



North American Association of Christians in Social Work
A Vital Christian Presence in Social Work

PO Box 121
Botsford, CT 06404
www.nacsw.org
888.426.4712

**“THE NEW GENERATION” OF SENIORS AND THE AGEISM
PARADIGM SHIFT**

By: Charlene Lane

**Presented at:
NACSW Convention 2011
October, 2011
Pittsburgh, PA**

“The New Generation” of seniors and the ageism paradigm shift

Societal construction of ageing has a role to play in the way seniors view themselves, there is the emergence of changing norms. The mirror image that is being reflected to the “new generation seniors” is revealing able bodied, independent, and autonomous individuals. Seniors surveyed in a study conducted at a Naturally Occurring Retirement Community (N.O.R.C) in Long Island, New York, strive to maintain a fierce sense of independence despite physical medical conditions. Seniors who are ageing well are distinguishing themselves from those who are not. For example, several seniors were proud to report that, “I have arthritis but I can still drive and climb stairs,” or “even though I have had some cardiac issues, I don’t need a home health aide.” However, one can also argue, that this sense of separation is based on functional ability driven by one’s own denial of the ageing process or the fear of the inevitability of becoming dependent if one lives long enough.

Although much of the literature has focused on the concept of ageism, ageist stereotypes and seniors internalization of ageist attitudes and beliefs; within recent times there has been a paradigm shift in some seniors’ views of themselves and their peers. Although much needed research still needs to be done in the area of seniors’ positive views of themselves. This positive shift in thinking can eventually result in the development of a new phenomenon, the “new generation senior.”

The paradoxical approach to ageism has its roots in the phenomenon of successful or optimal aging (Rowe & Khan 1987). It is postulated, that sometimes seniors are able to maintain positive views of themselves and make a concerted effort to live their lives completely differently from the niche society have carved for them.

Even though seniors are aware that negative stereotypes exist; they do not align themselves with the negative attributes. Many seniors interviewed, described a “typical senior” as being mobile, cognitively intact and independent and were proud to disclose they had the above-mentioned attributes. The other positive descriptions of “a typical senior” that emerged were such adjectives as caring, active and well informed. The above-mentioned finding can be paralleled with the paradoxical approach to aging which refers to “the phenomenon of successful aging or optimal aging” (Rowe and Khan 1987). In other words, according to a study by the MacArthur foundation there are three theorized aspect of successful aging as absence of disease or disability, maintaining high cognitive and physical functioning and being actively engaged with life (Nelson, 2004). The seniors in this study described themselves as being in good physical health, were cognitively intact and pride themselves in being active participants in “life.” For example, attending the senior center almost daily as well as traveling and serving on different advisory boards in their community. The above mentioned findings can be directly paralleled to a study conducted by the Research Institute Triangle (RIT) which stated, older members of communities are not only invested in their own network of family and friends, but are also interested in care about the greater community. (Research Triangle Institute International, 2003)

In order to fully understand the emerging ideals of the “new Generation” seniors, one must examine beliefs, from a historical perspective. Historically society has played a pivotal role in seniors perception of themselves. The way senior (as well as all individuals), perceive the world is directly connected to two theoretical approaches social construction and symbolic interaction. It is important to note, the “new generation” of seniors, individuals sixty-five and older, are redefining themselves and are not adhering to negative societal prescripts.

Social construction is a psychological theory that views individuals as having an activity role to play in the creation of their own experiences. Each individual perceives the world differently and ultimately creates his or her own meaning based on experiences and events (Burr, 2003). The symbols and images in society are created by individuals in society and conveyed to members by the media, language, and behaviors (Scott, 1995). Thus, individuals behave in accordance with how they believe they appear to others and to themselves as well. Individuals who are immersed in any culture internalize the views, beliefs, values, and stereotypes inherent in that culture, which directly shapes their perceptions about the world, including their view of aging (Nelson, 2005; Nelson, 2002; Horton, Baker, Cote, & Deakin, 2008; McGuire, Klein, & Chen 2008). Because of cultural norms, individuals may internalize (or adopt) and incorporate views/stereotypes held by others, into one’s self perception (Dale, Smith, Norlin, & Chess, 2006).

