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Reducing Ageism

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Ageism, used to describe "systematic stereotyping of and discrimination against people because they are old" (Butler 1969), is an umbrella concept that manifests itself in the beliefs, attitudes, expectations, attributions, and behaviors expressed by a community toward older people. The problem that ageism poses for a society increases in seriousness with the depth of its institutional creep. At the microlevel, ageist predispositions shared by a community are likely to be organized into a coherent set of cognitions and practices that are verbalized and reinforced in social contexts. If such views are widely held and systematically applied, they adversely affect the elderly population through limiting their opportunities and restricting their freedom. In the absence of resistance, ageism inevitably frames the ways in which policymakers think and shapes policy design, in effect, serving to legitimize past domination. Ultimately, ageism, if unchecked, makes it more difficult for everyone to think outside the square to reverse patterns of institutionalized passivity or dependency that have come to be regarded as part of normal aging. This describes the cultural context in which Butler coined the term *ageism* more than thirty years ago.

The facets of ageism that remain the greatest threat to the well-being of elderly people are those that are hardest to deal with: negative stereotyping, prejudice, stigmatizing behaviors, and our own fears about the aging process. Stereotypes pose a threat because they are often widely held and take on a social truth that goes unquestioned (Haslam et al. 1998). Prejudice is harmful because it is charged with negative emotion that undermines reason and destroys cooperative social relationships (Allport 1954; Harding et al. 1968). Stigmatizing behaviors are among the most potent weapons for driving people out of their communities, destroying their sense of self in the process (Crocker 1995; Goffman 1963). Finally, inability to resolve fear of aging limits the capacity to focus on others and

their needs. With limited capacity to take in information and empathize with older people, cooperative problem solving and enlightened policy formulation are seriously compromised. While these different facets of ageism are challenged more than they were thirty years ago, they continue to have a presence in our communities. They reinforce each other in creating a distinct and readily recognizable social group of "older person" in our society.

Ageism, like racism and sexism, is a form of domination of one group by another that threatens social harmony. Unlike racism and sexism, the domination achieved through ageism involves rescinding the opportunities and freedom afforded in adulthood. For all these reasons, ageism is an appropriate topic for political debate and for political intervention when domination is perceived to have reached a point where shared societal values, in particular basic human rights, are violated.

The past three decades have been characterized by the active pursuit of interventions to counter ageism. Butler (1989) has identified central interventions in the war against ageism in the United States, among them (1) the sharing of knowledge to demonstrate that the elderly could be productive; (2) assurance that intergenerational conflict was not warranted over the distribution of limited resources, associated particularly with health care and income transfers; and (3) the enhancement of opportunities for older persons to take control of their lives and maintain a healthy and dignified old age. While embracing the progress that has been made in reducing ageism, Butler warned of its reemergence: "Ageism is a primitive disease, and unfortunately, our fears about ageing are so deep that ageism will probably never totally disappear" (p. 146).

Not too distant from any "-ism" are fear and the perception of threat to security. Consequently, racism, sexism, and ageism are never eliminated or resolved in a society, just managed and contained. But as Butler points out, management of ageism takes on a special dimension. The phenomenon of aging is part of the expected journey of life for all of us and brings us closer to our own mortality. Whether this realization makes us recoil in horror or zealously work to make old age better depends on one's point of view. According to Guttman (1988), medical establishments are peopled by both gerophiles who want to protect and help and gerophobes who would rather deny that old age can give rise to difficulties.

This chapter reviews ways in which the most damaging facets of ageism—stereotypes, prejudice, stigma, and fear of the aging process—can be reduced through policies and intervention programs. It considers how the different facets of ageism are interrelated and warns against address-

ing one facet without considering the implications for other facets. Theories of stereotyping, prejudice, stigma, and fearful aging point to different sources for the emergence of an ageist stance. In particular, fears about not having dignity in old age may have a pronounced impact on how we respond to policies that are designed to break down barriers between age-defined social groups. This problem is discussed within the context of caregiving, where problems of stigma, shame, and closeness to the negative aspects of the aging process can undermine the best-laid policy initiatives for successful aging. Finally, society's readiness and willingness to engage with the process of degeneration and loss is proposed as the new challenge that must be met if ageism in all its guises is to be kept at bay.

Reducing Negative Stereotypes of Old Age

In the tradition of Lippmann (1922), stereotypes can be defined as "societally shared beliefs about the characteristics (such as personality traits, expected behaviors, or personal values) that are perceived to be true of social groups and their members" (Stangor 1995, p. 628). Stereotypes, positive or negative, are thought to provide us with a short-cut for perceptual processing (Fiske and Neuberg 1990). They allow us to avoid the time-consuming and cognitively demanding task of sifting through information about an individual to make a judgment about that person's interests, capacities, or needs. Instead, we rely on a heuristic that tells us that people who belong to a certain group are more likely to have interests, needs, and capacities of a particular kind. The perspective of the cognitive miser provides one theoretical lens for understanding stereotyping at work.

A second theoretical perspective has focused on the social dimension of stereotyping. According to Tajfel (1981), stereotypes serve a number of social functions, all of which revolve around the notion of providing individuals with a social identity. At the microlevel, stereotypes provide us with a well-differentiated social world, regulating our behavior and enabling us to maintain a relatively positive self-view through a process of defining ourselves as part of an in-group that is distinctive, in important and valued ways, from competing out-groups. At the macrolevel, Tajfel saw stereotypes serving not only the function of defining and differentiating status groups within society, but also of explaining the relationships among these various groups. Stereotypes are a convenient tool for bestowing status on groups and can be used to make out-groups the scapegoats for society's problems. Most significant, stereotypes provide one means by which challenges to institutional legitimacy and cries of institutional

injustice can be quelled. Members of society can be reassured that the problems lie outside, not within, the dominant group, and arguments for the need for social change can be discredited. In these ways, the security provided by society's institutions can be affirmed and maintained.

