Chapter 1

ATTITUDES and SOCIAL ISSUES that AFFECT OLDER PEOPLE

LEARNING OBJECTIVES

In this chapter, you will learn about:

* Ageist attitudes – what is their scope and implications?

* How education, health care, employment, legislation and sexuality reveal ageism.

* The difference between attitudes and beliefs.

* The attributes of an attitude.

* Attitudes toward sexual abuse, later life sexuality and well-being.

* How attitudes toward such social issues as abuse, sexuality, health, and well-being differ from ageist stereotypes.
INTRODUCTION

‘I think therefore I am.’ This famous saying defines what it means to be a human and alive. There is also a measure of truth in a reversal of that saying: I am what I think. What you think (e.g., about other people, your physical environment, your life) contribute to a sense of your own self as distinct from the selves of other people. Your thinking is part of your identity, affects your feelings (or vice versa) and helps to determine how you act. Although thoughts about social and other issues invoke processes rooted in the biology of our brains, our thoughts evolve with maturation and experience, and reflect the period of history in which we live. Winston Churchill, the British wartime Prime Minister, provided a witty illustration. He remarked that a young person without leftward political leanings had no heart but an old person with leftward leanings had no head. This quip about political thought during the middle years of the last century suggests the relevance of age and experience to attitudes during a particular historical epoch. This chapter examines attitudes and social issues that pertain to older people today.

Attitudes and beliefs refer to cognitions. Such cognitions are about something. The ‘something’ might be discrete (e.g., a person), categorical
(e.g., older people), temporal (e.g., an event), or hypothetical (e.g., the ‘big bang’ theory of the origin of the universe). These cognitions are structured into what George Kelly (1955) termed personal construct systems that determine the outlooks of people on their personal and professional lives. A convergence of outlooks within a profession or among the public can influence the kinds of regulations, rules, and policies put in place to control behaviour. Consequently, the significance of attitudes extends beyond the individual ultimately to the governance of society as a whole.

The term for attitudes that are common within a society and applied to a category of people is a stereotype. Common stereotypes include those based on racial, religious, and sexual characteristics. Such stereotyped attitudes and beliefs are always over-simplifications because the people within any category are heterogeneous except for a common characteristic that defines the category. This chapter begins with an overview of stereotypes of older people that find expression in public opinion, education, health care, employment, legislation, and lifestyle. Although stereotypes can and do affect the treatment of older people, stereotyped attitudes are not the only influence on such behaviour.

Research since the 1920s that examined relationships between attitudes and behaviour arrived at some surprising conclusions. Consequently, the section following the overview examines the underpinnings of attitude research with respect to definition, measurement, and causal influences.

The remainder of the chapter evaluates consistencies and discrepancies between stereotypes of older people and evidence pertaining to that cohort. What are the attitudes of younger people, of older people, and how does the evidence relate to these attitudes? The issues examined include personal and social concerns identified as important to all Canadians. What are these concerns? Read any newspaper or magazine
nowadays to find that the concerns that occupy the minds and thoughts of Canadians include violence, sexuality, well-being, and the self.

AGEISM AS A PERVERSIVE SOCIAL ATTITUDE

Dowd (1980) asserted that the status accorded to people in western culture increases from youth to middle age but declines thereafter. This trajectory holds true regardless of the age, social class, or gender of respondents. The consequences include a stereotyping of older persons that is usually negative but sometimes positive in direction (Palmore, 1990) – see Chapter 3 for more on the modernization theory of aging. The name for such stereotyping is ageism.

Some authors consider the roots of ageism to reside in fear and vulnerability toward aging and death (Martens, Greenberg, Schimel, & Landau, 2004; Martens, Goldenberg, & Greenberg, 2005). Put simply: old people forewarn young people of their own futures and it scares them. This fear may contribute to a marginalization of older people in industrialized countries and a reduction in their participation in social affairs (Solem, 2005). Other factors suggested to contribute to ageism include the social separation of young and older cohorts in modern society (Hagestad & Uhlenberg, 2005). There is also evidence that negative information about the elderly contributes to ageist attitudes. Kojima (1996) examined population opinion surveys in Japan conducted between 1990 and 1995. The proportion of respondents positively disposed toward a large aging population fell and the proportion having negative attitudes increased during this period. Kojima (1996) explained that this trend coincided with extensive media coverage of record-low fertility rates in Japan and the introduction of government policies to slow the rate of population aging.
Regardless of the reasons for its appearance, the expression of ageism varies with history and culture. Comparative analysis of young people in the United States with those in countries like Germany and Turkey show differences in attitudes towards aging (McConatha, Schnell, Volkwein, Riley, & Leach, 2003; McConatha, Hayta, Rieser-Danner, & McConatha, 2004). Compared with the North Americans, more young people in Germany have negative attitudes about aging but consider ‘old age’ to begin at a later chronological age. There are also gender differences, with females more negative about the aging of their bodies than males.

Researchers from Canada disagree about whether ageism is of social significance in this country. Over twenty years ago, Schonfield (1982) found that approximately 20 percent of respondents showed substantial ageist stereotyping, with evidence of some degree of stereotyping present in most respondents. He did not think that the former figure was especially high. Stones and Stones (1988) referred to ageism as a ‘quiet epidemic’ that contributes to benign neglect or indifference toward older people as a social category, but not necessarily to interpersonal antagonism. They reminded their readers that ageism refers to stereotyping of older people as a social unit but may not be a significantly influence on antagonistic behaviour in interactions with older people.

Research findings on ageism derive from many sources, including studies of undergraduate attitudes (Knox & Gekoski, 1989) and health care (Butler, 1975), literary and dramatic productions (Berman & Sobkowska-Ashcroft, 1987; Donlon, Ashman, & Levy, 2005), humour (Palmore, 1971), and legislative processes (Stones & Stones, 1998). The number of studies showing negative stereotyping is large. A compilation of
research findings on the attitudes of college students toward the elderly accessible at one university library includes nearly 40 references (Montgomery, 2000). Some studies use composite scales to compare levels of ageism in different cohorts (Rupp, Vodanovich, & Crede, 2005). A Canadian composite scale developed by Knox, Gekoski, and Kelly (1995) provides a useful measure of stereotypes and attitudes. The Age Group Evaluation and Description (AGED) Inventory contains evaluative factors of Goodness and Positiveness, and descriptive factors of Vitality and Maturity. The following paragraphs describe the manifestations of ageism on topics that received considerable attention from researchers. These topics include education, health care, employment, the legislature, and sexuality.

