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Chapter 8

Ageism in the Third Age



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8.1 Introduction

Older people are the largest group accessing and using care services within Europe (Eurostat 2015) and are often referred to as a “burden” (Beard and Bloom 2015). Improvements in public health, medical screening, timely treatments, and improved health and social care services in industrialized countries have all contributed to people living longer and healthier lives (Carr and Komp 2011). Average life expectancy is now estimated to be 78 years in developed countries and 68 years in less developed countries, with the gap continually narrowing every year. By 2045–2050, life expectancy is projected to reach 83 years in more developed countries and 75 years in less developed countries (Department of Economic and Social Affairs Population Division 2013).

Whilst a defining characteristic of the ageing process may involve increased vulnerability to a decline in health and wellbeing (Kirkwood 2014), novel approaches to wellbeing alongside complex biological, medical, psychosocial, political, and economic factors can influence both individual and group trajectories in later life. Ageing remains an extremely complex field in terms of understanding the relationships between these contributory factors and the transitions that connect them.

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Simultaneously, there has been a reorganization of health and social care services, caused in part by the universal adoption of economic rationalism, managerialism, and fiscal restraint (Hafford-Letchfield 2014). Not least, there has been a notable change in the retreat of government from its traditional role as a provider of institutional care, which has led to greater promotion of individualization while at the same time reducing eligibility for services (Scourfield 2010). These expectations and developments pose enormous challenges, tensions, and ambiguities for how the ageing trajectory and the multiple factors affecting it over the life course are understood.

The increasingly older population is accompanied by a new discourse about “active and successful ageing” (Foster and Walker 2014). However, the “good” and “successful” versus “bad” and “burdensome” dichotomy that is set up by this discourse may especially impact active older people who are averse to viewing their future older selves as a burden (Nelson 2005). Both “good” and “bad” ageing discourses differentiate between those who are “successfully” ageing and those people for whom successful ageing is not possible. This may contribute to tensions between third and fourth agers.

Discourses associated with ageing, and interactions between these two cohorts, may indeed contribute to intergenerational ageism. Although there are few empirical studies of these tensions, this chapter capitalizes on the timeliness of exploring such discourses by synthesizing some of the relevant literature and the possible themes to increase our understanding. We address previous classifications of ageing; demography; key concepts of the third and fourth ages; evidence of distancing between these two cohorts; and implications for health and wellbeing. We conclude with recommendations for further research.

8.2 Classifications of Ageing

Gerontology has always engaged with critical theory to question normative theories about ageing, wellbeing and the significance of deconstructing these theories to promote self-determination and human rights (Cocker and Hafford-Letchfield 2014). Age-related prejudice and discrimination is commonly seen as a social construction based on classification systems. Yet the classification of old age is ill defined. Morrow-Howell (2012, p. 379), writing her paper at the age of 60, asked, “Will we continue to use 60 or 65 years old to define the older population, even when the majority of people in that category will be there for 20 or 30 more years?”

To classify people from the age of 55 to over 100 as “old” implies that there have to be overwhelming commonalities in this period of life. Serra et al. (2011) believed that age classifications would serve to dispel the image of the “burdensome old” and suggested chronological age categories, such as octogenarians (80–89); nonagenarians (90–99); centenarians (100–104); semi-supercentenarians (105–109), and supercentenarians (110+). However, from the studies reviewed in this chapter, there are no references to sexagenarians (age 60–69) or septuagenarians (age 70–79), and there is

no apparent consistency in defining age groups. Using such categories would remove the words “young” and “old” from common parlance and would serve to describe cohorts over the life course. Further life-course categorizations would include denarian (age 10–19); vicenarian (20–29); tricenarian (30–39); quadragenarian (40–49); and quinquagenarian (50–59). These conventions, however, consider each category as homogeneous and based solely on chronology, and such theorizing denies the complex intersectionality of ageing and the importance of recognizing and responding to extremely divergent life experiences (Hafford-Letchfield 2013).

