# PERSPECTIVES IN SOCIAL GERONTOLOGY

ROBERT B. ENRIGHT, JR.
Editor

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# Perspectives in Social Gerontology

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*To Joan and Michael*

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# PREFACE

While developing reading lists for my undergraduate sociology courses in aging, I was drawn to original source materials as a way to introduce students to the wealth and diversity of ideas in social gerontology. I realized that many articles published in professional journals could be brought within the reach of my students if they were carefully selected, placed in a meaningful context, and organized in an integrated text. This volume is an effort to bring such original-source readings into the grasp of undergraduate and early graduate students.

Unlike textbooks that provide a distillation of ideas from many sources, this book introduces the reader to a set of concepts as presented by their original authors. This method gives the reader not only an appreciation for the richness of ideas and diversity of approaches involved in the study of aging, but also a genuine understanding of the way ideas are developed. The material presented here is not intended as a collection of theories to be memorized or arguments to be accepted, but as a set of individual contributions, each with its own strengths and weaknesses.

No single theoretical perspective is put forth in this collection. Instead, the articles are intended to demonstrate the diversity of viewpoints in the field. They were drawn from a variety of journals and were originally intended for readers from various fields, including sociology, psychology, political science, economics, policy studies, and nursing.

For the most part, the articles were published recently, and all of them are presented in their original form, except for minor editing in a few instances. They were selected not only because they should be easily understood by undergraduate and early graduate students, but also because they address issues of central importance to the field of gerontology. Readers will find them conceptually rich and provocative, without being methodologically or empirically complex.

From the perspective of social gerontology, human aging, including its biological and psychological aspects, takes place in social milieux. Moreover, it is not just individuals who age. Societies age as well, and an aging society affects the lives of both old and young. The articles included in this volume emphasize the social context, meaning, and impact of aging on all of us.

Two themes run through this collection. The first is the challenges of aging in contemporary American society. The aging of our nation's population has had and will continue to have a dramatic impact on our lives. Many issues face us as individuals and as members of society, including moral and ethical questions regarding the use of life-sustaining medical technology, access to health care, and the way we construct social policy to address our changing needs as we grow older.

The second theme is the diversity of ways that people experience old age. Gerontologists have shown that different people age at different rates, and that

even within any single person all features do not age at the same pace. Many of the articles included here take this notion a step further to demonstrate how social factors contribute to the diversity of ways people age.

This book is designed for use either as a text to accompany a comprehensive set of lectures or as a supplement to a standard text in social gerontology. It is divided into fifteen chapters that cover the essential topic areas in the field. Each chapter is self-contained and thus can be used in any order to fit the design of any course in social gerontology.

Each chapter begins with an essay that introduces the subject area, identifies major issues and questions, and describes how the articles fit into this context. Each chapter concludes with a series of discussion questions designed for use in class discussions or individual study. The questions are not designed for tests but to stimulate thought and dialogue on the readings.

Reading ideas as originally presented often generates a recognition that many questions remain unanswered. This encourages the reader to regard the questions in the field as issues to be grappled with rather than as problems to be left to the "experts." So observe the strength of these ideas, but do not overlook their flaws. Take this opportunity to read what others have written, but think for yourself. Challenge the thoughts presented here as well as your own. The final answers have not yet been found.

I am grateful to Karen Hanson of Allyn and Bacon for her support and faith in this project. I would like to thank the University Personnel Development Committee of the University of Wisconsin-Stevens Point for supporting this work with a grant and sabbatical leave and Professor Leslie McClain-Ruelle for helpful suggestions on my proposal. Professors Edward J. Miller and Lawrence Weiser provided helpful comments on the introductory essays. Carole Van Horn led me on searches through library data bases, and Christine Neidlein and the staff of the Interlibrary Loan Department obtained numerous articles for me to review. Jim Rasmussen of the Portage County, Wisconsin, Department on Aging provided timely help with technical aspects of government policy.

I would also like to thank Jodi Hewitt for assistance with the initial literature searches, Carol Chase for pursuing copyright permissions and organizing mounds of paper, and Amy Cattanach, Chris Ballweg, Deb Chapman, Lori Kresal, Sarah Wandke, and Jennie Zick for proofreading, library research, and skilled clerical work. Special thanks go to Lou Fossen, who kept the whole enterprise intact, for contributions above and beyond the call of duty; to my wife Joan for patient listening, careful proofreading, and valuable insights; and to our son, Michael Job, for joy and inspiration.

Robert B. Enright, Jr.