Ageism and education

Students’ knowledge and attitudes about aging benefit from exposure to positive information. Couper (1994) indicated that the prevailing educational philosophy in North America ignores aging as a topic during the high school years, thereby providing students with little information to counter ageist attitudes found throughout society. Several studies show that college students’ knowledge and attitudes about older people show improvement with information that is factual or designed to show the benefits of aging. Palmore (1988) found that knowledge about aging increased with education, and that courses on gerontology were beneficial. In a Canadian context, Matthews, Tindale, and Norris (1985) not surprisingly found education in gerontology to result in increased knowledge about aging. Canadian studies by Knox, Gekoski, and Johnson (1984) and Gfellner (1982) found attitudes to be more positive among students that had positive interactions with older people.
In applied educational contexts, a review of studies about medical students’ knowledge and attitudes about aging surprisingly concluded that instructional modules in geriatrics have little impact (Beullens, Marcoen, Jaspaert, & Pelemans, 1997). The probable reason is that such modules deal only with sickness. The authors cite courses on gerontology and interaction with the healthy elderly as ways to promote positive attitudes, and recommend their inclusion in the medical curriculum. Similarly, Hawley, Garrity, and Cherry (2005) found that police officers have better knowledge about pathological than normal memory in the elderly and make recommendations for training. Kane (2004) found that social work students perceived a lesser need for active intervention with old than with young clients because of differences in the problems frequently presented.

Ageism and health care

Many authors argue that ageism is pervasive in health care. Pulitzer Prize winning author Robert Butler (1974) addressed a Symposium on Geriatric Medicine as follows: ‘Medicine and the behavioural sciences have mirrored social attitudes by presenting old age as a grim litany of physical and emotional ills.’ In nursing homes, he spoke of a policy of pacification - the overuse of medication as a substitute for humane attention through diagnosis and careful treatment (Butler, 1975). This is but one example of poor health care based upon the old age of the patient. More than a decade later, van Maanen (1991) and Honeyman (1991) echoed Butler’s sentiments to the Canadian Medical Association. Evidence from Canadian nursing homes also supports Butler’s comments about pacification. Canadian homes use psychotropic medication but no more than those in other countries, however the physical restraint of residents is more frequent in this country (Canadian Institute of Health Information, 1998).
With respect to health care financing, ageist attitudes uphold the assumptions of an ‘apocalyptic demography’ (see Chapter 2) that influences health care policy (Gee & Gutmann, 2000). The assumptions are that (1) age brings about illness, (2) the treatment of illness incurs fiscal cost, and (3) population aging brings about an expectation of escalating cost. This reasoning seems to provide bureaucrats with compelling reasons to reconsider the wisdom of benevolent health care policies. However, health economists evaluate the apocalyptic demography hypothesis harshly, likening it to a ‘zombie’ that keeps walking despite its evident death (Evans, McGrail, Morgan, Barer, & Hertzman, 2001; Reinhardt, 2001). They argue that professional self-interest rather than demography contributes to projections about rising health care expenditure. The professional self-interest factors they identify include increased income for health care providers, a distraction of attention from poor health care practices, and the provision of a rationale for greater corporate involvement in health care (i.e., privatization – see Chapter xx). Evans and colleagues consider the apocalyptic demography hypothesis to exemplify the use of ageist arguments for the purpose of economic self-interests. They conclude that ‘we have nothing to fear from the aging of the population, only from those who continue to promulgate the fiction’ (p. 188).

Ageism and employment

The practice of mandatory retirement reviewed elsewhere in this book (see Chapter xx) invokes active discrimination based on age. Other negative stereotypes suggest that younger workforce members may lack requisite experience and that older workers may be unmotivated and
inflexible. Such attitudes can have implications for recruitment, salary, and termination. Although some countries introduced legislation to promote workplace equity, findings suggest that ageist attitudes continue to affect mainly the youngest and oldest groups of workers despite the emergence of equal opportunities legislation (McVittie, McKinley, & Widdicombe, 2003; Duncan & Loretto, 2004).

Ageism and the legislature

Lubomudrov (1987) examined congressional misrepresentations in the United States used to influence the legislative process. What he termed as negative (e.g., the elderly as poor, frail, ill-housed, etc.) and positive stereotypes (e.g., the elderly as well off, politically potent, etc.) were frequent. Human Rights Codes differ across provinces in Canada depending on how they invoke age as a prohibited ground for discrimination. Stones and Stones (1998) refer one such code (i.e., the Newfoundland and Labrador Human Rights Code) as one example of legislation that discriminates against older people. Under the terms of this Code, a senior can be denied access to public places or private dwellings, denied service, harassed, and even become the object of hate literature. Why is this? Because the Code age is a prohibited ground for discrimination only between ages 18-65 years (i.e., the employment age span recognized at the time the Code was written). Although legislators did not intend to enshrine ageism within the Code, the omission of age as a prohibited ground for discrimination does precisely that.

Ageism and sexuality

Starr (1985) wrote that nowhere is ageism more obvious than in attitudes toward sexuality. The common beliefs are that older people have neither interest nor capacity in a sexual relationship and an older person who breaks this taboo must be deviant and immoral. Butler and Lewis
(2002) and Stones and Stones (2004) reiterated this conclusion with evidence from both historical and modern times. Although the
development of the potency drug *Viagra* and the attendant publicity contributed to increased awareness of later life sexuality (Stones & Stones,
in press), a taboo that lasted for over a millennium is unlikely to fade away abruptly.

The preceding examples of ageism illustrate its pervasiveness as a social attitude. However, ageism is just one attitude among many that social
scientists have studied. In order to understand how attitudes (including ageism) relate to social issues of relevance to the elderly, we need to
consider the concept of attitude more broadly. The following section examines how social scientists define and measure attitudes, differentiate
attitudes from related concepts (e.g., beliefs), identify the attributes of attitudes, and take account of possible influences on attitudes.

ATTRIBUTES OF ATTITUDES

Definition and measurement

Social scientists have studied attitudes since the 1920s. The true home of the concept, however, is in social psychology where attitude
continues to remain ‘distinctive and indispensable’ (Allport, 1935, p. 198). Definitions of attitude refer to (1) a tendency (2) to evaluate (3) an
object with some degree of favour or disfavour (Eagly and Chaiken, 1993). In other words, an attitude represents a fleeting or enduring
tendency to positively or negatively evaluate an object that may be a person, a category of people (e.g., the elderly), or any other animate (e.g.,
dogs) or inanimate (e.g., global warming) instance, occurrence, or category. The target of an attitude is the person who experiences the object.

To illustrate – in the sentence, ‘*On waking up, I like a cup of coffee*’, the phrase ‘on waking up’ delimits the tendency; the target is ‘I’; the
evaluative term is ‘like’; ‘a cup of coffee’ is the object.

