Exploring Gaps in Understanding and Responding to Ageism: A Conceptual Model, Psychosocial Health, and Racialized Ageism

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Abstract
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The first manuscript draws from stereotype embodiment theory and theories of successful and productive aging to detail a conceptual model of interventions which may reduce internalized ageism and enhance psychosocial health for older adults. Possible micro-level interventions include physical activity, volunteering, technology use, and stress management. Meso-level interventions may include education, intergenerational contact, and narrative reframing. At the macro-level, anti-ageism policies may serve as upstream, preventive factors to combat internalized ageism and promote enhanced psychosocial well-being for aging adults.

The second manuscript arose from a three-year, community-engaged research partnership with a local non-profit. This is a cross-sectional, quantitative study which tests whether internalized age stereotypes mediate the relationship between volunteering and social connectedness for adults 50+. Results (n = 165) demonstrate that increased internalized positive, not negative, age stereotypes partially mediate the relationship between volunteering and increased social connectedness. This study suggests that internalized positive age stereotypes may function as a form of esteem to enhance psychosocial health as people age.

The third, qualitative manuscript explores the lived experience of the intersectionality of ageism with racism from a phenomenological perspective through in-depth interviews with twenty racially diverse older adults in the U.S. Mountain West. Five coders applied constants comparison methods through a three-cycle coding process. Six umbrella themes and 17 sub-themes were identified. The findings indicate how ageism may be racialized through stereotypes such as mental incapability. Practitioners can apply the findings to enhance support for older adults experiencing both ageism and racism and increase collaboration across anti-ageism and anti-racism initiatives. Future research should focus on racialized ageist microaggressions and the impact of intersectional experiences of ageism and racism on specific health outcomes.

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Andrew T. Steward

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Abstract

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The first manuscript draws from stereotype embodiment theory and theories of successful and productive aging to detail a conceptual model of interventions which may reduce internalized ageism and enhance psychosocial health for older adults. Possible micro-level interventions include physical activity, volunteering, technology use, and stress management. Meso-level interventions may include education, intergenerational contact, and narrative reframing. At the macro-level, anti-ageism policies may serve as upstream, preventive factors to combat internalized ageism and promote enhanced psychosocial well-being for aging adults.

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Introduction

Ageism is a prevalent and insidious social justice issue (Nelson, 2002; Palmore, 1999). Robert Butler first introduced and compared ageism to other forms of discrimination such as racism and sexism (1969). The term signifies any bias, stereotype, prejudice, or discrimination toward an individual solely based on that person’s age (Nelson, 2002). The World Health Organization (2021) recently launched a global campaign against ageism, calling it an “insidious scourge on society,” with harmful effects on the health of older adults. A recent systematic review about the impacts of ageism on health reviewed 638 articles covering seven million participants from 45 countries over 25 years. Effects of ageism on health were found in all 45 countries, with the prevalence of significant health impacts increasing over time (Chang et al., 2020). Health impacts were found at both the structural and individual levels of ageism across 11 health domains:

- exclusion from health research, devalued lives of older persons, lack-of-work-opportunities, denied access to healthcare and treatments, reduced longevity, poor quality-of-life and well-being, risky health behaviors, poor social relationships, physical illness, mental illness, and cognitive impairment (Chang et al., 2020, p. 7).
At the individual level of health, ageism was shown to be associated with seven of these domains: longevity, poor quality of life, poor social relationships, risky health behavior, mental illness, cognitive impairment, and physical illness (Chang et al., 2020, p. 8-9). In four of the domains (longevity, poor quality of life, poor social relationships, and risky health behavior), 100% of studies found that ageism was associated with these outcomes. These impacts were documented across countries including China, Australia, Turkey, the United States, and Germany. Another study reported that ageism is associated with over 17 million cases of the eight most expensive health conditions in the United States, in addition to a 1-year economic cost of $63 billion (Levy et al., 2020).

Our rapidly aging society reinforces the demand to better understand the nature and health impacts of ageism for older adults. A recent report funded by the National Institute of Aging (NIA) found that 8.5% of people across the world (617 million) were 65 or older, while the percentage was estimated to rise to almost 17% of the world population (1.6 billion) by 2050 (He et al., 2016).

Ageism may intersect with ableism (Gibbons, 2016), may be implicit (Levy & Banaji, 2002), and may be considered either positive or negative. Negative ageism denigrates aging as less valuable than youth or presumes an association between aging and disease, decline, or disability. Positive ageism, however, occurs when individuals assign qualities of wisdom and respect toward all older adults unrelated to context, which in turn may cause older people to feel pressure to live up to such expectations (Palmore, 1999). Positive ageism may come across to older people as paternalistic or even infantilizing rather than empathic in its message (Chonody, 2016).
Ageism has been described as a “prejudice against our feared future self” (Nelson, 2005, p. 207). Therefore, it is critical to understand how ageism is internalized and affects health across the lifespan. While research on internalized ageism has been limited until recently, existing literature identifies a significant association between internalized ageism and numerous public health outcomes. These outcomes include physical functioning (Levy et al., 2014a), mental health conditions (Levy et al., 2014b), cognitive decline (Levy et al., 2018), cardiovascular stress (Levy et al., 2000), likelihood of recovery from disability (Levy et al., 2012), and longevity (Levy et al., 2002). Yet, very limited research has addressed which interventions may be effective in reducing internalized ageism for older adults. Drawing from and building upon existing theories and research evidence is an important path forward to developing testable interventions.

Therefore, the first manuscript in this dissertation presents a conceptual model which aims to clarify potential pathways toward decreased internalized ageism and enhanced well-being for aging adults. Drawing from theories of productive and successful aging as well as recent literature, this conceptual model details activities or interventions at micro, meso, and macro levels which incorporate downstream, midstream, and upstream factors to reduce internalized ageism.

The second manuscript arose from a community-engaged partnership with a non-profit community partner which provides volunteer opportunities for adults 50+. Volunteering is tested as one activity at a micro/meso level which may be associated with both reduce internalized ageism and enhanced social connectedness for adults 50+. The manuscript draws from a convenience sample of volunteers 50+ years of age in the U.S.
Mountain West. Quantitative methods were applied; specifically, internalized positive and negative age stereotypes were tested as mediators in the relationship between volunteer hours and social connectedness.

The third manuscript addresses a separate gap in the existing knowledge base: the intersectionality of ageism with other social justice issues; specifically, racism. In terms of cultural and demographic influences, existing literature demonstrates negative attitudes toward aging to be universal rather than specific to particular cultures or regions (Officer et al., 2020). Ageism has been shown to be present across the demographics of age, sex, and race/ethnicity of both perpetrators and targets of ageism (Chang et al., 2020). Yet, there is a growing call to understand ageism through an intersectional lens (Gonzales et al., 2021), which acknowledges the impacts of power and oppression in addition to the multiple intersecting identities that make up one’s lived experience (Crenshaw, 1991). While preliminary research exists on the intersectionality of ageism with sexism (Krekula et al., 2018), ableism (Jönson & Taghizadeh Larsson, 2019), and ageism experienced among the LGBTQ community (Gewirtz-Meydan et al. 2018), a significant gap exists in literature on the intersectionality of ageism with racism (Torres, 2020). Therefore, the third, qualitative manuscript highlights a phenomenological study to explore the lived experience of the intersectionality of ageism and racism among Black, Latinx, Asian-American/Pacific Islander, Indigenous, and White older adults.

The following three manuscripts aim to enhance our understanding of and response to ageism by 1) conceptualizing and testing activities or interventions which may reduce internalized ageism and enhance psychosocial health for older adults, and
2) exploring the intersectionality of ageism with racism based on the perspective and lived experience of diverse older adults.
Manuscript One: Toward Interventions to Reduce Internalized Ageism

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Abstract

Ageism is an insidious form of injustice that is internalized from an early age with accumulating negative health impacts across the lifespan. Internalized ageism has been associated with numerous public health outcomes, including physical and mental health, functional impairment, cognition, cardiovascular stress, hospitalizations, and longevity. Research has begun to document how ageism negatively impacts health through psychological, behavioral, and physiological pathways. Yet, limited research has addressed interventions to reduce internalized ageism. This article draws from stereotype embodiment theory and successful aging, presenting a conceptual model which incorporates potential downstream, midstream, and upstream interventions at micro, meso, and macro levels. The need to examine how policy influences health through the three pathways involved in stereotype embodiment theory is discussed. This study provides a working model for scholars and practitioners to use when considering paths toward reducing internalized ageism and optimizing well-being for aging adults.

Keywords: Ageism, Internalized, Conceptual, Theory, Intervention
Ageism is a pervasive, largely unchallenged form of discrimination in Western society (Nelson, 2002; Palmore, 1999). The World Health Organization (2020) recently launched a global campaign against ageism, calling it “widespread and an insidious practice which has harmful effects on the health of older adults.” Ageism has been described as a “prejudice against our feared future self” (Nelson, 2005, p. 207). Therefore, ageism is a significantly internalized experience. While research on internalized ageism has been limited until recently, existing literature identifies a significant association between internalized ageism and numerous public health outcomes. These outcomes include physical functioning (Levy et al., 2014a), mental health conditions (Levy et al., 2014b), cognitive decline (Levy et al., 2018), cardiovascular stress (Levy et al., 2000b), likelihood of recovery from disability (Levy et al., 2012), and longevity (Levy et al., 2002b).

Yet, very limited research has addressed which interventions may be effective in reducing internalized ageism for older adults. Drawing from and building upon existing theories and research evidence is an important path forward to developing testable interventions. Therefore, this paper presents a conceptual model which aims to clarify potential pathways toward decreased internalized ageism and enhanced well-being for aging adults.

**Ageism**

Ageism signifies any bias, stereotype, prejudice, or discrimination toward an individual based solely on that person’s age (Nelson, 2002). Robert Butler first
introduced and compared ageism to other forms of discrimination such as racism and sexism (Butler, 1969). Ageism may intersect with ableism (Gibbons, 2016), may be implicit (Levy & Banaji, 2002), and may be considered either positive or negative. Negative ageism denigrates aging as less valuable than youth or presumes an association between aging and disease, decline, or disability. Positive ageism, however, occurs when individuals assign qualities of wisdom and respect toward all older adults unrelated to context, which in turn may cause older people to feel pressure to live up to such expectations (Palmore, 1999). Positive ageism may come across to older people as paternalistic or even infantilizing rather than empathic in its message (Chonody, 2016).

**Internalized and Implicit Ageism**

Internalized ageism has been defined as “a form of ingroup discrimination in which older adults marginalize and discriminate against other older people…including denying commonality with others within your own group” (Gendron et al., 2016, p. 998). Perhaps the foremost scholar on internalized ageism is Becca Levy of Yale University. Levy’s work details how some of the unique aspects of ageism relate to the way in-group and out-group preferences arise across the lifespan. The fact that old age seems so distant from childhood may contribute to the development of age stereotypes since aging may not seem relevant to the in-group of young people (Langer, 1989, Levy & Banaji, 2002). In most areas of scholarship on stereotyping based on social groups, a clear preference has been found for in-group over out-group identification (Levy & Banaji, 2002; Tajfel, 1981). However, ageism does not seem to function in the same way because older adults often demonstrate negative attitudes and beliefs toward other older people (Levy &
Levy and Banaji (2002) describe how this may be due to the phenomenon of internalized ageism across the lifespan, since by the time individuals reach later life, they have spent decades internalizing negative age stereotypes. Individuals are then confronted with the fact that they are at an age that corresponds with the negative age stereotypes that have already been so repetitively and unconsciously internalized. Therefore, older people may be especially vulnerable to ageism in later life because they may not have developed strategies to cope with or combat the impacts of ageism within their own age group. Levy and Banaji (2002) then describe how a common coping mechanism for older adults may be to simply not identify with their age group and instead continue to identify with the societally-approved preference for younger generations. In contrast to research about in-group identification based on gender or race, similar research based on age shows that older adults overall identify with younger generations to an equal measure as young people themselves (Greenwald et al., 2002; Levy & Banaji, 2002).

Levy and colleague Mahzarin Banaji have also described how “one of the most insidious aspects of ageism is that it can operate without conscious awareness, control, or intention to harm” (Levy & Banaji, 2002, p. 50). Prejudice toward individuals based on age has been described as different from prejudice based on race or gender because there is little explicit, public hatred toward older people in public discourse (i.e., historically there are no known hate groups toward older people), yet widespread acceptance of negative feelings and beliefs about older people has also been clearly documented (Levy & Banaji, 2002; Williams & Giles, 1998). Due to the critical way ageism operates at an
implicit, rather than explicit, level, Levy and Banaji initially used the term *implicit ageism* to describe both implicit age stereotypes and implicit attitudes toward aging. Implicit age stereotypes were defined as “thoughts about the attributes and behaviors of the elderly that exist and operate without conscious control” (Levy & Banaji, 2002, p. 51), while implicit age attitudes were defined as “feelings toward the elderly that exist and operate without conscious awareness, intention, or control” (Levy & Banaji, 2002, p. 51). Levy and Banaji (2002) described how implicit ageism may be especially harmful because it occurs without conscious awareness, and individuals are not likely to change their behavior if they are unaware of its influence or that it is even occurring.

Furthermore, these scholars discussed how implicit ageism can occur toward individuals of another age group, toward individuals of the same age group, and toward oneself (Levy & Banaji, 2002, p. 59-61). There is also a complex interaction between societal-level messaging and implicit ageism, as older adults may assume negative health outcomes are due to their advanced age (based on commonly held assumptions between aging and decline), when in reality a negative health outcome may actually be caused by the implicit, negative age stereotype itself (Levy & Banaji, 2002, p. 61).