# CONTENTS

# CHAPTER ONE

# Introduction: Real and Imagined Effects of Aging

Negative stereotypes of older people have existed for quite some time. In the past, old people were often characterized as poor, in failing health, sexless, and grouchy. While these depictions have not completely disappeared, most people realize that all older people do not conform to such descriptions. In the recent past, newer images of older people have developed that often portray them as vibrant, healthy, and capable of enjoying retirement. Sometimes these portrayals even go so far as to depict older people as wealthy and selfish. The new stereotype of the "greedy geezer" has come to replace the image of the poor, old grandparent sitting on the front porch in the rocking chair. Though less demeaning than earlier portrayals, the more recent stereotypes of older people as wealthy and greedy can be no less damaging.

Socially defined images of the elderly, or of any other group for that matter, can shape the way they regard themselves and how they are treated by others. Ultimately, the social perceptions of older people affect government policy. The "new ageism," driven by envy or resentment of the improved economic condition of the elderly in the United States, has led to the blaming of older people for the difficulties endured by others even when the genuine cause lies elsewhere (Sheppard 1990).

This introductory chapter includes articles from two authors concerned with damaging stereotypes about older people. Robert N. Butler coined the term "ageism" in 1968 to refer to bigotry against the old. In "Dispelling Ageism: The Cross-Cutting Intervention," Butler describes current manifestations of the "disease" of ageism, including the "greedy geezer" stereotype mentioned above. Nevertheless, Butler claims that these are not the views of people at large, and that most people favor keeping and even expanding entitlements for older people. Butler prescribes knowledge as the chief antidote for ageism. He calls for support for older people's sense of "mastery" and emphasizes the need to recognize their potential as contributors to society.

Gerontologists have put a great deal of effort into debunking commonly held myths about growing old. As inaccurate negative images of growing old become discredited, optimistic perceptions of growing old are developing, em-

phasizing the belief that getting older is not as unpleasant as many expect (Dychtwald and Zitter, 1988).

Although conditions for the elderly have generally improved in the last several decades, illness and disability are conditions still faced by many older people. How are the less fortunate treated in a society where older people are perceived as doing well? In the second selection, "Aging and Disability: Behind and Beyond the Stereotypes," Meredith Minkler argues that the emphasis on a positive outlook toward the aged can create an "elderly mystique" in which prejudice is directed not against all old people, but against those who are disabled.

In attempting to reach beyond stereotypical images of older people, researchers attempt to understand the true effects of growing old. As Kovach and Knapp explain in "Age, Cohort, and Time-Period Confounds in Aging Research," this often is not as simple as comparing older people with younger people at one point in time as is done in cross-sectional studies. The reason is that older people differ from younger people not only in age, but also in cohort membership (*i.e.*, the year they were born), and in the time-period they have reached old age. How does one know whether the differences between older and younger people are due to the effects of age, cohort, or time-period? Kovach and Knapp discuss the ways in which these effects can be confounded and the research approaches that can be used to distinguish between them.

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# 1

# Dispelling Ageism: The Cross-Cutting Intervention

*ROBERT N. BUTLER*

It is increasingly within our power to intervene directly in processes of aging, with prevention, treatment, and rehabilitation. It is also within our power to intervene in social, cultural, economic, and personal environments, influencing individual lives as well as those of older persons en masse. If, however, we fail to alter present negative imagery, stereotypes, myths, and distortions concerning aging and the aged in society, our ability to exercise these new possibilities will remain sharply curtailed. Fortunately, we can treat the disease I call "ageism"—those negative attitudes and practices that lead to discrimination against the aged.

## THE DISEASE

I originally coined the term "ageism" in 1968. As chairman of the District of Columbia Advisory Committee on Aging, I had been actively involved in the acquisition of public housing for older people. Stormy opposition arose against the purchasing of a high rise in northwest Washington. The causes for neighbors' negativism were intermixed, for not only were many of the future tenants black, they were also old and poor. In the course of a *Washington Post* interview, I was asked if this negativism was a function of racism; in this instance, I thought it more a function of ageism.[1]

As I originally defined it,

> Ageism can be seen as a systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this with skin color and gender. Old people are categorized as senile, rigid in thought and manner, old-fashioned in morality and skills. . . . Ageism allows the younger generation to see older people as different from themselves; thus they subtly cease to identify with their elders as humanbeings.[2]

Not incidentally, in my original formula I was just as concerned with older people's negativism toward young people as I was with young people's negativism toward old people.

I saw ageism manifested in a wide range of phenomena, on both individual and institutional levels—stereotypes and myths, outright disdain and dislike, simple subtle avoidance of contact, and discriminatory practices in housing, employment, and services of all kinds.