Older people’s experiences are not shaped by only one aspect of their identity, but by a combination of factors, such as gender, age, religion, disability, health, location, sexual identity, migration history, socioeconomic status, and ethnicity. Key processes that shape outcomes for older people may include the texture of day-to-day life, the decisions and assumptions that people make as individuals, and the interactions between people (Hafford-Letchfield 2013). One example is the impact of economic vulnerability on insecurity and sensitivity in the wellbeing of older individual households and communities (Victor 2013). External factors may also be mediated by internal factors such as an older person’s responsiveness and resilience to risks they face in later life. These critiques draw attention to the inadequate nature of normative life-course theories.

8.3 Perceptions of One’s Own Old Age

Heikkinen (2000) searched for a narrative of ageing in a study of Finns ($n = 20$) aged 80 in 1990, with a follow-up 5 years later ($n = 17$). The participants were all born in the same year and all lived in the same city in Finland. In her group, she found that experiences of ageing were expressed according to the positive and negative meanings that individuals attached to these experiences. In other words, she found that their experiences of ageing were heterogeneous, together with the social, physical, and cultural environments in which they occurred. At the baseline, her participants did not consider themselves to be old, as they were not experiencing problems with everyday life, thus placing her 80-year-old participants firmly in the third age. At follow-up, when they were 85 years old, most of her participants felt that they were now old, due to deterioration in health, loss of human relationships, and an increase in frailty and/or pain. The participants had to change the way they perceived themselves and the way they organized their days to match with their abilities.

Nicholson et al. (2012) interviewed 17 older people, aged 86–102 years and living at home, to gain an understanding of the experience of living and dying with frailty in old age. Their data analysis revealed three main themes: the dynamics of physical and psychosocial frailty, sustaining connections within the home, and connecting with death and dying. The first theme was concerned with increasing uncertainty and loss as a result of physical and psychosocial deterioration, which changed how the individual perceived themselves and how they were perceived by others. The second theme was concerned with the work and adaptations participants made

to compensate for increasing frailty in order to maintain satisfactory routines and sustain a feeling of being at home. The third theme focused on the participants' recognition that they were approaching the end of life, which the authors describe as "inhabiting the space between living and dying".

In exploring self-perceptions of ageing with those who had outlived the average age of their birth cohorts, both Nicholson et al. (2012) and Heikkinen (2000) highlighted resilience and capacity for change in contrast to traditional negative stereotyping. They showed the ability of much older people to change their perceptions of self and the rate at which they felt becoming old happened to them and the strategies they used to achieve this. According to Johnson and Barer (1997), older adults' re-conceptualization of their self-perception is thought to occur in the following four domains. In the first, one accepts the temporality of life and places oneself towards the end of it. In the second, the self-concept belies the reality of the situation; for example, although physically and/or mentally less competent than they used to be, they describe themselves as being in good health. In the third, they detached voluntarily from some aspects of the world surrounding them, such as unwanted roles and responsibilities. And the fourth involved living in the present—a "one day at a time" approach.

Comparing oneself to others is a widely reported positive strategy in developing or refining self-perception in old age: positive comparisons such as "I am much fitter than others are" or "I can still get around without a wheelchair, unlike my friend" are used to construct a more positive identity (Johnson and Barer 1997). However, these positive messages can also be said to emphasize loss of function: "I can *still* get around without a wheelchair" or "I can get around without a wheelchair ... but only around the house". Another strategy that is commonly used is to separate the mind from the body: for example, "It's just my knees that are old; my mind is still sharp".

The most common strategy in older age is to maintain a sense of control over both health and lifestyle, perhaps because ageing is a process over which people feel they have no control (Johnson and Barer 1997). Betts Adams et al. (2010) explored changes in activity and interest in the third and fourth ages (in their study this referred to ages 64–79 and 80+, respectively). They referred to the concept of selectivity introduced by Baltes and Baltes (1993), in which older people decided themselves where to focus their energies to best advantage. They found that both the younger cohort ($n = 50$) and older cohort ($n = 128$) demonstrated a pattern of disengagement from active pursuits in favour of more passive social and spiritual pursuits in the fourth age. Heikkinen (2000) suggested that individuals organize their daily life in a way that is consistent with their abilities. The participants in her study who described themselves as feeling old reported that they structured their days around their physical needs and had replaced earlier activities with more simple tasks. Nicholson et al. (2012) suggested that these daily routines not only provide a sense of control, or pass the time, but that they also serve to connect individuals to the past as well as the present through the provision of a pattern of work and rest. Routine, they suggest, can also be helpful in distracting the mind from unwanted thoughts of dependency or decline.