**Ageism and Health**

Our rapidly aging society reinforces the demand to better understand the nature and health impacts of internalized ageism for older adults. A recent report funded by the National Institute of Aging (NIA) found that 8.5% of people across the world (617 million) were 65 or older, while the percentage was estimated to rise to almost 17% of the world population (1.6 billion) by 2050 (He et al., 2016).
A recent systematic review about the impacts of ageism on health detailed the most information on this topic to date (Chang et al., 2020). This study reviewed 638 articles covering seven million participants from 45 countries over 25 years. Effects of ageism on health were found in all 45 countries, with the prevalence of significant health impacts increasing over time (Chang et al., 2020). Health impacts were found at both the structural and individual levels of ageism across 11 health domains:

- exclusion from health research, devalued lives of older persons, lack-of-work-opportunities, denied access to healthcare and treatments, reduced longevity, poor quality-of-life and well-being, risky health behaviors, poor social relationships, physical illness, mental illness, and cognitive impairment (Chang et al., 2020, p. 7).

At the individual level of health, ageism was shown to be associated with seven of these domains: longevity, poor quality of life, poor social relationships, risky health behavior, mental illness, cognitive impairment, and physical illness (Chang et al., 2020, p. 8-9). In four of the domains (longevity, poor quality of life, poor social relationships, and risky health behavior), 100% of studies found that ageism was associated with these outcomes. These impacts were documented across various countries as well. For example, ageism was associated with reduced longevity from nationally representative studies in China, Australia, the United States, and Germany (Chang et al., 2020, p. 8). Additionally, negative self-perceptions of aging among older Turkish women with low socioeconomic
status led to a lower quality of life (Top et al., 2012). Other research conducted in Germany found that age stereotypes better predicted health than the reverse (Wurm et al., 2007).

In terms of poor social relationships, ageism led to decreased social support, decreased social engagement, and increased social isolation (Chang et al., 2020, p. 9). When it comes to risky health behavior, ageism has been associated with poor diet, lower likelihood of taking medication as prescribed, unhealthy drinking, and smoking (Chang et al., 2020; Freeman et al. 2016). As ageism relates to mental health, depression has been the most commonly evaluated outcome. Studies indicate an association between ageism and onset of depression, increased depression over time, and lifetime depression (Bai et al, 2016; Chang et al., 2020, p. 9; Gum & Ayalon, 2018; Han, 2018; Han & Richardson, 2015; Kim, 2016; Kwak et al., 2014; O'Shea et al., 2017). Associations between ageism and cognitive impairment have been demonstrated in two meta-analyses (Chang et al., 2020; Horton et al., 2008; Lamont et al., 2015), experimental research (Chang et al., 2020; Lee & Lee, 2018; Levy, 1996), and in studies conducted in the United States, Germany, Ireland, and China (Chang et al., 2020; Levy et al., 2012; Gu et al., 2016; Seidler & Wolff, 2017; Sutin et al., 2015; Robertson et al., 2016). Specifically, worsened memory has been documented up to 38 years after the initial influence of ageism (Chang et al, 2020; Levy et al., 2012). In terms of physical health, ageism has been shown to predict functional impairment, chronic health conditions, the number of acute medical events, and hospitalizations (Chang et al, 2020, p. 9; Sun et al., 2017).
An association between ageism and functional decline has been documented in studies conducted across Australia, Israel, and the United States (Chang et al., 2020; Levy et al., 2002a; Sargent-Cox et al., 2012; Tovel et al., 2019).

**Internalized Ageism and Health**

Recently, scholars have begun to study both “other-directed” and “self-directed” determinants of ageism (Marques et al., 2020, p. 1). It is important to note that self-directed and internalized ageism are conceptualized as essentially identical in this article. Determinants of both self-directed and other-directed ageism were assessed for whether they were found at the intrapersonal, interpersonal/inter-group, or institutional levels (Marques et al., 2020). Self-directed ageism was found only at the intrapersonal level, not the interpersonal/inter-group or institutional levels. 13 other-directed determinants and one self-directed determinant were identified. The one self-directed determinant of ageism was physical and mental health status (Marques et al., 2020), suggesting a possible cyclical relationship between internalized ageism and health. It is important to note that race/ethnicity, sex, socio-economic status, education, employment, and marital status were not found to be determinants of self-directed ageism (Marques et al., 2020, p. 14). However, other studies have acknowledged and explored the double standard imposed by the combined influence of ageism and sexism (de Beauvoir, 1970; Stypińska & Nikander, 2018, p. 95).
One branch of scholarship on internalized ageism has focused on the measurement of subjective age. Subjective age incorporates multiple constructs, including felt age (i.e., what age someone feels they are), desired age (i.e., what age someone would like to be), and self-perceived age (i.e., what age someone thinks they look) (Kotter-Grühn & Hess, 2012, p. 468). Studies indicate that middle-aged and older adults prefer a younger subjective age for each of these constructs (Kleinspehn-Ammerlahn et al., 2008; Kotter-Grühn & Hess, 2012; Montepare & Lachman, 1989). A younger subjective age has been associated with a number of health outcomes, including good physical and mental health (Bergland et al., 2014). In particular, younger subjective age was associated with less symptoms of depression (Xiao et al., 2019) as well as better episodic memory and executive functioning (Stephan et al., 2014). Furthermore, a recent study found that younger subjective age predicted increased gray matter volume and decreased brain deterioration (Kwak et al., 2018). In contrast, research indicates that older subjective age contributed toward an increased likelihood of hospitalization (Stephan et al., 2016), dementia (Stephan et al., 2018a), and mortality risk (Stephan et al., 2018b).

In terms of prevention, Levy and her colleagues found that older adults with more positive self-perceptions of aging engaged in more preventive health behaviors over the course of twenty years. These preventive health behaviors included alcohol/tobacco use, diet, exercise, consistent use of medication, seatbelt use, and regular attendance at doctor appointments (Levy & Myers, 2004). In two longitudinal studies following older adults over twenty years, positive self-perceptions of aging were associated with more positive
functional health and increased longevity by an average of 7.5 years (Levy et al., 2002a; Levy et al., 2002b). Research has also demonstrated a stereotype-matching effect, such that older adults exposed to positive physical age stereotypes were more likely to have good physical balance (Levy & Leifheit-Limson, 2009). In another study, older adults were presented with positive age stereotypes both implicitly and explicitly. These positive age stereotypes increased participants’ positive self-perceptions of aging, which then contributed to enhanced physical functioning. Furthermore, the researchers found that the implicit intervention was more effective than the explicit intervention (Levy et al., 2014a). Another of Levy’s studies found that older veterans who were able to resist negative age stereotypes had significantly less mental health problems, such as suicidal ideation, anxiety, and PTSD, than veterans who embraced negative age stereotypes (Levy et al., 2014b). Furthermore, negative age stereotypes have been shown to increase cardiovascular stress measured by systolic and diastolic blood pressure, heart rate, and skin conductance (Levy et al., 2000b). In fact, younger people who embraced more negative age stereotypes were significantly more likely to experience a cardiovascular event over the following 38 years (Levy et al., 2009). Research also found that individuals who embraced more positive self-perceptions of aging were 44% more likely to recover from severe disability (Levy et al., 2012). In more recent work, Levy and colleagues have demonstrated that older adults with positive age beliefs were significantly less likely to develop dementia, even finding that positive age beliefs reduced the risk of dementia by 49.8% for individuals at higher risk due to carrying the ε4 variant of the APOE gene (Levy et al., 2018).
Overall, scholars have discussed the impact of negative attitudes and beliefs about older adults in contexts including everyday conversations (Hummert & Ryan, 1996; Williams & Giles, 1998), politics and voting behavior (Sigelman & Sigelman, 1982), the workplace (Butler, 1980; Finkelstein et al., 1995), and healthcare settings (Chang et al., 2020). The wide-ranging public health impacts of internalized ageism validate the need to explore this issue further.

**Stereotype Embodiment Theory**

Stereotype embodiment theory (SET) is a useful theory for conceptualizing how internalized ageism affects older adults. Becca Levy developed SET through her research on the health impacts of ageism. Levy describes how this theory “has four components: The stereotypes a) become internalized across the lifespan, b) can operate unconsciously, c) gain salience from self-relevance, and d) utilize multiple pathways” (Levy, 2009, p. 332).

In terms of how people internalize age stereotypes across the lifespan, Levy and colleagues describe how age stereotypes are often maintained or even strengthened across the life course (Levy & Banaji, 2002). This may be due in part to the prevalence and relative lack of awareness of ageism within public discourse. From an early age, children are presented with negative images of aging by popular stories and fairly tails such as Hansel and Gretel, in which older people are depicted as evil and malicious. In other stories such as Little Red Riding Hood, older adults are described as frail and gullible (Cohen, 2000; Levy & Banaji, 2002).
Additionally, older adults are at times mysteriously absent from popular media or are made fun of as weak or incompetent (Levy & Banaji, 2002; Kubey, 1980; Zebrowitz & Montepare, 2000).

Studies have shown that children report age stereotypes from their culture as early as six years old (Isaacs & Bearison, 1986; Levy & Banaji, 2002). Research describes how repetitive exposure to stereotypes enhances their strength at an implicit level (Dijksterhuis & van Knippenberg, 1998; Levy & Banaji, 2002; Levy et al., 2000; Murphy et al., 1995). Even when an individual witnesses an example that stands in contrast to an age stereotype, this may be seen as “an exception” which only further strengthens the stereotype (Levy & Banaji, 2002, p. 65). Research has also demonstrated how people are unconsciously and automatically categorized into social groups based on age, race, and gender (Banaji & Hardin, 1996; Devine, 1989; Hamilton & Sherman, 1994; Levy & Banaji, 2002; Perdue & Gurtman, 1990). Furthermore, studies indicate that during an initial encounter with another person, an immediate appraisal of “good or bad” occurs within a quarter second (Levy & Banaji, 2002, p. 65; Zajonc, 1980). While this process may in some ways have served as an adaptive function from an evolutionary standpoint, it may also lead to avoidance and ultimately decreased meaningful interactions with older people (Bargh, 1997; Levy & Banaji, 2002; Lewin, 1935; Palmore, 1998). Levy describes how young people “may have an incentive for holding negative age stereotypes, insofar as such stereotypes provide them with a short-term benefit” (Levy, 2009, p. 333).
However, an interesting quality of internalized ageism is that it negatively impacts the health of the same individual over the long-term. Therefore, negative age stereotypes held by youth will eventually impact these same individuals over time as they age.

Levy’s research also demonstrates the unconscious aspects of internalized ageism by showing that when older adults are subliminally primed with negative age stereotypes, they are more likely to write slower when given a handwriting task (Levy, 2000b) and reject life-saving measures when presented with hypothetical crisis scenarios (Levy et al., 2000a).

Levy explains how internalized ageism functions to “gain salience from self-relevance” because old age is a social construct distinguished by certain arbitrary dates, such as when older adults start receiving Social Security (Levy, 2009). Another example is fixing the retirement age at 60 or 65 years. While the practice of setting a fixed retirement age not only increases ageism at an institutional level, it also contributes toward the societal notion that the social and economic value of people past a certain age reduces drastically (Breda & Schoenmaekers, 2006; Stypińska & Nikander, 2018). Levy also illustrates the impact of “cues” from society which send the message that people are old and no longer needed (Levy, 2009). This may, in turn, contribute toward a loss of autonomy or control in terms of whether older adults feel they have power to make a difference in life outcomes through their own choices (Bytheway, 1995; Stypińska & Nikander, 2018).
Levy breaks down ageism into three components: age discrimination, negative age stereotypes, and negative self-perceptions of aging (Chang et al., 2020; Levy, 2009). In terms of the “utilization of multiple pathways,” Levy describes three primary pathways between ageism and health: psychological, behavioral, and physiological. The psychological pathway relates to self-fulfilling prophecies of what older adults believe they should expect about the aging process. The behavioral pathway involves older adults not engaging in healthy lifestyle behaviors because they may assume these are not worth the effort. Finally, the physiological pathway relates to an increased stress response for older adults who experience negative age stereotypes (Levy, 2009).

Successful Aging

Drawing from successful aging is an appropriate way to continue this discussion because it can help to better understand how healthy pathways influence outcomes for older adults. During the 1970’s and 1980’s, many gerontologists, as well as the public, became increasingly concerned about the health care consequences of America’s rapidly growing aging population. Many gerontologists sought to focus on a more holistic view of aging beyond the biomedical model; a model that would embrace the biological, psychological, as well as social components of aging. There was also a feeling that prevailing perspectives on aging focused heavily on disability, disease, and chronological age while seriously neglecting lifestyle and other psychosocial factors (Rowe & Kahn, 1998).
The theory of successful aging was tested in the 1990’s during a ten-year longitudinal study by the MacArthur foundation, showing that 70% of overall health outcomes in aging are related to lifestyle compared with only 30% being related to genes (for cognitive health, the study showed about a 50%: 50% ratio) (Rowe & Kahn, 1998). Overall, three major components were identified as comprising successful aging: 1) low risk of disease and disease-related disability, 2) high mental and physical function, and 3) active engagement with life (Rowe and Kahn, 1998, p. 38). Successful aging is currently operationalized in retirement communities and home settings across the U.S. where older adults take an annual “lifestyle review” and engage in programs based on physical, intellectual, social, and spiritual wellness through an initiative called “Masterpiece Living” (see www.mymasterpieceliving.com).

These findings bring a critical perspective to the health needs of older adults because research has shown that older adults are the least likely of any age group to engage in preventive health behaviors, yet people do continue to benefit from healthy behaviors across the lifespan. Research indicates that older adults receive less preventive healthcare than younger people, including cancer screenings, flu shots, and nutrition and exercise interventions (Alliance for Aging Research, 2003). Research has also demonstrated that older adults receive limited treatment for common, treatable conditions such as heart disease (Asch et al. 2000; Bowling 1999; Giugliano et al. 1998; Hillerbrand & Shaw 1990; Levy & Banaji, 2002). Perhaps in part due to less care and ageist assumptions in society, research has found that many older adults struggle to maintain a balanced diet (Zulkowski, 2000), and older age is correlated with less physical activity.
(Burton et al., 1999). It is important to note that research itself is biased by focusing more on preventive health behaviors for young and middle-aged people (Goldberg & Chavin, 1997; Levy & Myers, 2004). This bias may also be due to ageism because a focus on preventive health efforts among younger people may be due to an assumption that health decline is inevitable in later life (Levy & Myers, 2004). This assumption may lead to further assumptions that older adults may not benefit from preventive health behaviors or that changing health behaviors in late life is too challenging (Alliance for Aging Research, 2003; Levy & Myers, 2004).

