

Critically reflect how being labelled as an ‘older person’ might negatively impact upon one’s mental health.

Ageing is a natural and inevitable process, we can neither slow down or stop the process of biological ageing (Greco *et al*, 2018), according to the World Health Organisation (WHO) (2019(a)), this process begins at conception and concludes upon death. Wahl *et al* (2017) infers that although biological ageing is inevitable, ageing itself is a socially constructed concept, explaining, different human societies use various methods in their design of age, some use generational life courses or stage life courses and many use chronological age, Wahl *et al* (2017) argues nevertheless, that chronological age is also a social construct based upon the calendar, despite this chronological age often has a significant influence on the way an individual is perceived and therefore treated by wider society.

Terms such as “elderly” or “old” are conflicting and in modern discourse are becoming harder to define, traditionally people in the UK were considered old or elderly when they reached the age in which they could receive their state pension, which was conventionally aged sixty for women and aged sixty-five for men (Greco *et al*, 2018). However, better gender equality, increased employment opportunities, higher life expectancy and higher standard of health for longer have driven reform in the statutory retirement age and therefore state pension age (Carrino *et al*, 2018). This figure currently sits at approximately sixty-six for both men and women and is readily increasing, it is estimated to reach sixty-seven by 2028 (AgeUK, 2020).

Advances in health care, decline in fertility rates and higher life expectancy has resulted on a macro scale globally, and on a meso scale in the UK in ageing populations (Bronfenbrenner, 1979). This means individuals are living significantly longer than they were in the past, thereby, the WHO (2015) defines an older person as someone who has exceeded the average life expectancy rate of their birth age, suggesting that because populations are readily ageing, as is the basis of what is considered ‘old’. This process is happening at a considerably fast rate, much more rapidly than expected decades ago, it is estimated that one in five people (28.1%) in the UK will be sixty-five years old or above by the year 2030, with 6.8% of these being over seventy-five and 3.2% being over eighty-five (Office for National Statistics (ONS), 2017). WHO (2015) establishes that this offers profound implications for individuals and societies, particularly due to the added contribution older people can make to their communities while living longer and in better health, however, ageism and age discrimination still appears to create barriers to this becoming achievable in practice (Swift *et al*, 2019).

This essay intends to reflect upon how being labelled as old may negatively affect one's mental health focussing on ageism and discrimination (WHO, 2015), the mental health implications of ageism and labelling of older adults, ageism in health care and the effect this has on the mental health care received by older adults (Ayalon and Tesch-Romer, 2018) and, the effects of ageism and social isolation on older adults during the COVID-19 pandemic (Usher, 2020).

Despite patterns of ageing reforming dramatically, ageism, discrimination and stereotyping of older adults is still significantly prevalent in British society (WHO, 2015), ageism or age discrimination describes discrimination or poor treatment of an individual because of their age; this type of discrimination is known to permeate multiple facets of society such as employment and health care (WHO, 2015; Officer and De La, 2018). Labelling theory suggests that negative labels reinforce negative self-concept, in this context, suggesting that if someone is continuously labelled as 'old' they will begin to subconsciously act in the way society deems appropriate for someone who is "old"; this often means conforming social norms and living in a way which decreases life satisfaction and has influence on poorer mental health outcomes (Cohen, 2018; Greco *et al*, 2018). It also often means becoming devalued by society even further, because you confirm their assumptions (Cohen, 2018).

Swift *et al* (2019) indicates these discriminatory styles are often reflected in language or attitude used directly to or indirectly about individuals in areas of society such as media representations because of underpinning assumptions that they are "old". Frequently, stigmatisation and stereotyping of older people surrounds itself by the idea that older communities are homogeneous, often under these stereotypes older people are characterised as being ill, boring, weak and vulnerable (Holm *et al*, 2014).

The Royal College of Psychiatrists (RCP) (2018) expound that ageism and age discrimination is a pressing and contemporary issue which is blighting our society, despite ten years of government policies being derived to address and combat the problem. In theory, under the *Equality Act (2010)* age discrimination is outlawed and the ban on age discrimination ten years ago intended to ensure older adults were able to be treated fairly across all sectors of society such as health care, this essay will explore whether this has been made a reality in practice.

Age discrimination makes poor mental health and psychological wellbeing outcomes more prevalent in older people (RCP, 2018). Abrams *et al* (2017) expands on this, stating that ageism creates barriers which impede upon older people's chances of active and healthy ageing, active ageing being the process of optimising health, security and participation opportunities for the

quality of life of older people, active ageing encompasses continued participation of all areas of life; meaning, the focus is not solely on physical activity but social, civic, cultural and spiritual participation too.

