

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

The labelling of older people has been a centuries-old issue as demonstrated by Goodare (1998), who cites the witch-hunts in the 16th century as an example of how women (mostly) were persecuted, tortured and killed for nothing more than being old and poor. Similarly, Mkhonto and Hanssen (2017) propose that even now in parts of South Africa, particularly in townships and rural areas, older persons suffering with dementia are still labelled as witches and consequently ostracised, stoned or even burned, simply because their condition is misunderstood. Extreme examples perhaps, but despite a far greater understanding of the effects of labelling, many older people continue to be marginalised through stigmatisation and ageism.

Hillier and Barrow (2015) acknowledge that there are both positive and negative connotations attributed to the manner in which older people are portrayed. On one hand they are labelled as the experienced, worldly-wise doting grandparents – *sometimes referred to collectively as 'sageism'* – and on the other, frail, technophobic and crotchety. A qualitative study by Minichiello, Browne and Kendig (2000) ascertained that although a number of older people are determined to engage in active ageing, they are often subjected to negative stereotyping, even by healthcare professionals. The feedback from respondents suggested that older people are far more likely to experience a disparity in expected outcomes than that of younger people. They also appeared to be afforded fewer opportunities for joint decision making.

Ageism is a set of social relations that discriminate against older people and set them apart as being different by defining and understanding them in an oversimplified, generalised way (Minichiello, Browne and Kendig, 2000, p. 253).

To understand the impact of how labelling affects older people, Rothermund and Brandtstädter (2003) explored three theories to examine the relationship between stereotyping and self-view. Three hypotheses were explored. Firstly 'contamination hypothesis'; where self-views are influenced or 'contaminated' by the stereotyping of others. Secondly 'comparison hypothesis'; allowing pre-existing stereotypes to serve as a reference for behaviour. Lastly, 'externalisation hypothesis'; where individuals adopt stereotypical traits and behaviours as a projection of their own self-views. The study used a developed Flexible Goal Adjustment scale (FGA; Brandtstädter and Renner, 1990) to determine the individual

ability to cope with shifting goals and unexpected circumstances. As age increased and incidents of labelling and stereotyping became more prevalent, those that scored well in the FGA test were able to mitigate the negative affects through a willingness to overcome emotional obstacles and manage challenging situations. There is little evidence from this study however, to suggest what effect labelling may have on those who do not score so well on the FGA scale and it is perhaps those who should be of most concern.

With this in mind, a study by Armenta *et al.* (2017) demonstrated how age discrimination can affect not only emotional well-being and self-esteem, but also negatively impact on behaviour, cognition and even shorten life expectancy. The reduction in well-being was particularly evident in those individuals that did not identify strongly within a group or lacked strategies to help them feel younger and in doing so, improve their self-esteem. Similar conclusions were also borne out in the earlier work of Rodin and Langer (1980), who inferred that negative portrayals will often lead to negative internalised reactions such as withdrawal and disengagement; in much the same way as positive portrayals can lead to increased levels of emotional well-being. In addition, Nelson (2017) proposes that ageism presents a unique dynamic in so much as those who perpetrate stereotyping, may themselves eventually become the sufferers.

Examples of the detrimental effects of labelling can found in clinical settings one of which suggest Warmoth *et al.* (2015), are greatly misunderstood. Many older adults are frequently referred to as 'frail', without an adequate definition of how that is conceptualised. Without a clear understanding of someone labelled as frail may perceive themselves, there is a risk they will accept this as inevitable. There is a clear dissimilitude between 'being frail' and 'feeling frail' and without properly ascertaining that distinction, there is a potential for a reduction in well-being and a general decline in health, in some ways a self-fulfilling prophecy. Likewise McLafferty and Morrison (2004) note that in nursing, geriatrics is often undersubscribed as an area of speciality and is frequently viewed as mundane and sometimes less rewarding than other fields. Older patients reported feeling patronised and infantilised, feeling also as though they were a burden and therefore reluctant to seek help and assistance.

