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5

Briefing paper

The perception of ageing and age discrimination

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Briefing paper (5): The perception of ageing and age discrimination

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Key messages:

- Perceptions of ageing can subject older people to patronising forms of prejudice, which may be expressed in the language and tone used to communicate with older patients, the settings in which they are placed and the framing of treatment options.
- Health care professionals and organisations should be aware that older individuals are potentially vulnerable to age prejudice and stereotyping processes.
- Healthcare could benefit from much more deliberative questioning of age-based assumptions and of how attitudes interact with policies, structures and practice.

Introduction

Since the term ageism was introduced almost 50 years ago, research has explored the nature and manifestations of age prejudices and its consequences. It has shown that health and social care is a key context that has potential to put older adults at risk of experiencing prejudice and discrimination, and also has potential to perpetuate negative perceptions of ageing. In this brief we outline evidence about perceptions of ageing in the UK and explore their implications for, a) the health and wellbeing of us all as we age, and b) health care professionals and organisations. The brief highlights 'risk factors' at the individual, organisational and societal levels that contribute to ageism in health and social care.

It is nearly 50 years since US gerontologist Robert N Butler, in 1969, introduced the term ageism to describe prejudice and discrimination against people because of their perceived 'old' age. Underlying this prejudice is "a deep seated uneasiness on the part of the young and middle-aged – a personal revulsion to and distaste for growing old, disease, disability, and fear of powerlessness, 'uselessness' and death" (p243). Since then, other definitions have emerged which describe ageism as discriminatory decisions concerning people because of their age, whether young or old,¹ and the experience of unfair treatment, or the stereotyping of or discrimination against a person or group because of their age.² These recent two definitions recognise that ageism has the potential to affect anyone at any age, but in this briefing paper we focus on people's perceptions of ageing and growing old. We begin by outlining common negative and positive perceptions of ageing held by people in the UK, we then explore the consequences of these perceptions for decision making, health and well-being in later life, as well as how such perceptions underpin the types of prejudice and discrimination that people face in health and social care settings. We highlight circumstances that perpetuate negative perceptions of ageing, and situations that put individuals at an increased risk of experiencing age discrimination. We conclude by providing practical recommendations for mitigating ageism in health and social care settings and for minimising its impact on employees and users of these services.

Perceptions of ageing in the UK

In order to understand who might be vulnerable to age discrimination, we first have to understand how people define age groups such as 'young' or 'old' and the meaning of these categorisations in the UK. This subjective process of classifying others into age groups is known as 'age categorisation'. Age categorisation is a necessary precursor to people's application of age stereotypes. Therefore, the boundaries people apply to different age categories and common (mis)perceptions associated with the 'old-age' group are an important source of age discrimination.

How old is 'old'?

Age perceptions are partly psychological. In the 2008/9 ESS (European Social Survey) over 50,000 respondents were asked to estimate the age at which people stop being described as 'young' and to estimate the age at which people start being described as 'old'. On average, amongst over 2,000 respondents in the UK, people perceived that youth ended at 35 years and old age begins at 59. This may mean that people below 35 years and over 59 years are more vulnerable to age prejudices and discrimination due to their perceived 'young' or 'old' age respectively. Furthermore across Europe, our research showed that respondent's own age, gender and the country in which they live affected where they placed these age boundaries,³ such that as people get older their perceptions of the end of youth and onset of old age both increase (**Figure 1**). Further, women perceived the end of youth and onset of old age to be 3 years later than did men, whereas people in Greece perceived that old age starts at 65, those in Turkey perceive that old age starts at 55.³