According to the WHO (2004) mental health refers to a state of internal positive social, emotional and psychological wellbeing, a person who inhabits a state of positive wellbeing can effectively cope with the day-to-day stresses or worries of life and is able to recognise their own abilities and strengths while utilising them to make valuable contributions to their wider community and society. On the contrary someone in poor mental health may be unable or struggle to do these things, finding life and normal tasks much more difficult to cope with and carry out (WHO, 2004). The disengagement theory of age explains that as adults get older, they disengage from society because they are no longer participating in the same roles and activities as in their younger years, as a result society also disengages from the individual, this is much more likely if the individual is experiencing poor mental health and struggles to effectively participate in day-to-day activities (Larkin, 2009; WHO, 2004).

Mental health affects the way one can see and think about the world around them, poor mental health can have detrimental effects on a person's life at any age, likewise, mental wellbeing is as important at all ages (MentalHealth.gov, 2017). The Mental Health Foundation (MHF) (2016) infer that ensuring positive mental health is an important contributing factor of healthy and active ageing and positive wellbeing in later life, the general societal paradigm of ageing is often underpinned with the assumption that quality of life decreases with age, which is not necessarily true. Despite this assumption, government policy regarding mental health generally targets children, young people and working age adults which tends to mean adults up to sixty-five (MHF, 2016). RCP (2018) explains that as a result older people in the UK also receive unequitable treatment and care by mental health services, this will be explored in the next section of this essay.

As explained previously older people are generally stereotyped as unwell, frail and dependent individuals, these stereotypes are often echoed in health care practices, as most patients using these services will be temporarily ill and reliant. This, unfortunately, appears to reinforce and confirm negative ageist attitudes among health care professionals (Swift *et al*, 2017). Ageist stereotypes influence the decisions doctors make in terms of diagnosis and prescription, evidence suggests that older patients are significantly more likely to be incorrectly diagnosed or treated for mental health problems, than younger patients (RCP, 2018).

For example, in a randomised control study, one-hundred and twenty-one doctors were given case studies of patients with identical characteristics and symptoms of depression, one patient was eighty-one years old and the other thirty-nine, in almost all instances a more appropriate diagnosis was given by the doctor for the younger patient. Most doctors diagnosed the younger patient with anxiety and depression related disorders and prescribed them with relevant psychotherapies, whereas the older patient was more likely to be diagnosed with either a physical illness or dementia and prescribed with medication or counselling (Swift *et al*, 2017 cited in RCP, 2018). If these proposed diagnoses had been given to real patients, they would be considered direct examples of age discrimination, although this is a hypothetical and research-based example it does emphasise the dangers of ageism in health care and the need for better provision of mental health services for older adults (RCP,2018). While also suggesting that health care professionals consider the care and treatment of younger people is more important than that of older adults, thus, highlighting the need for elimination of age discrimination by health care professionals to ensure individuals are receiving correct diagnosis and appropriate treatment for mental health conditions (RCP, 2018).

AgeUK (2016) explain that amongst older adults, depression is the most common mental health problem affecting around forty percent of care home residents and twenty-two percent of men and twenty-eight percent of over sixty-fives who live at home in the UK. Nonetheless, Tadaros *et al* (2013) reveal that in most services only one in six old people are recipient of any treatment after diagnosis, while fifty percent of younger patients are directly referred to mental health services. Additionally, Burns and James (2015) convey that eighty-five percent of older adults with depression receive no treatment at all under the National Health Service, thus increasing the prevalence of these instances of depression worsening, obstructing the individual's chances of functioning independently and increasing the chances of suicide (Barnes and James, 2015; Ryan *et al*, 2008; Alexopoulos, 2006).

There has been a particular emphasis in recent years in recognising mental health with the same significance and prioritisation as physical health, despite this, it is evident that older people are still posed with more significant barriers to accessing mental health services and being treated with respect and dignity by health care professionals regarding their mental health than younger patients (AgeUK, 2019). Government policy has continuously overlooked older people in both mental health services and policy, completely disregarding the challenges posed by ageing societies. For instance, within the *Mental Health Act (1983)* Code of Practice which has been reviewed in recent years, there is no specific guidance for the mental health needs of older

adults, despite their being sections which focus specifically on children, people with autism and adults with disabilities (RCP, 2018; Department of Health, 1983).

Ayalon and Tesch-Romer (2018) suggest that the curriculum content of mental health training programmes are generally lacking adequate materials and resources related to geriatric mental health care specifically and as a result many health care professionals lack essential theoretical and research-based knowledge of ageing and the mental health of old people. This lack of knowledge subconsciously establishes age-based biases throughout health care, and drastically effects the likelihood of positive mental health outcomes for older patients (Bryant and Koder, 2015). Ayalon and Tesch-Romer (2018) stress that this is a global problem on a macro scale in the context of demographic change and population ageing which must not be ignored, claiming that if populations are getting dramatically older, we must not consider and treat older people as second-class citizens who are not deserving of adequate health care (Bronfenbrenner, 1979).

