The effect of ageism on older people and implications for nursing practice

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Abstract
Ageism has numerous negative effects on the lives of older people, including their health and well-being. In this reflective account a nursing student explores these effects in the context of an incident where she was inadvertently ageist. She considers what she has learned from this incident and the implications for nursing practice.

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ageism, discrimination, diversity, older people

I WROTE this reflection after an experience where I was inadvertently ageist. It encouraged me to explore the effect of ageism on older people’s health and well-being, considering the implications for nursing practice and my future practice as a mental health nurse.

Reflective writing is a way for nurses to consider a situation and gain a greater understanding of its effects, while incorporating further learning, to encourage best practice (Royal College of Nursing 2016). The purpose of this article is to share my learning, to highlight how nurses can be ageist with good intentions but with negative outcomes for older people.

Ageism
In 2016, the UK population was its largest ever, at 65.6 million, with an increasing proportion of people aged 65 and over (Office for National Statistics 2017). This increase is reflected globally as life expectancy has increased and, although this is positive, it has challenges, including the risk of ageism (United Nations Department of Economic and Social Affairs Population Division 2015). Ageism is a multifaceted concept that involves stereotyping older people in relation to social constructs, which can lead to stigma (Butler 1980, Levy and Macdonald 2016), prejudice and discriminative behaviour (Butler 1980, Chrisler et al 2016). Ageism can also be seen in institutional policies that reduce opportunities for older people to live a successful life (Butler 1980). It is also the only type of discrimination to affect everyone who lives into older age (North and Fiske 2012).

Before the 1950s older people were often valued for their knowledge and experience. Older people began to be seen as a burden for the family to look after as the ageing population grew (Butler 2009). About 50 years ago, ageism was identified and defined as an important social concern (Levy and Macdonald 2016). Palmore (2005) found that many people knew little about the ageing process, which led to negative attitudes and considerable differences in the treatment of older adults. This lack of knowledge or understanding of the ageing process has led to anxiety with younger people fearing the negative implications of ageing such as becoming physically debilitated. Ageing anxiety is significant as those who fear the ageing process are more likely to avoid or discriminate against older people than those without ageing anxiety (Shaw and Langman 2017).

Even ‘benevolent’ or positive ageism, such as avoidance of invasive medical treatment (Ben-Harush et al 2016), can have negative implications for the health of older adults (Chonody 2016). As healthcare professionals, nurses should be able to recognise where ageism is occurring and how it can be challenged to support older people to receive equal treatment and care (Kagan 2008).

My experience
I was sitting on the bus after a day at college. The bus was full and when an older woman got on, I stood up and told her to ‘take this seat’. However, instead of being appreciative as I had expected, she was offended that
I had insinuated that she should not stand up on the bus. She told me to ‘mind my own business’ and asked how old I thought she was. I apologised and got off the bus at the next stop because I felt uncomfortable about the scene I had caused. My first reaction was embarrassment and annoyance that the woman refused to see my gesture as kindness.

As I thought about it while walking the rest of the way home, I realised that even though I perceived this woman as older and therefore frail, her self-image was different. I had offended her by suggesting that she should not stand up on the bus. I was mortified that she challenged me in front of everyone on the bus but I also considered how degrading it must feel to have someone offer you a seat on a bus because you do not look like you can stand. I thought about how it must feel to age and to move from being the person offering the seat to the one taking it.

I then began to understand how what I thought was a kind gesture could appear hurtful. It made me think about how such a gesture would make me feel when I am older. I may appreciate the seat if I was struggling, but the idea that people would notice me struggling and pity me would be upsetting, especially if I had always been independent and able.

I thought about age and how what one person sees as old, another may not. These different views of age can have detrimental effects on older people, for example, negative views of older age can lead to people feeling the negative effects of ageing sooner, causing them to feel like an older person more quickly (Robertson 2016).

One longitudinal study found that people with higher levels of well-being and happiness led longer lives compared with those with the lowest levels of well-being. This correlation was independent of demographic factors such as age, sex, mental and physical health, showing the importance of higher levels of well-being for life expectancy (Septoe et al 2015). Moreover, a good quality of life in older age is achievable and clinicians should keep this in mind (Netuveli and Blane 2008).

A positive, holistic view of ageing is needed in a society with an ageing population. Clinicians may deny their own ageism (Rai and Abdulla 2012), but inequalities such as being given lower priority or too much medication while receiving a lack of care and comfort are still often documented (Skirbeck and Nortvedt 2014). Other examples of ageism include use of words such as ‘geriatric’, which can have negative connotations for older people (Ouchida and Lachs 2015). Healthcare professionals may make multiple presumptions about the diagnosis of a patient based on age, for example, that an older adult is in pain because they are ageing (Makris et al 2015).

