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SPECIAL ISSUE ON AGEISM

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EDITORIAL

The term “ageism” was coined in 1969 by Robert Butler, the first director of the National Institute on Aging (U.S.). He associated it to other forms of bigotry such as racism and sexism, defining it as a process of systematic stereotyping and discrimination against people because they are old. As an “ism” ageism reflects a prejudice in society against older adults.

But ageism is different from other “isms” (sexism, racism etc.) for primarily two reasons: age classification is not static and every body experience ageism unless he dies at an early age. Secondly one can be an "Ageist" (i.e. he/she may stereotype other people on the basis of age) with respect to both others and oneself. This is an important distinction with other "ism" as it may affect the self concept and well-being of an individual.

Today, it is more broadly defined as any prejudice or discrimination against or in favour of an age group (Palmore, 1990). Erdman Palmore, who has written extensively about ageism, lists the basic characteristics of stereotyping which forms the basis of ageism in his book *Ageism* (1990).

Ageism is manifested in many ways, some explicit, some implicit. The following piece by Edith Stein illustrates some graphic examples of negative ageism (Palmore, 1990):

“Older persons falter for a moment because they are unsure of themselves and are immediately charged with being ‘infirm.’

Older persons are constantly “protected” and their thoughts interpreted.

Older persons forget someone’s name and are charged with senility and patronized.

Older persons are expected to ‘accept’ the ‘facts of aging.’

Older persons miss a word or fail to hear a sentence and they are charged with ‘getting old,’ not with a hearing difficulty

Older persons are called ‘dirty’ because they show sexual feelings or affection to one of either sex.

Older persons are called ‘cranky’ when they are expressing a legitimate distaste for life as so many young do.

Older persons are charged with being ‘like a child’ even after society has ensured that they are as dependent, helpless, and powerless as children.”

Ageist attitudes are perpetuated in many ways, for example, the lack of positive images of the elderly in advertisements and on TV programs, and the widespread use of demeaning language about old age are noticed now a days.

In addition, institutions perpetuate ageism. Businesses frequently reinforce ageist stereotypes by not hiring or promoting older workers even when they are physically and mentally fit. Another example, is the use of state welfare funds which are often targeted at children and adolescents, and women (who are of productive age), while excluding equivalent services for older adults such as adult protective services (such as pension and other services) and geriatric physical and mental health services.

Human service professionals also perpetuate ageism. This is done more covertly by denying or limiting services, by not including aging issues in their schedule of activities. The same criticism can be made about training of professional social workers who receive little information about the aging process although many of their clients will be elderly.

Underlying these attitudes are myths and stereotypes about old age which are deeply entrenched in all the societies who claims themselves modern. . Even those who would not say that they are ageist probably have some ageist attitudes based on distorted or inaccurate information.

The most common of these negative myths and stereotypes about ageing are as follows:

Illness. Perhaps the most common prejudice against elders is that most are sick or disabled (Palmore 1990).

Impotency. A related stereotype is the belief that most elders have no sexual desire and no longer engage in any sexual activity. The few who do, are morally perverse or at least abnormal (Golde & Kogan, 1959; Cameron, 1970). Even physicians, who should know better, often assume that sexuality is unimportant in late life (Butler, 1975).

Ugliness. Another stereotype is that old people are ugly. Beauty is associated with youth, and many people, especially women, fear the loss of their beauty as they age. The following terms reflect this stereotype of ugliness: crone, fossil, goat, hag, witch, withered, wizened, wrinkled.

Mental Decline. Another common stereotype is that mental abilities begin to decline from middle age onward, especially the abilities to learn and remember, and that cognitive impairment (i.e. memory loss, disorientation, or confusion) is an inevitable part of the aging process (Palmore, 1988).

Mental Illness. A similar stereotype is that mental illness is common, inevitable, and untreatable among most aged. Both elders themselves and many health professionals think that most mental illness in old age is untreatable, which partially explains why few mental health professionals choose to specialize in geriatric mental health and also why elders use mental health facilities at one-half the rate of the general population (Lebowitz, 1987).

Uselessness. Because of the beliefs that the majority of old people are disabled by physical or mental illness, many people conclude that the elderly are unable to continue working and that those few who do continue to work are unproductive. This belief is the main basis for compulsory retirement policies and discrimination in hiring, retraining, and promotion.

Isolation. From a third to half of respondents to Palmore's Facts on Aging Quiz thought that, "the majority of old people, are socially isolated and lonely" and "the majority of old people live alone" (Palmore, 1988). Two-thirds of persons under 65 opined that loneliness is a "very serious problem" for most people over 65 (Harris, 1981).

Poverty. Views about the economic status of elders range varies and at present those who consider elders are poor tend to outnumber those who think elders are rich.

Depression. Since many believe that the typical older person is sick, impotent, senile, useless, lonely, and poor, they naturally conclude that the typical old person must also be depressed.

Political Power. Another stereotype is that the elderly are a "potent, self-interested political force" (Binstock, 1983). The assumption is that the political power of the elderly hampers our politicians from undertaking needed reforms.

Although much less prevalent, positive stereotypes about aging are also held by some people. They are usually far less damaging than negative stereotypes. An example of positive age stereotyping is that wisdom, dependability, kindness and compassion invariably accompany old age.

The consequences of ageism are similar to those associated with all attempts to discriminate against other groups: persons subjected to prejudice and discrimination tend to adopt the dominant group's negative image and to behave in ways that conform to that negative image (Palmore, 1990). The dominant group's negative image typically includes a set of behavioral expectations or prescriptions which define what a

person is to do and not to do. For example, the elderly are expected to be asexual, intellectually rigid, unproductive, forgetful, and happy, enjoy their retirement, and also be invisible, passive, an uncomplaining. They have different attitudes, interests and personality traits. This is the way by which younger generation would like to keep them away from them. The treatment of elderly not “as real people” but as different, as other being may be termed as psychological-distancing.

Palmore identifies four common responses of elders to these prescriptions and expectations: acceptance, denial, avoidance, or reform (Palmore, 1990). All of these responses can have harmful effects on the individuals. For example, an elderly person who accepts the negative image may “act old” even though this may be out of keeping with their personality or previous habits. This may mean that they stop or reduce social activities, do not seek appropriate medical treatment, or accept poverty. In essence, this internalization of a negative image can result in the elderly person becoming prejudiced against him/herself, resulting in loss of self-esteem, self-hatred, shame, depression, and/or suicide in extreme cases.

Denial of one’s status as an elderly person can also have negative consequences. One example, lying about one’s age may not seem significant, but it can further erode morale.

Avoidance of ageist attitudes may also take many forms. Examples include moving into age-segregated housing, self-imposed isolation, alcoholism, drug addiction, or suicide.

The reform response, Palmore’s last response pattern, is the antithesis of the avoidance response in that the person recognizes the discrimination and attempts to eliminate it. This attempt may be an individual one or a collective one through membership in an advocacy group such as powerful associations of senior citizens are coming up all over the world.

Ultimately, stereotypes are dehumanizing and promote one-dimensional thinking about others. Elders are not seen as human beings but as objects who, therefore, can be more easily denied opportunities and rights. For example, elders are frequently misdiagnosed or denied medical treatment because they are seen as “old” and, therefore, incurable. Elders are also frequently denied employment or promotion opportunities because they are “old” and less productive. Such discrimination is also evident on the social policy level where the elderly are blamed for having medical problems and consuming public resources rather than seeing them as having human needs requiring appropriate social responses.

Seeing people as objects also increases the likelihood that they may be subjected to abuse and other cruel treatment. Thus, ageism devalues this segment of the population, a vital human resource.

Ageism and Elder Abuse

The negative attitude (ageism) of younger generation towards older adults is due to the tendency for the elderly to arouse thoughts of dependence, poverty, sickness, frail body and finally death in others. This threatening aspect of the elderly instigates them to keep away elders physically and psychologically so that these ideas may not arise in them. This tendency is expressed in the form of “old people”, and referring them with derogatory terms. The evaluation of older adults on the basis of age or giving judgments on the basis of age means you are not considering them as a member of your own group. The intentional mistreatment or harm of another person is elder abuse. Abuser can be any one that an older person comes in contact with. For example he may be caregiver, a neighbour, or any other member who has negative attitude towards elderly persons. Abuse can be verbal, psychological, emotional and physical. Mostly elderly are abused by family members and relatives. Due to the fear of victimization, elderly people isolate themselves, and thereby become “a prisoner in their own home”.

How to combat Ageism?

A first step in this process is identifying personal attitudes which are ageist in nature. This can be difficult since most people will deny that they are prejudiced. However, until a person is aware of this or her own attitudes, little progress can be made.

Another approach which can modify ageist attitudes is personal contact with older adults. This is often an effective way to prevent or reduce the development of ageism, especially among young children. Many innovative intergenerational programs have been created which not only benefit children in this way, but also benefit the older adults. During these programs, positive aspects of aging can be emphasized so that the children will have a balanced picture of the older adults - and of themselves as they grow older. A good example of an intergenerational program is the recording of older adults' oral history by students.

More formal instruction and education about aging is also needed in professional schools whose graduates will inevitably serve the elderly. This is also true for schools of journalism whose graduates will have significant power in shaping public perception and opinion. In addition,

continuing education and in-service training programs in all fields should also include the aging process and related issues.

Social action and reform is another approach to counteracting ageism. This approach is particularly effective when directed at institutions.

Indian Studies on Ageism

Within the frame work of ageism, health and employment and social policies in India have not been analyzed as has been done in west. The primary reason for this is cultural. In Indian culture birth is not purely a biological birth. From birth child is indebted with three duties: service of elders of family and society, duties towards God and duties towards wiser persons. In this sense birth is not mere biological birth it is a social birth also. So service of parents (or elderly persons in family) is one of the important duty in Indian culture. Manusmriti (Chapter 2.121), says that “one who always serves and respects elderly is blessed with four things: long life, wisdom, fame and power. The state’s role is minimal. But, due to urbanization and globalization, the situation is changing gradually both in urban and rural settings. Now the Government has started pension schemes for poor elderly persons, concessions in railways and air fares, old age homes and day care centres. These schemes are insufficient looking to the population of older adults. So there is a need to analyze the Government policies with ageist outlook.

In India very few research studies have been conducted to study this phenomenon. Sharma (1970) in his study found out that college students showed predominantly negative attitude and beliefs about ageing and aged. The highest degree of negative attitude was shown in the area of conservatism-old people are more inactive type, having no hope from the future and having other worldly attitude. Subjects having older people in the family showed more negative attitudes towards older people. Furthermore, Sharma (2002) tried to find out the degree of ageism in college going students of both the sexes. A questionnaire containing a set of 6 problems: not having enough money to live comfortably, not having work to keep oneself busy, poor health, loneliness, lack of living space and fear of criminal attack on oneself was given to these subjects. The subjects were asked how they rate themselves and older persons on the same problems. It was found that male and female subjects differ in their stereotype towards ageing (or degree of ageism). It was also noticed that respondents having older member (grandfather or grandmother or both) in their family have negative image of older persons in comparison to the respondents not having older family members. Probably the younger

people think that caring of older persons snatches their leisure time. Anantharaman (1984) found that negativity was greater among older people with respect to variables such as financial situation, the future and insecurity. In comparison to urban younger generation rural younger generation of Punjab state revealed more positive attitude towards old age. Old people in the urban area expressed a greater sense of isolation and separation than in the rural area. Deb (1988) explained these differences on the basis of employment trends, economic factors, and family development. Ramamurty and Reddy (1986) found increasingly favourable attitudes for old people. According to them, increase in emotional and social maturity may have mellowed negative attitudes toward the elderly population. The mixed kind findings of Indian researches related to ageism may be due to the coexistence of both individualistic and collective cultures in urban and rural settings.

Cross-cultural studies:

Sharma (1971) found out the area-wise and overall stereotype of Indian students and these findings were compared with the stereotypes of student samples of countries viz. U.S., Japan, Puerto Rico, Sweden, Greece and England. The comparison revealed that Indian students have overall more negative stereotypes towards the older persons than U.S. The Greek considered older people more conservative, less active and more interfering than Indian students. The area wise differences between Indian sample and the sample from other countries were also noticed. The comparison reveals that all these cultures have negative stereotypes toward older people in the areas of conservatism, personality and interference. Prakash (1992) examined attitudes of Indian subjects towards the elderly people and compared to that of British and Canadian subjects. Indian subjects were found to attribute blame to the elderly for their poor health and low income in old age. Cross-cultural differences are evident in this study with Indians blaming the elderly to a greater extent, being less likely to consider the needs of elderly, and less eager to support governmental schemes for home help to elderly. The Indian subjects attitudes can be described as less favourable, humanitarian or welfare oriented when compared to British and Canadian subjects. Age, sex, work status and religion play a role in determining the attitudes. Williams, Pandey, Best and Pande (1987) compared Indian and American undergraduates' views toward young adults and old people. Indians generally viewed the old less favourably than Americans. The young were viewed as stronger and more active than the old in both the cultures although the degree of difference varied.

Summary of papers

Kelly Joyce, John Williamson and Laura Mamo's paper – *Technology, Science and Ageism: An Examination of Three Patterns of Discrimination* - have argued that there are three primary ways people use science and technology to produce ageist ideals and relations. The negative attitude towards older persons and ideal of youthfulness is forcing old people to inhabit a youthful body. In this context the authors have discussed two examples: the example of Viagra and Hormone replacement therapy. The rise of anti-aging medicine and insistence on the view that all aspects of ageing are pathological is the highest proof of the emphasis on youthful body. This direct targeting of ageing body is a first kind of ageism. All the recent advances in technological and scientific designs are made keeping in mind the youth and neglects ageing bodies. For example you may take answering machines, computers, cell - phones etc. are devised keeping in mind youthful able-bodied persons. As an example of the third type of ageism the authors have discussed the rationing of medical technologies. Finally they have concluded that, these techno-scientific forms of ageism, limits individual's ability to fully participate in political and civic life.

The paper - *Ageism and Social Exclusion in the United states: Implications for social policy and social work practice* - contributed by Yeon Shim Lee and Rashmi Gupta have examined the issues associated with ageism and social exclusion and its effects on older people in the United States. They have reviewed the range of social policies (such as income transfer policies, medicare and medic-aid, employment and social services) and social work practice and their impact on social exclusion of older people. It also has a comprehensive analysis of government policies and direct practices, their implications, and suggested strategies to cope with ageist attitudes.

Joan K. Davitt in his paper - *The Ageism Conundrum of Age Based Public Policy: Examples from the U.S.* - has emphasized that ageism in any form (positive or negative) is related to age stratification and age segregation in a society. This phenomenon generates a policy conundrum. Age based policy may support ageist assumptions about older adults. The paper discusses two examples of age based policy-employment/retirement and housing policy - in the U.S and their connections to ageism. The author has explained negative effects of both positive and negative forms of age discrimination and has given recommendations for

change. He has argued that policy makers must be more conscious of this conundrum when designing age based policies to prevent unintended support for ageist assumptions.

Douglas McConatha and Jasmin Tahmaseb McConatha in their paper - *Ageism and Modernization in Contemporary China*, addresses the relationships between age, ageism, and modernization focusing on the case of contemporary China. As China experiences its rapid rise into modernity it could face considerable social and cultural challenges in regard to its large aging population. They have discussed how China can potentially bridge the gap between the economic requirements of a technologically sophisticated economy and ongoing cultural heritage and necessity of honoring ones elders.

Arup K.Banerjee in his paper – *Ageism in Health Care: A British Perspective*, has shown that despite recent attempts to root out ageism, it is still found in health care in U.K. He talks about three broad categories of ageism in health care: primary, secondary and tertiary. When someone is denied an established and well validated treatment to an individual just because of chronological age is primary ageism. It is simply a denial of certain opportunities and facilities. The secondary ageism is about collective discrimination, such as, poor accommodation in hospitals, policies to avoid frail older patients with multiple pathologies. Such patients are not hospitalized or even seen by specialists. Tertiary ageism is about downgrading the specialty of elderly care. He also suggests the ways to encounter ageism.

D. Jamuna and P.V. Ramamurti's study - *Perceptions of Ageism Across the Generations* - empirically investigates the contemporary prevalence of ageism in the perceptions of young adults (20-40), the middle aged (40-60) and the old (60-80). The sample consisted of 120 rural and urban men and women in each of the three age groups. The tool consisted of a checklist of attitude towards ageism adapted from an inventory of attitudes towards the aged. Results indicate a high prevalence of ageism among the young compared to the middle aged and the old, though all age groups held negative attitudes towards ageing. Some strategies of debunking ageism have been suggested.

Indira J. Prakash's paper - *Psychological Issues in Ageism and Its Prevention* - explores the psychological issues in the development and prevention of ageism.

Is care-giving to parents or grand parents, a burden or a source of satisfaction? B. Deviprasad and N. Indira Rani have argued on this issue in their paper – *Older Persons and Caregiver Burden and Satisfaction in*

Rural Family Context. They have reported that large percentage of subjects (women) reported satisfaction in care giving and more women caregivers reported tiredness and worsening health due to stress arising out of their caregiving roles. They have also reported that higher age and lower income was found to bring down the caregiver satisfaction significantly. Caregiver stress theory suggests that stressors on the caregiver cause the caregiver to lash out against the elder. Factors of caregiver stress are: lack of motivation for caregiving, lack of supportive services, lack of coping skills, lack of resources/respite, isolation of the victim, and outside stressors (job, losses, etc.).

In the end I would like to thank all the authors who have contributed their papers for this special issue on ageism.

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Age Bias in Social Work Practitioners: Implications for Social Service Program Managers

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ABSTRACT

Social workers provide services that are integral to a growing segment of the worldwide population: older adults. Ageism is detrimental to service provision because inaccurate assessments produce flawed service planning. Due to the rapid aging of the population, practitioners will often encounter older people directly, if only as clients' family members. Current and non-biased knowledge about aging is important, and managers must help staff accurately assess clients' needs and plan effective services. A study of social workers' knowledge of aging found bias to be approximately the same as that in the general population, and found that attitudes, values, and stereotypical thinking arise from several sources including prior experience, regardless of work frequency with elders. The findings suggest strategies for administrators' reduction of ageism among staff.

Keywords : Age bias, Ageism, Management, Social work administration

In a rapidly aging worldwide population, many people remain quite viable, self-sufficient, and productive at advanced ages. In contrast to widespread beliefs about aging and being old, many older people do not live isolated, functionally impaired lives typified by

cognitive or personality declines, or by failing intellectual abilities (Maddox, 2001; Palmore, 2005). In fact, the individual uniqueness among older people along many dimensions is as pronounced as diversity among individuals at younger ages (Binstock, 1994). As has been well documented, the problem with inadequate or inaccurate information about aging is its tendency to promote stereotypical thinking, which results in ageism or negative attitudes toward aging (Palmore, 1998; Stewart, 2004). The purpose of this study was the examination of age bias in a professional population, social workers, who increasingly have direct and influential contact with a growing segment of the American population: older adults.

Researchers have suggested that those who work most closely with older people may be at risk for holding negative attitudes toward older people, due to their increased exposure to those who are ill and infirm (Lookinland & Anson, 1994). Many social workers are likely to work with older people or their families at some time during their careers (CSWE, 2001; Reed, Beall, & Baumhover, 1992). However, many of the studies on age bias were completed with samples of nursing and other medical students, but very infrequently with those not in a medical field, or with those who are no longer students and already practicing with older people. Many social work (and other) practitioners assist older adults who are not necessarily frail or incapacitated, and although some work in medical settings, they are not physiological medical professionals in the same way that nurses and physicians are. Rather, social workers primarily attend to behavioral and social aspects of the medical patient and the family. Therefore, this study examined ageism in a population of social workers, a population that is infrequently studied in that regard. The results of the study have important implications for managers and administrators who are charged with attracting, evaluating, and hiring competent staff.

Working definitions of “management” vary, and are sometimes used interchangeably with the term “administration”, particularly in the field of social work. For the purposes of this study, I am using a definition derived from Robert Weinbach’s writings on practical matters for social work professionals, which encompass an administrator’s charge to “facilitate the accomplishment of organizational goals” (Weinbach, 1998). While a broad definition,

this depiction of administrative function does include the ethical mandate to any social work organization's staff to practice competently and within their areas of expertise. (It would be difficult to imagine an agency's goals being met in any other manner.) Thus, competent practice must currently include an understanding of aging and of older people's needs, as social workers will encounter older people in most practice venues, whether or not the primary purpose of the agency is targeted to older individuals. Management is a proactive (rather than a reactive) endeavor (Weinbach, 1998) and as such, administrators need to make aging knowledge and updates in gerontology content available to their staff by means of continuing education opportunities and other avenues to current knowledge. In so doing, administrators will provide resources for good service delivery.

In relating social services management principles to the need for continuing education in aging matters, we can utilize typical categories of management functions to examine the areas in which a clear understanding of aging is important. Five frequently-cited categories of management tasks are *planning, organizing, staffing, leading or guiding staff, and controlling management operations* (Weinbach, 1998). By engaging in these five functions, the social work manager can help to shape various aspects of the work environment to be inclusive of older individuals as clients or as participants in the lives of other clientele.

Upon entering the workforce, few social workers have had adequate education in understanding aging processes or in practice concepts relating to aging (Takamura, 2001). Even so, prior studies have repeatedly shown that academic education in gerontology alone does not promote a definite career choice of working with elders, although classroom education coupled with field experience does appear to promote such choice (Davis-Berman & Robinson, 1989). Some suggest that contact with older people and life influences from that contact are related to positive attitudes toward aging (Miller & Dodder, 1984; Palmore, 1998). It seems reasonable, then, that the type, frequency, duration or other aspects of prior experiences with one's elders may also have a similar effect upon one's biases or prejudices that have been formed around aging. The field of social work is increasingly in need of practitioners who will work with older people, and any measures that can be undertaken to increase the likelihood of

choosing to work with elders will be important. Even if social work administrators have employed social workers who are age biased, some steps can be taken to increase contact and experience with older people, such as promotion of intergenerational programs or specific inclusion of older people in agency advisory panels, for example. Erdman Palmore, a leading researcher of age bias, suggests such contacts and programmatic focus as possible measures to combat age bias in communities (Palmore, 2005a).

In addition to the educational and work settings, another arena of experience or exposure to views of aging is through media representations of older people, at least in Western venues. The United States is a youth-oriented society; print and electronic media (television, advertising, e-mail jokes, stories, urban legends) portray older individuals as largely dependent, cognitively impaired, or incapable of decision-making (Ferraro, 1992; Vasil & Wass, 1993). Knowing the importance of academic, work, and general exposure to older people as influential in forming opinions and attitudes toward aging, it was deemed relevant to undertake a study of social workers' age bias specifically in relation to contact and experiences with older adults.

The Research Questions

The research questions surrounding age bias were the following:

1. Is the prevalence of age bias toward older people among a deliberately selected sample of social work practitioners the same as age bias in the general population?
2. What contextual or experiential factors are related to knowledge of aging processes? We see from a review of the literature that specific contextual or experiential factors explain variation in knowledge of aging processes. Family and social-relational influences, television and other media influences, and care-related experiences were assessed to determine significant correlations with knowledge about aging. I hypothesized that the more extensive the social and relational influences, the more accurate the knowledge of aging, and therefore the less exhibition of biased attitudes.

Method

A purposive sample was sought from various types of agencies and social workers in individual practice, as well as public departments of social services. Social workers at these agencies can be assumed to have some degree of higher education in their fields. All respondents had achieved either a baccalaureate or master's level degree in the field or in a related field of study. Very few, 2%, practiced at the level of Ph.D. or DSW. Having identified the sample frame, the author then enlisted the cooperation of state professional social work organizations in providing their membership lists, which comprised a random sample that included practitioners who have opportunities to engage in direct practice with, or who do actually engage in work with, older adults. (The state organizations provided standard, randomized lists which they offer to researchers.)

U.S. States with the highest percentages of populations of individuals over the age of 65 comprised the sample, as these states' current populations most closely typify the proportion of older individuals to be found in all states within the coming years. In part, these states were chosen as an approximation of projected future demographic conditions in most of the United States and perhaps globally. This choice allowed examination of public social workers' attitudes and experiences in environments in which they are highly likely to encounter elders in their work. Although this specialized selection decreased specification error by limiting demographic and other aspects of the sample selected, it also decreased, to some extent, the generalizability of findings to social workers in other states. Most importantly, however, it closely resembles situations that social workers and other practitioners are likely to encounter in the future with regard to exposure to older people.

In determining sample specifications, effect size and power analysis factors were derived from the work of Cohen, a primary source for power analysis factors (Pedhazur, 1997). Power analysis allows the strategic use of effect size, alpha or significance level, desired power, and N , or sample size (Pedhazur, 1997). Fixing any three of the elements determines the fourth, in this case sample size. Therefore, a minimum of 150 respondents were targeted for the survey research, and an N of 367 was ultimately obtained.

Measures

Experience. An author-developed questionnaire was used in the absence of existing measures that would meet the study's purposes. Experience questions were based on elements of contact and experience with older people; questions were devised from concepts defined in previous studies by researchers studying influences upon age bias (Gergen, 1991; Menec & Perry, 1995). Known influences include family biases and preferences, media and other public influences, and experience with older individuals in caregiving and care-receiving contexts (Aday, 1996; Davis-Berman & Robinson, 1989). An example of an experience item is the following: "I have been involved in giving care to an older person (over age 65)". A four-point scale of Likert-type responses included (a) does not apply to me; (b) very slightly applies to me; (c) somewhat applies to me; or (d) very much applies to me. The experience scale was subjected to reliability measures and factor analysis.

Knowledge and age bias. The Facts on Aging Quiz (FAQ), developed by Erdman Palmore (1998), was the instrument used to assess aging knowledge and age bias. This well-established 25-item true-false instrument has been widely used to assess both knowledge of aging facts and processes, as well as age bias, and is currently used in such studies despite its development (in its original version) nearly thirty years ago. The test contains 25 true-false questions pertaining to biological, social, emotional, and psychological traits of older people. (This instrument is also known as the "FAQ1" because other versions have been developed over the years.)

