Ageing and Older Adult Mental Health

Issues and Implications for Practice

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Contents

List of tables vii
List of figures viii
List of contributors ix
Acknowledgements xiii

Introduction 1
PATRICK RYAN AND BARRY J. COUGHLAN

1 Ageing: Historical and current perspectives 3
PATRICK RYAN, LENA O’ROURKE, MARCIA WARD AND CIAN AHERNE

EMMA FLYNN AND PATRICK RYAN

3 Ageism: Myth or fact? 36
JOHN LALOR AND PATRICK RYAN

4 Assessment of mental health issues: Approaches and frameworks 50
DENISE O’CONNELL-KEHOE AND BARRY J. COUGHLAN

5 Treatment of mental health issues: Reality versus best practice 66
HELEN DEMPSEY AND BARRY J. COUGHLAN

6 Ageing and dementia: Assessment and intervention 89
OLIVE O’REILLY, DEIRBHILE LAVIN AND BARRY J. COUGHLAN

7 Older adults’ experience of loss, bereavement and grief 109
PATRICK RYAN, BARRY J. COUGHLAN, ZARQA SHAHID AND CIAN AHERNE

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<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Depression and ageing: Assessment and intervention</td>
<td>127</td>
</tr>
<tr>
<td></td>
<td>MARY O'DONOGHUE AND PATRICK RYAN</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Elder abuse: Understanding pathways and processes</td>
<td>143</td>
</tr>
<tr>
<td></td>
<td>LUCY SMITH</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Elder abuse: What works and does not work to prevent it?</td>
<td>159</td>
</tr>
<tr>
<td></td>
<td>ELAINE SMITH AND NIAMH MARIA LONG</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Ageing and attachment</td>
<td>176</td>
</tr>
<tr>
<td></td>
<td>MAJA BARKER</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Ageing, relationships and sexuality</td>
<td>192</td>
</tr>
<tr>
<td></td>
<td>PATRICK RYAN, JESSICA DUDLEY, COLUM MACMAHON,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LORRAINE FEENEY AND ALISON BONHAM</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Caring for older adults: Who cares and who does not?</td>
<td>214</td>
</tr>
<tr>
<td></td>
<td>PATRICK RYAN AND ANNA WROBLEWSKA</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>The paradox of ageing: Why do older people look so happy when they have</td>
<td>230</td>
</tr>
<tr>
<td></td>
<td>nothing to look forward to?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>JUTTA ROISIN GREVE, PATRICK RYAN AND CIAN AHERNE</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Older adults: Key to the success of younger generations</td>
<td>248</td>
</tr>
<tr>
<td></td>
<td>PATRICK RYAN, CLAIRE O'SULLIVAN AND MAIREAD Smyth</td>
<td></td>
</tr>
</tbody>
</table>

Index  
265
Chapter 2

The biology of ageing
What works, what slows, what stops?

Emma Flynn and Patrick Ryan

Introduction

We have seen significant advances in our understanding of the ageing process during the last two decades. Our burgeoning knowledge informs us that there appears to be no such thing as a ‘normal’ ageing process. People age in unique ways depending on a multiplicity of factors including gender, ethnicity and cultural background, living in industrialised versus developing countries, in urban or rural settings. Climate, family size, life skills and experience are all variables that make people more and more diverse as they progress in age (World Health Organization [WHO], 1999).

To further add to the complexity, ageing also has a clear genetic heritability, which most likely is dependent on multiple genes. In genetic research it has been found that the lifespans of human monozygotic twin pairs are statistically more similar to each other than the lifespans of dizygotic twins, the extent of this difference indicates that around 25 to 33 per cent of what determines lifespan is genetic (Kirkwood, 2002). However, non-genetic factors are vital too. Therefore, there is significant interest not only in relation to identifying genes influencing human ageing but also in exploring gene–environment interactions.

There are, however, certain biases evident in research on the ageing process. The gerontologist Richard Atchley has written of researchers who focus on sickness, poverty, isolation and demoralisation in older people. Such researchers develop theories that seek to explain how people end up in such an unhappy state. They also tend to see ageing as a social problem according to Atchley (1982). Indeed, many studies involving older adults are conducted in clinics where only ‘sick’ people come. These individuals are often eager to participate in studies but healthy older people are rarely seen by doctors or researchers.

Conversely, Atchley credited other researchers who injected more positivity into their work: ‘They look at the elderly and see that most have good health, frequent contact with family members, adequate incomes, and a high degree of satisfaction with life’ (1982: 268). The well-being and general
health of the older person are not wholly determined by the biological changes and functional changes to which they are unavoidably subject. ‘For the fact of the matter is that in old age the individual’s powers of adaptation and compensation are quite as influential in matters of health as are involutive changes and functional disturbances’ (Vischer, 1966: 12). Indubitably, biological and psychological processes in ageing are inextricably linked.

It is therefore vital to view ageing from multiple perspectives, because if we only look through the lens of the deficit model of ageing we run the risk of neglecting the very real potential for compensation, adaptation, creativity and growth in old age. As Carlsen (1991: 18) points out; age is a tangle of complexity and ‘there are as many opinions and reactions as there are individuals’.

Ergo, while discussing the statement ‘Biology of ageing: What works, what slows, what stops?’ it is necessary to be cognisant at all times of the following principles.

1 There is no such thing as a ‘normal’ ageing process due to increased individual variability as we age.
2 Biological, psychological and social factors are inextricably linked in the ageing process.

Keeping such principles in mind, this chapter aims to challenge certain assumptions or myths around the ageing process. First, physical functioning in ageing will be explored, within which, the assumption that every organ and function fails will be challenged. Second, illness and disease in ageing will be discussed, examining evidence for and against the inevitability of illness and disease in old age. Third, cognitive functioning in ageing will be dissected, attempting to answer such questions as ‘Do all older people necessarily develop memory problems?’ Other topics to be discussed include sexuality in ageing and the menopause. Sexuality in ageing is very much a neglected subject in the extant literature, and it is an area that has been blighted by myth and misunderstanding. Of course, the menopause is closely tied up with a woman’s sexuality from a biological and indeed psychological perspective. A more complete discussion of sexuality will be offered in Chapter 12.

