotypes, create a limited social perspective on older people, and, as a consequence, older people are thought of and treated as if they are “all the same.” However, these myths are socially constructed, which means they can be challenged. Social work values stress the importance of social justice for those who are vulnerable and oppressed, and older adults are among those groups that can be at risk. Thus, it is important to confront the aging myths that we have been socialized to believe. Because these myths and stereotypes have a direct, negative impact on older people in terms of receiving services or opportunities within society, becoming more self-aware about how these ideas are limiting our conception of older people can facilitate change.

In this chapter, we focus on ageism and how it impacts older adults. We begin with a definition of ageism and how our history and culture have contributed to the construction and manifestation of ageism in contemporary society. We then explore positive and negative aging myths that perpetuate ageism and their impact on older adults. Ageism affects everyone, and we provide several theoretical explanations for ageism at the individual and societal levels as well as a discussion of the intersection of ageism and other personal characteristics, such as race and ethnicity. Finally, we present ways in which we can all help reduce ageism.

Exercise Box 2.1: Doctor's Office Anecdote

Older people often get less treatment when they visit their healthcare provider, and their medical concerns may be dismissed as aging-related. Consider your experiences in healthcare. Have you ever felt dismissed? Have you ever had an experience where your concerns were said to be age related? Ask an older person (or middle-aged person) in your life if they have ever had these experiences.

Consider this anecdote about an older man who goes to see a doctor about knee pain:

The doctor says to him, “You should expect this. You are getting older.”

The man replies, “My other knee is just as old, but it does not hurt.”

After thinking about this anecdote, is your perception of healthcare for older people altered?

Source: Allen, J. (2016). Ageism as a risk factor for chronic disease. *The Gerontological Society of America*, 56(4), p. 611.

AGEISM

The term *ageism* was first coined and defined in 1969 by psychiatrist Robert Butler as “prejudice by one age group toward other age groups” (Butler, 1969, p. 243). In later writings on the topic of ageism as experienced by older adults, he further defined it as “a process of systematic stereotyping of and discrimination against people because they are old” (Butler, 1975, p. 35). Thus, ageism is best described as a difference in one’s feelings, beliefs, or behaviors based on another person’s chronological age (Levy & Banaji, 2002). Although ageism can be experienced at any age, such as the young toward the old or the old toward the young, in this chapter, we refer to ageism in relation to the age discrimination experienced by older adults.

Ageism is often explained as if it is the same as other forms of prejudice, such as sexism or racism. But ageism is different. Generally speaking, one’s gender or race is part of a lifetime of lived experiences, including the effects of stereotyping, prejudice, and/or discrimination. But ageism occurs later in life and is thus unfamiliar when young (Cruikshank, 2009). Despite the unfamiliarity for young people in experiencing ageism, everyone will in fact encounter old age at some point, barring premature death; therefore, ageism is unique when compared to other forms of prejudice and discrimination.

Upon first meeting someone, there is a tendency to automatically categorize the individual along three social characteristics—age, sex, and race. This categorization process inevitably leads to the creation of stereotypes as our brains quickly process information about other people. When these categorizations are left unchecked, we can come to believe that anyone who belongs to a particular group is *this way* and thus *not like* me. For example, we may recognize someone as “older” and then think, “I bet she/he doesn’t use modern technology.” This thought is followed by the notion that using new technologies is good (it is what I do!), and therefore, this person and I do not share anything in common. It is this process of “othering” that leads to ageism or prejudice against older people and can in turn lead to *discrimination* or the differential treatment of an individual based on their status as an older person.

Ageist beliefs promote differential treatment of older people by individuals and organizations alike. “They legitimate the use of chronological age to mark out classes of people who are systematically denied resources and opportunities that others enjoy and, conversely, who are granted concessions for services and benefits they are assumed to need” (Bytheway, 2005, p. 339). As a result, many people dread old age. Aging was once seen as something natural, but now it is both a social and personal problem.

Aging has been described as the “neglected stepchild of the human life cycle” (Butler, 1975, p. 1). In other words, socially, we do not think about what it is like to live as an older person. And once one reaches this life stage, we might assume that “it’s all over now.” But the fact is that older adulthood and how it is experienced is dependent on many factors, such as physical/mental health, personality, previous life experience, social support, financial status, access to medical care, and housing. Thus, older adulthood is experienced in different ways by different people depending on their circumstances, and just like other life stages, older adulthood has both joys and sorrows (Butler, 1975).

History of Ageism

Attitudes toward older people have changed over time. In pre-modern times, the average life expectancy was significantly lower than it is now. As a result, “old age” was not really an issue. Nonetheless, religion, culture, and ideology shaped social attitudes toward older adulthood (Johnson, 2005). In religious texts, such as the Bible and the Koran, older people are revered. They are wise, hold a position of authority, and are treated with dignity and respect. These works have held a prominent position across many societies and have thus influenced the ideas around the way that older people should be treated. This influence, in fact, has been so great that these notions were later reflected in the legal system, in particular the succession of wealth, which occurs down the paternal line.

Therefore, older men enjoyed a position of status and power within the community in pre-modern times. Women, on the other hand, could only enjoy such elevation of position if they were married to a man of wealth and status given the patriarchal social structure. “Both survival and the opportunity to benefit from it were, and to a large extent still are, highly class related” (Johnson, 2005, p. 567). Today, we see this reflected in the fact that those with money and power age better and later. In other words, when someone has the ability to access a multitude of resources, her/his living conditions, including housing, food, medical care, and leisure time, are far superior and will allow them to “age” more slowly than their counterparts in lower socio-economic positions where life is much harder (Johnson, 2005).

Contrary to popular beliefs that suggest that older people were revered in their communities, there was not one consistent pattern of caring for older people in past centuries. However, because religious beliefs shaped cultural values around family obligations, those who survived to reach older adulthood were likely to be cared for by their families. But the challenge of taking care of a family member who was weak or frail would have been significant in a time period where working for food, shelter, and warmth consumed much of their time. For those without money or land, their treatment as an older person was quite bad. Nonetheless, older adults had greater status in past centuries than the ones that were to come. Keep in mind that older people in Native American communities would have enjoyed a position of power and status as leaders and historians. Moreover, African



Source: Tarbell, 1907.

Americans, Hispanic Americans, and Asian Americans would likely have held kinship values that demanded respect for elders. This discussion is meant as a general historical overview of ageism.

Two major social events significantly shifted these more benevolent attitudes toward aging and older adults (Nelson, 2005). The printing press, introduced around 1440, contributed to a decreased status of older people within the community (Nelson, 2011) along with increased literacy (Branco & Williamson, 1982). In the past, older adults would have been seen as the knowledge keepers for the community. Now, historical information could be easily kept *and* reproduced with ease. Next, the Industrial Revolution (1760–1840) saw younger people moving away from the farms and into the city seeking manufacturing work. Older people not only did not have the knowledge to guide the young people in their factory work but they were also draining financial resources given that they could not participate in the workforce. Yet at the same time, modern advances in medicine were extending life expectancy. The emergence of negative terms to describe older people began to be used during this era, and the idea that older people are a problem began to take hold (Johnson, 2005). In the next section, we turn to the way that ageism is reflected in the current, American cultural context.

Culture of Ageism

Today, ageism is likely the most socially accepted form of prejudice (Nelson, 2002). Many people are not even aware of their ageist thinking and probably do not intend to be hurtful in their ageist words or actions. Most Americans do not think of ageism in the same way that they might racism; that is, as an unacceptable form of prejudice (Nelson, 2002, 2005). In fact, ageism is ingrained and seen as normative within our culture (Chonody & Teater, 2016a). As a result, many Western cultures, including the United States, can be readily described as “youth dominated.” Young people are seen as the embodiment of all that is valued—beauty, vitality, and longevity. Aging, on the other hand, is associated with disgust. Older people represent failure; they have “let themselves go.” This point of view on aging is culturally reinforced and supported, and negative characteristics are attributed to older people simply because they are “old” (e.g., Kite & Johnson, 1988).

Ageist beliefs are so much a part of the culture that they are thought of as facts instead of stereotypes (Nelson, 2011), and most Americans feel okay about expressing their stereotypes openly. The combined cultural focus on youth and acceptance of stereotypes as truth leaves older people with significant status loss. In turn, this loss in status is used to justify the devaluation of older adults solely based on age. This cycle is self-perpetuating in that confirmation of a stereotype is used to justify differential treatment, which is then used to reinforce the stereotype. For example, let’s say you know an older adult who is “out of touch” with popular culture, and as a result, you intentionally exclude this older person from conversations that include popular culture references. This, in turn, reinforces the stereotype that older people “don’t get it.”