*Source: Annals of the American Academy of Political and Social Science, 503,* 138–147. Reprinted with permission from Sage Publications, Inc., Newbury Park, CA 91320. 

Lately, we have seen a rising chorus of voices further criticizing the aged, suggesting that they have had too many advantages. These views come from powerful quarters: politicians, scientists, and philosophers. Interestingly enough, however, these rumblings of intergenerational conflict are not the views of the people at large. National polls and surveys reveal just the opposite, that persons of all ages wish to see older persons keep their entitlements or even have them expanded. An excellent case in point is the recent spectacular rise of the long-term-care issue on the nation's agenda in both the halls of Congress and the recent presidential race.

In light of these surveys, which do not support intergenerational conflict but, rather, reaffirm the needs of older persons, how can we justify the continuation of the practice of ageism? On the one hand, I do believe that the last decade has witnessed a steady improvement in the attitudes toward the aged, in part a consequence of general public education, increased media attention, the expansion of education in the community, colleges, and universities, and the continuing growth of gerontology. On the other hand, the success is uneven, of course. Residual pockets of negativism toward the aged still exist, most occurring subtly, covertly, and even unconsciously. Like racism and sexism, ageism remains recalcitrant, even if below the surface. But it can be—and has been—churned up from its latent position.

To ensure a reasonable place for older persons in society, we need to review some of these contemporary myths, stereotypes, and distorted facts, which must be dispelled or reduced.

## CURRENT MANIFESTATIONS

Unfortunately, even the medical profession is not immune to ageism. Medical ageism is contracted in medical school. In fact, it was there that I first became conscious of prejudice toward age, there when I first heard the term "crock"—originally applied to patients with no organic basis for disease thought to be hypochondriacal—applied to middle-aged women and older people. Other terms abounded as well: "gomer" ("get out of my emergency room"); "vegetable"; and "gork" ("God only really knows" the basis of this person's many symptoms).

Medical schools do everything to enhance this virus. The first older person that medical students encounter is a cadaver. Fresh out of college, young people are confronted with death and their own personal anxieties about death, yet they are not provided with group or individual counseling. Not long after, they are exhausted with sleeplessness and hostility for not learning everything fast enough; by the time they are in their third or fourth year of medical school, they are ripe for cynicism. Then comes the internship, and they are working in excess of eighty hours per week, up in the middle of the night—and there is still one of those "gorks" to see.

Few medical school graduates enter the field of geriatrics. In fact, on the whole, physicians do not invest the same amount of time in dealing with elderly patients as they do in their younger counterparts. Doctors question why they should even bother treating certain problems of the aged; after all, the patients are old. Is it worth treating them? Their problems are irreversible, unexciting, and unprofitable.

Then, too, the disease manifests itself in the hospitals themselves. A New York geriatrics professor, currently working at a hospital that, like others, is financially hemorrhaging, fears that his hospital will begin to view the elderly as quite unattractive once administrators see a recent report compiled by accountants tabulating the costs of each diagnosis-related group. Their report gave two tabulations—one for those over 70 and one for those under 70. They correctly con-

cluded that the over-70 group costs the hospital more.

The severe cutback of services following the $750 billion tax cut inaugurated by the Reagan administration has brought steady criticism that Social Security and Medicare provide entitlements for older people yet deny them for the young. Newspapers report that the elderly's median income has risen significantly more than that of any other age group, basically due to Social Security benefits. From such distorted figures has emerged what one author has termed the "New Ageism,"[3] a dangerous viewpoint that envies the elderly for their economic progress and, at the same time, resents the poor elderly for being tax burdens and the nonpoor elderly for making Social Security so costly.

Capitalizing on such distorted figures, many are prepared to churn up these worst views of old people. Not long ago, a cover article of the *New Republic* criticized our society for pampering our "affluent" elderly population, the "greedy geezers." The article began:

> Thirty percent of the annual federal budget now goes to expenditures on people over the age of 65. Forty years from now, if the present array of programs and benefits is maintained, almost two-thirds of the budget will go to supporting and cosseting the old. Something is wrong with a society that is willing to drain itself to foster such an unproductive section of its population, one that does not even promise (as children do) one day to be productive.[4]

Groups such as the Americans for Generational Equity promote displacement of Social Security. Wall-Streeter Peter Peterson, former U.S. secretary of commerce, vehemently opposes Social Security; media commentators, seeing the aged as an affluent group, urge Social Security "bashing" and call for privatization of one's retirement planning, which would benefit business and, hence, Wall Street.