Cultural systems are dynamic systems of symbols (physical, visual, and linguistic) that are never completely static or unchanging. Thus, at times, opinion leaders or societal claims-makers can explain or give meaning to a given societal phenomenon (Burke, 1989; Pawluch & Woolgar, 1985). These “claims-makers” influence what is considered socially acceptable and desirable in ways that often define generational or “cohort” ideologies, for example, of conservatism or radicalism. The way in which we construct or make meaning of the images and events in social life is directly connected to the images reflected in our “societal mirrors.” It is important to note that images are reflected and reinforced through language. Humans’ interpretations and definitions of the world produce social realities in the form of shared understandings among people. These, in turn, give rise to social rules, norms, identities, concepts, and institutions. However, as people stop accepting, believing in, or taking for granted these constructions, the constructions can change. Throughout history, individuals in society have both conformed to as well as challenged set institutionalized assumptions and routines (Klotz & Lynch, 2007)

Society’s view on the elderly is socially constructed. Individuals, who ascribe to ageist beliefs, attribute prejudicial beliefs, views, and stigmas about another solely based on ones’ chronological age (Green, 1993; Hooyman & Kiyak, 2008; Bytheway, 2005; Morgan & Kunkel, 2001).

The concept of ageism, or the harboring of negative views about another based on his or her chronological age, cannot be explored without looking at the role of “symbolic interactions” in the construction of “ageist” assumptions. Ageist assumptions derive from the messages that are conveyed by society about individuals in a certain

age group. In other words, symbolic interactionism reinforces meanings that have been socially constructed. These meanings are generated in everyday life, through close observational work and intimate familiarity, and observing others, as well as through personal connections.

Symbolic interactionism describes the meanings that emerge through societal interactions (Gilleard & Higgs, 2000; Howard, 2000). Symbolic interactionism is the vehicle through which individuals make meaning of the behavior and appearance of others in the world. Individuals in society develop a sense of who they are and or who they are supposed to be based on interactions and expectations of others (Rozario & Derienzisin, 2009).

According to Becker (1993), individuals behave in their direct responses based on the way others in society respond to them, and in so doing, anticipate behavioral outcomes based on prior experiences. In our youth-oriented society, there are many negative images and stigmas attributed to individuals 65 and older who draw their meaning of the world based on these images. Some individuals of this age may eventually internalize the stigmas of labeling, stereotyping, and discrimination (Link & Phelan, 2001; Horton, 2008; Harris 2005) attached to old age into their own self-identities and images of the world. One cannot begin to explore the concept of symbolic interactionism without mentioning Herbert Blumer (1969) and pioneers before him, George Herbert Mead (1934) and Charles Horton Cooley (1902), all of whom believed that individuals develop beliefs and values based on their interpretations of communication (messages) received from society.

Cooley (1902) developed the concept of the “looking glass self,” and “metaperception,” which is the perception of perception. In other words, our perception of “the man in the mirror” is directly influenced by societal dictates. According to Cooley (1902, p. 142), 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. In addition to Cooley, Mead (1934) first outlined the philosophical underpinnings that help to explain how individuals respond in direct relation to their society and societal dictates. In *Mind, Self and Society*, (1934) Mead raised the idea that our view of ourselves develops through our social interaction with others.

Blumer (1969) postulated that symbolic interactionism results in individuals ascribing meaning based on the responses he or she receives from other members of society. Using this as a model, I would argue that many older adults construct their self-images by internalizing ageist social messages (e.g., that wrinkles and grey hair are unattractive); they may change their behavior based upon these expectations. Seniors may not disclose certain conditions to their primary care physicians because they believe it is a normal part of aging. Seniors may experience that others do not value what they have to say or listen to them, and as a result, they may not raise questions.

Seniors’ views of self and the world govern interpretation of the world based on their interaction with others (Biggs, 2005; Stets & Burke, 2000). Seniors may perceive themselves as old, unproductive, frail, asexual, and dependent based on negative

interactions with others. They may internalize or self-categorize these negative stereotypes based on societal mores. I would hypothesize the internalization of negative images and or an ageist belief has a negative effect on seniors' ability to advocate for themselves, and specifically for this study, within medical settings.

Bowling, (1999), Jopling, 2007, Grant (1996), and Williams (1999) suggested that ageist attitudes might contribute to a lower level of health care for seniors. For this reason, despite seeking care from their primary care physicians, ageist attitudes place seniors at risk of being diagnosed and treated inadequately.

The literature has revealed that ageist attitudes have become embedded in health care institutions (Bowling, 1999; Chen et al., 2002; Grant, 1996; Fischer, Wei, Solberg, Rush, & Heinrich, 2003). Ageism in the health care arena manifests itself in several areas, including whether or not to perform certain surgical procedures, make referrals for participation in clinical trials, and for types of treatments recommended to seniors. (Habicht, Witham, & McMurdo, 2008; McMurdo, Witham, & Gillespie, 2005).