Messages that old is “bad” are also communicated throughout multimedia outlets and cultural artifacts. It is subtly expressed when someone says, “How many years young are you?” or calls an older woman “young lady.” These interpersonal communications

reinforce cultural norms that aging is bad (Cruikshank, 2009). Such messages are also promoted commercially. For example, greeting cards, memes, and cartoons joke about being “over the hill” or having a “senior moment,” which basically say “sorry to hear you are another year older” (Nelson, 2011, p. 40). Being “old” and aging are undesirable, and birthdays represent death and decline. Older people are depicted as forgetful, frail, bad drivers, incontinent, sagging, wrinkly, and grumpy, among other things. Society is flooded with these messages, which supports the maintenance of an ageist culture. It is important to note that ageism and ableism often overlap but are distinct



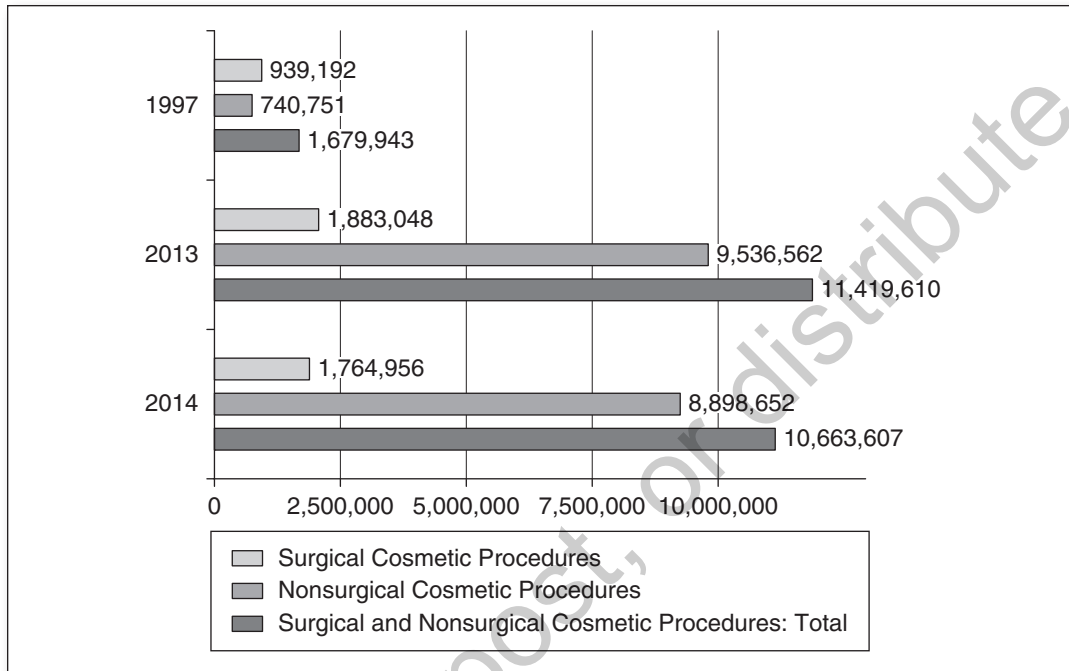
from one another. **Ableism** is defined as discrimination or prejudice against people with disabilities and favoritism to able-bodied people. Consider the picture below—what does this communicate to you about older people and expectations of older bodies?

TV and film play out these negative stereotypes with full blown portrayals of older adults as incompetent, sexually and physically unattractive, and physically weak or frail—all for the entertainment of the audience. They are the butt of the joke (Zebrowitz & Montepare, 2000), and attitudes toward older adults are influenced by the way that they are portrayed through this medium. The media consistently promotes this, which in turn nurtures ageism and personal anxiety

regarding the aging process (Chonody & Teater, 2016b). But why do we even condone these negative messages and portrayals of older people (Nelson, 2011)?

As we have seen, antiaging norms have become a regular part of American culture, and as a result, they are readily expressed through and reinforced by an “antiaging movement,” which dictates that physical signs of aging should be hidden. Antiaging products to cover age-related “flaws” are estimated at \$80 billion per year in the United States and are expected to increase to \$114 billion by 2015 due to increased use by Baby Boomers (Crary, 2011). Figure 2.1 illustrates the increase in the surgical and non-surgical cosmetic procedures performed in the United States by comparing figures from 1997 to 2014.

The marketing of these products goes without much notice. Much like greeting cards (Nelson, 2002), “no magazine or products are labeled ‘anti-black’ or ‘anti-woman’ but ‘anti-aging’ is a very common label for commercial products, including books” (Cruikshank, 2009, p. 144). Why do we spend money on these products? Why would we have unnecessary surgery to hide the physical signs of aging? Social messages repeatedly tell us that aging is unattractive and should be avoided at all costs. And we believe it without question (Nelson, 2011). Are Eastern cultures more accepting of aging? Read more in Text Box 2.1.

Figure 2.1 Surgical and Nonsurgical Procedures Performed

Source: American Society for Aesthetic Plastic Surgery. (2013). Cosmetic procedures increase in 2012. *Statistics, Surveys & Trends: Press Center*. Retrieved from www.surgery.org/media/news-releases/cosmetic-procedures-increase-in-2012.

Exercise Box 2.2: Taking Inventory

Take an inventory of your cosmetics, lotions, face wash, creams, perfumes, colognes, and hair and body products. Consider the following:

- Why did you purchase these particular products?
- To what extent do these products speak to “antiaging” or “youth” promotion?
- Are you surprised by what you found? Why or why not?
- Has what you learned in this chapter impacted your feelings about these kinds of products? Why/why not?

Text Box 2.1: International Focus: Are Attitudes Toward Aging and Older Adults Better in the East?

Much like Western cultures, Eastern cultures have been influenced by spiritual beliefs and religious or philosophical texts, including Confucianism in China and Hinduism in India. These belief systems, like those of Christian doctrines, promote filial piety or the care of elders (North & Fiske, 2015). This in combination with the interdependent or collectivistic culture that promotes the group or community needs over individual needs leads us to believe that Eastern cultures express a greater reverence for older people. But this generalization is much more complex given that "Eastern culture" includes a great many countries with a diverse range of cultural beliefs and practices. A meta-analysis of 37 studies that included over 21,000 participants from 23 different countries found that the attitudes of participants from Eastern cultures were more *negative* overall than those from the West (North & Fiske, 2015). Participants from both the East and the West indicated that older adulthood is associated with wisdom, but they also believed that attractiveness and the ability to learn new things declined. Similarly, Yun and Lachman (2006) found that South Koreans had more aging anxiety when compared to Americans, including fears about their physical appearance. The effects of industrialization and population aging are likely impacting cultural beliefs about aging and older adults (North & Fiske, 2015), and increased globalization is making the world smaller with American values influencing other societies (Chonody & Teater, 2016b). Thus, regardless of geographical location, people are exposed to negative messages about aging and older people.

Positive and Negative Aging Myths

Ageism, like other forms of prejudice, is based on both positive and negative stereotypes. *Stereotypes* create false pictures of older adults and keep our thinking narrow by limiting what we actually "see" when encountering an older person (Fiske & Taylor, 1991). Once we have developed stereotypes about older people, we seek to unconsciously reinforce them. For example, if an older person was dressed in a modern, hip way, but was also quite grumpy, we would be more likely to remember the grumpiness because it reinforces our idea of what older people are like. Before you read further, complete the exercise in Exercise Box 2.3.

Exercise Box 2.3: Your Views of Older Adults

Spend a few minutes making a brief list of the characteristics and traits that come to mind when someone says "older adult." What about when someone says "elderly"? What about "senior citizen"?

- Were there any differences in your lists?
- If so, why do you think this was the case?
- Overall, were your lists more positive or negative?
- What term promotes the strengths perspective?

Positive Aging Myths

Positive stereotypes about older adults include these descriptors: wise, kind, dependable, and happy. Many people probably consider positive stereotypes a supportive stance, not an ageist one (Cherry & Palmore, 2008), and these attributes do appear to be pleasant representations of older adults. But they can “undermine the status and treatment of older persons in society” (Cherry & Palmore, 2008, p. 857) and support a limited view of older adulthood even if they do seem deferential to age at face value (Chonody, Webb, Ranzijn, & Bryan, 2014). Whenever an individual is presumed to be a “certain way” because of group membership, then their individual characteristics are being downplayed. Thus, even a positive stereotype reduces an older person to a cliché instead of honoring their individuality. Thus, appreciating the positive qualities of the person—which may include wisdom, kindness, dependability, and happiness—should not be thought of as characteristics of older people per se, but this older person in particular.

Positive stereotypes also support *paternalism* or the act of keeping a group or member of a group in a subordinate position with the practice of doing something for or to a person for “their own good.” In other words, positive ageism encourages negative beliefs, such as that older adults are dependent, weak, or incompetent and, therefore, in need of someone to take charge and make decisions on their behalf. In Table 2.1, positive aging myths are discussed as well as the facts that counter them. For example, are older people wise?

Table 2.1 Positive and Negative Myths About Older Adults and the Facts

Myth	Reality
<i>Positive Stereotypes</i>	
Wise	Research findings suggest that older people are more likely to behave in rational ways and are more emotionally stable (North & Fiske, 2012), which may be indicators of wisdom. However, wisdom is not easy to measure. By virtue of living longer, older people have had more life experience, but does that necessarily make someone “wise”? Wisdom comes from learning from life experience, not just surviving them. Thus, some older people likely are wise, while others may not be.
Kind	Research does indicate that people become more agreeable, conscientious, and less neurotic as they age (Allemand, Zimprich, & Hertzog, 2007). So perhaps this translates as “kind,” but other factors likely influence kindness, such as current mood state, presence of physical pain or being in the midst of problems, and other personality traits, among other things.
Dependable	Older people may be more dependable when compared to younger people, and research evidence supports this to some degree. For example, older people have the lowest crime rates among all age groups, and in a work setting, they have lower absenteeism and turnover rates (Palmore, 1998). But these facts do not reflect the older people who are not dependable in many ways, including those who commit crimes, call in sick to work, or misuse drugs.

