Check Your Ageism at the Door: Implicit Bias in the Care of Older Patients

Dorothy E. Stubbe, M.D.

> Ageism is prejudice against our own future selves.
>
> Ashton Applewhite (1)

Ageism is a social construct of old age that portrays aging and older people in a stereotypical, often negative, way (2). It is an alteration in feeling, belief, or behavior in response to an individual's or group's perceived chronological age. Like racism and sexism, ageism "others" older individuals in an undesirable or condescending manner. In their 2002 work, Levy and Banaji (3) proposed two primary characteristics of ageism: it can operate without conscious awareness and without intended malice, and all humans, to varying degrees, are implicated in the practice of implicit ageism.

Implicit biases are particularly insidious, in that they are acquired over time from subtle or not-so-subtle indications of how individuals of a certain class are treated (4). Ageism is somewhat unique in the evidence for widespread implicit stereotypes, including by those who are older and are the recipients of this prejudice. In addition, ageism is a prejudice against individuals whom all of us may expect to become (1, 3). Typical ageist stereotypes may include frailty, burdensomeness, senility, dependency, not contributing to society, and being an annoyance. Alternatively, there may be more paternalistic stereotypes that characterize older individuals as cute and childlike (1, 3). Physicians and mental health providers hold the same levels of implicit bias as other members of society (5–7). In fact, correlational evidence suggests that these biases are likely to influence diagnosis and treatment decisions and recommended level of care in some circumstances (5, 6, 8). For example, in mental health care, the implicit notion that older individuals may naturally be expected to be depressed because of their age may lead to low levels of care for depression and suicidality (9).

Patient-centered doctor-patient communication, in which the physician solicits the patient's perspective and enhances the patient's feelings of partnership and understanding, has been demonstrated to increase patient adherence to treatment, improve satisfaction with care, and to decrease patient distress (10, 11). However, older patients are often not provided this autonomy because of perceived or documented cognitive decline. Physicians may neglect to provide referrals or to spend increased time to ascertain the level of autonomy that is appropriate for the patient's level of disability, choosing to talk to the patient's children or caretakers rather than discuss options in a manner that the patient can assimilate.

Clinical Vignette

Ms. Betty Taylor took some time getting into the waiting room to meet with Dr. Jane Montgomery. The door was heavy, and Ms. Taylor struggled to keep it open while navigating through with the help of her cane. When she entered, she walked with slow resolve toward the receptionist and whispered her name. The receptionist smiled warmly and handed Ms. Taylor a clipboard with forms to collect demographic information and rating scales. "Can you please fill these out?" the receptionist asked gently. "There is also an electronic form on the tablet there. I can help you with it if you are comfortable with electronics."

Ms. Taylor scanned the room: There was one other patient. "No, this will be just fine, thank you," Ms. Taylor whispered uneasily, as she clasped the clipboard and sat on the far side of the room.

Dr. Montgomery scanned the waiting room to find Ms. Taylor, who was partially obscured by an office plant. Ms. Taylor was 78 years of age and had been referred to Dr. Montgomery by her primary care physician because of concerns about her sleep difficulties, poor appetite, and lack of energy. A medical work-up with ECG and lab work yielded normal findings. The primary care physician had known Ms. Taylor for many years, and he was concerned about depression and early dementia. She passed the basic mental status exam and memory testing. Except for degeneration of her hip cartilage, she was quite healthy for a woman of her age.

Dr. Montgomery silently held the door while Ms. Taylor crossed the room, steadying herself with her cane with each step. Sensing her discomfort with the encounter, Dr. Montgomery did not speak until the door had closed behind them. "It's good to meet you, Ms. Taylor," Dr. Montgomery began when Ms. Taylor was seated. "Dr. Johnson said that you haven't been yourself lately and asked if I could help."

"Please, call me Betty," Ms. Taylor insisted, appearing self-conscious. "With all due respect, doctor, I don't know why he referred me to a psychiatrist. Did he say he thinks I'm crazy? I'm just old. When people get old, they don't have energy. So, I'm old. I don't need a shrink to tell me that," she retorted.