The biology of ageing

Before considering physical function in ageing it would be fruitful to examine the biological processes involved in ageing. As previously suggested, ageing has a strong heritability that most likely is dependent on multiple genes. Evolutionary theory posits that ageing is not programmed,
like development, but rather is the result of an ‘inevitable decline in cellular repair and maintenance functions accompanied by stochastic accumulation of damage and decline in function’ (Larsson, 2008: 114). Nevertheless, evolutionary theorists argue vehemently that organisms are programmed for survival, not death.

The central tenet of the disposable soma theory suggests that our body is merely a disposable vehicle for transmitting the genetic material to the next generation. Hamilton (1966) and Charlesworth (1980) developed a mathematical evolutionary theory of ageing. They argued that ageing can arise through two possible mechanisms that are not mutually exclusive. First, deleterious types of genes with late ages-of-action rise to higher frequencies than deleterious gene types with early ages-of-action, ‘This is an inevitable consequence of the declining force of natural selection with increasing age’ (Phelan & Rose, 1997: 65). The second hypothesis is that ageing arises from selection for individual genes if those genes have both positive effects with an early age of action and negative effects with a later age of action. This mechanism is known as antagonistic pleiotropy (Phelan & Rose, 1997). There are of course a plethora of biological theories of ageing that include:

- altered proteins (Levine & Stadtman, 1996);
- deoxyribonucleic acid (DNA) damage and less efficient DNA repair (Harley, 1991);
- inappropriate cross-linking of proteins, DNA and other structural molecules (Bjorksten, 1974);
- a failure of neuroendocrine secretion (Mobbs, 1996);
- cellular senescence in the cell culture system (Hayflick, 1965);
- an increase in free radical-mediated oxidative stress (Harman, 1981);
- and changes in the order of gene expression (Helfand & Rogina, 2000).

Keeping such biological theories of ageing in mind, ageing is therefore expected to be expressed as a large number of diverse, often unrelated mechanisms. Some individuals, therefore, will succumb to cardiovascular disease, others to cancer and others will experience complications arising from Alzheimer’s disease (Phelan & Rose, 1997).

**Physical function, illness and disease in ageing**

Plato once said that ‘we are bound to our bodies like an oyster is to its shell’ (cited in Cash, 2004: 1). Hence, our life experiences are unavoidably influenced by the body we inhabit. Decline in physical function is commonly observed in older age and has important outcomes with regard to quality of life, falls, health care use, admission to residential care and...
mortality (Sibbritt et al., 2007). Nevertheless, ‘among individuals of similar chronological age some individuals appear to be resistant to decline in physical function while others appear more vulnerable’ (2007: 382). There is now a general consensus that decline in physical functioning in older adults is dependent on a range of diverse factors, not just age. For instance, Stuck and colleagues (1993) conducted a systematic review of 78 studies and found that increased risk of functional decline among community-living older people was associated with cognitive impairment, depression, multiple morbidity, increased and decreased body mass index, low frequency of social contacts, low level of physical activity, no alcohol use compared with moderate use, poor self-perceived health, smoking and vision impairment.

As people age they are at higher risk of developing chronic diseases, which in turn may result in disability. Indeed, chronic diseases such as cardiovascular diseases, diabetes and cancer are predicted to be the main contributors to the burden of disease in developing countries by 2020 (WHO, 1999). As Vischer (1966: 19) suggests ‘we can only ever hope to understand old age if we also take the preceding period of life with its inner experiences, its various stages of internal and external development, its physical and psychic occurrences into account’. Therefore, from a lifespan perspective, research has found that foetuses undernourished in the womb grow up to be adults more likely to suffer from a variety of diseases, including coronary heart disease and diabetes. They also seem to age faster than people who receive good nutrition during early life.

Malnutrition, particularly during the first year of life, childhood infections such as polio and rheumatic fever, and exposure to accidents and injuries all make chronic and sometimes disabling diseases more likely in adult life. Undoubtedly, lifestyle factors in adolescence and adulthood such as smoking, excessive alcohol consumption, lack of exercise, inadequate nutrition or obesity, greatly add to disease and disability at any age in adulthood (WHO, 1999).

There is, however, in the extant literature a struggle to distinguish between ‘normal ageing’ and disease. J. Grimley Evans once stated that ‘in fact, to draw a distinction between disease and normal ageing is to attempt to separate the undefined from the indefinable’ (Grimley Evans, 1988: 40).

The ageing process in terms of physical functioning is also influenced by gender. Women live longer than men and this advantage in life expectancy is very much biological. Women appear to be more resilient than men at all ages but particularly during infancy. In adulthood a biological advantage remains, at least until menopause, for instance, hormones protect women from ischaemic heart disease (WHO, 1999). Conversely, longevity makes women more likely to suffer from chronic diseases commonly associated with old age. For example, research shows that women are more likely to suffer from osteoporosis, diabetes, hypertension, incontinence and arthritis than men (WHO, 1999).
In general, the capacity of our biological systems (e.g. cardiac capacity, muscular strength) improves during the first years of life, reaches its peak in early adulthood and declines thereafter. The rate of decline is mostly determined by external factors relating to adult lifestyle: smoking, alcohol intake, diet and social class. To illustrate, the natural decline in cardiac function can be accelerated by smoking, with the result that the person will have a much lower functional capacity than would normally be expected for his or her age, indeed ‘the gradient of decline may become so steep as to result in disability’ (WHO, 1999: 14).

It is crucial to note that contrary to common opinion, the majority of individuals remain fit and able to care for themselves in later life. A small minority of old people, mostly the very old, become disabled to the point that they need care and assistance with activities of daily living. ‘The most recent findings for developed countries show that severe disability is declining in older people at a rate of 1.5% per year’ (WHO, 1999: 15).

It is important to be cognisant of the many cognitive, emotional and social factors that have been found to moderate the negative effects of illness. For instance, perceived personal control is tied up with notions such as mastery, hardiness, or self-efficacy. It is generally accepted that people differ in the extent to which they believe they can deal with or manage aspects of their life. Perceived internal control over health or illness has been associated with a range of positive outcomes in older populations, e.g. psychosocial adjustment and improved quality of life (Kempen et al., 1997, cited in Woods & Clare, 2008: 58). Johnston et al. (1999, cited in Woods & Clare, 2008: 55) found that perceptions of control over recovery significantly predicted recovery from disability 6 months following an acute stroke (mean age 69 years). Fisher and Johnston (1998) demonstrated that perceived control beliefs can influence pain-related behaviours.