Due to distribution of the surveys to social workers engaged in a variety of subfields such as adult services, children's services, and individual or family work, the non-specific distribution obscured, to some extent, the focus of the study as bias- or ageism-related. Table 1 shows the distribution of sample characteristics.

Results

The major dependent variable in this study's primary analysis is social workers' knowledge of aging processes. Table 2 shows that social workers' knowledge of aging and the derivative factor, age bias, are similar to those of the general population, and while it is not high in relation to the general population, any age bias is to be considered deleterious to effective practice in any profession.

Table 1 : State of Residence, Experience and Work-Related Activities[illegible]

Table 2. Age Bias by State in Relation to General Population

Age Bias by State	Percent scoring an age bias	Percent bias in general population	Percent bias in social work population	Percent bias in study population
Florida	37%			
Iowa	24%	33%	27-32%	29%
Pennsylvania	29%			
West Virginia	26%			

Table 3. Knowledge of Aging, and Age Bias Scores

	Total n=367			Florida n=113			Iowa n=91			Pennsylvania n=76			West Virginia n=87		
	Mean	SD	Range	Mean	SD	Range	Mean	SD	Range	Mean	SD	Range	Mean	SD	Range
Know- ledge (FAQ) scores	20.2	3.5	8-25	18.7	3.5	8-25	21.4	3.5	10-25	20.6	3.0	13-25	21.0	3.2	12-25
Age Bias	.29	.45	0-1	.37	.48	0-1	.24	.43	0-1	.29	.45	0-1	.24	.44	0-1
	Age Biased	%		Age Biased	%		Age Biased	%		Age Biased	%		Age Biased	%	
	109	29		42	37		22	24		22	29		23	26	

Table 4. The Prediction of Age Bias from Experience Factors
Coefficients(a)

Model		Unstandardized Coefficients		Standardized Coefficients		t	Sig.
		B		Std. Error	Beta		
1	(Constant)	14.740		1.223		12.048	.000
	Value Source	.495	.121	.242		4.104	.000
	Social-Relational	.029	.121	.012		.237	.813
	Elder Competence	.168	.107	.093		1.577	.116

a Dependent Variable: Total FAQ score (Facts on Aging Quiz)

Model Summary

Model	R	R Square	Adjusted Square	Std. Error of the Estimate
1	.300(a)	.090	.082	3.331

a Predictors : (Constant), Value Source, Social-Relational, Elder Competence

The experience variables were identified from a factor analysis relating to the origination of knowledge about aging, such as “Most of my attitudes about older people come from my family.” The variable named a “social-relational factor” was derived from survey questions regarding caregiving or care-receiving and elder individuals, and the elder alertness variable came from such questions as “Most older adults in my experience have been alert and oriented.” Each of these questions was preceded by an instruction to use the age 65 as a guideline for “older adult”-type terms, as 65 is often the age marker for older adults in the gerontology literature.

Tests of the Assumption of No Difference in Social Workers and General Population

Assumption. There is no difference in the prevalence of age bias among social work practitioners in comparison to the general population, as all people have varying early and ongoing experiences that produce biased or non-biased attitudes.

Approximately 30% of this sample (n=109) were found to be age biased, whether they held negative or positive bias. The assumption was supported by this analysis in that this sample exhibited a relatively high degree of age bias overall, but was consistent with that found in the general population and in social work practitioners. The percentage of social workers found to hold age bias in prior studies has been between 27-32% (Palmore, 1998). Table 3 shows that nearly 30% of this study’s sample responded incorrectly to subsets of negative ageism-related questions on the Facts on Aging Quiz (FAQ), or to one or more of the 5 questions that indicated positive ageism. Thus, among social work practitioners who work with older people or who have the propensity to do so, age bias was found to exist to a degree similar to that of the general population.

Test of the Hypothesis: Contextual Factors Explain Variation in Knowledge of Aging

A linear regression analysis predicted three specific contextual or experiential factors that explain variation in knowledge of aging processes. Family and social-relational influences, television and other media influences, and care-related experiences were significantly correlated with knowledge about aging. The more extensive the social and relational influences, the more accurate the knowledge of aging.

Table 4 shows that those with close relationships and those who perceived older people as oriented and alert did not score as highly on the FAQ.

Discussion

This study revealed two important aspects of age bias among the social work population represented by this sample:

1. age bias exists among social work practitioners
2. family influences and television and other media significantly influence one's perception of aging and risk for age biased attitudes

Social work managers can have a direct and influential impact upon an organization's response to the rising need for expertise in aging practice. The functional areas of social work administration outlined earlier can provide a structure by which to incorporate aging issues into the day-to-day operations of the workplace. Ageism is detrimental to service provision because inaccurate assessments produce flawed service planning, but due to the rapid aging of the population, practitioners will often encounter older people directly, if only as clients' family members. Current and non-biased knowledge about aging is important, and managers must help staff accurately assess clients' needs and plan effective services. These findings suggest strategies for administrators' reduction of ageism among staff.

Application of Age Bias Findings to Management Functions

Planning and staffing functions. Having accurate knowledge of aging will enhance social workers' ability to assess clients' actual change or decline (or growth and improvement), and will decrease the likelihood of basing interventions upon erroneous assumptions. Managers can plan for effective services by putting into place adequate education and training in aging issues to assure that staff skills are up-to-date and accurate. A more accurate assessment of clients' needs and capabilities will result in greater client autonomy and better services to older clients overall.

Nearly 30% of the sample indicated age bias by responses to established measures of ageism. In 1987 fewer than 30,000 social workers engaged in professional work with older people or their families; however, by 2010, now only a few years in the future, 60,000

social workers will be needed for work with the same population (NIA, 1987). One condition fostering the risk of age bias among practitioners is the lack of students and faculty with interest in aging work, as they often perceive work with older people as less interesting and less-valued than work with other populations. Many students indicate a lack of interest in gerontology specialization, and those who have felt interest perceived little faculty or curricular support (CSWE, 2001).

Organizing function. Perhaps one way of presenting aging studies (both in aging academic studies and in workplace continuing education) is the manager's attention to the practitioner's age, period, and cohort as a vehicle to understanding the current perspective. Culture (and "culture" pertains to the workplace culture as well as larger societal culture) is integrally related to the ways in which people view themselves, their peers and significant others, and one's age or "placement" in society due to various socio-cultural factors. Thus, differences among practitioners of different ages, cultural or ethnic background, and education level as factors associated with early experiences, can also be taken into account as a programmatic consideration. Administrators and program managers may be able to match interests, age and experience, and life values or perspectives when assigning work duties and when delegating work with specific client populations, or at least raise these possibilities for staff discussion.

Leading/guiding function. A simple initial solution to ageism is the provision of additional ongoing information and training for staff. This training can take the form of in-service education, aging-relevant reading lists, support for return to academic coursework or seminars, workshops, intergenerational opportunities, and conferences dealing with aging matters. Additionally, daily attention to aging specifically when discussing family case material or when planning clinical interventions can be a managerial role, as would promoting collaborative projects with agencies and organizations attuned to aging needs in the community.

Controlling agency operations. This function of management operations incorporates ideas from the preceding functions, such as hiring effective, competent staff, and maintaining continuing education opportunities and supporting these by allowing time for educational

pursuits or agency-sponsored financial support for coursework. An assessment of the best “fit” of various staff to client needs is an operations function. Some aspects of age bias or the potential for inadvertent bias could be important in agency recruitment and hiring practices. Specific questions regarding aging knowledge and experience or prior work with elders may help the agency administrator designate work areas, choose work roles for incoming employees, or provide appropriate orientation and workplace updates. One might also review agency intake procedures and standardized forms to ascertain their reflection of a life-course perspective or attention to elder family members. Are aging matters integral to the organization, or are they “tacked on” and seemingly afterthoughts? The manager’s operations tasks include an integrating function with regard to older clients.

Although any experience-related influences could be tempered by accurate aging information in social work and other human services practice venues, the majority of human services students have received little aging-related material. Thus, employees new to the workplace and to the profession are entering with a disadvantage in terms of preparation for a possible lifetime of work with an aging population. The data from this study show that ongoing education and updating of basic knowledge about aging processes and expectations can be integral to the effective practice of current clinicians, and that they are not important only for students. Thus, while inclusion of gerontology content in the social work curriculum is important, it may be even more critical to provide ongoing gerontological education for social work practitioners already in the field, as they are already engaging the burgeoning population of older individuals and their families. Perhaps another simple approach would be a greater emphasis upon specific orientation of new staff. This orientation could be provided by longtime employees who have had a good deal of experience in working with elders and their families. Regardless of the methods used to shore up skills for working with aging clients, social work administrators can play an increasingly significant role in assuring that older clientele receive social work services based upon accurate, timely, unbiased assessments and plans of treatment.

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Technology, Science, and Ageism: An Examination of Three Patterns of Discrimination

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ABSTRACT

In this article, we argue that there are three primary ways people use science and technology to produce ageist ideals and relations. The first directly targets the aging body itself. Normative behaviors for aging bodies are redefined so that old people are now required to inhabit a youthful body. We discuss two examples of this pattern—Viagra and Hormone Replacement Therapy. We also show how the emphasis on youth reaches new heights with the rise of anti-aging medicine and its insistence that all aspects of aging are pathological. The second form of ageism neglects aging bodies in technological and scientific design. Everyday technologies such as answering machines or computers are often devised with a youthful, able-bodied person in mind. To illustrate this pattern, we discuss cell phones and computers. Finally, we address a third form of ageism: the rationing of medical technologies. We discuss direct and indirect rationing to illustrate this practice. In conclusion, we show how these techno-scientific forms of ageism limit individuals' ability to fully participate in political and civic life.

Keywords: Technology, Ageism, Medicalization

Science and technology are central to the normative definitions and lived experiences of aging. The design and use of technologies can enable aging people to participate more fully in civic and political life. Alternatively, they can reproduce ageist practices and biases. As

social products, technologies can be designed in a range of ways and put to a variety of uses, each of which redefines behaviors, perceptions, and lifestyles associated with aging.

In this article we discuss three ways science and technology contribute to the social construction of ageist ideals and experiences. Drawing on literature in medical sociology, gerontology, and science and technology studies, we show how the medicalization of aging bodies, the design of technologies, and health care rationing all help produce ageism in contemporary life. These examples demonstrate the importance of putting science and technology at the center of future empirical investigations of aging and ageism.¹ Throughout this article we focus on the United States, but we hope that the analysis presented here will foster similar analyses of developments in other countries and cross-national comparisons.

The Medicalization of Aging

The twentieth century was marked by an increasing tendency to define mental, physical, and emotional processes as illnesses. This trend, known as medicalization, was initially described by sociologists Irving Zola (1972), Eliot Friedson (1970), and Jesse Pitts (1968).² In his canonical essay "Medicine as an Institution of Social Control," Zola noted how alcoholism, having trouble sleeping, pregnancy, and other behaviors and bodily processes once defined as socially unacceptable or normal became redefined as illnesses by the 1970s. As additional aspects of life were redefined as medical problems, physicians and other health care professionals gained more control over the management and treatment of people. Zola (1972) expressed concern about the expansion of medicine's jurisdiction over new areas of life, noting that "the labels health and illness are remarkable 'depoliticizers' of an issue." That is, medical labels turn social issues (e.g. structural reasons for addiction, sleeplessness, and the like) into an individual "illness" in need of a medical not a political solution.

Medicalization affects all ages, but it has particular implications in an ageist society. In societies that position youthful bodies as the norm, the changes associated with aging are ripe for being labeled pathological. As Zola cautioned, turning such processes into illnesses depoliticizes underlying cultural and structural causes. The opportunity to challenge the ageist bias that causes their very construction is lost.

Sociologists and gerontologists have spent years documenting the transformation of the emotional, mental, and physical changes associated with aging into “illnesses” (Cruikshank, 2002; Estes and Binney, 1989; Gubrium, 1986; Kaufman, 1994; and Lock, 1993). For example, the biomedical construction of Alzheimer’s disease redefined memory loss as an illness category during the 1960s and 1970s (Gubrium 1986). What had been a normal component of aging was reconfigured into disease through the creation and delineation of medical diagnostic categories.

This early work provides key insights into the way aging was transformed into pathology. However, major transformations have occurred in the organization of biomedicine in the United States since this research. The last two decades witnessed the increasing privatization of health care as for-profit hospitals, clinics, and health insurance companies increased in number. The use of technologies grew in diagnostic and treatment practices, and care moved from the hospital to the home as hospitals stays were shortened and the responsibility for care work shifted to families and friends.

The medical knowledge landscape also changed. Medical technology, pharmaceutical companies, and hospitals increasingly used direct to consumer and product placement forms of advertising to shape medical care. Simultaneously, patients gained more opportunity to educate themselves about biomedical matters as support groups and organizations were formed, self-help literature boomed, and medical search engines such as MEDLINE became available.

Working at the crossroads of medical sociology and science and technology studies, Clarke A. *et al.* (2004) offer a reconceptualization of the medicalization thesis in light of these broader changes. Drawing on a core science and technology studies idea that technologies—defined broadly as any application of knowledge (e.g. drugs, the built environment, and machines) — are central to daily life, the authors focus on the meaning and content of scientific knowledge and technological applications. Through this focus, Clarke and her colleagues emphasize the need to put technology and science at the center of analysis of new medicalization processes.

Clarke *et al.*, suggest the term “biomedicalization” be used to demarcate contemporary medicalization processes given the significant transformations in medical knowledge and practice. They

outline five processes in particular that constitute biomedicalization: (1) the increasing privatization of biomedicine with for-profit companies and hospitals gaining in prominence; (2) the extension of risk and surveillance categories resulting in more and more healthy conditions being labeled as pre-disease or at the very least risky; (3) the escalating use of technology and science in clinical practice and home care; (4) the availability of new computer technologies, such as the internet, that change knowledge production and distribution; and (5) the production of new individual and collective health-related identities such as “chronic fatigue syndrome” or “fibromyalgia” (Clarke *et al.*, 2003). Together these processes help produce the conditions needed to spur the expansion of biomedical categories and treatments into more and more areas of life.

Clarke and her colleagues’ expansion of the medicalization thesis provides a theoretical framework for new considerations of the relations between ageism, economic interests, stratification, and medicine. To illustrate the ageist bias of biomedicalization processes, we offer two illustrative examples.

Case Study #1: Viagra

In research and clinical trials from 1989 to 1994, Pfizer Pharmaceutical researchers realized that UK-92480 (the early name of Viagra) increased blood flow to the genital region (Loe, 2004). After this finding, Pfizer continued to investigate the link between the substance and the production of erections. In 1998, the company received approval from the Food and Drug Administration to market and distribute the drug, now known as sildenafil or Viagra. Drugs, however, need a disease, and the disease needs to be recognized by both medical professionals and the public in order to garner widespread support. The medicalization of men’s sexuality included a conceptual shift from impotence to erectile dysfunction (Fishman, 2007).

Shortly after Pfizer received FDA approval, E. *et al.* (1999) published an article in *JAMA*—one of the most prestigious medical journals in the United States. Laumann *et al.* found that 31% of the 1410 men surveyed had sexual dysfunction. Within the context of the study, any man who reported ever having experienced premature ejaculation, erectile dysfunction, or low desire received the disease label. This broad definition of sexual dysfunction increased the

number of potentially “sick” men and made sexual dysfunction sound like a pressing problem. Although the initial publication neglected to include financial disclosure information, it was later revealed that two of the authors (Laumann and Rose, 1999) consulted for Pfizer. Despite the expansive definition of sexual dysfunction and the economic relations between the authors and Pfizer, the article performed critical work in establishing sexual dysfunction as a serious public health problem.

Pfizer further promoted the disease and the drug by launching an aggressive advertising campaign. In 1997, the FDA clarified advertising requirements for pharmaceutical companies (Nordenburg, 1998). The new regulations allowed companies to market drugs directly to consumers on television and radio as long as certain adequate provision requirements were met (e.g. refer customers to physicians or pharmacists, provide a toll free number, or provide the name of a website or print ad that had more information). This change marked a shift from previous years during which a moratorium limited pharmaceutical advertisements on television and radio. Pfizer took advantage of the regulatory change and broadcasted advertisements that featured erectile dysfunction and its cure—Viagra—on American airwaves. The *JAMA* article, advertisements, and news articles all helped “educate” people about erectile dysfunction and the benefits of treatment.

The rise of Viagra redefined sexuality for old men and women. In the Viagra era “normal for males, as defined by Pfizer Pharmaceuticals and its experts, is having a consistently hard and penetrative penis, feeling eighteen again, and never having to worry about occasional problems with erections” (Loe, 2004). While this definition of normal is hard for men of any age to accomplish, it is particularly difficult for old men to embody. Purchasing and using Viagra is one way this ideal can be achieved. The redefinition of male sexuality affects women as well. Whether women enjoy penetrative sex or not, the existence of Viagra (and other similar drugs) raises “new concerns for women regarding marital obligations and sexual duty” (Loe, 2004). Female partners of Viagra users are now expected to be sexually active until death.

The biomedicalization of sexuality illustrates the connections between ageism, medicine, pharmaceutical companies, and media.

The rise of Viagra capitalized on ageist practices that position the youthful body as the norm. Creating an erection on demand and having frequent sex are activities commonly associated with younger bodies. Putting aging bodies at the center would create a different ideal. However, old bodies are not privileged as the model for aging sexualities. Instead, old men and women are expected to adjust their sexual practices to mimic youthful expectations and desires.

Case Study #2: Hormone Replacement Therapies

Ageism and medicine also intersect in the development and use of hormone replacement therapies. The use and marketing of hormones have a long history in the medical marketplace. Medical practitioners experimented with hormone supplements throughout the 1920s and 1930s, and the first estrogen pill, Premarin, was introduced in 1942 (Neel, 2002). Premarin, which is still prescribed today, is made from pregnant mares' urine—a fact that is evoked in the drug's name: Pre(gnant)Mar(e)in.³ The pharmaceutical company Ayerst (now Wyeth-Ayerst) initially promoted the drug for a variety of conditions associated with aging, including menopause.

Menopause was defined as unnatural throughout the 19th and 20th centuries in Europe and the United States. The Victorians viewed it as a sign of sin and decay, while early 20th century Freudians viewed menopause as a neurosis. During the twentieth century, physicians, researchers, and pharmaceutical interests transformed the deviant status of menopause into a biomedical disease (Palmlund, 2006). Part of the broader trend of biomedicalization, the medical profession defined menopause as a deficiency disease, which helped give doctors control over this bodily process (Bell, 1987).

The definition of menopause as pathological and the promotion of Premarin and other hormone therapies intensified in the 1960s. Gynecologist Robert Wilson (1962, 1963, 1966), a man who had financial ties to pharmaceutical industries, was a key supporter of both projects, published scientific articles in *JAMA* and the *Journal of the American Geriatric Society* as well as the popular book *Forever Feminine* to convince the public and medical professionals about the value of hormone replacement therapy. Illustrating the framing of menopause as pathological, Wilson called women who did not use estrogen replacement therapies “castrates.”

Sales of Premarin and other estrogen replacement therapies steadily increased throughout the late 1960s and the 1970s. The Food and Drug Association's announcement in 1986 that estrogen replacement pharmaceuticals helped prevent the bone loss associated with osteoporosis further fueled the market (Kling, 2000). Offering additional medical reasons to prescribe estrogen products, the announcement increased the perceived legitimacy of the drugs and prescriptions soared. By the 1990s, there were estrogen only and estrogen-progestin combination drugs available to "treat" menopausal symptoms. Millions of women used the drugs, and the multi-million dollar market thrived (Palmlund, 2006).

In 2002, the Women's Health Initiative's decision to stop a clinical trial on estrogen-progestin combination therapies (e.g. Prempro, Premphase) due to clear evidence of increased risk of heart disease, stroke, and breast cancer put a damper on the hormone replacement bandwagon. This announcement was soon followed by a second one. In 2004, the Women's Health Initiative halted a trial on estrogen alone therapies (e.g. Premarin) when it became clear that participants had an increased risk of stroke and blood clots deep in veins. Moreover, the study showed that the drug regime did not reduce the risk of coronary heart disease as had been claimed (NIH, 2005).

These studies (and the publicity that surrounded them) resulted in numerous women stopping their HRT use. However, the tendency to define menopause as pathology remains. As with the rise of Viagra and the biomedicalization of old men's sexuality, the definition of menopause as a pathological state arises in part from ageist ideas that use the youthful body as the point of contrast. Compared to menstruating, ovulating youthful women, menopausal women are defined as lacking. The visible changes associated with post-menopausal life (e.g. wrinkles, dry skin) are also interpreted through an ageist lens. In an ageist society, signs of aging become signs of deviance. They should be avoided whenever possible.

Companies continue to look for new ways to capitalize on the desire to erase the changes associated with menopause. Despite the dangers associated with estrogen-alone and estrogen-progestin combination therapies, some women still use these drugs. Vitamins, minerals, and herbal remedies, such as black cohosh, are also

promoted (see, for example, Cornworth, 2007) and bio-identical hormones represent a booming new market. Such hormones are made from yam and soy, and are considered to be more similar to hormones a woman's body makes than pharmaceutically produced ones. However, hormones produced from yam or soy derivatives are not *more natural* than pharmaceutical products. As Love Susan and Sue Rochman (2006) point out, "Premarin (estrogen alone) and Prempro (a combination of estrogen and progestin) are made from pregnant mares' urine, which also comes from a natural source."

Viagra and hormone replacement therapies are two examples that signal the biomedicalization of aging. Many more examples abound. New diseases such as pre Alzheimer's or mild cognitive impairment are being invented and the disease categories associated with aging are proliferating. Moreover, each disease identity comes with a corresponding treatment regime and an array of specialists. The creation and practice of such diseases enrolls a range of actors including pharmaceutical companies, medical specialists, media outlets, patients, and consumers.

In the future, new research should explore how race, class, sexual orientation, and nationality shape the contours of biomedicalization processes. Biomedicalization is a stratified and uneven practice. As such, it can affect various groups in particular and locally situated ways. While some researchers document the uneven effects of biomedicalization processes (see, for example, Cruikshank, 2003; Lock, 1993; Martin, 1989), examination of this issue is all too rare.

Anti-Aging Medicine: The New Face of Biomedicalization?

The biomedicalization of aging reaches its logical conclusion in the rise of anti-aging or age-management medicine. Within this emergent field all aging becomes pathological. Physicians no longer aim to carve out aspects of aging as disease. Instead, the process of aging itself is something to be avoided at all costs.

Anti-aging medicine proliferated in the 1990s (Mykytin, 2006). During this decade, physicians and other anti-aging proponents tried to gain scientific legitimacy by creating professional organizations such as the American Academy of Anti-Aging Medicine [A4M] and journals such as the *Journal of Anti-Aging Medicine*. The A4M's full scale assault on aging can be seen in their three basic rules of anti-

aging: “don’t get sick, don’t get old, and don’t die.” These rules, which are posted on their website, represent ageism at its most extreme.

The A4M and other anti-aging organizations promote numerous tactics to help people reach the “triple digit lifespan.” Stem cell research, nanotechnology research, and cancer treatment research all provide potential anti-aging interventions. Anti-aging clinics and practitioners can also encourage off label uses of prescription drugs such as human growth hormone. It is claimed that human growth hormone increases muscle mass, decreases fat, increases energy and sexual desire, and can therefore counteract the effects of aging. Despite critical evaluation of these assertions by physicians (see, for example, Vance, 2003), about 20,000 to 30,000 Americans took human growth hormone as an anti-aging medicine in 2004 (Maugh, 2007).

The desire to eliminate aging is strong in an ageist society, and those who accept aging as a normal component of the life course can have low status. Geriatrics medicine has traditionally emphasized aging as a normal process. Guiding the aging process is more important than using unnecessary medical interventions. Geriatric medical doctors are typically paid less than many other specialties and are not considered prestigious in a medical context where technological and scientific interventions are valued. Not surprisingly, the number of doctors specializing in geriatrics medicine is small. Only 9 out of 145 medical schools in the United States have departments of geriatrics (Gross, 2006). Yet, even as geriatrics is a low-paid, low prestige profession, its twin—anti-aging medicine—is growing rapidly despite the reservations and skepticism on the vast majority of American physicians.

Technology Design and Ageism

Technology design is another site where technology, science, and ageism intersect. While some technologies such as walkers or pill dispensers are designed for elderly users, most technologies are designed with a youthful, able-bodied person in mind. Although technological design does not determine which people use a technology or how they use it, built-in assumptions about ideal users can hinder full participation and equal access to a particular apparatus. The reliance on the youthful body in design practices can exclude old

people from using computers, the internet, and other technologies that are now crucial for participation in political and cultural life.

Science and technology studies (STS) scholarship provides a useful framework for examining the relations between technologies and users. In the 1980s, scholars working in STS began to articulate the importance of analyzing how designers—intentionally and unintentionally—have an ideal user in mind when they create technologies. In his classic essay “Do Artifacts Have Politics?”, Winner Langdon (1980) examined an array of technologies (e.g. overpasses on Long Island, NY, machines used to make metal castings) to show how each had an imagined user embedded in it. For Winner, technologies have political qualities; design is one way specific forms of power and authority are embodied.

During the same decade that Winner called for analyses of the politics embedded in artifacts, other STS scholars began examining how people use technologies in daily life. Pinch Trevor and Bijker Wiebe (1984), working within the social construction of technology (SHOT) approach, theorized users as key social groups that create multiple meanings of technologies. Feminist historian Ruth Schwarz Cowan (1987) also called for research that examined the junction between the consumer and his or her choices about technologies. Since this early work, STS scholars have produced a rich literature that analyzes how users contribute to the social shaping of technology (see, for example, Moore, 1997; Oudshoorn & Pinch, 2003; Taylor, 2006). While STS rarely takes up aging and ageism as a central concern, the focus on the relations between technologies and users provides an entry into such analyses.