From either a cognitive miser or social identity perspective, policy initiatives that seek to counter stereotypes of older people need to highlight the variability in the characteristics, interests, and capacities of this age group. Resistance to persuasion may come from a number of sources. Most notably, individuals may dislike the complexity of the message, preferring the order, predictability, and efficiency that comes with knowing that someone belongs to a particular social group that can be broadly characterized in certain ways.

This type of resistance is sidestepped by initiatives that promote positive stereotypes of older age groups. Research has shown that individuals hold multiple stereotypes of older people (Brewer, Dull, and Lui 1981) that are both positive and negative (Braithwaite 1986a; Braithwaite, Gibson, and Holman 1986; Golde and Kogan 1959; Lachman and McArthur 1986; Luszcz and Fitzgerald 1986; Schmidt and Boland 1986). The portrayal of positive elderly role models through advertisements, literature, film, and news stories on television, in the papers, and on radio provide alternative images to traditional negative stereotypes. Broadening the base and nature of stereotypes about a social group so that stereotype diversity and complexity becomes the norm is one step forward in the terms Butler (1989) outlined.

Positive stereotyping to counter negative stereotyping should be recognized as only a partial answer, however. Although we know that each individual can hold a number of stereotypes, we also know that priming is crucial in determining whether a positive or negative stereotype is triggered in a particular situation. The hard problems for combating ageism arise when individuals are visibly losing their capacities to perform tasks that they had been able to perform in the past. It is unlikely to be beneficial for a perceiver to have positive stereotypes in one's repertoire of responses if the perception of failing capacities triggers a negative stereotype instead. Stereotypes are highly sensitive to context (Hummert et al. 1998), and we often have little control over the context or priming event (Bargh, Chen, and Burrows 1996).

On the other hand recent research has provided some evidence that we are not always at the mercy of our primed cognitions. Individuals are able to suppress negative stereotypes (von Hippel, Silver, and Lynch 2000). Willingness to make the effort to suppress stereotypes is likely to be bol-

stered by providing increased exposure to the diversity of social roles performed by the elderly population. Observing elderly people carrying out a variety of social roles has been shown to override the more restrictive stereotypes of the past (Kite 1996). As long as opportunity to contest new stereotypes is welcomed, the restrictive implications of stereotyping for individual freedom hopefully can be limited.

Reducing Prejudice toward the Elderly

A concept that is closely related to stereotypes theoretically and empirically is prejudice. Negative stereotypes of old people are likely to fuel prejudice toward the elderly and vice versa. Prejudice is used to describe "the holding of derogatory attitudes or beliefs, the expression of negative affect, or the display of hostile or discriminatory behavior toward members of a group on account of their membership in that group" (Zebrowitz 1995, p. 450). As with stereotyping, respect for individual differences disappears when prejudice comes into play. Prejudice differs from stereotypes, however, in its emphasis on affect or emotion. Stereotypes about a group have a quality of social truth and may be held as statements of fact by large segments of the population with little emotional overtone. At best, stereotypes represent ignorance, not hostility. Prejudice, on the other hand, is emotionally charged. The sources of prejudice are multiple (Allport 1954; Duckitt 1992) and the relative importance of the sources poorly understood (Agnew, Thompson, and Gaines 2000). Socialization experiences that take into account cultural history and social norms provide one source for understanding prejudice. A second approach has been psychodynamic, conceiving of prejudice as a manifestation of internal conflict and the displacement of hostility onto less powerful groups (Adorno et al. 1950). A third approach has recognized the importance of specific experiences and the interpretation of those experiences in relation to the negatively evaluated group.

Common to all these perspectives is the relevance of threat, of feeling deprived, frustrated, or hurt in some way by the presence of the other group. Prejudice is thought to be fueled by competition for limited resources and reduced by cooperative ventures where interdependency furthers the agendas of both groups (Zebrowitz 1995). Attempts to improve intergenerational relations through intergenerational cooperation have been documented in the literature. Butler (1989) has described Generations United in the United States as a program that has built a coalition across age groups that is working together to improve life prospects for

children and elders alike. As governments throughout the world look to social capital as a means of strengthening care provisions, cooperative ventures across age groups are emerging. The Homeshare program, first trialed in the United States, has spread to Britain and Australia. The programs enable older people to remain in their homes and allow younger people to have rent-free accommodation in exchange for some housework and meal preparation.

Providing opportunities for different age groups to help each other is likely to meet with opposition in some quarters, particularly if the prejudice of one group toward the other is deep. Social identity theorists would argue that cooperation is dependent on the parties developing a shared social identity. Contact and communication are not enough. In this respect, openness to establishing a positive relationship to others is an important quality. Agnew, Thompson, and Gaines (2000) have shown that attitudes of openness and flexibility are important determinants of who is most likely to express prejudice toward the elderly and who is not.

Consistent with this line of argument are the findings of Galinsky and Moskowitz (2000). In their study, perspective taking, the strategy of imagining how we would feel and act if we were in the same situation as the other, increased self-other overlap when undergraduates evaluated an older target. Moreover, when the undergraduates expressed their views about the older person, they were more positive in their evaluations, and their tendency to stereotype was reduced.

