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Ageism, Racism, Sexism, and Work With Older Healthcare Clients: Why an Intersectional Approach Is Needed in Practice, Policy, Education, and Research

Michelle D. Hand and Emily S. Ihara

Abstract

Women are subject to health disparities across the life course, owing to multiple factors, including sexism, ageism, and other forms of structural discrimination and mistreatment which have been linked with greater risks for sexual violence and related trauma as well as resulting problems with physical and mental health as well as overall wellbeing. Thus, a more intersectional approach to healthcare and social service delivery for older women is expressly needed, particularly since the COVID-19 pandemic, to address UN Global goals of advancing health and wellness, gender equality, less disparities altogether, and with this, greater justice. As such, in this article, timely needs for practice, policy, research, and education will be explored, to address intersectional prejudice and discrimination, chiefly among older women who are members of non-dominant populations, to improve healthcare and social services and social justice, principally in later life.

Keywords

ageism, age discrimination, well-being, health, mental health

Department of Social Work, George Mason University, Fairfax, VA, USA

Corresponding Author:
Michelle D. Hand, Department of Social Work, George Mason University, 4400 University Dr., MS 1F8, Fairfax, VA 22030, USA.
Email: mhand2@gmu.edu

Introduction

It has been estimated that over 80% of U.S. adults older than 50 years have experienced age-based discrimination, which is problematic, as age-based prejudice can predict poorer ratings of mental health and shorter lifespans (Chonody & Wang, 2014; National Poll on Healthy Aging, 2020). Research has demonstrated that global inequities in healthcare are unduly experienced in later life, owing to a combination of social, financial, and health-related challenges, which highlight longstanding needs for further interdisciplinary education among healthcare professionals on intersecting structural factors that disproportionately impact older clients (Dharmarajan et al., 2021). This is especially true for older women (Chrisler et al., 2016; Meyer et al., 2020) and members of racial and ethnic nondominant populations, such as among older Black, Indigenous and People of Color (BIPOC) as well as for older members of the lesbian, gay, bisexual or pansexual, transgender, queer or questioning (LGBTQ+) community, who experience greater (and cumulative) health disparities across the life course (McCarron et al., 2020; National Institute on Aging, n.d.; Solomon et al., 2022).

As has been demonstrated during times of crisis, including during the COVID-19 pandemic, older adults and particularly, older adults from nondominant populations have disproportionately lost their lives owing to ageism and additional forms of structural discrimination (Solomon et al., 2022). Structural discrimination can be understood as organizational and societal level oppression (such as through redlining, for example, or the widespread withholding of investment in specific communities owing to the race or ethnicity of the majority of the members within a given community) which deprives whole populations and communities of resources, power, quality health and well-being, and other human rights and opportunities (National Institute on Minority Health and Health Disparities, 2023). As the American Medical Association (AMA; 2021) has reported, this can impact educational attainment and thus, employment, wages, housing, safety, and criminal justice, and health care, including through the denial of privilege (e.g., White or male privilege) despite insidious disparities in the distribution of resources. Structural discrimination can occur on the basis of race, class, gender, sexual orientation, ability, physical characteristics (e.g., weight), religion, ethnicity, immigrant or refugee status, language proficiency, or may involve a combination of these and other factors (National Institute on Minority Health and Health Disparities, 2023).

For example, since the COVID-19 pandemic, roughly one in every 188 members of the Navajo Nation lost their lives, most of whom have been 60 years or older, which has been linked with both ageism and racism (Solomon et al., 2022). As Burnes et al. (2019, p. e2) have shared, ageism is commonly defined as "the stereotyping, prejudice, and discrimination against people on the basis of their age." Ageism is linked with the degrading treatment of older clients, such as through "baby talk," other aspects of infantilizing older adults and attributing client concerns, like depression, to old age in general (Chrisler et al., 2016, p. 86).

At the individual level, ageism and ageist stereotypes are also often internalized, which can substantially hinder physical and mental health and wellness in later life, such as through promoting feelings of limited agency and dependence (Ayalon & Tesch-Römer, 2017; Chrisler et al., 2016). This is noteworthy, as beliefs relating to age have recently been linked to health, such as trouble with sleep, heart disease, and psychological difficulties, with negative beliefs being linked to poorer health (Levy, 2022).