For example, computers and internet sites are typically designed with a youthful body in mind. The movement of cursors on websites or documents requires precise hand-eye coordination, and the font size on many web sites is geared toward those who can read small print. Although people age in a variety of ways, these qualities are more commonly found in younger bodies. People who experience changes associated with aging (e.g changes in hand stability or vision) will not be able to use information technologies as easily as those who do not. Given that companies, governments, and organizations use internet sites to distribute information in the United States, such design barriers are a concern. Cost and cultural familiarity influence computer use

among old adults (Cutler *et al.*, 2003; Selwyn, 2004), but technological design can also create a significant barrier.

Ageism also shapes the design of pharmaceuticals. Most pills are sold in standardized sizes. Standardized doses can affect all people, but it can especially harm older people. As people age, the liver's ability to process medication and the kidney's efficiency in eliminating it decline (*Consumer Reports on Health* 2005). Thus, smaller doses may be more appropriate for old people—a fact ignored in the “one size fits all” approach to pill design.

Groups that traditionally advocate for the interests of the old have not called for action on design issues. For example, the American Association of Retired Persons (AARP), an American organization that represents approximately 38 million people age 50 and over, recognizes that design bias exists. This recognition is done through technology: the AARP includes two links on its website that allow viewers to increase and decrease font size. It also discusses technologies aimed at older people in promotional articles such as “Life Online: Demystifying the Communications Gap.” However, the AARP does not focus on the relation between design and ageism in its reports or advocacy campaigns. Moreover, even when the organization discusses technologies geared toward older people, it does not comment on the ageist designs of new or existing technologies. Instead, all new technologies (e.g. Skype, Vista) are discussed without giving any consideration to the biases of design.⁴

Despite the lack of action by the AARP and other organizations, some companies and non-profit organizations are designing products for aging people. The Center for Research and Education on Aging and Technology Enhancement at the Georgia Institute for Technology is one project that thinks about design through the bodies and abilities of older people.⁵ Companies such as Life Solutions Plus and Marilyn Electronics sell dressing aids, arthritis aids, and other products aimed to ensure independent living. These types of products make it possible for people with different abilities to participate more fully in daily life.

Recent changes in cell phone design illustrate how technologies change when old people are the imagined user. Like computers and the internet, cell phones were initially designed with an able-bodied, youthful person in mind. The small buttons and print on cell phones demand precise hand-eye coordination and the lack of contrast

between the text and background on the LCD screen requires visual acuity. Given these design constraints, it is not surprising that old people have not purchased and used cell phones to the same degree as younger consumers.

In recent years, however, cell phone companies changed the technologies to accommodate aging users. In 2004, Tu-Ka, a Japanese mobile phone company, recognized that they were missing a potential market, and designed a phone with elderly users in mind (Nakamoto, 2004). The phone has large buttons, no LCD panel, and the buttons light up when its time to use them. Shortly after Tu-Ka's release, Fujitsu, another mobile phone company, launched the Raku-raku (easy-easy) phone line (Lewis, 2005). While the phone's name recreates the ageist idea that old people need things to be "easy," its design takes changes in hearing and conversational styles into account. The Raku-raku phone instantly converts all incoming voices to a slower speed so that it is easier for listeners to understand what is being said.

Such changes in design practices challenge the ageist bias of many technologies. Nonetheless, until computers, pharmaceuticals, and other technologies that are central to daily life are reconfigured with the aged body in mind, design will be a key form of ageist discrimination. As long as younger people develop and market technologies to other young consumers, old people will continually be excluded from new technologies (Cutler, 2005).

Rationing of Health Care

The third key area that science, technology, and ageism intersect is health care rationing. Age-related rationing can be direct or indirect (Adams *et al.*, 2006). Direct ageism occurs when health care policies or guidelines clearly state that goods or services are unavailable to people of a certain age. This form of rationing does not take into account the varied ways people age and is less common as it tends to create controversy.

Indirect ageism takes place when clinicians' or organizations' ageist ideas influence clinical encounters and the provision of services. This form of ageism is difficult to recognize since it can occur behind the scenes in one-on-one encounters, and/or be coded as unrelated to

age in health care policies. Nonetheless, patients are more likely to encounter this ageist practice than direct forms of discrimination.

For example, physicians' assumptions about age can cause them to disregard old people when they mention new physical or mental problems. When heard through an ageist lens, patients' knowledge about changes in their bodies and minds is dismissed as a normal part of aging. Age biases may also prevent clinicians from presenting the full range of treatment options to elderly patients. Studies have shown that patients over 65 often do not get appropriate treatment for cancer, heart disease, and depression (Anti-ageism Taskforce, 2006). Although financial access to health care, sexism, and racism can contribute to this pattern, it is also related to the intentional and unintentional ways ageism shapes the clinical encounter.

Conclusion

National and local policies that invest in technologies and science have helped create what Robert Butler, calls "a revolution in longevity." Particular technologies and scientific knowledges such as the practice of antisepsis in medicine and the use of engineering and chemistry to create safer water supplies can extend life expectancy. The availability of better glasses, higher quality hearing aids, appropriate medications, and safe and reliable public transportation all contribute to one's ability to participate fully in life as we age.

In this article we highlighted three ways science and technologies help produce ageism in contemporary life. Biomedicalization, technological design, and health care rationing are three key sites where technologies, science, and ageism can co-produce inequalities. Future research should examine how national policies and ideologies contribute to these practices, highlighting differences and commonalities between nations.

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(Endnotes)

- ¹ This article builds upon Joyce and Mamo (2006). In this piece, Mamo and Joyce argue that it is time to “gray the cyborg” and put science and technology at the center of analyses of aging. Drawing on a central assumption of science and technology studies, we argue that a focus on science and technology is crucial to understand aging identities and experiences.
- ² For good overviews of the medicalization thesis, see Conrad (1992) and Rosenfeld & Faircloth (2006).

- ³ Animal rights groups critique the treatment of the pregnant horses used to make Premarin and other similar hormone replacement pharmaceuticals. For example, People for the Ethical Treatment of Animals (PETA) challenge how the horses are kept in small stalls during their pregnancies as well as the fate of the foals born on the ranches. For a summary of PETA's evaluation of Premarin, see http://www.peta.org/mc/factsheet_display.asp?ID=73
- ⁴ To view the technology related articles posted on the AARP website, see <http://www.aarp.org>.
- ⁵ For more information on the Center for Research and Education on Aging and Technology Enhancement's projects and publications, see <http://www.psychology.gatech.edu/create/index.htm>.

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Ageism and Social Exclusion in the United States: Implications for Social Policy and Social Work Practice

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ABSTRACT

Ageism is one of the most widespread prejudices in American society. It is a prejudice that disproportionately affects millions of older Americans, and ranges from prejudicial attitudes toward older persons to degrading media images to discriminatory practices to institutional policies that perpetuate stereotypes about older people (Butler, 1969, 1980). In particular, ageism is inextricably linked to social, economic, and political exclusion. Such exclusion commonly results in poverty, which in turn, generates the need for income transfer and other social programs. Given the burgeoning of the aging baby boomer population in the U.S. in the coming decades, developing effective social policies and social work practices to address social exclusion through age-related changes have become even more important. The purpose of this article is (1) to examine the issues associated with ageism and social exclusion and its effects on older people in the United States, (2) to review the range of social policies and social work practice used to combat exclusion, and (3) to provide a comprehensive analysis of the impact of government policies and direct practice. Implications for social policies and practice are listed

Key words : Ageism, Social Exclusion and Its Effects

Elderly population is increasing due to advancements in medicine and improvement in health and so ageism is an issue that is affecting more and more people. Second, with the advancements in health care,

more people will die of old age rather than die prematurely, which suggests that older adults inevitably become a threat to people's ability to manage death related fear. Earlier research on attitudes towards aging reveals that as more prejudice is directed towards older people, the more people fear this aspect of life. The more people derogate the older people, the more the elderly people will reflect not only the future that inevitably leads to death, but also one in which by old people are not culturally valued.

In American society old adults are seen as declining, dependent and evoke in others fear about their own death. Old age is a reminder of our own vulnerability and what makes life meaningful. American world view is based on productivity and growth and adherence and pursuit of these values promote self-esteem. Based on the world view that in old age people have to give up goals and aspirations such as athletics and having children as biologically it may not be feasible, this brings about reminders of losing a sense of meaning and moving towards death. This passage of seeing elderly exposes people to their own existential dilemma's and fears which motivate most people to ignore, belittle and isolate the elderly. A wide range of pressures also affect people as they move into their 60s and beyond: for instance, economic deprivation stemming from the loss of income, due largely to retirement, problems arisen from chronic health conditions, and hardship associated with the impact of changes in life course transition. Butler and Lewis (1973) furthermore draws parallels with these other forms of oppression, where ageism is described as 'a process of systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this for skin color and gender.'

One major effect of ageism is that the news media, the academics and the social environment in which the older adult lives perpetuates ageism as it depicts older adults as being dependent, needy and to be pitied. Over a life time of being bombarded with negative stereotypes about old age, the elderly internalize the negative messages and begin to use the negative self talk by remarks, such as "I forget where I kept my keys, I must be getting old" or "I do not have the strength that I used to have as I am getting older." This negative self-talk eventually becomes a self fulfilling prophecy as we see that older adults start playing the part, especially in institutions as become dependent on the

nursing staff to do basic things for them. Socially excluded from the normal activities of citizens in mainstream society, the aged often become marginalized and disenfranchised.

Demographic and Social Trends in the U.S.

The U.S. is an aging society, with 12.1 percent of its population aged 65 and over while children under 18 accounted for 25 percent in 2005 (U.S. Census Bureau, 2005). Like all the advanced industrialized countries, the U.S. has experienced an increasing life expectancy, a decreasing mortality, a declining birthrate, and a rising immigration. By 2004, life expectancy had risen to 80.4 years for women and 75.2 years for men (National Center for Health Statistics, 2007).

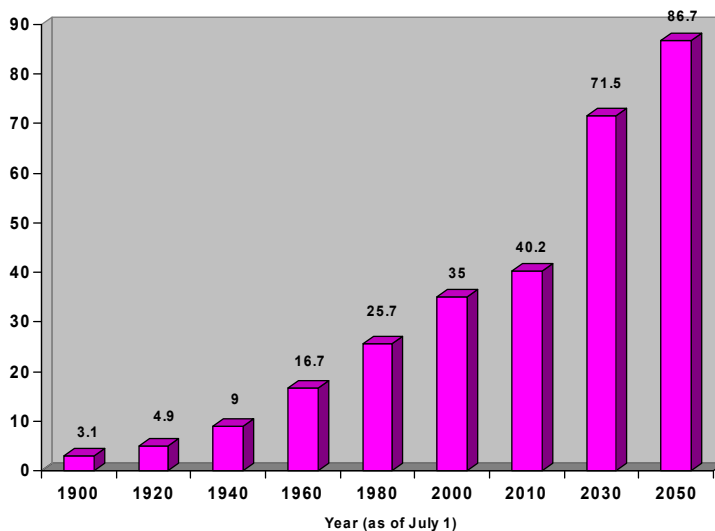


Fig. 1 : Number of Persons age 65 and over, 1900-2050 (Numbers in millions)

Source: U. S. Department of Health and Human Services. *Administration on Aging* (2006). Snapshot: *A statistical Profile of Older Americans Aged 65+, p. 1*. Retrieved January, 2006 from www.aoa.gov/PRESS/fact/pdf/Attachment_1304.pdf - 2006-04-05

The U.S. has had an exceptionally high rate of an older population—nearly 35 million of the population is 65 or older in 2005, increased from 3.1 million in 1900 to 31.2 million in 1990. By 2050, one in five Americans or almost 87 million of the population will be age 65 or over (U.S. Department of Health and Human Services,

2004b). During the period 2010-2030, the majority of the older population will be Baby Boomers (those born between 1946 and 1964) as they begin to turn 65 in 2011. Individuals age 85 and over comprise the most rapidly growing elderly group with approximately 4.2 million in 2000, nearly 42 times the number in 1900 (Federal Interagency Forum on Aging-Related Statistics, 2004). In 2005, women accounted for over 57 percent of the population age 65 and over and 67 percent of the population age 85 and over.

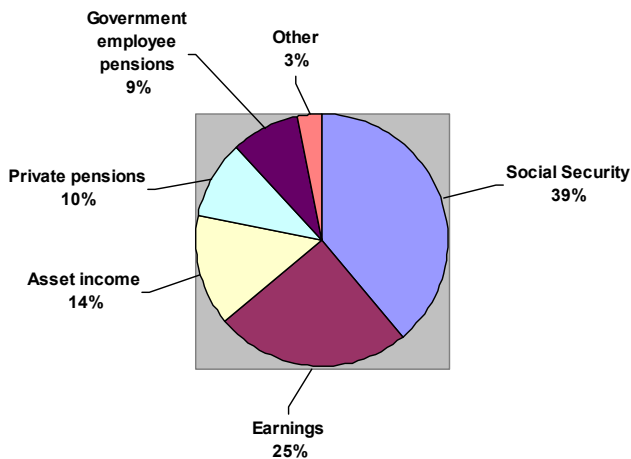


Fig. 2. Income of the Aged Population: Shares of Aggregate Income by Source, 2002

Source: Social Security Administration (2004). Fast Facts and Figures about Social Security, 2004. Office of Research, Evaluation, and Statistics. Washington, DC: SSA Publication (No. 13-11785), p. 6.

The U.S. elderly population has become more diversified. In 2005, non-Hispanic Whites made up about 81 percent of the U.S. older population (U.S. Census Bureau, 2005). Blacks consisted of just over 8 percent, Asians made up approximately 3 percent, and Hispanics (of any race) accounted for roughly 6 percent of the older population. However, the percentage of the older population among ethnic minority groups will more than double—from 17 percent in 2000 to 38 percent in 2050. The older Hispanic population is the fastest-growing ethnic group within the elderly population (U.S. Department of Health

and Human Services, 2003). The group is expected to be about 7 times larger in 2050 than it was in 2000 (13.4 vs. 1.8 million) and is expected to be larger than the older black population by 2028. This demographic trend will have important policy implications in areas of retirement income, health care, employment, housing, and community social services.

Poverty and Income among the Elderly

The rate of the elderly age 65 and over living below the poverty line significantly dropped from 35 percent in 1959 to less than 10 percent in 2005 (U.S. Census Bureau, 2005). In 2002, aggregate income for older people age 65 and over came primarily from six sources: Social Security (39 percent), earnings (25 percent), asset income (14 percent), private pensions (10 percent), government employee pensions (9 percent), and other (3 percent) (Social Security Administration, 2004). Social Security benefits have been the most common source of income. The proportion of the aged population with asset income was about 55 percent in 2002. Home ownership is the largest asset type, accounting for 78.5 percent of their median net worth in 2000 (U.S. Department of Health and Human Services, 2004a). Although private pensions accounted for only a small proportion of total income, they more than tripled their share over the 40-year period, from 3 percent in 1962 to 10 percent in 2002. The percentage of the aged receiving government employee pensions has increased from 9 percent to 14 percent. Strikingly, the proportion of seniors who received earnings was significantly diminished from 36 percent in 1962 to 22 percent in 2002. Nearly one out of three seniors (31.5 percent) earned less than \$10,000 in 2002—albeit in employment.

Multiple Disadvantages: Gender, Race, and Class

Despite a decrease in poverty rate in the general aged population, certain groups have faced multiple disadvantages and remain excluded. They tend to experience discrimination and encounter a “double jeopardy,” because of the combined effects of age, gender, race, and class. This applies, for example, to women, and in particular, to women of color and women without a spouse, to some minority ethnic groups, and to people living persistently on a low

income. They are more likely to be poor and to lack health insurance and less likely to receive adequate earnings.

It is the conventional interpretation that women tend to earn less than men and these gender differences are particularly pronounced late in life. In 2004, 12 percent of older women lived below the federal poverty line, compared with 7 percent of older men (U.S. Department of Health and Human Services, 2006b). In that same year, the median income for men age 65 and over was \$21,102, compared to \$12,080 for women. What is involved is cumulative effects of a relatively shorter work history of women and the economic, social, and political inequalities women face throughout their lives. As a result, a significant number of older women are left in poverty, isolation, and invisibility.

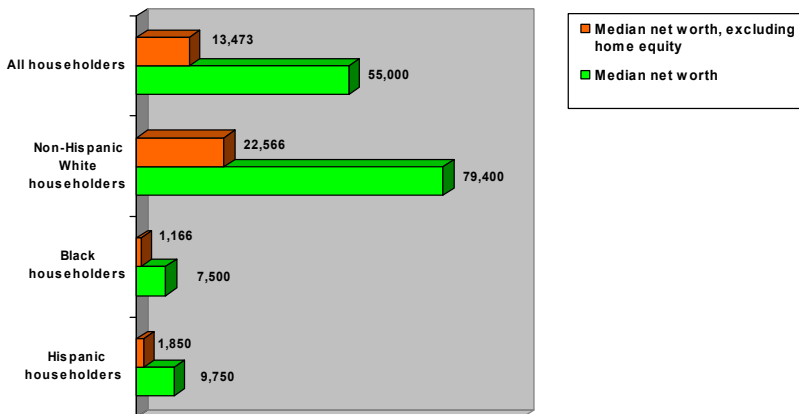


Fig. 3 Median Net Worth and Median Net Worth Excluding Home Equity of Households by Race and Hispanic Origin of Householder, 2000 (2000 dollars)

Source: U.S. Census Bureau (2003). Net Worth and Asset Ownership of Households: 1998 and 2000. U.S. Department of Commerce. Economics and Statistics Administration. Washington, DC, , p. 13.

Table 1
The population age 65 and over living in poverty^a, by selected characteristics, 200. (Percentage)

Selected characteristics	65 and over	65 and over living alone	65 and over, married couples	65.74	75 and over
<i>Both sexes</i>					
Total	10.4	19.2	5.1	9.4	11.7
Non-Hispanic					
White alone ^b	8.3	16.1	3.8	6.9	9.8
Black alone ^c	23.8	37.2	11.8	23.3	24.4
Asian alone ^d	8.4	23.4	6.1	6.9	10.9
Hispanic (of any race)	21.4	44.1	16.0	20.2	23.1
<i>Men</i>					
Total	7.7	15.6	5.3	7.7	7.8
Non-Hispanic White alone	5.8	12.1	3.8	5.6	6.0
Black alone	18.1	30.2	11.3	18.1	18.2
Asian alone	6.8	- ^e	7.1	4.9	10.6
Hispanic (of any race)	19.3	37.2	17.0	19.0	19.8
<i>Women</i>					
Total	12.4	20.5	4.9	10.8	14.1
Non-Hispanic					
White alone	10.1	17.4	3.7	8.0	12.2
Black alone	27.4	40.6	12.3	27.2	27.7
Asian alone	9.6	25.3	5.2	8.7	11.1
Hispanic (of any race)	23.0	47.1	14.9	21.2	25.6

Note:

- ^a The poverty level is based on money income and does not include non-cash benefits such as food stamps. Poverty thresholds reflect family size and composition and are adjusted each year using the annual average Consumer Price Index.
- ^b The term “non-Hispanic White alone” is used to refer to people who reported being White and no other race and who are not Hispanic.
- ^c The term “Black alone” is used to refer to people who reported being Black or African American and no other race.
- ^d The term “Asian alone” is used to refer to people who reported being Asian as their race. The use of single race population in this report does not imply that this is the preferred method of presenting or analyzed data. The U.S. Census Bureau uses a variety of approaches.
- ^e Base is not large enough to produce reliable results.

Growing income disparities among diverse ethnic groups still persist. The median net worth of older white households (\$79,400) is over 10 times greater than that of older black households (\$7,500) in 2000 (U.S. Census Bureau, 2003). Nearly one in four African American elderly age 65 and over lived in poverty, almost doubled the general aged population in 2002 (Federal Interagency Forum on Aging-Related Statistics, 2004). Black elderly women were at greater risk of poverty among all ethnic groups, almost three times more likely than non-Hispanic White women (27.4 percent vs. 10.1 percent) in 2002. Similarly, elderly Hispanic people face a high rate of poverty (21 percent). Substantial differences have also emerged in different household types. Nearly one in every five individuals age 65 and over who live alone lived in poverty in 2002 (19.2 percent). The poverty rate among women age 65 and over who live alone (20.5 percent) was nearly four times larger than that of married women at the same age group (4.9 percent) in 2002.

Social exclusion rooted in marginalization and cumulative disadvantages must be understood in implementing services and socioeconomic development strategies. Greater poverty gaps suggest considerable income disparities among certain population. A recent report from the Organization of Economic Cooperation and Development (OECD) (OECD, 2006a) revealed that the U.S. had the highest income inequalities among 9 countries and is the only country with larger income discrepancies among the elderly than the working age group¹.

This reflects the inadequacy of retirement income arrangements, further deepening already substantial inequalities existing in the course of an individual's employment.

Social Policies and Social Work Practice for the Elderly in the U.S.

Attempts to confront social exclusion are the focus of a wide range of social policies and social work practice in the U.S. They are directly or indirectly formulated in all major social policies. This section examines several policies and social services that are of particular importance to the elderly.

of income due to retirement, disability, or death of a breadwinner. Coverage is almost universal—nearly 96 percent of the jobs in the United States are covered (Social Security Administration, 1997). It is also a work-related, compulsory, and contributory program—workers finance the program through a payroll tax that is levied under the Federal Insurance and Self-Employment Contribution Acts. Social Security is a pay-as-you-go system in which today's workers and employers pay for today's recipients.

In December 2003, 47 million persons were receiving monthly benefits totaling \$470.8 billions (Social Security Administration, 2005). The majority of those beneficiaries were retired workers (63 percent), and 12 percent were disabled workers. The remaining 25 percent were spouses, children, survivors, or dependents of retired or disabled workers. In December 2003, of all OASI beneficiaries, 85 percent were aged 65 or older, with 8 percent of those aged 62-64. Among DI beneficiaries (disabled workers and their spouses and children), only 0.9 percent were aged 65 or older. In 2002, nearly 90 percent of the aged population received Social Security benefits (Social Security Administration, 2004). Additionally, Social Security was the key source of income for 66 percent of aged beneficiaries, providing at least 50 percent of total income, and it was the only income source for 22 percent. For older Americans in the lowest fifth of the income distribution, the receipt of Social Security benefits accounts for nearly 83 percent of aggregate income.

A major impact of Social Security is reducing the proportion of pensioners experiencing poverty. Social Security kept 39 percent of the aged population out of poverty in 2002 (U.S. House of Representatives, 2004). The poverty rate for elderly people was lower than that of the general population in 2002 (10.1 vs. 11.7 percent). As recently as 1969, before the inception of the Social Security cost-of-living adjustments (COLAs), the poverty rates for the elderly again rose sharply, doubled that of the general population (25 vs. 12 percent). It is widely accepted that along with other existing social benefits, Social Security has made a significant contribution to reducing poverty among the elderly.

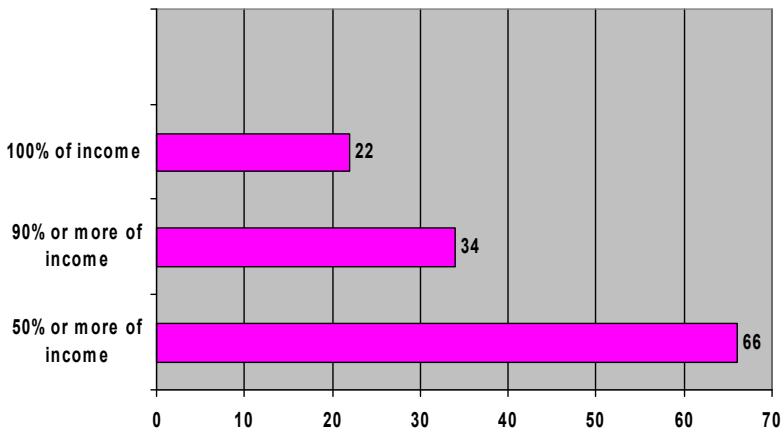


Figure 4. Reliance on Social Security, 2000: The Aged Receiving Social Security Benefits by Relative Importance of Benefits to Total Income

Source: Social Security Administration (2004). Fast Facts and Figures about Social Security, 2004. Office of Research, Evaluation, and Statistics. Washington, DC: SSA Publication (No. 13-11785), p. 7.

2. *The Supplemental Security Income (SSI)* is a means-tested, monthly cash payment for aged (at least 65 years old), blind, or disabled persons whose income is below a certain level (Social Security Administration, 1997). Unlike OASDI, it is a federally administered public assistance program funded through general revenue taxes. Federally administered SSI payments varied by age group, ranging from an average of \$491 for beneficiaries under 18 to \$344 for those 65 or older, with an average of \$417 (Social Security Administration, 2004).

In 2003, twenty-nine percent of the 6.9 million SSI beneficiaries were aged 65 or older, declined from 61 percent in January 1974. Women are the largest group and constitute 70 percent of the 2 million senior beneficiaries while accounting for 58 percent of total SSI beneficiaries. A portion of older people receives SSI in combination with Social Security. In 2003, more than 57 percent of SSI beneficiaries aged 65 or older also receive OASDI benefits. Other types of unearned income, such as veterans' pensions or income from assets, made up of 15.4 percent of

income of SSI beneficiaries age 65 or older. Only a small portion of their income is generated from earnings, about 1.4 percent. Because of the low level of benefits and the stringent requirements for eligibility, aged beneficiaries of SSI were raised to only 75.8 percent of the poverty threshold in 2002.

B. Medicare and Medicaid

Combating social exclusion is an important feature of health and medical care, notably through developing health promotion schemes for older people and enhancing access to a variety of health and support services, and facilitating the participation of consumers in the design and management of care packages.