Social psychologists were also among the first researchers to explore systematically different ways to measure attitudes. The main measures included Thurstone’s (1928) method of equal intervals, Guttman’s (1941) cumulative method, and Likert’s (1932) summative method.

1. Thurstone’s (1928) method of equal intervals proceeds in three stages. Judges rate statements for the degree of favour or disfavour toward an attitude object. The items selected for inclusion are those that represent different levels on the evaluative dimension. Respondents rate their levels of agreement with each statement. This method fell into some disfavour because of its complexity.

2. Guttman’s (1941) cumulative method uses statements ordinarily graded for degree of favour or disfavour toward the attitude object. If the measure is truly cumulative, respondents should disagree with all items below a threshold level but agree with all those above that level. The threshold level reflects the attitude.

3. Likert’s (1932) summative method uses statements rated by respondents for level of agreement. The scores are summed across items (i.e., with negative items reverse scored), and the attitude is represented by the summed score. This method is currently the most popular because of its simplicity.

Attitudes and beliefs

An attitude is not the same as a belief. A **belief** is simply a statement that a respondent thinks is true. A statement like, ‘older drivers are at
high risk of dying in road accidents’, expresses a belief rather than an attitude. This belief may or may not be true but, by itself, it does not convey an evaluation. An attitude always conveys an evaluation. If somebody says, ‘Older drivers should be banned because they are a danger to themselves and others’, ‘I hate driving because of all the slow and dangerous older drivers on the road’, and ‘I won’t be in a car with an older driver because they drive so badly I might be killed’, it is reasonable to infer a negative evaluation. With respect to the preceding examples, research on accidents does support a belief that seniors are at high risk of fatality in automobile crashes (Bédard, Guyatt, Stones, & Hirdes, 2001). However, the fatalities that occur are frequently because older people are at increased risk of mortality if injured. Figure 1.1 provides an illustration with 1999 data from the Fatal Accident Reporting System (FARS) in the United States. The number of people killed in automobile accidents in which a fatality occurred exceeds the number of people uninjured or injured only for people aged over 60 years regardless of whether the occupant of the vehicle was the driver or a passenger. People of younger ages were more likely to be uninjured or injured than killed. Consequently, Figure 1.1 offers no factual support to attitudes or beliefs that older people cause more traffic fatalities than younger people. The odds of dying in a road accident do increase after age 60 years, but the preponderance of people involved in fatal road accidents are young rather than old.

----- INSERT FIGURE 1.1 ABOUT HERE -----

The distinction between attitudes and beliefs finds its counterpart in the types of measures used in research on ageism. Matthews, Tindale, and Norris (1985) described a Canadian ‘facts on aging’ quiz that measured only beliefs about aging and the aged. In contrast, the Age Group
Evaluation and Description (AGED) Inventory by Knox, Gekoski, and Kelly (1995) includes attitudinal content (i.e., the respondents’
evaluations of aspects of aging). The items on the AGED contrast bipolar pairs of adjectives (e.g., timid versus assertive) with the respondents
asked to indicated the pole that best describes old people. Consequently, differences in research findings obtained with the respective types of
measure likely relate to differences between beliefs and evaluative bias with respect to aging.

Attitudes and response consistency
Psychologists consider attitudes to belong to a category of concepts – variously termed latent variables, hypothetical constructs, or cognitive
schema – that also includes learning, memory, and personality (MacCorquodale & Meehl, 1948). These concepts (1) intervene between a
stimulus and a response, (2) are inaccessible to direct observation, and with (3) their properties are inferred from consistencies in the responses
to related stimuli. The stimuli might be questions about something asked by an interviewer or items on a survey. The responses include the
answers or other reactions (e.g., time to respond) to the stimuli.

We need the concept of attitude to account for consistencies and dissimilarities between different modes of responding to related stimuli.
Although most attitude measures rely on self-report, the items may address cognitive, affective, and behavioural modes of responding. Most
research findings showed evaluative responses to correlate across these domains (Breckler, 1984; Eagly & Chaiken, 1993; Zanna & Rempel,
1988). Campbell and Fiske (1959) refer to such consistency as convergent validity. The complement to convergent validity is discriminant
validity, which means that items within one domain should correlate more strongly with each other than with items in other domains. Table
1.1 illustrates these distinctions by showing the expected levels of correlation between Likert-scale agreement with cognitive, affective, and behavioural attitude statements about old people. We expect high correlations between items that measure the same mode of responding and moderate correlations between items that measure different modes of responding regardless of whether the statement is positively or negatively keyed.

<table>
<thead>
<tr>
<th>Item type</th>
<th>Cognitive</th>
<th>Affective</th>
<th>Behavioural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Items</td>
<td>Old people are wise</td>
<td>Old people are mentally slow</td>
<td>I enjoy talking with old people</td>
</tr>
<tr>
<td>Wisdom</td>
<td>*</td>
<td>High</td>
<td>Moderate +</td>
</tr>
<tr>
<td>Slowness</td>
<td>*</td>
<td>Moderate -</td>
<td>Moderate +</td>
</tr>
<tr>
<td>Enjoyment</td>
<td>Moderate -</td>
<td>Moderate +</td>
<td>Moderate +</td>
</tr>
<tr>
<td>Boredom</td>
<td>High -</td>
<td>Moderate -</td>
<td>Moderate +</td>
</tr>
<tr>
<td>Volunteer</td>
<td>*</td>
<td>Moderate -</td>
<td>Moderate -</td>
</tr>
<tr>
<td>Work</td>
<td>*</td>
<td>Moderate -</td>
<td>Moderate -</td>
</tr>
</tbody>
</table>

* Values of the hypothetical correlations include strength (moderate, high) and direction (+, -).

Measures of ageism tend to conform to these expectations. Knox, Gekoski, and Kelly’s (1995) Age Group Evaluation and Description (AGED) Inventory distinguished between descriptive factors and evaluative factors. The former are cognitive and the latter affective. Rupp, Vodanovich, and Crede (2005) also find cognitive and affective distinctions in their analysis of responses to the Fraboni Scale of Ageism, and corresponding correlations with other measures of age related attitudes.
Social scientists traditionally assumed that attitudes have a predictive or even a causal relationship to behaviour. However, there was much debate about this issue during the 1970s. Wicker (1969) reviewed 42 mainly laboratory studies that included correlations between attitudes and behaviour. He found the correlations to be weak or nonsignificant in most of the studies. There were strong reactions to Wicker’s paper. Hovland (1959), in an earlier account, had stated that attitude-behaviour correlations might be weaker in laboratory research than survey research because the attitudes studied tend to be less important to the respondents. Furthermore, laboratory studies constrain the choice of actions to those chosen by the researcher, whereas people in natural settings express their attitudes by behaviours of their own choosing.