Galinsky and Moskowitz (2000) have argued strongly for the superiority of perspective taking over suppression as an approach for controlling stereotyping and prejudicial behavior. They liken suppression to an avoidance response, which does nothing to cure the problem. In contrast, perspective taking is a preventive strategy that appears to forge links between young and old, at least for the duration of that particular encounter. From a practical point of view, perspective taking poses a new challenge in the quest to reduce ageism. Those who are old, middle aged, and young must find time to spend with each other, an issue to which we return later in this chapter.

According to Harding and associates (1968), prejudice is an attitude that departs from three ideal norms: the norm of rationality, the norm of justice, and the norm of human-heartedness.[1] Departure from rationality refers to persistence in relying on stereotypes even when they have been exposed, a lack of interest in uncovering new evidence, and resistance to recognizing individual differences. Departure from justice describes unequal treatment and is closely allied to discrimination, where oppor-

tunities are denied to individuals for reasons that are irrelevant to the requirements of the situation. Departure from the norm of human-heartedness is the most unusual of the three ideal norms, not because it does not exist in the community (Braithwaite and Blamey 1998) but because commonly it is not part of our scientific vocabulary. The norm of human-heartedness may be the most important norm to activate in countering ageism. It "enjoins the acceptance of other individuals in terms of their common humanity, no matter how different they may be from oneself. The acceptance is a direct personal response, in either feeling or action, and includes the area of 'private' as well as 'public' relationships" (Harding et al. 1968, p. 5). The norm of human-heartedness is society's expression of endorsement for the kind of intervention advocated by Galinsky and Moskowitz (2000) in their work on perspective taking.

Reducing Stigma in Relation to the Elderly

Stigma has been defined as any peculiar marking of the body thought to be a sign of somewhat general degeneration (English and English 1958). The definition helps focus our understanding of stigmatizing where individuals are rejected from the social group because they have an attribute that compromises their humanity in the eyes of others (Jones et al. 1984). Crocker (1995, p. 633) uses Goffman's (1963) terms to capture the essence of the concept: "the stigmatized have a 'spoiled identity.'" *Stigmatizing* and *stereotyping* are used interchangeably in the gerontological literature, but from the perspective of ageism reduction, there is merit in at least attempting to tease them apart.

All three concepts of stereotyping, behaving prejudicially, and stigmatizing involve labeling the whole person. In the case of stereotyping, the core issue is inaccurate labeling because group homogeneity is assumed and individuality is not taken into account. In short, imperfect knowledge renders the individual invisible. In the case of behaving prejudicially, the core issue is unfair labeling because truths, half-truths, and untruths are stitched together in a loose, but often indefensible, psychologic to underscore dislike for a group and domination of that group. In the case of prejudice, unsubstantiated ideology justifies derogatory treatment that renders the individual invisible. In both cases, an onlooker might question the legitimacy of the perceiver's judgment on the basis of information adequacy or distortion.

Stigmatization is different. The problem is not with the information that the perceiver takes in but rather with the perceiver's response to that

information. The core issue in stigmatizing is that an individual has an attribute that is visible, in most cases uncontroversially so, and the perceiver finds the attribute so unacceptable that he or she wants the bearer out of sight. The offending attribute may be a facial blemish. Options for restoring social harmony are limited: The bearer can stay out of sight or have the blemish removed, or the perceiver can become desensitized to the blemish. When there is no evidence that the stigma poses a threat to a society, the process of desensitization would appear to be the respectful option. Desensitization should be relatively simple, providing the perceiver accepts the principle that stigmatizing another person is inappropriate. In practice, stigmas are often bolstered by prejudices and stereotypes that lend them an air of legitimacy. In such cases, convincing a group to break with stigmatizing practices may be a challenge.

The stigma of fading physical attractiveness, for instance, continues to flourish and appears to be almost the prime feeder of the beauty industry. Interestingly, the stigma is thought to affect women more strongly than men (Snyder and Miene 1994). There is little doubt that cosmetic companies and cosmetic surgeons trade on stigmatizing practices: Wrinkles and sags are visible, they are unacceptable in a world that hankers after status, and they are consequently removed from view by cosmetic companies and cosmetic surgeons for a handsome fee. High status for women demands success in battling wrinkles and sagging skin, a stigmatizing tradition that was exposed to much acclaim by Wolf in *The Beauty Myth* (1991). In spite of our assault on ageism and the support of feminism in debunking beauty truisms, wrinkles and sags remain almost universally targets to erase, not embrace.

Many personal characteristics that elicit a stigmatizing response cannot be removed or changed easily. Immobility, frailty, forgetfulness, and widowhood are among the physical, psychological, and social characteristics that are known to elicit stigmatizing responses. While these characteristics have rightly been uncoupled from aging because they are not inextricably tied to aging, they nevertheless are more likely to occur as we grow older. Consequently, any discussion of reducing ageism must give some consideration to the stigma of loss.

We stigmatize other human beings through displays of displeasure or disapproval, the creation of social distance, and avoidance. Stigmatized individuals respond by feeling rejected by their social group—not for what they have done but because of whom they are. Unless the stigmatized individual has the capacity to remove the stigma, rejection is global and enduring and can be damaging to identity.

Institutionalized stigmatizing, that is, removing people from mainstream society because of increased age or an age-related loss, has become less common over the past three decades, but examples are still familiar to most of us. Elderly people with dependency needs routinely were moved out to aged-care homes and hospitals. Workers as they approach 65 still face compulsory retirement in some countries, including Australia. In these cases, the stigmatizing conditions of being removed from mainstream institutions have been offset by a concerted effort to reinterpret these events as points of transition rather than as breaks with normal life. The stigma of "being put out to pasture" has been replaced by notions of new opportunities and, in some cases, "greener pastures."