How older people view themselves and their peers has an impact on how they make choices and whether or how they engage with services. Sarkisian et al. (2002) found that having low expectations of ageing not only had a negative impact on preventative health behaviours, but also indicated a low engagement with healthcare services for conditions such as depression and urinary incontinence. Half of the participants in their study expected ageing to lead to depression, dependency, decreased ability to have sex, more aches and pains, trouble sleeping, less energy, and becoming less attractive. Those with low expectations were less likely to seek healthcare for age-associated conditions. Levy and Myers (2004) measured the attitudes of older people aged 50–80 years ($n = 241$) towards their own ageing to explore how age beliefs predicted a variety of preventative health behaviours and the impact of these over a 20-year period. Older people with a positive self-perception of ageing reported engagement in more preventative health behaviours over the course of the study, with significantly higher self-rated health than those with a negative self-perception of ageing. This predictive value of ageing self-perceptions may therefore be valuable to those researching or practising preventative health behaviours. In contrast, Jopp et al. (2008) found that both young-old and old-old people showed high levels of valuation of life (VOL), which reduced from the third to the fourth age. Nonetheless, this study supported earlier work in demonstrating that, despite high levels of health impairment, the oldest-old can still hold high levels of VOL through a complex process of balancing the positive and negative aspects of life. The young-old group in this study placed a higher value on health factors, while the old-old placed more value on social factors.

Litwin and Stoeckel (2013) examined the associations between social networks, life satisfaction and feelings of wellbeing in a young-old cohort (60–79 years) and an old-old cohort (80 years and over) from the second wave of the Survey of Health, Ageing and Retirement in Europe study ($n = 14,728$). They found that social networks were greatly valued in very old age, but not in the same way as in younger-old adults: for example the older cohort living with one or more adult children reported this as having a positive impact on wellbeing, while the younger cohort demonstrated a negative association between living with adult children and quality of life. Other opposite findings between the cohorts studied by Litwin and Stoeckel (2013) included living with a spouse; this related to better quality of life in the younger group, and was negatively associated with quality of life by the older participants. Similarly, being in receipt of personal or practical assistance from someone outside the household had a negative impact on wellbeing for the younger cohort, but a positive impact on wellbeing for the older cohort. Associations between social networks and life satisfaction were also found to be opposing between the two cohorts; for example, having a greater number of grandchildren was associated positively by the younger cohort and negatively by the older cohort.

Exploring the potential for isolation and loneliness in old-old age was a key part of a study by Fischer et al. (2008). In interviews with people aged 85 years ($n = 15$),

they encouraged participants to reflect on their various perspectives on life. These included important life events, the experience of growing old, experiences of loneliness, difficult life events, positive life events, and experiences of comfort and consolation. Four themes emerged: embracing weakness and strength; embracing slowness and swiftness of time; embracing reconciliation and regret; and embracing connectedness and loneliness (Fischer et al. 2008). Their findings suggest the importance of embracing the contradictions and challenges that come with longevity, and echo Erikson's stages of psychosocial development. This comprehensive psychoanalytic theory identifies eight stages of life, which occur in healthy developing individuals from infancy through to late adulthood. The stages unfold as an individual advances through the life course and each stage is characterized by a psychosocial crisis of two conflicting forces, those in later adulthood being integrity versus despair (Erikson 1968). The theory was updated in the late nineties to include a ninth stage, allowing for the increased ageing of the population (those over 80); the conflicting forces being dystonic versus syntonic, illustrating a negative or positive approach to facing the challenges of ageing (Erikson 1997).