Probably the most compelling evidence was research showing a weak correlation of attitudes with discrete behaviours but stronger correlations with summed indexes of behaviour. Weigel and Newman (1976) provided an example in which they obtained correlations between attitudes toward environmental preservation with unobtrusive measures of behaviours taken six months later. The findings showed the correlations of attitude with discrete behaviours to average about $r=.32$, but the correlation with a summed index to be $r=.62$. The stronger correlation with the summed index was not a surprise. Somebody with a given attitude toward an object may express it unevenly for any number of reasons (e.g., fear of a social penalty if the attitude is unpopular), with attitude being only one among many influences on behaviour (Ajzen & Fishbein, 1975). Current theories tend to agree that attitudes have implications for behavioural inclinations rather than strong effects on specific behaviours (Eagly & Chaiken, 1993).
Influences on attitudes

Many social theorists incorrectly assume that attitudes depend exclusively on learned experience. Campbell (1963) even defined attitude as an *acquired* condition. An implication of this hypothesis is that differences in attitudes arise from differences in experience. However, other researchers suggested a strong influence of personality or genetic predisposition (Costa & McCrae, 1980; Olsen, Vernon, Harris & Jang, 2001). The implications of this hypothesis are that attitudinal differences may depend less on nurture than nature and that attitudes may be harder to change than many social theorists had contemplated.

Studies that purport to show genetic influences on attitudes use a twin research paradigm. This paradigm contrasts identical twins with fraternal twins. Because identical twins share fully common genes whereas fraternal twins have only 50% of genes in common, it follows that if attitudes have a genetic influence, the attitudes of identical twins should be more similar than between fraternal twins. Examples of studies that show greater similarity of attitudes between identical than fraternal twins include Waller, Kojetin, Bouchard, Lykken, and Tellegen (1990) who studied religious attitudes, and Eabes, Eysenck, and Martin (1989) who showed a genetic influence on other attitudes. Recent Canadian research on twins provides consistent evidence, with findings of a genetic contribution to 26 of 30 attitudes.

The evaluative concept of attitude that emerges from the discussion in this section of the chapter has implications for consistency across different kinds of response and for behavioural inclinations across a range of situations. Although attitudes may relate to life experiences, they
also show effects because of predispositions that may affect resistance to change. The final sections of the chapter examine attitudes with respect to social issues that affect older people (i.e., elder abuse, sexuality, well-being, and the self). Based on the content discussed in this section, the attitudes of younger people are likely to affect their behaviour toward older people and the attitudes of older people are likely to affect their own behaviour.

ATTITUDES AND ELDER ABUSE

Hudson (1991) clarified our understanding of elder abuse and neglect by providing a standard definition agreed upon by an international panel of experts. This definition refers to abuse as a special case of harmful behaviour that occurs in the context of a trust relationship. Abuse refers to destructive behaviour, while neglect refers to a failure to provide required help. The people that seniors should be able to trust include unpaid caregivers (e.g., a relative, a friend) and professional helpers (e.g., doctors, nurses, lawyers). Behaviours not considered examples of abuse include those by confidence tricksters who prey on older people. Such crimes are not examples of abuse because the criminal is a stranger rather than somebody in a position of trust.

Definitions similar to that by Hudson (1991) are in use throughout Canada (e.g., British Columbia InterMinistry Committee on Elder Abuse, 1992). Although such definitions capture the global meaning, they do not distinguish between types of abuse. One way to classify cases pertains to the kind of harm done (e.g., damage to the physical, mental, or financial well-being of seniors). Another way pertains to the type of social expectation the behaviour violates (e.g., legal, ethical, professional, or social standards of acceptability) (Stones, 1995). The latter has
the advantage of consistency with the rule-based system that dominates legal logic.

The federal government and every Canadian province attempted in various ways to combat elder abuse beginning in the 1980s (Health and Welfare Canada, 1987, 1990). Ontario leapt ahead of the other provinces in 2002 with funding provided by its government for a Provincial Strategy to Combat Elder Abuse. This strategy complements the efforts of agencies, facilities, and community organizations by coordinating community services, training frontline staff, and raising awareness through public education (Stones, 2005).

Ageism and elder abuse
Several Canadian authors implicate ageism as a category or influence on elder abuse. Namiash (1998) refers to social or collective abuse, which includes ageism and its effects. McDonald and Collins (2000) remark on the inherent ageism in some theories about elder abuse (e.g., the social exchange model) that equate aging with increased powerlessness. Other authors suggest that ageism may reduce sensitivity to the expressed concerns of older people or a failure to take those concerns seriously (Wolf, 1997).

Examples of ageism cited by these authors include a failure to treat complaints of abuse by old people as seriously as similar complaints proffered by young people. Wolf (1997) provided a review of such neglect. The treatment of pain by physicians provides a related example from health care, with older people frequently receiving less aggressive treatment than younger people. Stones (2006) reports on a tendency by some physicians to treat agitation in old continuing care residents by chemical or physical means rather than pursue careful investigation of the
situational causes of that agitation. Beaulieu (1995) similarly wrote about prevalent practices in long-term care as examples of systemic abuse that would not be tolerated outside an institutional context.

**Strength of attitudes toward abuse and violence**

There is a paradox concerning group membership and attitudes pertaining to that group. Lindville (1982) carried early studies in what was to become a classical series by distinguishing between ‘in groups’, to which the respondent belongs, and ‘out groups’, to which the respondent does not belong. Lindville (1982) found that attitudes toward ‘out groups’ tend to be more extreme than toward ‘in groups’. In one study, she found the attitudes of college students towards (positive or negative) vignettes of an older person to be extreme relative to comparable vignettes of someone their own age. She explained such findings based on a complexity-extremity hypothesis: people with a complex understanding (members of an ‘in group’) have moderate attitudes toward the object in question; people with a simpler, less differentiated understanding (members of an ‘out group’) have more extreme attitudes.

Research on attitudes toward violent behavior shows a trend consistent with this hypothesis. More young than old people are the victims of violent crime. Statistics Canada regularly reports homicide rates more than 60% higher for people aged 15-44 years than for those aged 65 years and older. Consequently, one might think that younger people should have more fearful attitudes toward violent crime than older people have. Paradoxically, however, older Canadians have more fearful attitudes than those of younger Canadians (Statistics Canada, 2000), with similar findings found among older and younger Americans (Dowd, Sisson, & Kern, 1981). Although such differences are open to multiple
influences, the interpretation derived from the complexity-extremity hypothesis is that young people have a more complex understanding of violence in modern society than have older people, and this makes them less fearful.