Dr. Montgomery mused quietly, considering how to respond. She worked with many older patients, yet differentiating early dementia from depression was complex. Dr. Montgomery had taken a seminar several years ago to help her understand and more effectively treat her geriatric patients. She was aware of the implicit biases that most people harbor about older individuals, including doctors and those who are in the geriatric age group. She tried to recognize her own biases and those of her patients. Had Ms. Taylor succumbed to her own "ageist" biases and given up on enjoying life? Dr. Montgomery emitted an unintentional sigh.

"What do you enjoy doing, Ms. Taylor—excuse me, Betty?" Dr. Montgomery asked.

"What do you mean?" Ms. Taylor snapped.

"You know—for fun," Dr. Montgomery queried, ignoring the irritation in Ms. Taylor's voice.

"Fun? My husband died two years ago, and my kids want me to move to an assisted living home, and you ask me what I do for fun?" asked Ms. Taylor, with an exasperated sigh.

"Oh my—it has been a really difficult time for you!" Dr. Montgomery reflected.

"Yes, really hard," said Ms. Taylor. "And being old—you know, no one listens to what I want. My kids worry I will fall-… ." She was quiet for a moment and then looked up pensively at Dr. Montgomery. "Do you think I should just put myself in an old folks' home to die?"

Dr. Montgomery's eyes softened. "Getting older is tough in our society. You're worried that your family will forget about you."

"Yes," Ms. Taylor replied, her eyes welling. "But I don't want to be a burden. Maybe it's better to just go."

Dr. Montgomery pondered. "No wonder you aren't sleeping or eating well. Your stomach must be tied in knots with all of this going on. And with your husband gone, it must get lonely."

Ms. Taylor replied, "That's just what my kids say! They say to go to the old folks' home because there will be lots of people there just like me. Just like me? When they need help going to the bathroom and eating?"

Dr. Montgomery nodded empathically. "Here's my suggestion, Ms. Taylor. Let's meet again to sort out what you want and how to help you get joy back into your life. And then meet with your children to review options that you will feel okay about, and they won't worry constantly that you will fall."

Ms. Taylor contemplated this for several moments. Then she nodded. "Okay, we can try that. When shall I come back? Oh, and please call me Betty," Ms. Taylor said with a wink, as she exited the office.

Tips for Recognizing and Minimizing Implicit Bias Toward Geriatric Patients

Approximately 20% of persons above the age of 65 suffer from some form of mental illness (12). Many of these older adults prefer to consult a primary general practitioner and often do not seek out mental health clinicians. When referrals to mental health practitioners are made, older adults are less likely to follow through on these referrals (13). A proposed explanation for why aging individuals may avoid mental health care is that these patients may hold both ageist negative attitudes toward themselves as well as negative attitudes toward mental illness: "double stigmatization" (5). Patients who perceive themselves negatively because they are aging are at higher risk of anxiety and depression, yet these older individuals are also more likely to avoid the presumed secondary stigma associated with mental health care (5, 13).

For mental health professionals, ageist stereotypes may steer recommendations away from psychotherapy, with the notion that older individuals are resistant to change or do not want psychotherapy. The overuse of psychiatric medication in older adults is well documented, even though there are higher risks of adverse effects (14, 15).

In treating geriatric patients, it is important to pay attention to one's own implicit biases, those of colleagues, and those of one's patients and their families (16). With this insight, one may become more attuned to the details that facilitate older patients' comfort and optimize their autonomy. The following tips may help:

1. Ensure that the patient and caregiver (if there is one) feel welcome—the space should be easily accessible, with clear signage (if needed) and welcoming office staff who are attentive to privacy concerns.
2. Consider transference and countertransference issues related to ageism with each of your older patients.
3. Directly address age-related stigmas, including self-ageism and "self-double stigmatization" and misperceptions. Providing education about these common obstacles can increase older patients' attendance and engagement in treatment (15); for example, proactively raising frequently asked questions and concerns held by older patients, such as
   A. "Seeking mental health treatment means that I'm weak."
   B. "A younger clinician can't understand me."
   C. "I'm too old to change."
   D. "Treatment won't help bring my deceased spouse back."
4. Use methods to optimize the patient's autonomy, such as the following:
   A. Provide extra time for appointments, when possible, to allow time for questions and concerns and to review treatment options.
   B. Articulate the goal of ensuring that the patient participates optimally in his or her care decisions.