(Continued)

Table 2.1 (Continued)

Myth	Reality
Happy or serene	Older people may be somewhat “happier” than people in other age groups. Based on previous research, it does appear that negative emotions do decline with age while positive emotions remain fairly stable throughout middle age with only a slight decrease in older adulthood (Charles, Reynolds, & Gatz, 2001). Depression is less common in older adulthood, while reported life satisfaction tends to also be pretty stable across different life stages (Diener & Suh, 1998). So while older people may be better at emotional regulation and experience a decrease in negative emotions as they age, personality, previous levels of happiness and life satisfaction, access to resources, and many other personal factors will shape the extent to which an older person is “happy.”
Negative Stereotypes	
Ill/disabled	For those over 65, 44% rated their health as excellent or very good compared to 64% of those 18–64. Older people are likely to have at least one chronic condition, such as arthritis (most common) or high blood pressure (U.S. Dept. of Health & Human Services [UDHHS], 2013), but these conditions do not necessarily mean that an older person is “disabled.”
Neurocognitive impairment (i.e., dementia)	Alzheimer’s disease is the most common type of neurocognitive impairment (commonly referred to as dementia); however, only around 12% of Americans over 65 have this disease. Age is a significant risk factor, and for those over 85, around 33% have Alzheimer’s disease. Neurocognitive impairment is not part of the normal aging process, and many older people do not have significant impairment in memory and functioning (Alzheimer’s Association, 2012). Further, findings from a review of the literature suggests that remaining active and adding aerobic exercise several times a week improves information processing in older adults (Staudinger, 2015). Studies such as these indicate the plasticity of cognition and that loss is not a normal part of aging.
Live in a long-term care facility	In 2011, only 3.6% of Americans age 65+ lived in a long-term care facility. Over half of all persons not living in a facility are living with their spouse, and about 28% lived alone (UDHHS, 2013). Due to the increased longevity of women, they are more likely to live alone.
Cannot change or are stubborn	Older people have the capacity to continue to learn new things as they age, and research indicates that older adults respond well to therapeutic interventions (Stanley et al., 2009). Being open to change and having the opportunity to explore novel situations, ideas, and activities are important factors when considering the ability (or desire) to change. In fact, evidence from a literature review suggests that when older people are exposed to new activities, their openness to novel experiences increases (Staudinger, 2015).

Myth	Reality
Useless, unproductive, or are a burden on society	Americans are working longer, and approximately 18% of those over 65 are still working (UDHHS, 2013). But productivity is not simply measured by paid work. Volunteer rates decline somewhat by age, but around 24% of older people volunteer their time (U.S. Dept. of Labor, 2014). And grandparents are raising approximately 6% of children under the age of 18 (U.S. Census Bureau, 2014). Older people continue to make significant contributions to society and their families.
Isolated and depressed	Just over 25% of all older people live alone, but the majority are married and living together (UDHHS, 2013). In a longitudinal study, older adults who had a previous high level of social engagement only decreased their involvement slightly over time (Thomas, 2011). Thus, one's level of social involvement earlier in life is likely mirrored in later life. Moreover, the replacement of friends is a dynamic process that does not change much with age. In other words, new friendships replace old friendships as people move away, lose touch, or die. As mentioned above, depression is actually less prevalent in older adults than younger people (Fiske, Wetherell, & Gatz, 2009), but it can be particularly detrimental to older people.
Poor	The poverty rates among older adults is virtually the same as that for other age groups—about 10% of Americans live below the poverty line (U.S. Census Bureau, 2015).
Sexually inactive or uninterested in sex	In a recent study, 18% of men and 8% of women age 60–69 indicated that they had sexual intercourse once or twice a month, and 45% and 35% respectively reported daily kissing and hugging. Additionally, 11% of both men and women in this same age group report self-stimulation once or twice per month (AARP, 2010a). Erectile dysfunction (ED) and a decrease in vaginal lubrication post-menopause along with the availability of a sexual partner impact the sexual lives of older people. However, sexual and intimate activities can be quite broad, and this remains a part of people's lives. Attitudes toward sex and sexual expression shape behavior, and as the Baby Boomers reach older age, additional shifts in sexual activity will likely occur given the generation in which they were raised.
Grouchy or grumpy	The ability to regulate emotions improves with age (Carstensen & Mikels, 2005), and thus, there is no reason to believe that older people are grumpier than any other age group. In one study, it was found that neutral facial expressions on older adults were often misread as sad by younger people (Fredrickson, Collins, & Carstensen, 1989). So perhaps there is a misinterpretation of mood based on misread affect. Also, if someone is in physical pain (e.g., arthritis) or is feeling frustrated/overwhelmed, such as what might occur in a fast moving society, the individual may get grumpy—but this can happen at any age!
Cannot use technology or learn new things	While older people have been late adopters of technology, a recent study found that 60% of older adults use the Internet, and of those individuals, 71% go online every day or almost every day. And 77% of older people have a cell phone. Income and access to technology play a role in the use of technology as does physical challenges (Pew, 2014b).

Negative Aging Myths

Negative stereotypes include such beliefs that all older people are ill or have cognitive decline; live in long-term care facilities; are useless, isolated, and/or depressed; and are grumpy. Negative beliefs, like positive ones, homogenize older people or treat them as if they are all the same. And as a result of this, these beliefs are seen as natural (Calasanti, 2005) and used to justify prejudice and discrimination. In fact, beliefs in negative stereotypes were found to help explain comfort in spending time with older adults; that is, the more negative stereotypes that a participant endorsed, the less comfortable she/he felt being with older people (Chonody et al., 2014). Negative stereotypes are addressed in Table 2.1, and the reality about older adulthood is presented. For example, do most older people live in long-term care facilities?

Ageism: The Impact on Older Adults

Ageism has many social as well as interpersonal implications for older adults, including employment, medical care, and issues of independence (Chonody & Teater, 2016a). Negative beliefs about aging can be both hurtful and harmful to older people. Perceived age discrimination negatively affects health over time (Luo, Xu, Granberg, & Wentworth, 2012) and impacts life expectancy. Negative self-perceptions of old age influence health by generating increased stress, which in turn weakens the immune system and increases the likelihood of illness (Staudinger, 2015). Similarly, belief in negative stereotypes about aging impacts memory. In a 38-year longitudinal study, researchers found that memory performance decline was 30% greater for older adults who held negative aging stereotypes (Levy, Zonderman, Slade, & Ferrucci, 2011). In another longitudinal study of people age 50 and over, it was found that those who had a more optimistic perception of aging lived about 7.5 years longer than those who were pessimistic (Levy, Slade, Kunkel, & Kasl, 2002).

Ageism can also be internalized by older adults and expressed through *age passing*—presenting yourself as younger than your true age—or through comments that suggest that the only thing that has changed over time is the body, which neglects the experiences and emotional changes that occur throughout a lifetime (Cruikshank, 2009). We are socialized into an ageist belief system, and cultural norms and values perpetuate this system. Given enough time, we “oppress ourselves. . . either we try to avoid the aging process or we lose self-esteem because of the selves we feel we are becoming” (Calasanti, 2005, p. 8). Older people may also express *internalized ageism* by actively trying to separate themselves from “other” older people; that is, those who are healthy may avoid those who are not and may not self-identify as part of the demographic of “older person” (Butler, 1975).

Interpersonal ageism is also harmful to older adults and is likely quite common. In a large study in England with over 7,500 respondents, nearly 37% of those over the age of 65 reported that they had experienced age discrimination (Rippon, Kneal, de Oliveira, Demakakos, & Steptoe, 2014), which is consistent with findings in the United States (Luo et al., 2012). In a smaller study, over 70% of the respondents reported experiences with some form of ageism (Palmore, 2001). The assumption that they were hard of hearing because of their age happened frequently; however, the most common ageist behavior they experienced was being told an ageist joke (Palmore, 2001).

Younger people, including professionals and family members, often infantilize older people. One such way is the use of *elderspeak* where a childlike tone is used to communicate with older people. The use of elderspeak has been found to lower an older person's self-esteem and cause them to question their ability to accomplish a task (Kemper, Vandeputte, Rice, Cheung, & Gubarchuk, 1995) or enact the performance of aging stereotypes, such as talking or moving more slowly (North & Fiske, 2012; Staudinger, 2015). Similarly, when older adults were exposed to negative stereotypes, it was found that their driving confidence decreased (Chapman, Sargent-Cox, Horswill, & Anstey, 2014) and in another study, this exposure impacted memory performance (Levy & Leifheit-Limson, 2009).

Ageism: How It Impacts Everyone

Ageism keeps aging at a distance instead of it being thought of as part of our entire lifespan. This type of thinking creates a false barrier in the aging process (Butler, 1987; Calasanti, 2005). So when we think about ourselves as old, we think that it will never happen to us—this is only something that happens to other people (DeBeauvoir, 1972). American culture reinforces these messages, suggesting that youth can be maintained through sheer will (e.g., diet, exercise, and antiaging products; Chonody & Wang, 2014b). Thus, we approach old age with a sense of ambivalence.

However, we are all in fact aging, and one's personal view on getting older is essential. Anxiety about aging creates a negative attitude toward the aging process, promoting the idea that this stage of the life course will be the worst phase and marked by loss. "The more a person is convinced that aging is an inevitable process of physical decline and loss of autonomy, the less this person will believe that she or he can exert influence on her or his aging process" (Staudinger, 2015, p. 200). However, fear of aging is much like any other potential threat to well-being, and there is a choice to be made on how to approach it (Braithwaite, 2002). We can choose fear, dread, and shame or meet it headlong with hope, acceptance, and humor. In fact, this anxiety about aging propels ageism at the social level. When beliefs about aging are negative, attitudes toward older adults are also likely to be based on negative stereotyping (Braithwaite, 2002). And in turn, this ideology maintains aging anxiety and a negative perspective on older adulthood and contributes to fears about death.