1. Medicare is the second largest social insurance program in the U. S. The 1965 amendments to the Social Security Act established health insurance plans for persons aged 65, so-called “Medicare.” The major objectives of Medicare were to provide elderly people with prepaid hospital and optional medical insurance. The current Medicare system consists of four parts: compulsory Hospital Insurance (HI), or Part A; a voluntary program of Supplemental Medical Insurance (SMI), or Part B; the Medicare Advantage program, or Part C; and the Medicare Prescription Drug, Improvements, and Modernization Act of 2003 (MMA), or Part D. Although Medicare traditionally was made up of two parts (HI and SMI), Part C (established by the Balance Budget Act of 1997) expanded beneficiaries’ options for participation in private-sector health care plans. The MMA or Part D was added in 2003.

Unlike today’s younger workers with no universal health coverage, nearly all older Americans have Medicare as their primary source of health insurance. In 2003, more than 41 million people were enrolled in one or both of Part A and B (Center for Medicare & Medicaid Services, 2004). Medicare offers acute care, inpatient hospital care, physician services, skilled nursing facility care, and hospice services. Yet a number of cost-sharing aspects of Medicare leave almost half of health spending to be covered by other sources. Many beneficiaries have supplemental insurance to fill these gaps and to obtain services not covered by Medicare: an employer sponsored retiree health plan, private “Medigap” insurance, or Medicaid (if the person is eligible).

Table 3 :Pewcentage of Medicare enrolled age 65 and over who reported problems with access to health care, 1992-2000.

Reported Problem	1992 1999	1993 2000	1994	1995	1996	1997	1998		
Difficulty in obtaining care	3.1	2.6	2.6	2.6	2.3	2.4	2.4	2.8	2.0
Delayed getting care	9.8	9.1	7.6	6.8	5.5	4.8	4.4	4.7	4.8

Medicare has achieved important policy goals, such as providing greater access to health and medical care for the elderly people, preventing institutionalization, and contributing to user satisfaction. According to the Federal Interagency Forum on Aging-Related Statistics (2004), only 2.9 percent of older people enrolled in Medicare reported difficulties in obtaining health care services in 2000. Despite the important progress made in health care services, the limitations from a social exclusion perspective are still evident. A particular concern was heightened with a rapid increase in health care costs. Moreover, average costs were substantially higher for people with lower incomes, for people at older ages, and for people with multiple chronic conditions. There is also concern about the imposition of cost-containing features, precipitating more stringent requirements, and higher out-of-pocket costs for the elderly. Another area of concern relates to non-institutional social services for people who are chronically ill but not covered by Medicare. More progress should be made in areas such as improving preventive care for the elderly, developing a continuum of home- and community-based long-term care services, and addressing inclusive, universal health care coverage to all.

2. Medicaid is a means-tested public assistance program and offers medical and health related services for individuals and families with low incomes through direct payment to suppliers of the program. It is the largest source of funds for medical care and related services to America's poorest people, covering about 14

percent of the population (U.S. House of Representatives, 2004). Medicaid is a cooperative endeavor between federal and state government and hence it is financed by shared federal and state funds. Within broad federal guidelines, states determine eligibility standards and establish type, amount, and duration of services. Medicaid policies are, therefore, complex, and vary among states. Unlike Medicare, Medicaid is a means-tested program. Assets and resources are tested against established thresholds determined by each state. Yet states must cover “categorically needy” individuals (which usually include recipients of SSI and families with dependent children receiving cash assistance) and certain low-income Medicare beneficiaries.

Although almost half of the recipients of Medicaid are children, the greatest single outlay goes to the aged population. The elderly comprised 11 percent of all Medicaid recipients in 2002, but they made up approximately 26 percent of the Medicaid budget (Center for Medicare & Medicaid Services, 2004). Payment for long-term nursing home care alone accounted for 37 percent of the Medicaid budget. Medicaid has become the *de facto* subsidy for the middle class, covering elderly parents of current middle class who spend down their assets (Karger & Stoesz, 2006). States find this program a costly burden even with the federal government absorbing 50 to 83 percent of the cost. Medicaid has led to important gains in health promotion and health care utilization. However, there are also drawbacks that tend to have a disproportionate impact on the elderly prone to social exclusion. For example, important gaps exist in coverage for the elderly and disabled (i.e., limited long-term care) and in the low eligibility limits set for Medicaid coverage. Such weaknesses become even more apparent when states cutback in Medicaid coverage because of lower state revenues.

When older people are placed in health care settings being inactive is promoted and reinforced by younger staff who outline in many ways on how older people should behave. Older people avoid doing things when they are placed in nursing home/or hospital setting as they are unsure on how to behave. Attitudes of hospital staff will influence the way patients feel about themselves and can promote negative images. As older people avoid new activities they become less active. Their belief in the negative attitudes of the hospital

employees becomes a self-fulfilling prophecy. As they become less active they also lose self-esteem and become depressed.

C. Employment

Discrimination from employment and gainful activities epitomizes a key component of social exclusion. At one level, such exclusion relates to a lack of economic security and income adequacy in retirement. Such exclusion has impacts on both individual elderly and the communities where they live. At another level, there is growing recognition of the current trends underscored significance of employment opportunities for older workers: increasing life expectancy, rising financial strain associated with costs of living and health care, and mounting debates on the waste of human capital as a result of structural discrimination in employment based on age. The magnitude of the age discrimination is highlighted by recent statistics revealing that between 1977 and 2002, lawsuits awarding monetary benefits due to age discrimination in the workplace have exceeded an estimated \$861 million from 1992 to 2004 (U.S. Equal Employment Commission, 2007).

Employment and ageism: In general, it has been found that employers think that older adults are less productive, have less relevant skills, are resistant to change and new technology, are less trainable, leave employment sooner so that training them has a lower rate of return, and are more prone to absenteeism and ill health (Taylor & Walker, 1993, 1995; Tillsley 1990; Trinder *et al.*, 1992). Ageism and discrimination in recruitment is, therefore, evident in the widespread use of overt and covert upper age limits in job advertisements and in training and promotion opportunities, as well as exit policies.

To counter act, these beliefs a large body of industrial gerontological research argues that age is a poor proxy for performance (Doering *et al.*, 1983; Grimley Evans *et al.*, 1992). As a result, the aim of recent government-backed campaigns against ageism, and much academic literature, is being done to persuade employers that discrimination against older employees is not only irrational but also commercially damaging. An argument against ageism and discrimination against older workers can lead to a sub-optimum use of human resources, including a poor return on

investment in human capital. A second view from a broader labor perspective is the use of older workers as a contingent labor force or 'reserve army' to be drawn into the labor market as and when conditions demand. This has repercussion on the older adult employee for whom mobility to another job may not be feasible given the family commitments and having a settled lifestyle. In a research, students were asked to rate the employability and work performance of older adults. A majority of the students rated 'resistant to change' as one of the major problems of old age. Women faced 'double jeopardy' of age and sex, as aging women are perceived to be unproductive, ineffective, intellectually rigid and asexual and having a marked decline in job performance (Martens, Greenberg, Schmel & Landau, 2004). Ageist attitudes with regard to the labor market, early mandatory retirement can be perceived both as working for and against the interests of younger people. It may be viewed as enhancing the employment prospects of younger people, but at the same time, it has the potential to adversely affect dependency ratios.

The Age Discrimination in Employment Act (ADEA) of 1967, signed into law by President Lyndon Johnson on December 15, 1967, protects most workers from ages 40 to 69 from discrimination in hiring, job retention, promotion, terminating, and wages of workers. Since 1978, it has prohibited mandatory retirement in most sectors, with phased elimination of mandatory retirement for tenured workers, such as college professors, in 1993. The ADEA was later amended in 1986 and again in 1991 by the Older Workers Benefit Protection Act (Pub. L. 101-433) and the Civil Rights Act of 1991 (P.L. 102-166). The ADEA applies only to employers with 20 employees, thus offering less protection. An age limit may be legally specified in the circumstances where age has been shown to be a "*bona fide occupational qualification* reasonably necessary to the normal operation of the particular business" (*BFOQ*). In practice, *BFOQs* for age are limited to the obvious or when public safety is at stake (for example, in the case of age limits for pilots and bus drivers). Legislation to eliminate the "70 cap," applied to those who reach 70 and are not covered by the ADEA, has failed in Congress, despite reform efforts and the powerful advocacy by such groups as the American Association of Retired Persons and the Gray Panthers.

D. Social Services

Social services are another essential component of policies devised to cultivate social inclusion. It has a direct role in meeting the needs of older people and in helping the involvement of older people in mainstream social activities. The clearest expression is viewed in the Older Americans Act (OAA) of 1965, a primary source of social services for the elderly.

Older Americans Act (OAA) of 1965: Since the elderly comprises a larger segment of the voting population, they have attracted the interest of politicians more than other minority groups. On July 14, 1965 the Older Americans Act (OAA) was signed into law by President Lyndon Johnson. It established the Administration on Aging within the Department of Health, Education, and Welfare. Title XVIII covering Medicare and Title XIX covering Medicaid were also signed into law in 1965. The OAA was directed to providing older Americans with increased opportunities for participating in the benefits of American society. The objectives of the OAA encompassed: (1) an adequate income in retirement in accordance with the general standard of living, (2) the accomplishment of the best possible physical and mental health without regard to economic status, (3) the provision of suitable, adequate, and affordable housing, (4) opportunities for employment with no discriminatory personnel practices because of age, (5) the pursuit of meaningful activities in civic, cultural, and recreational opportunities, and (6) efficient community services that provide access to low-cost transportation and social assistance. The major government agency responsible for administration of programs is Administration on Aging (AoA), an agency of the U.S. Department of Health and Human Services (DHHS). The Act created an “aging network” at the federal, regional, state, and local levels. Nationwide there are more than 27,000 service provider agencies to provide the needed services and programs to the elderly. Notwithstanding its achievements of greater social integration, there are some concerns about the relatively low level of funding and vulnerable groups within the older population who are less likely to claim benefit entitlement than others (for instance, the oldest groups, ethnic minority groups, and older people in rural and deprived urban areas).

Conclusion

This present study critically examined government policies and social work practice responding to ageism and their impacts on social exclusion of older people in the U. S. Developing policies and social services to tackle social exclusion have been a crucial element of government interventions. Recently, more attention has been paid to this issue, largely emerging out of concern for a rapidly increasing aging population. The major policies and aging services to alleviate institutional barriers were highlighted and reviewed.

1. Implications for Social Policy in Aging:

The review of this study indicates that the impact of policies on social inclusion in the U. S. has been uneven. Policy has been relatively successful in combating certain types of problems that help eliminate stereotypes and myths about older people and age-related changes. Among the major successes are the decrease in elderly poverty, the rise in income among older people, the improvements of health and medical care, and the focus on dismantling age discrimination in employment. On the other hand, it has been less effective in mitigating inequalities and disparities, whose effects have been accumulated over the life course into old age. These experiences of marginalization and multiple disadvantages were more pronounced in groups, such as older women (especially, women of color), those with low income, and ethnic minority groups.

Despite the implementation of a broad array of policy packages, legal and practical supports for older Americans are still comparatively weak. Many would insist that there has been no comprehensive policy regarding the elderly and the diverse needs of the elderly have rarely been the predominant factor in decision-making. Moreover, U.S. policy has focused on poor elderly far more than it has on the elderly in general, and on antipoverty policy, stressing social assistance and means-tested benefits as its primary strategy with exceptions of Social Security and Medicare. Dire statistics reveal the immediate needs for comprehensive safety-net measures and social protection system for older people. Three types of policy development would be suggested:

- 1) Reforming social security and pension systems along with labor market measures: As the baby boomers move into retirement, escalating expenditures on social security will be likely to be

financed by taxes on a smaller number of workers. Public spending on Medicare is projected to mount even more rapidly. Furthermore, with insufficient average public pension entitlements, a current pension system is mainly characterized by strong link between earning histories and pension entitlements, all of which significantly widens income inequalities among the elderly. Reform efforts should be translated into three systematic objectives (OECD, 2006b): (1) the promotion of long-term financial maintainability of social security, (2) an adequate income in retirement, and (3) encouragement of older workers to carry on working. A large stride could only be made when such reform begins with labor market policies, such as providing incentives to alleviate existing early retirement or raising effective retirement age.

- 2) Strengthening measures to challenge ageism in the labor market: Eradicating barriers in the labor market requires effective actions by government, employers, and older workers, which addresses the full range of issues preventing older people from working. It is vital to expand the scope and quality of employment opportunities available to older workers. Carefully designed policies that allow flexibility in incorporating income from employment and pensions will more adequately enhance financial security for the elderly. Employers' personnel practices will also be key factors in determining the employment opportunities of older workers. Encouraging employers to participate more actively in adoption of anti-discrimination policies is not only a sound economic strategy, but also a good strategy in the long term. The U.S. could learn from recent development in France and Germany where employers have received subsidies to recruit and train older workers (Frerich, 1995; Taylor & Walker, 1993).
- 3) Developing comprehensive social protection agenda: A shift in emphasis from means-tested to universal entitlements is likely to be more effective and inclusive way of ensuring minimum standard of living for all older people. The full potential benefits of policies aiming at social inclusion will only be realized if proactive safety measures adequately address considerable variations and complex differences, not only between age groups, but also within elderly groups, particularly, those facing "double

jeopardy” who still remain excluded from key services and benefits.

2. Strategies to cope with Ageist Attitudes

One response to ageism that older adults have used is direct confrontational responses, such as retaliating directly to the offender or reporting it to the Equal Employment Opportunity Commission (EEOC). This stance can mitigate the effect of perceived discrimination on psychological distress because confrontation can alter the situation and reduce the sense of helplessness and victimization. However, confrontation might exacerbate the distress due to ageism because direct responding can contribute to instigation and escalation of conflict and hostile interaction. Also, confrontation may not be an option available to relatively powerless groups, such as visible minority immigrants. Serious outcomes can result, for instance, fear of losing a job, inadequate social support at work place, and lack of institutional sanctions for reporting ageist incidents militate against confrontational responses to ageism. Forbearing responses include passively accepting the experiences or not reacting may be the most viable method of recourse for older adults. Forbearance may reduce the association between ageist attitudes and depression because it might help to avoid direct hostilities. However, it could contribute to further distress because the situation is not altered and the sense of helplessness and victimization may be amplified.

Ageism can be dealt with in a number of ways, such as policy changes (Braithwaite, 2002), using the media to portray favorable images of the elderly (Palmore, 2001), with education about aging, and death, and with contacts with older adults. Another way to reduce ageism would be learning how to cope with the fears of our own aging and mortality. Research on death education has shown mixed results, as in some studies participants stated that their death anxiety was reduced and in another study death education brought about increased levels of death anxiety. Finally, there is limited research on the meaning and effects of ageism and its other forms of disadvantage and discrimination. There is paucity of research on people with cognitive impairments which would contribute to health care research.

At the macro level a way to reduce ageism may be to broaden our values in what makes life meaningful. In Asian cultures older adults are valued for their wisdom and close relationships with the elderly are respected (Gupta, & Pillai, 2002). The clearest conclusion is that a shift from Western values that emphasize rugged individualism and capitalism to collectivism where older people are appreciated will be one of the key hallmarks of social inclusion agenda of the aged for the 21st century.

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Footnotes

¹The nine countries studied were Finland, France, Germany, Italy, Luxembourg, Norway, Sweden, United Kingdom, and United States. To examine income inequality among different age groups, Gini measures were used for individuals using equivalised household incomes for working-age (18-64) and old-age (65+) groups. United Kingdom showed that the basic and means-tested pension elements indeed helped to reduce inequalities among the elderly. To a lesser extent, social protection systems in the Nordic countries also presented an equalizing effect, although income discrepancies there were already comparatively limited among the working-age group.

The Ageism Conundrum of Age Based Public Policy: Examples from the U.S.

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ABSTRACT

Ageism is the systematic stereotyping of and discrimination against people because of their age. Age discrimination can be positive (inclusive) and negative (exclusive). Ageism influences and is influenced by both positive and negative forms of age discrimination which in turn is related to age stratification and age segregation in a society. The dynamic tensions between these social phenomenon generates a policy conundrum. Age-based public policy, which is generally meant to positively discriminate on behalf of older adults, may support ageist assumptions about older adults. This paper looks at two examples of age-based policy in the U.S., related to employment/retirement and housing policy and their connection to ageism. Negative effects of both positive and negative forms of age discrimination are explicated along with recommendations for change. I argue that policy makers must be more conscious of this conundrum when designing age-based policies to prevent unintended support for ageist assumptions.

Key Words: Ageism, Age discrimination, Housing, ADEA, Employment

Ageism is defined as “the process of systematic stereotyping of and discrimination against people because they are old” (Butler, 1969). Implied in this view is a negative image of older persons. Older adults are thus believed to be unattractive, asexual, less intelligent,

unemployable, unproductive, senile, rigid in thought or manner, and/or old fashioned (Butler, 1969, Atchley, 2000). When a person acts on their ageist beliefs, they discriminate against individuals due to their age (Atchley, 2000).

However, age discrimination can be positive or negative (Kapp, 2001). In other words age may be used as a criterion for inclusion or exclusion. For example, if a grocer offers a 5% discount to senior citizens, this is a form of discrimination by age, but it benefits older adults, they are included. Many U.S. public policy programs (e.g. Medicare, the Older American's Act) originally or currently discriminate by age; one must be a certain age to be eligible. On the other hand, negative age discrimination reflects exclusionary tendencies e.g., refusing to hire older workers.

One can argue, however, that ageism supports both forms of discrimination by age. The key to ageism is that older adults are judged not as individuals but as members of a social category with certain traits (Quadagno, 2002). That judgment can generate both positive and negative consequences. Age discrimination and ageism are interlaced with each other but also with the tendency to divide our society by age strata with age-graded roles and opportunities (Atchley, 2000). Examples of age stratification can be seen in our educational systems, in employment and in practices of labor de commodification. Ageism and age stratification can also contribute to age segregation, the systematic limiting of interaction (social, physical and emotional) across age strata. Age segregation in turn reinforces ageism and age discrimination. In other words, the more a society focuses on age stratification, the more likely it is to segregate by age, which reinforces misunderstandings of individuals in other age strata and can lead to stereotypes and age discrimination.

This dynamic relationship between these social phenomena generates a policy conundrum. Age-based public policies may exacerbate ageist beliefs about older adults which may then generate the need for additional public policies to counteract negative forms of age discrimination. In this paper, I offer two examples of this in existing U.S. policy on employment/retirement and housing. The employment example demonstrates the relationship between age stratification and ageism. The second, from housing policy, provides an example of the connection between age segregation and ageism. In

both cases, I highlight the negative effect of discriminatory practices on both the elderly and society.

AGEISM AND AGE STRATIFICATION IN EMPLOYMENT/RETIREMENT POLICY

The Social Security Act was enacted in 1935 to respond to the widespread economic distress caused by the depression. The Act included provisions for unemployment compensation, aid to needy children, blind and aged, and child welfare and maternal health services (Derthick, 1979). However, the main provision related to older adults was that of Old Age Retirement Insurance. This program enabled eligible older adults to leave the labor force with an adequate income for their retirement. The emphasis on a retirement scheme as the major component of the legislation was useful during this time for several reasons. First, older workers could be more easily constructed as deserving of relief because they had worked all of their lives. Also given the greater number of physically challenging and labor intensive manufacturing jobs and higher rates of medical morbidity at that time, older workers as a class were more likely to have a harder time managing in the labor market. By giving them an adequate income, the government could decommodify these workers, thus freeing jobs for younger workers. And, they could reduce the elderly's financial dependence on family for income security once they left the labor market. In this way, older workers were an expedient political group. They were deserving due to their years of labor, their physical health status in relation to manual labor and the boost this would bring to the economy overall.

While granting access to economic security, however, this Act may have inadvertently increased negative stereotypes about older workers' capabilities and productivity levels (Koff and Park, 1999). This program reinforced negative stereotypes of older citizens as being dependent, vulnerable, and physically frail or mentally incompetent and unproductive. Given the type of labor market when the Social Security retirement program was created many older adults may have needed the release from the labor force. For many older workers, years of physically grinding manual labor in factories or construction certainly negatively affected their health status as they aged, making it more difficult for them to perform in such demanding work settings.

However, demographic changes in the U.S. began to render this image obsolete. First, medical advances reduced morbidity and mortality allowing people to live longer on average and with greater active life expectancy. Likewise, technological advances shifted the nature of work in the U.S. resulting in fewer physically demanding jobs in manufacturing (Akabas and Gates, 2006). Thus the idea that most older workers could not perform the tasks required in this technologically advanced economy grew outmoded.

In fact, research on older workers confirms that job performance is not necessarily affected as one ages. Studies have shown that older workers, on average, do not lack aptitude compared with younger workers, (Schwartz and Kleiner, 1999) plus they tend to be more motivated, loyal and have a solid work ethic. They also have been shown to be more willing to work flexible schedules and to offer valuable mentoring skills from invaluable years of experience (Lockwood, 2003).

However, cultural lag resulted in a slower shift in attitudes and beliefs about the elderly and their productivity in relation to employment, requiring government intervention to counteract negative age discrimination in employment. Although efforts had been under way since the 1950s to eliminate arbitrary age discrimination in employment, it wasn't until the late 1960s that legislation was officially enacted.

ADEA

Passage of the Age Discrimination in Employment Act in 1967 (ADEA, P.L. 90-202, 29 U.S.C. §§ 621-634, regulations at 29 C.F.R. § 1625) was influenced, in part, by the civil rights movement and by shifting morbidity and longevity patterns in the U.S. In fact, a provision in the Civil Rights Act of 1964 instructed the Secretary of Labor to study "the factors which might tend to result in discrimination in employment because of age" and to make recommendations for legislation to prevent arbitrary discrimination in employment because of age" (Civil Rights Act of 1964).

The Secretary of Labor reported in 1965 that there was widespread age discrimination in employment (U.S. Dept. of Labor, 1965). Age discrimination is based on negative stereotypes about older worker's productivity levels and abilities, rather than on dislike or

intolerance toward older workers, as is the case in racial discrimination (Querry, 1995-1996). The Labor report exposed the injustice of using group traits rather than individual abilities to judge a person's employability (Querry, 1995-1996). The report emphasized discrimination in hiring practices and mandatory retirement based on an arbitrary age limit (Frolik, 1999).

In passing the legislation, however, Congress went beyond the report by covering all employment practices. ADEA prohibits arbitrary age discrimination in hiring, termination, promotion, compensation, terms/conditions, and privileges of employment (Querry, 1995-1996). It also restricts employer's ability to "limit, segregate, or classify his employees in any way which would deprive or tend to deprive an individual of employment opportunities or otherwise adversely affect his status as an employee, because of age" (ADEA). Private employers with more than 20 employees, employment agencies, and labor unions, as well as federal employers are covered under this Act (Kapp, 2001). Originally ADEA made it illegal to discriminate in employment practices against employees age 40 - 65 (Tichy, 1991). This upper age limit was raised over time to 70 in 1978, and eliminated for all but academics in 1986 and for academics in 1993.

The explicit purpose of the ADEA stated in the Act's preamble was: "to promote employment of older persons based on their ability rather than age; to prohibit arbitrary age discrimination in employment; to help employers and workers find ways of meeting problems arising from the impact of age on employment" (29 U.S.C. § 621(b)). The implicit goal was to enable those older workers who preferred or needed to keep working to do so. It was not intended to mandate work for older workers or retirees.

Age discrimination is generally based on false assumptions about older workers capability rather than outright intolerance, which is the case in racial discrimination. Thus, Congress allowed for certain employer exemptions against an age discrimination claim. These include: 1) where age is a bona fide occupational qualification reasonably necessary to the normal operation of a particular business, 2) where the action is based on reasonable factors other than age (RFOA), 3) to observe the terms of a bona fide seniority system, 4) to observe the terms of a bona fide employee benefit plan, or 5) to

discharge or otherwise discipline an individual for good cause (29 U.S.C. @ 623 (f)) (Koff and Park 1999; Tichy, 1991).

In some cases age may be a factor in one's ability to safely perform the job, such as police officer or firefighter and can thus be used as a qualifying criterion for such employees (Kapp, 2001). Also employers can require medical exams for applicants over age forty but only when it is directly related to the specific work to be performed and when exams are required for all applicants regardless of age (Tichy, 1991). Under ADEA employers can use a reasonable factor other than age such as an individual's disability to hire, fire or promote employees, as long as age is not used as a proxy for the RFOA. Likewise, employers can promote a younger employee over an older employee due to greater seniority of the younger employee. In addition, the employer cannot establish a mandatory retirement system, but can legally offer a retirement incentive as long as it is voluntary (Kapp, 2001; Tichy, 1991). An employer is allowed to fire or refuse to hire/promote based on an individual's qualifications or actual job performance, but cannot use chronological age as a proxy for job performance.

Problems with ADEA abound. First, the act does not clarify the term arbitrary (Querry, 1995-1996). Second, ADEA has had little effect on hiring decisions as such discrimination can be very difficult to prove (Jolls, 1996). Third, Harper (1993) contends that ADEA and the Older Worker's Benefit Protection Act of 1990 do little to protect workers in relation to retirement incentives. Exit incentives can and have been used by employers "to defeat the intent if not the letter of the ADEA" (Frolik, 1999, p. 67). Employers offer retirement incentives as a way to reduce the workforce through attrition rather than forced layoffs. Older workers in most cases cost employers more for a variety of reasons (service time, higher health care costs, etc.). Thus it benefits the company more, to reduce the number of older workers (regardless of productivity levels) than to reduce the number of younger workers (Harper). "...Conditional age-based exit incentives can be used to achieve precisely what the ADEA seeks to eradicate: the age-based elimination of productive older workers who would prefer continued employment to retirement." (Harper, p. 69).