Age categorisations by people in different age ranges

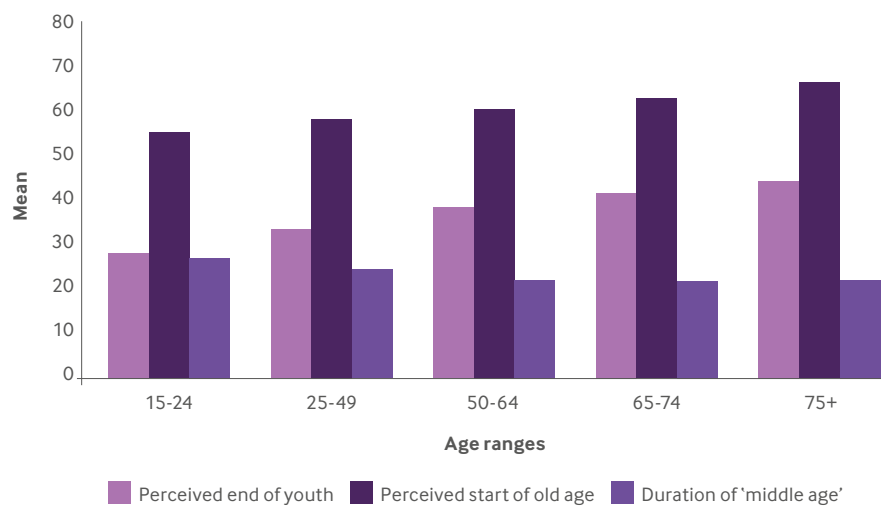


Figure 1 Perceived end of youth, start of old age and duration of middle age (mean estimated age) within the United Kingdom, by people in different age ranges.

People's use of age categorisations may also vary depending on work context and client groups. For example, in a health care setting, O'Donovan, Herlihy and Cunningham (2015) found that undergraduate radiation therapists training in Ireland (mean age of 21 years old) estimated the start of old age to be 65, whereas practicing radiation therapists (age range 26 – 30 years old) perceived old age to start at 70.⁴

Declining health, status and contribution to society

Research from the US, UK and across Europe suggests that compared with younger people, older people are likely to be stereotyped as frail, ill and dependent,^{5,6} and to be viewed as having low social status.^{3,7} Findings from the ESS revealed that people aged 70 and over are seen as contributing relatively little to the economy and being a 'burden on health services' (**Figure 2**).^{3,8} Unfortunately, such views are expressed and perpetuated frequently in the media. We are currently completing an analysis of over 1,500 articles from broadsheet and tabloid newspapers from across the political spectrum, which reveals that older people are most frequently depicted as consumers of finite resources (eg rising cost of pensions, rising cost of care), (**Figure 3**).

Increasing wisdom, experience and morality

Perceptions of ageing are not all bad. There are positive perceptions of older people as wise, experienced and more moral than younger adults.^{3,12,13} Research conducted for Age UK in 2006,¹⁴ showed that people have very clear ideas about the specific competencies of younger and older age groups, some of which favour older people. For instance, compared to a typical 25-year-old, a typical 75-year-old was more likely to be viewed as polite, good at settling arguments, understanding others' view points, and having a healthy diet. Whereas typical 25-year-olds were more likely to be viewed as taking enough exercise.¹³

Mixed perceptions of ageing

Many of these negative and positive representations of ageing can be captured within a psychological model of stereotypes, which has been supported by over 10 years of national and international research. The 'stereotype content model' proposes that stereotypes of younger and older age groups can be described along two basic dimensions of *competence* and *warmth* (otherwise referred to as friendliness).^{15,16} Work conducted in the UK has shown repeatedly that mixed stereotyping is applied to older people who are viewed as having high warmth (positive), but low competence (negative).^{17,3,18} This mixed 'doddering but dear' representation results in feelings of pity for older people.¹⁶ Thus society appears to hold 'benevolent', but patronising views of older people, which depict them as warm and friendly but as not requiring or deserving of power or voice because of their perceived low status and declining competence.

Consequences of perceptions of ageing

A unique aspect of age-based prejudice compared with prejudices against other groups, is that our own perceptions of other older people ultimately become self-relevant and applied to the self. This 'self-stereotyping' causes people to restrict their horizons if they see themselves as 'too young' or 'too old' to pursue certain activities or roles. There is clear evidence that age stereotypes, whether one's own attitudes to ageing or through discrimination from others, can a) negatively impact on the ageing processes by influencing health and wellbeing, and b) influence decision making processes and performance on cognitive or physical tasks. They also result in discrimination in health and social care settings.

Age-stereotypes influence health and wellbeing

A growing body of longitudinal research conducted in the US (see Table 1 for examples of how perceptions of ageing can be measured) reveals that people with more negative perceptions of ageing tend to engage less in preventative health behaviours such as eating a balanced diet, exercising and abstaining from use of substances such as alcohol and tobacco.¹⁹ They also have worse functional health in later years,^{20,21} are slower to recover from myocardial infarction,²² and ultimately die younger.^{23,24} For instance, the Ohio Longitudinal Study of Aging and Retirement which followed 660 adults aged 50 years and over for a 23-year period, revealed that individuals who held more positive perceptions of ageing lived 7.5 years longer on average compared to those who endorsed more negative perceptions.²⁰ This research controlled for a host of confounding variables known to be associated with health and mortality.