THEORETICAL EXPLANATIONS FOR AGEISM

Unlike race and sex, age is something that is experienced by everyone. That is, "old age" is a category that we hope to join one day by virtue of continuing to live our lives. When one is in a position of privilege—that is young—it can be difficult to see the importance of age, even if one has experienced prejudice due to another social characteristic, such as gender (Calasanti, Slevin, & King, 2006). Nonetheless, young people may readily place older people in the category of an out-group member. But older adults were once young, too. "Thus, the relationship of the non-old to the old is unique" (Greenberg, Schimel, & Martens, 2002, p. 28). It is odd that we live in a society that actively supports prejudice against a group to which we all hope to belong (Nelson, 2002).

Thus far, we have focused much of this chapter on social and cultural manifestations of ageism, but now we turn to those theories that explain how and why ageism exists within the individual. Of course this is not to exclude the role of culture and social norms and values, rather these theoretical perspectives seek to highlight the reason that these cultural messages are maintained without awareness or question at the individual level and ways in which they can be challenged. We focus on three such theories here, but acknowledge that there are a number of others, such as the structural functionalism perspective or countertransference.



Intergroup Contact Theory

Intergroup contact theory, developed by Gordon Allport in 1954, was originally used as a theoretical perspective to understand racial prejudice and as an approach to challenge stereotypes and negative attitudes that fuel prejudice from one group toward another. Allport (1954) hypothesized that mere contact between two different groups is not enough, but rather stereotypes and attitudes from one group toward another

can only be changed when the contact between two different groups is structured along the following four conditions:

1. The two groups are of *equal status*. One group is not teaching or mentoring the other, but both groups are equally participating in the interaction, and both groups have a say in the direction of the contact.
2. The two groups are working toward a *common goal*. There is a purpose and goal to the interaction, and both groups are equally working to achieve the goal.
3. There is *cooperative interaction* between the two groups where they are willing to interact and participate.
4. There is *institutional support* for the contact where any change as a result of the contact would be supported through social and cultural environments.

Intergroup contact theory, oftentimes referred to as the “contact hypothesis,” is used to structure interactions between two different groups in order to challenge biases. For example, to challenge stereotypes and negative attitudes of young people toward older adults, with the aim of combating ageism, an intergenerational program involving creative activities was developed using the four conditions of the contact hypothesis. After the program concluded, the young people reported changes in their attitudes toward older

adults and were able to refute negative stereotypes (Teater, 2016). One young person commented: “I think it’s the more you know an older person, the better your relationship with them is, and you won’t think of them as stereotypes much, unless they are like a stereotype.” The young people reported finding commonalities between themselves and the older adults and reported a desire to interact with older adults in the future.

Therefore, intergroup contact theory can be used to explain how ageism can be sustained and ways in which it can be challenged. For example, when young people have limited exposure to older people, they tend to believe in negative stereotypes about older people. Negative stereotypes and attitudes are also sustained if a younger person has a “negative” experience with an older adult, such as living with a frail relative (Allan & Johnson, 2009) or experiencing “educational” activities that involve imagining that one is an older adult or simulating loss of physical functioning (Meshel & McGlynn, 2004). However, research indicates that through both high quality and increased quantity of contact, attitudes toward older adults significantly improved (Bousfield & Hutchinson, 2010; Teater & Chonody, 2017a). As found in the study by Teater (2016), positive contact, based on the contact hypothesis, can facilitate a new perspective on older people; that is, they are not different from the younger person, just older. The importance of intergenerational contact is discussed throughout the book as it has the power to not only improve ageist attitudes but also provide the opportunity for social and emotional growth for both older and younger people alike.

Social Identity Theory

Social Identity Theory (SIT), developed by Tajfel and Turner (1979, 1986), explains the ways in which people attach themselves to or identify with a social group, and the ways in which people view themselves and others within their social group (in-group) compared to others who are not in their social group (out-group). People may self-identify with a particular social group or may be prescribed to the social group by the dominant culture. The group (or groups) to which a person belongs is the *in-group* and those who do not fit in the in-group belong to the *out-group*.

According to SIT (Tajfel & Turner, 1986), there are three stages to the identification and evaluation of the in-groups (“us”) and the out-groups (“them”). First, *social categorization* occurs when we assign people to either the in-group or the out-group (e.g., females versus males; Republicans versus Democrats; young versus old), which provides us with information about that person, such as their characteristics, beliefs, traits, abilities, or disabilities. Second, *social identification* takes place when the individuals in the in-group subscribe to the “defined” characteristics, beliefs, traits, abilities, or disabilities. In this sense, individuals identify with their in-group and actively seek membership to the group, as it is their identity and source of self-worth. Finally, *social comparison* happens when individuals in the in-group compare their group membership to those in the out-group. Individuals’ identity and self-worth is defined by their membership to their in-group. They tend to view their in-groups in a positive light and hold stereotypes and negative attitudes toward those individuals in the out-group; this makes them feel good to be a member of the in-group and enhances their self-worth.

Exercise Box 2.4: Your Group Membership

Make a list of all the groups to which you belong that you believe informs your identity.

- In what ways is each group the "in-group"?
- In what ways is each group the "out-group"?
- Spend some time thinking about how you view your group membership in comparison with other groups.

SIT can be applied to ageism by exploring the interplay between the young (in-group) and the old (out-group). Young people often hold stereotypes and negative attitudes toward older adults as this reinforces their identity and self-worth as young people; likewise, older adults (as the in-group) may view younger people (as the out-group) in a negative way as it makes them feel better about being old. What is interesting when applying SIT to ageism is that the young people in the in-group will eventually move out of the in-group into the out-group of older adults. SIT suggests that individuals moving from the young (in-group) into the old (out-group) can do so in one of three ways:

1. Social Mobility

Individuals (literally or figuratively) attempt to remain a part of the young group (in-group) for as long as possible; thus, choosing not to identify with the less-preferred out-group. For example, individuals may participate in recreational activities socially constructed as activities for younger individuals (e.g., playing football), or may use beauty treatments, or undergo plastic surgery.

2. Social Creativity

Individuals embrace their move from one group into another, focus on the more positive aspects of the new group, and creatively establish this as their identity. For example, older adults who participate in a weekly singing group refer to themselves as "Goldies."

3. Social Competition

Individuals acknowledge their move from the in-group to the out-group and aim to tackle the stereotypes and negative attitudes associated with their new group in order to create a more positive image for their new group. For example, participating in the work of the AARP, Inc. (Kite & Wagner, 2002).

As with the intergroup contact theory, when individuals spend more time with someone that is thought of as a member of an out-group, individuals can come to understand the

commonalities that are shared across groups. In turn, stereotypes can be challenged, and attitudes toward this “out-group” are then improved.

Terror Management Theory

Terror management theory (TMT) is based on the writings of Ernest Becker (1962, 1973, 1975) who wrote about humans’ unique self-awareness regarding their own mortality. Becker proposed that this knowledge terrifies us. But, we cannot escape it even though we will do what we can to actively avoid thinking about it. Therefore, ageism acts as a protective mechanism against death anxiety associated with the knowledge of our own mortality by creating a barrier against reminders that we are going to die (Martens, Goldenberg, & Greenberg, 2005; Martens, Greenberg, Schimel, & Landau, 2004). In other words, we can avoid the most direct reminder of death—older people. Not only are they closer to death but they are also aging. And those physical signs of aging are indicators of decline (Greenberg et al., 2002).

Much like intergroup contact theory and SIT, TMT also includes the idea of “us” versus “them” or in-groups and out-groups (Greenberg et al., 2002). The old are a threat to the fate of younger people—fading beauty and health and finally, death (Greenberg et al., 2002). The older person reminds us that life is finite. In avoiding older adults, younger people can suppress the knowledge that that they too will grow old and one day, they will die. Younger people subscribe to the stereotypes about older people that support how they are different from them (e.g., frail, inactive, in decline) as this helps younger people feel better about being a member of their in-group, which in turn supports their identity and self-worth. But in this process they are further fueling their terror of growing old because that means moving into the out-group of older adults, which is equated with their negative beliefs and eventually death. To avoid death, younger people attempt to further remove themselves (as a group of young people) from older adults, thus, amplifying ageism toward older adults (Nelson, 2011).

AGEISM AND INTERSECTIONALITY

Society is stratified along the lines of social characteristics. For example, men enjoy a privileged status within society in which they reap such benefits as higher salaries for the same work that is performed by women. But this stratification is not limited to gender. Race, class, sexual orientation, ability, religion, and age, among other characteristics, also divide society. This system is “unified in its function of privileging some while oppressing many” (Chonody, 2016, p. 207).

These different kinds of social stratification intersect to create multiple forms of oppression. In other words, belonging to multiple groups who are oppressed puts the individual in an increasingly vulnerable position because the effects of these “multiple oppressed identities are cumulative” (Chonody & Teater, 2016a, p. 267). Moreover, being “old” is associated with loss in and of itself. So regardless of the rewards that one may receive by belonging to a desired group, loss will still be associated with age. Consider the discussion

of age with regard to presidential candidate Hillary Clinton as presented in the media. As of 2015, she was 68. Donald Trump was 69. But some reporters suggested that Hillary may be “too old” and “too distracted as a grandmother” to be the president. The intersection of ageism and sexism are illustrated by these comments.