8.4 The Creation of the Third and Fourth Age

Distinctions between the third and the fourth age have generally been determined by the average life expectancy in a population/demography-based or a person-based equation (Baltes and Smith 2003). In developed countries, a population-based equation would put the transition from third to fourth age at 80–85, whereas a person-based equation depends on the estimated maximum lifespan of the individual. The transition from third to fourth age could be at 60 years for some and at 90 years for others.

The original concept of the third age is associated with Neugarten (1968) and the fourth age with Laslett (1994), who both sought to dispel the marginalization of the old. Neugarten (1968) stated that in social organizations, the relations between individuals and between groups are organized by age differences, but little attention had been placed on age grading to show relationships between generations. Similarly, with reference to age grading, Laslett (1994) argued that after retirement the "old" were a consumer group of growing importance, with the potential for achieving personal fulfilment and active participation in the economy, politics, and policy making, making the newly retired a different group of older people from the oldest old. This development in ideas about later life served to emphasize autonomy, agency and self-actualization. It also served to distinguish the concept of the fourth age, with dependency as a key marker in the transition.

Narratives that describe the third age as an opportunity and the fourth age as a threat point to a discursive "othering" wherein the fourth age functions as social imagery of a fear of incapacity, poverty, and decrepitude, rather than age per se (Higgs and Gilleard 2014). "Within this social imagery, old age is represented less

as a status and more as a state of being, one that is typically envisioned through discourses about the costliness, the frailties and the indignities of old age” (Higgs and Gilleard 2014, p. 10).

George (2011) suggested that creating distinctions between a third and fourth age only serves to postpone the onset of what seems to be old age and creates a more severe form of ageism for those in the fourth age. She wrote, “Just as the image of the third age is socially desirable because it is not old age, the image of a fourth age is socially undesirable because it reinforces negative stereotypes of later life. Fourth agers will be viewed as frail, dependent, lonely, sick and as coping with impending death” (George 2011, p. 253).

So how does this creation of a distinction between the active and the dependent old impact those making the transition from the third to the fourth age?

8.5 The Third Age Distancing Itself from the Fourth Age

Leaving paid employment to pursue hobbies and engage in activities that the time constraints of work would normally not allow makes retirement, once seen as the end of one’s life, now attractive (Kuh 2007). Retired active people can partake of successful active ageing strategies which generally exclude the old-old, the frail old, and the disabled, who are less likely to be able to pursue these activities (Betts Adams et al. 2010). Gilleard and Higgs (2011a) suggested that members of the third age can reject old age as a collective voice through lifestyle choices, but this can only come with economic stability and health. Where people in the third age are not conceptualized as being really old, it is argued that this group wish to distance themselves from the ageist stereotypes seemingly afforded to those in the fourth age. This is demonstrated by George (2011, p. 253) who wrote, “The eagerness of many to proclaim the third age strikes me first and foremost as a desire to avoid or postpone being labelled as old and suffering the negative social stereotypes that accompany that label. The image of the third age appears to reflect the same desire to view oneself and have others view one as not being old.” However, Higgs and Gilleard (2014) suggested that such distancing, in order to avoid being classed as one of the oldest old, is potentially damaging to individuals in both age groups.

8.6 Evidence of Distancing

There is very little robust evidence to help understand the concept of distancing between the third age and the fourth age, especially due to methodological inconsistencies in determining what is meant by “old” and “oldest old”. Characteristics, personal appearance, identifying traits, and practices that might link a person to the

fourth age are actively forestalled by some. This might be related to how people seek to maintain their appearance through cosmetic means in the quest to avoid being seen as one of the “real” old. As Hazan (2009, p. 98) put it, “The liminal geography of the third age stretches between the face-lifted edges of a dream of middle age and the murky terrains of lived in and feared old age.”