Finally, recent case law in this area has made it difficult for older workers to win a claim around the use of age proxies (e.g., years of

service) (Bailey, 2001; See *Hazen Paper Co. v. Biggins*, 507 U.S. 604 (1993)). In the *Biggins* case the Supreme Court held that age and years of service are “analytically distinct” and thus cannot necessarily be considered age-based. This decision has also enabled employers to use reduction in force strategies to eliminate older (and generally more costly workers) from their payrolls. According to Minda (1997) these strategies are largely immune to ADEA litigation as they are generally couched in economic necessity for the employer, and thus are considered “reasonable factors other than age”. Although there may be a correlation between age and seniority, pension status, or wage rates, the Supreme Court has ruled that these correlations do not always hold and thus are not age proxies (*Hazen Paper Co. v. Biggins*, 507 U.S. 604 (1993)). Such case law developments have made it increasingly difficult for older adults to sustain an age discrimination complaint in the face of downsizing, and cost-reduction strategies.

“Decisions in the wake of *Hazen Paper* have demonstrated simply that where there is a tenuous connection between the proxy and actual age discrimination, and the plaintiff fails to demonstrate that the employer’s explanation is unworthy of credence, the employer should prevail (in the absence of other evidence).” (Bailey, 2001, p.15) However, where the proxy has a direct connection to age, as in the case of Medicare eligibility, courts have found that this cannot be allowed as a reasonable factor other than age (RFOA) (See *Erie County Retirees Ass. V. County of Erie*, 220 F.3d 193 (3d Cir. 2000); Minda, 1997).

The intent behind this legislation was to promote a different construction of older workers as a class. In other words, assumptions should not be made about the productivity level of an employee simply due to chronological age, but rather the employee’s actual ability to perform the job should be the major relevant criterion. However, employers have long held different opinions about older workers some based on biased attitudes about productivity levels. The fact that an upper age limit was part of the original legislation speaks volumes to the degree that ageism infiltrated thinking in the U.S. at that time. Such attitudes still prevail, albeit to a lesser degree.

However, there is also an economic incentive to eliminate older workers which complicates the ageism argument. Older workers tend to cost employers more in terms of wages and benefits. Add to that a

technologically advanced industrial sector that requires much less skill, craft, or experience to complete job tasks, and older workers may become redundant. This scenario is bolstered by the fact that workers age 62 and over in the U.S. have an available source of income, through social security, if they leave (or are forced out of) the labor market. However, that income source has come under increasing scrutiny and criticism in the past few years. Opening the door for possible reduction in or elimination of this age-based program.

The U.S. and other western democracies are concerned about their ability to maintain entitlement programs such as social security in light of the rapid aging of the population. Such increased pressure on entitlements increases pressure to raise the retirement age or reduce benefits. Also private employment-based pensions in the U.S. are experiencing major financial shortfalls and many are filing for bankruptcy, thus eroding the private income that retirees will receive in the future. Likewise, health care costs continue to rise and recent policy changes in the U.S. have increased out-of-pocket expenditures for retirees in the Medicare program. All of these factors may generate pressure in the future for older workers to continue working to supplement retirement income. However, with ageism still rampant in the U.S., can older workers actually remain in the workforce? Will ageism come full circle in this vicious policy cycle? We started with the need to decommodify older workers to stimulate the economy and prevent their financial dependency. This, however, contributed to negative assumptions and stereotypes about older workers as a class, making it harder for older workers to maintain or obtain employment. Now the potential erosion of the social security benefit may mean that older workers will need to remain in the labor force longer than they have in the recent past. But ageism in our society will continue to make it very difficult for older workers to remain in the labor market. It is a conundrum indeed.

Americans with Disabilities Act: Added Protection Against Employment Discrimination

Until 1990 older employees who had adverse action taken against them (firing, failure to promote, etc.) due to RFOAs had little recourse (Hood, 1998). However, in 1990 Congress passed the Americans with Disabilities Act (ADA P.L. 101-336, 104 Stat. 327 (1990), 42 U.S.C. 12101-12213 (1994)) and this may help those older workers who are

terminated for health reasons. This would be the case whether age is used as a proxy for health status (e.g. as a bona fide occupational qualification) or whether health status alone is the “reasonable factor” given (Kapp, 2001).

The ADA (specifically Title I) prohibits public and private employers with 25 or more employees from discriminating “against a qualified individual with a disability because of the disability of such individual in regard to job application procedures, the hiring, advancement or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment. (42 U.S.C. § 12112 (a)). A disabled person is defined under the Act as one who either: 1) has an actual physical or mental impairment that substantially limits one or more major life activities; 2) has a record or past history of an impairment...; 3) is regarded as having an impairment... (42 U.S.C. § 12102(2)(A, B, C). A qualified individual with a disability is defined as a person “who can perform the essential functions of the job with or without reasonable accommodations” (42 U.S.C. § 12111(8). Such accommodations can include reassignment or restructuring of the job, providing special aids or training, and access to employer provided facilities such as cafeterias, lounges, and fitness centers (42 U.S.C. § 12111(8). The employer must provide these accommodations unless they can show that it would “impose an undue hardship on the employer” (Kapp, 2001; Hood, 1998).

According to Kapp (2001) and Hood (1998) an older worker with arthritis prior to ADA could be terminated under the “reasonable factors other than age” exemption of the ADEA. “Now, however, that same employer may be liable under the ADA if it could reasonably accommodate her arthritis on the job.” (Hood, p.8). Employers can no longer simply use health as either a BFOQ or a RFOA to fire or demote an older worker. Under ADA employers now have to explain why they could not accommodate the older worker’s health condition (Hood). (See www.eeoc.gov/docs/accommodation for further guidelines on the ADA.)

AGEISM AND AGE SEGREGATION IN HOUSING POLICY

The second example of a public policy conundrum related to ageism can be found in housing. There are two critical policies which support the concept of age segregation in housing policy. The first is

related to government subsidized housing for the elderly, referred to as section 202. The second, is the senior-only exemption of the Fair Housing Act Amendments of 1988. We will first look at government sponsored housing policy and then analyze the housing exemption.

Federal Housing Program

The first seniors-only housing program referred to as section 202 was created by the National Housing Act of 1959. This program focused on assisting the financially needy elderly who were independent and ambulatory. “While housing projects included some special features for older people, such as emergency call buttons, few services were tied to the complexes.” (Pynoos and Nishita, 2005, p.245) The program was not focused on providing nursing homes or other assisted living facilities. Rather, policy makers were more concerned with the economic need of many elderly who could not find affordable housing on their limited and fixed incomes. The rent for these units was (and is) subsidized, residents pay 30% of their income for rent and the remainder is paid by the program. Instead of folding low-income senior applicants into existing, age-integrated housing programs, a separate, age-segregated housing program was created.

Assumptions behind this age-segregated housing included: seniors preferred to live in age segregated environments; age segregated communities were safer for seniors; age segregated communities would provide quantitatively and qualitatively better opportunities for social interaction and mutual support on age-related issues like poor health or retirement (Nelson, 2003; Pynoos and Nishita, 2005).

The Fair Housing Act Exemption

The Fair Housing Act of 1968¹ prohibited discrimination in the sale, rental or financing of housing on the basis of race, color, religion, or national origin. The act’s purpose was to promote residential integration and reduce segregation especially by race (Nelson, 2003).² The Fair Housing Act Amendments of 1988 (FHAA, P.L. 100-430, 102 Stat.1619 (1988) 42 U.S.C. §. 3601-3619) also made it illegal to discriminate on the basis of disability and family status. Adding family status invalidated the “adults only” restrictions of many housing complexes (Kapp, 2001) which made it very difficult for families with children to find adequate housing in decent neighborhoods with

appropriate amenities. “Congress included familial status as a protected class because of evidence that housing discrimination against families was pervasive and often affected minority families disproportionately” (Nelson, 2003 p.4.). This practice was believed to be a smoke screen for racial discrimination.

However, the FHAA provided an exemption for senior housing defined as: federal or state housing designated by HUD as being designed for the elderly; “housing intended for and solely occupied by persons age 62 or over; housing intended and operated for occupancy by at least one person age 55 or over per unit. Under this third and least restrictive option, a housing complex had to meet 3 additional criteria: eighty percent of the units must be occupied by someone age 55 and over; management must publish and follow policies which demonstrate intent to provide housing for persons age 55 and over”; and housing complexes were required to show that significant facilities and services designed to meet the physical and social needs of older adults were provided (Kapp, 2001, p. 18; Napolitano, 1999; (42 U.S.C. § 3607(b)(2)(C)).

Many age-segregated condominiums, cooperatives, mobile home parks and other complexes, however, did not provide such services. Absent clear regulations on what “significant facilities and services” meant, the courts narrowly construed the exemption rule (Napolitano, 1009). This forced complexes to provide services or lose their exemption, resulting in increased condo/coop fees which were particularly problematic for lower-income seniors. Thus, housing and senior advocacy groups pressured Congress to rectify the problem. Congress enacted the Housing for Older Persons Act in 1995 (P.L. 104-76), which eliminated the facilities and services requirement and established a four-prong test to determine exempt status (Kapp, 2001; Panjwani, 1995). The test requires that the housing be intended and operated for older persons; 80% of units are occupied by at least one individual 55 or over; the provider has policies and procedures to show the housing is for older residents; and the provider complies with HUD regulations (Panjwani).

One problematic with section 202 and this exemption and the four-prong test is that it unintentionally reopens the door for “adult-only” apartment complexes in this case senior-only. Although senior-only housing is a positive form of age discrimination, because seniors

are included, does such segregation promote ageism? First, ageist opinions and attitudes held both by the general population and internalized by the elderly influence the perception that age segregation is a better condition under which to live and that it is preferred by most if not all elderly. However, if we replaced the word age with race, would we be so comfortable making this argument? By separating age groups in communities the everyday opportunities for interaction across generations are necessarily reduced. Such interaction is essential to the development of understanding and awareness of diverse groups. The critical questions are: by maintaining segregation do we support ageist attitudes/beliefs (e.g. older adults are old fashioned, set in their ways, don't like children and teens, etc.); by reducing interaction across generations do we generate additional misconceptions and false assumptions due to lack of contact?

Another problematic with the exemption affects older adult grandparents/relatives raising their grandchildren/other kin. Increasingly the U.S. is seeing grandparents and other older relatives play a much larger role in the upbringing of children. In many cases grandparents become the sole caregiver for the child (children). "More than three million children in the U.S. live with older relatives, and in at least one million homes a grandparent is the sole or primary caregiver." (ABA, 1998). A grandparent or other older adult surrogate parent who resides in senior-only housing can be evicted if their grandchild/niece, etc., comes to live with them due to the senior-only exemption.

This can affect them whether they live in federally subsidized housing or in private senior-only housing complexes. Ironically, this is more likely to affect African American and Hispanic older adults. Data from the U.S. Census show that 4.2% of white children under age 18 lived with a grandparent while 13% of African American children and 7.5% of Hispanic children lived with a grandparent (U.S. Census, 2000 as cited in Nelson, 2003). The emotional, physical and financial stress of moving can be very difficult for an already stressed family unit in these circumstances, given that the majority of grandparent caregivers are single, female and low income. Interestingly, the overall intent of the FHA and its later amendments was to increase residential integration by race, disability status and family status. However, by maintaining age segregated housing we may further exacerbate other

forms of segregation and housing discrimination, especially by race, not to mention, complicating difficult kinship care situations.

Furthermore, the focus of the original federal elderly-housing program and the elimination of the significant services and facilities requirement for senior-only housing complexes combines ageism with ableism. Until passage of the ADA heightened our awareness of ableism, many senior-only communities had strict policies about seniors with disabilities residing in the complex. Persons with disabilities, including older adults', housing rights are protected via the ADA (Titles II, public services, and III public accommodations), Section 504 of the Rehabilitation Act (29 U.S.C. § 794) and the FHAA which made it illegal to discriminate in the sale, rental, terms, conditions or privileges of sale/rental or in the provision of services or facilities because of a handicap of the buyer/renter, someone intended to live in the property, or someone connected with that buyer/renter (Kapp, 2001). Individual home sellers and owner occupied buildings with four or fewer rental units are exempt from the policy. The FHAA focuses on the denial of residency or placing conditions on residency, refusal to make reasonable accommodations to policies, practices, and services, and refusing to allow residents to make reasonable accommodations to the dwelling or common areas to allow a person with a disability to have full enjoyment (U.S Dept. of Justice and Dept. of Housing and Urban Development, 2004).

The FHAA may be applicable in cases where independent living complexes or communities refuse to rent to seniors in a wheelchair or with other disabilities. Several courts have ruled that tenant selection standards even in senior housing can not exclude seniors with a disability (U.S. v. Cisneros, 818 F. Supp. 954 (N.D. Tex. 1993)). "Because FHAA extends coverage to almost all multifamily dwellings, both Independent Living Communities (ILCs) and Assisted Living Communities (ALCs) fall under the scope of the Act and are therefore in violation of the Act if the resident selection process considers the existence of a disability." (Ziaja, 2001, p. 4) Providers may be exempt from this policy if they can show that the discriminatory policy is fundamental to the nature of the facility and such a change would instill an undue burden related to accommodation on the facility.

Finally, the FHAA may also prohibit certain state or local regulations (e.g. zoning and fire safety codes) which restrict certain

types of housing operators from admitting residents with certain disabilities. For example one federal court found on behalf of a plaintiff who applied for admission to a public housing authority apartment. She was denied an apartment due to her “inability to live independently”. The court found that this provision violated the FHAA (Cason v. Rochester Housing Auth., 748 F. Supp. 1002 (W.D.N.Y. 1990); Ziaja, 2001).

Age segregation as a housing policy is problematic for several reasons. First, it may promote ageism by reducing intergenerational interaction. Second, the idea that independent seniors don’t want to live around less-ambulatory older adults only reinforces ageism. It is a form of internalized ageism where the older adult is avoiding an image of older adults who are viewed as less valued. This fear of being around someone who is “less able” is supported by and endorses many negative stereotypes that comprise ageism (e.g., unproductive, incompetent). Further, age segregated communities are less able to adapt to changing societal needs such as the increase in grandparents raising grandchildren.

CONCLUSION

There are no easy solutions to these policy conundrums. I would argue that we may have greater flexibility in altering housing policy. First, a focus on universal design in new construction and rehabilitation of existing housing, holds tremendous promise in terms of making housing safe and accessible to all regardless of ability (Pynoos and Nishita, 2005). This could enable integration of housing complexes for all types of people. We can continue to support the economically needy elderly by expanding existing housing voucher programs, enabling them to find affordable, decent, and safe housing. Of course housing integration is a very sensitive topic and these changes would not be easy to make. It would require major cultural reprogramming to open minds to the benefits of residential integration (whether by age, race, ability, etc.).

But if we were to eliminate all age-based policy what might we be looking at? If we eliminate the age-based component of social security benefits, what would happen to those older workers who cannot continue to function adequately in the labor market? We could potentially expand the existing social security disability benefit and

apply it to all age groups in order to cover those older workers who are no longer able to contribute in the labor market. The dilemma for this option is that such a program would be much more expensive to administer (due to subjective functional eligibility assessments). Program efficiency would plummet, running the risk of increased cost for the program or at best the same costs to cover fewer people. This might erode support for the program or it might increase stigma attached to the program recipients. The other dilemma is that until we eliminate ageism in society we continue to run the risk that older workers (no matter how able) will be discriminated against in the workplace.

In this article, I have shown how both positive and negative age-discrimination in public policy can support ageism. It is not my intention to argue that age-based public policies should be eliminated. Rather, it is my goal to highlight the potential that policy has in supporting ageism either directly (negative discrimination) or indirectly (positive discrimination). Policy makers must consider this conundrum when designing or enacting policy to proactively prevent the continuation of ageism.

I am also not suggesting that public policy is the sole contributing factor to ageism. On the contrary, ageism is a social construction that is generated by, but also embedded in the people and structures of society. So we must work on a cultural level to counteract ageism as well. However, if we continue to employ age-based public policy without consideration of the potential to support ageism and the prospects of unintended consequences, we may never escape the vicious cycle.

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Endnotes

- ¹ Originally Title VIII of the Civil Rights Act of 1968
- ² FHA was amended in 1974 to include sex as a protected class (Nelson, 2003).

Ageism and Modernization in Contemporary China

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ABSTRACT

Improved nutrition and expanded access to health care have triggered a global increase in life expectancy. By the year 2040 demographers expect there to be 400 million elders in China (Jackson & Howe, 2004). This paper addresses the relationships between age, ageism, and modernization focusing on the case of contemporary China. As China experiences its rapid rise into modernity it could face considerable social and cultural challenges in regard to its large aging population. We discuss how China can potentially bridge the gap between the economic requirements of a technologically sophisticated economy and ongoing cultural heritage and necessity of honoring ones elders.

Key words : Age, Ageism, Modernization, Cultural challenges

Improved nutrition and expanded access to health care have triggered a global increase in life expectancy. This spike means that greater numbers of older adults continue to live healthy and productive lives—often well into their eighties. In the 21st Century, later adulthood can be a healthy, productive, and satisfying time of life (Baltes & Carstensen, 1996; Diener, Diener & Diener, 1995). These improvements, though, are often undermined by a widespread ageism that has an ongoing negative influence on how older people perceive themselves and are treated by others (McConatha, Volkwein, Schnell, Leach & Riley, 2003). Prejudice and discrimination against older adults, ageism — (Butler, 1989) is similar to racism and sexism. If

one lives long enough, he or she may well become a target of age discrimination.

In the past, the percentages of the general population over the age of 65 have been higher in Western societies, a statistic that reflects better nutrition, health care, and sanitation available in technologically advanced nations. In the next 50 years, however, dramatic demographic and life style changes are expected to take place in many parts of the non-Western world. By the year 2040, for example, demographers expect there to be 400 million elders in China (Jackson & Howe, 2004). Many of these elders may lack access to health care in a society that, up until recently, held the Confucist's idea that "...a person should respect their elders and that the older one is, the more respect one deserves."¹

Contemporary China presents an example of the positive and potentially negative consequences of modernization. In many ways, modern China is a contradiction. Since the late 1970s, China has experienced a remarkable economic growth—roughly 7% per year. Although the economic changes brought on by the boom have in many ways improved the lives of Chinese citizens, the dramatic growth has not resulted in a concomitant growth in the job market. This disconnect has partially devolved from the realities of doing business in state owned enterprises, which have had to close or downsize, which, in turn, means that they have had to lay off millions of workers. Older workers are really caught in a bind, for once they have been laid off, these workers are often denied long promised pensions and health care support. These losses have a negative impact on the quality of their lives in later adulthood.

Such treatment of elders in a place like China flies in the face of modernization theory. Cowgill (1986) has suggested that a systematic relationship exists between aging and modernization. According to this theory, people in less technologically advanced societies, who tend to be considered "old" at a younger age, tend to wield more economic and social power than do older adults in more industrialized countries, (Cowgill, 1986). As China experiences its rapid rise into modernity it could face considerable social and cultural difficulties in regard to its large aging population. How can one bridge the gap between the economic requirements of a technologically sophisticated economy and ongoing cultural heritage and necessity of honoring ones elders?

The connection an expected sharp rise in the population of Chinese elders to the social and economic side effects of its transition to a modern society may well result in additional complexities: job loss, a dip in status, and a decline in pensions and health care benefits. In such a climate, one can anticipate a parallel growth in the fears and anxieties that are common in contemporary industrialized societies. In fact, this dilemma of rapid modernization may result in a crisis which must be faced by China's elders.

Aging in the Middle Kingdom

Overall population growth in China is expected to show a concomitant rise in the number and percentage Chinese elderly. The number of people over 60 in China exceeded 90 million at the end of 2001, accounting for about one half of Asia's over-60 population and one fifth of the world's total, according to the report from the Chinese Academy of Sciences. Experts have urged relevant sectors of Chinese society to take measures to improve social welfare and medical care systems for senior citizens. As in the United States (US), the burden of care for this group is being magnified by the expanding number of two earner families thus reducing the at home care now available. Again, as in the US, the community and institutional facilities needed to help ease this burden are currently inadequate.

More than 70 percent of China's seniors are financially supported and looked after by their families and less than 17 percent of them enjoy pensions, with the number decreasing. About 70 percent of seniors are concentrated in rural areas and almost wholly depend on support from their children because of the lack of a social welfare system for older people in rural regions. Those who are childless or do not live with their children make up 25.8 percent of the total elderly population. In Beijing, the rate is 34 percent. These people and those not being cared for by their families may be a heavy burden on the economic resources of the nation as it begins to invest in infrastructure development (McConatha, 2004). The New York Times recently reported "The government, state banks and companies and foreign investors collectively spent \$200 billion in the first 11 months of last year on basic infrastructure projects, one quarter more than they spent in 2001, according to the State Statistics Bureau. That represents about 15 percent of China's gross domestic product, or about the proportion that the US spends on health care (NYTimes, January 13, 2003).

Statistics also show that the number of Chinese people older than 60, about 11 percent of the country's current population, is increasing at a rate of 3.2 percent per year. The vice-minister of Civil Affairs, Li Baoku has stated that this huge aging population brings various social and economical problems to China that must and will be addressed. According to Zhang Wenfan, president of the Chinese Old-age Association "the elderly will be a big burden for China through the year 2050 when that population will reach 400 million, accounting for 25 percent of the total"(Beijing Times, August 21, 2002).

Given these statistics, China aims to gradually set up a series of networks for the aged, including social endowment assurance programs and a looking-after service by 2010. But the honor accorded the elderly in China can and should be an object lesson to the US. Many gerontological experts in China agree that respecting and providing for the elderly is a traditional virtue of the Chinese people and will be continued. But help will be needed. China plans to support its aging population through a combination of family programs and a modern pension system. Nevertheless, based on experience in the US and elsewhere around the world, ageism may develop into a pernicious issue in China as the society modernizes. With regard to the rising electronic global village, it may be possible to assist China in its process of modernization through the selective and careful application of technology, particularly through the use of the Internet and other electronic media designed to help the elderly maintain their elevated status (McConatha, McConatha & Dermigny, 1994).

Ageism

China does not have a history of ageism. In fact most Asian nations have had a long history of honoring their elders and pride themselves in the veneration shown to their "Honorable Elders" (see Palmore, 2001; McConatha et al., 1991). As modernism becomes a part of the daily lives of the people of a new China it is possible to forecast a dramatic change in this ethos that may result in increased ageism and negative stereotyping.

Age is, of course, both a biological and social classification. It helps organize an individual's self-image, identity, and social role expectations across the life span (Crawford, Bryan & Luszcz, 2000). Attitudes towards aging provide a framework for understanding one's own aging experiences as well as providing a template for age grading

of a society's older adults. Studies have found that children and young adults often have negative perceptions of ageing, these negative attitudes tend to emerge from ageist stereotypes (Hepworth, 1995; Hamilton & Sherman, 1994).

Ageism has been found to be widespread around the world. As a set of beliefs and practices, ageism fosters a biased way of understanding older men and women and the aging process (Butler, 1989). Negative views of aging are systematically internalized. They influence self-image and increase fear and anxiety associated with one's own aging. Images equating youth with positive physical and psychological attributes are prevalent in contemporary societies, whereas positive images of older men and women are still scarce (McConatha, Schnell, & McKenna, 1999).

Changes in lifestyle, improved health care, and increased life expectancy have resulted in an increasing number of older adults who have challenged the traditional images of old age. However, studies indicate that older adults continue to be perceived as depressed, unattractive, ill, disabled, lonely, deteriorated, and even ready to die (Haught et al., 1999). These images reinforce societal attitudes that "old age" is something to be denied and feared. Comparing the aging self to the culturally constructed ideal of youth can result in a diminished self-image (Dumas, Laberge & Straka, 2005). Studies focusing on women's self concept, for example, have found that once women are no longer perceived as "youthful," they are more likely to develop negative attitudes about themselves and anxiety about aging (Dumas, Laberge & Straka, 2005). Considering her personal aging experience, Simone de Beauvoir (1972) explored ageism and its classic influences on the process of aging. In her book, The Coming of Age, de Beauvoir writes poignantly about the painful ways in which widespread ageism negatively influences self-image.

While there are a number of ways in which people attempt to maintain a "youthful" self, eventually the signs of age catch up and it becomes impossible to deny the aging process. When the physical signs of aging become impossible to ignore, people then may attempt to distance themselves psychologically from their own aging. When faced with images of older adults they tend to think, "I will stay young, at the very least on the inside." Andrews (1999) refers to this obsession as "trying to pass". "Trying to pass" triggers even more

aging-related anxiety and frustration because it is a battle that ultimately cannot be won. It can result in spending the last years or even decades of life in denial.

Aging and Anxiety in Other Cultures

Lasher and Faulkender (1993) have discussed anxiety and fear about aging as contemporary worldwide cultural phenomena. Perceived differences between older and younger people cannot be reduced to biological differences alone. These differences are socially and culturally constructed; they are reinforced through a culturally constructed system of values and beliefs. Although negative views of “old age” and the aging process are pervasive, culturally specific factors influence these. Cross-cultural research can help explain the importance of culture as an essential ingredient in understanding social behavior (Singelis, 2000). Significant differences tend to exist between Western and non-Western societies; however, a studies have found that even a comparison of attitudes toward aging in two Western countries such as Germany and the U.S. also yields many differences.

There are considerable sociological similarities that link Germany and the U.S. There are also significant cultural differences as well. German companies, for instance, can publicly state that they will lay off workers older than fifty-one years of age. The German media portrays the increasing number of older adults as a threat to the well being of society. This portrayal fuels potential intergenerational conflict. A popular German weekly ‘Die Woche’ even featured a headline “War to the Old” (October, 1995). Another weekly magazine (*Focus*, June 1996) summarized discussions about pensions and long-term insurance with the headline “Old Against Young: How the Old Steal the Future From the Young” (Thimm, Rademacher, & Kruse, 1998). Such media coverage is likely to reinforce negative views of aging and further promote negative stereotypes of older adults.