Research has shown that seniors' medical problems are perceived by some health care providers as irreversible, uninteresting, and unprofitable (Butler, 1989; Gunderson, 2005). The fact that some seniors may not be recommended for physical rehabilitation because of views that they cannot withstand the rigor of rehabilitation or will not benefit sufficiently from it (Kane & Kane, 2006), is yet another manifestation of ageism in the medical arena.

It is important to note that although seniors are underrepresented, there may be reasons other than ageism excluding them from clinical trials or particular types of medical care in the community (Rehwagen, 2005; Townsley, Selby, & Siu, 2005; Robb, C Haley, W & Becker, 2003). Seniors may be excluded from participation in clinical trials because they do not comprehend the consent forms and therefore cannot grant informed consent. There are also individuals of all ages who have multiple medical conditions that make them ineligible for research; however, older adults are more likely to have multiple medical conditions than other age groups. Others with a terminal diagnosis may not live long enough for the duration of the trial or cannot risk being in a “placebo” group where withholding medical intervention can be detrimental (Choulia, Kearney, Stott, Molassiotis, & Miller, 2004; 2000). Individuals with multiple chronic conditions may not benefit from surgical procedures because the procedures might further compromise their already compromised immune systems. There may also be seniors who are not appropriate candidates for clinical trials because of contraindications or the risk involved when taking more than one type of drug. Although there are valid reasons for excluding individuals from clinical trials, such as poor prognosis of success and inability to grant informed consent, seniors may be excluded solely because of age.

Research suggests that after a lifetime of exposure to a culture’s age stereotypes, older individuals direct these age stereotypes inward (Levy, 2000). However, there is a gap in knowledge as it pertains to internalized age stereotypes and its effects, if any, in the primary care arena. It is important to note that, there can factors other than ageist beliefs that affect seniors’ experiences with their primary care

physicians. For example, seniors may believe their primary care physician is not adequately meeting their medical needs because they are old, when indeed the primary care physician realized that the patient's prognosis is poor and in so doing no additional intervention would yield a positive result. Some seniors may be too frail to sustain certain medical treatments, hence the reason for the primary care physician not presenting the option.

Levy and Myers (2004) examined the effect of negative age stereotypes on the elderly. He stated that seniors who believed negative age stereotypes exhibited diminished cognition, performance, and a will to live. Hess, Hinson, & Hodge (2009) concluded from their study that, older adults who held on to negative age stereotypes performed poorly on memory tests because they believed they should. Chasteen (2005) reported that negative memory-related stereotypes could lead to vast decrements in memory performance. Rozario and Derienzisin (2009) reported that some seniors in their study attempted to separate themselves from peers who met negative societal-defined age stereotypes. For example, some seniors would refer to themselves as different physically and cognitively from old, old individuals and others whom they perceived as disabled, dependent, and "grouchy".

As previously mentioned, within recent times there has been a Paradigm shift as it pertains to ageing. Compared to seniors in the past; as evidenced in this study and supported in studies by (Ferrario, Freeman, Nellett & Scheel, 2008; Bowling & Dieppe, 2005 and Minkler & Fadmen, 2002) individuals sixty-five and older, despite having chronic illnesses are living more active fuller lives and have a positive out look to ageing. The emergence of the "new generation" senior has an impact on the changing

perceptions of seniors by health care professionals. There appears to be the emergence of counter-transferential ageing well attitudes. Just as in a therapeutic alliance where there are feelings and emotions transferred between a client and therapist, seniors positive views of themselves are being transferred to helping professionals who are slowly altering their previously held negative views of seniors. Recent studies (Mc Kinlay & Cowan, 2003; Happell & Brooker, 2001 and Jester, 2005) have shown that Nursing students as well as so some medical professionals are espousing a more positive approach to seniors and aging.