These changes have been executed and accepted in a relatively short period of time. At the University of Queensland from 1966 to 1976, Elsie Harwood and George Naylor directed a research program called Operation Retirement. They recognized the importance of involving older citizens in mainstream institutions postretirement (Harwood 1974; Naylor and Harwood 1970). On a regular basis, a group assembled to learn German and to play the recorder at the university. Programs of this kind are hardly innovative these days. Senior citizens attending universities, offering special tuition for children with learning disabilities, or operating advice services for new business owners are among the many stories that continue to make the news. We may wonder, however, why they are not more commonplace and still newsworthy after thirty years. Longino, McClelland, and Peterson (1980) have described how elderly communities develop their own subcultures that are integrated, pro-elderly, and self-affirming. They also note, however, that these communities are retreatist and do not foster a politically active aging consciousness. Possibly, older citizens shy away from commitments with mainstream society. Possibly, older citizens are wary of offering their services unless they know that they will be welcomed and valued.

It may be that the social damage of stigmatizing lies not so much in implementing transitions but in the message of disrespect that can be communicated through downgrading the status of individuals and cutting them off from society (Blaney 1994). This point is an important one for interventions. Transitions may be an inevitable part of the aging process, but as a society, we have choice and responsibilities for how they are managed. They can be managed with respect, consultation, and inclusion or, alternatively, with disrespect, domination, and deceit.

To the extent that we are social beings, our self-worth depends on the worth ascribed to us by others. Arendt (1967) has described the devastating

effects of Hitler's policies of segregation in relation to the Jewish population in Germany during the Third Reich. Stigmatizing actions that separate us from others destroy the essence of our social being and induce a passivity that robs us of ourselves. Thus, aged-care policies that rob individuals of their identity need to be identified and resisted at all times.

It would be a mistake to consider such policies a thing of the past or to underestimate the difficulty of identifying and reversing them. Transitions are constantly the concern of policymakers, and stigmatizing behavior creeps in when arrangements for transitions are handled disrespectfully. Here are two Australian examples of policy that perpetuates stigmatizing behavior.

The first example relates to nursing home regulation. For a short period in Australia's history, nursing home regulation was resident focused, more so than anywhere else in the world (J. Braithwaite 1993; J. Braithwaite et al. 1993). Government nursing home inspectors were obligated to talk to residents and their families about the care that they were receiving. The regulatory procedure was hailed a great success (J. Braithwaite et al. 1993) until the government decided to go down an audit trail and downgrade the role of residents and their families to that of "the complaints mechanism." This change raises an interesting question. Who among us would think it appropriate for someone to inspect our own home without explaining to us why they were coming and without showing an interest in what we thought about it all?

Admissions procedures to nursing homes in Australia provide a second example of how policy can inadvertently foster stigmatization. Nursing home beds are subsidized by the government, but in order to qualify for the subsidy, the bed has to be occupied. Thus, when an offer is made to someone on the waiting list, the individual, or more often families, are pressured into accepting immediately unless they have the money to hold a bed for future use. Most families cannot afford to pay to hold a bed. In these circumstances, how would we respond to being told by our families that we would be moving out in the next day or two and would need to get our things together to move into a nursing home room that we would be most likely sharing with a stranger? If this happened to us tomorrow, what would we do? If Arendt is right, we would do nothing. We would be herded off with others like us, we would be decultured, and before long, we would lose our sense of self.

Examples of implementing separation with strategies of disrespect, domination, and deceit are not uncommon, and they are not necessarily strategies that are explained by stereotypes or prejudice. Sometimes they

have more to do with the way stigma is handled by those with power and an unquestioning sense of their superior knowledge and understanding. When we look at nursing home placements and workplace terminations, disrespect, domination, and deceit often are responses to social awkwardness and a well-meaning desire to minimize the anguish and pain of the situation for everyone. As a society, we struggle with failure and loss. It is hard to acknowledge that we or a loved one cannot take care of ourselves, or that we put others at risk because we can no longer do things as well as we could. The stigma of poor performance remains at the heart of our capitalist economies and our social structures. Inevitably, the identities of those so affected are threatened, highlighting the need to pursue policies that encourage the adoption of new and valued social identities when the time for residential or work transitions arrives.

Sometimes, however, the new identities challenge some basic values of society, and there is nothing to be done other than to face the value conflict head on. Nowhere is this more evident than in dealing with degeneration of a cognitive or social kind. An interesting example of stigma associated with mental deterioration came to attention recently with the publication of Bayley's (2000) book about the last year of the life of his wife, the renowned novelist Iris Murdoch. In this book, Bayley shares his experiences as he cares for his wife in the final stages of Alzheimer's disease. At the time of the book's release, reports of outrage attracted the attention of the world's news media.[2] The story was one of shock that a husband would expose the details of his wife's degenerating condition and in so doing tarnish the memory of someone who was revered for her fine intellect and literary talents. The well-intentioned desire to remember Murdoch at her peak reveals one of our yet unchartered stigmas, that of mental deterioration. The question that needs answering when we consider a talented person who is losing her mental capacities is, Where does disrespect lie? Is disrespect to be owned by a husband who struggled to come to terms with his wife's deterioration, or by a society that cannot truly value a life lived with stigma?