Despite these barriers, research does indicate that preventive health behaviors make a difference in the lives of older adults. For example, older adults who quit smoking past age 65 can increase their longevity (Taylor et al., 2002). Adults over age 75 who engage in exercise have also been found to increase muscle mass and mobility (Fiatarone et al., 1994) while slowing functional decline (Gill et al., 2002). Furthermore, four factors (physical activity, regularly eating fruits and vegetables, moderate alcohol consumption, and not smoking) contributed significantly to successful aging over the course of sixteen years, with increased odds of 33% for the addition of each lifestyle behavior (Sabia et al., 2012). Other research has shown that exercise, stress management, cognitive interventions, and social engagement programs contribute toward improved emotional and cognitive health outcomes for older people (Depp et al., 2010). Successful aging has also been approached through strategic and compensatory approaches to memory enhancement (Nyberg & Pudas, 2019).
In terms of stress management, reduced allostatic load has been associated with a lower risk of mortality (Karlamangla et al., 2006), while low levels of stress through activities such as exercise may lead to positive changes in the brain as people age (Prolla & Mattson, 2001; Rattan, 2004).

Successful aging has inspired a handful of related terms in the present-day aging industry. Synonymous terms may include active aging and healthy aging. Active or healthy aging programming is building momentum due to the increased longevity and demand of the baby boomer generation.

**Neighboring Theories to Successful Aging**

Successful aging is comparable to several other neighboring theories, including positive psychology, self-efficacy theory, activity theory, disengagement theory, and Erikson’s stages of human development. Leading scholars for positive psychology include Martin Seligman and Mihaly Csikszentmihalyi, and it is relevant to note that the development of positive psychology occurred in the 1990’s, coinciding with the development of Rowe and Kahn’s research on successful aging. It can be argued that successful aging is an offshoot of positive psychology applied more specifically to the aging population. Positive psychology is a reaction against psycho-analysis and a problem-based view of mental illness and draws from the long tradition of humanistic philosophy (Srinivasan, 2015). Alfred Bandura’s self-efficacy theory also influenced both positive psychology and successful aging in its focus on the realization of human motivation and potential (Bandura, 1982).
Furthermore, activity theory and disengagement theory influenced early stages of the development of successful aging, as described by Martin (2015, p. 17):

“Activity theory stated that aging successfully meant maintaining middle-aged activities and attitudes into later adulthood... Disengagement theory, on the other hand, meant that a person aging successfully would want, over time, to disengage from an active life.”

Erikson’s stages of later life also helped frame the concept of successful aging because during “generativity versus stagnation... the challenges involve successful mastery of work life, creative activity, and raising a family” (Martin et al., 2015, p. 17; Erikson, 1950) while “ego integrity is achieved through evaluation of one’s life as having been a fulfilling and satisfying one” (Martin et al., 2015, p. 17; Erikson, 1950).

**Productive Aging**

Another broad and noteworthy area of scholarship neighboring successful aging is that of productive aging. Productive aging focuses on active engagement with life through volunteerism, continued vocational pursuits, and caregiving in particular (Morrow-Howell & Greenfield, 2016). Productive aging was initially developed by Robert Butler and colleagues (Butler & Gleason, 1985). Productive aging arose out of the booming aging population, increased longevity, and an effort to reframe the capacity of older adults to continue contributing their skills and knowledge to society (Butler, 2002). The productive aging movement was also developed to promote a more positive view of aging because, despite the mainstream view, the majority of older adults are active and continue to contribute to their communities (Bass, 2006; Hart et al., 2002).
A Conceptual Model Toward Reducing Internalized Ageism

Figure 1 details a conceptual model proposing factors which may contribute toward decreased internalized ageism. Broadly, this model depicts the relationship between ageism and health outcomes. Based on SET (Levy, 2009), ageism includes age discrimination, negative age stereotypes, and negative self-perceptions of aging. SET also theorizes that ageism influences negative health outcomes through psychological, behavioral, and physiological pathways (Levy, 2009). In the psychological pathway, self-efficacy has the most empirical support to date as a mediator between ageism and health (Chang et al., 2020). Other potential mediators with preliminary evidentiary support include perceived control (Levy et al., 2002) and purpose in life (Kim, 2016). Self-efficacy has mediated the relationship between self-perceptions of aging and physical functioning (Tovel et al., 2019), self-perceptions of aging and healthy eating (Klusmann et al., 2017), stereotypic beliefs about aging and health-promoting behaviors (Yeom, 2014), and self-stereotypes of aging and cardiovascular stress (Levy et al., 2000). In the behavioral pathway, physical activity has functioned as a mediator between ageism and health (Chang et al., 2020). For example, physical activity mediated the relationship between expectations regarding aging and functional health (Li et al., 2013), self-perceptions of aging and self-rated health (Beyer et al., 2015), and expectations regarding aging and physical and mental health (Kim, 2009). These studies demonstrated that ageism contributed to less healthy lifestyle behaviors, which in turn led to decreased physical health. In the physiological pathway, biomarkers of inflammation/stress have served as a mediator between ageism and health (Chang et al., 2020).
For example, a C-reactive protein partially mediated the relationship between self-perceptions of aging and longevity (Levy & Bavishi, 2018).

Based on successful and productive aging, moderators have been included to disrupt the psychological, behavioral, and physiological pathways proposed by SET (Levy, 2009). Although SET posits that ageism negatively impacts health, Figure 1 proposes that healthy lifestyle and productive engagement may mitigate or potentially even reverse this process at an individual level.

In terms of the psychological pathway, while ageism may negatively impact health through mediators such as self-efficacy, it is also known that active or productive engagement in physical, social, and cognitive pursuits can boost self-efficacy for older adults. For example, physical activity has been shown to have a strong effect on self-efficacy, with self-efficacy mediating the relationship between physical activity and quality of life for older adults (Mudrak et al., 2016). One specific form of exercise shown to increase self-efficacy for older adults is Tai Chi (Tong et al., 2018). In terms of social engagement, self-efficacy has played a prominent role in research on volunteerism (Kossowska & Laguna, 2018; Wang et al., 2011). In particular, studies have indicated that volunteering increases self-efficacy for middle-aged and older adults (Brown et al., 2012). In terms of cognitive engagement, a growing literature has demonstrated the impact of computer use on self-efficacy among older adults. For example, older adults demonstrated increased computer self-efficacy when using online health information (Hall et al., 2015).
Additionally, a recent qualitative study describes self-efficacy as a theme as it relates to technology use in general, in addition to being an outcome of technology use among older veterans (Leone et al., 2018).

Figure 1 proposes that education and narrative reframing are potential moderators which may disrupt the behavioral pathway in SET. The behavioral pathway in SET posits that ageism negatively impacts health because older adults may assume that engaging in healthy lifestyle behaviors may not be worth the effort (Levy, 2009). It seems plausible that education and narrative reframing may assist older adults in shifting their thinking to better understand the benefits of healthy lifestyle behaviors into later life, leading to behavior change. Education and narrative reframing interventions have already been tested and shown to reduce ageism directly (Burnes et al., 2019; Busso et al., 2019; Sweetland et al., 2017). Figure 1 indicates that education and narrative reframing interventions can both be applied to combat ageism directly and to serve as a moderator within the behavioral pathway of stereotype embodiment.

In terms of the physiological pathway, Figure 1 posits that stress management interventions may be applied to disrupt the negative impacts of ageism on health through this pathway. For example, mindfulness (Sharma & Rush, 2014; Szanton et al., 2011), meditation (Goyal et al., 2014; Hersoug et al., 2018), and yoga (Sharma, 2013) are particular approaches which have been shown to reduce stress, providing justification to investigate whether these forms of engagement may disrupt the negative influence of ageism on health through the physiological pathway.
Overall, the moderators incorporated into the three pathways in SET may be seen as downstream factors, since these moderators are posited to function after ageism has already begun to influence health through psychological, behavioral, and physiological pathways.

This model also highlights midstream factors which may more directly impact ageism itself. These include intergenerational contact, education, and narrative reframing. Therefore, education and narrative reframing may function as both downstream and midstream factors. A recent systematic review and meta-analysis found that a combination of education and intergenerational contact showed the strongest effect toward reducing multiple dimensions of ageism (Burnes et al., 2019). These dimensions of ageism included knowledge about aging, attitudes toward older adults, anxiety regarding one’s own aging, and interest in working with older adults (Burnes et al., 2019). An intergenerational, lifelong learning initiative was also shown to reduce age stereotypes in MSW students (anonymized, in press). Furthermore, the Frameworks Institute (https://www.frameworksinstitute.org/) has developed educational, narrative interventions to reframe how people think about aging and impact a variety of ageism-related outcomes (e.g., attitudes toward aging, collective efficacy toward aging, implicit age bias, us vs. them thinking, knowledge of systemic aging supports, etc.) (Busso et al., 2019; Sweetland et al., 2017).

Finally, anti-ageism policy has been included in this model as an upstream, preventive factor. To this author’s knowledge, limited research directly addresses the impact of anti-ageism policy on older adults’ health. However, perceived age
discrimination is an important component of SET (Levy, 2009), and research does describe the impacts of perceived age discrimination in the workplace on health outcomes such as lower self-rated health and increased depressive symptoms (Marchiondo et al., 2017). Anti-ageism policy has been included to ensure this model provides recommendations for interventions at multiple levels (i.e., micro, meso, and macro). One specific policy that could be evaluated in terms of its impact on internalized ageism and health among older adults is the Age Discrimination in Employment Act (ADEA). This act was enacted in 1967 and has three primary aims:

“(1) to promote the employment of older persons based on their ability rather than age, partly through re-educating employers; (2) to prohibit ‘arbitrary’ age discrimination in employment; (3) to help employers and workers find ways of solving problems arising from the impact of age on employment.” (Macnicol, 2006, p. 235; House Report No. 805, 1967, p. 74-76)

Although SET is primarily conceptualized from a micro-level perspective, it is important that scholars address interventions across the micro, meso, and macro levels, which are all important in influencing how ageism is embodied and impacts the health of older adults. However, gaps in research connecting macro-level interventions to internalized ageism and health, along with the preventive and potentially more widespread impacts of macro-level interventions, make interventions at the macro level critical for future researchers to explore.
Figure 1

A Conceptual Model Toward Reducing Internalized Ageism

Note. This figure conceptualizes potential interventions to reduce ageism through downstream, midstream, and upstream factors. Downstream factors are indicated by "*DF," midstream factors by "*MF," and upstream factors by "*UF." The midstream factor "IG Contact" stands for "intergenerational contact."

Ageism includes age discrimination, negative age stereotypes, and negative self-perceptions of aging. Self-efficacy is a mediator within the psychological pathway, physical activity is a mediator within the behavioral pathway, and stress biomarkers are a mediator within the physiological pathway in stereotype embodiment theory (Levy, 2009). Physical, social, and cognitive engagement may include exercise, volunteering, and technology use, respectively. Stress management may include mindfulness, meditation, and yoga. Health outcomes may include physical/mental health, functional ability, cognition, less hospitalizations, recovery from disability, less cardiovascular events, and longevity. This model draws from Burnes et al., 2019; Chang et al., 2020; and Levy, 2009 in particular.
Discussion

The conceptual model presented in this article may be useful for scholars and practitioners when considering paths toward interventions to reduce internalized ageism and promote well-being for aging adults. Drawing from recent systematic reviews (e.g., Burnes et al., 2019; Chang et al., 2020), this model utilizes three pathways within SET (psychological, behavioral, and physiological) (Levy, 2009) and incorporates downstream, midstream, and upstream factors, pointing toward potential interventions at micro, meso, and macro levels. Micro-level interventions via successful and productive aging pursuits such as physical activity, volunteering, technology use, and stress management may serve as downstream factors to mitigate or perhaps reverse negative health impacts of ageism already occurring at an internalized level. Meso-level interventions such as education, intergenerational contact, and narrative reframing may serve as midstream factors which more directly combat ageism, while in some cases also functioning as downstream factors. Finally, scholars and practitioners should test whether anti-ageism policies may serve as upstream, preventive factors to combat ageism before it begins to have deleterious effects on health through the three pathways of stereotype embodiment.

Interventions to reduce internalized ageism are in their infancy, and the current literature exists primarily at the midstream level. This midstream research highlights how intergenerational contact, education, and narrative reframing interventions may be effective in reducing ageism (anonymized, in press; Burnes et al., 2019; Busso et al., 2019; Sweetland et al., 2017). Figure 1 also highlights how one path toward interventions
at the downstream level may involve combining approaches to successful or productive aging with SET. Figure 1 also makes clear the need for many more interventions to be tested at the structural, upstream level. The Chang et al. (2020) systematic review does discuss how ageism in the workplace may lead to workplace-related outcomes such as early retirement, but the present study is focused on health, rather than work-related, outcomes.