The complexity-extremity hypothesis also applies to elder abuse. However, the attitudes of young people toward elder abuse are those expressed by an ‘out group’, whereas older people evaluate elder abuse from the perspective of an ‘in group’. Findings by Stones & Bédard (2002) showed that the strength of attitudes toward elder abuse and neglect is more negative in younger than in older people. Stones and Pittman (1995) were able to relate the strength of negative attitudes of younger people toward elder abuse to other measures of attitude extremity.

Stones (2004) reported other evidence consistent with the ‘in group’ versus ‘out group’ paradox. Matched groups of older respondents living independently or in long-term care homes rated two sets of elder abuse items. The first set consisted of generic items that were examples of abuse that could happen to any senior regardless of residence. The second set of institutional abuse items referred only to abuse in institutional settings. Both groups of respondents belong to an ‘in group’ with respect to generic abuse, but only the long-term care residents belong to an ‘in group’ with respect to institutional abuse. The findings show no differences between the residential groups on the generic items but more moderate ratings by long-term care than by community residents on the institutional abuse items (see Figure 1.2). Consequently, the findings with the institutional abuse items affirm the paradox that members of the ‘in group’ (i.e., institutional residents) have less negative attitudes towards examples of abuse than do members of the ‘out group’ (i.e., community residents). Qualitative findings from the study indicated that
the differences between groups did relate to a more complex understanding by the institution residents. Responses to an item on physical restraint provide an example. Whereas the community residents mainly considered the overuse of physical restraint to be unacceptable, the long-term care residents were more likely to mention safety issues and understaffing as relevant to their attitudes.

Attitudes toward elder abuse, therefore, appear to differ depending on whether or not the respondent belongs to a target population. These findings have implications for the following discussion on the under-reporting of elder abuse.

----- INSERT FIGURE 1.2 ABOUT HERE -----
Several studies examined attitudes toward elder abuse among non-professionals or compared attitudes across professions. The comparisons include professionals and the public (Hudson & Carlson, 1998), younger and middle-aged people (Childs, Hayslip, Radika, & Reinberg, 2000), different occupations (Payne & Berg, 1999), and ethnic minorities (Hudson, Armachain, Beasley, & Carlson, 1998). The studies found overall similarity between the attitudes of professionals and the public but also some differences. Payne and Berg (1999) found the attitudes of nursing home professionals to differ from those of the police and college students (e.g., with the differences related to professional practices). Older Korean-American women were less likely to perceive abuse than African-Americans or Caucasians (Moon & Williams, 1993). Consequently, the findings suggest that although attitudes toward elder abuse share common features among different target groups, there are also differences across groups.

Stones & Bédard (2002) attempt to reconcile these discrepancies within a threshold model of attitudes toward elder abuse. They reason that when different target groups rate behaviours for level of abuse, the groups are consistent about those behaviours evaluated as more or less abusive (e.g., ‘hitting a senior’ is more abusive than ‘opening a senior’s mail without permission’). They provide evidence to support this hypothesis, as did Stones and Pittman (1995). However, the target groups may differ about whether or not the evaluation is sufficiently negative to exceed a threshold for abuse (i.e., defined as the lower end of an abuse continuum). Stones and Pittman (1995) selected items that were close to the thresholds for inclusion in their Elder Abuse Attitude Test (EAAT).
Attitude change and elder abuse

Educators such as Podnieks and Baille (1995) suggest that attitude change is among the key aims in the prevention of elder abuse: ‘Education is not only about acquiring information, it is also about changing attitudes, behaviours, and values’ (p. 81). The targets of elder abuse education they identify include not only professionals, but also caregivers, the public, children, and seniors. Although senior may actively avoid exposure to information about elder abuse (Vernon-Scott, 2003), findings by Kipper (2001) suggest that attitude change may result from such exposure.

Little evidence is available that attests to the outcomes of public education on elder abuse. Although Podnieks and Baille’s (1995) review of elder abuse education cites no research on outcome evaluation, a subsequent study finds higher levels of reporting in communities that have higher levels of training for professionals (Wolf, 1999). A study in Quebec that aimed to change beliefs and attitudes in ethnic communities included outcome evaluation (Lithwick, Stones, & Reis, 1998). The intervention in this study proceeded in two phases. The first phase comprised four sessions of elder abuse education with members of eleven Community Senior Mistreatment Committees. The second phase involved a community awareness initiative organized and discharged by each committee. The data evaluated were from the Community Senior Mistreatment Committees. The committees had an average of 16 members drawn from the same ethnic community. The members included men and women with a mean age of 58 years. Committee members completed a battery of measures, including the Senior Behaviour Inventory (SBI), before and after the intervention. The SBI includes the Elder Abuse Attitude Test (EAAT; Stones & Pittman, 1995) and items on beneficence that a panel of 25 judges rated as not examples of ‘poor treatment’ of seniors (Lithwick, Reis, Stones, Macnaughton-Osler,
Gendron, Groves, & Canderan, 1997) (see Table 1.2). The purpose of the beneficence items was to provide a validity check against which to compare responses to the EAAT items.

**TABLE 1.2: ABBREVIATED SENIOR BEHAVIOUR INVENTORY (SBI)**

The following items refer to how people sometimes behave toward seniors. They only refer to behaviour by someone a senior has reason to trust. That person could be a relative or someone who takes care of the senior. That person could also be someone paid to help or look after the senior's affairs (e.g., doctor, nurse, homemaker, lawyer). The questions do **not** refer to how strangers treat seniors. Do you understand the kinds of people the questions refer to? Please indicate whether the behaviours below are (1) not abusive, (2) possibly abusive, (3) abusive, (4) severely abusive, or (5) very severely abusive towards a senior if done by someone a senior has reason to trust. Remember that the questions don't apply to acts by a stranger.

<table>
<thead>
<tr>
<th>Item</th>
<th>Not Abusive</th>
<th>Possibly Abusive</th>
<th>Abusive</th>
<th>Severely Abusive</th>
<th>Very Severely Abusive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EAAT items</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steals something a senior values</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pushes or shoves a senior</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lies to a senior in a harmful way</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opens a senior’s mail without permission</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Withholds information that may be important to a senior</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unreasonably orders a senior around</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tells a senior that person is ‘too much trouble’</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fails to provide proper nutrition</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disbelieves a senior claiming to be abused without checking</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The results showed differences in knowledge and attitudes before and after the intervention. Although the largest gains in knowledge concerned resources to help mistreated seniors, findings with the Senior Behaviour Inventory showed that attitudes toward elder abuse and neglect were more negative after the intervention. This occurred because the intervention sensitized the respondents toward elder abuse. Because the beneficence items on the SBI showed no such change, these findings suggest that the education had effects on attitudes that were specific to elder abuse and neglect.