There is also a presumption that older adults do not have capacity, particularly those with dementia, which means they are often left out of decision-making about their own care (Larsson and Osterholm 2014). I need to keep this in mind as a nursing student and remember that promoting independence is as important for older people as it is for the rest of the population.

**Ageism’s negative consequences**

Stereotyping has been shown to correlate negatively with the overall health of older adults because it influences how they view themselves, for example, if a culture expects older adults to be debilitated and unable to look after themselves, then as people age in that culture they will believe that stereotype and embody its characteristics such as weakness (Dionigi 2015, Chisler et al 2016).

In particular stereotyping has a negative effect on health when combined with other forms of discrimination, for example, ageism and sexism can affect women’s self-image (Rosenthal 2014). Likewise, LGBT people may be isolated when they become older due to a lifetime of discrimination (Fredriksen-Goldsen et al 2013). When people believe negative stereotypes, it has an adverse effect on their cognition (Nelson 2016) and self-esteem (Sabik 2015).

The negative consequences of ageism can be seen in the workplace (Iweins 2013) and in healthcare (Kagan and Melendez-Torres 2015, Allen 2016). Older people’s health is often overlooked or dismissed by healthcare professionals, for example, pain not being investigated (Ben-Harush et al 2016). Ageism is particularly prevalent in young adults and, in its most extreme form, can be associated with elder abuse (Yon et al 2010). Research has also found that younger adults do not want to work with older people (Nix 2016).

Despite the evidence that highlights the negative implications of ageism for older adults, it is still documented in multiple locations. Lagacé et al (2012) asked older people living in a care home to evaluate whether the communication they received from staff was ageist and found that residents did recognise that some communication was ageist.

Other studies have also found ageism in day-to-day life (Achenbaum 2014) and in healthcare (Kagan and Melendez-Torres 2015). Healthcare professionals may make multiple presumptions about the diagnosis of a patient based on age, for example, that an older adult is in pain because they are ageing (Makris et al 2015).

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Torres 2015, Ouchida and Lachs 2015, Williams et al 2017). These findings concern me as I presumed that healthcare professionals would notice when they are being ageist and make attempts to correct it. However, like everyone else, healthcare professionals may not always be aware when they are engaging in ageist behaviour. Healthcare staff should develop a greater awareness of their own preconceptions and challenge them to ensure older adults are treated with the same level of dignity and respect as other age groups.

Even though people recognise healthy ageing as an ideal to strive for, ageing is still often widely feared (Calasanti 2016), suggesting society is not doing enough to help people understand that it can be positive. One potential solution is for Western society to adopt the approach of other cultures who believe older people should be respected. In a study by Laidlaw et al (2010) many Chinese people living in Britain showed more ageism than Chinese people who lived in China, suggesting that ageism was ingrained in British culture.

This could be addressed by representing older people more positively in the media (World Economic Forum 2012). The internalisation of media ideals of beauty has led to negative attitudes towards older people (Haboush et al 2012), but presenting positive images of the ageing body could increase self-esteem, particularly in older women (Sabik 2015).

Communication
Research has shown that many nursing students express positive views about ageing (Neville and Dickie 2014, Demir et al 2016) as do many nurses (Polat et al 2014). However, healthcare professionals may be unintentionally ageist, for example, by using infantilising ‘elderspeak’.

Elderspeak refers to any changes in the way people communicate with older people that resemble the adjustments made when talking to young children (Samuelsson et al 2013). Using elderspeak can lead to worsening moods, decreased ability (Chrisler et al 2016) and resistance to care (Williams and Herman 2011). Despite these negative findings, elderspeak can still be observed in healthcare settings.

In one study, 80 videos of communication in a care home were recorded, which showed that elderspeak was used in 84% of conversations, leading to residents feeling patronised and becoming resistant to care (Williams et al 2017).

Without this reflection, I may have shown ‘beneficent’ ageism (Chonody 2016) by using elderspeak without realising its negative implications. People can have different interpretations of words: terms such as ‘dear’ and ‘senior’ can be offensive to some but acceptable to others.

Communication with older adults should be tailored to them as individuals, just as it should be with all age groups. Educational programmes aimed at understanding, recognising and changing behaviours to reduce elderspeak and other forms of inadvertent ageism are important (Alden and Toth-Cohen 2015).

Conclusion
After this experience, I decided to be more sensitive about how I approach older people and the language I use when talking with them. I ask older people if they would like a seat rather than telling them to sit down, remembering to keep the principles of promoting independence, dignity and individuality in mind. I have learned the importance of sensitivity in an act of kindness and responding to each person as an individual.

References