At the structural level, one potentially fruitful area of scholarship to push the field forward would be to test the impact of policies on internalized ageism and health among older adults. As previously mentioned, one specific policy that may be beneficial to explore is the Age Discrimination in Employment Act (ADEA). The House of Representatives recently passed an amendment to this act called the Protecting Older Workers Against Age Discrimination Act (2020). This amendment to the ADEA would 1) allow complaining parties to use any type of evidence to support their claims, and 2) ensure that complaining parties do not need to prove that age was the only reason for an unlawful employment practice. This amendment still needs to pass through the Senate and receive presidential approval. Therefore, should this legislation pass, scholars could compare older adults’ internalized age stereotypes, perceived age discrimination, or self-perceptions of aging through large, nationally representative data sets before and after implementation of the amendment. Future research could also examine differences across countries by comparing other policies or laws with the ADEA or investigate period effects by analyzing the impact of various changes in legal precedent or approaches to implementation at different time periods.
Relevance to Social Work

Internalized ageism and its impact on the health of older adults is a critical issue for social workers, as this issue directly influences the health, basic needs, and social justice concerns of the growing aging population. The demand for competent social workers to support the rapidly growing number of older adults is greater than ever. Social work values such as the dignity and worth of a person, clients’ right to self-determination, and the profession’s commitment to social justice (National Association of Social Workers, 2017) fit well as a response to the complex and critical social justice issue presented by internalized ageism and its impact on older adults’ health.

Social workers are uniquely able to respond to the needs of the rapidly aging population through a multi-level, social justice framework. One of the grand challenges of the social work profession is to “advance long and productive lives” (American Academy of Social Work and Social Welfare, 2018). Clear evidentiary support exists for a wide range of positive health outcomes, even longevity, for older adults who experience less internalized ageism. Therefore, efforts to better understand and reduce internalized ageism should be given attention within social work practice, particularly given the rapidly growing aging population. The prevalence and epidemiology of the impacts of internalized ageism on older adults’ health also make clear that this issue needs to be understood and addressed across micro, meso, and macro levels. Social workers are trained to practice at each of these levels and therefore should be competent to approach this issue from a variety of impactful perspectives. Furthermore, one of the core values of the social work profession is social justice (NASW, 2017). Ageism is a critical social
justice issue which has many layers of complexity. Much more attention should be given to the social justice implications of internalized ageism and health among older adults, particularly through a critical lens which will support increased collaboration and social change within practice.

The present article may also be useful in the classroom by promoting in-depth, critical discussions about ageism with social work students. The proposed model is a practical tool which can be discussed with students who may benefit from exploring the pathways and potential interventions to reduce internalized ageism. Students and instructors/practitioners should also apply their knowledge and field work experience to brainstorm other relevant applications of this working model within their practice. As this is the first model proposed on interventions to reduce internalized ageism, it is the author’s hope that students and practitioners alike will feel comfortable applying and adapting the model to their own work, in addition to considering ways this model can be improved.

**Conclusion**

In regard to potential insights and applications from the proposed conceptual model, it is important to consider how simply encouraging aging adults to choose healthy lifestyle behaviors (e.g., exercise or mindfulness at the downstream level) may not be as effective or preventive as focusing on upstream factors (e.g., changing policy), since ageism has in itself been shown to decrease healthy lifestyle behaviors. Encouraging healthy lifestyle may have minor effects toward reducing internalized ageism in older
adults, while the area of most urgent need lies in addressing upstream determinants. In particular, the field would greatly benefit from scholars and practitioners focusing their attention on how policy influences older adults’ experience of internalized ageism and health, as these connections are severely understudied.

Drawing a lesson from a scholar in another critical area of social justice (racism), Jones (2000) described how institutional racism must be addressed first, which should then impact personally-mediated and internalized racism. Similarly, structural interventions are likely to be the most robust in mitigating and preventing the health impacts of internalized ageism. However, social workers contribute and collaborate in invaluable ways to support clients across all levels of practice. The conceptual model offered in this article highlights the current state of the literature and can help scholars, practitioners, and students consider potential paths toward reducing internalized ageism across micro, meso, and macro levels of social work practice.
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Manuscript Two:

Do Internalized Age Stereotypes Mediate the Relationship Between Volunteering and Social Connectedness for Adults 50+?

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Abstract

The productive aging literature describes a wide range of psychosocial benefits of volunteerism for older adults. A growing, compelling body of literature drawing from stereotype embodiment theory identifies significant, negative public health impacts of internalized age stereotypes. Yet, little research explores which activities may reduce internalized ageism and enhance psychosocial health as people age. This cross-sectional parallel mediation study examines whether internalized age stereotypes mediate the relationship between volunteering and social connectedness for adults 50+. A convenience sample of volunteers (n = 165) 50+ years of age in the U.S. Mountain West completed an online survey primarily during the COVID-19 pandemic. The independent variable is volunteer hours per week ($M = 6.45$, $SD = 5.38$). The dependent variable is social connectedness measured by five positively worded items from the UCLA loneliness scale ($M = 4.32$, $SD = 0.63$, and $\alpha = .86$). The indirect effects of five internalized positive (e.g., “wise” and “capable”) ($M = 4.85$, $SD = 0.68$, $\alpha = .72$) and five negative (e.g., “grumpy” and helpless”) ($M = 1.20$, $SD = 1.02$, $\alpha = .74$) age stereotypes were tested. Results (n = 165) indicate that increased internalized positive, not negative, age stereotypes partially mediate the relationship between volunteer hours and increased social connectedness, while holding constant relevant covariates. Although positive age stereotypes have long been considered a form of ageism, the results of this study suggest that internalizing positive age stereotypes may function as a form of esteem (particularly during the pandemic) to promote enhanced psychosocial health as people age.

Keywords: Internalized Ageism, Older Adults, Volunteering, Social Connections, Loneliness
Social connectedness is conceptualized as the opposite of loneliness and includes a sense of embeddedness or belonginess within a network of social ties (Jong Gierveld & Kampuhls, 1985; de Jong Gierveld & van Tilburg, 2006; Zelenka, 2011). Existing literature focuses more on constructs of loneliness and social isolation as compared with the positively worded alternative of social connectedness. A 2018 AARP survey reports that 35% of adults over age 45 in the U.S. express feeling lonely. Research also demonstrates a concerning link between loneliness/social isolation and increased death related to coronary artery disease (Heffner et al., 2011; Hwang et al., 2020; Steptoe et al., 2013), suicide (Fässberg et al., 2012; Hwang et al., 2020), incident dementia (Hwang et al., 2020; Kuiper et al., 2020) and all-cause mortality (Hwang et al., 2020; Yu et al., 2020). Due to increased prevalence, scholars now describe loneliness as a “behavioral epidemic” (Jeste et al., 2020). It is also recognized that older adults are particularly vulnerable to loneliness and social isolation during the COVID-19 pandemic (Hwang et al., 2020).

Compounding these issues, ageism is described by the World Health Organization (2020) as “widespread and an insidious practice which has harmful effects on the health of older adults.” A growing literature documents how ageism is internalized across the lifespan, with accumulating negative health impacts such as decreased longevity (Levy et al., 2002b), physical functioning (Levy et al., 2014a), likelihood of recovery from disability (Levy et al., 2012), mental health concerns (Levy et al., 2014b), cardiovascular events (Levy et al., 2000c), and cognitive decline (Levy et al., 2018). In terms of social outcomes, a recent systematic review details how ageism is significantly associated with
“poor social relationships” along with ten other health domains (Chang et al., 2020, p. 7). Specific outcomes within the poor social relationships domain include low social support, poor social engagement, and social isolation (Chang et al., 2020, p. 9). A potential cyclical relationship between health and self-directed/internalized ageism is also indicated (Marques et al., 2020). Yet, very little research explores whether health-promoting activities may reduce internalized ageism and enhance psychosocial health as people age.

Based on activity theory, engagement in meaningful social activity is one way older adults can promote positive health outcomes as they age (Lemon et al., 1972). Participation in social activities is associated with increased social connectedness and overall well-being among older adults (Cornwell et al., 2008). The productive aging literature also documents how volunteering is one activity which may effectively reduce loneliness (Lee, 2021) and enhance other psychosocial health outcomes such as a sense of purpose, life satisfaction, and perceived growth among older adults (Jongenelis et al., 2021; Morrow-Howell & Greenfield, 2016; Pardasani, 2018). While productive aging research does not directly address ageism, a conceptual model drawing from productive aging suggests volunteering as one activity which may reduce internalized ageism and enhance psychosocial health for older adults (Steward, 2021). The present study focuses on social connectedness (a positively worded alternative to loneliness) as a psychosocial health outcome by examining the following research question: Do internalized age stereotypes mediate the relationship between volunteering and social connectedness for adults 50+?
Background

Activity Theory and Social Connectedness

Activity theory suggests that engagement in social activities may contribute to a variety of enhanced health outcomes for older adults, including increased social connectedness and social support (Lemon et al., 1972; Lubben & Gironda, 2003; Morrow-Howell, 2010). Social connectedness is defined as “the opposite of loneliness” or the “affective sense of being embedded in a network of social ties” (Zelenka, 2011, p. 12). Much of the existing gerontological literature focuses on constructs such as loneliness, social isolation, social support, or social networks rather than social connectedness as an outcome. Existing research on social connectedness documents how age is positively associated with activities promoting social connectedness such as neighborly socializing, attendance at religious services, and volunteering (Cornwell et al., 2008). This research also describes how older adults may adapt when there is a decrease in connectedness via interpersonal networks by increasing connectedness through formal associations with civic organizations and other forms of productive engagement (Cornwell et al., 2008).

Productive Aging and Volunteerism

The productive aging literature focuses on active engagement with life through volunteerism, continued vocational pursuits, and caregiving (Morrow-Howell & Greenfield, 2016). Much academic work has described the benefits of volunteering for older adults, which include: decreased loneliness, isolation, depression, and functional
limitations, as well as enhanced sense of purpose, self-rated health, self-esteem, and quality of life (Haski-Leventhal, 2009; Hong & Morrow-Howell, 2010; Lee, 2021; Li & Ferraro, 2006; Morrow-Howard & Greenfield, 2016; Morrow-Howard et al., 2003; Jongenelis et al., 2021; Narushima, 2005; Pardasani, 2018; Rozario, 2006; Tan et al., 2006). It is proposed that, similar to the benefits of paid work, volunteering may contribute to positive outcomes due to increased social, physical, and cognitive activity (Fried et al., 2004; Morrow-Howard & Greenfield, 2016). However, not all volunteering leads to positive outcomes. For example, research indicates that volunteerism through political activism may lead to increased distress (Berry et al., 2007; Morrow-Howard & Greenfield, 2016).

Loneliness and Social Isolation Among Older Adults

Given the fact that limited literature focuses on social connectedness as an outcome among older adults, this section will emphasize the negative health impacts of loneliness and social isolation (two separate yet interrelated issues). According to the National Institute on Aging (2019), loneliness is a subjective, perceived sense of feeling alone while social isolation is an objective condition of physical separation from others. The most recent survey by AARP (2018) found that 35% of adults 45+ in the United States are lonely. Social isolation and loneliness are associated with a 29% and 26% increased likelihood of mortality, respectively, and researchers recommend that these issues be added to lists of public health concerns (Holt-Lunstad et al., 2015). Strong evidence supports the relationship between remaining socially engaged and positive health outcomes for older adults (Rowe & Kahn, 1998). Furthermore, recent research
indicates that a lack of social relationships more strongly enhances mortality risk than obesity (Flegal et al., 2013; Holt-Lunstad et al., 2010; Holt-Lunstad et al., 2015). Loneliness is now considered a “behavioral epidemic” (Jeste et al., 2020), along with increased opioid overdoses and suicides, which have contributed to a reduction in the average U.S. lifespan for the first time since the 1950’s (Arias & Xu, 2019; Jeste et al., 2020).

**Stereotype Embodiment Theory**

Stereotype embodiment theory (SET) is a useful theory for conceptualizing how internalized ageism affects older adults. Becca Levy developed SET and describes how this theory “has four components: The stereotypes a) become internalized across the lifespan, b) can operate unconsciously, c) gain salience from self-relevance, and d) utilize multiple pathways” (Levy, 2009, p. 332).

In terms of how people internalize age stereotypes across the lifespan, Levy and Banaji (2002) describe how age stereotypes are often maintained or even strengthened across the life course. Studies have shown that children report age stereotypes from their culture as early as six years old (Isaacs & Bearison, 1986; Levy & Banaji, 2002). Additionally, repetitive exposure to age stereotypes enhances their strength at an implicit level (Dijksterhuis & van Knippenberg, 1998; Levy & Banaji, 2002; Levy et al., 2000a; Murphy et al., 1995).
Levy’s research demonstrates the unconscious aspects of internalized ageism by showing that when older adults are subliminally primed with negative age stereotypes, they are more likely to write slower when given a handwriting task (Levy, 2000a) and reject life-saving measures when presented with hypothetical crisis scenarios (Levy et al., 2000b).

Levy explains how internalized ageism functions to “gain salience from self-relevance” because old age is a social construct distinguished by certain arbitrary dates, such as retirement or when older adults start receiving Social Security (Levy, 2009). Levy also illustrates the impact of “cues” from society which send the message that people are old and no longer needed (Levy, 2009). This may, in turn, contribute toward a loss of autonomy or control in terms of whether older adults feel they have power to make a difference in life outcomes through their own choices (Bytheway, 1995; Stypińska & Nikander, 2018).

In terms of the “utilization of multiple pathways,” Levy first breaks down ageism into three components: age discrimination, negative age stereotypes, and negative self-perceptions of aging (Chang et al., 2020; Levy, 2009). Further, Levy describes three primary pathways between ageism and health: psychological, behavioral, and physiological. The psychological pathway relates to self-fulfilling prophecies of what older adults believe they should expect about the aging process. The behavioral pathway involves older adults not engaging in healthy lifestyle behaviors because they may assume these are not worth the effort.
Finally, the physiological pathway relates to an increased stress response for older adults who experience negative age stereotypes (Levy, 2009).

**Ageism and Health**

Ageism signifies any bias, stereotype, prejudice, or discrimination toward an individual based solely on that person’s age (Nelson, 2002). Robert Butler first introduced and compared ageism to other forms of discrimination such as racism and sexism (Butler, 1969). A recent systematic review documents significant effects of ageism on health across 45 countries, with the prevalence of significant health impacts increasing over time (Chang et al., 2020). Health impacts were found at both the structural and individual levels of ageism across 11 health domains. At the individual level of health, ageism was shown to be associated with poor social relationships in addition to decreased longevity, poor quality of life, risky health behavior, increased mental illness, increased cognitive impairment, and increased physical illness (Chang et al., 2020, p. 8-9). In terms of poor social relationships, ageism led to decreased social support, decreased social engagement, and increased social isolation (Chang et al., 2020, p. 9).