With regards to physical health outcomes such as management of symptoms, recovery, or even survival, much research has focused on identifying coping strategies that can be considered ‘adaptive’. Problem-focused coping has been shown to be more adaptive when there is something to be done to alter or control the stressor event. Conversely, emotion-focused coping is more likely to be adaptive where the person has little control over the event or if his or her resources to deal with it are diminished. Likewise, with regard to social support, there is a large body of evidence that suggests that social support effectively reduces distress during times of stress (e.g. Cutrona & Russell, 1990; Taylor, 2007). Social isolation has been associated with poorer survival and reduced quality of life among older populations (Woods & Clare, 2008). For instance, Evers et al. (2003) found that patients with rheumatoid arthritis (mean age 57 years) who had good social support reported less pain and better physical functioning than those who were less well supported.
Cognitive function in ageing: myths and science

Rabbitt (1977, cited in Salthouse, 1990: 323) once stated:

In view of the deterioration of memory and perceptual motor performance with advancing age, the right kind of question may well be not ‘why are old people so bad at cognitive tasks’ but rather ‘how, in spite of growing disabilities, do old people preserve such relatively good performance?’

For the purposes of this discussion a distinction should be made between cognitive ability that can be defined as the person’s intellectual level as measured by conventional tests of intelligence and cognitive functioning. Cognitive competence is not as easy to define. Salthouse (1990) suggests that it can be interpreted as the utilisation of one’s abilities – cognitive, interpersonal and others in adapting to particular situations. Therefore, keeping this distinction in mind, it may be possible for an individual with a low level of cognitive ability to achieve a high level of competence by maximising his or her usage of available abilities for functioning in specific situations (Salthouse, 1990).

A common finding arising from laboratory studies and psychometric investigations is that although increased age appears to be associated with lower levels of cognitive functioning, observations of the same middle-aged and older adults outside of the laboratory environment generally demonstrate that they perform occupational and daily activities quite successfully (Hess et al., 2003). Such discrepancies in age-related trends in cognitive ability and cognitive competence have been attributed to differences in (1) the type of cognition being examined; (2) the representativeness of either the behavioural observations, or the samples of individuals; (3) the sensitivity of the measurement or evaluation; and (4) the amount of relevant experience (Salthouse, 1990). Therefore, research on cognitive functioning in older adults has been wanting thus far because of such methodological limitations.

However, compelling new evidence from functional neuroimaging forces us to reconsider the rather pessimistic view of recent times which assumed that cognitive ageing is a process of progressive mental loss (Reuter-Lorenz, 2002). It has been discovered for example that in the domains of working memory and episodic memory, older adults recruit different brain regions from those recruited by younger adults when performing the same tasks. ‘...older adults show prominent changes in the recruitment of prefrontal regions, and a conspicuous increase in the extent to which activation patterns are bilateral’ (Reuter-Lorenz, 2002: 394). Results such as these are generating new hypotheses about the processes underlying age-related cognitive declines and the exciting potential for compensation.
Until relatively recent times, the lesion model was the prevailing approach to the neuropsychology of ageing. This approach explicitly described ageing as a ‘deficit-laden trajectory where cognitive abilities and their neural substrates decline progressively’ (Reuter-Lorenz, 2002: 394). However, neuroimaging findings have allowed us to see that the older brain is complexly different to the younger brain rather than a reduced, inferior brain as the older research, and indeed common perception, would have us believe. For instance, even when behavioural performance is matched younger and older adults demonstrate different brain activation patterns; this implies that they engage different brain areas to accomplish the same tasks. Additionally, some senior-specific activation patterns are associated with optimal performance, thus suggesting compensatory potential in the ageing brain (Reuter-Lorenz, 2002).

Fergus Craik and his colleagues proposed the resource-reduction hypothesis that suggests that the appropriate cognitive strategies could recruit enough resources to improve the effects of ageing (Craik, 1986). Some behavioural evidence backs this claim up. For example, engaging in elaborative encoding e.g. making animacy judgements improves ageing memory and can occasionally reduce age differences in performance. Also, facilitating this kind of ‘environmental support’ for ageing memory can result in greater activation of prefrontal regions, leading to near age-equivalent activation levels in some studies. ‘Thus, older adults can activate the requisite brain regions and engage in effective semantic processing when given the appropriate strategies’ (Reuter-Lorenz, 2002: 395). However, such compensatory strategies do not simply make brain activity young again. Under conditions that equate younger and older adults’ performance, age differences in brain activity are still evident (Reuter-Lorenz, 2002). The compensatory-recruitment hypothesis highlights the potential for brain plasticity over the lifespan.

If we accept that cognitive performance declines with increasing age in elderly people, a question that continues to confound neuroscientists is to what extent this decline is the consequence of ‘normal’ or non-pathological ageing as opposed to neurodegenerative disease such as Alzheimer’s disease (Anderton, 2002). Evidence from autopsy studies and recent magnetic resonance imaging have shown that at a gross level, there is a decrease in brain volume and weight in individuals over the age of 60 years. The brain regions most affected are the hippocampus and frontal lobes. However, as Anderton (2002) points out, it has been proven that genetic factors such as ApoE4 and other unidentified genes contribute risk for developing Alzheimer’s disease. It is perhaps more likely that the combination of genetic and environmental factors will determine whether individuals suffer this disease or escape, regardless of the age they live to (Anderton, 2002).

The appearance of numerous plaques and tangles with concomitant Alzheimer’s dementia is the most common form of pathological ageing.
The question as to whether Alzheimer’s disease is pathological in the sense that it is a disease or alternatively is just accelerated normal ageing remains because the characteristic lesions are present in small numbers in the brains of intellectually normal old people (Anderton, 2002).

Emerging evidence suggests that exercise and general fitness has a significant influence on cognitive functioning in old age. Churchill et al. (2002) suggest that a lifetime of exercise can result in enhancements in a number of aspects of cognition. Cross-sectional studies have reported benefits of aerobic exercise on both peripheral and central components of reaction time. Also, exercisers have been shown to outperform non-exercisers on tasks such as reasoning, working memory, Stroop, Trails-B, Symbol Digit, vigilance monitoring, and fluid intelligence tests. Undoubtedly, lifestyle differences (e.g. diet, smoking, nutrition) co-vary with exercise, therefore these variables may also account for part of the relationship between fitness and cognition (Churchill et al., 2002).