For members of a stigmatized group, anticipating the reactions of others is somewhat unpredictable. The literature documents not only reactions of distaste and displeasure, but also a second reaction that seeks to counter the negativity of the first through offering sympathy and concern (Langer et al. 1976; Scheier et al. 1978; Katz 1981). In some cases, sympathy and concern can backfire because it is expressed in an exaggerated and unnatural manner (Crocker 1995). This observation provides some interesting conflicts for ageism reduction. The perspective taking advocated

earlier may lead the nonstigmatized to share the humiliation of the stigmatized to the point where they overcompensate. Research relating to communication patterns reveals that an overaccommodating style by the young toward the elderly can be seen as patronizing (Hummert et al. 1998; Williams and Giles 1998), and elderly people have their own way of dismissing the unwanted attention (Williams and Giles 1998).

Stigmatizing is a problem that requires coordinated action at both the individual and the societal levels. Considerable progress has yet to be made in uncoupling loss from the negative emotions of repulsion and shame. Resolving this societal problem shows signs of being a major challenge. The first step, however, may be more manageable.

Langer and associates (1976) have raised questions about the extent to which stigmas follow from feelings of dislike or disgust, as has always been assumed. Instead, they have put an argument for interpreting reactions to stigma in terms of discomfort arising out of novelty (Langer et al. 1976). They investigated this idea in the context of physical disability. They noted that novel stimuli give rise to the desire to stare. Staring is part of normal exploratory behavior, but it is also deemed socially unacceptable. Consequently, the individual who encounters something unfamiliar in a social context where staring is prohibited will be in a state of conflict. Conflict generates discomfort, which leads to avoidance.

Langer and associates (1976) tested this hypothesis by giving subjects in one experimental group time to familiarize themselves with a physically disabled confederate whom they could observe through a one-way mirror. In a subsequent interaction with the person, the research team observed seating arrangements and found that compared to a control group, those who had time to familiarize themselves with the disability sat closer to the confederate and were less likely to seat themselves at an angle so that the confederate was out of view. Most interestingly, this effect was not mediated by self-reports of liking for the confederate. These findings suggest that stigma as novelty should be the first port of call when planning interventions to deal with stigmatizing behaviors.

If this is so, the stigma associated with old age should be reduced through giving more public exposure to those aspects of aging that leave us feeling conflict ridden, confused, inept, or ill at ease. Of central importance in the context of aging is the stigma of loss. In an achievement- and success-oriented society, the norms and scripts for dealing with failure and loss with the appropriate amounts of respect, concern, and acceptance are strikingly absent. Awkwardness and overcompensation are the more common scripts that we encounter.

Overcoming these boundaries may require stepping outside real life into the world of make-believe and the institutions of the arts. Comedy has always been an important forum for broaching taboo subjects and finding ways to talk about that which is unspeakable. Film, drama, television, and literature can ease us into coming to terms with stigma. Documentaries and public affairs programs can then ride on the coattails of an arts-initiated desensitization process and provide the information and shared experience required to break down barriers that separate older persons psychologically, socially, and physically from society.

Reducing the Fear of Aging

Fear of aging is conceptualized here as holding a negative attitude to one's own aging process, making an appraisal that the final life stage will be the least pleasant because it is dominated by loss. As Berezin puts it (1972), "The older one becomes, the more losses he [or she] sustains" (p. 34). Physical and physiological changes are likely to adversely affect one's health, friends and other loved ones die, and financial resources diminish. Berezin points out that "what is significant about the changes that do occur, both internally and externally, is not the fact of their occurrence but rather how they are met and mastered" (p. 34).

Fear of aging can be conceptualized like any other threat to our wellbeing. We can allow the fear to grow and dominate our view of aging, we can deny its existence, or we can try to come to terms with it, lessening its power over us in the process. In the last case, fear of acquiring attributes that will limit quality of life is likely to become a motivator for adaptation (Markus and Nurius 1986; Cross and Markus 1991; Hooker and Kaus 1992; Ogilvie 1987). The literature on stress suggests that successful adaptation can be accomplished in two ways.

First, the early stress and coping research identified the value of interpreting outside events as challenges rather than threats or losses, and of seeking and finding solutions to the problems at hand (Folkman et al. 1986; Lazarus and Folkman 1984). Pursuing an active problem-solving approach to aging at all stages of life is likely to prove beneficial. Individuals can learn more about the aging process, adopt a healthier lifestyle to lower the risk of poor health, plan for retirement, and make provisions for care, should that be required. Providing individuals with the belief that they can take steps to improve the quality of life in their old age is likely to help reduce fear of the aging process significantly and strengthen the resolve of individuals to be a "golden ager."

The essence of this approach is control. The second approach, represented by the work of Antonovsky (1972, 1979, 1987), reminds us that some things are beyond control. One of Antonovsky's major contributions to our understanding of adaptation is to shift our frame beyond personal control to management. Antonovsky conceptualizes demands, that is, life events and hassles, not as abnormal experiences but as part of the normal state of living. In other words, Antonovsky starts from the premise that the normal state of living for everyone is more chaotic than orderly and that adaptation is a continuous creative process that involves us in learning, critical thinking, and effort. For Antonovsky, the never-ending threats from the inner and outer environments create tension that we relieve through using our resistance resources: freedom to enter new social roles, modify existing norms, feel connected to others, and have a strong sense of meaning in life and a belief that life can be managed. Without resistance resources, the tension produced by threats and demands eventually leads to breakdown. Part of the account Antonovsky offers is that successfully negotiating one's way through the life course has more to do with an ability to transcend difficulties through giving them meaning than through shaping them directly to suit our liking. Antonovsky uses the term *sense of coherence* to describe the capacity to make sense out of what happens to us, to incorporate our experiences, good and bad, into a meaningful whole, and to comprehend our situation to the point of managing it. Antonovsky's sense of coherence, when applied to the context of elderly people, raises issues similar to those discussed by Erikson in his work on the search for ego integrity in later life and the avoidance of despair (Erikson, Erikson, and Kivnick 1986). The difference is that Antonovsky's account of successful adaptation is an ongoing process on offer to all age groups.