**Positive and Negative Ageism**

Erdman Palmore described that ageism is comprised of both negative and positive stereotypes (Palmore, 1999). Negative ageism denigrates aging as less valuable than youth or presumes an association between aging and disease, decline, or disability. Negative age stereotypes may include: “illness, impotency, ugliness, mental decline,
mental illness, uselessness, isolation, poverty, and depression” (Palmore, 1999, p. 20).

Positive ageism, however, occurs when individuals assign qualities of wisdom and respect toward all older adults unrelated to context, which in turn may cause older people to feel pressure to live up to such expectations (Palmore, 1999). Positive ageism may come across to older people as paternalistic or infantilizing rather than empathic in its message (Chonody, 2016). Palmore detailed that positive age stereotypes may include: “kindness, wisdom, dependability, affluence, political power, freedom, eternal youth, and happiness” (Palmore, 1999, p. 34). It is important to recognize that both negative and positive stereotypes comprise ageism, although the negative stereotypes may be more commonly recognized and discussed.

**Internalized Ageism and Health**

A unique quality of ageism is that old age is something all people will experience given a long life. In fact, ageism has been described as a “prejudice against our feared future self” (Nelson, 2005, p. 207). Research demonstrates how ageism is internalized with accumulating negative health impacts across the lifespan (Chang et al., 2020; Levy 2009). A recent systematic review examined both “other-directed” and “self-directed” determinants of ageism (Marques et al., 2020, p. 1) (self-directed and internalized ageism may be viewed synonymously). Physical and mental health were the only self-directed determinant of ageism identified (Marques et al., 2020), suggesting a possible cyclical relationship between internalized ageism and health. Race/ethnicity, sex, socio-economic status, education, employment, and marital status were not found to be determinants of self-directed ageism (Marques et al., 2020, p. 14).
In terms of prevention, Levy and Myers (2004) found that older adults with more positive self-perceptions of aging engaged in more preventive health behaviors over the course of twenty years. These preventive health behaviors include alcohol/tobacco use, diet, exercise, consistent use of medication, seatbelt use, and regular attendance at doctor appointments (Levy & Myers, 2004). In two longitudinal studies following older adults over twenty years, positive self-perceptions of aging were associated with more positive functional health and increased longevity by an average of 7.5 years (Levy et al., 2002a; Levy et al., 2002b). Research has also demonstrated a stereotype-matching effect, such that older adults exposed to positive physical age stereotypes were more likely to have good physical balance (Levy & Leifheit-Limson, 2009). In another study, older adults were presented with positive age stereotypes both implicitly and explicitly. These positive age stereotypes increased participants’ positive self-perceptions of aging, which then contributed to enhanced physical functioning. Furthermore, the researchers found that the implicit intervention was more effective than the explicit intervention (Levy et al., 2014a). Another of Levy’s studies found that older veterans who were able to resist negative age stereotypes had significantly less mental health problems, such as suicidal ideation, anxiety, and PTSD, than veterans who embraced negative age stereotypes (Levy et al., 2014b). Furthermore, negative age stereotypes have been shown to increase cardiovascular stress measured by systolic/diastolic blood pressure, heart rate, and skin conductance (Levy et al., 2000c). In fact, younger people who embraced more negative age stereotypes were significantly more likely to experience a cardiovascular event over the following 38 years (Levy et al., 2009). Research has also found that individuals who
embraced more positive self-perceptions of aging were 44% more likely to recover from severe disability (Levy et al., 2012). In more recent work, Levy and colleagues have demonstrated that older adults with positive age beliefs were significantly less likely to develop dementia, even finding that positive age beliefs reduced the risk of dementia by 49.8% for individuals at higher risk due to carrying the ε4 variant of the APOE gene (Levy et al., 2018). Overall, most of the existing literature focuses on the relationship between internalized ageism and physical/mental health outcomes. There appears to be a gap in connecting internalized ageism with outcomes of social well-being, such as social connectedness.

Studies have found that perceived age discrimination and self-perceptions of aging vary according to smaller age subgroups in later life. Specifically, people in their 50’s have reported experiencing more unfair treatment than people over age 60; yet, they were also less likely to describe this unfair treatment as age discrimination (Giasson et al., 2017). Midlife, particularly ages 50-59, may be an especially critical transition period when positive self-perceptions of aging particularly buffer against the perceptions and experiences of age discrimination (Giasson et al., 2017).

A recent systematic review documents ageism as a social determinant of health with impacts at least as consistent and significant as racism (Chang et al., 2020). While another recent systematic review and meta-analysis documented intergenerational contact and education as offering the most promising interventions to reduce ageism (Burnes et al., 2019), very few studies were found to address internalized ageism. To our knowledge, limited research explores whether volunteering may be effective in reducing
ageism or internalized ageism. However, a recent conceptual model of interventions to reduce internalized ageism drew from theories and literature on productive and successful aging (Steward, 2021). Volunteering is one activity identified at a micro/meso level which may help to both reduce internalized ageism and enhance psychosocial health for older adults (Steward, 2021).

Study Aim & Hypothesis

Therefore, the purpose of this study is to examine whether internalized positive and negative age stereotypes mediate the relationship between volunteering and social connectedness for adults 50+. We chose to include individuals 50+ years of age given that adults may be experiencing a critical transition period from mid to later life when the effects of ageism may become more salient. Given that both negative and positive age stereotypes have been conceptualized as components of ageism, the hypothesis of this study is that decreased internalized positive and negative age stereotypes will mediate the relationship between volunteering and increased social connectedness.

Methods

Participants

This is a cross-sectional, parallel mediation study, utilizing two mediators operating in parallel without affecting one another (Hayes, 2022). The inclusion criteria are individuals 50+ years of age who are currently volunteering and reside in the U.S. Mountain West (including the states of Colorado, New Mexico, Arizona, Nevada, Utah, Idaho, Montana, and Wyoming). The research initially began through a research
partnership with a community non-profit which provides volunteer opportunities for adults 50+ in a city in the U.S. Mountain West. Partnering with this non-profit allowed the researchers to pilot survey questions and adapt/develop the survey in consultation with adults 50+ in the earliest stages of survey design. In consultation with the older volunteers, the decision was made to utilize the dependent variable of social connectedness as a positively worded alternative to loneliness or social isolation. Over time, we sought to expand the sample size by incorporating a convenience sample through email/social media recruitment scripts and a one-page info sheet distributed to community organizations serving adults 50+ across the U.S. Mountain West.

Data were gathered through a 15-minute, online survey. The surveys were completed between October 10, 2019 through July 9, 2021 (primarily during the COVID-19 pandemic). This research was approved by the institutional review board at the university (IRB #1462845-5). Consent was obtained from all participants online prior to completion of the survey.

Measures

**Social Connectedness.** Five items measure respondents’ levels of social connectedness. These items are drawn from a positively worded adaptation of the UCLA loneliness scale (Russell, 1996; Zelenka, 2011). Participants are asked: “How much of the time do you feel…” with example response options including: “that there are people you can talk to/feel close to/who understand you?” Items are measured on a five-point Likert-type scale (1 = Hardly ever or never to 5 = Nearly always). We created a summary
score outcome variable by taking the mean of the five items to measure social connectedness through one item ($M = 4.30, SD = 0.64$, and $\alpha = .86$), with a higher score indicating higher levels of social connectedness.

**Internalized Positive and Negative Age Stereotypes.** These items are measured via the self-stereotypes of aging scale (Fernández-Ballesteros et al., 2017), which is an adaptation of the image of aging scale (Levy et al., 2004). Five positive (“capable,” “positive outlook,” “active,” “healthy,” “wise”) and five negative (“walks slowly,” “helpless,” “lonely,” “grumpy,” “sick”) stereotypes are measured separately. These internalized age stereotypes are assessed through the question: “Please indicate how much each word or phrase matches the image you have of yourself.” Based on recommendations from older adults during pilot testing, we also added: “It's okay to disagree. There are no right or wrong answers.” Items are measured on a six-point scale (0 = Does not match at all, 6 = Completely matches). We created separate mean score variables to measure internalized positive age stereotypes ($M = 4.85, SD = 0.68, \alpha = .72$) and internalized negative age stereotypes ($M = 1.20, SD = 1.02, \alpha = .74$), with higher scores indicating higher internalization of these stereotypes.

**Volunteer Hours Per Week.** Volunteer hours per week is measured by one item which asks: “How many hours per week of volunteer or service work are you currently providing?” Participants manually enter the number of volunteer hours per week in the online survey ($M = 6.45, SD = 5.38$).
**Demographic Variables and Other Covariates.** The demographic variables and other covariates are collected through self-report. Age is measured as a continuous variable. Due to no respondents self-reporting as transgender, gender non-confirming, or other gender identities, gender was dichotomized to 0 = female, 1 = male. Functional limitation was measured by one item drafted by the authors stating “To what extent does a physical, mental, or emotional condition limit your ability to participate in daily activities?” with response options on a four-point scale from 0 = does not limit participation at all to 4 = significantly limits participation. Due to relatively low numbers of participants with minoritized racial identities, race was dichotomized to 0 = minoritized, 1 = White. Education was dichotomized to 0 = Bachelors degree or less, 1 = Masters or Doctorate. Employment was dichotomized to 0 = not working for pay which includes “retired,” “out of work and looking for work,” “out of work and not looking for work,” and “caregiver or homemaker,” and 1 = working for pay which includes “employed for wages” and “self employed”. Self-rated health was measured on a five-point scale (1 = poor to 5 = excellent) via a one-item mean variable of two separate items: self-rated physical and mental health in the last month. Other volunteer experience in the past five years was measured as 0 = no, 1 = yes.

**Statistical Analysis**

Variables of interest had less than 3.1% missing data; therefore, we used listwise deletion to account for missing data. Analyses were conducted using the Statistical Package for the Social Sciences (SPSS) version 27.0. First, we conducted descriptive statistics and bivariate correlations across all variables.
We applied the statistical approach described by Hayes (2018) by conducting the following set of ordinary least squares (OLS) regressions: 1) the dependent variable (social connectedness) was regressed on the independent variable (volunteer hours per week), 2) the mediators (internalized positive and negative age stereotypes) were regressed on the independent variable (volunteer hours per week), and 3) the dependent variable (social connectedness) was regressed on the mediators (internalized positive and negative age stereotypes). The above three steps were conducted while holding constant all covariates. This approach determines the best fitting model by the least squares criterion by minimizing the $SS_{\text{residual}}$ (Hayes, 2018). This analytic method was selected given the relatively small sample size and cross-sectional design. Other methods, such as structural equation modeling, require longitudinal data, larger datasets, and latent variable models (Hayes et al., 2017; Lacobucci, 2010).

Indirect (mediation) effects were estimated by applying bootstrapping procedures (Hayes, 2018). Standardized indirect effects for 5,000 bootstrapped samples were calculated to test the significance of indirect effects. Confidence intervals were set at the 95% level. This process approximates the sampling distribution of the indirect effects. Prior literature suggests that indirect effects should be interpreted as significant when the 95% confidence interval does not include zero (Shrout & Bolger, 2002).

Results

Sample characteristics and bivariate correlations across all variables are presented in Table 2.1. This cross-sectional sample is comprised of 165 volunteers with an average
age of 68.18 (SD = 9.09) and more female (77%) than male (23%) volunteers. In terms of race, 92.1% of volunteers identify as White, and 7.9% identify with a minoritized group. Half of the volunteers (50.3%) has a Masters or Doctorate degree. Most volunteers (74.5%) are not working for pay. Volunteers did not report that functional limitations significantly impact their daily activities (72.1% of volunteers report that a physical, mental, or emotional condition “does not limit,” 21.2% report that these conditions “slightly limit,” and 4.2% report that these conditions “somewhat limit” their participation in daily activities). The volunteers report “very good” health on average (4.8% report “fair” health, 30.9% report “good” health, 47.3% report “very good” health, and 17% report “excellent” health).