For Kagan and Melendez-Torres (2013), the threat of a nurse's own advancing years is perhaps a worrying glimpse into what their own not-too-distant future may hold. They acknowledge the fear and vulnerability an older person may experience in what is often an already distressing situation. Patients are usually sympathetic to the heavy workload of

doctors and nurses but are equally justified in their frustrations at not wanting to be the troublesome patient that presses the buzzer for assistance. Communication issues are also prevalent in care home settings and an evaluation of patient/carer transcripts by Williams *et al.* (2016) revealed around 43% of interactions surrounding daily activities and routines included childish or diminutive exchanges. Similarly, Tuckett *et al.* (2009), depict a care home environment where residents feel disrespected and generalised as being cognitively impaired, with very little self-determination. The overall result appeared to leave residents with an increased sense of vulnerability. Vulnerability is however a somewhat abstract concept and perhaps necessary to gain a better understanding of why older people are often labelled in this way. Clark and Preto (2018) illustrate this with examples of how the term is often used to describe elderly patients as justification for accessing services and support. In addition, they suggest the term is sometimes used in a paternalistic, controlling manner than can foster dependency and reduce autonomy.

Healthcare is not the only environment where older people are labelled though and Branine and Glover (2018) highlight the challenges faced by those employed as part of an ageing workforce. Age, they assert, is often used against employees because of expectations of achievement, or maybe lack of. Ageism is also creating an artificial barrier to achievement in older employees, which leaves them feeling excluded and powerless. The perceived strengths of older employees they suggest, attributes such as experience and wisdom are often ignored in favour of younger, more physically able workers. There are also instances where the issue is less about physical ability and more about physical appearance. This can be seen specifically in an employment study by Handy and Davy (2007). The focus of the study was primarily older women, seeking re-employment through agency work. Despite employment legislation preventing discrimination of older workers, they found empirical evidence to suggest that agency recruitment staff regularly and deliberately used screening methods to eliminate prospective candidates. This practice left mature female jobseekers feeling redundant and fearful for their own financial security. It was also proposed that discrimination of this kind was also skewed by issues of sexism, where women were more likely to experience ageism through employment at a younger age than men, leaving them feeling unattractive and incompetent.

This double-edged sword of ageism and sexism experienced predominantly by women is also a view shared by Nelson (2016a), who infers that despite making up the majority of older persons; women generally feel they have less power and agency than their male counterparts.

This is also exemplified in the suggestion that mental health therapists are somewhat reluctant, even dismissive of female clients in the belief that are prone to being overly emotional. Nelson (2016) goes on say that in respect of older people, the assumption is that they are merely lonely and therefore of lesser consequence. For older workers in general, the workplace can be an area of conflict and resentment, with senior employees often feel judged as incompetent and declining in capacity. The two studies that were cited reported significant negative self-views that resulted in a lack of motivation, low expectations and a reluctance to develop new skills. The problem is not confined to the West though, even in China, where elders were once traditionally revered, Bai, Lai and Guo (2016) explored changing attitudes to older generations and highlighted growing problems with mental health and depression amongst older people. Older members of society are increasingly being stigmatised as unproductive and in turn hold negative views of their own, believing that they have become a burden. Data analysis of almost 1000 participants revealed 41.9% believed older people were a burden, a further 41.9% perceived them as somewhat of a burden and just 17% considered them not a burn. A worrying statistic given that almost 11% of China's population is over 65 years of age.

Ageism, it would appear, should be considered a global problem and as such, so should mental health issues arising from it. A systematic literal review by Chang *et al.* (2020) was conducted to explore global health inequalities as a direct result of structural ageism, as well as on an individual level in respect of negative self-views. To gain a better understanding, they explored the health impact of ageism through three distinct elements of discrimination, stereotyping and negative self-beliefs. Data examined included the denial of access to health services and medical procedures, as well as exclusion from clinical trials and exclusion of workplace opportunities. The study concluded that there was clear and significant correlation between ageism and adverse health outcomes. Of the 422 studies reviewed there was evidence that 95.5% of participants experienced poorer health outcomes, across all countries. Of the 1,159 associated studies, 74% recorded ageism as having a negative health impact globally. Although not much information was given regarding the detail of the health issues affected – *due largely to the wide range of studies reviewed* – the data did reveal that on an individual level, older people that were susceptible to negative stereotypes of ageing were more likely to develop dementia-related conditions such as Alzheimer's, than those individuals that held more positive self-views.