Focus on the menopause

When exploring ‘The biology of ageing: What works, what slows, what stops?’ the menopause is a particularly relevant topic, because for a woman it signals the end of an important part of her life. The consequent infertility means she can no longer bear any more children. In many ways the menopause is an excellent representation of how ageing is a bio-psychosocial phenomenon where one domain cannot be fully appreciated without the other.

From an evolutionary perspective, the menopause is paradoxical because it appears to contradict Darwinian principles, closing down reproductive capacity long before ageing in other body functions is very far advanced (Kirkwood, 2002). Symptoms associated with menopause include an increase in somatic and psychological complaints. Approximately 75–80 per cent of women experience vasomotor symptoms. Other reported symptoms include forgetfulness, fatigue, problems concentrating, irritability, depressed mood, decrease in libido, mood swings and sleep disorder (Sjöberg et al., 1997). Research on menopause has mostly come from the disciplines of psychiatry, gynaecology and endocrinology. Therefore, the biomedical view has prevailed in the last decade. A consequence of the biomedical view has been the promotion of hormone replacement therapy (HRT) as a treatment for all menopausal symptoms – ‘... a trend which has been conceptualised as the “medicalization” of the menopause’ (Sjöberg et al., 1997: 61).

A further consequence of the biomedical view is the dearth of research on women’s psychological experiences of menopause. Controversy continues as to whether depressed mood is more common among menopausal women. Some studies have found that dysphoric mood is related to menopausal status and the biological changes associated with menopause.
(Freeman et al., 2004). Others would argue that the changes in social roles and family are more important in determining mood changes rather than changes in hormone levels. It is therefore assumed that those women who have invested the most in motherhood and child rearing will grieve the loss of reproductive ability the most (Sjöberg et al., 1997). However, others have failed to find evidence that the empty nest period is a time of crisis. It has been found in fact that women become more reflective and more willing to satisfy egoistic impulses during this transition. For many menopause is viewed more as a new lease of life (Sjöberg et al., 1997).

Indubitably, interaction of psychological and biological factors is vital in determining women’s reactions to hormonal changes. As with many aspects of ageing, early experience, personality, earlier coping style and acquired behavioural patterns will all colour individual reactions to the menopause. For instance, stressful life events such as bereavement and divorce are correlated with more severe symptoms. Social support is another important variable. With regard to personality, a strong association between personality traits and psychological symptoms has been found during menopause. Women with more severe symptoms had lower self-esteem, were more emotionally dependent and had a more negative attitude to menopause. ‘It is suggested that an integration of disciplines into an interactive approach to menopause be allocated, one that recognizes the interplay between the individual woman and her psychosocial environment’ (Sjöberg et al., 1997: 64). It is proposed here that much more research, particularly of a qualitative nature, into women’s experience of the menopause would not just help to balance the medicalised view of the subject but also give important insight into the reality of the experience for women.

Conclusion

This chapter has sought to provide a balanced view of the biology of ageing. Although certain physiological changes are inevitable in ageing, it is clear that age is just one variable in a very complex equation that determines capacity, functionality and ability. For example, the decline in physical function is dependent on a range of diverse factors, not just age; e.g. exercise, mental health and social support to name but a few.

With regard to new scientific advances in the biology of ageing, due to genetic complexity a variety of drug targets may become available for ‘treating’ ageing. However, the same complexity may make it very difficult to predict the action of different anti-ageing drugs (Larsson, 2008). Scientists are currently exploring the control of ageing in laboratory animals and they are very close to applying this knowledge to human subjects. Phonetic engineering may be one such application, this involves taking cells from a person’s body, altering them genetically so as to ameliorate ageing.
mechanisms, and then re-planting those cells to the person of origin (Phelan & Rose, 1997).

Indeed, scientists have already created longer-living mice. Mice are closely related to humans; with many of the same genes, cell types, organs and diseases (Phelan & Rose, 1997). These scientific advances have obvious positive implications regarding the possibility of slowing down or even in some cases preventing the onset of neurodegenerative disease such as Alzheimer’s disease. However, as the reader can imagine, there are unavoidable ethical dilemmas inherent in any attempt to alter a person’s genetic composition.

With regard to cognitive functioning, new evidence from functional neuroimaging has forced us to reconsider the pessimistic assumption that cognitive ageing is a process of progressive mental loss. Other research suggests compensatory potential in the ageing brain. It has also been found that exercise and general fitness has a significant influence on cognitive functioning in old age.

The menopause has been explored and viewed as an excellent representation of how ageing is a bio–psycho–social phenomenon. However, research has failed to highlight the importance of the psycho–social realm with an overemphasis on the biomedical view. Although the menopause is often associated with a decline in sexual interest or functioning, research evidence has been contradictory in this area. Indeed, new research challenges the assumption that ageing and sexuality are mutually exclusive while accepting that certain physiological changes are normal – issues that will be dealt with more comprehensively in Chapter 12.

Evidence is emerging from research that appears to challenge the assumption that the process of ageing is all about dysfunction, disability and despair. Flanagan’s study (1978) investigated the lives of three cohorts of participants, aged 30, 50 and 70, with 1000 participants in each cohort. The results of this study demonstrated that three factors were especially important in maintaining quality of life: (1) material comforts, work and health; (2) intimacy, close friends and opportunities for socialising; and (3) ongoing opportunity to exercise cognitive capacities and creative expression. Birren (1983) reported that the majority of individuals in this study described their lives as ‘good, very good, or excellent’.

Is it not easy to criticise those who voice their despair? To turn our backs as we search for nuggets of hope and alternatives to the darker side of our last years? I think so: Isn’t this our dilemma? Which way to look, what to believe, what to hope for.

(Carlsen, 1991: 18)

This quote perfectly encompasses the quandary we face as social scientists, indeed as humans; do we dwell on our biological limitations or do we seek
to vanquish them? Because although this chapter has shown that certain biological changes are inevitable, indubitably how a person adapts, copes and compensates for these changes will ultimately determine ‘what works, what slows and what stops’ as we age.