Age stratification, at least in part, can be explained by the capitalistic nature of the United States where productivity and innovation are associated with youth (Hopkins, 1980). Older people then are the opposite of this—obsolete, slow, rigid—and they need to be forced out of paid employment to make way for younger people (Butler, 1969). The social inequality that occurs as the result of aging is seen as “natural” (Calasanti et al., 2006), much like the negative stereotypes that were discussed earlier in this chapter. “The power, resources, and rewards attributed to certain members of society are used to maintain this privileged status through the creation of social policy to support it and the reinforcement of social norms that legitimize it” (Chonody, 2016, p. 207).

Sex and Gender Roles

Sex and gender are two different concepts that have social meaning. *Sex* simply refers to one’s biological status as male or female whereas *gender* refers to the way in which society then attributes different characteristics to each sex. For instance, women are thought to be emotional, and men are thought of as strong. Given these social characteristics—which are thought of as natural—men and women are assigned different gender roles, such as women should take care of children because they are more emotional and better equipped for the role, and men should be in positions of authority because they are strong and exhibit leadership skills. Both sex and gender influence the way that aging is experienced. Social norms guide the way in which aging is approached and dictates certain standards for how it is to be done “well” according to one’s gender (Chonody & Teater, 2016a). Both ageism and sexism help maintain male power and privilege; thus, the focus of this section is on how this social structure impacts older women.

Double Standard of Aging

Susan Sontag first discussed the *double standard of aging* in 1972, which proposes that the aging process impacts women and men differently. Women, especially White women, are judged primarily by their faces whereas men are seen as a whole. That is, a man might have a “rugged” face but that does not deter from his attractiveness given that he is more than just his face. On the other hand, a woman’s face is seen as a “canvas” whereby she creates a different version of herself—one that has been corrected through the use of make-up. As women age, they are “much more heavily penalized than men” for the changes that occur on their faces (Sontag, 1997, p. 23). “One of the biggest obstacles to women’s complete self-acceptance in late life is the judgment that loss of attractiveness (by conventional norms) is a tragic fact of life rather than a belief that can be examined and repudiated” (Cruikshank, 2009, p. 150).

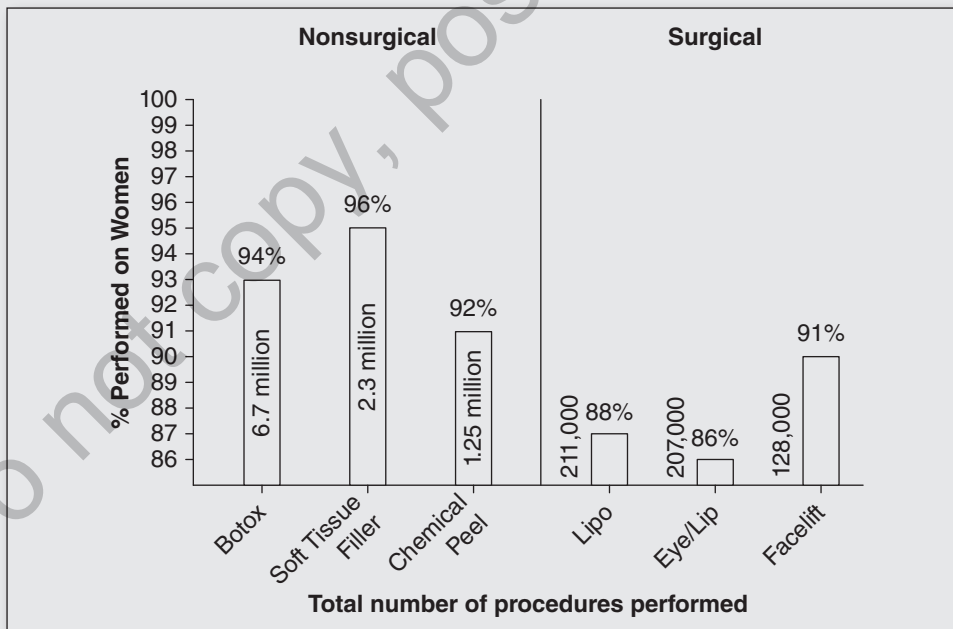
Women are also expected to buy into ageist beliefs and illustrate some degree of “age shame.” The idea that a woman would never tell her age once she is past a certain age is illustrative of this shame. “To answer truthfully is always indiscreet” and is associated with loss in “sexual value” (Sontag, 1997, p. 19). Many women feel that once they are past menopause they have lost their sexual appeal. These kinds of ageist myths are promoted

through the media when an older person is presented in this asexual stereotype, which feeds these aging anxieties (Chonody & Teater, 2016a). Understanding the way that everyone is being sold these ideas is an important step in becoming more aware of the ways in which we can create new ideas about aging and beauty. In Text Box 2.2, learn more about “beauty work” and the industry that supports it.

Text Box 2.2: Beauty Work: The Consumerization of Aging

The combination of antiaging norms and gender expectations for attractiveness has resulted in an industry that primarily targets the fears of women who feel pressure to remain looking young. This pressure is realized in the form of face creams, Botox, face lifts, tummy tucks, lip injections, and other forms of alterations that present a body and face that is consistent with femininity and youth. Plastic surgery has expanded its range to include numerous procedures that remove wrinkles, a normal sign of aging, which promotes age passing (Bayer, 2005). The American Society for Aesthetic Plastic Surgery (2014) reports that more than 10 million cosmetic procedures are performed each year with a 9:1 ratio favoring women and is a \$12 billion industry in the United States alone. In the figure below, the top noninvasive and invasive procedures are shown along with the percentage performed on women.

Figure 2.2



Source: Based on information obtained from: American Society of Plastic Surgeons. (2015). *2014 Plastic surgery statistics*. Retrieved from <http://www.plasticsurgery.org/news/plastic-surgery-statistics/2014-statistics.html> and The American Society for Aesthetic Plastic Surgery. (2014). *Cosmetic surgery national data bank*. Retrieved from <http://www.surgery.org/sites/default/files/2014-Stats.pdf>.

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While plastic surgery is now accessible to many women, antiaging products are commonplace. Bayer (2005) uses the term “cosmeceuticals”—a combination of cosmetic and pharmaceutical—to describe the medicalization of physical aesthetics, which is packaged as antiaging products. Such an industry is promoting the idea that aging can be fought as long as one has the resources to purchase the “right” products, and the media spreads the word.

Women find themselves in the position of understanding the marketing trick, but fear loss of attractiveness, and this drives the industry. Study results reflect this duality in that women reported that they were critical of antiaging messages found in the media, yet they acknowledged use of antiaging products (Muisse & Desmarais, 2010). These products “do not make us less old, [but] they do perpetrate the myth and the expectation that we can fix our brokenness with a growing range of often costly consumer products” (Holstein, 2006, p. 320). Ageism is not thwarted by the antiaging industry but rather it acts to perpetuate the notion that aging is disgusting (Calasanti, 2005). “When we combine the belief that we should control aging with industry promises of slowing or altering the aging process, the pressure to not ‘look old’ increases exponentially” (Calasanti, 2005, p. 11).

Caregiving Roles

Older people may need assistance with activities of daily living (ADL), such as bathing, dressing, eating, and maintaining a household, as they age due to chronic conditions like arthritis or illnesses such as neurocognitive impairment (i.e., dementia) or cancer. Family and friends provide most of this care informally, and this care determines whether or not an older person lives in a care facility. For those older people with a family member caregiver, only 7% are living in a long-term care facility or assisted living facility, but this jumps to 50% for those who do not have a caregiver (Family Caregiver Alliance [FCA], 2015).

Women disproportionately provide family caregiving—more than 66% of all care—and this is conservatively estimated at \$150 billion in unpaid services (FCA, 2015). For many women, they are part of the “*sandwich generation*”; that is, they are caring for both their aging parents and their growing children (FCA, 2009). Most caregivers are middle aged and are likely to be employed in addition to caregiving responsibilities (FCA, 2015). It is also increasingly common for women in later adulthood, say 60 or 70, to be caring for an aging mother in her 80s or 90s (Chonody & Teater, 2016a).

Race and ethnicity are important considerations of caregiving. According to the Family Caregiver Alliance (2009), people of color provide more care than White caregivers, and this intersection of race, gender, and age can have a major impact on them. For example, the higher poverty rate for racial/ethnic minority groups (discussed more in the next section) means that these caregivers are half as likely to be able to access respite care or other paid support to help them with caregiving (FCA, 2015). In addition, women from a lower socioeconomic status have increased demands for care, averaging around 20 or more hours per week. This creates a cycle of financial struggles—high care demands require time away from work, which in turn creates greater economic pressures and causes additional health effects for the caregiver.

For all caregivers, significant health and emotional tolls are likely, including higher mortality rates, increased use of alcohol, depression, and more chronic health conditions (FCA, 2009). The stress of trying to manage multiple households, work, and recreation weakens the immune system and creates vulnerability to emotional exhaustion. For social workers, we should consider the needs of both the caregiver and the older adult—either of which may be our client. Just as we would work with parents when a child is our client, inclusion of the caregiver (where appropriate) is also essential to good practice. Read Text Box 2.3 to find out more about social work practice in long-term care facilities. Caregiving is discussed further in Chapter 8.

Text Box 2.3: Occupational Profile: Working in Long-Term Care Facilities

Social workers working in long-term care facilities work with residents by identifying their psychosocial, mental, and emotional needs through assessment and providing interventions that develop or aid in the access of services to meet those needs. Social workers will aim to work with the residents and their support systems (families; significant others) to support and foster independence, autonomy, and dignity to maintain and enhance well-being and quality of life. The tasks of the social worker may be clinical, educational, and/or administrative.