Nelson, T. (2016b), elaborates further on the link between ageism and reduced health outcomes. Confronting ageism, they propose, is fundamental to healthy ageing but the institutionalised nature of these pernicious stereotypes, have become a barrier to progress. Going on to suggest that reluctance by older people to be viewed in this stigmatised way could actually be preventing them seeking the help and support they need, delaying vital treatment and access to services. Ageism in this respect then becomes an unnecessary and harmful distraction, preventing vital and timely interventions. Aside from the physical implications of labelling, such cardiovascular stress and impacted recovery times, there is evidence to suggest memory and cognition become impaired and a measurable decrease in the will to live. The recent Covid-19 pandemic brought this issue into sharp focus, with many elderly and older people targeted with abuse and ridicule. Issues of morbidity, age and underlying health conditions became contentious discussion points as restrictions on the wider population were introduced and in response, Jimenez-Sotomayor, Gomez-Moreno and Soto-Perez-de-Celis (2020) analysed a cross-section of over 18,000 tweets pertaining to older people and Covid-19. Around a third were aimed at providing information but the vast majority were either derogatory, contained ridicule or were simply ageist and offensive. Morbidity statistics for the virus indicated that age was a significant factor in expected outcomes, leaving many older people feeling vulnerable, but a large proportion of the social media abuse – *mainly from individual accounts and comprising of personal opinion* – suggested older people were a burden on the healthcare system and to some degree expendable.

In the realms of social media there appears little recourse for those who find themselves victimised purely because of age. In the workplace environment there has least been some progress. Irving (2012) asserts that with the introduction of The Employment Equality (Age) Regulations (2006) in England and Wales, does at least address not only issues of how older people are treated in the workplace but also acknowledged the emotional distress of age discrimination by awarding damages by way of the ‘injury to feelings’ clause. Despite this however, there were discrepancies regarding a gender pay gap in terms of awards with women receiving less favourable amounts of compensation than their male colleagues. The Older People’s Commissioner for Wales has pledged to recognise and indeed celebrate the contribution that older people make to society (Older People Wales, 2016). Through the *Ending Everyday Ageism* campaign they hope to empower people challenge the problem that is not only too prevalent but all too often goes unchallenged. A review by the commissioner

is also planned to examine the role of the media who although uniquely placed to promote ageing in a positive way, are themselves frequently guilty of portraying older people through the use of negative stereotypes.

Devising a strategy for coping with an ageing society was the focus of a consultation paper from the Welsh Government that was scheduled for publication in March, 2020 (Gov.Wales, 2020). Due to the Covid-19 pandemic the publication was delayed and in the interim period, issues relating to the way older people access services and how they are perceived more generally became more pertinent. Although the fundamental aims of the strategy remained, the pandemic lead to revision of some aspects. They aimed to not only celebrate the contribution of older people to society but also give them a voice in policy making at the heart of Welsh Government. They estimate that by 2038, a quarter of the population in Wales will be over 65 and with the Well-being of Future Generations (Wales) Act (2015) committing the Welsh Government to 'create a Wales we all want to live in' (Gov.Wales, 2020, p. 3), they are determined to tackle stereotypes and reduce intergenerational tension.

As our populations continue to rise, so too do the statistics for mental health support. Although the most recent report from the Mental Health Foundation (2016) for Wales may be considered outdated, research suggests that figures for the rise in access to mental health services are probably somewhat conservative, particularly in light of the recent pandemic. Despite this, it highlighted a worrying increase in those seeking support from mental health services, a trend that continued across all the age groups featured. In the over 65 age group, it determined that around 28% women were prone to depression, compared with around 22% of men, the highest of any age group. Perhaps the most alarming statistic though, was that around 85% of older people suffering with depression receive no help or support from the health authority. Likewise, a report from The Royal College of Psychiatrists (2018) emphasises this same argument, drawing attention to the failings of National Health Service (NHS) in this respect, the body that should be best placed to support them. In their view, this example of healthcare inequality is a clear example of age discrimination and at odds with general government policy approach, advocating access to mental health service for all, regardless of age.