Volunteers’ mean score of 4.30 for social connectedness is closest to an average response option of “often,” indicating that participants report feeling socially connected often. The mean value of 4.85 for internalized positive age stereotypes signifies that volunteers overall identified fairly strongly with the positive age stereotype terms (on a scale from 0-6). The mean score of 1.20 for internalized negative age stereotypes indicates that volunteers overall did not identify strongly with the internalized negative age stereotype terms (on a scale from 0-6). The average number of volunteer hours per week is 6.45 (SD = 5.38).
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<th>Variable (n)</th>
<th>Mean or n (Percent)</th>
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<td>Male (1)</td>
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<td>White (1)</td>
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<td>Bachelors or Less</td>
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<td>Working for Pay</td>
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<tr>
<th>Self-Rated Health</th>
<th>Count</th>
<th>Mean</th>
<th>Standard Deviation</th>
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<th>p Value</th>
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<tr>
<th>Volunteer Experience in Past 5 Years</th>
<th>Count</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>t Value</th>
<th>p Value</th>
</tr>
</thead>
</table>

* p < .05; ** p < .01
Table 2.2 details the results of the regression analyses while holding constant all covariates. After listwise deletion, the number of volunteers was reduced to n = 165. Results are organized with internalized positive age stereotypes as the dependent variable in model 1: F(9, 144) = 10.55, p < .001, $R^2 = .40$, followed by internalized negative age stereotypes as the dependent variable in model 2: F(9, 144) = 2.18, p <= .05, $R^2 = .12$, and social connectedness as the dependent variable in model 3: F(11, 142) = 3.98, p < .001, $R^2 = .24$). Significant direct effects are observed between volunteer hours and internalized positive age stereotypes ($\beta = .02$, p <= .05) and between self-rated health and internalized positive age stereotypes ($\beta = .52$, p < .001). Significant direct effects are observed between self-rated health and internalized negative age stereotypes ($\beta = -.27$, p <= .05). Results indicate significant direct effects between internalized positive age stereotypes and social connectedness ($\beta = .21$, p <= .05), between internalized negative age stereotypes and social connectedness ($\beta = -.16$, p < .001), and between volunteer hours and social connectedness ($\beta = -.02$, p <= .05). Model 1 explains 40% of the variance in internalized positive age stereotypes, model 2 explains 11% of the variance in internalized negative age stereotypes, and model 3 explains 18% of the variance in social connectedness.
Table 2.2

Regression Results Predicting Internalized Positive Age Stereotypes, Internalized Negative Age Stereotypes, And Social Connectedness (n = 165)

<table>
<thead>
<tr>
<th></th>
<th>Model 1: Internalized Positive Age Stereotypes</th>
<th>Model 2: Internalized Negative Age Stereotypes</th>
<th>Model 3: Social Connectedness</th>
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<tr>
<td></td>
<td>B</td>
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<tr>
<td>Internalized Positive Age Stereotypes</td>
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<td>Internalized Negative Age Stereotypes</td>
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<tr>
<td>Volunteer Hours/Week</td>
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<td>*</td>
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<td>Age</td>
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<td>Gender</td>
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<td>Functional Limitation</td>
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<td>Race</td>
<td>.002</td>
<td>.99</td>
<td>.16</td>
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<tr>
<td>Education</td>
<td>.01</td>
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<td>Employment</td>
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<tr>
<td><strong>Self-Rated Health</strong></td>
<td>.52</td>
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<td><strong>Other Volunteer</strong></td>
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<td>.12</td>
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<tr>
<td><strong>Experience in Past 5 Years</strong></td>
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*Statistical significance at the p<.05 level
**Statistical significance at the p<.01 level
***Statistical significance at the p<.001 level


Figure 1 depicts the mediation model. The results indicate that increased internalized positive age stereotypes partially mediate the relationship between volunteer hours per week and increased social connectedness. Internalized negative age stereotypes did not mediate this relationship. Bootstrap estimates and 95% confidence intervals suggest that the indirect effect of internalized positive age stereotypes is statistically significant, $\beta = .04, (.003; .10)$.

Figure 1 A mediation model of the independent variable (volunteer hours per week) on the dependent variable (social connectedness) through the mediators of internalized negative and positive age stereotypes. $a$ represents the direct effect of volunteer hours per week on internalized negative and positive age stereotypes, $b$ represents the direct effect of internalized negative and positive age stereotypes on social connectedness, and $c'$ represents the direct effect of volunteer hours per week on social connectedness, while holding constant relevant co-variates. For $a$ and $b$ direct effects, volunteer hours per week to internalized negative age stereotypes is denoted by $a_1$, volunteer hours per week to internalized positive age stereotypes is denoted by $a_2$, internalized negative age stereotypes to social connectedness is denoted by $b_1$, and internalized positive age stereotypes to social connectedness is denoted by $b_2$. $a_1^* b_1$ represents the indirect effect of the independent variable on the dependent variable through the mediator of internalized negative age stereotypes, and $a_2^* b_2$ represents the indirect effect of the independent variable on the dependent variable through the mediator of internalized positive age stereotypes.
Discussion

This study offers a novel contribution by demonstrating how volunteering may be associated with internalized age stereotypes, which are in turn associated with enhanced social connectedness for adults 50+. To our knowledge, little if any prior research has connected the productive aging literature with internalized ageism or documented how internalized ageism that is positive or negative may differentially help explain the relationship between volunteering and enhanced psychosocial health for older adults. While research has begun to synthesize determinants (Chang et al., 2020) and interventions to reduce ageism (Burnes et al, 2019), few studies have focused on internalized ageism, despite strong evidence that the way ageism is internalized across
the lifespan is directly associated with numerous negative public health outcomes (Levy et al., 2018; Levy et al., 2014a; Levy et al., 2014b; Levy et al., 2012; Levy, 2009; Levy et al., 2002a; Levy et al., 2002b; Levy et al., 2000c). Better understanding whether internalized age stereotypes help explain the relationship between volunteering and social connectedness is particularly valuable given growing concern about epidemic levels of loneliness (Jeste et al., 2020), as well as the prevalence and negative impacts of ageism during the COVID-19 pandemic (Morrow-Howell and Gonzales, 2020). This study offers a preliminary contribution, and we recommend researchers continue to draw associations between volunteerism, ageism, and psychosocial health, given that there is already a robust literature on the benefits of volunteerism on psychosocial health for older adults.

It is important to note, however, that this study’s hypothesis was not validated. We hypothesized that volunteering would decrease both internalized negative and positive age stereotypes, given that both negative and positive age stereotypes have been conceptualized in seminal literature as essential components of ageism (Palmore, 1999). However, this study did not find a significant association between volunteering and internalized negative age stereotypes. Furthermore, we found that volunteering was associated with increased, not decreased, internalized positive age stereotypes. Yet, these internalized positive age stereotypes were associated with increased social connectedness. We posit that internalized positive age stereotypes may function as a form of esteem for aging adults, which may also be associated with enhanced social connectedness. Future research may need to explore measurement and conceptualization to further delineate positive ageism from positive self-perceptions of aging. This may also be a way of
interpreting this study’s results, in that measuring ageism through internalized positive age stereotypes may be more accurately described as self-perceptions of aging.

This finding does, however, make sense when placed in context with some of the literature by Levy and colleagues. Positive age stereotypes are associated with good physical balance among older adults (Levy & Leifheit-Limson, 2009), while neighboring constructs such as positive self-perceptions and views of aging are associated with more positive functional health, increased longevity (Levy et al., 2002a; Levy et al., 2002b) and a reduced risk of dementia (Levy et al., 2018). The present study builds upon this literature by incorporating volunteerism as an independent variable and demonstrating a potential mediating effect of internalized positive age stereotypes between volunteering and health, rather than focusing solely on the relationship between ageism and health.

It is also important to discuss the relevance of the COVID-19 pandemic, which was ongoing during most of the time data were being collected for this study. The University of Michigan poll on healthy aging found that 56% of adults 50+ reported feeling isolated from others in 2020, as compared with 27% of adults 50+ in 2018 (Piette et al., 2020). Furthermore, negative age stereotypes are common and largely unchallenged in the media and mainstream society during the COVID-19 pandemic. For example, the hashtags #boomerremover and #grandmakiller were trending on social media during the pandemic (Morrow-Howell and Gonzales, 2020). As the virus was initially spreading, sentiments were expressed that the threat was not severe because it would primarily affect older people, that medical interventions should target younger generations, and that a targeted lockdown of older adults offered a promising solution to
reopening the economy (Acemoglu et al., 2020; Ault, 2020; Barnes, 2020; Morrow-Howell & Gonzales, 2020). Yet, the reality of older adults’ contribution during the pandemic is that over 30% of Baby Boomers and 25% of the Silent Generation volunteer, with a contribution valued at $73.5 billion (Corporation for National and Community Service, 2018a; Morrow & Gonzales, 2020). In the midst of the pandemic, older adults with extensive experience in medical professions such as social work, nursing, and medicine are applying their skills through volunteerism to combat the pandemic (Morrow-Howell & Gonzales, 2020; Van Buren, 2020). Therefore, it is possible that during the pandemic particularly, volunteering may have boosted identification with positive age stereotype terms for some older adults such as “capable” and “active,” and these positive stereotypes may have been protective for aging adults who were surrounded by so much negative messaging and disregard of older people throughout the COVID-19 crisis. Thus, volunteering may be one activity strongly supporting older adults’ knowledge during the pandemic that they are very much needed in society. At the same time, we acknowledge that negative ageist messaging is nothing new in society and is not likely to go away once the pandemic is more resolved.

The findings from this study can be applied by practitioners working with adults in mid to late life who may be struggling with loneliness or the impact of ageist stereotypes on their well-being. Practitioners can recommend volunteering as one health-promoting activity associated with both increased internalized positive age stereotypes and social connectedness. Clients 50+ years of age may experience negative psychological and emotional impacts related to the epidemic levels of loneliness (Jeste et
al., 2020) and widespread negative age stereotypes heightened during the COVID-19 pandemic (Morrow-Howell and Gonzales, 2020). Practitioners can support clients in processing how negative and positive age stereotypes may impact their well-being differently based on their own unique context and life experience. Practitioners can also educate clients that activities associated with internalized positive age stereotypes, such as volunteering, may also be associated with enhanced social connectedness.

Similarly, the implications of this study for social service organizations suggest that partnering with older volunteers can help promote a healthy workforce based on the association between volunteering, internalized positive age stereotypes, and enhanced social connectedness. Partnering with older volunteers is one way organizations can promote diversity, equity, and inclusion as it relates to age. Organizations can refer to the findings of this study to highlight how developing networks of older volunteers within the workforce can promote increased internalized positive age stereotypes and social connectedness at a time when the harmful impacts of negative ageist stereotypes and loneliness are widespread (Morrow-Howell and Gonzales, 2020; Jeste et al., 2020; WHO, 2020).

**Limitations**

Despite the novelty of this study in connecting volunteerism with internalized ageism and social connectedness, there are a few limitations. First, the cross-sectional design of this study precludes any claims that can be made about causality. The directionality of findings also remains unclear due to the cross-sectional design. For
example, it is possible that higher levels of social connectedness due to existing strong social networks and resources among this more privileged sample may be influencing older adults’ access and ability to participate in volunteerism. In fact, one recent study did find that social connectedness in later life is highly influential toward one’s ability to volunteer (Dury et al., 2020). Future research should apply longitudinal methods and quasi-experimental or experimental designs with a larger sample size, as well as measures that capture time frames with increased specificity to document differences in outcomes for volunteers and a comparison group of non-volunteers. Additionally, the convenience sampling approach in the present study limits generalizability and likely contributed to reaching adults with greater privilege and access to resources, such as technology and internet use, to complete the survey. This likely led to a sample that overrepresents White (92.1%) and highly educated participants (50.3% have a Masters or Doctorate degree). The lack of racial diversity in this sample is a significant limitation, and future research is needed to determine if findings would be similar or different when adults with more racially and educationally diverse identities are represented. While prior research has not found race to be a significant predictor of self-directed/internalized ageism (Marques et al., 2020), further research is needed. One recent qualitative study found that 20 Korean older adults were not satisfied in general with their aging, and this was attributed in part to age discrimination within the socio-cultural context (Choi et al., 2021). More qualitative studies are needed to highlight the perspective and lived experience of internalized ageism among diverse communities.
It is possible that the association of internalized positive age stereotypes with increased social connectedness may only hold up with this more privileged section of the population. We also acknowledge that the sample for this study includes adults who overall report low levels of functional limitation. It is quite possible some of the positive age stereotypes, such as “capable” and “active,” may be more problematic for individuals living with disabilities or greater functional limitations. Future quantitative research should explore whether increased internalized positive age stereotype are associated with increased social connectedness in adults with greater functional limitations. Additionally, it would be useful for future qualitative studies to explore how older adults with significant functional limitations perceive positive age stereotypes. It is possible that internalized positive age stereotypes may not function as a form of esteem with this group but may conflict with their lived experience in terms of how they define positive views of aging and health.

**Conclusion**

Overall, this study highlights a promising area for researchers to explore: whether productive aging pursuits such as volunteering may influence internalized age stereotypes, in turn enhancing social connectedness for older adults. Volunteer opportunities should continue to be encouraged for adults 50+ as a means of boosting positive views of aging, supporting social connectedness, and providing meaningful opportunities as adults transition from mid to later life. While this study focused on social connectedness, future studies may focus on additional psychosocial health outcomes, such as decreased depression, an increased sense of purpose, increased self-esteem, or
improved cognitive health. Future research should continue to think critically about the function of internalized positive age stereotypes, including in which contexts (and for which communities) these may serve as a form of esteem, as well as when internalized positive age stereotypes may be more problematic in their impact on psychosocial health for adults 50+.

However, this study demonstrates how volunteering may be associated with increased internalized positive age stereotypes, which are in turn associated with enhanced social connectedness. This helps elucidate that internalized positive age stereotypes may be an important pathway between volunteering and psychosocial health that future research should further explore.

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Manuscript Three:

A Phenomenological Understanding of the Intersectionality of Ageism and Racism
Among Diverse Older Adults

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Abstract

Background and Objectives

Ageism is a prevalent, insidious social justice issue which has harmful effects on the health of older adults. Preliminary literature explores the intersectionality of ageism with sexism, ableism, and ageism experienced among LGBTQ+ older adults. Yet, the intersectionality of ageism with racism remains largely absent from the literature.

Research Design and Methods

This qualitative study explores the lived experience of the intersectionality of ageism and racism among older adults from a phenomenological perspective. Twenty participants 60+ years of age (M=69) in the U.S. Mountain West identifying as Black, Latino(a), Asian-American/Pacific Islander, Indigenous, or White engaged in a one-hour interview between February and July 2021. A three-cycle coding process applied constant comparison methods. Five coders independently coded interviews, engaging in critical discussion to resolve disagreements. An audit trail, member checking, and peer debriefing enhanced credibility.

Results

Six umbrella themes and 17 sub-themes were identified. The umbrella themes are: 1) racism experienced differently based on age, 2) ageism experienced differently based on race, 3) blurred lines (with all examples at the structural level), 4) comparing/contrasting experiences of ageism and racism, 5) othering or discrimination (including hate and violence), and 6) microaggressions.
Discussion and Implications

The findings indicate how ageism may be racialized through stereotypes such as mental incapability. Practitioners can apply the findings to enhance support for older adults and increase collaboration across anti-ageism and anti-racism initiatives. Future research should focus on racialized ageist microaggressions and the impact of intersectional experiences of ageism and racism on specific health outcomes.