The solutions to problems of stereotyping, prejudice, stigma, and fear of ageing offered in this chapter all head in the same direction: facilitating more open communication, perspective taking, more information exchange, less censoring of taboo topics, more problem solving, and developing the capacity to transcend a need to control events that are not to our liking. These are all desirable outcomes, but how can these goals be achieved in our society, particularly in relation to ageism?

The Interrelationships among Stereotypes, Prejudice, Stigma, and Fear of Aging

A widely held assumption in the gerontological literature is that the components of ageism are loosely interconnected and together lead to discriminatory actions whereby older people are denied the opportunities,

benefits, and quality of life offered to other age groups. Questions regarding overlap among the different facets of ageism were raised by Langer and associates (1976), who challenged the assumption that nonverbal expressions of avoidance were more credible indicators of prejudice than verbal measures in which respondents denied having negative feelings. They suggested that people might be telling the truth and that behaviors that were being interpreted as derogation may have really been expressions of discomfort and conflict.

Ageist Ideology versus Discrimination

In 1988–1989, research on the components of ageism was conducted using a sample of 195 students at the Australian National University. The purpose of the study was to find out if endorsement of commonly held stereotypes, negative attitudes to elderly people, fear of one's own aging, and discriminatory behavior were interrelated.[3] If the components of ageism are not tied together at least loosely, initiatives to reduce one problem cannot be expected to have a spin-off effect that will solve other problems. If the various facets operate somewhat independently, many different approaches will be required to make an impact on ageism. Finally, if some components are inversely related, attempts to bring about change on one front may undermine progress elsewhere.

Part I of the ageism study (Braithwaite, Lynd-Stevenson, and Pigram 1993; Pigram 1987) involved constructing scales to measure four facets of ageist ideology along with a measure of awareness of ageism in the society. The Attitudes to Elderly People scale measured comfort with elderly people, feelings of closeness and friendship, through to avoidance and lack of interest in them. The Attitudes to One's Own Aging scale measured fear of loss and concerns about one's capacity to manage through to enthusiasm about the opportunities of old age. The Negative Stereotype Endorsement scale measured the extent to which respondents believed elderly people are slow, forgetful, and distractable as opposed to focused, able, and energetic. The Positive Stereotype Endorsement scale measured the extent to which respondents believed elderly people are friendly, accepting, and sympathetic as opposed to intolerant, biased and unsociable. The Awareness of Ageism scale measured the extent to which individuals believed that elderly people were given respect, consideration, appreciation, and opportunity by members of society through to the extent to which they were targets of discrimination.

Scores on the ageism scales were intercorrelated to find out the extent to which they cohered to form an ageist ideology. Having a negative attitude

Table 11.1
Pearson Product Moment Intercorrelations among Scales Measuring Facets of Ageism

Scales[a]	1	2	3	4
1 Negativity to elderly				
2 Negativity to ageing	.37***			
3 Incapable-capable stereotype	.28***	.36***		
4 Unsociable-sociable stereotype	.29***	.10	.28***	
5 Awareness of ageism	–.18**	–.02	–.08	.01

[a]For all these scales a low score indicates high levels of negativity about older people, and awareness that ageism exists in society.

to elderly people was significantly correlated with feeling negative about one's own aging. Butler (1987) has argued that fear of aging is a key driver of ageism in our society. Those with negative attitudes to the elderly and the aging process were also more likely to endorse the stereotype of elderly people as incapable and ineffective. Systematic denial of the positive stereotype did not come from those with a fear of aging but rather from those who held a negative attitude to the elderly as a group. This finding suggests that the presentation of positive stereotypes is probably of limited use in moving the more prejudiced away from their ageist position.

The results in table 11.1 support the notion that the components of ageism are interrelated. Endorsement of negative stereotyping, negative attitudes to elderly people, and fear of one's own aging work together to promote an ageist ideology. While awareness of ageism in society was high in this sample (78 percent expressed at least some support for this view), awareness was poorly related to holding an ageist ideology oneself. Thus, exposure of ageist practices through the media or advocacy groups may do little to change the ageist ideology of individuals.

Part II of the ageism study examined age discrimination. Prior to completing the ageism questionnaire, participants took part in an experiment to assess ageist practices. Using a two-by-two between-subjects experimental design, each student was given a transcript of an employment interview, purportedly conducted with a woman who had applied for the position of tutor in psychology. Half the students were told that the tutor was 27 years old, the other half that she was 59. Transcripts varied also in terms of the applicant's interest in being primarily a teacher or researcher. Those who participated in the study were required to make two judgments. First, they were asked how much they would like the person as a tutor (rated on a five-point scale from "not at all" to "very much"), and

second, they were asked how likely it was that the candidate would actually get the job on a four-point rating scale from "less than a 25 percent chance" to "more than a 75 percent chance."

Having found evidence of ageist ideology and awareness of ageism in society, we were not surprised to find age discrimination when it came to tutor preference and expectations of success. The 27 year old was given higher ratings on how much the students would like her as a tutor and on likelihood of success in getting the job. What surprised us was that when we looked at the ninety-one students who had evaluated the 59 year old as a tutor, we were unable to find any relationship between any of the ageism scales and either liking or expected success. We had hypothesized that those with ageist attitudes would be among those who gave the lowest ratings to the older applicant on both personal liking and likelihood of success (see Braithwaite, Lynd-Stevenson, and Pigram 1993 for further details).