Some suggestions have been made for dealing with ageism in health care settings, regarding policy, the RCP (2018) infer that in moving forward, a mental health strategy must be derived for the UK which includes a specific and detailed framework for meeting the mental health needs of older people, this strategy should include clear resources and pathways to meet these needs. The RCP (2018) also explain that we must simply learn to value the contribution that older adults make to society and consider old age to be a period which can be embraced and enriched through employment, volunteering, relationships and caring for family members. It is essential for a paradigm shift to occur so that social, civic, cultural and economic participation becomes a social norm in later life, this, in turn, will help older adults in feeling more comfortable with embracing their later years and reduce the risk of negative mental health (RCP, 2018). Changing attitudes throughout society will require informed and well-equipped health and social care staff in the fields of ageing in general and mental health in old age, therefore, the RCP (2018) believe serious enquiries in to training new and existing staff in health care to ensure that this is possible.

Conclusively, ageist stereotypes have a detrimental effect in mental health practice and labels such as “weak” and “vulnerable” cannot be used as substitute for adequate and correct diagnosis in the mental health of older adults. Therefore, reducing and overcoming age discrimination must be considered a national priority (Ayalon and Tesch-Romer, 2018). The activity theory of ageing establishes that the more engaged and involved older adults are with their wider community and society, the more likely they are to age successfully and encompass

higher life satisfaction in their older years (Mauk, 2010). The COVID-19 pandemic, however, has created significant barriers to societal engagement and participation (Usher, 2020), especially for older people, this will be explored in the next section of this essay.

The COVID-19 pandemic has unprecedentedly impeded upon the lives of all individuals, in an unbiased manner regardless of age; however, physiological characteristics of ageing such as decreased immune system functioning, increase the risk of both becoming seriously ill and the prevalence of death if contracted in an older person (Previtali *et al*, 2020). Consequently, older people have become a focal point in political discourse and media depiction of COVID-19, as well as being a significant target in many of the regulations implicated to combat the pandemic (Ayalon *et al*, 2020).

Chronological age has been utilised as a foundation for various policies and restrictions during the pandemic across the globe, this is despite there being no international agreement of which age is most suitable to use as a guideline for what constitutes as old and therefore vulnerable – thereby illustrating the limitations of the thresholds (Previtali *et al*, 2020). Using chronological age to collectively define and categorise older adults, overlooks the individual differences and circumstances of adults of a particular age and therefore establishes ageist assumptions and stereotypes within society (Ayalon *et al*, 2020). Many of these policies are underpinned by a portrayal of all older people, particularly those over the age of seventy as helpless and frail individuals who offer no useful contribution to society (Ayalon *et al*, 2020). Previtali *et al* (2020) implies that in order to protect individuals at risk, illness and poor health associated with chronological old age must be considered, however, emphasises the fact that in no way does being chronologically old mean one is vulnerable, in ill-health or unvaluable to society.

Media and government depictions of old age throughout the pandemic have often portrayed older individuals to be at risk of death due to COVID-19 and should therefore stay at home, these depictions have entirely disregarded older adults who are fit and healthy individuals, with no underlying health conditions (Previtali *et al*, 2020). The unconscious effect of this, can be considered in the impact it has had on the mental health of older people (Ayalon *et al*, 2020), Kessler and Bowen (2020) suggest that COVID ageism is and should be considered a public mental health concern, explaining that ageism is causing unique form of anxiety for older people. They explain that older adults are fearful now not only the disease itself and the subsequent health implications of catching COVID-19, but also, the fear of unequitable and inadequate treatment if infected, due to prioritisation of younger patients who are assumed to

be of more valuable to society in the long term; thus, causing older adults to feel valueless, unappreciated and invisible (Kesler and Bowen, 2020).

Stereotype embodiment theory establishes that negative stereotypes concerning age can become internalised and can have influence on an older person's perception of their own ageing, which can thereby have detrimental effect on both their physical and mental health (Levy, 2009). Similarly, self-fulfilling prophecy theory proposes that false expectation by society on an individual can subconsciously lead to its own confirmation (Sternberg, 2011).