Table 1 – How perceptions of ageing can be measured

Name of the measure	Measure used by	Example items	Response
5-item Attitudes Towards Own Ageing Subscale of the Philadelphia Geriatric Center Morale Scale (Liang & Bollen, 1983; Lawton, 1975)	Levy & Myers (2004); Levy, Slade, & Kasl (2002); Levy, Slade, Kunkel, & Kasl (2002); Maier & Smith (1999); Sargent-Cox, Anstey, & Luszcz (2014).	“things keep getting worse as I get older” “I have as much pep as I had last year”	7-point scale ranging from <i>strongly disagree</i> to <i>strongly agree</i>
9-item Positive Age Stereotype Subscale of the Image of Aging Scale (Levy, Kasl, & Gill, 2004)	Levy, Slade, May, & Caracciolo (2006)	“When you think of old people in general, how much do the following words match the images or pictures that you have?”	Participants responded by rating the extent to which nine listed positive age stereotypes match their perceptions of older people
17-item short form Aging Perceptions Questionnaire (APQ) (Barker, O’Hanlon, McGee, Hickey & Conroy, 2007)	Robertson, Savva, King-Kallimanis, & Kenny (2015)	“as I get older I continue to grow as a person” “I get depressed when I think about getting older”	5-point scale ranging from <i>strongly disagree</i> to <i>strongly agree</i>

More recent research has explored the impact of age stereotypes on known biomarkers for Alzheimer’s disease. Analysis of the Baltimore Longitudinal Study of Aging revealed that even when controlling for relevant health and demographic variables, those holding more negative age stereotypes earlier in life (over 20 years earlier) had significantly steeper decline of hippocampal-volume and significantly greater accumulation of neurofibrillary tangles and amyloid plaques than those holding more positive age stereotypes, even after adjusting for relevant variables.²⁵ Collectively, these studies demonstrate the powerful way that our perceptions of ageing, which are learnt through processes of socialization, are cultural-based risk factors for worse health and wellbeing.

A second body of literature has explored the effects of being a target of prejudice, discrimination and exclusion on health and wellbeing. An analysis of 134 studies suggests that experiencing discrimination – based on age, gender, race, sexual orientation or other discrimination – is associated with both worse psychological well-being and physical health.²⁶ Further research found that perceived everyday discrimination among 6,377 older adults (based on any group membership, not just age) was associated with increased symptoms of depression, worse self-rated health, functional limitations and chronic illness over a period of two years.²⁷ Given that more people experience ageism than any other form of prejudice,³ this evidence implicates age discrimination as damaging to wellbeing across the population.

Age-stereotypes influence decisions we make and task performance

There are also more immediate and situated effects of age stereotypes. If older people sense that others are judging them in terms of their perceived *old*-age and the associated age stereotypes, they become at risk of inadvertently acting in line with those stereotypes. A review and meta-analysis of 32 published and unpublished academic papers on older people’s cognitive and physical performance revealed that highlighting age or age stereotypes led to lower memory and cognitive test scores.²⁸ These performance decrements have been attributed to the threat of stereotypes and their influence on the emotions, motivations and behaviours of older adults.²⁹ These ‘stereotype threat’ effects have been experimentally demonstrated on both physical (hand grip performance) and cognitive tests similar to those used in medical assessments.^{30,31} While it is recognised that these types of tests are rarely used in isolation for diagnosis, bias in the settings and conduct of such tests may contribute towards less accurate assessment of the deficiencies and support needs of older adults.

Age stereotypes can also affect other health related behaviours and motivations. For instance, older people who were made aware of negative stereotypes of ageing reported feeling lonelier and displayed more frequent help-seeking and dependent behaviours.³² We (and others, eg Levy et al, 1999-2000) have also found that amongst older adults (mean age 70) triggering negative old age stereotypes, even outside of conscious awareness, can be sufficient to reduce their motivation for a longer life, known as 'will-to-live'.⁶ Both threats to performance and changes in will-to-live are routes through which age-stereotypes impact negatively on individuals, and have potential to bias medical assessments leading to inappropriate diagnoses and unsuitable levels of support.

Manifestations of ageism in healthcare settings

One in three people in the UK report experiencing age-discrimination.³ How then does ageism in health and social care settings manifest in relation to the attitudes of health care professionals, and ways in which age discrimination can be directly or indirectly experienced by older people, including the denial of treatment and use of ageist language and patronising communication?