Age UK (2016) refer to the lack of access to services for older people, not so much as a failing of the NHS, but as a fundamental crisis in the social care system as a whole. The crisis they say is fuelling media coverage in which elderly patients are regularly labelled as 'bed

blockers' and suggesting they occupy hospital beds unnecessarily. Age UK (2016) acknowledge there is an issue with timely discharge of older patients but this was due largely to lack of community healthcare support, delays in assessments and issues surrounding funding. Calls to Age UK's helpline indicated that delays in hospital discharge left elderly patients feeling understandably frustrated. Not all media portrayals have sought to vilify elderly patients awaiting discharge though and Marshall (2016) – *whom it should be noted* – writes for the left-leaning newspaper *The Guardian*, insists labels such as 'bed blocker' are deeply offensive and undermines the whole ethos of compassionate care. This view echoed the sentiments of Payne (2016) – *writing for the BMJ* – who believes this type of labelling depersonalises vulnerable patients and leaves them feeling unjustly guilty.

A comprehensive study of communication between health professionals and older patients was undertaken, exploring data from 91 focus groups of patients and 85 focus groups of health and social care professionals, across six European countries (Woolhead *et al.*, 2006). As to be expected with a study that not only spans across countries but also a range of health care settings and authorities, results varied quite significantly. Despite these variations, a common theme emerged. Professionals that displayed effective communication skills meant patients felt valued, listened to and respected. Conversely, when patients experienced poor communication, they felt as though they were being denied their dignity. Many of the professionals acknowledged that listening to patients was crucial, ensuring they were given adequate time to speak and not finishing sentences for them. Dignity, it was suggested, is all too often assigned to status and not simply afforded to all. There was a need for greater attention to detail such as ensuring patients had access to appropriate belongings like spectacles, hearing aids and dentures. The study also highlighted the frequent use of 'pet' names and instances of patients being called by their first name without first establishing how they would prefer to be addressed. Labelling also frequently took place, with patients being referred to as 'tasks' or even labelled by their condition, all of which depersonalised them and had a detrimental effect on their dignity.

Depersonalisation and issues of identity in older people can have a profound effect in some aspects, perhaps none more so in respect of their sexuality. Jen (2019) proposes this may be particularly true in older bisexual women, suggesting that as they age, their sense of belonging within the LGBTQ community becomes diminished through the conflict of social constructions surrounding ageing. This sense of detachment and loss impacted negatively on their mental health, more so than was reported by women who identified as lesbian. Peel and

Harding (2016) interpret this ambivalence as result of transitioning sexuality, with many older women having undergone changes to not only how they identify, but with what groups they identify with. As they age, this is further complicated by a new set of labels and cohorts. Another consideration put forward by Kenny (2013), is that physical changes that take place in later life mean issues such as the menopause and erectile dysfunction, lead to stereotypical views that older people are asexual.

In conclusion, what research has shown is that being labelled as old has many connotations and that how labels, stigma and stereotypes affect individuals is further nuanced by personal circumstance and experience. One theory as to why there is so much stigma attached to ageing is related to how individuals perceive their own self-identity and process positive information. Widrick and Raskin (2010) theorise that the 'golden section hypothesis' (Adams-Webber, 1977) that predicts people tend to process information at a ratio of 68.1% positive to 38.2% negative, actually reverses during ageing. What the study concluded was this was in fact true but not for all, suggesting that certain individuals are more susceptible to the negative effects of stigma and that other factors such culture and economics were also influential. This reversal of positive self-identity may also feed into theories around sexuality in older people, particularly as discussed earlier in the LGBTQ community. Stein, Beckerman and Sherman (2010) convey concerns of many older gay people facing the prospect of going into long term care, fearing they may not be accepted by staff or other residents and worried it will lead them 'going back in the closet' to hide their sexuality.

Although there appears to be a wealth of research and study into how and why people are labelled and marginalised simply through age, detailed research on the effect and outcomes this may have on older people's mental health however seem somewhat lacking and would benefit from further analysis.

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