Avoiding the use of aids and equipment or living in environments that might put them (in their own and other people’s eyes) in the oldest old category is another way some older people distance themselves from the fourth age. Distancing is not purely physical, but can also be demonstrated in attitudes and behaviours. An Israeli study (n = 955) by Bodner et al. (2012), using the Fraboni Scale of Ageism (Fraboni et al. 1990), found that in cohorts of young (18–39), middle-aged (40–67), and old (68–98) participants, middle-aged participants were significantly more ageist than younger and older participants. In all age groups, men showed more avoidance and stereotypical attitudes toward older adults than women. The authors then subdivided the old age group and found participants aged 81–98 held more ageist attitudes than those aged 68–73. The authors concluded that ageism changes across the lifespan and it is necessary to explore the reasons why ageist attitudes change in different stages of life. One reason has been suggested by Iecovich and Lev-Ran (2006) in their examination of the attitudes held by well older people towards disabled older people living in the same facility (n = 140: age >64). Well older people tended to hold more negative attitudes towards frail older people when they lived in an integrated facility, with the more able voicing a preference for segregated facilities. Iecovich and Lev-Ran suggested that holding these negative attitudes may ameliorate the frightening thoughts of one’s own mortality, and recommended that further gerontological studies examine intergenerational prejudices.

Similarly, Gilleard and Higgs (2011a) reported that some older people avoid exposure to forms of assessment that may put them in a category for health and social care services, thereby avoiding “objectification” as a “needy” older person. Such assessments may result in recommending aids or equipment to the individual because of physical problems. This may not be acceptable to some who feel this would then make them look old. However, the consequences of refusing aids and adaptations can be damaging to the individual, their families, and other people they are close to. For example, if individuals seek to compensate for and actively hide disabilities, such as memory loss or hearing loss, they may isolate themselves for fear of being “found out”. Such avoidance of help was found by Costley (2008) to be the result of an effort by the old (defined by Costley as ages 69–91) to resist the social stigma of old age. However, an earlier US study by Hackstaff et al. (2004) found that some older people refused services for a myriad of personal reasons, including cost or fear of new people.

Despite the dearth of evidence, there is a clear message that some older people do not want to be seen as the “burdensome” oldest-old, and that this ageist distancing of the third age from the fourth age can be detrimental to an individual’s health and wellbeing.

8.7 The Fourth Age

The lifespan is finite and with added years come the losses and illnesses of old age (Cohen-Mansfield et al. 2013). Whilst these may come at earlier or later stages in one's older years, if people live long enough they will experience them, and they will have to adapt to the changes forced upon them. Lloyd et al. (2014, p. 2) wrote of the "event horizon" that puts one into the fourth age, which is seen as a point of no return: "It is within the power of others—professionals and carers—to determine when an individual has lost the capacity for self-care and management of everyday life and thus makes the transition over the event horizon into the fourth age." In making such a transition, Holstein (2011) suggests that individuals have to reinterpret their lives, as some identities they have will disappear and new identities will appear. However, Chang et al. (2013), in agreeing that frailty, comorbidity, and disability are common major health problems affecting the oldest old, suggested that health promotion strategies, careful management of comorbidities, and targeted strategies to prevent further disability can and should be provided by integrated knowledgeable teams.

In his seminal text, *Why Survive?*, Butler (1975) saw the potential in people considered the oldest old (Achenbaum 2013): "We must ask ourselves if we are willing to settle for mere survival when so much more is possible" (Butler 1975, p. xiii). Butler advocated for interdisciplinary care together with enhancement of older people's resources and resilience whilst attending to the health issues that frequently come with advancing years. He stated that the gains of ageing need to be celebrated because old people are survivors.

Coleman and O'Hanlon (2004) called for more positive meanings to be associated with later life, particularly to overcome cultural failures in supporting people's end of life needs. Jopp et al. (2008) concurred with Butler (1975) in the findings from their study of valuation of life in very old age. The participants in this study were 65–94 years of age ($n = 356$) and this sample was stratified by gender and age (5-year age groups). They found that despite increasingly negative conditions such as physical and social loss, community dwelling older adults maintain a high attachment to, and value of, life. Jopp et al. (2008) suggested the need for professionals to develop interventions that enhance the positive features of old age and temper the negative, in order that older people may live a satisfying and valuable life, even if not always a healthy one.