Attitudes of health professionals

Attitudes about and behaviours towards others can be 'implicit', meaning they can operate without conscious awareness or control.³³ Research in the US suggests that 95% of people hold negative implicit ageist attitudes, which is higher than the average proportion of people holding negative implicit attitudes towards others based on gender or race.³⁴ Research comparing the explicit and implicit ageist attitudes of 17 British geriatric nurses and 32 accident and emergency nurses with those of 34 student nurses revealed that although they did not differ on explicitly held attitudes (which are mostly positive), the practicing nurses, who had greater contact with older patients, held more negative implicit attitudes than the student nurses.³⁵ This may be due to the more contact practicing nurses' have with unwell older adults. Although several studies support the notion that some nurses and nursing students hold negative attitudes towards older people,^{36,37,38,39} one study found that health care professionals (radiologists) did not exhibit ageist attitudes.⁴ Differences between attitudes held by different groups of professionals suggests that the type and level of contact with older people influences attitudes to ageing.

A review of research on health and social care professionals' attitudes towards older adults resulting from their contact with older patients, indicated that whilst more contact was linked to more positive attitudes it was also related to benevolent stereotyping.⁴⁰ More importantly, a study of 56 care workers in the UK found that the quality of experienced interactions between older adults and social care professionals was linked to other attitudes towards older people.⁴¹ Specifically, care staff who had poor quality (negative) interactions with service users held more negative attitudes towards service users.

A qualitative study of 17 British nurses revealed how they categorised and described older patients recovering from anaesthetic as 'confused' or 'wandering', while a similar younger adult was described as 'disorientated'.⁴² Nurses who expressed negative attitudes towards older adults also reported feeling uncomfortable around older adults and found them cantankerous, prone to complain and inflexible.^{43,44} Other research from the US revealed that acute care nurses that held more negative attitudes towards older adults were more in favour of using physical restraints (Helmuth, 1995), but this has not been replicated in Australia and, as far we know, is untested in the UK.⁴⁵ It has been suggested that nurses' use of negative stereotypes during handovers could perpetuate negative attitudes, especially from senior to more vulnerable junior nurses.⁴⁶

Together these studies suggest that when health professionals make decisions and judgments about older adults, they may not be aware that these are affected by implicit ageism or age biases that devalue older patients, and thus will not notice the harmful consequences that follow.

Dehumanisation

Dehumanisation is defined as “the denial of full humanness to others”⁴⁷ and can lead to discriminatory, abusive, demeaning or degrading behaviours. Eldercare settings can be dehumanising if they lack opportunities for personalisation and if people have little control over their own space and support.^{48,49} In addition, some healthcare professionals have been accused of using dehumanising language when talking to and about older people, for example referring to older patients as ‘crinklies’ and ‘crumbles’ or referring to patients merely by their condition “We have two hips and a knee today” in the surgical ward.⁵⁰ Drury et al’s (under review) study of care workers in England revealed that carers who perceived the interactions with service users to be more negative, were more likely to hold dehumanising attitudes towards them and other older adults in general.⁴²

Denial of treatment

Age discrimination can be experienced directly, where an individual is treated less favourably (eg where an older person is refused access to a particular service because of their age) or indirectly, where an apparent neutral rule or practice that applies to everyone (seeming to be equal), puts a particular group at a disadvantage.^a There is evidence that older people have experienced both forms of discrimination in health care.

In a randomized control trial, 121 physicians were asked to assess, diagnose and prescribe treatment for two identical patients (via case studies) presenting with depression, who varied only by age (39 or 81). Not only did physicians take longer to reach decisions for the older patients, but both the diagnoses and the treatments advised differed. Younger patients were more likely to be diagnosed with depression and anxiety, whilst the older cases were diagnosed with dementia or a physical illness. The younger patients were then more likely to be prescribed a wide range of relevant therapies including psychotherapy, pharmacotherapy and referral to inpatient or specialist treatment. In contrast, older adults were prescribed supportive counselling. The researchers believe that because the patients were identical other than age, perceptions of ageing must have affected the physicians’ decisions leading them to be less likely to diagnose the appropriate disorder and treatment for older patients.⁵¹