These findings show ageism and age discrimination as being unconnected. The reasons at this stage are unclear. Some may rightly question whether a 59 year old is old. The problem may be one of mistakenly measuring "old-ageism" as opposed to "middle-ageism," although for 18-year-old students who made up most of this sample, the distinction between a 59 year old and a 69 year old is relatively subtle. Alternatively, it may be that the behaviorally damaging component of ageism in this experimental context is covert. Dovidio and Gaertner's (1986) research suggests that the worst side of ageism, like sexism and racism, has "gone underground" and cannot be measured through conscious beliefs. Or it may be, as Langer and associates have proposed, that discrimination is fueled by something more benign, such as novelty.

In the ageism study, the test for discrimination was an employment context. The novelty-familiarity explanation fits the findings to a point. Most tutors were doing postgraduate studies so that students would be most familiar with tutors in their late 20s. In keeping with the familiarity hypothesis, students preferred the younger applicant and also thought that the younger applicant was more likely to be offered the job by the university. The younger applicant matched the prototype of university tutor better than the older applicant.

But the familiarity argument did not explain the second preference the students expressed. The applicant with a commitment to teaching rather than research was the preferred choice of students even though they were not convinced that her chances of success were higher. A broader but not dissimilar concept that has been put forward to explain discrimination is social attractiveness (Puckett et al. 1983). We choose people whom we

perceive as enhancing our quality of life. Fitting in, being easy to get on with, and bringing knowledge or status to the workplace are factors that drive personal preferences. This is not to dismiss novelty. Novelty, as described by Langer and associates (1976), may simply be one factor that reduces social attractiveness.

This argument suggests that older job applicants should be as successful as younger applicants, providing they are armed with social attractiveness. It needs to be acknowledged at this point, however, that social attractiveness is a far more complex phenomenon in the outside world than it is in the laboratory. Social attractiveness is likely to be lower in cases where older job applicants have been denied access to new technologies, they are not familiar with new ways of doing work, and superannuation and employment policies make appointment costly and difficult. At the level of individual preferences, social attractiveness may well be the important factor. But social attractiveness may be shaped not by an individual's efforts, achievements, and abilities but by a society that regulates, both intentionally and unintentionally, access to opportunities.

When societies recognize deficiencies in the social system that deny opportunities on a systematic basis to a group, multiple remedial steps can be taken. Among these are affirmative action and antidiscrimination legislation. Both types of legislation are important in signaling the intent of a society to combat discrimination, but their effectiveness is bound by human ingenuity. In the normal course of events, selection processes are devised to suppress the pull of social attractiveness and put appointment by merit in its place. Legislation is devised to rule out age (or race or sex) as a reason for nonappointment. There is, however, no safeguard against a committee's developing a shared and unspoken view that an applicant does not suit the job as well as others. It is not so much that the applicant lacks the desirable qualities; rather, others have more of these qualities. In this context, ageism as lower social attractiveness goes undetected and unchecked.

The ageism study illustrates how advances in combating an ageist ideology may require deeper change in how one thinks about aging than is provided through increasing community exposure to positive stereotypes. It also warns that a less ageist ideology, even when inscribed in law, may have a limited impact on discriminatory actions. While we remain uncertain about the nature of the relationship between ageist ideology and discriminatory action, we can be relatively confident that the relationship is not simple.

Caregiving, Stress, and Stigma

The ageism study illustrated independence between ageist ideology and discriminatory practices; work with caregivers has revealed how policies designed to be inclusive of older people are undermined by the stigma of degeneration.

The initial focus of our caregiving work was understanding the burden of care, defined as the extent to which caregiving frustrated the satisfaction of basic human needs for order, belonging, and self-esteem (Braithwaite 1990, 1992, 1996). The theoretical framework for this work was provided by the crisis-of-decline model. The essential propositions of the model that were supported by data were as follows: Caregiving burden is related to (1) care receiver degeneration, which bears a heavy stigma, (2) caregiver unpreparedness in the form of not having cultural knowledge about this type of care, (3) relationship damage as caregiver and care receiver unsuccessfully battle decline in one partner, (4) enmeshment as the caregiving role becomes all-consuming, and (5) coercion, since no alternative is on offer for most caregiving dyads.

Caregiving in circumstances where degeneration is occurring can be interpreted as a story of stigma and isolation. In Western societies, caregiving eventually tends to become the responsibility of one person. As this person takes on more and more, the caregiving dyad retreats, becoming increasingly isolated from society. It is interesting to note how caregivers receive many more offers of support than they ever accept or feel comfortable accepting (Braithwaite 1986b, 1987). Caregivers and care receivers conspire to preserve their privacy, not wanting to involve too many others in their affairs. At the same time, all indications are that they do not retreat into blissful solitude. The overwhelming proportion of caregivers say they would not wish the caregiving role on their children (Braithwaite 1990).

Stigma affects the caregiver in two ways: through being the person responsible for the care receiver, particularly when the care receiver engages in socially inappropriate behavior, and through a shared identity with the care receiver, often built over many years as a beloved parent or spouse. Either way, the caregiver becomes engulfed in a state of shame. Shame is felt on behalf of the care receiver who can no longer attract the status of earlier times and causes embarrassment and shock to others. Shame also creeps in as caregivers fail in their bid to restore their care receiver to good health. Shame of either kind leads to the same outcome: withdrawal and avoidance of others (Ahmed et al. 2001).