ATTITUDES AND LATER LIFE SEXUALITY

Butler and Lewis (2002), and Stones and Stones (2004) described ageist depictions of later life sexuality in folklore, the arts, western religion, history, and the sciences. The features of these depictions include lack of sexual interest, incapacity, and moral prohibition. Box 1.1 illustrates sexual ageism from a senior’s perspective.

--- INSERT BOX 1.1 ABOUT HERE ---
Butler and Lewis (1988) described folklore depictions of old people as likeable but asexual beings. However, the stereotypes are decidedly negative for older people who behave in sexually explicit ways. Whereas adjectives that depict the behaviour of a sexually active young man have positive connotations (e.g., lusty, virile), similar behaviour by an old man elicits adjectives connoting just the opposite (e.g., lecherous, foolish). Folklore similarly depicts behaviour considered ‘provocative’ or ‘seductive’ in a young woman to show mental disorder, moral weakness, and a loss of dignity (e.g., ‘mutton dressed as lamb’) if present in later life.

Starr (1985) reported that traditions of later-life sexual proclivity in literature and the visual arts emphasized depravity and incapacity. A frequent character was the cuckold – a ‘sugar daddy’ whose wealth attracts a young woman who soon becomes unfaithful because of her partner’s impotence. Such depictions in the arts and modern media affect the attitudes even of older people. Donlon, Ashman, and Levy (2005) find a correlation between negative images of aging in people aged 60+ years and the amount of television they watch.

The preceding examples of sexual ageism are consistent with beliefs that originated from teachings by the early Christian church that sex is sinful outside the contexts of marriage and procreation (Stones & Stones, 2004). Consequently, sexuality in old people was seen as sinful because of limited procreative potential. These ideas originated with writings by St. Augustine (354-430 A.D.) who, based on what now seems flimsy logic, reasoned that lust and passion are evils we must endure only to procreate the species. Although protestant reformers attacked St. Augustine's doctrines in later centuries, the linkage of sex with sin continues to persist in our culture. The other major religions in the world make no such connection (e.g., Taoism, Confucianism, Hinduism, Buddhism, and Islam). These religions embrace sexuality as a source of
pleasure and solace, some consider it a means to enlightenment, and none stereotypes sexuality in later life so negatively.

The quintessential religious condemnation of sexuality in older women occurred in the witch-hunting era in Europe during the 15th to 17th centuries. The official manual on witch hunting was the *Malleus Maleficarum* (*Hammer of Witches*, 1486), which equates the origins of witchcraft with carnal lust. This manual indicated that deviant sexuality could provide evidence for witchcraft. Records indicate that approximately 90% of witches were women, mostly aged in their 50s or 60s, and many had served as midwives. Women during this epoch had good reason to be modest in their sexual display.

Attitudes of older people toward sexuality

A major study by the American Association of Retired Person (AARP; 1999) measured attitudes and beliefs in the context of later life sexuality. The survey included items on sexual satisfaction, the relevance of sexuality to a good quality of life, and attitudes toward sex outside marriage. Figure 1.3 shows similar levels of sexual satisfaction between the sexes (although more females than males reported being very satisfied) and a shallow decrease in satisfaction with age. The finding of somewhat higher sexual satisfaction in females than males is consistent with findings from other studies (Matthias, Lubben, Atchison, & Schweitzer, 1997). Men in the AARP (1999) survey who were sexually satisfied were usually married to a partner perceived as romantic and sensitive to their needs. Sexually dissatisfied men had either no partner or a partner perceived as non-romantic. Sexually satisfied women usually had married partners perceived as sexually imaginative and exciting lovers. Sexually dissatisfied women were mainly without a partner. Consequently, much of the decrease in sexual satisfaction with age appears to relate to the absence of a partner in late life.
Figure 1.3 shows that the belief that sex is important to quality of life was more frequent among men than women but its prevalence decreases with age in both sexes. The findings are opposite for the attitude that sex outside marriage is wrong, with the frequency higher among women than men and an increased prevalence with age in both sexes.

Attitudes toward sexuality in long term care homes

Long-term care brings special challenges because a significant proportion of residents have some form of dementia. Lichtenberg (1997) believes that sexual expression in residents of long-term care homes with and without dementia brings different ethical challenges. For the cognitively intact, the issue of privacy is primary to their ability to enjoy sexual relations. For people with dementia, the question of their competency may be paramount. Although there is no good reason to prevent people with dementia from enjoying a sexual relationship, it is important to respect their desires and ensure an absence of coercion or unwanted persuasion.

A study by Walker, Osgood, Richardson, and Ephross (1998) compares the attitudes of the staff of long-term care facilities with those of older people, including residents of nursing homes. More staff members than older people consider sexuality to be an important concern. Older people are more tolerant about homosexuals residing in nursing homes, and more of the older people than staff members think the latter should
facilitate access to erotica. On the other hand, more of the older people than staff think family members need telling if residents form a romantic attachment.

Although many long-term care institutions now provide privacy rooms to facilitate the sexual enjoyment of cognitively intact residents, there is little evidence on the outcome of such initiatives. The barriers to overcome include not only the attitudes of staff but also those of the residents, whose attitudes may reflect mixed feelings of benevolence, envy, or concern toward those having romantic liaisons.

ATTITUDES AND WELLBEING
Wellbeing can be viewed as a continuum comprised of mental and physical health at one pole and disease and disability at the other (also see the discussion in Chapter 10). Attitudes about wellbeing fall into two main groupings: the outlook of professionals; and attitudes about wellbeing in the public at large.

Attitudes of professionals
The concern of professionals is with the disease and disability pole of the well-being continuum. The medical vernacular refers to old people as ‘a problem’, the senior activist Madeline Honeyman told the Canadian Medical Association in 1991 (Stones & Stones, 1996). They can be a problem to the physician because older patients have chronic illnesses that typically necessitate longer consultations. Furthermore, because treatment of chronic disease is less likely to result in a cure compared with acute disease, physicians may find treating older patients less
rewarding. Older people are a problem to administrators of acute care hospital because they typically stay longer after admission. They may become known as ‘bed-blockers’ if their discharge is delayed because of lingering illness and a failure to locate suitable alternative accommodation. Older people may even be a problem in continuing care homes, which are designed to house them, if they fail to fit in or comply with a home’s routine. Treating the elderly as problems rather than people (i.e., dismissing their needs) is just one charge of ageism laid against health care professions.