Specific job functions of a long-term care social worker can include

- conducting social history and psychosocial assessments;
- developing care plans for residents that identifies needs, interventions, and goals;
- providing interventions to assist residents in coping with their transition and adjustment to a long-term care facility;
- providing support and education to residents/family members/significant others to assist in understanding the placement and facility issues in addition to referring them to appropriate social service agencies;
- providing group work for residents/family members/significant others;
- providing clinical interventions to address catastrophic events that occur during the resident's stay in the facility;
- coordinating resident discharge planning and make referrals for appropriate home care services;
- providing education to staff regarding the role of the social worker and the psychosocial needs of the residents and their families/significant others, including problems of aging and disability;
- providing education to staff regarding cultural diversity and dignity in care;

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- providing education to staff and residents regarding how to prevent, recognize, and report abuse, neglect, and mistreatment;
- providing education to residents and families/significant others regarding their rights and responsibilities, problem-solving skills, and external supports that are available in the community; and
- providing end-of-life care planning.

Source: NASW Massachusetts Chapter. (2001). *Nursing home model job description*. Retrieved from <http://www.naswma.org/?90>.

Economic Issues

In terms of income and retirement, women are more likely to live in poverty and be in need of social services (Arber & Ginn, 2005). Women still make less money than men and are more likely to have gaps in their work history due to having children, which means that the overall amount of retirement is also affected. The capitalistic system in the United States also favors men (Estes, 2005). Traditional gender roles support the role of men in the paid work force, and their value and status are intertwined with how well they do it. Women, on the other hand, are suited to nurturing roles, such as childcare and domesticity; these activities are not rewarded monetarily and do not enjoy a high status in society as they are seen as something that women are just good at doing (Estes, 2005). Nearly 60% of all women over the age 16 are working or looking for work, and women comprise 47% of the paid labor force (U.S. Department of Labor Statistics, 2015). Yet the accumulation of wealth remains a male endeavor.

Part of the reason for this is that women still primarily work in “pink collar” fields—those jobs associated with women’s “natural” nurturing skills, such as teaching, nursing, social work, childcare, waitressing, and counselors. These occupations pay less on average, and the more female dominated the profession, the more the pay goes down. Therefore, it is not just one factor that creates more poverty for older women. It is the combination of lower pay associated with the work that they do, which leads to lower lifetime earnings and lower retirement. This combined with a longer life expectancy and a greater likelihood of living alone due to widowhood creates a situation that many older women face as they try to manage their economic position. For many older women, they will need support from government assistance to meet their basic needs (Estes, 2005). Further discussion of economic issues is addressed in Chapter 8.

Race and Ethnicity

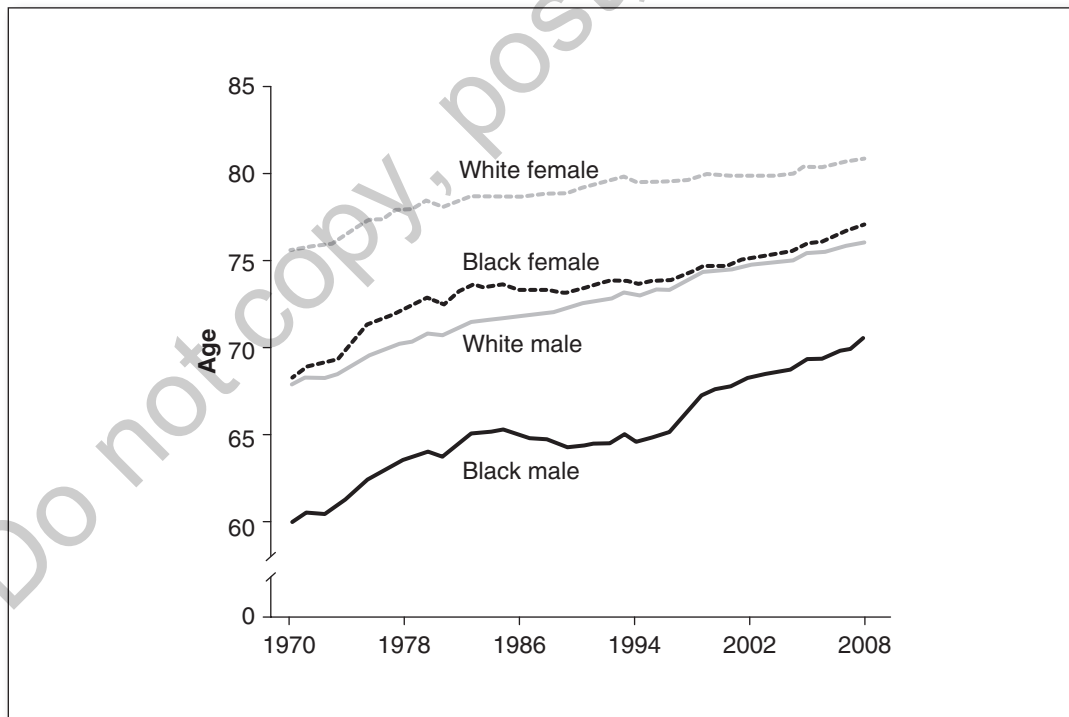
The increased number of older adults projected over the course of the next 50 years means that diversity will also increase. Understanding the way that age and race intersect and create increased vulnerability for older people who are part of racial/ethnic groups

is important to social work practice. However, it is also important to note that there is a greater deal of diversity within racial/ethnic groups. For example, Hispanic Americans represent a wide range of people from different countries and cultures, including Cuba, Mexico, and Puerto Rico, among others. Disparities in health, wealth, education, income, and mortality are discussed here. The interrelationship of these factors are complex, but it is safe to say that the lived experience for people of color in the United States is different than the one experienced by Caucasians.

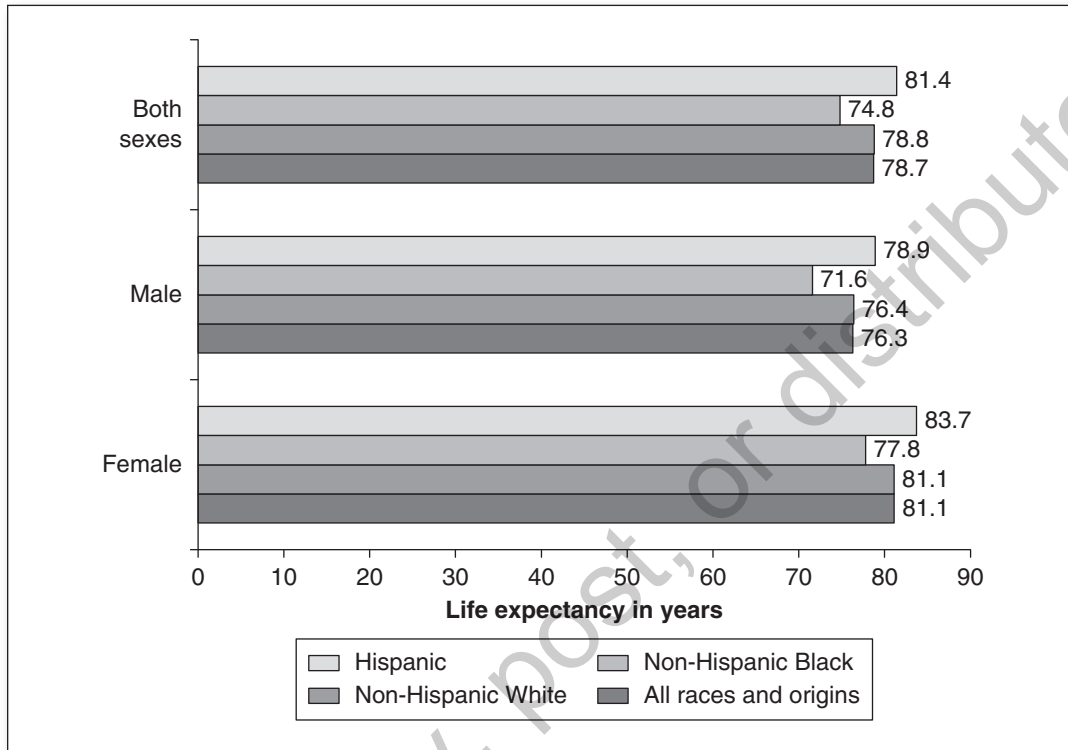
While life expectancy is increasing, the gains for African American men and women still lag far behind White people (Centers for Disease Control and Prevention, 2012). In Figure 2.3, we can see the large gaps based on race and gender. In Figure 2.4, however, we see that African Americans of both genders do not live as long as either Hispanic Americans or Caucasians, but Hispanic Americans of both genders outlive White Americans.

Educational attainment is differential by racial/ethnic groups despite overall educational gains over the past decade (Administration on Aging [AoA], 2014b). As of 2014, 84% of those 65 and older had completed high school, and 26% earned a bachelor's degree or higher. For older African Americans, high school completion was lower at 74% as was college completion at 17%. Similar patterns are seen for Hispanic Americans,

Figure 2.3 Life Expectancy at Birth by Race and Sex



Source: Centers for Disease Control and Prevention. (2012). *National vital statistics reports: United States life tables, 61, 1–64*. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_03.pdf.

Figure 2.4 Life Expectancy at Birth by Hispanic and Non-Hispanic Origin and Sex

Source: Centers for Disease Control and Prevention. (2013b). *Death in the United States 2011: NCHS data brief* (No. 115). Retrieved from <http://www.cdc.gov/nchs/data/databriefs/db115.pdf>.

albeit lower. Only 54% had completed high school, and 12% were college educated (AoA, 2014b). Lack of opportunity and social structural barriers are key contributors to these lower educational levels among people of color.