References

- Becker, H. (1993). *Outsiders: Studies in the sociology of deviance*. New York, NY: Free press
- Biggs, S. (2005). Beyond appearances: Perceptive on identity in late life and some implication for methods. *Journal of Gerontology*, 60(3), S118-S128]
- Blumer, H. (1969). *Symbolic interactionism: Perspective and methods*. Princeton, NJ: Prentice Hall
- Bowling, A. (1999). Ageism in cardiology. *BMJ*, 319, 1352–1355.
- Burr, V. (2003.) *Social constructionism* (2nd ed.). New York, NY: Routledge.
- Burke, P. (1991). Identity process and social stress. *American Sociological Review*, 56(6), 836–846
- Bytheway, B. (2005). Ageism and age categorization. *Journal of Social Issues*, 61, 361–74.
- Chen, C., Robb, C., & Haley, W. (2002). Ageism and mental health and health care: A critical review. *Journal of Clinical Geropsychology*, 8, 1–12.
- Chouliara, Z., Kearney, N., Stott, D., Molassiotis, A., & Miller, M. (2004, April/May). Perceptions of older people with cancer of information decision making and treatment: A systematic review of selected literature [Review of the articles *Cancer Treatment*]. *European Society for Medical Oncology*, 15, 1596–1602.
- Cooley, C. H. (1902). *Human nature and the social order*. New York, NY: Scribner's
- Dale, O., Smith, R., & Chess, W. (2006). *Human behavior and the social environment: Social systems theory*. New York, NY: Pearson.
- Fischer, L., Wei, F., Solberg, L., Rush, W., & Heinrich, R. (2003). Treatment of elderly and other adults patients for depression in primary care. *Journal of the American Geriatric Society* 51(11), 1570–1573.
- Gilleard, C., & Higgs, P. (2000). Cultures of ageing: Self, citizen and the body. *Ageing and Society*, 21, 799–801.
- Grant, L. (1996). Effects of ageism on individuals and healthcare providers: Response to healthy aging. *Health and Social work*, 21, 213.
- Green, B. (1993). *Gerontology and the construction of old age*. New York, NY:

- Gunderson, A. (2005). Rural physicians' attitudes toward the elderly: Evidence of ageism. *Managed Health Care* 14(3), 167–176.
- Habicht, D., Witham, M., & McMurdo, M. (2008). The under-representation of older people in clinical trials: Barriers and potential solutions. *Journal of Nutrition, Health and Aging*, 12, 94–196.
- Hooyman, N., & Kiyak, H. (2008). *Social gerontology: A multidisciplinary perspective*. New York, NY: Pearson.
- Howard, J. (2000). Social psychology of identity. *Annual Review of Sociology*, 26, 367–393.
- Horton, S., Baker, J., Côté, J., & Deakin, J. M. (2008). Understanding seniors' perceptions and stereotypes of aging. *Educational Gerontology*, 34(11), 997–1017.
- Kane, R., & Kane, L. (2005). Ageism in healthcare and long-term care. *Generations* 29(3), 49–54.
- Klotz, A., & Lynch, C. (2007). *Strategies for research in constructivist internal relations*. New York, NY: M. E. Sharp.
- Levy, B. (2000). Handwriting as a reflection of aging self-stereotypes. *Journal of Geriatric Psychiatry* 30, 300–340.
- Link, B., & Phelan, C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27, 363–385.
- Jopling, K. (2007). Older people deserve just, equal treatment. *Working with Older Adults*, 11(2), 24–26.
- McGuire, S., Klein, D., & Chen, S. (2008). Ageism revisited: A study measuring ageism in east Tennessee USA. *Nursing and Health Services*, 16, 11–16.
- McKinlay, A., & Cowan, C. (2003). Student nurses' attitudes towards working with older patients. *Journal of Advanced Nursing*, 43(3), 298–309.
- Morgan, L., & Kunkel, P. (2001). *Aging the social context* (2nd ed.). Stanford, CA: Sage.
- Nelson, T. (2002). *Ageism: Stereotyping and prejudice against older persons*. Cambridge, MA: The MIT press.
- Nelson, T. D. (2005). Ageism: Prejudice against our feared future self. *Journal of Social Issues*, 61(2), 207–221.
- Pawluch, D., & Woolgar, S. (1985). How shall we move beyond constructivism? *Social Problems*,

33(2), 159–162.

Rozario, P., & Derienzis, D. (2009). So forget how old I am: Examining age identities in face of chronic conditions. *Sociology of Health and Illness*, 31, 540–553.

Rehwagen, C. (2005.) Older people are wrongly excluded from drug trials. *British Medical Journal*, 331, 1360.

Scott, J. (1995). *Sociological theories*. Brookfield, VT: Edward Elgar.

Stets, J., & Burke, P. (2000). Identity theory and social identity theory. *Social Psychology Quarterly*, 63, 224–237.

Townsley, C., Shelby, R., & Siu, L. (2005). Systemic review of barriers to the recruitment of older patients with cancer to clinical trials. *Journal of Clinical Oncology*, 23, 3112–3124