Another charge is that health care professionals give lower priority to older patients. Some research on this issue measures attitudes within the health care professions whereas other research infers attitudes through analysis of health care practices. Recent examples include research on treatment priorities (Kane, 2004), pain (Brown, 2004), screening (Jerant, Franks, Jackson, and Doescher, 2004), and recruitment into clinical trials (Townsley, Selby, & Siu, 2005). Other charges include the overuse of physical and chemical restraint to pacify residents in long term care settings (Brink, Stewart, & Stones, 2004) and the use of ageist language that strips residents of autonomy and dignity (Nussbaum, Pitts, Huber, Krieger, & Ohs, 2005).

As a qualification to the preceding charges, no author argues that most or even a small minority of health professionals are overtly ageist – just the opposite, in fact – but rather that the health care system makes some kinds of ageism invisible (e.g., pacification disguised as treatment) and it ought not to tolerate ageism in any form. Health care professionals work within strictures dictated by their professional organizations and government policies that apply to health care practices and workplaces. If ageism is inherent in those policies and practices, the blame extends
to levels much higher than the proximate interactions between the health care professional and older patient.

Attitudes of the public

Despite the charges of ageism in acute health care settings and continuing care homes, the majority of consumers report satisfaction with their experiences in health care. Annual reports of patient satisfaction with acute care hospital experiences indicate that approximately 85% of patients report overall satisfaction (CIHI, 2005). Similarly, about 85% of residents of Ontario continuing care facilities report overall satisfaction as do their families (HRCC, 2005). The residents’ satisfaction is highest for medical care and lowest for the autonomy allowed them. Their families are least satisfied with the living environment and provisions for activities and entertainment.

Other research on public attitudes examines the positive pole of the well-being continuum. The findings show that the attitude of most respondents of any age is positive about their health. Health Canada (2000) reports that 78 percent of seniors described their health as good, very good, or excellent. The AARP (1999) survey similarly shows that just over 80 percent of people aged 45+ years evaluate their health as good, very good, or excellent, without major differences because of cohort or sex. Kozma, Stones, and McNeil (1991) noted that ratings of perceived health were high among older Canadians. Findings from a 1999 telephone survey of 1,000 representative Canadians sponsored by Manulife Financial included three questions relevant to physical and mental health: perceived health; worrying about health; feeling depressed. Figure 1.5 shows high rates of endorsement for perceived good health and low rates for worries about health and feelings of depression. The absence of cohort differences on any measure provides no evidence that attitude toward personal health changes with age (also see Chapter 10).
However, some caution is necessary regarding the interpretation of satisfaction ratings and other measures of wellbeing. In earlier discussion of influences on attitudes, there was mention of the importance of personality and other enduring dispositions. A subsequent chapter in this book on Mental Wellbeing and Mental Disorder reviews evidence that attitudes about wellbeing show a strong influence by personality in addition to life experiences. Such evidence might help explain why those older people with multiple chronic disorders continue to evaluate their personal health positively.

ATTITUDES AND THE SELF

Findings on attitudes toward the self by older people show two main influences. The first is a negative appraisal of a diminishing future. The second is a positive appraisal of themselves against other people.

The AARP (1999) survey provides evidence for the former. The survey includes a ladder-of-life on which respondents indicate where they stood in the past (five years ago), present, and future (five years hence). This measure is similar to one developed in Canada by Schonfield (1973). The findings show that all cohorts and both sexes thought they stood higher on the life satisfaction ladder five years ago compared to now, and that they would stand lower than now five years into the future. These findings are consistent with Dowd’s claim of devaluation as people progress from midlife to old age.
Another AARP survey examined attitudes toward physical attractiveness in a national telephone survey of over 2000 Americans (AARP, 2001). This survey asked respondents to rate their personal attractiveness on a 10-point scale and to estimate the age when physical attractiveness attained its peak. The findings show both negative and positive evaluations. Because the age of peak attractiveness is in the midlife span, older respondents think their peak attractiveness is past. However, the mean rating of personal attractiveness by both older men and women is close to 6.5 on the 10-point scale. Consequently, the respondents continue to consider themselves as attractive even though the age of peak attractiveness is behind them.

Subjective age refers to ratings of looks and feelings relative to those of age peers (i.e., whether the respondent looks or feels younger or older than a reference group of other people the respondent’s age). Findings by Montepare and Lachman (1989) showed the range for subjective age to be compressed compared with that for chronological age. Teenagers had a subjective age older than their years; middle-aged and older respondents had a subjective age younger than their chronological age. Sata, Shimonka, Nakazato, and Kawaai (1997) replicated these findings in Japan with over 1,800 respondents aged 8-92 years. Findings from the Canadian 1999 Manulife Financial survey also provide replication.

The research findings on attitudes toward the self include evidence for evaluations by older people based on both realistic and unrealistic considerations. Negative evaluations of personal status are realistic to the extent that they accord with the dominant values in western culture that devalue later life. In other words, the negative appraisals are consistent with the ageism entrenched within our culture. Positive
evaluations of subjective age are unrealistic because the mean subjective age within any cohort should mathematically correspond with chronological age. Consistent findings that older respondents rate themselves subjectively younger than they would rate their age peers suggest that seniors devalue the latter because of their age. Consequently, the findings on subjective age may reflect the respondents’ own ageist attitudes.

CHAPTER SUMMARY 6

The term used to describe stereotyped attitudes toward older people is ageism. Although some researchers argue that ageism is not a pervasive phenomenon, the evidence suggests otherwise. There is evidence for ageist attitudes in such diverse fields as literature and the arts, the sciences, health care, the legislature, and sexuality.

Key ideas to remember from this chapter include: 7

* The definition of an attitude is a tendency to evaluate an object with favour or disfavour. Attitudes differ from beliefs in that the latter lack an evaluative component.

* Measures used in gerontological research may include content on attitudes, beliefs, or both; they may assess cognitive, affective, and behavioural modes of responding. Although attitudes have implications for behaviour, attitudes are predictive of general trends in behaviour rather than of behaviour in any specific situation. Influences on attitudes include enduring dispositions as well as life experiences.
* Elder abuse and neglect refer to behaviour toward older people by those in positions of trust. Ageist attitudes may exacerbate the frequency of elder abuse and present barriers toward the reporting of abuse.

* Attitudes toward elder abuse show reasonable consistency throughout society, but differ somewhat among different professions and across minority groups. Compared with young people, the attitudes of older people toward elder abuse and neglect are less negative. This finding is consistent with other research on complexity-extremity showing attitudes lower in extremity when rating an ‘in group’ rather than an ‘out group’, with seniors belonging to the former and young people to the latter with respect to elder abuse. There is limited but positive evidence that community education can change attitudes toward elder abuse and neglect.