References


Chapter 3

Ageism
Myth or fact?

John Lalor and Patrick Ryan

Introduction

At the outset, it is useful to establish what is meant by the notion of ageism. Like any other emotive issue, the very use of the concept can offer it a face validity, particularly when it becomes part of the vocabulary of the general population. Those who are exposed to it argue strongly for its endemic presence in society whereas sceptics might argue that the concept can be applied to all ages at all stages in life if we simply listen to how people cope with the human condition as it develops from conception to death. The use of age to separate different cohorts of society is not unusual, so why make this a particular issue when dealing with older adults?

Ageism can be seen as a ‘process of systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this for skin colour and gender’ (Butler & Lewis, 1973: 30). The Charter of Fundamental Rights of the European Union (2000: Chapter III, Article 21(1)), asserts that ‘Any discrimination based on any ground such as sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age or sexual orientation shall be prohibited’. So clearly, there exists a philosophy that to make older adults vulnerable on the basis of age is inherently wrong. But how is the concept managed in critical thinking?

Clarity of definition

There are two differing issues to be addressed. First, does ageism exist? Second, if yes, what is the basis for it? This is an important distinction: often, so averse are we to countenance any ‘ism’, we automatically discount the possibility that there is any validity whatsoever to the ‘ism’. Returning to the chapter title, more must be achieved than simply investigating the existence of ageism. Should ageism exist, it is necessary to examine whether or not it is wrong to hold, and act upon, the beliefs that form its premise.
After all, if it was entirely unjust and immoral to practice sexism in its purest form, there could be no barrier to women and men competing side-by-side in Olympic weight lifting. If this logic was practised in terms of physical ability, we could not prevent the legally blind from driving and flying aeroplanes. Or how about at the other end of the age spectrum: should not we include children and adolescents of all ages in the same pool for examinations and sports? So, are there inherent differences related to being aged? If so, is it not entirely ethical to hold ageist views, and to practice their consequences?

Economics and Utilitarianism

The creed which accepts as the foundation of morals, Utility, or the Greatest-Happiness Principle, holds that actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness.

(Mill, 1863/1972: 6)

The historical context to our concept of ‘old age’ must be understood to further understand the concept of ageism. A quick examination of Britain and the USA during their respective Industrial Revolutions offers useful insight. England’s population in 1750 was 6 million, rising to 9 million in 1800, and to 12 million by 1820. A proportion of this increase can be attributed to a decrease in infant mortality rates, which fell from about three in every four in 1730–1749, to three in every ten by 1810–1829 (Buer, 1926). However, quite striking were the improvements in life expectancy: in the USA, this has effectively doubled during the past 200 years; in the nineteenth century it increased by 15 years, and it has increased by another 25 years since 1900 (Smith, 1993). In other words, for someone to be ‘old’ in the year 1800 would have meant they had lived beyond the age of 40 years.

Writing in the early 1800s John Stuart Mill followed in the footsteps of Jeremy Bentham as an advocate of Utilitarianism, which he defines in the quotation above. By way of offering reassurance to those who might accuse him of advocating a selfish individualism, Mill explained that his philosophical creed was actually a ‘standard of morality’ that uses happiness of the greater number of people as its ultimate goal. His formulation of the ‘Greatest-Happiness Principle’ encompassed intellectual as well as sensual pleasures.

Despite his efforts to guard against abuse, Mill failed to foresee the potential consequences of pursuing the happiness of the greater number of people. Being a Classical–Liberal, Mill should have foreseen that, to maintain the principle of ‘the greater good’, one must, as a consequence, sacrifice the remainder; ‘the lesser good’, so to speak. To paraphrase Norman Cohn (1967), this ethical principle was to become a warrant for the
inhumanity of Leninist–Marxism, Maoism, Naziism and Fascism. A principle must be judged not on its ‘intentions’ but on the consequences of its completed execution. In terms of how we treat our elderly, how might a Utilitarianism framework be evidenced?

First, we need to consider that conscious thoughts, and the basis by which we live our lives, do not necessarily coincide; praxis need not be so obvious. How our beliefs lead to behaviours becomes more obvious, however, when we face difficulties. For instance, what happens to people’s careers as unemployment rises? How do we allocate finite resources in our health service – especially as tax revenues fall, putting further pressure on the system? Again, we return to economics.

In terms of Utilitarianism, people ask a simple question: who gets what? Or, as Friedrich Hayek (1944) asked, ‘Who, Whom?’: who decides what action to take, and who is the beneficiary. As will evolve in this chapter, Utilitarianism, couched in the fuzzy language of the ‘Greatest-Happiness Principle’, utterly fails to protect those who do not fall within the parameters of Mill’s ‘greater number of people’. What guarantees are there for them?

Health service provision

Utilitarianism within a socialised health system does something quite pernicious. Given the pyramid scheme-like nature of any publicly funded system (Borden, 1995), the unfunded liabilities of a health service ensure that some will lose out. And those who have ceased to contribute to the tax-net – irrespective of their contributions throughout their working years – will always lose out to those who have their working days ahead of them.

How might a Utilitarian ideology affect the health and well being of our aged? Rathmore and colleagues (2003) found that elderly patients are less likely to receive guideline-indicated therapies when hospitalised with myocardial infarction. Indeed, research in the USA suggests that, due to the pressure placed on physicians by health maintenance organisations (HMOs) and medical centres, less time is being spent with elderly patients (Levy & Banaji, 2002). Robb and colleagues detail more specific ways in which differential medical treatment exists for older adults (Robb et al., 2002), citing physician–patient interaction, the use of screening procedures and treatment of varied medical problems.

But sometimes it is not simply economic rationing; sometimes a deciding factor is the health service provider’s concept of the place that older adults occupy in society. In an Australian study comparing nurses’ attitudes towards ageing with those of other health professionals, nurses were found to have less accurate knowledge of ageing than other health professionals. In particular, nurses expressed higher anxiety about ageing and were more likely to believe working with older adults was associated with low esteem
in the profession. Interestingly, nurses were more likely to hold positive attitudes if they had received gerontology education, and worked outside the residential care sector (Wells et al., 2004).

