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*"A Vital Christian Presence in Social Work"*

## **AGEISM ALIVE AND WELL**

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## **Ageism Alive and well**

Ageism is alive and well. Whether we want to admit it or not ageism like sexism and racism is a form of prejudice that directly affects the care individuals sixty-five and older receive.

In an epoch where there are growing numbers of individuals sixty-five and older aging in place, (growing old in their respective communities) as well as seeking health care, it is imperative that helping professions are sensitized to the impact of ageism on the level of care rendered to seniors. The concept of ageism will be expounded upon with particular emphasis on its etiology, areas where helping professionals manifest ageist attitudes and the impact of this prejudice on the lives of seniors.

The concept of ageism, which speaks to perceptions, held by others solely based on one's chronological age, (Butler, 1989 and Palmore, 1999) might play a role in the level of care seniors receive and how they perceive themselves in relation to their illness and their age. Prejudice speaks to preconceived sometimes unconscious notions, stereotypes, and dislike against another group of people or individual because they appear to be different from one self or the dominant group (Adorno et, al., 1950; Dovidio, et al., 2000; Devine, 1989). The concept of "ageism" cannot be explored without mentioning Robert Butler who first coined this term in 1969. Ageism like racism and sexism is a form of unconscious prejudice against another. The concept of ageism refers to negative age related stereotypes where younger individuals view their elderly counterpart as different from themselves (Hagestad and Uhenberg, 2005). Other components include prejudicial attitudes or disposition towards aging and older people based on the belief that aging makes people unattractive, unintelligent, and asexual, unemployable, and mentally incompetent. (Atchley & Barusch, 2004 p.439; Cuddy & Fisk, 2006 and Kane 2005)

As Social Workers/helping professionals, we bring to the table our values, mores and beliefs. At times, we too fall into the “ageist trap” believing that certain services are not optional solely because of an individual’s chronological age. Negative thoughts and attitudes are dictated by the society in which we reside. One way to overcome ageist attitudes would be to redefine societal values. There are scholars like Shalomi and Miller who are attempting to restructure our thinking by introducing the concept of SAGING as opposed to AGEING; leaning heavily on the concept that aging is synonymous with great wisdom.

The questions remain, how do helping professionals view the elderly? Moreover, what impact does held beliefs have on services rendered and or received? The concept of social exchange speaks to helping professionals’ expectations as it pertains to treating seniors as well as seniors’ expectations the helping professionals. Internalized ageism or the way in which seniors perceive growing old, can have a direct impact on social exchange. Simply stated, the helping professional may have beliefs on what services should or should not be rendered based on an individual’s age. Seniors themselves may harbor unconscious ageist attitudes, believing they are less than worthy recipients for a particular type of service because of their age.

There is a direct connection between the concept of ageism and social exchange. This action and exchange process is solely based on perceived expectation and outcome (Atchley & Barusch, 2004: 439 and Cropanzano & Mitchell 2005). Data on ageism suggests that the elderly own attitudes and perceptions of themselves can have an impact on the anticipated “exchange” between themselves and their Social worker (as well as other helping professionals)

Because of held beliefs, seniors may themselves buy into the preconceived stereotypes that they are untreatable and that certain ailments are a “normal part of aging.” This self-fulfilling prophecy may lend itself to seniors actually believing they are untreatable. Social

Exchange also examines levels of expectation in relationships or in other words the concept of “reciprocity.” This framework of exchange assumes that people try to maximize their rewards and minimize their costs in their interaction with others.

The manner in which services are exchanged is directly linked to the images society has constructed of different individuals (the elderly in particular). The construction of ageism, (or the manner in which seniors are perceived) cannot be explored without looking at symbolic interactionism, which speaks to the theory that meaning emerges through societal interactions. Symbolic interaction is the vehicle via which individuals make meaning of their world. It is important to note, symbolic interactionism reinforces meaning that has been socially constructed, with its prime concern being to analyze meaning of everyday life, via close observational work and intimate familiarity, from which develops an understanding of the underlying form of human interaction. According to Becker and McCall (1999) individuals behave in direct response to the way others in society respond to them and in so doing anticipate behavioral outcomes based on prior experiences. Cooley (1902) takes the concept a step further and develops the concept of the looking glass self. In other words, how we perceive “the man in the mirror” is directly influenced by societal dictates. According to Cooley, individuals develop their sense of self according to the following: the imagination of one’s appearance, the imagination of judgment of the appearance and the feelings ascribed to the appearance.

Seniors may perceive themselves as old, unproductive, frail, asexual and dependent. They may internalize or self categorize these negative stereotypes based on societal mores.

Blumer (1969) postulates, that symbolic interactionism results in individuals ascribing meaning to everything based on the response he/she receives from the society at large. As seniors internalize ageist societal beliefs, they may act according to expectations. For example,

they may not disclose certain conditions to their primary care physicians because they believe “it is a normal part of aging.”

Social Workers as well as other helping professionals have been grappling with meeting the needs of individuals sixty-five and older. Social Workers have also been remiss as it pertains to addressing the mental health needs of individuals in the sixty- five and older. There have been instances where individuals sixty-five and older were not recommended for psychotherapeutic interventions because it is believed they cannot benefit. Sometimes the necessary recommendations to mental health clinics are overlooked because some of the behaviors manifested by seniors may be perceived as “a normal part of aging.”

In addition to social workers, other helping professionals like Primary Care Physicians have been grappling with meeting the mental health needs of their senior patients for some time; since the 1980's, physicians have failed to recognize 30%-50% of patients with depression (Williams, et al 1999). The inability to effectively detect and treat depression in the elderly can be attributed to physicians feeling inadequately trained in geropsychiatry resulting in, physicians possibly ascribing presenting symptoms to a condition other than depression (Coyne and Gallo, 2000). Disturbing data has revealed, “Approximately 75 percent of elderly persons who commit suicide had visited a primary care physician within the preceding month, but their symptoms were not recognized or treated.” (Birrer & Vemuri, 2004 p.2375) The National Institute of Mental Health stated, “14.3 of every 100, 00 people age 65 and older died of suicide in 2004,” (National Institute of Mental Health, 2008) this number exceeds the suicide rate in the general population. One sees the increasing rate of suicide in industrialized nations especially, with persons over the age of 65” (Moscicki, S: 139, 1995).

As helping professionals, we must be cognizant that ageist attitudes exist and at all times offer the same level of the individuals in our care regardless of their chronological age.

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