The disparities found in educational attainment have a lifelong impact on income, wealth, health, and mortality. One study found that African American men with less than 12 years of education lived on average 14 years less than White men who had at least 16 years of education (MacArthur Foundation, 2008). For women, they average about 10 years lower life expectancy. The importance of race is profound. For the most highly educated African Americans, life expectancy is still shorter than it is for Whites (MacArthur Foundation, 2008). "At the root of the educational disparity in longevity is a profound inequality of opportunity and the strain that life at the bottom creates" (MacArthur Foundation, 2008).

People of color are also likely to earn less money than White people and more likely to live in poverty. The poverty rate for older adults is 10.2%, but for African Americans, the poverty rate is 18.7% and for Hispanic Americans, the rate is double at 20.4% (AoA, 2014b). But "wealth captures an important dimension of the economic standing of individuals age 65 and older, and racial differences in wealth are much larger than those for

income” (Williams & Wilson, 2001, p. 164). Wealth, unlike income, provides access to further resources, including something that can be counted on when income wanes, such as what happens during retirement or a period of unemployment or disability.

Socioeconomic status also impacts health with those with more money enjoying a better health status than those who live in lower socioeconomic brackets. The key issue to long-term health status, however, is risk factors. People who live in poverty are exposed to more environmental toxins, poor housing, less healthy food, decreased amount of recreational/leisure time, and limited access to preventive healthcare. Over time, these risk factors have a cumulative impact on health, and these exposures are disproportionately affecting people of color (Williams & Wilson, 2001). Health risks related to behaviors are discussed in Chapter 5, and environmental risks are explored in Chapter 9. In Text Box 2.4, the intersection of HIV/AIDS and age is considered.

Text Box 2.4: The Intersection of Aging and HIV Disease: Managing Stigma

When the first cases of HIV/AIDS were documented in the United States over 30 years ago, it was viewed as a disease that primarily affected younger people. However, the advent of highly active antiretroviral therapy (HAART) has drastically improved treatment, and as a result, many people living with HIV/AIDS are aging with what is now considered a chronic illness (Cahill & Valadéz, 2013; Emlet, 2006). A common misconception is that adults age 50 and over are not at risk for contracting HIV. But according to the most recent data from the Centers for Disease Control and Prevention, adults 50 and older comprised 21% of the new cases of HIV diagnoses in 2013, and are frequently diagnosed at later stages of the illness resulting in a poor prognosis for treatment and mortality (Centers for Disease Control and Prevention, 2015a; Ellman, Sexton, Warshafsky, Sobieszczyk & Morrison, 2014). Many older adults living with HIV/AIDS have to manage the symptoms and treatment of multiple chronic illnesses (e.g., diabetes, hypertension) including HIV/AIDS as well as the effects of HIV related stigma (Cahill & Valadéz, 2013; Emlet, 2006; Foster & Gaskins, 2009).

HIV/AIDS continues to be one of the most stigmatizing illnesses worldwide and persists due to its early association with intravenous drug use, prostitution, and populations that are marginalized due to sexual orientation, race, gender, and class. HIV related stigma is defined as “prejudice, discounting, discrediting, and discrimination directed at people perceived to have AIDS or HIV as well as at the individuals, groups, and the communities with which they are associated” (Herek et al., 1998, p. 36). While overt forms of HIV discrimination have significantly declined, older adults may still fear and/or experience rejection due to ageism and other stigmatized aspects of their social identity (e.g., sexual orientation and race). For instance, an older gay man living with HIV may experience the effects of ageism, homophobia, and the stigma associated HIV status. Consequently, older adults diagnosed with HIV/AIDS are at risk of double or triple stigmatization (Cahill & Valadéz, 2013; Emlet, 2006; Foster & Gaskins, 2009).

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As a result of ageism and other stereotypes that characterize older adults as asexual, the sexual health of older adults is not typically assessed within the healthcare setting, nor are older adults educated about their HIV risk or routinely tested for HIV (Cahill & Valadéz, 2013). Once diagnosed and fearing rejection, older people may not readily disclose their HIV status to family, friends, and potential sexual partners (Cahill & Valadéz, 2013). The internalization of stigma associated with aging and HIV may cause psychological distress characterized by shame, guilt, anger, and social avoidance (Emler, 2006). The layering of HIV stigma with other stigmas such as ageism has the potential for increased isolation and decreased social support among a population that is already vulnerable.

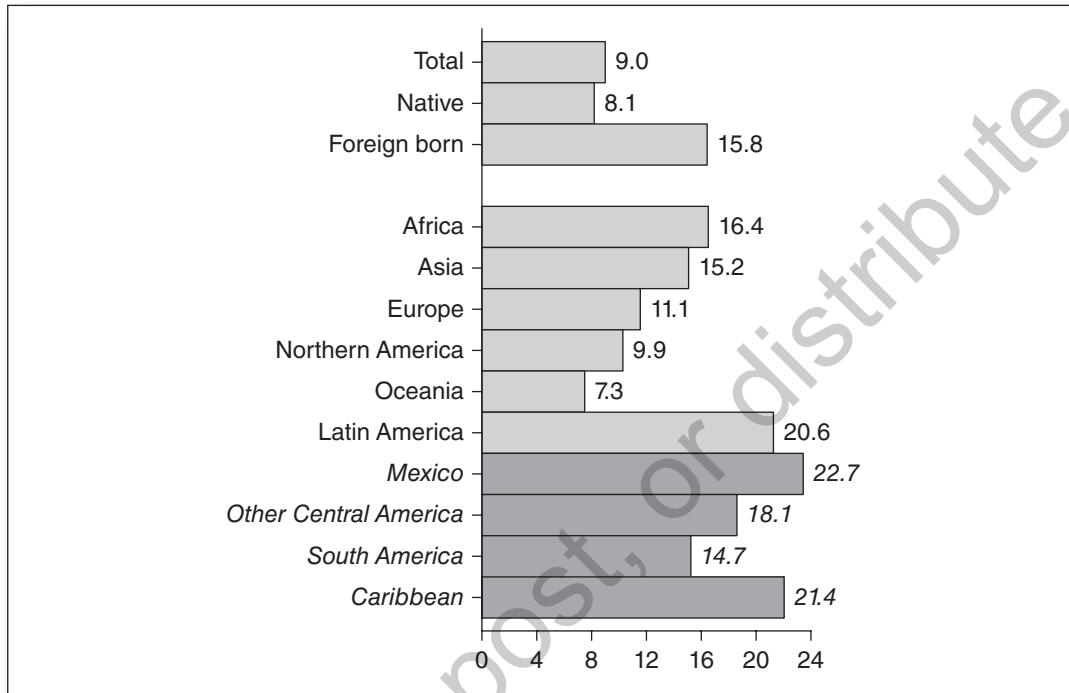
Vickey Sultzman, PhD, LCSW, Assistant Professor of Social Work. She studies HIV and intersectionality with race and gender.

Immigration and Acculturation

Immigrants face similar issues as people of color in the United States, such as racism and discrimination. In a recent study of older Chinese people living in the United States, researchers found that 21 % of participants reported past experiences of discrimination, and nearly half reported that they responded to this treatment in passive fashion, meaning they did not take action against the perpetrator of the discrimination (Dong, Chen, & Simon, 2014). These experiences are important for both the immediate and the cumulative impact, which can influence health and well-being.

Understanding the unique experience of foreign-born older adults is important to social work practice. About 12% of those over 65—or 1 in 8—were born in another country before coming to the United States. While Europe used to be the most common birthplace for newly arrived immigrants, it is now Latin America (Grieco et al., 2012). Challenges associated with aging in a foreign country are related to a number of factors, including English language skills, income, social support, and health status. However, for those individuals who were born elsewhere, but have lived in the United States for a long time, they likely face the same kinds of difficulties that their U.S. born peers face (Population Reference Bureau [PRB], 2013).

On average, foreign-born older adults will have access to less personal income, but they will also have a higher household income compared to those born in the United States. This is related to the fact that many will live in an extended family household where more resources can be shared and greater household income will be enjoyed. But country of origin also plays a role. For example, Mexican-born older adults have significantly less household income compared to U.S. born older people (Grieco et al., 2012). Despite the on

Figure 2.5 Poverty Rate for People 65 and Older

Source: U.S. Census Bureau. (2012a). The foreign-born population in the United States: 2010. *American Community Survey Reports*. Retrieved from <https://www.census.gov/prod/2012pubs/acs-19.pdf>.

average higher household income for some immigrant groups, most older immigrants are more likely to live in poverty compared to those born in the United States. In Figure 2.5, we can see the large differences in the poverty rate across different immigrant groups. Interestingly, foreign-born older people have better health and a longer life expectancy than those who are U.S. born (PRB, 2013). Healthier eating habits and stronger social ties likely work as protective factors; however, once an immigrant becomes assimilated and acculturated, this higher health status disappears, likely due to U.S. diets and lifestyles (PRB, 2013).

Sexual Orientation and Gender Identity

In a 2012 Gallup poll, 3.4% of respondents identified as lesbian, gay, bisexual, or transgender (LGBT), but the degree to which sexual orientation and gender identity can truly be captured is challenging, especially among older adults. Given that the cultural context in which older people were raised, many may feel uncomfortable self-identifying as a member of a sexual minority, or they may not be out about their sexual orientation or gender identity at all.