The frustration within the editorial board of the *British Medical Journal* is palpable. In their article entitled ‘A new beginning for care for elderly people? Not if the psychopathology of this national service framework gets in the way’, Grimley Evans and Tallis (2001: 807) unleash their fury at the bureaucracy within Britain’s National Health Service (NHS). Concerning The National Service Framework for Older People, the authors lament the ‘split personality’ between the desires of an ‘external reference group’ of experts brought in to advise on policy, and an ‘in group’ of civil servants that ‘subserves a political agenda’, and write their own policy, anyway. From the point of view of these civil servants, care in ‘proper hospitals’ is too expensive when it needs to be delivered to older people.

Just in case the hoops through which a doctor must jump are lost on the public, Leonard Peikoff (1985: 420–1) demonstrated the effects of the multiple steps of government intervention:

In medicine, above all, the mind must be left free. . . . The DRG administrator [in effect, the hospital or HMO man trying to control costs] will raise hell if I operate, but the malpractice attorney will have a field day if I don’t – and my rival down the street, who heads the local PRO [Peer Review Organization], favours a CAT scan in these cases. I can’t afford to antagonize him, but the CON boys disagree and they won’t authorize a CAT scanner for our hospital – and besides, the FDA prohibits the drug I should be prescribing, even though it is widely used in Europe. And the IRS might not allow the patient a tax deduction for it, anyhow. And I can’t get a specialist’s advice because the latest Medicare rules prohibit a consultation with this diagnosis. And maybe I shouldn’t even take this patient, he’s so sick – after all, some doctors are manipulating their slate of patients, they accept only the healthiest ones, so their average costs are coming in lower than mine, and it looks bad for my staff privileges.

Again, although the bureaucracy within medicine so reviled by Grimley Evans and Tallis (2001) and Peikoff (1985) may delay, irritate and upset the otherwise able-bodied, consider what it does to those more infirm and vulnerable. Consider, as has been done here, the effects that Utilitarian principles have on Hayek’s ‘Who, Whom?’ (1944): the eternal rationing decision that so often goes against the aged. As Peikoff (1985) points out, with the mounting pressure of litigation on the doctor’s shoulders, would it not ease his worries to simply fob off some of his older clients? Sadly, in a climate of increased litigation and regulation, this is a logical proposition.
The ultimate Utilitarian sacrifice

Taking the Utilitarian argument to its natural consequence, we are forced to deal with the arguments for and against euthanasia. Although it is a brave doctor or judge or family member who argues that the elder patient in question must continue to live as he or she suffers from an agonising, terminal illness, does the individual not have ultimate property rights over his or her own life? What about the traditional demand that someone is proven *compos mentis* before their decisions are considered?

So, let the unmentionable be mentioned: more euthanasia relieves pressure on finite resources; remembering the tenets of Utilitarianism, this makes perfect sense. The Australian philosopher, and Princeton University professor, Peter Singer (2009: para 23) writes:

> When a human being once had a sense of the future, but has now lost it, we should be guided by what he or she would have wanted to happen in these circumstances. So if someone would not have wanted to be kept alive after losing their awareness of their future, we may be justified in ending their life; but if they would not have wanted to be killed under these circumstances, that is an important reason why we should not do so.

At first glance, there is reason here. It would be remiss to suggest that the current authors can ever know the desires of an unconscious or senile, elderly cancer patient or stroke victim. Bearing Singer’s view in mind, recall the case of Terri Schiavo, the American woman who, in 1990 at the age of 26, suffered respiratory and cardiac arrest, resulting in extensive brain damage, and a diagnosis of ‘persistent vegetative state’. There being no living will, her husband, Michael, testified that Ms Schiavo had stated previously that she would not wish to be kept alive, should there be no hope of recovery. Despite continuous protestations from Ms Schiavo’s parents, a local Florida court ruling in favour of Michael Schiavo, allowed Ms Schiavo’s life-support to be disconnected on 18 March 2005. She died almost 2 weeks later.

Next, consider the view of Britain’s National Institute for Health and Clinical Excellence (NICE), which recently stated that ‘patients should not expect the NHS to save their life if it costs too much’ (cited in Winnett, 2008). NICE has now rejected the so-called ‘rule of rescue’ that stipulates that people facing death should be treated regardless of the costs. In a report on ‘social values judgement’, the regulator explained: ‘When there are limited resources for healthcare, applying the “rule of rescue” may mean that other people will not be able to have the care or treatment they need’ (cited in Winnett, 2008: para 5). Further, the ruling contradicts the advice of NICE’s Citizens’ Council, which said that a rule of rescue was an essential mark of a humane society. NICE’s defence was that its role was to determine how best to allocate the health service’s limited resources.
Finally, still considering Singer’s proposition, it must be asked what else he believes, as context will assist our understanding. ArcLink, an American online advocacy group for people with developmental disabilities would not quite support Singer’s views (ArcLink, 2009). It cites Singer’s claims that society cannot bear the economic burden of treating people with significant cognitive disabilities as full members of society, as well as Singer’s erosion or outright denial of civil rights to members of society who are seen as less valuable than those in power. After all, Singer believes that not all humans are ‘persons’, as to qualify as such, and to deserve the subsequent moral consideration, beings must be self-aware, and capable of perceiving themselves as individuals through time. Singer claims that some people with life-long cognitive disabilities never become ‘persons’ at any time throughout their lives. He claims that some people who acquire cognitive disabilities cease to be ‘persons’. For example, Singer writes:

This means that to end the lives of people, against their will, is different from ending the lives of beings who are not people. Indeed, strictly speaking, in the case of those who are not people, we cannot talk of ending their lives against or in accordance with their will, because they are not capable of having a will on such a matter.

(Singer, 1995: 197–8)

Whereas ArcLink’s focus is people with developmental disabilities, Singer nicely expands the argument for the current topic by discussing people who acquire cognitive disabilities. Substitute a child with developmental disabilities with an elderly patient in the later stages of dementia, and the consequences of a moral position become clear. As stated above, a principle must be judged not on its ‘intentions’ but on the consequences of its completed execution.

Those who would accuse Michael Schiavo’s opponents of intervening in the life of a private individual need to consider what they are supporting, and the principles they will be propagating. The room for manipulation of the medical system – stemming from ageism, economic difficulty, or otherwise – is vast. Ms Schiavo’s life ended purely on unsubstantiated evidence of her wishes, coupled with the views of healthy human beings observing the incomprehensible state of Ms Schiavo’s life.