Germany also faces one of the steepest declines in birth rates of any advanced nation (Cockerham, 1997). By the year 2040, there are expected to be 56 people over the age of 65 for every 100 people between the ages of 20 to 64. This proportion is considerably higher than in the United States. As the German population continues to “age” a growing number of older men and women will become eligible for old age benefits, increasing pressure on the government to

continue to provide extensive services to an increasingly larger segment of the population. Germany has a comprehensive system of social welfare system based on a history of paternalism dating back to the 1880's and the social policies of old imperial Germany. Germany was the first country to introduce a system of universal health insurance and old age pensions in the late 19th century (Cockerham, 1997). The current system in Germany creates a readiness on the part of its citizens to claim and use the welfare benefits to which they feel entitled (Smith, 1987). A welfare society rests on the assumption that the gainfully employed support those who are unable to work. This social contract, however, can only be sustained if the labor force can support the increased number of retired people.

In the U.S. the arguments over Social Security benefits have often employed highly negative images of older people as "Greedy Geezers". However, recent studies in the United States indicate that only a small percentage of people, 13% of three thousand people between the ages of 18 and 64 who were questioned believe that older men and women have too much power (Hemphill, 1995; Reinemer, 2001). By contrast the majority of people surveyed indicated that older men and women are not "Greedy Geezers" using up resources. In fact they stated that rather than cut services, Medicare should expand to pay for long term care (Reinemer, 2001).

Aging is often associated with physical and psychological decline as well as the psycho-social variables above and thoughts of aging can result in considerable fear and anxiety. Lasher and Faulkender (1993) define aging anxiety as "combined concern and anticipation of losses centered on the aging process". Fear and anxiety about the aging process can begin early in life. Mosher-Ashley and Ball (1999), for example, explored the attitudes of college students toward their own aging and older adults. In comparing the attitudes of business, psychology, occupational therapy, and nursing majors in the United States, they found that although older adults were seen as knowledgeable and enjoyable to be with, they were also perceived as having physical problems and being dependent on others.

In a similar study in Nigeria, Baiyewu et al. (1997) explored caregiver attitudes who lived at home with an older person. Overall, Nigerians in the general population tended to have positive attitudes

toward older adults, however, caregivers had the most positive views; while hospital workers had the poorest. The researchers concluded that negative attitudes toward aging are less relevant for those who are emotionally close to an older person. Thus the quality of the contact with an older person appears to be influential in determining attitudes toward aging. Schwartz and Simmons (2001) suggest that attitudes toward older adults may be improved by ensuring favorable contact conditions.

Similar to China, Turkey is also a country in transition. Contemporary Turkey has struggled with industrialization and modernization and the aging population has not received significant research attention. Turkey has, until recently, had a “young” population (Imamoglu & Imamoglu, 1992). Given the recent increase in the older adult population, however, there is a need address factors that effect the aging process in Turkey. According to World Fact Book (July 1998 estimation), 31 % of the population of Turkey is between 0-14 years, 63% are between the ages of 15-64, and only 6 % are over the age of 65. Current life expectancy in Turkey is somewhat comparable to the US, 72 years for men and 75 years for women. Turkey tends to be a traditional, Islamic culture, with a collectivist orientation (Aykan & Wolf, 2000), a society which focuses on close-knit family relationships. Like in many countries, children or other relatives are expected to provide for the needs of older adults. Despite recent social change and an increase in urbanization, parents continue to support their children often well into adulthood. By the same token, children continue to emphasize respect for parents and to assume responsibility in caring for them in old age (Imamoglu & Imamoglu, 1992). An extended multi-generational family has generally been considered the ideal family in Turkey (Sunar, 1988).

Studies that have addressed attitudes toward aging in Turkey have found conflicting results. Imamoglu and Imamoglu (1992) studied the life situations and attitudes of the Turkish older adults in relation to the age and gender of the respondents. They compared Turkish respondents with those of a comparable Swedish sample. In the Turkish sample, the researchers included 166 females and 282 males, with a mean age of 62.4. Surprisingly, Turkish respondents, although they reported more frequent contacts with family and other social connections, expressed more negative attitudes toward aging. They

also felt lonelier and less satisfied with their life than the Swedish sample. As a consequence, contact with older family members may decrease somewhat.

Bacanli, Ahokas, and Best (1994) explored stereotypes of older and younger adults in Turkey and Finland. Turkish respondents reported shorter life expectancies and defined "old" as occurring at an earlier age than Finnish participants. Women in both countries also reported lower life expectancies than actual life expectancies. Men's life expectancies were more realistic. The researchers suggested that compared with men, women appeared to be less optimistic about getting older.

There are significant cultural differences between Turkey and the United States, which extend to attitudes towards aging and older adults. Although changes noted previously are beginning to take place in Turkey, studies would indicate that older adults still hold considerable prestige and are valued and respected. They also tend to have somewhat more intergenerational contact and closer extended family relationships than in the United States (Aykan & Wolf, 2000 & Bacanli et al., 1994). However, education and contact appears to have a significant influence on attitudes toward aging. Educational institutions in the United States have provided extensive education programs on aging and gerontology. Young adults have the opportunity to learn about the aging process and gain more realistic views about later adulthood. These programs have not yet been offered in Turkey.

The results of a recent study of attitudes about aging in Turkey and the U.S. (McConatha et al., 2004) support the notion that ageism still appears to be widespread. This study focused on a comparison between young and middle-aged adults from the United States and Turkey. Significant between country differences were found with regard to attitudes toward aging. Given the collectivist nature of Turkish society and the fact that older adults tend to have higher status in that society, it was anticipated that Turkish participants would have fewer concerns about the aging process than participants from the United States. Surprisingly, however, Turkish participants appeared to be psychologically more concerned about aging. This concern may well evolve from the social and economic transitions taking place in contemporary Turkey (Gerlin, 2002). Sunar (1988) discussed two

conflicting themes which emerged in Turkish students' views about their older family members. The first focused on more positive attributes such as respect, gratitude, affection, and responsibility. The second tended to be more negative and focused on impatience with their dated ideas and attitudes. These negative views may increase as the older adult population increases, unless economic circumstances improve and more realistic views of the aging process are presented through education programs.

There are, as of yet, few countries in which extensive education programs are geared toward increasing awareness of the aging process. There are also few education and social service programs in place to help meet the needs of older adults. Lack of access to accurate aging related information can result in increased fear and anxiety of aging and concerns about later adulthood. As the population of older adults grows around the world, it will become increasingly important to address concerns regarding aging and the needs of older adults in order to avoid an epidemic of "ageism". (McConatha et al., 2004).

Contradictions of Modernization:

The process of globalization will play an increasingly important role in how aging and older adults are viewed. The global economy and technological advancement will, in many ways, help define aging and attitudes towards older men and women in the 21st Century. Changes in roles and attitudes are likely to influence the entire developmental process and extend to the arenas of employment, health care, lifelong learning, and social services in many developing countries as well as in developed nations (Weaver, 1999; McConatha, 2002).

Changing social structures are also likely to create new opportunities for older adults. For example, older adults can play an important role as educators. Increased life expectancy and changing demographics are also likely to create new concerns for an increasing older adult population. Some studies have suggested that more collectivist countries which have previously held their elderly in high regard may begin to experience ageism as a result of diminishing resources (McConatha et. al. 1991)..

China faces many challenges as it turns toward an emblem of the modern nation state. As the younger population continues to expand and the number of available workers grows, the number of older Chinese leaving the work force will increase. Well before the second half of this Century, the number of elders in their 6th and 7th decade will triple. The 80+ population will expand eightfold to 100 million individuals (Future Watch, 2004). However, 20 years before this happens, there will be a sharp decline in the number of working age adults creating a dependency ratio in the later half of the 21st Century that has yet to be seen in modern times, dropping from a high of 8:1 in 1980 to less than 2:1 by 2040. Within a single generation “....this transformation that took the United States and Europe 150 years to experience, will occur in China in just one generation.” (Jackson & Howe, 2004)

The causes of this “time bomb” are clear: Falling fertility rates (less than 1.0% in some major cities) the one-child policy and growing affluence. What is not set in stone are the ways in which various segments of Chinese society will respond to these abrupt changes. Among the issues and institutions most affected by these shifts are Chinese attitudes toward the elderly, the family and other informal caregivers, the social status of the elderly, retirement programs, and of course, health care.

Modernization theory predicts a fall in status of the elderly as society advances. In China however the strong tradition of Confucianism may require a rethinking of both the theory and the role of the elderly in a modern society. As technology advances and tools for living and working transcend the physical limitations set in the past by bio-physical changes in the body, there may well be a continuation of the high status of older Chinese family members. Certainly there will be more older individuals using the tools that today seem linked to youth cultures as these “children” will be the very ones making up the youthful lower end of the aging spectrum by 2050.

One consequence of the growth in the dependency ratio will be the increased burden upon families and other informal structures to help sustain and care for this expanding population. As we have seen in Japan in the last two decades, the number of two income earners required to support families in many modern economies leaves little

time for family home care (McConatha et al., 1991). This will leave many elderly Chinese at the mercy of local, provincial or national programs. Most researchers do not see these entities stepping up to the plate to address this problem.

Much of the status of the elderly has to do with societal attitudes toward the population. Attitudes may indeed remain stable as mentioned above, but the government might be wise to consider undertaking systematic programs to assure that this is the case. Without an enduring high regard for the oldest in the society, China may be faced with the necessity of creating a U.S. like Medicare program to care for these individuals in order to circumvent the extraordinary costs associated with national care for an elderly population abandoned or ignored by family members.

Early during this rapid growth of elders in the population, retirement programs must be reconsidered. As mentioned at the outset, the decline of state supported pensions has created an immediate problem for the Chinese. There are solutions, however. Privatization of pensions and contributions by companies can offset some of this problem. If private companies do not create (or at least contribute to government run) pension programs, the situation in China will become dire. As it modernizes and privatizes its economy, it is essential that the unfunded liabilities of dealing with 400 million senior citizens be addressed head on.

And finally, as with the United States, health care is a major problem of the 21st Century. With China expecting to have 30 percent of its population over 60 by 2050, concerns over health care will grow even more. As the population grows more urban, more elderly and more ill, new programs will be needed in order to train geriatricians who can meet the expanded needs of this population. Traditional Chinese medicine has many “remedies” which can address the concerns of older men and women. What it does lack, at present, are the human resources and facilities to treat individuals who will live well beyond the life expectancies of the past. Traditional healing systems may not be able to deal with the chronic and debilitating illnesses of old age like Alzheimer’s disease, most cancers or stroke.

Conclusions

The 21st century has been called the “The Century of China.” Certainly economic developments and the rapid and successful modernization and even commercial privatization has resulted in considerable changes. But there are still many challenges China needs to face. Rapid modernization and related changes in Chinese society have raised social and gerontological concerns expressed in this paper. There are a number of positive signs. Life expectancy has risen from a mere 41 years in 1950-55 to over 70 by 2004. An annual GDP of 7% or more portends a rosy economic outlook for the near term, and its “Open Door” program which began in 1978 has ushered in many reforms that have improved the live of many Chinese citizens regardless of age.

However, there are also concerns on the horizon for today’s Chinese elderly population. China can be a model for changing social structures resulting from modernization. During the next few decades, China must address these concerns and decide how it plans to cope with demographic and social trends that will have a profound impact on today’s older adults as well as its future elders. If the social, health and retirement policies that are capable of addressing these looming crises are met with the planning and foresight that greeted the economic transitions of the last few decades, then China may indeed remain the Middle Kingdom for the middle aged and beyond.

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Footnotes

¹http://www.bergerfoundation.ch/glossaire/chine/glossary_tao_confu.html

Ageism in Health Care - A British Perspective

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There are three common forms of prejudice in society : Racism, Sexism and Ageism. Whilst the first two are fought hard by the victims and perpetrators reprimanded , the last one gets ignored by most, including the aggrieved ! Furthermore such prejudice and negative attitude to old age and the aged, can be caused by the elders themselves. How often it is said by an older individual "you can't do anything for me Doctor - it's my age; don't waste time on me".

Health care is an integral part of day to day social life and the professionals there are also members of the same society with similar attitudes and prejudices.

Let's look into the types of age-prejudice which can and do exist within such a global scenario. This can be divided into three broad categories : Primary, Secondary and Tertiary (Banerjee, 1998, 2003). Primary ageism is evident when someone is denied an established and well validated treatment to an individual just because of chronological age. Examples of such ageist discrimination will be quoted and discussed later. Denial of certain opportunities or facilities also could be counted within this category. Secondary Ageism is about collective discrimination e.g., poorer accommodation in hospitals for older and frailer patients, policies to avoid frail older patients, with multiple pathologies, being admitted to hospital or even to be seen by a specialist doctor. The story goes that once the Director of Medical Education , a Pathologist himself, in a District Hospital had suggested dumping the out dated medical books from the main hospital Library to the local Geriatric Department, commenting "for older people old books are quite

adequate !!” Such remarks , even jokingly made, do , not only, reflect bad taste but a dangerous underlying attitude ! Tertiary Ageism is about downgrading the specialty of Elderly Care and those who are committed to it. A fully trained excellent nurse working in a Rehabilitation Unit for Older people or even in a Stroke Ward , is frequently looked down upon by her colleagues working in more glamorous areas eg Operating Theatres or Maternity Units. A highly qualified Physician in Geriatric Medicine with a metre long list of peer reviewed publications and several monographs , is often labeled as a ‘clinical undertaker’ or a ‘social activist’ !

The overall attitude to old age is partly responsible for this. This is the era of youthfulness and rat –race, - as faster as possible. Time for ignoring and being indifferent to the past. Everyone is running all the time; whether they are going anywhere is, however, questionable. Older people are ‘history’; they are no longer financially productive , politically powerful or sexually presentable. Therefore they do no longer matter. Yes, by all means be kind to them and give them food and shelter but that is all; they are no longer full members of the society. Leave them to spend time with God ! They are second class citizens with third class status ! Accordingly the special needs for the old and the infirm remain unmet. The shelves are too high in the supermarkets, corner shops and local post offices close down, no rest provisions for the weak and infirm in hypermarkets with mile long alleyways ! Anti –ageing creams (although these are useless) are advertised by 21 old dolly-birds ; one rarely sees an older model in a clothing brochure. How often does one see a special page for senior citizens in a Newspaper similar to those for children?

Sadly the health professionals reflect the overall social attitude to older people and are not immune to ‘ageism’ themselves. A survey among different categories of hospital staff in four large hospitals revealed a significant level of ‘ageist’ attitude to older patients, born mainly out of ignorance. Those with specialized training in Elderly Care were, however, more positive to ageing (Hanley, Khan, Kumar & Banerjee, 2004). Fortunately not all is bad and unhelpful. In the UK, older people can travel free in public transports during the off-peak hours, receive additional payments for heating in Winter along with other benefits – some means –tested. But these are ‘official’ state

measures, often paid out of the life long contributions made by all. This is due to the country's Welfare system; doesn't impart a positive attitude to old age !

Despite an Welfare state with health- care 'free' at the point of delivery and a state pension for all retired citizens, the working class people face significant financial hardship after retirement. Those with personal savings and/or additional occupational pensions are somewhat better but a large proportion of the retired people depend on a state pension grossly inadequate for a reasonably comfortable living. Costs of heating and other utilities have been steadily increasing at a much faster rate than inflation, but the annual increase in state pensions remain pegged at the minimum possible level. Accordingly poverty is increasingly evident among the ordinary older people. 'Wealthism' comes into the equation ; money empowers people , poverty weakens ! A poor old person is more likely to be discriminated exactly the same way as a poor young person often is.

In the UK, privately purchased care with the aid of Health Insurance system is very common but Chronic on-going problems are not usually 'covered' by the insurers - so a) the old can't afford Private Health care anyway and b) quite often those available are of no great usefulness to many of them who are chronically sick or demented. This must be an example of 'ageism' in a very broad sense. On the other hand, although a few, there are very rich retired people too, enjoying a very happy living.

Rationing of medical care is inevitable in one form or another. All medical personnel make decisions each day on withholding certain forms of treatments from certain categories of patients. Withholding Gall Bladder surgery from a person of a BMI of 46 is not rationing, it is a safe clinical practice! Or discontinuing antibiotics from a terminally ill patient likely to die within a few days is also a sensible clinical practice. However, when a 75 year old is denied anti- cancer drugs or renal dialysis without any valid clinical reason, that amounts to rationing. Interestingly, such treatment could then be 'purchased' in the Private market by a 'rich' 75 year old ! It is ,perhaps, difficult to comprehend such a scenario in countries like India where there is no such 'cradle to grave' National

Health Service provision at the Tax payers' expense. Individuals need to 'pay' for their care anyway.

With the steady increase in costs of medical care, expensive medicines, complex advanced techniques etc., constant debates are taking place whether chronological age should be considered in the overall measurements of cost-effectiveness (Harris, 2006). Quality Adjusted Life Years (QALY) have been used as an argument to deny certain medications or treatments to older people. Demarcation between Rationing and Age Discrimination becomes difficult in such circumstance (Gold *et al.*, 1996). As mentioned earlier, it is likely that some form of Age-based 'rationing' will be introduced in an increasing number of areas but that should be done overtly with everyone's knowledge and consensus. There must not be any place for personal prejudice or dogma in health care.

Severe unscrupulous rationing or denial of care can in some instance amount to 'negligence'. The victim, if not well informed or vocal, may not appreciate such 'neglect' and protest such denial. More knowledge, better user-friendly information and advocacy should ultimately be able to rectify such serious face of ageist discrimination in health care. Fortunately such situation does not arise often.

Let us now look at a few specific areas of ageist approach to the provision of care.

A report published by the Royal College of Physicians of London had identified the general inequity in the provision of both non-invasive and invasive cardiological services to older people and had recommended some restorative actions (RCP Report, 1991). The media (BBC, 1997) had been fairly open and critical of any such discriminatory practice. Despite such publicity and campaign, the situation is not yet perfect; cardiac catheterizations are often denied to older patients (Bowling, 2001). Coronary Care Units also follow ageist policies on admissions to the units and on thrombolysis (Dudley & Burns, 1992). Subsequent to the Govt's National Service Framework for Older People (DOH, 2001) and an unequivocal stand against all forms of ageist practice within the NHS, things are beginning to improve. A survey of a number of Critical care units, looking after seriously ill cardiac patients, failed to note any ageist

bias in their patient selection (Hubbard *et al.*, 2003). This, however, couldn't confirm whether there were any choices made among the overall patient population prior to surgery or even their referrals to specialist centers. Improvements have also been occurring in CABG, Angioplasty, Valve Replacements etc according to a reported survey (Lawson-Matthew, 1995). It may be difficult to understand this anomaly between the young and the old in countries like India where such medical care is largely dependent on peoples' ability to pay; it would be interesting to find out whether any such discrimination exists in the 'free' state sectors.

Provision of Renal services e.g., CAPD and Transplantation is also restricted towards older people; according to the official Govt sources (Hansaard, 2000) about two thirds of patients above 70 with renal disorders are refused dialysis or transplantation. The Welsh Health Dept has recently released guidelines for Renal Services (2006) attempting to overcome any ageist discrimination. Unfortunately shortage of donor kidneys is also a major problem here. Younger Asian communities have been implicated as larger net recipients yet refusing to donate their organs.

In the cancer service also such discrimination has been observed. Only a miniscule number of older subjects are seriously investigated for a correct diagnosis; even fewer ultimately receive any curative treatment (Turner *et al.*, 1999). The British Thoracic Society had commented on the inappropriate and unfair handling of elderly lung cancer patients most of whom are denied treatment (Agnew, 1997). Expensive anti cancer measures, medications etc are considered as wasteful on older patients who are unlikely to have a longer life span anyway !! Explanations are offered, highlighting the possible 'toxicities' and 'complications' in older patients. Even the media in the UK are becoming increasingly aware of such discriminatory practice in cancer care. Critical comments have been made on the 'exclusion' of over 70s in the large bowel cancer screening program, thereby 'missing' nearly 25% of such cancers in the community. It seems such an exclusion was necessary to fit in with inadequate national health care resources 'prioritized' for younger individuals ! (The Daily Telegraph, Sep 13 , 2006) - was it rationing or discrimination ?

Although cerebrovascular disorders or Strokes occur in people of all ages, these are more common in older people with equally devastating clinical, social and fiscal consequences. Sadly it is broadly considered as a 'old person's disease' with a lower priority in national resource allocation. The British Stroke Association, the major national charity promoting higher standards in stroke care and research / training, has enough evidence of ageist discrimination towards and within it (Stroke Assocn, 2004). Since the publication of the Govts Service Framework (NSF for older people, 2001) with stroke as one of the target areas, the situation has somewhat improved; although it is far from satisfactory and remains patchy and fragmented (RCP Sentinel Stroke Audit, 2004). A more recent report (Young, 2006) has identified discriminatory practice in the field of stroke prevention. Transient Ischaemic Attacks, a well known precursor of a full stroke, still remain under- investigated and subsequently under-treated without any clinical justification (Fairhead and Rothwell, 2006).

Stroke Disorders, if to be handled appropriately for a better outcome, warrant special knowledge and expertise; an effective multi – professional team is essential. A 'cure' for stroke is not yet available; certain measures, if properly taken, may , in some instances result in a better outcome. Accordingly, everything possible should be done to reduce its incidence. Aggressive treatment of TIAs are therefore so important .

Mental Health Care including for Alzheimers Disease has also been criticized on their unfairness to older clients. Whilst Alzheimers is principally a disease of old age, other mental conditions in older people do not always receive the fullest possible attention or assessment either (Burns *et al.*, 2001). The overall facilities and care provisions for Alzheimers are usually inadequate. The scientific evidence for the efficacy of the new treatments for AD, remains controversial; it would therefore be inappropriate to make any claim for ageist practice in this respect. But non controversial social care and support for the care-givers are also grossly inadequate. Had this condition affected the younger population or children, the sceanario would have probably been totally different.

In the UK, where the health care is provided from the general taxation resources by the State, 'evidence – based' clinical practices tend to get priority and fundings. Accordingly clinical trials and credible clinical research become closely linked with the delivery of care. One of the difficulties with the clinical practice of old-age medicine (not widely known in the sub continent) is lack of such research –based evidence in many areas. Anecdotal practice becomes commonplace which cannot stand scientific evaluation or scrutiny. Even more dangerous is the practice of prescribing medications to older individuals with multiple pathologies, by extrapolating their safety and usefulness only on younger trial subjects. In 1997, at a survey of all the published papers in four well-known peer-reviewed British Journals, nearly 30% of those were found to exclude older subjects without any apparent reason (Bugeja, Kumar & Banerjee, 1997). A similar survey undertaken a few years later (McMurdo *et al*, 2006) had only shown a small improvement in such 'ageism' in research. It had been suggested that all researchers and trialists ought to remain aware of this issue with revisions of their protocol designs. Multiple co-morbidities and medications might be the reasons for such behavior in the usual practice of research (Bene & Liston, 1998). With the health care delivery becoming increasingly dependent on 'evidence' accrued from research activities, exclusion of older subjects or avoidance of research on ageing and age-related disorders, must be unethical warranting a change in research practice.

In a resource –limited publicly accountable health –care system, some element of prioritization and targeting are bound to occur. It can be argued that application of measures and methods of 'unproven' value is also incorrect and unethical. But that is not the issue here. Methods of reconsidering or rationing care provisions through Deference, Delay, Dilution and Discharge, are becoming increasingly common; and this is disadvantaging the older people more than any one else (Banerjee, 1998).

Education and specialized training in elderly care and in medicine of old age is encouraged in the West; although its extent and depth remain somewhat questionable. The antagonists claim that there was nothing special about old age or older people - they are all adults!! I remember a similar argument against

Paediatrics ,during my medical student days in Calcutta ; ‘well’ used to say the Professor of Medicine ‘children are little adults – place them in cots and give them small quantities of medicines.’

To day it is unthinkable for a sick child not to be looked after by personnel without specialized qualifications in childhood medicine or nursing. Failure to provide tailor made specialized and effective care also amounts to ‘indirect negligence’ and reflect age –prejudice. Inclusion of a comprehensive training package in Geriatric Medicine within the undergraduate medical curriculum has been accepted in the UK for more than 30 years with nearly 40 academic centres around the country. Specialized nurse training has also been on going for may years; so in the fields of Therapy services , Social work and many other areas. Despite all these , problems still exist. As mentioned earlier, general attitude to old age still remains largely negative. The three factors which are likely to be the ‘drivers’ of health care throughout the globe, are a) Technological advances and innovative medications; b) Demographic changes and c) Consumerism. Perhaps it is this last factor which will change the ‘attitudes and actions ‘ of the Professionals and the State in due course. In this country , Doctors are no longer on the driving seat - the Patients are gradually taking over that role. Choice , Information , Empowerment , Decision – sharing etc are now the hot terminologies and the professionals , particularly the Medics , are expected to comply with these. The General Medical Council is increasingly being ‘run’ by Layities and doctors’ self-regulatory system is slowly being taken over by the general members of the public. As a result . hopefully, individual views and /or prejudices on Age or any particular form of treatment or on the venue of its delivery, etc will all change.

In countries like India , where large amount of health care is still purchased by the individual patients or their relatives, such ‘consumerism’ already exists. Accordingly chances of any blatant ageism are unlikely. The apparent lack of ‘specialization’ in this area and inadequacies of appropriate service provisions for older people ,however, do look like ‘discriminatory’ , at least to an outsider. Poor understanding of the ageing process, influences of ageing over illnesses and vice versa, widespread polypharmacy on older patients , poor or non –existent Rehabilitation infrastructures,

virtual absence of long term specialized care facilities, are not in keeping with the twenty -first century global scenario. Many might label these as 'ageist'! Training for health professionals of all kinds, in these areas, are at best patchy and at worst, non – existent ! In many situation, the older people are nothing but a commercial commodity !