Background: Structural Age-Based and Intersectional Discrimination and Health

Even prior to the COVID-19 pandemic, at the relational level, interactions between younger and older adults have also been limited, and social policies have promoted distinct spaces for older adults to intermingle separate from society at large, such as in "senior centers" and "'senior living' facilities," (Chrisler et al., 2016, p. 87). Still, older adults are not generally considered "minorities," or nondominant members of society by most society members and healthcare practitioners (e.g., physicians, nurses, nursing assistants, social workers, psychologists, counselors, psychiatrists, as well as administrators and staff in the hospital, acute care and long-term care settings, or hereafter "healthcare professionals"). Yet, Chrisler et al. (2016, p. 88) have suggested that minority stress research on older adults may be warranted given the ways they are discriminated against. More focus is needed on the potential impacts this may have on the immune systems of older adults as well as how societal, organizational, relational, and individual age-based discrimination may further aggravate chronic illnesses (Chrisler et al., 2016).

This is especially true for women and other members of nondominant groups in later life, as for example, women already face greater hardships than men, such as those owing to sexism and in turn, lower average pay, double standards at work and in the community, greater risks for emotional, physical, and sexual violence, and poorer treatment in the healthcare system (Chrisler et al., 2016). And the older women are, the greater their inequality (Chrisler et al., 2016), including with regard to risks for sexual violence (Bows & Westmarland, 2017), resulting trauma (Hand et al., 2021) and with this, greater health disparities and more poverty (Chrisler et al., 2016).

While women live longer than men, older women are not only more likely to experience poverty, but are also more likely to live in isolation, to experience symptoms of depression, and to experience problems with physical functioning (NIA, n.d.), such as owing to disabilities, including dementia (World Health Organization, 2021). Older women are also more likely to experience hypertension in the United States than men (74.3% of older women in the United States between the ages of 65 and 74, and 86.0% past the age of 75 compared to 66.7% and 74.3% of their older male counterparts) as well as obesity (45.9% of older women between 65 and 74 years, and

36.1% past 75 years compared to 41.9% and 36.1% of older men; Centers for Disease Control and Prevention [CDC], 2023), which have been linked with early life trauma (Offer et al., 2022; Palmisano et al., 2016). Women over the age of 85 years also make up the majority of stroke patients in the United States, which is projected to double in the next 40 years (Rodgers et al., 2019).

Globally, older women less frequently receive support and treatment for health disparities than men as well, and owing to discriminatory social norms and policies, older women are likely to experience arthritis, poor vision, and hearing, as well as to die from cancer or heart disease (WHO, 2021). As Carmel (2019, p. 3) has explained "the gender gaps in education and income continue to exist in old age and they affect older adults' health and well-being," with low income and poor health being directly related. Still, it is also noteworthy that education levels are substantially higher among both men and women in wealthier nations, such as the United States, Canada, Western Europe, Japan, New Zealand, and Australia, in comparison to Namibia, South Africa, Malaysia, India, China, Brazil, Bolivia, sub-Saharan Africa, Asia and poorer nations in the Middle East (e.g., Afghanistan or Yemen; Carmel, 2019).

And in violent relationships with intimate partners, older male perpetrators are still in control, and continue to perpetuate physical, sexual, and psychological violence (Meyer et al., 2020). Experiencing violence across the life course has also been linked with physical pain, problems with mobility, anxiety, suicidal ideation, loneliness, and problems with self-esteem in addition to those mentioned relating to posttraumatic stress and depression (Meyer et al., 2020). More and more older women are not only living alone in Western countries, but this trend is on the rise in rural areas of nations that are considered developing as well, which is also impacting the health of older women globally (Carmel, 2019). To add to this, research has demonstrated that healthcare providers are often dismissive of the health-related concerns of older women (Meyer et al., 2020).