As discussed previously, oppressed identities can have a cumulative effect on the individual. For example, an older person of color who is also gay has multiple stigmatized identities. The way that these identities are managed may have an impact on the individual's adjustment to the aging process (Fredriksen-Goldsen & Muraco, 2010). According to a review of current research by Fredriksen-Goldsen and Muraco (2010), older lesbian women are more likely to live in poverty, much like their heterosexual equivalents, but they are also likely to have a larger social network and a partner. Their summary also indicated that for older gay men, African Americans experienced greater ageism than Caucasians and greater racism than younger African Americans. These findings illustrate the complexities of multiple stigmatized identities and how they may intersect to create increased social and personal vulnerabilities.

Exercise Box 2.5: Your Personal Characteristics

- Consider your personal characteristics (gender, race, etc.).
- How might these intersect with your experience of aging in a negative way?
- How might they intersect to create protective factors?

REDUCING AGEISM

Through this chapter, we have explored ageism, the ways in which it affects older adults as well as younger people, and have examined the intersection of ageism with other individual characteristics. Now that we have this information, what can we do to reduce ageism? Although we have a good understanding of what fuels and sustains ageism, there is still much work to be done to reduce or eliminate it (Nelson, 2011). Theories such as SIT and TMT indicate that ageism is perpetuated by young people's desire to feed their self-worth and positively promote their identity (within the in-group) when compared to older adults (as the out-group) and the ultimate fear of moving from the in-group to the out-group, which signifies that death is approaching. Therefore, logical approaches to reducing ageism appear to be the elimination of the "non-permeable" boundary between the in-group (young) and out-group (old) and the reduction of the fear of death and dying.

The implementation of the four conditions of the contact hypothesis in the development of programs and activities that bring different generations together may be one way in which to blur the boundaries between the young and old. Intergenerational programs are designed to "bring people together in purposeful, mutually beneficial activities which promote greater understanding and respect between generations" (Beth Johnson Foundation, 2001). Such programs have been found to provide mutual benefits across the age spectrum, such as feelings of being valued, respected, and understood; enhanced knowledge

and skills; meaningful, respectful, and trusting relationships; increased self-esteem and self-confidence; and a better understanding of the “other” generation (Newman & Hatton-Yeo, 2008). In particular, those intergenerational programs that were created based on the contact hypothesis have been found to yield more positive results compared to those programs that were not (Gilbert & Ricketts, 2008). Therefore, bringing the young and old together through purposeful activities where each group is seen as equal (e.g., one group is not teaching or mentoring the other) could be a potential strategy for chipping away at rigid boundaries that divide people by age and, thus, reducing young people’s fear of aging and ultimately becoming a member of the “old” group. In Text Box 2.5, we introduce you to the “Gray Panthers,” a group that fights ageism in society.

Text Box 2.5: The Gray Panthers

The Gray Panthers are a national organization that focuses on social injustice and economic inequality, including healthcare, ageism, the environment, and sexism among others. The group was started by Maggie Kuhn in the 1970s when she brought together a few of her friends who were all retiring from religious organizations or social work agencies to address issues faced by retirees. “Gray Panthers” was actually a nickname given by a talk show producer, and it stuck. The Gray Panthers are an action-oriented group that seeks to change laws and society for the better. In the 1970s, they participated in anti-war protests, performed street theater to promote healthcare as a human right, and formed the “National Media Watch Task Force” to create guidelines for media monitoring of age discrimination. As an intergenerational program, they continue to advocate for welfare reform, accessibility to prescription drugs, and educational justice.

This information is based on a PBS documentary summary about the Gray Panthers, which can be found at <http://www.pbs.org/independentlens/maggiiegrows/panthers.html>.

Additionally, educational programs that challenge stereotypes and negative attitudes toward older adults, present the realities of the aging process, and encourage people to face their fears of death and dying could be a step toward reducing ageist beliefs and attitudes. Educational programs that provide evidence against aging myths could challenge stereotypes and negative attitudes of the young to the old and, thus, reduce young people’s fear of growing old. Nelson (2011) argues that we should continue to explore the underlying causes of the fears of aging and death and use such emerging knowledge to design educational programs that can teach people from an early age not to fear death. Programs that take an “active problem-solving approach to aging at all stages of life” by including information about how to make healthy lifestyle choices and plan for retirement and future care could reduce the fear of aging as individuals are more likely to see how they can actively contribute to their quality of life as they age (Braithwaite, 2002, p. 323).

Providing educational programs to professionals who are delivering services to older adults can also aim to challenge ageism. Such programs can focus on respectful and meaningful ways in which to communicate with older clients, such as speaking in a normal manner versus elderspeak. Arber et al. (2014) indicate that qualities of professionals such as enthusiasm, respect, clarity, organization, and interest in the older adult's prior knowledge are important in contributing to positive outcomes for older adults. Professionals should also acknowledge that older adults are not homogenous; thus, each individual should be treated as an individual based on her/his specific needs, wishes, and abilities. Professionals should be trained to promote autonomy of older adults and actively include them in the direction of their care and desires for their daily life and their future (Teater & Chonody, 2017b).

Finally, at a more macro level, the portrayal of older adults through the media and commercial venues should be challenged. Older adults should not be viewed as a separate group within society but rather as a natural position along the aging continuum. In this sense, older adults should not be depicted in terms of what they are deemed unable to do (as often judged against middle-age standards) but rather as what they can do. Any changes in the mind and body that occur due to the aging process should be portrayed as natural and not as something to be embarrassed of and, thus, avoided at any cost. In Table 2.2, six ways to reduce ageism are provided along with practical steps you can take to reach this goal.

Table 2.2 6 Tips on Reducing Ageism

Goal	How to Work Toward It
Become more aware of personal biases and identify aging myths that you may have believed were facts.	<ul style="list-style-type: none"> • Do not participate in the degradation of older adults and aging, such as using phrases like “over the hill” and “senior moments” and avoid cards, memes, cartoons, movies, or TV shows that depict older adults in a stereotypical fashion. • Avoid elderspeak; speak to older adults as you would any other adult. • Educate and discuss with others how language use and some media promote ageist thinking and prejudice.
Recognize the diversity in older adults and focus on acknowledging the individuality of the person.	<ul style="list-style-type: none"> • Get to know an older relative, neighbor, or acquaintance. • Assume all people are mentally and physically able until informed otherwise.
Participate in and engage with intergenerational opportunities.	<ul style="list-style-type: none"> • Volunteer in your local community. • Consider ways in which to include older adults in educational or social programs or opportunities.

Goal	How to Work Toward It
Find ways to strengthen social perspectives on older adults and challenge stigmatized issues of care, such as increased dependency.	<ul style="list-style-type: none"> • Write an op-ed piece for your local paper. • Post positive stories and images of older adults on social media.
Review policies and practices at the agency level and within the larger social context to identify instances of stigmatization or ways in which policies treat older people as if they are invisible.	<ul style="list-style-type: none"> • Educate people in the community and people you know about discriminatory policies. • Write to your local legislators to express your support (or not) for particular bills and policy changes. • Vote for politicians that are interested in promoting active aging policies and programs.
Actively engage in the promotion of institutional policies and procedures that strengthen the context of care for older people.	<ul style="list-style-type: none"> • Advocate at your agency. • Participate or organize awareness programs. • Share information through social media sites.

Based on the “Ten-Point Plan for Ageism Reduction” from Braithwaite (2002, p. 331–332).

SUMMARY

Throughout this chapter, we have considered the concept of ageism and how it impacts older adults and everyone, regardless of age. History has helped to shape how we view and portray older adults today, and our current culture continues to feed our stereotypes, myths, and negative attitudes. We stressed in Chapter 1 that older adults are not a homogenous group and should be treated individually. Throughout this chapter, we have also highlighted how ageism does not impact all older adults in the same way, but rather individual characteristics and traits will intersect with ageism and yield varying consequences for individuals. We have provided three theories that help to explain the manifestation of ageism in individuals and ways in which it can be combated through structured contact. If we are able to explain how ageism is created and sustained, then we can better develop interventions that will tackle and reduce it. We have provided you with six tips on reducing ageism and challenge you to implement some of these actions and add further tips and strategies to the list throughout your practice.

KEY WORDS

Ageism
 Discrimination
 Ableism
 Stereotypes
 Paternalism

Social categorization
 Social identification
 Social comparison
 Social mobility
 Social creativity

Elderspeak
Age passing
Internalized ageism
Intergroup contact theory
Social identity theory
In-group
Out-group

Social competition
Terror management theory
Sex
Gender
Double standard of aging
Sandwich generation

CRITICAL THINKING QUESTIONS AND ACTIVITIES

1. Identify an older person in the media (e.g., film, television, online, print). How is this person portrayed? Do you agree or disagree with the portrayal? What stereotypes emerge from the depiction?
2. Review the six tips on reducing ageism in Table 2.2. Identify at least one item from the “how to work toward it” column and implement this strategy. Explain why you selected this item, how you implemented it, and reflect on the extent to which you believe your action was effective.
3. Consider the three theories discussed in this chapter (intergroup contact theory, social identity theory, terror management theory). Based on one or more of these theories, develop a brief program (intervention) that aims to reduce ageism. Identify your target participants, describe the aims of the program, and explain the structure and content of the program, and how the program will achieve the aims.
4. Consider how culture shapes beliefs around presentation of age, and think about the following questions: (a) What age should a woman stop wearing a miniskirt? (b) What age should a woman stop dyeing her hair? What if she dyes it blue? Does this perspective change if the person is a man? (c) What age should you stop wearing body piercings? (d) When should a woman not consider a tattoo? What about a man? and (e) What age is too old to go to a dance club?