*Keywords:* ageism, racism, racialized, intersectionality, phenomenology
Ageism is a prevalent and insidious threat to the well-being of older adults (World Health Organization, 2021b). A recent systematic review found that ageism is associated with adverse health outcomes in 95% of (422) reviewed studies across 45 countries and 11 health domains, with the prevalence of adverse outcomes increasing over time (Chang et al., 2020). Another study reported that ageism is associated with over 17 million cases of the eight most expensive health conditions in the United States, in addition to a 1-year economic cost of $63 billion (Levy et al., 2020). In terms of cultural and demographic influences, Officer et al. (2020) conducted a study across 57 countries, finding that low levels of respect for older adults and negative attitudes toward aging were universal rather than specific to particular cultures or regions. Ageism has been shown to be present across the demographics of age, sex, and race/ethnicity of both perpetrators and targets of ageism (Chang et al., 2020).

There is a growing call to understand ageism through an intersectional lens (Gonzales et al., 2021), which acknowledges the impacts of power and oppression in addition to the multiple intersecting identities that make up one’s lived experience (Crenshaw, 1991). While preliminary research exists on the intersectionality of ageism with sexism (Krekula et al., 2018), ableism (Jönson & Taghizadeh Larsson, 2019), and ageism experienced among the LGBTQ community (Gewirtz-Meydan et al. 2018), a significant gap exists in literature on the intersectionality of ageism with racism (Torres, 2020). Therefore, we pursued a qualitative, phenomenological study to explore the lived experience of the intersectionality of ageism and racism among diverse older adults.
Background and Objectives

Ageism

The World Health Organization (2021a) recently launched a global campaign against ageism, calling it an “insidious scourge on society” with harmful effects on the health of older adults. Robert Butler (1969) first introduced and compared ageism to other forms of discrimination such as racism and sexism. The term signifies any bias, stereotype, prejudice, or discrimination toward an individual solely based on that person’s age (Nelson, 2002). Ageism may intersect with ableism (Gibbons, 2016), may be implicit (Levy & Banaji, 2002), and may be considered either positive or negative. Negative ageism denigrates aging as less valuable than youth or presumes an association between aging and disease, decline, or disability. Positive ageism, however, occurs when individuals assign qualities of wisdom and respect toward all older adults unrelated to context, which in turn may cause older people to feel pressure to live up to such expectations (Palmore, 1999). Positive ageism may come across to older people as paternalistic or even infantilizing rather than empathic in its message (Chonody, 2016).

Intersectionality

Intersectionality is a term coined by Kimberlé Crenshaw (1989; 1991) to help describe how experiences of discrimination based on race and sex cannot be fully understood through these identities on their own, but rather in the way oppression functions through interactions across multiple identities.
Intersectionality acknowledges that all individuals are complex beings with multiple overlapping identities that comprise our interactions and experiences with issues of privilege and oppression (Hanna et al., 2021).

Intersectionality in general is a gap in ageism-related research. As Krekula (2018, p. 36) stated: “analytic and theoretical work increasingly zoom in on the coexistence of various intersecting forms of oppression…These challenges are yet to be taken up in the discussions regarding ageism.” Despite this, a preliminary literature has begun to develop on the intersectionality of ageism with sexism, ableism, classism, ageism and culture, and ageism experienced among the LGBTQ+ community. While an in-depth summary of existing research on these intersectionalities is beyond the scope of this article, a few examples related to gendered ageism, ageism and sexuality, and ageism and culture will be described next. Following this, an overview of the gaps in understanding the intersectionality of ageism with racism will be outlined.

**Gendered Ageism**

Some of the earliest attempts to understand ageism from an intersectional lens were through the intersection of age and gender. “Gendered ageism” was described in the context of workplace discrimination in the private and public sectors (Itzin & Phillipson, 1995; Krekula et al., 2018). Scholars have argued that the effects of workplace discrimination on recruitment, employment, promotion, and pensions necessarily involve the confluence of age and gender-based discrimination (Krekula et al., 2018). Gendered ageism is seen by many scholars as a “double jeopardy” in which the power of patriarchy
combines with a cultural focus on youth to increase vulnerability for older women (Barrett & Naiman-Sessions, 2016; Krekula et al., 2018). Furthermore, feminist scholars have described how women experience ageism across the lifespan through its intersection with appearance and sexuality-based discrimination in the workplace (Clarke & Griffin, 2008; Granleese & Sayer, 2006; Krekula et al., 2018). Therefore, some scholars use the term “triple jeopardy” due to the mistreatment based on physical appearance that often goes hand-in-hand with ageism toward women (Granleese & Sayer, 2006; Jyrkinen & McKie, 2012; Krekula et al., 2018).

Ageism and Sexuality

Broadly speaking, sexuality in later life continues to be viewed as taboo by mainstream society. Myths that older people are not as sexually desirable, do not want to engage in sex, or even that it is shameful for older people to be sexually active continue to predominate public perception (Gewirtz-Meydan et al., 2018; Gewirtz-Meydan & Ayalon, 2017). More specifically, the LGBTQ+ population experiences a particular invisibility throughout the aging process (Gewirtz-Meydan et al. 2018), leading some older people to hide their sexual identity in later life even after openly sharing this identity in earlier years (Gewirtz-Meydan et al., 2018; Hafford-Letchfield, 2008). It is also likely that the societal and interpersonal sources of stigma experienced by transgender individuals and adults with multiple marginalized identities contributes toward an accumulation of negative physical and mental health outcomes across the lifespan (White Hughto et al., 2015). Furthermore, research has shown how women may fight social invisibility related to ageism by immersing themselves in the world of beauty
products and cosmetic surgery (Clarke & Griffin, 2008; Gewirtz-Meydan et al., 2018).
Heterosexual ideals related to being young, strong, or sexually-dominant also promote
ageism and anti-aging consumerism within society (Gewirtz-Meydan et al., 2018; Hurd
Clarke, 2010; Katz & Marshall, 2003). Additionally, a distinction has been made between
“the third age and the fourth age” (Gewirtz-Meydan et al., 2018, p. 151), where older
people in the third age are expected to buy into the anti-aging consumer culture, but
individuals who reach the fourth (oldest) age are expected to conform to the stereotype of
a disengaged, non-sexual lifestyle (Gewirtz-Meydan et al., 2018; Wada et al., 2015).

**Ageism and Culture**

In terms of cultural and demographic influences, a recent study analyzed data
from across 57 countries, finding that one in two people held moderately or highly ageist
attitudes. Notably, variation was not found related to particular cultures or regions
(Officer et al., 2020). Research has identified a greater prevalence of public health
impacts of ageism in developing countries and for people with low levels of education
(Chang et al., 2020). Ageism has been shown to be present across the demographics of
age, sex, and race/ethnicity of both perpetrators and targets of ageism (Chang et al.,
2020). However, one study found that Hispanic men and women have been shown to
have more positive satisfaction with aging than non-Hispanics (Schoenhammer, 2018).

When looking broadly at the influence of collectivistic and individualistic cultures
on ageism, a recent meta-analysis of 37 articles covering 23 countries and 21,093
participants found, contrary to conventional thinking, that individualistic rather than
collectivistic cultures were associated with more positive attitudes toward aging (North & Fiske, 2015). This meta-analysis found negative attitudes toward aging to be more common in Eastern rather than Western countries. Further nuance highlighted how the rapidly aging populations and rise of industrialization within Eastern countries may be contributing to these outcomes. More specifically, negative attitudes toward aging were commonly found in East Asia as compared with South or Southeast Asia and countries in Europe which are not predominantly English-speaking (North & Fiske, 2015).

**Ageism and Racism**

One notable area which appears to have not received attention in the literature to date is the intersectionality of ageism with racism. Race and ethnicity have primarily been studied as independent variables or covariates in quantitative studies, with non-significant or inconclusive associations between race/ethnicity and ageism-related outcomes (e.g., Marques et al., 2020). Evidence for the minimal scholarship on the intersectionality of ageism with racism is offered in a recent scoping review of 336 studies from 1998 to 2017 across journals specializing in aging or race/ethnicity with titles mentioning the terms “aging/old age” or “ethnicity/race” (Torres, 2020, p. 337). This study found that only 10.4% of included articles referred to racism and/or racial discrimination, while “alluding to racism/racial discrimination in passing” (p. 340) and “suggesting that racism/racial discrimination play a role” (p. 341) were much more common than “leaving no doubt that racism/racial discrimination plays a role” (p. 342).
**Racialization.** We acknowledge that an exploration of the intersectionality of ageism with racism may bring up examples of how ageism is racialized. Therefore, it is important to define the term “racialization,” which involves the social construction of race whereby a dominant racial group creates a dominant racial narrative to meet the needs of that dominant group (Hanna et al., 2021). A clear example of racialization is enslavement, which was initially justified through the narrative that Africans’ souls could be saved through conversion to Christianity (Hanna et al., 2021; Tisby, 2019). Yet, after a generation of enslaved people had been converted and it was illegal for Christians to enslave other Christians, Africans were racialized as less than human in order to justify chattel slavery (Hanna et al., 2021). Another example of racialization is how the Latinx community, and in particular Mexicans, are racialized through explicitly pejorative terms, fueling racist stereotypes and xenophobia (Armenta, 2016; Hanna et al., 2021). To our knowledge, the concept of racialization has not yet been applied to ageism-related research.

It is critical for gerontological practitioners and scholars to understand the ways that intersecting experiences of oppression based on ageism and racism may impact the lived experience of diverse older adults. Given the paucity of research on this topic, the present study aims to explore the follow research question from a phenomenological perspective: “What is the lived experience of the intersectionality of ageism and racism among diverse older adults?”
Research Design and Methods

This is a qualitative, phenomenological study (Creswell, 1998) with the aim of exploring the intersectionality of ageism and racism among diverse older adults. This study was approved by the IRB at the university (IRB approval #1715548-8), and all participants provided their consent to participate in a 60-minute, audio recorded interview prior to being interviewed. Participants were also informed they may be contacted in the future to discuss findings of the study with their permission. The inclusion criteria are adults 60+ years of age residing in the U.S. Mountain West who identify as Black, Hispanic/Latino(a), Asian-American/Pacific Islander, Indigenous, or White. Given that racism is a focal topic explored in the interviews, the number of White participants was limited to five. We used purposive sampling to recruit participants via email recruitment scripts, one-page flyers, and social media posts with organizations serving older adults. Existing community relationships were prioritized to ensure a trusting and reciprocal relationship has been established. The first author (who identifies as White) also consulted with two colleagues who are members of Indigenous communities in drafting a letter to tribal council members in the U.S. Mountain West.

Morse (1994) recommends a sample size of at least six participants for phenomenological research. Twenty participants were included in the present study. Table 3.1 details demographic information about the participants, including pseudonyms, age, self-identified gender, race, ethnicity, education, and employment background. The mean age of participants is 69 (range: 60-94). There are 12 female participants, seven male participants, and one gender fluid participant. The sample is highly educated, with 6...
participants having a high school or some college education, 8 participants holding a Bachelors degree, 2 Masters, and 4 participants with a PhD or JD. There is a relative balance in terms of employment status, with 13 participants currently retired and 7 working at the time of the interview. Seven participants identify as Black or African American, four as Hispanic or Latino(a) (including one participant with both Hispanic and Indigenous heritage), three participants as Asian-American or Pacific Islander (including Japanese, Filipino, and Chinese older adults), one participant is a Cherokee tribal member who identifies as both American Indian and White, and five participants identify as White or Anglo (with one White participant having Jewish ethnicity).

Given the sensitive nature of the interview topics including racism and ageism, all participants were given the option to interview with a member of the research team based on affinity with racial identity and age cohort, if preferred. Nineteen participants opted to interview with the first author, while one participant chose to interview with an interviewer based on affinity with racial identity. Participants were given the option to interview by Zoom or phone. Nineteen interviews were conducted online via Zoom and one interview occurred by phone. No interviews occurred in person given public health guidelines during the COVID-19 pandemic. Interviews occurred between February and July 2021. Interviews were semi-structured and one-hour in length. Participants were asked to use a pseudonym throughout the interview as one approach to help ensure confidentiality. Pseudonyms were self-selected by participants or by the interviewer if the participant expressed no preference. Demographics were gathered at the beginning of the interview, followed by open-ended questions about the participants’ family background,
cultural and social experiences. They were asked open-ended questions about experiences of ageism and racism, followed by an exploration of when these experiences may have occurred in the same situation (or when it was difficult for a participant to tell the difference between ageism or racism). Finally, participants were asked about ways of coping with and finding support in response to experiences of ageism and racism. Findings related to coping and support are beyond the scope of the present study. Questions remained broad and open-ended to access the lived experience of participants and allow significant space for rapport between the interviewer and participant (Padgett, 2017). A full list of interview questions is provided in the Appendix. Examples of interview questions include:

- *Have you ever felt you were treated differently by others because of your age/race/ethnicity? Is there a specific example of a time you felt that way you could share with me?*

- *How has ageism/racism impacted your life?*

- *How has your experience of racism changed over the course of your life?*

- *Have you ever felt that you were treated differently by others because of both your age and racial/ethnic background at the same time (or it was difficult to tell the difference)? Is there a specific example of a time you felt that way you could share with me?*

All interviews were audio recorded and transcribed to ensure accuracy in data collection. Based on the phenomenological approach, the interviews and analysis focused on the meaning, significant statements, and “essence” of the participants’ experience of
the intersectionality of ageism and racism (Padgett, 2017). Each transcript was read multiple times by the first author, and analytic memos were written throughout the coding and analytic process. Interview transcriptions were coded in Atlas.ti by a team of five coders who identify as Black, Latinx, Asian-American, and White; therefore, diverse identities and perspectives informed the coding and analytic process. Modified constant comparison methods were applied (Boeije, 2002; Lincoln & Guba, 1985) in which the coding team individually coded transcripts, followed by critical team discussion to resolve coding disagreements. Constant comparison methods include the following steps: 1) coding of individual transcripts, 2) comparing codes across transcripts to develop categories, 3) analyzing if and how categories may be connected, and 4) creating new categories, combining categories, or deleting categories (Boeije, 2002; Lincoln & Guba, 1985).