Even among patients with the same diagnosis, differences in treatment based on age are apparent. The Royal College of Surgeons in England (2012) report that “Incidence of breast cancer peaks in the 85+ age group, while the surgery rate peaks for patients in their mid-60s and then declines sharply from approximately the age of 70” (p4). This pattern was repeated for eight different surgical procedures. Further research shows age bias in the treatment of transient ischaemic attacks and minor strokes and the under use of mental health services among older people.^{52,53} Differences in the treatment of younger and older individuals with the same condition presents a kind-of indirect ageism, whereby the cost-benefit analysis which justifies the distribution of limited resources disproportionately disadvantages older adults.^{54,54} For instance, the use of QALYs (Quality Adjusted Life Years) to assess the relative cost effectiveness of treatments and procedures for Alzheimer’s disease, osteoarthritis, osteoporosis or age-related macular degeneration, can be problematic and tend to work against those who are older, with fewer remaining years.⁵⁴

Beyond diagnosis and treatment, a further issue is the exclusion of people over 65 and 70 from participating in clinical trials.⁵⁵ Although the situation is improving, this is a clear form of age discrimination outside the NHS which has knock-on effects on treatments available for older patients.⁵⁴

a In this case, any policy or practice that treats age groups differently, is unlawful unless it can be objectively justified, see Department of Health’s (2012) report on implementing age discrimination legislation for more information.

Language, communications and interaction

A qualitative study exploring ageist practices in clinical settings interviewed 57 health workers, the majority of whom worked in acute or community NHS settings. The study reported that ageism arose in 10 aspects of communication between workers and service users.⁵⁶ Broadly, these aspects fell into two groups; either patronising behaviour, with roots in stereotypic perceptions of older adults, or disrespectful behaviour linked to dehumanising attitudes. Patronising and stereotypic communication and behaviour included: not fully informing an older person about their condition, treatment and/or care, assuming they would not understand or want to be bothered about it; labelling older people as 'daft' or 'demented' if they have a problem understanding; talking to, or about, older people in a patronising way – eg treating them like children, and shouting at an older person even if they are not deaf. Disrespectful communication included; not giving enough or appropriate information about medicines, instead instructing older adults to 'just take them'; discussing personal or sensitive issues with an older adult loudly and within earshot of others; and speaking 'on behalf' of an older adult without prior consultation.

A form of patronising communication that some older people have reported experiencing in health care settings is known as 'elderspeak'. Elderspeak is similar to displaced baby talk, denoted by high pitch, slow rate of speaking, reduced complexity (eg reduce sentence length), and simpler utterances.⁵⁷ Evidence suggests that people who use this mode of communication may become over-accommodating, and presume the needs and response of the person they are communicating with, rather than letting them communicate their needs and wants themselves.⁵⁸

Ryan, Meredith, MacLean, and Orange (1995) proposed a 'communication enhancement model' for use by care providers to overcome problems of poor communication with older adults in health care settings. The model promotes health in old age by stressing recognition of individualised cues, moderation of communication to suit individual needs and situations, appropriate assessment of health/social problems and empowerment of both older adults and providers.⁵⁹

Implications for health and social care

At the individual level, health care professionals and organisations should be aware that older individuals are potentially vulnerable to age prejudice and stereotyping processes; patients might self-stereotype or be at risk of stereotype threat effects, which have implications for how well they respond to cognitive and physical performance tasks, as well as for their decision making, preventative health behaviours and rehabilitation. It is particularly important, therefore, that health care professions should be careful not to stereotype, use demeaning or patronising language, or use age as a justification for health treatments.

One way to combat ageist attitudes is to learn about both explicit and implicit forms of ageism.³⁵ It is important to raise awareness that regardless of our explicitly positive views about older adults or our desire to uphold equality issues, we are all susceptible to both patronising 'positive' and unconsciously internalised negative age stereotypes, which can have subtle and negative effects on our thoughts, feelings and behaviour. A recent education-based intervention conducted during a nursing undergraduate module in Spain, focused on the importance of person-centered care and discussion of age-based stereotypes, and successfully reduced negative stereotypes about ageing.⁶⁰

Williams and colleagues developed an intervention that informed care staff of the importance of socialising with older adults.^{60,61,62,63} The intervention focused on communication barriers within the care context and the positive and negative aspects of elderspeak. It used simulated and real videotaped staff-resident interactions, from which participants were able to (1) identify aspects of elderspeak in their own interactions and those of others, and (2) reenact the interaction using effective communication strategies. Findings revealed that participants gained knowledge about their own communication patterns, especially their use of elderspeak. They also used fewer psycholinguistic features of elderspeak after training.