So what needs to be done about ageist behaviour and practice in health care, whichever country it might exist and whatever form it might take. In the UK , the National Service Framework for Older People has commenced to address this problem as their number one target; 'all forms of discrimination on the basis of chronological age must be rooted out of health care practice'. This kind of official stance is a good start but such 'ambitions' must result in concrete outcomes with change of practice. In societies with largely patient purchased 'private' health care with or without medical insurance arrangements, the insurance policies often discriminate against the old with 'exclusion' clauses for conditions likely to affect the aged e.g., the chronic disabling disorders. This is expected as the 'profit' margins on such conditions are nil ; insurers making a loss instead. The State can only take corrective action through official actions and by legislation if necessary. In the UK, at long last , such an Age Discrimination Act (2006) has been passed by the national parliament against a lot of opposition by commercial employers and agencies. Although this is primarily against discriminatory practice in employment , this is bound to have implications for health care as well. For the health –care areas, a National Director (called the 'Tsar') for Older Peoples' Services has been appointed by the Govt., with responsibility for the overall 'care' of older people.

'Consumerism' will be an effective pathway for a non – ageist health service. All professionals are characteristically scared of 'complaints' and 'convictions', legalistic hassles etc . Even if nothing can ultimately be established and they are 'cleared' , their reputation gets tarnished by bad publicity! Pressure from patients and their relations querying the medical 'decisions' of certain inactions towards an elderly patient or inadequate treatment resulting in delayed or no improvement, will begin to be questioned. Better information on age and related problems will enable the

consumers to ask questions and to seek reasonable answers. Unexplained deaths or sufferings would no longer be accepted as simply a feature of old age and God's will !!

The best and most plausible approach would be better education and training for all health care personnel ; hopefully this alone would correct the negative attitude towards old age and its resulting ills.

The world population is ageing at a very fast rate. For the first time in history, there are more over 65 s than under 15 s in the UK. Each year the human longevity is increasing by about three months. Like discriminations on the basis of race and gender, discriminatory practice in health care towards older individuals is unethical, immoral and wrong. This message is spreading loud and clear in this country. It needs to reach the rest of the globe.

The children are our future and must be looked after well and carefully nurtured . The elders are our heritage and history ; they should also be looked after and respectfully heeded. Ageing is not a disease and unlike HIV/AIDS , can't be 'cured' and is , biologically speaking , universally 'fatal' . Like AIDS , however, some of its undesirable effects can be 'prevented' and 'treated' . Looking after its elders properly, enriches the intrinsic values of a society. Let's do it .

SUMMARY

Despite recent attempts to root it out , discriminatory practice on the basis of chronological age is still widespread in the British Health Care system. The National Service Framework for older people and the appointment of a Tsar for Older Peoples' Services have been steps in the right direction. As Ageism is born out of a general negative social attitude to the elders, an educational approach is likely to be more effective. As the East is rapidly copying the West in virtually everything, the plight of elders are likely to deteriorate in the subcontinent with elders being increasingly undervalued. Consumerism in health care as well as better financial prowess might prevent discriminatory behaviour in medical practice. Examples of such age discrimination in the UK in a variety of clinical settings have been cited and discussed. As ignorance tends to be the basic of all

forms of discrimination, wider specialisation with greater knowledge of Ageing and Elderly might be the way forward.

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Perceptions of Ageism Across the Generations

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ABSTRACT

Ageism portrays a set of negative discriminatory attitudes and related behavioural manifestations toward the aged in a society. Despite a significant ten percent of the world population (20% in some countries) being old, they suffer many indignities. This study empirically investigates the contemporary prevalence of ageistic perceptions in the young adults (20-40), the middle aged (40-60) and the old (60-80). The sample consisted of 120 rural and urban men and women in each of the three age groups. The tool consisted of a checklist of attitude towards ageism adapted from an inventory of attitudes towards the aged. Results indicated a high prevalence of ageistic perceptions among the young compared to the middle aged and the old, though all age groups held negative attitudes towards ageing. Some strategies of debunking ageism are suggested.

Ageing, is an inevitable life long process, marked by stages of life like infancy, childhood, adolescence and adulthood. Each stage is identified by relevant developmental tasks, appropriate skills, responsibilities and opportunities. Old age is the last of these stages. The objective of the science of gerontology (ageing) is to find answers to certain questions such as why we become old? What happens when we become old? What are the needs and concerns of old age? and How people look upon old age ?

Fear of growing old, may be an universal and natural apprehension for many. The fear may be minimal in some social groups and exaggerated in those that nurture ageism. Ever since Butler (1975) introduced the concept of ageism, the word has become ubiquitous. Ageism simply refers to the negative stereotype of the

elderly and their behavioural manifestations. Such an attitude then, may lead to a denial that we are aging and it may also lead to an aversion for the aged, who are living symbols of what we will become. Furthermore, one's reaction and adjustment to changes in middle age and fear of growing old surely affect one's reaction and adjustment to old age.

Ageing is also a socially constructed phenomenon. In many societies age is used as a prime criterion (age graded society) in the assignment of people to opportunities i.e., for e.g., one's age partially determines the roles we play. It is to state that, older people may be less active not because of their biology or the aging process but because they are expected to present an image of inactivity. Social roles sometimes do not permit the aged to be active and involved. Age norms constrain people to behave in given ways. Age norms form a social clock that works alongside the biological clock that limits and guides behaviour through our individual life cycles.

The increased life expectancy in India is leading to four generation families. The interaction of intergenerational families can be a source of great personal enrichment, but it can also produce tension and conflict among the generations in the family resulting from differences in perceptions and values. These value differences may be a source of age prejudice or ageism within the family. Social and technological change may be a major factor in causing age prejudice, primarily because the more rapid these changes, the greater the possibility of value conflicts. However, some basic value orientations may remain fairly constant across several generations.

Negative stereotypes of the aged abound and are often harsh. Stereotyping can be direct and it can be subtle. Certainly some old persons may fit all the negative images. However, individual variations are seen. Tuckman and Lorge (1967) were among the first gerontologists to study stereotypes and found that old people were perceived as being set in their ways, unproductive, rigid, uncouth, a burden to their children, and in their second childhood. Other studies on stereotypes and attitudes, reported similar findings that young people viewed as bound to the past, and old age as an unpleasant experience.

On the other hand, some studies on young children and high school students have shown positive attitude toward the aged (e.g., Anantharaman, 1981; Kullai Reddy, 1984, 1990). Nevertheless, we need more studies on attitudes towards old age to be more specific in explaining how negative images affect the elderly. The negative stereotypes of the aged must be disproved if we are to have a favourable picture of older people. A second way is to debunk the stereotypes. They are to be countered with accurate information.

Ageism in employment and careers in different job categories is common for both sexes. Discrimination based on age is severe for older workers. Most old persons are denied employment because of their age. The type and reasons for discrimination against the older worker vary. In some instances, stereotypes about older workers have been a part of the discriminations on the job against the elderly.

It is clear from the above that ageistic attitudes prevail in different age groups and in work situation. The negative attitudes towards aged, and ageing in the society reinforce ageism and nurture ageistic practices in different spheres of the society. Prevalence of ageism is dependent upon a whole gamut of factors like age, gender, educational level, type of family, the nature of interaction with the elderly, and personality. An attempt was made through this study to ascertain how different age and gender groups of the current (present) population perceive ageism.

The present study had the following objectives:

1. To study the nature and prevalence of various stereotyped perceptions of the elderly.
2. To study the variation in these stereotyped perceptions as per age group (the young adult, the middle aged and the older persons) and gender groups.
3. To suggest means of countering these ageistic views.

Methodology

The study attempts to investigate the prevalence of ageistic images in the young, the middle aged and the older persons. A total sample of 240 men and women were drawn by a multi stage random sampling technique from rural and urban areas of two districts

(Chittoor and Kadapa) consisting of 80 in 20-40 age group; 80 in 40-60 age group; and 80 in 60+ years. A check list of characteristics of the elderly was adapted from the standardized inventory of attitudes towards the aged (Ramamurti, 1968). The checklist consists of 25 negative characteristics of aged and aging. The test retest reliability of the checklist was 0.86 (interval of 15 days with N=60). The inventory was in Telugu, the regional language and responses to statements recorded. The subjects were individually interviewed and the significance of the study was explained to them to ascertain their cooperation.

Results and Discussion

Ageism portrays a set of negative discriminatory attitudes and related behavioural manifestations towards the aged in a society. The elderly suffer many indignities. To realize the first objective, data on perception of ageism in the young, middle aged and the elderly subjects was scored. The perceptions of these groups were analysed content wise (i.e., statement wise). Also the age differences in the perceptions were analysed to gain an understanding of the three generational dispositions towards ageism.

The percent of men and women holding the negative perception in each of the age and gender categories were worked out (See table-1). It could be seen that there were considerable variations in the percent of persons holding the negative perceptions.

There were no substantial variations between the genders in these perceptions in most of the 25 characteristics listed. The averages of negative perceptions for the 25 characteristics listed showed for men and women in the 20-40 age group were 47.2 and 47.5; in the 40-60 age group were 49.7 and 50.8; in the 60-80 age group they were 45.4 and 46.3, respectively.

Taking the averages of the percent of population holding negative views for the age groups it is seen that negative views of ageing were less (45.9) in the older age group (i.e., 60-80) compared to the young and middle age groups (47.4 and 50.5). It is noteworthy that the older age group also attributed ageistic (negative) perception to old age and the views were only a shade different compared to the young and middle aged groups. It means that nearly a majority of the total population held negative views of the aged.

Table-1 : Percentage of Men and Women in Each of the Three Age Groups Endorsing Each of the Characteristics of older People

Sl. No.	Particulars	20-40		40-60		60-80	
		Men	Women	Men	Women	Men	Women
1.	Forgetful	34	30	64	62	80	78
2.	Frequent illness	31	38	61	58	60	65
3.	Weak	62	60	54	51	70	74
4.	Wrinkled skin	28	31	51	48	58	61
5.	Bald and grey hair	61	65	68	70	54	46
6.	Dirty, smelly	28	30	21	24	13	17
7.	Constipation	17	19	27	29	40	42
8.	Chronic diseases	36	31	31	34	60	52
9.	Falling tendency	44	42	49	52	51	47
10.	Slow in work	60	64	60	54	70	64
11.	Burden to family	55	51	64	66	70	72
12.	Poor vision and hearing	56	60	52	50	32	24
13.	Dull taste and smell	28	31	55	57	35	34
14.	Short tempered, no patience	25	20	41	39	40	42
15.	Authoritative, critical	61	67	44	54	20	18
16.	Of no use to others	72	69	54	59	50	58
17.	Conflict with the young	74	67	36	35	31	35
18.	Rigid	51	53	48	46	21	19
19.	Spiritual religious and godly	59	60	57	62	55	64
20.	Superstitious	66	70	49	51	30	34
21.	Not fit to modern living habits	78	80	61	63	50	47
22.	Not fit for sex life	49	47	64	66	46	44
23.	Living in their past	55	51	32	34	32	30
24.	Spoil grand children	29	31	55	59	18	21
25.	Always dosing, wake up early	26	29	45	47	54	60
Gender Average		47.2	47.5	49.7	50.8	45.4	46.3
Age Group Average		47.4		50.5		45.9	

Since there were considerable variations in the percent of the three age groups holding negative views among the different ageistic characteristics listed, it would be interesting to go into the details of the perception of the different characteristics. If we consider the young adult group the characteristics that carried a moderate to high per cent of the population were: weakness, baldness and grayness, slow in work, burden to the family, poor vision and hearing, authoritative and critical, they were of no use to others, conflict with the young, rigid, godly and religious, superstitions, not fit to modern life and rooted in their past.

The characteristics endorsed by a fair number of middle aged persons were: forgetful, frequent illness, weakness, wrinkled skin, falls, slow in work, burden to family, poor vision and hearing, poor taste and smell, authoritative and critical, no use to others, spiritual and godly, rigid, superstitions, not fit for modern life, and spoil grandchildren by overprotecting them.

The characteristics mostly endorsed by the old themselves were forgetfulness, frequent sickness, weakness, wrinkles, baldness and grey hair, constipation, falling tendency, slow in work, burden to family, worthlessness, spiritual and godly, not fit for modern life, sleepiness, and waking early.

The characteristics endorsed by all the three groups were; weakness, baldness and grey hair, slow in work, a burden to family, being of no use to others, spiritual and godly, not fit for modern life. These views were held by more than 40% of the groups. It is interesting to note that none of the characteristics were totally endorsed by any age group but only by the majority (at most).

Several of these characteristics have some truth (but not the whole truth) on which they are based. Yet, the old are stereotyped into that characteristic. For instance, not all old people have these characteristics, only less than a majority have these characteristics, eg., constipated bowels, frequent illness, dirty, smelly, short tempered, critical, authoritative, conflict with the young, rigid, spiritual and godly, superstitious, etc., It is seen that these characteristics can be found in individuals of other age groups as well and not only in the older persons. Also, some of these characteristics don't show up until late in the old age, with many in the young old group (60-75) not

showing these characteristics. These facts suggest that some of these characteristics are used as criteria for “exclusion” or marginalization of the aged, and putting them in an “out group” i.e., social distancing by ascribing “Minority Group Status”. It is some thing that hints at “Not me” anyway but “he/she” has these !

Stereotyping and labeling seem to fulfill a human need to structure and organize situations. Yet, stereotyping is usually inaccurate. When we generalize by putting people into categories, we tend to over simplify reality and information and try to emphasize a few characteristics that are accepted as an “adequate” description. Stereotypes can lead to strong emotions, such as hatred.

It is therefore necessary to devise intervention strategies to debunk these views of the older persons. One way to debunk this is to draw attention to the older people who have made significant contributions in their old age. Another way to debunk negative stereotypes is to counter them with accurate information. For e.g., the myth persists that the aged as a group suffer cognitive decline. More specifically, certain common beliefs are that (1) the mental faculties of aged decline and (2) aged are senile, child like and out of touch with reality. The older people are said to decline in intelligence, learning ability, and many. However, longitudinal studies on older persons over many years have found little overall decline in intelligence scores. Other studies show that aged individuals are just as capable of learning as younger people although they may take some time to learn new things. Longitudinal studies by Baltes and Schaie (1974;2003) on intelligence in the 21-70 age range subjects show that two out of four measures of intelligence increase with age. It is to conclude that general intellectual decline in old age is largely a myth. The researchers found “crystallized abilities” (verbal Comprehension, numerical skills, induce reasoning etc.,) and visualization (the ability to organize and process visual stimuli) increase with age even to the 70’s. Number of studies show little overall decline in intelligence with age. The reason is that the design of IQ tests have been particularly responsible for stereotyping old people as declining in intelligence. Tests to measure only those abilities are inappropriate for tapping the wisdom of the aged. Studies show that those who exercise their minds keep themselves mentally alert (Baltes & Schaie,1974, 2003; Birren & Schaie, 1996).

Research by providing evidence to the contrary is necessary and needs to be documented as evidence to debunk the stereotypes. By using the print and electronic media, and school curriculum the positive aspects need to be projected. Television shorts and cartoons can be developed depicting the positive aspects and usefulness of older people and discrimination they experience due to the incorrectness of stereotypes of the older people. In families too, parents may promote in their children respect and regard for older people. If these are consistently carried out, in due course, the attitudes towards older people would tend to become positive.

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Psychological Issues in Ageism and its Prevention

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ABSTRACT

Psychologists need to examine the origins and impact of Ageism on the well-being of older people. Media, medical services and often, older people themselves perpetuate ageist attitudes. Like any other form of discrimination, Ageism also dehumanizes the older people and curbs their rights. Prevention of Ageism needs action both at individual and group levels. Awareness, activism, and advocacy are essential for fighting against Ageism. Active aging can counteract many of the negative stereotypes. This paper explores the psychological issues in the development and prevention of Ageism.

Keywords : Original Ageism, Well-being Against Attitude, Prevention of Ageism

When Robert Butler, the Grand Old Man of Gerontology, coined the term "Ageism" in 1968 (Butler, 2005) to identify age stereotypes, not many empathized with the term. Most thought it was another of the 'isms' that crops up in literature. Nearly forty years down the line, this particular 'ism' has been experienced by millions of people. Research evidence is accumulating that ageism is universal and omnipresent. This is evident by the fact that Palmore and colleagues thought it fit to publish an "Encyclopedia of Ageism" in 2005. This book lists more than 135 topics from A to V - Abuse in nursing home to Voice quality - all related to ageing and age stereotypes (Palmore *et al.*, 2005).

Psychologists need to examine the reasons for ageism and ageist attitudes. Palmore discusses the most common of these negative myths and stereotypes about aging (1990). Most young people, sometimes old people themselves, believe that old age is synonymous with sickness and disability. Statistics contradicting this that only 5 percent of 65+ are institutionalized is often overlooked. Even Physicians assume that sexuality is unimportant in old age (Butler, 1975). Culture of youth worship finds old age ugly. When factors such as motivation and learning style are taken into account, chronological age does significantly influence learning ability. Yet, people consider all old people as senile. Mental illness is neither common, nor inevitable, nor untreatable in the elderly population (Prakash, 2000). Nor are all the old people dependent and useless. Studies of employed older people under actual working conditions generally show that they perform as well as, if not better than, younger workers on most measures. Yet, employers may hesitate to hire an older person (McCann & Giles, 2002). Consistency of output tends to increase with age, and older workers have less job turnover, fewer accidents, and less absenteeism than younger workers. (Riley & Foner, 1968).

Unlike sexism or racism, ageism is not constant in the sense, age classification is not static. Everyone, if he or she lives long enough, will join the rank of the 'aged' one day. One moves ahead progressively in the life cycle and hence age classification is continuously changing. As a result, people may hold ageist stereotypes against others when young and may develop attitudes towards self as they age. Ageism occurs in consumer based and economy focused society where older people who cannot work are seen as "disposable citizens" or as having outlived their usefulness to the economy.

Psychologists show that ageism is perpetuated not only by the media, but also by medical and other services. Woolf (1998) in a comprehensive article discusses different reasons for the development of ageism. The first factor that is postulated to contribute to ageism is the fear of death in Western society. Western civilization conceptualizes death as outside of the human life cycle (Bulter & Lewis, 1977). As such, death is experienced and viewed as an affront to the self. Death is not seen as natural and inevitable part of the life course. This can be contrasted with Eastern philosophy where life and death are all part of a continuous cycle. The argument is that since age

and death are often associated, the fear of death gets translated as dislike of aging. This may not be very convincing as even in Eastern culture where death is not 'expected' to be feared, ageism is seen. Indians with their concept of an eternal soul are also prone to ageism.

Kastenbaum (1973) hypothesizes that ageist attitudes and stereotypes serve to insulate the young and middle-aged from the ambivalence they feel towards the elderly. This ambivalence results from the fact that the older adult is viewed as representing aging and death. Butler (1969) states : "Ageism reflects 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 a fear of powerlessness, 'uselessness', and death" (p. 243). This represents the most commonly argues basis for ageism (as cited by Woolf). Young centered culture is another factor considered responsible for ageism (Traxler, 1980). Persons who are dependent on physical appearance and youth for their identity are likely to experience loss of self-esteem with age (Block, Davidson & Grumbs, 1981). In societies where productivity is emphasized, once again, old age and dropping out of work force is valued negatively.

Gray Panthers (2006) is an intergenerational organization dedicated to promote social justice for all identify different types of ageists. The Pretenders are those who refuse to believe in aging and think that it is all in one's head. The Discriminators are quick to point out the realistic limitations of aging. The Exceptionalists perceive themselves as productive and useful to society while their peers are in bad shape, useless and boring. The Colonists are usually politicians who preface any word related to aging with the possessive noun such as 'out senior citizens', 'my elderly'. The Patronizers are happy as long as the old are in their place and are left there. Gray Panthers argue that none of us is immune to ageism. Ageism percolates society and we are all ageists.

Consequences of Ageism

Any discrimination whether it is due to gender, race of age will have similar consequences. The group discriminated against assumes the characteristics of a minority group. It starts internalizing the

negative images attributes which affects self esteem. The stereotyped views of the dominant group may consist of a set of behavioural expectations and prescriptions. In general, the consequences of ageism are similar to those associated with all attempts to discriminate against other groups : persons subjected to prejudice and discrimination tend to adopt the dominant group's negative image and to behave in ways that conform to that negative image (Palmore, 1990)

Robert Butler (1968) explained that ageism allows the younger generations to see older people as different from themselves; thus they subtly cease to identify with their elders as human beings. Ageism often intersects with and can be reinforced by other kinds of discriminations such as racism, sexism, and "able-bodied-ism" (where preference or greater social value is given to people who do not have impairments or disabling conditions).

Palmore (1990) identifies four common responses of elders to these prescriptions and expectations : acceptance, denial, avoidance, or reform. All of these responses can have harmful effects on the individuals. For example, an elderly person who 'Accepts' the negative image may "act old" even though this may be out of keeping with their personality or previous habits. This may mean that they stop or reduce social activities, do not seek appropriate medical treatment, or accept poverty. In essence, this internalization of a negative image can result in the elderly person becoming prejudiced against him/herself, resulting in loss of self-esteem, self-hatred, shame, depression, and/or suicide in extreme cases.

'Denial' of one's status as an elderly person can also have negative consequences. One example, lying about one's age may not seem significant, but it can further erode morale. Another example is the attempt to "pass" for a member of the dominant, younger group by undergoing cosmetic surgery, having hair transplants, or using widely advertised anti-aging products such as air dyes, skin creams, cosmetics, etc. While these practices are widespread, the quest for eternal youth can become inappropriate and, ultimately, self-defeating for those who attempt to stop the natural aging process entirely. 'Avoidance' of ageist attitudes may also take many forms. Examples include moving into age-segregated housing, self-imposed isolation, alcoholism, drug addiction, or suicide. The 'Reform' response, is the antithesis of the avoidance response in that the person recognizes the

discrimination and attempts to eliminate it. This attempt may be an individual one or a collective one through membership in an advocacy group such as the powerful American Association of Retired Persons.

Ultimately, stereotypes are dehumanizing and promote one-dimensional thinking about others. Elders are not seen as human beings but as objects, who therefore, can be more easily denied opportunities and rights. Stereotypes are accepted, perpetuated and reinforced in language, in medical practice, in policy and programs not just in individual relationships. For example, elders are frequently misdiagnosed or denied medical treatment because they are seen as "old" and, therefore, incurable. Elders are also frequently denied employment or promotion opportunities because they are "old" and less productive. Such discrimination is also evident on the social policy level where the elderly are blamed for having medical problems and consuming public resources rather than seeing them as having human needs requiring appropriate social responses. Seeing people as objects also increases the likelihood that they may be subjected to abuse and other cruel treatment. Elder abuse is closely related to ageist attitudes. Devaluing human beings on the basis of age goes against the basic principles of civic society.

Fighting Ageism

If ageism is so rampant how does one fight it. Perhaps the first step is to recognize the phenomenon itself. Defining what constitutes ageism itself creates some awareness regarding its effects. One needs to recognize the ageists as well. Then one has to develop strategies at individual and social level to counteract it.

Rodeheaver (1990) suggests that in order to counteract ageism, changes must be made in the systems which perpetuate it. Media, popular culture, business institutions, government and medical system all of them perpetuate stereotypes. Individuals with ageist attitudes are part of such systems. Therefore, changing individual ageist attitudes is a fundamental approach to reducing ageism. A firm step in this process is identifying personal attitudes which are ageist in nature. This can be difficult since most people will deny that they are prejudiced. However, until a person is aware of this or her own attitudes, little progress can be made.

Another approach which can modify ageist attitudes is personal contact with older adults. This is often an effective way to prevent or

reduce the development of ageism, especially among young children. It is a well known fact in social psychology that contact and frequent interaction reduces prejudices. Many innovative intergenerational programs have been created which not only benefit children, but also the older adults. Prakash (2003, 2004) reports some such studies carried out in India. Using drawings depicting older people, attitudes are elicited in children. Then psychoeducational programs are carried out to change the attitudes in the positive direction. During these programs, positive aspects of aging can be emphasized so that the children will have a balanced picture of the older adults - and of themselves as they grow older adults' oral history by students. Schools could contribute in their own way by including aging issues in curricula. Encouraging school students to do small projects involving older people helps forge a link between the two generations.

Many older people have sought more active and vigorous ways of combating ageism. They aim at social action and reform. This approach is particularly effective when directed at institutions. Gray Panthers which have watchdog committees to monitor and respond to negative media images of older adults is a good example of what collective force of people can achieve. Civic groups and churches can also be effective advocates along with other institutions in the community.

The Canadian Network of the Prevention of Elder Abuse (n.d) gives some tips. They are as follows :

1. Identify the myths and misinformation
 Recognizing the myths that abound about older people can be very revealing. The quiz developed by Palmore (1977) is a handy tool in this regard. When people can sift facts from fiction they would be taking the first important step toward better understanding of aging.
2. Go beyond the stereotypes. People should recognize that labels like seniors or elders do not really give comprehensive understanding of the persons. It has to be recognized that older people are heterogeneous. Each person has to be looked upon as an individual.
3. Learn more about aging. Correct information about aging is one way to resist negative stereotypes.

4. Learn about ageism and discrimination. One needs to learn about how discrimination manifests in several areas of life. Also useful is to know the interactive effect of different types of discriminations.
5. Listen to seniors who have experienced ageism. Perhaps nothing can be more enlightening than finding out from people how and in what context they have experienced ageism. Experiential accounts help in better understanding.
6. Monitor media and respond to ageist material Old people are often portrayed negatively by mass media. Just as now feminist groups monitor and protest against negative media portrayal, older people also need to register their protests.
7. Speak up about ageism. At an individual level each one of us must take the role of a teacher. Older persons should tactfully point out when others use ageist language or display such attitudes.
8. Watch out for own language. Very often old people themselves use ageist idioms, words and images. One has to be more observant of this trend.
9. Talk openly about ageing issues and ageism. Like other forms of discrimination, ageism has to be taken out of the cupboard and thrown up in broad day light. Being silent about such incidents is an indirect way of accepting it. The more unvoiced the concern, more appropriate it appears to behave in ageist way.
10. Build intergenerational bridges to promote understanding. Often people are ageist because they do not know better. Generation gap has to be addressed for harmony among people.
11. Provide support for organizations that address ageism. Now a days, as awareness has spread, older people are organizing themselves to fight ageism. Organizations that address the issue of discrimination should be strengthened. Size and adequate finance add to the clout of such organizations.
12. Push for changes from your elected representative. People should educate the politicians whom they elect. Keeping them informed of key aging issues is a way of influencing policies and change ageist policies.