The role that stigma plays in isolating caregiver and care receiver becomes evident in respite care usage. Caregivers are strong advocates of

respite care, but their usage patterns belie their agitation for more and better services (George 1988; Gibson et al. 1996; Lawton, Brody, and Saperstein 1989; Montgomery and Borgatta 1989; Oktay and Volland 1990). In investigating the impediments to using respite, great reluctance emerged among those who had an intimate and loving relationship with the person they were caring for (Braithwaite, 1998). They used respite in emergencies, but always hoped that they would not need it again. These findings were interpreted as a sign of the dependency, trust, and intimacy in caregiver–care receiver relationships that could not be equaled by those outside. Added to this may be elements of distrust in a society that is not always tolerant or respectful of vulnerability.

In 1997, the Commonwealth Department of Health and Family Services sponsored the Caregiver Recreational Respite Program, a trial program geared toward increasing the use of respite care among caregivers and giving them an opportunity to reengage with the community (Braithwaite, Pollitt, and Roach 2000). The program recruited thirty-nine caregivers who took part in a leisure activity of their choice through attending weekly sessions over a seven-week period. The program was an enormous success for those who attended, but the recruitment process was painfully slow. We anticipated that we would be flooded with applications, but this was far from the case.

The program was designed to offer support at a number of levels. Respite was organized through professional agencies, taxis were organized to take caregivers to and from the sessions, materials were provided through the research program, and we had good contacts with doctors and caregiving networks in the district. We were open to arranging programs of any kind, responding to public demand. Two specific responses from caregivers surprised us. First, most caregivers preferred to make their own respite arrangements through their informal network rather than use professional services of their choice that we would pay for. It also surprised us that most caregivers were recruited through informal networks with a go-between who encouraged the participant to come forward and become involved. In the course of the evaluation study, we were interested in understanding the reluctance to come forward, who benefited most, and why.

Some caregivers had difficulty accepting the role of caregiver. Such acceptance meant recognizing deterioration in someone they cared for that could not be dismissed as "normal." The stigma of disability prompted the protection offered by denial. Regardless of acceptance of terminology, caregiving that was demanding brought with it enmeshment. Of most

concern was the harm induced by two types of enmeshment: relationship enmeshment, whereby caregivers tried in vain to find a sense of their own worth in the eyes of the care receiver, and role enmeshment, whereby caregivers and care receivers excluded others from participating in the caregiving process. Interestingly, those who benefited most from taking part in the program were caregivers with a strong commitment to caregiving who were facing loss through a degenerating relationship with the care receiver.

These findings demonstrate that policies offering respite support make sense from the point of view of relieving the caregivers' stress, but their likely effectiveness is complicated by other factors. Respite provides escape from a situation that is laden with stigma. Whether caregivers feel they can or should take advantage of respite depends on their relationship with the care receiver (Braithwaite 1998). On the positive side, it seems highly likely that respite can disrupt the buildup of tension and fatigue (Braithwaite, 1986b, 1987), but it cannot address the basic source of the problem: stigmatization, shame, and isolation. More broadly, stigma and shame appear to be major impediments to caregivers' feeling willing and able to take advantage of formal and informal services. Ironically, these services are often supported by governments in a bid to be inclusive of caregivers and care receivers and responsive to their needs.

A Ten-Point Plan for Ageism Reduction

This chapter suggests ten action plans for ageism reduction:

1. Heightening sensitivity to the stereotyping of older people.
2. Creating greater exposure to diversity in the personal characteristics of older people.
3. Having greater commitment to recognizing and responding to diversity in dealings with older people.
4. Making deliberate use of perspective taking to see the older person as an individual.
5. Seeking out opportunities for intergenerational cooperation.
6. Taking advantage of opportunities to promote the social attractiveness of older people.
7. Strengthening institutional practices that promote the norm of human-heartedness.
8. Desensitizing ourselves to the stigma of degeneration and dependency.

9. Reviewing policies and practices for evidence of stigmatizing through disrespect, particularly the disrespect communicated through treating older people as an invisible group.

10. Mandating inclusiveness of older people in policy planning and implementation.

In order to implement these ten steps, we need to consider whether the institutions are in place to deliver on them. This question is beyond the scope of this chapter, but I wonder if the institutions of family, work, and governance provide the time and space for reflective dialogue over issues relating to ageism. Common to all the steps is the assumption that nestled within our institutions are places for cooperation, reflective dialogue, shame acknowledgment, and collective problem solving. Such space is often held hostage to competitive struggles for dominance, efficiency, and ritualized outputs that result in the generation of much activity without coming to terms with the problems at hand. Stepping back to take a broader view of our institutional structures for dealing with all types of "-isms" may be a necessary first step for making progress on addressing ageism. The second step should be the definition or creation of spaces where young, middle-aged, and elderly people from all walks of life can get to know each other enough to build mutual respect, develop cooperative relationships, and reignite the norm of human-heartedness.

Notes

1. *Ideal norms* are defined by Williams (1960) as standards of conduct that everyone feels an obligation to follow, even if they are not always followed.

2. Later reviews of the book were positive, reflecting the often observed pattern of stigmatizing reactions being followed by more sympathetic ones.

3. Previous work in this population had identified negative stereotypes relating to competence and positive stereotypes relating to sociability (Braithwaite 1987). In this study, 70 percent of participants endorsed the negative stereotype of low capability, and 63 percent endorsed the positive stereotype of high sociability.

This study did not set out to measure prejudice in the form of threat or hate or stigmatizing in the form of disgust. The focus was on negative attitudes associated with lack of interest in and affection for elderly people and conscious discomfort with elderly people. In this work, these attitudes were highly correlated and formed one scale.

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