C. Request written permission to speak with family members and caregivers.
D. If a caregiver is present, speak directly to the patient and request permission to seek further information from the caregiver.
E. Consider utilizing a peer mentor support—an older patient who has benefited from treatment and can provide information and support.
F. Provide multimodal methods of communication—for example, discussions, written handouts, a recording of the conversation, informational videos, caregiver participation, and so forth to improve understanding. Review treatment options concretely.

5. Utilize a team approach, with close collaboration between health and mental health professionals, care coordinators, occupational therapists, physical therapists, and others, as appropriate.
6. Identify and optimize strengths, interests, assets, and resiliencies. Care coordinators may assist the patient in accessing activities and supports that they would enjoy. They may also assist with resources and support for the caregiver (if there is one).

AUTHOR AND ARTICLE INFORMATION

Child Study Center, Yale University School of Medicine, New Haven, Connecticut. Send correspondence to Dr. Stubbe (dorothy.stubbe@yale.edu).

Dr. Stubbe reports no financial relationships with commercial interests.

Focus 2021; 19:322–324; doi: 10.1176/appi.focus.20210010

REFERENCES

1. Applewhite A: This Chair Rocks: A Manifesto Against Ageism. New York, Celadon Books, 2016
2. Ayalon L, Tesch-Römer C (eds): Introduction to the section: ageism—concepts and origins; in Contemporary Perspectives on Ageism, Vol. 19. Cham, Switzerland, Springer, 2018
3. Levy BR, Banaji MR: Implicit ageism; in Ageism: Stereotyping and Prejudice Against Older Persons. Edited by Nelson TD. Cambridge, MA, MIT Press, 2002
4. Payne K, Niemi L, Doris JM: How to think about "implicit bias." Scientific American, March 27, 2018. https://www.scientificamerican.com/article/how-to-think-about-implicit-bias
5. Bodner E, Palgi Y, Wyman MF: Ageism in mental health assessment and treatment of older adults; in Contemporary Perspectives on Ageism. Vol. 19. Edited by Ayalon L, Tesch-Römer C. Cham, Switzerland, Springer, 2018
6. Robb C, Chen H, Haley WE: Ageism in mental health and health care: a critical review. J Clin Geropsychol 2002; 8:1–12
7. FitzGerald C, Hurst S: Implicit bias in healthcare professionals: a systematic review. BMC Med Ethics 2017; 18:19
8. Stone J, Moskowitz GB: Non-conscious bias in medical decision making: what can be done to reduce it? Med Educ 2011; 45: 768–776
9. Burroughs H, Lovell K, Morley M, et al: "Justifiable depression": how primary care professionals and patients view late-life depression? A qualitative study. Fam Pract 2006; 23:369–377
10. Beck RS, Daughtridge R, Sloane PD: Physician-patient communication in the primary care office: a systematic review. J Am Board Fam Pract 2002; 15:25–38
11. Stewart M, Meredith L, Brown JB, et al: The influence of older patient-physician communication on health and health-related outcomes. Clin Geriatr Med 2000; 16:25–36, vii–viii
12. Karel MJ, Gatz M, Smyer MA: Aging and mental health in the decade ahead: what psychologists need to know. Am Psychol 2012; 67:184–198
13. Kessler EM, Agines S, Bowen CE: Attitudes towards seeking mental health services among older adults: personal and contextual correlates. Aging Ment Health 2015; 19:182–191
14. Ruxton K, Woodman RJ, Mangoni AA: Drugs with anticholinergic effects and cognitive impairment, falls and all-cause mortality in older adults: a systematic review and meta-analysis. Br J Clin Pharmacol 2015; 80:209–220
15. Wyman MF, Gum A, Arean PA: Psychotherapy with older adults; in Principles and Practice of Geriatric Psychiatry. Edited by Agronin ME, Maletta GJ. Philadelphia, Lippincott Williams & Wilkins, 2011, pp 177–203
16. Burnes D, Sheppard C, Henderson CR Jr, et al: Interventions to reduce ageism against older adults: a systemic review and meta-analysis. Am J Public Health 2019; 109:e1–e9