Gray Panthers, the most influential advocacy group has its own set of tips to combat ageism. Their plan says that the hardest part in fighting ageism is to accept the fact that we are all ageists. To stamp out ageism, they say 'quit complimenting people on how young they look'. Promoting intergenerational sharing, not blaming age for everything (old as disorganized, young as poor planners, for example) and taking the media to task for ageist reports also helps. There is a difference between laughing with and laughing at elderly. Knowledge and approaching every person as an individual are two important weapons to fight ageism. Palmore (2005 a) suggests both individual actions and group actions for fighting ageism. Individual action consists of getting facts, eliminating own prejudices, avoiding ageist jokes, terms, language, and acting appropriately when faced with ageism. Group actions are more powerful and may take the form of rallies, lobbies, passive resistance, supporting political campaigns and so on. In another article Palmore (2005 b) lists strategies for reducing ageism. They are : testing ageism (determine level of prejudice); education, propaganda and exhortation; slogans that are catchy; listing benefits of aging; using religion, media and personal contact; setting models of successful aging, and even therapy to counteract negative effect of ageism. Social structure changes in economy, government, family, housing and health care are also recommended by him.

Ultimately it appears that people who are growing older need to actively fight ageism. Otherwise, they will be living out a 'self fulfilling prophecy' - a prophecy that has been created and fed by social stereotypes and prejudices. Awareness, Activism, Advocacy and Active aging are the weapons to fight ageism. No country, no culture is free from ageism at present. In the future, this trend may increase as old people become a noticeable presence in the population. Hence, there is a need to educate people regarding ageism and ageist attitudes. Active or productive aging encourages people to remain healthy and independent as long as physically possible. Mental attitudes of hardiness, openness to new experience and self esteem help people retain their dignity in spite of societal attitudes. It also gives them the necessary strength and motivation to fight ageism.

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Older Persons, and Caregiver Burden and Satisfaction in Rural Family Context

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ABSTRACT

The present study is aimed at assessing the burden among the caregivers of the elderly in rural families and to standardize and compare Burden Assessment Scale (BAS) and Caregivers' Reaction Assessment scale (CRA) in Indian context. A Sample of 300 (176 women and 124 men) caregivers of the elderly was selected using a systematic sampling method from three village panchayats of a predominantly rural mandal (Padmanabham) of Visakhapatnam district, Andhra Pradesh. An interview schedule covering basic socio-demographic data and the two measures i.e. BAS and CRA was used to collect data from the caregivers. Findings reveal that burden and satisfaction of care giving is associated with sex and age of caregiver, and family income. A large percentage of caregivers expressed satisfaction about the care-giving role played by them. However, only a small percentage of women, as compared to men, expressed satisfaction about their care-giving role probably because the major burden of caring the elderly was actually shouldered by women rather than by men. Similarly, more women caregivers reported tiredness and worsening health due to stress arising out of their care giving roles. Lastly, evidence showed that higher age and lower income was found to bring down the caregiver satisfaction significantly.

Key words : Elder care, Caregiver burden, Caregiver satisfaction, Caregivers, Family relationships.

The growing number of aged population as a result of the increase in the life span of the individuals, and the continuing preference of older persons to stay with their young are some of the reasons which led to the emergence of caregiving as an important aspect of family life (Bali, 1999). In India, home based care with family members as primary caregivers still remains as the first and often the only option for a majority of the elderly (Puri, 2004). So, the most common type of living arrangement for the elderly in India is found to be living with married sons and their families (Prakash, 1999). According to 2001 Census, the aged (60+) in India constitute 7.4 percent of the total population whereas for A.P. it is 7.6 percent. There is an 11.8 percentage increase in the population of the older persons over the earlier decade, which was 6.54 percent. According to Census, 2001, nearly 75.0 percent of the elderly live in villages. The dependency ratio of the elderly is reported to be higher in the rural areas as compared to urban areas (NSSO 52nd round). Therefore, family care giving emerged as an important area of study.

One of the outcomes of caregiving is caregiver stress and burden. Several questions come to our mind when we think of caregiving and caregiver burden in family context. Who are the primary caregivers of the older persons in Indian family context? Which factors are associated with caregiver stress or lack of it? What measures are used to assess these variables and so on. Studies show that caregiver stress is reported to be associated with such variables as family income, age of caregiver, kinship relationship, caregiver's attitude and certain attributes of the care recipient i.e. the elderly (Jamuna, 1997). It is found that women are traditionally caregivers in Indian families (Prakash, 2001, 1999) especially in rural communities (Jamuna, 1997; Chakrabarthi, 1999; Sharma, 2003). Also women report greater levels of stress as they are often engaged in the care giving of two generations— rearing their own children and providing long term care to the elder relatives which results in great cost to their well-being both physical and psychological (Prakash, 1999; Hirst, 2005). Caregiver stress was reported to be high among daughters-in-law followed by spouse and daughter (Jamuna, 1997). Thus, there is a clear 'feminization of caring'. For men the most common caregiver

was the wife followed by daughter-in-law and in the case of women, it was mostly the daughter-in-law followed by the daughter (Prakash, 1999; Sharma, 2003). The other stressors which affect the quality of care giving were work demands, availability of social support, health status of the caregiver (Jamuna and Ramamurthi, 1999), and the changes and modifications which have been taking place in interpersonal relationships as a result of changes in external realities (Vijaykumar, 1999).

Another important aspect in studies on caregiving is caregiver satisfaction. Compared to the literature on the burden of caregiving, studies are sparse focusing on the rewards and gratifications of elder care (Decalmer and Glendenning, 1997). Davies (1980) observed that caregiver satisfaction is possible only when the recipient of care was seen as a valued person rather than as a problem. Similarly, Cartwright et al. (1994) observed that caregiver satisfaction is also dependent upon the meanings ascribed to care i.e. perceiving caregiving as a satisfying and pleasant relationship and of finding rewards in the several acts of care giving.

Caregiver burden is one of the most studied topics in gerontological literature. However, fewer studies are done on rewards and satisfaction of care giving than on caregiver stress. Therefore, it was thought that a study based on a large and a systematic sample of caregivers in a rural family context would yield meaningful comparison and conclusions on both caregiver burden and caregiver satisfaction. Moreover, the social and psychological stress experienced by family caregivers in the family context is an important area of study. Though several scales have been developed to measure caregiver burden and stress, not many scales are available to measure these aspects in Indian context. Hence, there is a need to identify and standardize independent measures of the caregiver burden and caregiver satisfaction on an Indian sample. Thus, the purpose of the present study is to examine the discriminating capabilities of two measures i.e. in measuring the caregiver burden and satisfaction and to explore how age, sex, income of the caregiver affect the different variables relating to care giving.

Objectives

1. To assess the burden and satisfaction experienced by the caregivers of the older persons in Indian rural family context.
2. To use and compare the two measures i.e. Burden Assessment Scale (BAS) and Caregivers Reaction Assessment (CRA) scale in measuring the caregiver burden and caregiver satisfaction among the sample respondents.
3. To find out the association between the caregiver burden and caregiver satisfaction with relevant variables such as age, sex, income etc of the caregivers.

Method

Sample

Seven villages in three panchayats from a predominantly rural mandal (Padmanabham) of Visakhapatnam district, Andhra Pradesh formed the setting for study. A Census sample of these villages was taken and 822 elderly of both sexes were enumerated. From this sample, 300 caregivers who were having at least one older person (60+years) living with them under their care for a period of 6 months or more prior to the date of study were selected using a systematic sampling method. Thus, the median duration of stay of the older person with the caregiver came to be 31.5 years (range: 1year – 60 years). When there are more than two older persons in a family, one *referent* elderly was chosen by using a random procedure method. The caregiver responded to the interview keeping this referent elderly in mind.

Tools Used

An interview schedule was used which covered a) Socio demographic variables such as age, income, education, occupation and so on of the caregiver and the elderly, b) the Burden Assessment Scale (BAS) and c) the Caregiver Reaction Assessment (CRA) Scale. Both the measures were translated into Telugu. The reliability of the Telugu versions was determined by test-retest method by administering the test to 22 elder caregivers in an urban setting. The alpha coefficients for the pre and posttests came to be .81 and .87 for BAS and .52 and .72 for CRA respectively.

Explanation of the measures used

The Burden Assessment Scale (BAS)

The BAS developed by Reinhard and Horwitz (1995) is a 19-item questionnaire with response options on a 4-point Likert-type scale (from *not at all* to *a lot*). It is a unidimensional scale. Ten items measure objective burdens (such as missed days at work), and nine assess subjective burdens (such as feelings of guilt). Objective burdens are those that alter an activity or resource, whereas subjective measures are measured by affect or perspective. Thus, missed days at work or school, reduced leisure time, and changes in personal plans are objective burdens, and feelings of shame, guilt, and worry are subjective burdens. The total burden score, which taps both objective and subjective dimensions, is calculated by summing response values for all items. Scores range from 19 to 76 with higher scores indicating greater levels of burden. In the present study the alpha coefficient for the Burden Assessment Scale (BAS) is 0.78

The Caregiver Reaction Assessment (CRA)

Given *et al.* (1992) developed this multi dimensional scale, which is a 24-item measure with response options on a 5-point Likert-type scale. The response options range from strongly agree to *strongly disagree*. Two questions from the original scale (22 and 23) were deleted as these questions were found to be repetitive and eliciting similar answers from the respondents caused confusion to the interviewer and the respondent. The measure assesses five dimensions of caregiver reactions. They are impact on schedule (5 items), caregiver's esteem/satisfaction (6 items), lack of family support (4 items), impact on health (4 items), and impact on finances (3 items). Five items (3,7,13,15, and 19) are reverse scored. Total scores range from 22 to 110 with higher scores indicating greater burden or stress. The alpha coefficient for the Caregiver Reaction Assessment (CRA) is 0.71.

Findings

Profile of the caregiver and the elderly

Table 1 gives the socio-demographic details of the sample caregivers. As can be seen, around 64 percent of the sample caregivers are women. The mean age of caregiver is 43 years (S.D=15.6). The age range is 16 – 75 years. Women caregivers are slightly younger

(mean=42.9, S.D=14.84) than men (mean= 43.2, SD= 16.87). Majority of them belonged to backward castes (68.7 percent), followed by other castes (19.3 percent) and Scheduled castes (12.0 percent). More women are found to be illiterate as compared to men and nearly 86 percent of the caregivers are married. More than half (53.7 percent) reported their family as extended type i.e. having two generations with unmarried extended relatives. The mean family income came to be Rs. 1730/- per month (S.D=278.8) with a range between Rs.100/ - Rs.3, 000/-. As regards the duration of stay of the elderly with the caregiver, around half of them reported the duration to be 16- 40 years. Of the older persons who were under the care of the sample caregivers, around 59 percent are women who are slightly younger (mean=67.0 S.D=6.44) to men (mean=67.5, S.D=6.77). In terms of marital status, around half of the elderly (51 percent) are married followed by widowed (48 percent).

Table 1 : Profile of the sample caregivers

Variable	Men (n=109)	Women (n=191)	Total
<i>Sex</i>	36.3	63.7	-
<i>Age</i>			
Below 30years	32.1	27.8	29.3
31 to 57 years	37.6	51.8	46.7
58 yrs and above	30.3	20.4	24.0
<i>Marital status</i>			
Married	86.2	86.4	86.3
Unmarried	9.2	3.1	5.3
Widowed	3.7	7.9	6.3
Divorced	0.9	0.5	0.7
Separated	-	2.1	1.3

Religion

Hindu	97.2	100.0	99.0
Christian	2.8	-	1.0

Caste

Backward Caste	71.6	67.0	68.7
Other Castes	17.4	20.4	19.3
Scheduled Caste	11.0	12.6	12.0

Educational level

Illiterate	67.0	84.3	78.0
Primary	17.4	10.5	13.0
Secondary	13.8	5.2	8.3
Inter and above	.9	.3	0.3
Professional	.9	.3	0.3

Family type

Nuclear	16.5	28.8	24.3
Joint	25.7	19.9	22.0
Extended	57.8	51.3	53.7

Duration of stay of the elderly

Up to 15 years	14.7	31.4	25.3
16 – 40 years	58.7	46.6	51.0
41+ years	26.6	22.0	23.7

Income

Belo Rs.1000/.	18.3	28.8	25.0
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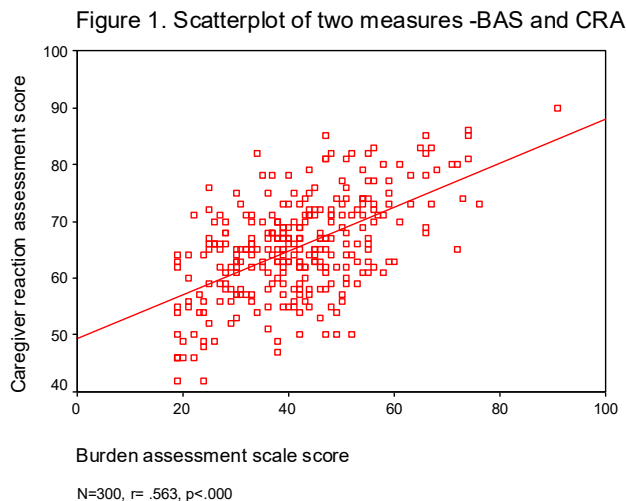
Rs.1001 to Rs.2000/.	57.8	48.2	51.7
Rs.2001 and above	23.9	23.0	23.3
<i>N</i> = 300	100.0	100.0	100.0

Relationship with the elderly

Coming to the relationship of the caregiver to the elderly, of the 300 sample caregivers, 25.7 percent are wives, 23.3 percent are sons followed by daughters-in-law (22 percent) and daughters (13 percent), and husbands (8.0 percent). The remaining eight percent (8.0) are other relatives. When enquired who takes care of the older person when she or he falls ill, the relationships figured were: wife, son, daughter, daughter-in-law and husband (in the case of women elderly), in that order.

Comparison of the BAS and CRA measures

To begin with, a strong positive relationship between burden assessment scale (BAS) and the caregiver reaction assessment score (CRA) can be seen by examining the scatter gram (Figure 1). There is a discernable pattern concentrating along the regression line which confirms the close association ($r = .563$, $p < .000$) between the two scores.



Next, Table 2 shows the means of BAS and CRA scores obtained on certain key variables such as age, sex, income, and type of family of the caregiver. As can be seen, both the measures showed a similar trend in reflecting the differences on all the variables. Thus, with the increasing age of the caregiver, the caregiver stress also increased. Women caregivers reported higher levels of burden and stress (66.2 on CRA and 43.1 on BAS) as compared to male caregivers. Further, an inverse relationship is seen in the case of family income and the mean scores on these two measures i.e. the lower the income the higher the stress levels reported.

Table 2: Comparison of BAS and CRA scores of the caregivers

Caregiver Variable	BAS		CRA	
	Mean	SD	Mean	SD
<i>Age</i>				
Below 30 years	36.1	11.6	60.8	8.5
31 to 57 years	42.8	11.7	66.2	7.8
58 years	46.2	14.0	69.6	8.2
<i>Sex</i>				
Male	39.1	10.8	64.2	7.3
Female	43.1	13.6	66.2	9.4
<i>Family income</i>				
Up to Rs.1000	50.5	14.1	70.5	8.8
Rs.1001 to Rs.2000	38.5	10.4	63.7	7.7
Rs.2001 and above	38.9	12.1	63.8	8.8
<i>Family type</i>				
Nuclear	46.2	13.4	69.0	8.9
Joint	39.9	13.5	64.4	8.7
Extended	40.3	11.8	64.2	8.2

In terms of type of family, caregivers from nuclear family background reported higher levels of stress on both CRA and BAS.

As the caregiver reaction assessment scale is a multidimensional measure, an attempt is made in Table 3 to study the relationship between sex and the different dimensions of CRA measure. In this measure, of the four (4) subscales, caregiver esteem or satisfaction covers the rewards of care giving. The rest of the sub scales are: the impact of caregiver's stress on the work schedule, family support, health and financial resources of the caregiver. The numbers of items in the original scale are given in the table. The responses to agree and strongly agree are combined and shown (Table 3)

Table 3 : Impact of care giving on caregivers esteem, on schedule, finances, health and family support

Item	Item No.	Agree Men (103)	Strongly agree Women (191)	Total (300)
Caregiver esteem				
Privileged to care for...	1	97.2	88.4	91.7
Resent having to take care of...	7	76.1	57.0	64.0
I really want to care for...	9	97.2	89.0	92.0
Not able to do enough for...	12	86.2	79.6	82.0
Caring makes me feel good...	17	87.2	78.5	81.6
Caring for ...is important to me	20	94.5	89.5	91.3
Impact on Schedule				
My activities are centered around...	4	18.4	33.5	28.0
Have to stop work in the middle...	8	12.9	24.6	20.3
I visit family/friends less...	11	11.9	12.5	12.3
Have to eliminate things from schedule...	14	5.5	16.2	12.3
Difficult to find time for relaxation	18	5.5	16.7	12.7

Lack of family support

Others have dumped caring for...	2	38.5	39.8	39.3
Very difficult to get help from family...	6	19.3	25.6	23.3
My family works together to care for...	13	11.0	22.0	18.0
Since caring for...my family abandoned	16	3.7	1.0	2.0

Impact on health

Since caring tired all the time	5	12.9	27.2	22.0
My health gotten worse since caring for...	10	7.3	12.0	10.4
I have enough physical strength to care for...	15	7.3	16.7	13.3
I am healthy enough to care for...	19	15.6	18.8	17.7

Impact on finances

My financial resources are adequate...	3	37.6	41.4	40.0
Caring put financial strain on family...	21	28.5	41.9	37.0
It is difficult to pay for the health needs of elderly...	24	34.0	46.6	42.0

As a whole, a large percentage of caregivers expressed satisfaction about the care-giving role played by them. More specifically, the trend shows that on caregiver esteem subscale a slightly less percentage of women, as compared to men expressed satisfaction about their care-giving role. At the same time, more men i.e. 76 per cent reported resentment for having to take care of the elder relative than women caregivers (57 percent). Similarly, with regard to impact on health, more women caregivers reported tiredness and worsening health because of stress arising out of their care giving

roles. Moreover, on all other subscales, more women reported interruption of schedule, constraints on social interaction, less visiting of relatives, and strain on financial resources. On the whole, the reason for lower percentage of women expressing satisfaction over care giving and reporting of higher levels of burden on other scales could be because the major burden of caring the elderly is actually shouldered by women rather than by men.

Relationship between caregiver stress and key variables

From the above discussion, it is found that caregiver stress is correlated with sex and age of the caregiver, and family income. To explore the relationships further, correlations between BAS and CRA scores, and the variables namely age of the caregiver, family income, including duration of stay of the older person with the caregiver – were explored. The values are shown in Table 4.

Table 4 : Inter correlations between BAS and CRA scores and the variables of the caregiver

	Family Income	Duration of Stay	CRA	BAS
Age of the Caregiver	−0.070	0.74**	0.44**	0.33**
Sig. (2-tailed)	0.224	0.000	0.000	0.000
Family income	–	−0.014	−0.18**	−0.19**
Sig. (2-tailed)		0.804	0.001	0.001
Duration of stay		–	0.39**	0.30**
Sig. (2-tailed)			0.000	0.000
CRA			–	0.56**
Sig. (2-tailed)				0.000

N= 300

** Correlation is significant at the 0.01 level (2-tailed).

As can be seen, there is a strong and statistically significant correlation between the age of the caregiver, the duration of stay, and the scores of the two measures, though there is no significant correlation with family income. While the age is positively correlated to both the scores (i.e. BAS and CRA), an inverse but weak relationship is seen between family income and the caregiver stress (r

= -.19 for BAS and $r = -.18$ for CRA, both significant at $p < .001$). Thus, this accounts for the stronger relationship between age of the caregiver and caregiver stress than with family income. It can also be seen that the duration of stay is strongly correlated with the scores of the two measures.

Now, the next step is to find out which of the three variables, that is, age of the caregiver, family income, and duration of stay of the elderly with the caregiver – are related to caregiver stress and which explains most of the variation in the caregiver stress?

As the duration of stay of the elderly is found to be positively correlated with age of caregiver ($r = .74$, $p < .000$) and with the scores of the two measures, partial correlations were run controlling for the age of the caregiver. Then, the relationship between duration of stay with the BAS ($r = .08$, $p < .16$) and CRA ($r = .10$, $p < .06$) scores disappeared. However, the association between caregiver's age and BAS ($r = .17$, $p < .00$) and CRA ($r = .2$, $p < .000$) was still strong and was statistically significant even though duration of stay was controlled. That is, with the increasing age the caregiver is likely to face more caregiver stress, irrespective of family's economic background. And the caregiver burden is not related to the length of stay of the elderly with the caregiver.

Relationship between the sub scales of CRA and key variables

An attempt is made to analyze the relationship between the subscales of CRA and the key variables i.e. age of the caregiver, and family income.

Table 5 : Inter correlations between family income, age of caregiver by caregiver satisfaction and other subscales of CRA

Variable	Caregiver satisfaction	Impact on health	Impact on schedule	Lack of family support	Impact on finances
Age of the care giver	0.041	0.419**	0.280**	0.208**	0.241**
Sig. (2-tailed)	0.474	0.000	0.000	0.000	0.000
Family income	-0.016	-0.153**	-0.065	-0.125*	-0.174**
Sig. (2-tailed)	0.788	0.008	0.26	0.03	0.00
Caregiver satisfaction	—	-0.411**	-0.304**	-0.374**	-0.247**
Sig. (2-tailed)	—	0.000	.000	0.000	0.000

N=300

** . Correlation is significant at the 0.01 level (2-tailed).

* . Correlation is significant at the 0.05 level (2-tailed).

The data in Table 5 show the correlations between the five subscales of CRA and the two variables. It can be seen that the age of the caregiver shows strong and positive correlation with the four areas i.e. impact on health, schedule, lack of family support, and impact on finances. While the age has a strong association with the impact on health, there is a strong negative correlation between the caregiver satisfaction and impact on health. Similarly, family income is also inversely correlated with the impact on health. This indicates that, as the age of the caregiver is increasing the impact of stress relating to care giving on their health is increasing. With regard to family income, it was found that the lower the income, the greater the negative impact of care giving on health.

Impact on work schedule also shows positive correlation with caregiver's age and inverse relationship with caregiver satisfaction thus indicating that higher disruption of the daily routine results in lower care giving satisfaction and that the impact will increase with the age of the caregiver. In terms of lack of support, again with the increase in the age of caregiver, the chances of counting on family support to help to take care of the elderly seems to become less frequent. Similarly caregiver satisfaction appears to come down significantly with the financial constraints experienced because of care giving and this impact appears to scale up with the increase in the age of the caregiver. More importantly it was found that both the age of the caregiver and family income are weakly related to care giver satisfaction.

It may be recalled that the age of the caregiver and the family income were found to be strongly associated with the two measures of caregiver stress and burden. To explore the relationship further between, care giver's age and family income with the caregiver stress, stepwise regression analysis was done. It is observed that both the variables i.e. caregiver's age and family income put together explain 14 percent of the BAS score, where as caregiver age itself contributes up to 11 percent. In the case of CRA, both the variables were found to explain 22 percent of the variation, where as the age of the caregiver is found to contribute up to 19 percent variation of CRA scores. Both the

relationships were significant for BAS and CRA at $F(2,297) = 24.97$, $p < .000$ and $F(2,297) = 41.41$, $p < .000$ respectively.

Conclusions

In the present study, the sample caregivers from rural family context are middle aged (mean age=43 years), predominantly illiterate, poor (mean income=Rs.1730 pm) and are mostly from extended households. Most of the caregivers of the elderly are wives followed by sons, daughters and daughters-in-law.

A significant finding is that the sex of the caregiver is one of the strong explanatory factors for caregiver stress and women reported higher levels of caregiver stress as compared to men. This may be probably because the major burden of caring the elderly is actually shouldered by the women who are the conventional caregivers in the family. Though a considerable number of caregivers expressed satisfaction over care giving role played by them, only a small percentage of women expressed their satisfaction about their care-giving role. The caregivers from nuclear households reported higher levels of burden as compared to joint or extended households.

Next, the caregiver burden was found to increase with the increase in the age of the caregiver. Similarly, caregivers from lower income households reported higher levels of burden and it decreased as the income level of the caregiver increased. Further analysis revealed that the age of the caregiver was an important contributing factor than the family income. That is, with the increasing age, the caregiver is likely to experience more stress irrespective of their income levels. Also, evidence shows that the lower the income of caregivers, the greater the impact of care giving burden on health of the caregiver. And that is found to bring down the caregiver satisfaction significantly.

Coming to the comparison of the two measures used in the study i.e. BAS and CRA, they reflected similar trend with reference to differences on sex, age, and income variables. Therefore, it can be concluded that these two measures are able to capture the caregiver stress and burden in a similar manner. Hence, either of the measures can be used effectively in studying the stress relating to elder care. Next, as compared to BAS, CRA being a multidimensional scale could

bring out the impact of stress on such specific dimensions as health, family support and financial strain. Furthermore, except with the sex of the caregiver, the caregiver satisfaction did not emerge as a strong factor either with income or with the age of the caregiver.

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