Developing the work of Butler (1975), Jopp et al. (2008) and Nicholson et al. (2012) sought to capture the dimensions of social, psychological, and physical frailty among people aged 86–102 ($n = 17$), but found that participants did not describe themselves as frail and gave examples of resilience and capacity in the face of old declining or failing health status. Nicholson et al. (2012) conceptualized the social identities of the third and fourth age as liminal—passing from one culturally

defined state or status to another. They considered the transition between ages to involve three distinct stages: the preliminal, liminal, and postliminal. Liminality is described as a threshold space, a space between social structures that is fluid and allows for the potential redefinition of self-identity. Nicholson et al. (2012) suggested that as their participants simultaneously seemed to be living across the third and fourth ages, then the attributes of people in this space are necessarily ambiguous both in terms of their inner conflicts and also in relation to the provision of services by the welfare state. They concluded that frailty is a persistent liminal state, as there is no movement from one stage to another. Therefore frail older people are continually modifying their identities through the construction of personal habits, routines and stories. In order to allow these individuals to lead long and valuable lives, Nicholson et al. (2012) identified a need for older people and health and social care professionals to find shared meanings and understandings of the continual and shifting state of frailty.

A study by Koch et al. (2007) found that ageism was rife in acute hospital settings and that people in the fourth age were most at risk of losing their dignity, identity, and independence when in contact with health and welfare services. Lloyd et al. (2014) explored the perseverance, adaptation, and maintenance of dignity and identity more generally in the fourth age. They found that the way people dealt with ageing and changed health status was dependent upon their views of themselves, how they could or should present themselves in public places, how others behaved towards them, and how accessible the built environment was. The majority of participants ($n = 34$) felt negative about ageing, that it was something that happened to them and for which they could not prepare. In contrast to these participants, other studies (Kornadt and Rothermund 2014; Koss and Ekerdt 2016) found that planning and preparatory activities for age-related changes helped and were organized by life domains. These domains differed between preparing for the third age (activities peaking around age 65, focusing on leisure, work, and fitness activities, and appearance) and in preparing for the fourth age (activities continued linearly up to age 80, focusing on independence, housing, and financial issues). These preparatory activities also involved accepting, rather than preventing age-related changes. Koss and Ekerdt (2016) focused specifically on how anticipation of the fourth age influences third age decisions about housing in later life. These authors suggest that given the strong association between the fourth age and residential or nursing home care, that where one lives becomes not only a question of accommodation but also a visible marker of one's location in relation to the third and fourth ages. A study by Ayalon (2014) examining older people's attitudes on admission to living in Community Care Retirement Communities (CCRC) in Israel revealed that these communities were viewed either positively as luxurious hotels, or negatively as the "last stop".

8.8 Age and Disability

The stress of coping with disability can have a detrimental effect on physiological wellbeing and quality of life, such as increased falls and their association with increased morbidities. In relation to the arbitrary differentiation between the third and fourth age, promoting health becomes even more important when chronic conditions begin to appear and interventions need to be in place to prevent further loss of function (Levy and Myers 2004; Wells 1992). Yet age does not mean disability. In an analysis of the health of centenarians, Hitt et al. (1999) observed that health span equals lifespan. In a later study of American centenarians, Rau and Vaupel (2014) noted a marked delay in disability towards the end of the centenarians' long lives and identified centenarians as models of ageing well. The study concluded that as one approaches the limits of lifespan; diseases (morbidity) must have been delayed (or escaped) towards the end of these longest lived lives. This study illustrated that instead of the aging myth that “the older you get, the sicker you get”, it is much more the case that “the older you get, the healthier you've been”. These concepts are important when examining ageing discourses and research findings for third and fourth age interventions, and how transition points throughout the life course might be recognized as appropriate mediators in promoting positivity and wellbeing.