Violence and health disparities among women across the life course and in later life are also disproportionately experienced by women of color (Chrisler et al., 2016). For example, as Chrisler et al. (2016, pp. 88–89) have pointed out, "older women of color have a lifetime of experience with racism, older sexual minority women have long experience with homophobia, and transgender elders have experience with transphobia." A recent study by Harlow et al. (2022) has also demonstrated that even in mid-life, long before later life, Black women are more likely than White women to experience traumatic events, such as violence and the loss of a close family member, along with greater poverty, financial and legal stressors, and higher rates of depression, which has been linked with poorer self-reported ratings of health.

Structural discrimination, such as structural ageism (or widespread age-based oppression; Levy, 2022), racism (or systemic unjust treatment based on race; LaFave et al., 2022; Solomon et al., 2022), ableism (systemic oppression based on ability; Dhanani et al., 2022), sexism (systemic oppression owing to sex or gender) and heterosexism (systemic oppression of members of the LGBTQ+ community

owing to sexual orientation) can ultimately impact health (Bows & Westmarland, 2017; Hand et al., 2021). Research has demonstrated that a greater reported frequency in encounters with these forms of prejudice have been predictive of more problems with physical health and wellness (Chrisler et al., 2016; Dhanani et al., 2022; LaFave et al., 2022; Levy, 2022).

Furthermore, while older adults often internalize ageist stereotypes and social norms and as such, attempt to distance themselves from later life, such as through using special creams, hair products and undergoing surgical procedures to look younger, ageism impacts men and women differently (Chrisler et al., 2016). Evidence of growing older, such as gray hair and wrinkles are generally characterized as "distinguished" in older men, yet growing older is linked with perceptions of women being unattractive and "old" (Chrisler et al., 2016). Thus, research has suggested that women are determined to be "old" earlier in life, are criticized more harshly for their appearance and behavior as they are told to "act their age," and in mainstream media, older actresses assume less leading roles than older men (Chrisler et al., 2016, p. 88). This is problematic, as the majority of older adults are female, as women generally live longer than men, and encounter more experiences with the healthcare system, including in later life (Chrisler et al., 2016).

It is for all of these reasons that in this article, we will explore pressing needs for research, practice, policy, and education to address intersectional prejudice against older adults, especially among those who are members of racial, ethnic, sexual, and gender-based nondominant groups.

Conceptual Framework

To explore current needs for research, practice, policy, and education to address structural discrimination and oppression among older adults, particularly of color, we turn to a framework informed by Trauma Theory, Antiracism, Critical Feminist Gerontology (which is rooted in intersectional feminism and critical gerontology), and the Social Ecological Model. Contemporary Trauma Theory is used to explore how crises that are experienced with inadequate support are reasonably linked with psychological or physical, thus emphasizing the needs for help and recovery that emphasize structural and multilevel responsibility rather than victim blame (Goodwin & Tiderington, 2022). Combined with this, antiracism requires support for antiracist ideas and policies, by considering what is wrong with policies, rather than what is wrong with individuals, to target racist policies and actions (Kendi, 2019).

In addition, intersectionality is used to explore how power imbalances disproportionately impact nondominant populations according to their interconnected identities (Ma et al., 2021), and Critical Feminist Gerontology is used to explore these disparities across the lifespan while advancing justice (Bows, 2018), attending to a call to address sexism and ageism in efforts to attend to longstanding health disparities experienced by older women (Carmel, 2019). These frameworks complement the Social Ecological Model, which acknowledges that health inequity is linked with unequal access to

resources, thus, confronting the notion that health can be understood without multilevel considerations, namely at individual, relational, organizational, and societal levels (Golden & Wendel, 2020; Hand, 2020; Hand et al., 2021).

Discussion

Intersectional discrimination has been linked with cumulative burdens, such as among older women who have endured denigrating and stigmatizing treatment by service providers, such as due to racism, sexism, heterosexism, ableism, classism, and/or other forms of prejudice (Chrisler et al., 2016). Addressing these forms of intersectional prejudice in later life by promoting more realistic and multifaceted understandings of older women could result in enhanced client relationships, more equitable treatment, and greater adherence to treatment plans (Chrisler et al., 2016). Moreover, links have long been established between ageism and other prejudice, such as racism, sexism, and heterosexism, suggesting that addressing one form of prejudice, such as ageism, can help with challenging other prejudiced beliefs as well (Chonody & Wang, 2014).