During the pandemic older adults have been advised to stay at home and quarantine, isolate or shield, even after imposed full lockdown restrictions were relaxed, due to ageist perceptions of vulnerability (Coughlin & Yoquinto, 2020 *cited in* Previtali *et al*, 2020). Enforced quarantine or isolation is an unfamiliar, unnatural and unpleasant experience which imposes separation from loved ones and everyday routines which many individuals rely on for positive mental health and general wellbeing. Also, older adults are at higher risk of psychological damage in long periods of isolation due to already being a marginalised group within society (Perrin *et al*, 2009 *cited in*, Usher, 2020). In many instances, isolation and quarantine periods have caused negative adverse effects for these older adults, particularly for individuals who live alone or rely on services within their community for any type of social contact. Whereby, keeping them safe from infection by COVID-19 has brought on differentiated negative physical and mental health outcomes, the next section will focus on this (Usher, 2020)

Social isolation is the absence of high-quality social relationships at different levels in your community and wider society, loneliness however, is an internal feeling negative feeling, often experienced when social contact and relationship needs are not met (Zaveletta *et al*, 2014; Usher *et al*, 2020). Social isolation is as harmful to one's health as smoking sixteen cigarettes a day (Holt-Lunstad *et al*, 2010) and significantly increases the prevalence of developing depression and anxiety disorders, loneliness and isolation also increase one's risk of developing dementia by fifty percent (National Academies of Sciences (NAS), 2020).

Older adults during the pandemic have become much more exposed to the effects of social isolation and loneliness and are thereby also exposed to the negative mental health implications connected to it (Usher *et al*, 2020). Suggesting, that in practice ageist COVID attitudes, in some cases, can cause a self-fulfilling prophecy in old people (Armitage and Nellmus, 2020; Sternberg, 2011). Meaning, even in absence of infection of COVID-19, those older adults who were in generally positive mental and physical health and may not have considered themselves

vulnerable or weak prior to isolation periods, can end up developing mental health conditions that in turn do make them vulnerable (Usher *et al*, 2020). Especially when considering that social isolation also makes an individual more susceptible to physical health conditions such as heart disease and increases an individual's risk of dying prematurely (NAS, 2020)

Usher *et al* (2020) suggests that social support is vital amongst the uncertainties of the pandemic, explaining that in its absence considerable mental and physical health implications will be felt by society, especially for marginalised groups such as the elderly. He also explains that if this support is not adequately provided the mental health effects on the elderly will not simply end adjacent to the end of the quarantine period; the effects will be long term mental health conditions such as post-traumatic stress disorder and severe anxiety regarding re-entering the "normal world" effects that in old age may be irreversible (Usher *et al*, 2020). Conclusively suggesting that the effects of ageism during the COVID-19 pandemic have had and continue to have devastating effects on the mental health of older adults and if unaddressed may have serious and irreversible damage for individuals and wider society (Usher *et al*, 2020).

To conclude, despite the introduction of the *Equality Act (2010)* over ten years ago, many areas of British society are clearly still underpinned by ageism, and older adults are not being considered or treated with the same respect as younger people, or as they deserve, suggesting that the act is not working in reducing discrimination based on age. Ageist assumptions which perceive older people to have no useful contribution to make to society, are resulting in many older adults withdrawing from society instead of remaining actively participant. In turn this is having negative effects on the mental health of older adults and contributes to the prevalence of development of social isolation, depression and death (Ayalon and Tesch-Romer, 2018; NAS, 2020).

Also, in the UK, a country which prides itself of their NHS and a commitment to caring for its citizens, it is rather shocking to come to understand the level of ageism and age discrimination which is underpinning health care systems and provisions (Swift *et al*, 2017). It is blatantly apparent that these negative ageist attitudes are impeding upon older adults receiving the care they vitally need in relation to their mental health and even resulting in individuals being misdiagnosed with mental health problems in which they do not have or receiving no diagnosis at all, which cannot be accepted (RCP, 2018).

The COVID-19 pandemic has seen new and unique problems for the mental health of older adults, imposed lockdowns have meant that the prevalence of development of mental health

problems is significantly increased for all individuals across the UK (Usher, 2020). However, ageist representations of older adults being weak and vulnerable individuals puts them at increased risk of social isolation, loneliness, depression dementia, heart disease and death (NAS, 2020), this really does emphasise how important it is to eliminate ageist stereotypes and individuals to ensure better positive outcomes for older adult's futures (RCP, 2018). The COVID-19 pandemic in many ways regarding older adults has also proven the labelling theory to be true in practice, as negative and ageist labels have resulted in conformity and conformation by older individuals which has adversely, devalued their position in society further (Usher, 2020, Cohen, 2018).

The RCP's (2018) suggestions regarding reducing ageism in healthcare appears relevant to the problem of ageism overall, in order to protect the mental health and life satisfaction of older adults in UK society, a paradigm shift must occur. This shift must ensure that we as British Citizens learn to value and appreciate the contribution older adults make to society whether they be big or small and remember that they have fifty or more years' experience of contributing to society than younger generations and should be respected correspondingly. In doing this, the risk of mental in health in old age will reduce and older adults are more likely to continue in social, civic, economic, voluntary and cultural participation in their later life, which in turn will benefit the individual, but also society overall (RCP, 2018; Mauk, 2010).

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