What about those people, for example, who suffer from acute pain caused by terminal cancer and who wish to die by euthanasia? Many will likely be *compos mentis*. Conversely, elderly people who are *non compos mentis* cannot reassess their earlier desires – stated during full health – that they would never wish ‘to be a burden’. Finally, such deliberations by those within the medical and legal profession do not begin at a persistent vegetative state. What about at the inability to recognise one’s children? Or having to live in a dark, unkempt nursing home, with nobody visiting?
When does the undeniably severe persistent vegetative state become ‘nothing to live for’? Combine Singerian disregard for diminished cognitive abilities, with a creaking, unfunded health system and the arguments in favour of euthanasia become more appealing. After all, you might think, I wouldn’t want to live like that.

**Economic necessity and justice?**

The demographic decline of European economies is significant. Consider that the fertility rate of 2.1 children per woman is a requirement for a population to remain stable (Eurostat, 2004). Those nations around the 1.3 mark – i.e. almost all of the 10 of the 2004 EU accession states, as well as Germany, Spain, Italy and Greece – can, by the end of the century, expect a population of one-quarter of today’s figure (European Commission, 2007). Even Ireland, at a comparatively high 1.99, lies below the optimal, population-stabilising level of 2.1.

What does this mean to the older adult cohort of the population? Given that there are a decreasing number of workers per pensioner, a real and substantial fiscal headache is on the way. Using figures from the United Nations (2003) and Eurostat (2004) it can be established that, in 1950, in those nations that are now in the European Union, less than 10 per cent of the population was 65 years of age or older. Back then, 66 per cent of the population were working and therefore tax-contributing. By 2050, we can expect the figure for those contributing to the tax-net to reach an absolute maximum of 50 per cent – but, in reality, some amount less, because of individual choices, childrearing, illness, etc. Almost one-fifth of society will be 65–79 years of age, and almost 12 per cent will be over 80 years of age – and these figures, in which the majority will have some form of state stipend, are certain. According to the United Nations World Youth Report, life expectancy in Europe will have risen from the 1950–1955 level of 66 years of age, to 83 years of age by 2050 (United Nations, 2005). To be blunt: someone born in the late 1800s had likely been working since their mid-teens, and, after retiring, had enjoyed the state pension for a couple of years, tops. In 2050, things will be very different.

Taking this into account, returning to the subject of work and the taxes that one pays, it might be a good idea for our elderly to continue in employment beyond their mid-sixties. Indeed, the various governmental departments of finance would thank them for it. But that simple solution is not generally available to state institutes as:

At the moment it is legal in Britain to force a worker to retire after the age of 65 . . . [M]any workers who don’t want to leave their jobs will be out of them anyway on their 65th birthday, with little more than a
carriage clock and a few kind words to speed them on their way. Or as Age Concern head Gordon Lishman more poetically puts it: “The Government continues to consign tens of thousands of willing and able older workers to the scrap-heap”.

(Murray-West, 2009: para 1)

Age Concern, an advocacy group for the aged in the UK, along with Help the Aged, have responded with justified outrage (Age Concern, 2009). Although this case will continue for some time, at present, the European Court of Justice has given older British workers a stay of execution. European judges have confirmed that the UK government has to overcome a high hurdle to justify forced retirement and so will struggle to show that its national default retirement age of 65 satisfies European Union age discrimination rules when the case returns to the British courts. Age Concern and Help the Aged have condemned British ministers for ‘sending mixed messages’ to older workers by encouraging people to work beyond the age of 65 yet keeping legislation that prevents many from doing so (Age Concern, 2009: para 4).

This sort of legislation is baffling. Joerres (2009), writing in the *Wall Street Journal Europe*, reports that one of the biggest mistakes companies make is to alienate employees aged 50 and older by assuming they are no longer interested in training and career development. Consider the irony: chief executive officers (CEO) and other senior executives tend to be in their fifties or sixties, yet it is regularly assumed that middle managers of the same age are no longer interested in challenging work and development. If a former CEO is qualified to serve on a Fortune 500 firm’s board of directors in his seventies, why would a manager not, at a comparable skill and experience level, be just as capable of working in another capacity at the same age?

So, who is pushing for these laws? Who stands to gain from barring the so-called elderly from the workplace? Still, do we not have a responsibility to our elderly population, so as not to pressurise them into working into their twilight years, seeing as their mental abilities will apparently be diminishing from their sixties?

The evidence is compelling that receiving a good education in the first two decades of life reduces the risk of developing dementia later on (De Ronchi, 2005; Butcher, 2008). In particular, low education is a known risk factor for Alzheimer’s disease (Hall *et al*., 2007). Using the Buschke Selective Reminding Test, researchers have reported that each additional year of formal education delayed the time of accelerated decline by the equivalent of 0.21 years. Moreover, whereas one’s chances of developing dementia after the age of 85 is between 40 and 50 per cent, for those 65 years of age and older, it is between 5 and 10 per cent (Levine, 2006) – likely far less than the general public would have estimated.
Still, severe cognitive decline does not appear to be an inevitable process (Franco et al., 2007). They report that Alzheimer’s disease is only genetically determined to a small extent. Significantly – given this age of increasing awareness of health and self-care – many modifiable environmental and lifestyle factors (e.g. smoking, nutrition, physical inactivity and low social activity) are thought to play a key role in its development (Blennow et al., 2006; Briones, 2006; Harman, 2006). So, with increased longevity, accompanied by increased health span, significant numbers of the labour force reaching a fixed retirement age will likely still have a full or considerable capacity for production (Franco et al., 2007).

Now, given the evidence for the power that the individual has to protect against dementia, should society not respond accordingly? Given that there is far weaker evidence for ageist policies – after all, what other reason is there for expelling the over-sixty-fives from the workplace? – than many would assume, why is it still prevalent?

**Politics**

It would appear, then, that driving elderly people out of the workforce is founded more out of political necessity than neuro–psychological evidence. We return to economic necessity – and especially in these times of sharply rising unemployment, where there is an excess of labour supply over demand.