* The western world has a long history of ageist attitudes toward later life sexuality. Although satisfaction with their sexuality showed little change with age, satisfaction was lower in the absence of a partner.

*Charges of ageism against professionals involved with health care are legion. However, the satisfactions among patients in acute and continuing care settings are high. Ratings of health care within the public are mainly positive at any age.

*Attitudes toward the self have negative and positive trends. The trend is negative when evaluating the past with the present and future. The
trend is positive when respondents compare themselves to other people their age. Both trends may reflect cultural devaluation of the elderly as internalized by the respondents.
KEY TERMS

Abuse

Ageism

Attitude
  Definition
  Measurement
  Object

Belief

Health

Institutional residence

Life satisfaction
  Models

Pacification

Self

Sexuality
  Behaviour
  Cognition
Desire
Satisfaction
Subjective age
Violence

STUDY QUESTIONS

1. Define the term attitude. Discuss the nature of relationships between attitudes and behaviour.

2. Is ageism a pervasive problem in Canada?

3. Do older people have similar attitudes toward elder abuse as younger people? Critically evaluate the evidence.

4. Discuss the common belief that older people have little interest in sexuality.

5. Provide evidence on whether older people have negative attitudes toward their health and their lives?

6. Explain the relevance of ageism to attitudes toward the self.

SUGGESTED READINGS

Special Issue on Ageism (2005) *Journal of Social Issues, 61* (2)


BOX 6.1: EXAMPLES OF ATTITUDES ABOUT ROMANCE IN LATER LIFE
Majorie Charles remembers that woman from the St. John's telling five hundred seniors in Cornerbrook they were sexy. It was eighteen years ago now - at the yearly convention of the Newfoundland Pensioners and Senior Citizens Federation. "And the funny thing was - she was right on the money," Marjorie recollects. "Even though she was young, from the university, and probably hadn't ever set a foot inside a fish plant, which usually means she knew naught worth telling. But I was wrong about that, b'y, was I wrong! That woman knew people, really knew people. No matter the wrinkles on my face and fingers a bit knurled with arthritis, that woman saw the person inside was the same as when I was twenty."

Lee Stones has memories of that day, too. First terror then amazement, finally joy mixed with humility. Strong emotions often accompany attitude change. The Federation's President wanted her to talk on ‘Putting the Zing Back into Your Relationships’. He asked Lee to suggest ways to improve the romantic lives of older people. At first, Lee thought he was kidding. Did older people even have romantic lives? Sure, she sometimes saw some sweet old couple - probably married forever - holding hands in the park. But holding hands is far from passion, and isn’t passion the key to romance? Also, most of her grandmother's friends were widows. Surely, they weren’t lusting after romance, if only because of a shortage of men their age.

Just the thought of talking about romance to people like her grandmother gave Lee the shakes. The working families of her adolescent upbringing didn't talk much about sexuality. The edict was ‘Don't you fool around and you won't get pregnant!’ That was about all she remembered of her at-home sexual education. The idea of sex between her parents, even her grandparents (God forbid), was not only unspeakable but unthinkable. Such were the times a decade or more before the potency drug Viagra changed forever society’s attitudes toward later life sexuality.

But Mike Pickett, the Federation’s President, was insistent. A few months later, after much reading, thought, and discussion about the topic, Lee arrived at the convention floor. “That’s she, that’s the one.” Marjorie Charles remembers pointing Lee out to a friend. “I even went up to her and said, ‘We really, really, look forward to your talk,’ thinking only of smut. Wasn’t I the catty one?”

Soon Lee found herself on stage before the microphone, hundreds of eager old faces looking up at her excitedly. “I controlled my nerves but a price,” she recalls. “My heart thumped to the rhythm of a fast Newfoundland jig. I asked myself for the umpteenth time, ‘What madness made me agree to this?’ Will they think me presumptuous, even a hussy?” And so, with much misgiving, she gulped in air and began.

“What was memorable,” Marjorie recalls years later, “wasn’t so much her advice, but her assumption that we needed advice. She could have been talking to somebody of her own age. She didn’t treat us like people sexually dead - and I must admit, I acted dead in that way - but just in need of awakening. I did wake up right there and then, and so did many other people. We knew what we wanted, longed for even, widows like us. But we couldn’t talk of it. To speak about sex and we’d face the youngsters’ ridicule - even our children - ‘specially our children. When
she’d finished, we didn’t just clap. Oh no! We cheered, drummed the floor with our feet, on and on, must’ve been for a good three minutes. What a racket, b’ry! The reason was she saw us like we are and wasn’t afraid to say so.”

“I learned so much from those people,” Lee says now. “I told them what I knew, as though to friends. Of course I was unsure about whether I would shock them. But they shocked me. They shocked the sexual stereotyping right out of my head. I have no doubts now that people remain sexual to the end of their days. It was joyful to experience, but humbling because I’d been so wrong before. They changed my beliefs, my attitudes, and I think I changed theirs. What happened that day was that the formerly unthinkable (to me) or unspeakable (to them) became open to discussion.”

Lee Stones continued to give talks on later life sexuality to avid audiences across Canada. She coauthored two editions of book on the topic (Stones & Stones, 1997, 2004), and often acts as consultant for long-term care facilities to help staff, who are still reluctant to accommodate the sexual needs of residents. Two years after the Cornerbrook convention, Marjorie Charles had a romance with a tourist from Nova Scotia. They married, and settled near Halifax.
Figure 1.1 Driver and Passenger Injuries in Fatal Motor Crashes by Age

Based FARS (1999)
Figure 1.2: Percent of Generic and Institutional Abuse Items Rated ‘Severely Abusive’ by Community and Continuing Care Residents

% of Abuse Examples Rated as 'Severely abusive'

Based on Stones (2004)
Figure 1.3: Attitudes toward their Own Sexuality by Sex and Age

Based on ARRP (1999)
Table 1.4: Endorsement of Good Perceived Health, Worries about Health, and Depression on the Manulife Financial Survey

<table>
<thead>
<tr>
<th>Age group</th>
<th>% Endorsement</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 to 24 years</td>
<td>80.00</td>
</tr>
<tr>
<td>25 to 34 years</td>
<td>60.00</td>
</tr>
<tr>
<td>35 to 44 years</td>
<td>40.00</td>
</tr>
<tr>
<td>45 to 54 years</td>
<td>20.00</td>
</tr>
</tbody>
</table>

Based on Manulife Health Styles Survey (1999)