At the organisational level, health care settings should be careful not to perpetuate dependency, dehumanization and negative age stereotypes either directly (eg through signage and instructions) or indirectly (eg through age segregation and categorisation). In many health care settings the focus is largely on what can be done for the service user, not how they can co-produce, co-create or support people to keep and maintain a level of independence and control over their lives.

For example, while age-differentiated services that have developed over time in response to a need are not inherently ageist, they have the potential to be discriminatory if older people's services are disproportionately under-resourced in comparison to children's or adult services. Further, the categorisation of hospital wards by age is potentially problematic for patients and staff. For patients, being put on the 'geriatric ward' is an unwelcome categorisation of themselves as 'old', which they may not agree with or wish to be perceived as. For staff, the age categorisation of wards can serve to strengthen age-stereotypes, which can then bias perceptions of new and existing patients, as well as older people in general. To help reduce prejudiced attitudes in health care settings, organisations should identify and reduce circumstances and/or environments creating poor quality interactions between care staff and service users,⁴² and where possible patients on age segregated wards should have opportunities to share and join mixed age spaces (eg a garden) and activities.

As a society there is more to be done to promote more positive perceptions of ageing that encourage us to value older people and their contribution to society. This requires a more critical response to the way older adults are represented in the media – challenging the impression that older people are merely consumers of finite resources and focusing on their potential as an asset, providing over £61 billion to the economy through employment, informal caring and volunteering.⁶⁴ Are older people bed blockers, or are they trapped in hospital?^b Changing default perspectives, which are largely based on stereotypical representations of older people, and challenging how older adults are viewed should gradually weaken negative perceptions of ageing that have the potential to negatively affect us all.

^b Grateful to the Age Action Alliance's Attitudes to Age working group for this example

Recommendations

Based on the insights from this review we propose three recommendations for raising awareness and two practical recommendations that can help reduce negative perceptions of ageing and age discrimination in health and social care.

- 1) Societal narratives that denote older adults as a burden on health care resources and a drain on the economy need to be challenged in recognition of the many ways that older adults contribute to services and the economy throughout their lives to reduce this common (mis)perception of ageing.
- 2) Health care professionals and organisations should be aware of the different ways ageism can manifest in health and social care settings. For example, age discrimination is not just about fair access to treatment but can also arise in the interactions between health care professionals and patients. Understanding more about the explicit and implicit forms of ageism, how they are manifested, and their consequences, should help to prevent ageism.
- 3) Health care professions and organisations should be adopting practices and approaches that avoid perpetuating dependency, dehumanisation or negative age stereotypes, such as promotion of co-production, reducing categorisations and promoting use of communal spaces.
- 4) Those responsible for training health care professionals should be aware of how negative perceptions of age can influence individual's performance, motivations and behaviours. Health care professionals should be cautious not to make a patient's age salient before administering tests that could be vulnerable to age-based stereotype threat effects (eg memory, cognitive performance, physical performance). They should be aware that negative perceptions of ageing and attitudes to age can create psychological barriers to rehabilitation, motivation and response to treatment.
- 5) As part of their Equality and Diversity policy and culture, health care organisations should identify and address the circumstances or conditions that create poor quality interactions with patients, which have shown to have a negative impact on health care professionals attitudes towards service users and older adults in general.

Conclusions

In this Brief we have shown that perceptions of ageing in the UK include a problematic set of negative (eg incompetent, ill, frail, dependent) and positive (e.g. friendly, moral, wise) elements, that can subject older people to patronising forms of prejudice. These are subtle but powerful and can be expressed in the language and tone used to communicate with older patients, the settings in which they are placed and the framing of treatment options. The Brief highlights that negative perceptions of ageing can impact on individuals as they age. For example they can affect the health care decisions that patients make for themselves (eg will-to-live). Being a target of prejudice and discrimination can also have detrimental effects on health and wellbeing. Ageism is a problem for health and social care professionals and organisations, for example in the decisions that professionals make, which have the potential to lead to misdiagnoses or may deny older people treatment. The categorisation of wards by age, prolonged negative interactions between care workers and service users, and representations of older adults in the media as consumers of finite resources are three risk factors that contribute to the perpetuation of negative perceptions of ageing. We conclude that in order to maximise the prospects for patients and clients' healthy ageing, healthcare could benefit from much more deliberative questioning of age-based assumptions and of how attitudes interact with policies, structures and practice.

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