Such efforts are also needed to address the Global Goals recently established by the United Nations (UN; The Global Goals, 2022), focused on working to ensure improved health and wellness as well as gender equality, less overall inequalities, and with this, justice, including at the organizational and societal levels, with likely impacts at the individual and relational level. Accordingly, considerations for research, policy, practice, and education are discussed below.

Implications for Research

More research is expressly needed on ways to improve intergenerational relationships (Monahan et al., 2020), such as through intergenerational learning opportunities, community-building activities, and through social media platforms (Soto-Perez-de-Celis, 2020). Further knowledge of ethnic and cultural perspectives on aging, family roles, illness, death, dying, and institutionalization is needed as well (Chonody & Wang, 2014).

And more research is urgently needed to examine links between racism, classism, sexism, heterosexism, as well as other forms of discrimination and the health of older members of racially nondominant groups to better understand and urgently attend to the ways intersectional prejudice are linked with health (LaFave et al., 2022; NIA, n.d.). This must begin with a further representation of and support for BIPOC, LGBTQ+, and other nondominant populations as well as those who live in poverty in clinical trials and in later life research (Ma et al., 2021). NIA (n.d., para. 21) has underscored a need to "oversample" for these populations in research along with the need for cross-national databases focused on intersectional health disparities across the life course and in later life.

For example, structural prejudice and oppression continue to maintain the underrepresentation of older Asian Americans in research, policy, and education, despite health inequities

across the life course impacting this population, including since the pandemic (Ma et al., 2021). Thus, future research, particularly with older adults who disproportionately experience discrimination owing to structural oppression, should be trauma-informed, emphasizing participant voices, promoting choice and transparency, and including older adults in research plans as much as possible. Moreover, further research is needed on the ways early-life experiences impact health for older adults, to inform interventions to address these disparities in health owing to systematic discrimination (NIA, n.d.).

Implications for Policy

Greater exposure to older adults has been shown to be useful in addressing ageism and the same is true with regard to greater exposure to diverse populations and impacts on intersectional prejudice (Chonody & Wang, 2014). As such, policymakers should work to encourage intergenerational relationships (Monahan et al., 2020), such as through funding for research on intergenerational healthcare education, as well as through support for intergenerational learning opportunities and community building (Soto-Perez-de-Celis, 2020), including among practitioners and administrators in healthcare settings.

In addition, further policies are needed to identify and address intersectional discrimination (Chonody & Wang, 2014; Monahan et al., 2020; NIA, n.d.), such as through ensuring diverse and antiracist hiring practices (Monahan et al., 2020) and inclusive, respectful language (Soto-Perez-de-Celis, 2020), and initiatives that ensure further representation of women and other nondominant populations in research across the life course that is conducted to inform future healthcare policies (NIA, n.d.). Further support for understanding intersectionality and strengthening diversity and trauma-informed approaches in healthcare education and trainings, the workplace, and in research will help advance justice and with this, improved health in later life (Ma et al., 2021). And at the societal level, as Solomon et al. (2022, p. 286) have shared, more financial support is especially needed in rural areas, particularly for American Indigenous elders (not to be confused with the pejorative term "elderly"), such as through "releasing constraints on federal funding and policy for American Indian and Alaska Native initiatives."

Implications for Practice

Healthcare practitioners should work to further consider and confront systematic discrimination across the life course and particularly in mid- and later-life along with internalized ageism to promote greater health equity (Ayalon & Tesch-Römer, 2017). This may begin with inclusive, antiracist, and trauma-informed education and training, especially as positive aging attitudes are linked with 7.5 years of longer lives (Soto-Perez-de-Celis, 2020). Thus, new wisdom and experience that adults in later life can offer should be welcomed (Soto-Perez-de-Celis, 2020), across races (Ma et al., 2021), ethnicities, genders, sexual orientations, and classes.

To encourage this, more training is needed on the psychological, sociological, and physical aspects of aging as well as on how to navigate and improve services, such as

through attending to needs surrounding social determinants of health (Chonody & Wang, 2014). Further ongoing efforts toward fact-checking, addressing myths and stereotypes linked with age, race, gender, sexuality, ability, class, and other factors that place some populations at disproportionate risks for structural discrimination, and speaking out are also needed (Soto-Perez-de-Celis, 2020).