Daniel Callahan, expounding the old-age-based rationing of health care originally suggested by former Colorado Governor Richard Lamm in 1983, sees older people as "a new social threat . . . that could ultimately (and perhaps already) do great harm."[5] Programs that benefit the elderly, says Callahan, consume an ever increasing percentage of our taxes; health care expenditures, especially, are becoming extremely disproportionate and costly as the number of our elderly grows. We should use our money to help a sick child live rather than waste it on the old, who have already lived full lives.

It is noteworthy that this sense of renewed threat or concern about the number and proportion of older persons comes in a century of extraordinary increase in average life expectancy. Indeed, in the United States alone there has been a gain of 28 years of life expectancy since the year 1900, nearly equal to what had been attained over the preceding 5000 years of human history. Eighty percent of this gain derives from marked reductions in maternal, childhood, and infant mortality rates. The remainder comes from reductions in death from heart disease and stroke. Although there is considerable chronic disease and disability at later ages, the expanding average life expectancy has yielded large numbers of increasingly vigorous, healthy, and productive older people.

Ageism may bear a relationship to the proportion of older persons in a society. A threshold that might be regarded as an achievement has, instead, become regarded as a burden. Ironically, the long-sought-for gain in life has been met by anxiety. What should have been a celebration has become a sense of threat. What should have been a message of hope has become a matter of despair.

Indeed, my impression, gained from wide travels in varied societies, cultures, and political systems—the Soviet Union, the People's Republic of China, Sweden, France, Argentina, Canada, Mexico, Israel—is that

these concerns are universal, in response to the increasing numbers and proportions of older persons. Societies are afraid this increasing older population will become unaffordable, lead to stagnation of the society's productive and economic growth, and generate intergenerational conflict.

## TREATMENT

Georges Bernanos wrote, "The worst, the most corrupting lies are problems poorly stated." Let us then state these problems as they really are, putting various myths and distortions into their proper perspectives. In order to treat this disease, we first need to realize what is really true about persons. One antidote to ageism is knowledge.

### Knowledge, the Primary Intervention

The belief that neither societies nor individuals will be able to deal with the avalanche of age is reminiscent of the ancient Greek saying, When the Gods are angry with you, they give you what you want. Presumably, human beings wanted an extended life. But the truth is, there has been no extension of the natural inherent life span from the beginning of time, as far as is known. What has happened is an increased survivorship. More and more persons have been able to live out a full life.

Another myth is that all old people are senile and debilitated. But senility is not inevitable with age; rather, it is a function of a variety of brain diseases, most notably Alzheimer's disease and multi-infarct dementia. Nor are the great majority of older people so afflicted. Unfortunately, there may always be some residual gerontophobia and ageism resulting from discomfort and distaste for age and its disabilities. Some profound and pervasive disorders of old age—mobility problems, dementia, and incontinence—are unattractive and provoke disgust and fear.

Then there is the myth that all old people are affluent. Although the elderly are about as likely to be poor as younger populations, income and assets are distributed more unevenly among the elderly, concentrated highly among the rich old. In our rich nation, only 5.6 percent of older people have incomes in excess of $50,000 a year.

Simply stated, the old are, on the whole, the poorest of adults. Of our 28.0 million Americans aged 65 and over, 2.6 million fall below the parsimonious government-recognized poverty line. Two-thirds of them live alone on incomes of less than $104 a week; the other third are couples sharing $131 a week. Additionally, 4.5 million elderly are near-poor. Half of these live alone, existing on between $104 and $156 a week; the other half—elderly couples—live on between $131 and $195 a week.[6] Those in the oldest category—85 years and older—have the lowest income and the greatest percentage of chronic illness. They are more likely to require medical services but less able to afford the care they need.

Widows are the primary victims of elderly poverty and thus bear the brunt of ageism's assault. Their luck in living longer than men has, paradoxically, compounded their problems. Of elderly women, 41 percent are near-poor, contrasted with 17 percent of elderly men. The fact that 75 percent of the poor elderly are women reflects their lower wage levels during their working years, inadequate and inequitable Social Security coverage, and the increased risk of financial devastation from widowhood. Their poverty rate increases with age, from 15 percent for those 65–74 years old to 26 percent for those 85 and older. Of those over 85, 8 percent—50,000 widows—are forced to live on less than $76 per week. Two-thirds of the noninstitutionalized elderly who live alone are widows; over half of them became poor after their husbands died, probably due to consuming medical and funeral expenses and lost pension income.[7] Thus it is really women