It is politically more advantageous to see a man in his mid-sixties ‘offered’ early retirement, thus freeing up capital to employ a college graduate, than have the latter be added to the live register. The myth that in their twilight years people get a little slow and lose their sharpness is indeed useful. The national debt to gross national product ratio is on an upward slope, but, it is the future generations that will have to solve that problem. As for the unions and Leftist commentators and advocates, it is a 65-year-old’s right to retire. We are not in the Dickensian nineteenth century anymore; the days of people worrying about employment and living standards in their sixties is a vestige of greedier, grubbier times. And, as for the employer, early retirement just makes sense. You don’t exactly have time to research the latest edition of *Neurology* or the *BMJ* to find out that cognitive decline is not what you assume. Anyway, some have the attitude that these third-level graduates have far better comprehension of computers, technology, and all that.

If we consider that there is finite employment at any one time, to maintain low levels of unemployment, sacrifices will be made. Witness the rationale behind the enactment of the 35-hour week in France – introduced by the former Socialist Prime Minister, Lionel Jospin, in 2000, and scrapped in 2008 – where people were forced by law to work less hours, thus, in theory, freeing extra hours for others to complete. So, although it
would make no sense to disbar large portions of people from the workforce because of their sex or sexuality, those who must be sacrificed tend to be the older workers. (It should be added that any reluctance to employ women due to the affordability of maternity leave or childcare does not imply a reluctance to employ women \textit{per se}, unlike being unwilling to employ an older adult purely because of their age.) And one cannot but get a sense that elderly people are seen as expendable in a rigid, highly regulated economy. Afflicting also the young, France’s employment laws create bars to entry for the older generation wishing to return to the workforce (Hayden, 2006).

According to Joerres (2009: para 2), chairman and CEO of Manpower Inc., ‘The loss of productivity and intellectual capital as baby boomers leave the work force could devastate some businesses’. (‘Baby Boomers’ are those within the glut of children who were born soon after the Second World War, and therefore all reaching retirement – and in search of their social security payments – over the next few years.) Joerres (2009: para 1) warns about ‘the inadequate pool of younger workers to fill those roles’ left by the Baby Boomers. Indeed, although income deficits to fund the retirements of the Baby Boomers is an imminent problem, Joerres touches on the oft-neglected aspect of the loss of these people to the workforce: their knowledge and accrued wisdom of years of problem solving and to some degree ‘having seen it all before’.

A bizarre contradiction exists. Conventional wisdom points towards the retirement of the sixty-somethings as being something of a logical response to deficits in cognitive and physical abilities. However, Joerres (2009: para 4) points to employers’ viewing coming retirements as cost-saving opportunities with trepidation, considering it ‘dangerous and shortsighted’. Perhaps too much faith is put in the idea that employers know who benefits their business, and in what way. Joerres explains that many employers assume that all employees want to exit the workforce as soon as they are financially able.

\section*{Conclusion}

The situation of how older adults are treated is rife with contradictions. Work, in place of retirement, has been shown to be detrimental to one’s health but forced retirement is also detrimental to one’s health (Donahue, 2007). However, retirement can bring health improvements (Siegrist & Wahrendorf, 2009). Our pensions are about as stable and guaranteed as the economic boom that underwrote them. We are not having nearly enough children, who, in time, would be paying the taxes to fund the health, welfare and pension services required by the older generation. There is a cognitive loss – but not in the assumed neuro–psychological sense. It is in the workplace, where able-minded workers are leaving, or, more accurately,
being forced to leave and taking with them years of useful and useable knowledge and skill.

If these points appear challenging in their contradictory, self-defeating nature, that is because they are simply that illogical and futile. How ironic that, as the world gets richer – yes, even when you take into account the present economic crisis – our treatment of elderly people remains inconsistent at best.

It seems contradictory to many, but the mental health of the aged and our pension systems can both be better ‘cared for’ by allowing the aged the dignity of working until such time as they genuinely desire retirement. How sad that anyone needs to be ‘allowed’ to work. How sad that, after having ended slavery, enacted suffrage, and normalised to an encouraging extent the differing sexualities within society, we are still at this point in terms of dealing with age. In short, this ‘ism’ is still alive and well.

How ironic, when we consider the evidence. We find that the age of retirement has a significant influence on remaining life expectancy (Franco et al., 2007). Tsai et al. (2005) reported an improvement of mortality with increasing age at retirement, independent of socioeconomic status. Life expectancy for those retiring at age 55 was found to be 5 years shorter compared with those who retired at age 65. This is supported by a Danish study, which found that the increasing mortality of early retirement recipients is consistent with the adverse effect on health, due to the retirement process itself (Quaade et al., 2002).

As Murray-West (2009: para 3) reported, concerning the upholding of the law enforcing retirement at 65, ‘this decision is all the more poignant in the light of research this week from Prudential, showing that workers are delaying retirement because of the poor state of their investments and fears over the direction of the economy’. The Prudential report went on to explain that many who would have retired this year do not expect to be able to leave their jobs until 2012 or later. Further, about a quarter of those who are delaying drawing their pension this year believe that they will never be able to afford to retire. It begs the question as to if it is possible to get any more benevolent towards the aged than granting them the freedoms that bring about, as a consequence, increased life expectancy, financial security, dignity, a sense of purpose and good mental health.

Work is not solely seen as a means to an end; selling one’s labour for an adequate sum is not the only purpose of working. Likewise, the desire to have children is not simply because of some evolutionary, animalistic concern for the continuation of the species. We are social beings who need the benefits of social interaction. And maybe sitting in a day centre surrounded only by others their age, or staring out a window in a nursing home, is not the best place to enhance your development as an older adult.

As asked above, is ‘old age’ not a continually shifting, relative term, anyway, given our expanding life expectancy? Think how much more
knowledge, wisdom, experiences and skills one can have acquired since the age at which one’s ‘elderly’ predecessors would have passed away in the 1800s. Indeed, if more care were taken to not obstruct those who are in their sixties from reaching, and continuing in, their potential, maybe we might see even less cognitive decline thereafter. Science indicates that this is indeed the case.

Given that our affluence will enable many of us to reach our ninth decade, it makes sense to give ourselves the freedom to make those last decades as independent, comfortable, mentally sharp, and, above all else, as dignified as possible. It also offers the opportunity to tackle and undermine yet another ‘ism’ in society.

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