As part of such efforts, greater awareness is expressly needed surrounding disrespectful communication directed at older adults and particularly toward older women (Ayalon & Tesch-Römer, 2017), and especially toward racially and sexually nondominant populations who live on the margins owing to structural inequality. Thus, a strong organizational social media presence and even greater efforts to educate the public are recommended (Soto-Perez-de-Celis, 2020). Currently, more accessible information on COVID-19 testing and prevention are urgently needed as well, especially for older refugees and immigrants (Cheng, 2022; Ma et al., 2021).

Implications for Education

In addition to exploring their own internalized age-based prejudice (Ayalon & Tesch-Römer, 2017), healthcare students should be trained to identify and address ageism, racism, sexism, and other forms of prejudice within and beyond fieldwork practicum, across disciplines (Chrisler et al., 2016), using an intersectional and trauma-informed approach. Stronger intergenerational relationships are also needed (Monahan et al., 2020), including in healthcare education, through further intergenerational learning opportunities and more classes and assignments that offer greater exposure to later life (Soto-Perez-de-Celis, 2020).

In particular, intergenerational service learning can improve knowledge and empathy in educational and practice settings (Monahan et al., 2020), which may in turn, impact self-reported ratings on mental and physical health among clients along with improved overall health outcomes. Further, ageism should be considered a key aspect of diversity in healthcare education (e.g., in social work, psychology, psychiatry, nursing, public health, and other related healthcare disciplines). And more work is needed to challenge stereotypes linked with intersectional sexism and ageism (Bows, 2018; Carmel, 2019; Hand, 2020; Hand et al., 2021) nationally and globally (Carmel, 2019) in general education and particularly in education for health care professionals, to ultimately promote greater empowerment of girls and women across the life course, in efforts to strive toward greater equity.

Conclusion

Education and intergenerational exposure have been shown to have the most substantial impact on perceptions and attitudes (Chrisler et al., 2016). Thus, further work is needed to promote education as well as mass and social media representations of older adults that reflect positive aging and values in efforts to advance justice for nondominant populations in later life in particular. Such efforts could help to address

intersectional discrimination in later life and with this, longstanding inequities in the healthcare system that disproportionately impact older adults, and chiefly older women and transgender individuals of color, across the lifespan and most notably in later life. Healthcare workers must recognize these individuals as adults, as indeed they are, and avoid immediately assuming limited knowledge or capacity for decision-making, as they also advocate for a more trauma-informed and intersectional approach to client-centered care.

Research, policy development, and practice interventions are especially needed to challenge the social stigma that is linked with growing older, particularly among older women of color (Chrisler et al., 2016). As part of such efforts, violence and abuse in later life should be more closely monitored and reported (Soto-Perez-de-Celis, 2020). And future interventions to address ageism should be intersectional (Chrisler et al., 2016), influenced by cultural contexts that account for race, ethnicity, gender, sexuality, ability, and local as well as familial social norms and values (e.g., in urban and rural areas alike, and considering multiple family contexts; Burnes et al., 2019). Thus, a more intersectional approach is urgently needed to attend to the UN's Global goals of promoting health and wellness, gender equality, less inequalities overall, and as such, greater justice (The Global Goals, 2022).

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ORCID iD

Michelle D. Hand https://orcid.org/0000-0002-3481-7778

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Author Biographies

Michelle D. Hand is an Assistant Professor of Social Work at George Mason University. Her research focuses on holistic strategies for addressing sexual violence and trauma across the life course, particularly among individuals and communities that are considered nondominant or at-risk, owing to structural inequalities, through nature-based approaches (e.g., community gardens and farms) to promote healing. Her work has been published in premier scholarly journals, in books, and has been presented at several national and international conferences, including at Harvard Law School's "Just Food?" Forum, on social gardens for change.

Emily S. Ihara is a professor and chair of the Department of Social Work. Ihara's research interests focus on interventions, policies, and system changes necessary to eliminate health inequities for vulnerable populations across the life course.