8.9 Discussion

But what does the evidence reveal? A census of the characteristics of fourth agers in England and Wales in 2011 (Office for National Statistics 2013) showed an increase of almost 25% in people aged 85 or over since 2001. The number of centenarians living in the UK has risen by 65% over the last decade, to 14,570 in 2015. In this group, 850 people were 105 years old or older—double that of 2005 (Office for National Statistics 2013). Given that frailty is a defining attribute of the fourth age (Gilleard and Higgs 2011b), it is important to note that in 2010, only 25% of the 85–89 year olds in the UK are classed as frail (Clegg and Young 2011). Later statistics show that in England, for example, 37% of people over 80 are providing 20 h or more of care a week, while 34% per cent are providing 35 h or more (Age UK 2017). This overlap of third and fourth age characteristics blurs traditionally prescribed transitional boundaries. Kydd and Fleming (2015) suggested that it is an individual's periodic vulnerability at any given time that needs to be managed rather than their age. The fourth age can be seen as a celebration. For example, Tornstam (2005, 1989) introduced the concept of “gerotranscendence”, which sees ageing as part of a person's life-long development and recognizes how individuals embrace the age they are in at whatever age they are. Koch et al. (2007), recording centenarians' stories, found an alternative to negative stereotyping in these people's strong and resilient sense of self, a finding outlined in earlier work by Kaufman (1986).

The respondents were matter of fact about their difficulties and losses, which they considered to be a part of life. The overarching finding was that these centenarians had a sense of self that was strong and resilient (Koch et al. 2007). Similarly, Jopp et al. (2008) highlighted the resilience of the oldest old, and the gratitude and celebration of having lived a long life. Experience of losses and deficits were not a focus for these survivors, but were events in their long lives and in no way extraordinary. This reinforces work by Serra et al. (2011), who referred to this group as the most celebrated and least understood cohort.

An additional consideration of age and disability is the ageing of the younger generation. After the 2008 recession, retirement ages have become more flexible, final salary payments have become rare, and a long paid retirement is not guaranteed. The western world is experiencing changes due to digital technology, reduced unskilled labour, greater consumption of high-calorie, low-nutrient fast foods, higher unemployment, and sedentary lifestyles. Many of these factors have been shown to be contributing to a global rise in obesity and accompanying long-term conditions such as type 2 diabetes, coronary heart disease, and cancer (OECD 2017). As a result, the ageing of this generation is not predicted to be as healthy, long, and well-funded as the ageing of the “baby boomers” (Age UK 2017).

8.10 Conclusions

Since its definition in the 1960s, ageism has been seen as an uncontested phenomenon. It is both universal and individual, and deleterious, but it is also unpredictable and unique. Age-related changes may be inevitable, but they depend on a range of physical, social, economic, political, and global factors. At any stage in life, health promotion and illness prevention strategies will serve to ameliorate certain conditions, and self-care at any age is necessary for physical, psychological, and spiritual wellbeing.

Although ageing is a natural process, how societies view their older citizens and how old age is viewed by individuals will colour both the way older people are treated and the way they view themselves. Chronological ageing is no longer viewed as an illness, with many older people living well into their fourth age and beyond. However, the ageing trajectory is unpredictable and the insecurities that come from not knowing how one will age can manifest itself in a form of ageism—that of not wanting to belong, or to be seen to belong—to the fourth age. This chapter has explored the concept of old age and discussed the age stratifications of those classed as old. The positive aspects of ageing have been seen in the third agers, who are active, engaged, and pursuing their own interests. This in turn has created the fourth agers—those (erroneously) classed as the dependent old. At some point in a third ager’s life, they will reach a point where they need help with their everyday living. This point may be associated with increased loss of physical function, and may be labelled as the point, or the event horizon, at which they enter the fourth age. For this reason, some third agers may strive to avoid entering into this fourth age. For

many this is seen as the point of “no return” and signals the end of life. However, when reviewing the literature on centenarians, it would appear that this much feared transition to the fourth age can become a celebration as individuals reach their 100th year. In fact in many societies, the 100th year is seen as a triumph, as it celebrates survival and resilience.

At the heart of this discourse is the fear of the unknown. Many people fear dependency, loss of agency, loss of dignity and death. The experience of very old age is unpredictable and many services are not geared to the needs of the frail old. Perhaps if people felt more supported within their societies, with health and social care services geared to the oldest old, then the fourth age would not be so feared. This is clearly an area for future research.

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