**Step 1: Coding Individual Transcripts**

Given the lack of theory or prior research on the intersectionality of ageism with racism, the coding process was inductive. Four coders independently coded the first two interviews by applying in-vivo (Seale, 1999) and open coding methods (Saldaña, 2015). Applying in-vivo coding based on direct quotes from participants can help increase the trustworthiness of findings (Seale, 1999). After independent scrutiny of the first two interviews by four coders, the coding team engaged in critical discussion to resolve coding disagreements and discuss the team coding process. This process was then repeated with two more interviews. After the first four interviews were coded, the four coders engaged in critical discussion about the coding process thus far, including
decision-making related to examples of what should be coded or not. The coding team resolved disagreements and came to a consensus regarding the code labels to be used. Through this critical discussion, the team created a codebook which includes a full list of codes, code definitions, and exemplar quotes. The codebook contains six demographic codes and fifteen codes related to the interview content such as a values code, five ageism codes, five racism codes, and an intersectionality code.

For first cycle coding, four coders applied the codebook by double-coding an additional eight interviews. In this double coding, two researchers independently coded two interviews at a time, meeting as pairs afterward for critical discussion to resolve coding disagreements. After these eight interviews were double coded, the four coders reconvened to discuss any questions or issues that had arisen throughout the coding process. For example, a question arose whether a new code should be added when racism was described in other countries as compared with the U.S. It was decided that a new code was not necessary, given that racism in other countries had only arisen once and this phenomenon did not specifically help answer our research question in a unique way. The reader may refer to the audit trail in the Appendix for a full description of decisions made by the team throughout the coding process.

After this double coding process of eight interviews, the first author collaborated with a fifth coder to return to the first four interviews, this time applying the agreed-upon codebook to code these first four interviews. The first author and fifth coder independently coded the first four interviews, followed by critical discussion to resolve coding disagreements.
Following this, the first author independently coded the final eight interviews, incorporating feedback from the coding team throughout the coding process based on prior collaborative work.

**Step 2: Comparing Codes Across Transcripts to Develop Categories (“Umbrella Themes”)**

For second cycle coding, the first and second authors convened in person. Given that the research question of the present study can best be addressed through understanding the intersectionality of ageism and racism, the first author printed out all the “intersectionality” codes (other codes may be applied as the focus of separate research projects). The intersectionality code is defined in the codebook as “any example of the intersection of ageism and racism in a participant’s experience.” The first and second authors independently sorted the intersectionality codes in separate rooms through an inductive process of grouping codes together based on commonalities. In this way, we allowed the data to speak for itself rather than imposing our thoughts about potential themes onto the data. After this independent coding process, the first and second authors met to discuss their coding process, resolve coding disagreements, and reach consensus upon low-level inference categories (Seale, 1999). These low-level inference categories constitute the six “umbrella themes” of the study’s findings.
Step 3: Analyzing Umbrella Themes to Identify Unique Sub-Themes

For third cycle coding, the first author applied the same inductive coding process to sort all the quotations within each umbrella theme based on commonality, identifying 17 unique sub-themes.

Step 4: Co-Analysis to Redefine and/or Simplify Themes

The first author then consulted with the second author and two senior scholar co-authors to gather additional feedback for the purpose of redefining and/or simplifying the umbrella and sub-themes. For example, one umbrella theme was originally labeled “experiences of being avoided or categorized.” However, the second author suggested that this theme should include the word “discrimination” due to examples of hate and violence in the sub-themes. Therefore, the label for this umbrella theme was changed to “othering or discrimination.” Additionally, under the umbrella theme “microaggressions,” there were originally two separate sub-themes titled “questioning of intelligence or ability” and “reaction of surprise,” but through analysis it was determined that these sub-themes could be simplified into one sub-theme, titled: “questioning or a reaction of surprise at intelligence/ability.” Finally, there were originally twenty sub-themes, but three sub-themes were omitted after identifying that these themes had a representative quote from only one participant.

Peer Debriefing and Member Checking

A table of the umbrella and sub-themes was shared with two senior scholars with extensive experience in qualitative, gerontological research for the purpose of peer
Peer debriefing can help minimize potential bias by challenging the interpretation of the data, coding process, and findings (Given, 2008). Feedback from peer debriefing was incorporated by updating sub-themes related to physical appearance and more clearly articulating the difference between intersectionality and racialization. In addition, the table of the themes and a striking quote from one of the research participants (“To me, ageism is based on pity, racism is based on hate”) were shared with all study participants to elicit their feedback as a form of member checking (Teddlie & Tashakkori, 2009). Seven participants shared varying perspectives and new insights through the member checking process either by phone or email, and this information was incorporated into the data. In addition to peer debriefing, this member checking process helped enhance the credibility of findings (Teddlie & Tashakkori, 2009). Throughout the process, the first author created and maintained an audit trail of all steps in the coding and analytic process such that another researcher would be able to validate the findings (Rodgers & Cowles, 1993).

Results

The six umbrella themes and 17 sub-themes are outlined next, along with exemplary quotes. Participants are identified with their pseudonym, age, self-identified gender, and self-identified race and/or ethnicity.
Racism Experienced Differently Based on Age

This umbrella theme includes examples where participants primarily share about an experience of racism, but also reflect about how age or ageism intersects with and may influence the experience of racism in different ways.

Compounding Oppression

This sub-theme refers to the accumulation of disadvantage or the multiplying impacts of oppression across the life course. For example, Ladybugg, a 69 year-old Black woman, described: “I can definitely say that the things that have happened to me that I remember were worse or, I should say, more noticeable as I got older.” Additionally, Bubba, a 64 year-old Black man, shared an example of ageism adding to experiences of racism within workplace discrimination: “Age hasn’t really reared its head until I’ll call it maybe four years ago…So that one job lasted maybe three months before I got bounced out, but I could tell they didn’t like the experience from an older Black guy.”

Disrespect

This sub-theme refers to quotes where participants describe being treated with less respect as they age. For example, Sylvia, a 64 year-old Hispanic woman, added another layer when describing experiences of racism in saying that “it’s pretty tough…They see that you’re on the older age and sometimes that can be a sign of respect, but when they have that type of mentality, nothing is…They feel like they can attack you anyway.” Conversely, there was one example from David, a 66 year-old African
American man, of experiencing less perceived stereotype threat in later life in terms of interactions with the police:

I just think they see an older guy, and they like, ‘Oh. God, he’s not a threat. He’s an old Black man,’ whereas before, if I was perceived as younger or if I was younger, there was a whole different attitude.

**Increased Resilience/Wisdom**

This sub-theme refers to quotes describing how older age has brought more wisdom, resilience, resolve, or indignation in knowing how to respond to unfair treatment. For example, James, a 69 year-old man who originally identified as Black but later emphasized not wanting to be labeled, described:

When I was younger, it was anger and frustration, and humiliation, which brought forth a lot of stress…living longer you become wise and aware of what’s always been there. You get to see the things…that were always there that were both positive and negative…That’s what age brings you.

**Ageism Experienced Differently Based on Race**

This umbrella theme includes examples where participants primarily share about an experience of ageism, but reflection also includes how race or racism may intersect with and influence the experience of ageism in different ways.
Cultural Differences and Physical Appearance

This sub-theme refers to quotes where participants describe how there may be more respect for elders in their own culture than the dominant White American culture, as well as individual reflections about how some racial groups may not appear to age as much or as quickly as other groups. For example, Devyn, a 66 year-old gender fluid Filipino, stated:

As far as ageism, I feel more respected within my extended family. I don’t get that at all from the White community…I get surprised by the fact that there is no respect for the elderly, whereas there is within my own culture.

Additionally, Rhonda, a 65 year-old Black woman, denied experiences of ageism, explaining:

I thought about that and then I thought, well, Black people have a lot of melanin in their skin and because of that, their collagen and the components that hold the skin together, for some reason, is stronger and so for that, we don’t age as fast…I don’t feel like I’m discriminated because of age, because I don’t think a lot people knew how old, or even now today know, how old I am. Most people are shocked when I tell them I’m 65.
**Intersection of Disparities**

This sub-theme refers to quotes describing how multiple disparities (including medical and financial disparities) may be the result of the intersection of racism and ageism. For example, Rhonda, a 65 year-old Black woman, described: “One thing that comes to mind is finances when it comes to age and it comes to race. I would like to have a lot of savings in, but I don’t think there’s a lot of Black families that do.”

**White Privilege**

This sub-theme refers to quotes where participants acknowledge their White privilege in relation to ageism and/or racism. For example, Katie, a 72 year-old White woman, stated:

My experience…is a miniscule amount of what somebody of color experiences…people in my age group, they suddenly become a group, which is what people of color have always been, right? If you’re a White person, you’re an individual. You’re not seen as a group at all. You’re seen as an individual until you hit a certain age… People of color have always had that experience. They’re part of a group.

**Blurred Lines**

This umbrella theme includes examples where distinguishing between ageism and racism may not seem clear.
**Structural Intersections of Ageism and Racism**

Interestingly, all the examples identified where participants described that it was difficult to discern the difference between ageism and racism appeared to be at the structural level. Examples include when applying for jobs/doctoral programs, discrimination in the workplace, technology-related stereotyping, discrimination in healthcare settings, disparities in receiving public benefits, profiling based on race and age, and being followed in public places (e.g., when shopping). Specifically, Lilly, a 63 year-old African American woman, shared:

> Going to the doctor’s office…and they make an assumption and decide, ‘Oh, well, you don’t need that particular treatment plan,’ it’s like, ‘Are you saying that because I’m older or are you saying that because of my race?’

Black Eagle, a 63 year-old Black woman, described her experience in an interview for a doctoral program:

> The person in charge of the program…pretty much told me that I was wasting my time because they were going to take all their resources and invest it in younger students. She just made me feel like I was old and decrepit and didn’t have anything to contribute at all…That one, I struggled with that being racialized or ageism. And ageism was there, that’s pretty prominent, but I also wondered about all those other components.

**Comparing/Contrasting Experiences of Ageism and Racism**

This umbrella theme includes examples of participants reflecting about the perceived differences or similarities between ageism and racism.
**Similarities: Being “Placed in a Box” or Tokenized**

This sub-theme refers to examples where participants describe the similarities between ageism and racism in terms of being categorized, othered, or tokenized in some way. For example, David, a 66 year-old African American man, described:

I thought in a lot of cases…I was just kind of the Black guy in the group…because White people wanted to feel they were progressive… Instead of being the only Black guy, I’m still the only Black guy in most cases, but now I’m the only Black old person in some of my communities.

Devyn, a 66 year-old gender fluid Filipino, described how people are often surprised by their physical and mental ability, saying: “I get placed into a box, whether it’s negative or positive. And then they’re surprised by what they hear and what they see.” James, a 69 year-old man who originally identified as Black but later emphasized not wanting to be labeled, described experiences of ageism in the following way:

They’ll use a white brush to say you fit in this category or that category, and you always have to make yourself clear in what you’re asking or they’re going to paint you with a white brush…just how they want to see you.

**Physical Appearance**

This sub-theme refers to quotes where participants describe similarities and differences in terms of how discrimination based on physical appearance occurs in both ageism and racism. For example, Bubba, a 64 year-old Black man, stated that “The
similarities [between ageism and racism] are using appearance to put someone in the position of the other,” while Devyn, a 66 year-old gender fluid Filipino, stated: “I think that for a lot of us who our skin color, makes us stand out…you feel like an outsider.” Some participants described a difference between ageism and racism in that participants cannot hide the color of their skin, but it may be possible to take efforts to try to look younger such as wearing makeup or dying one’s hair. For example, Estu, a 64 year-old Latina woman, stated “you can do a makeover, you can color your hair and all that, but you can’t change the color of your skin.”

**Racism and Ageism: Overt or Covert?**

This sub-theme refers to examples of racism and ageism being more clear/overt or hard to distinguish/covert. For example, Black Eagle, a 63 year-old Black woman, shared that “With ageism, it’s in and out. Racism is constant and that’s consistent. I live with that all the time on a daily basis…It’s hard to tell if it’s ageism. It’s easy to tell if it’s racism.” David, a 66 year-old African American man, used the words “overt” and “covert” when describing his experiences of racism and ageism over time:

I think that pretty much up until I could probably say my 40s maybe, I’ve had some overt racism experiences. The covert are too many to number even to this day, and I'm not sure now the difference between that and how ageism mixed with that, and it tends to shape towards more ageism, I think, in my latter years than the racism. At least the racism isn't as overt, it might be more covert. The ageism is a little more overt, but not extremely overt, I would say.
When describing ageism specifically, David described:

The aspect of ageism is just a little different and I don't know if I know a true example of what that looks like because I'm in it. Kind of hard to see yourself swimming when you're in the pool. I think I'm experiencing it. It's a part of my life now, but I don't know if I can give you specific examples.

“Ageism…is Something all of us Experience. Racism…is our Differences, Right?”

This sub-theme refers to quotes describing how ageism is a universal experience given that all people age throughout life, whereas racism exists because some groups have used their power to oppress and discriminate against other groups based on perceived differences. Participants shared additional nuance; for example, Maggie, a 64 year-old Chinese woman, stated: “Ageism is, of course, overboard, right? Whether you are Chinese, Caucasian, or Black…It really has nothing to do with where you’re coming from. It’s just something that all of us experience…Racism, of course, is our differences, right?” Similarly, David, a 66 year-old Black man, stated: “Ageism is an equal opportunity offender...People can be racist toward you even in ageism, and that’s the difference.” Lorena, a 61 year-old Hispanic woman, shared a somewhat different perspective:
You’re born with one, and you get used to one, and ageism, all of a sudden, it hits you. You haven’t had a chance to get used to it. With racism, you lived with it…When you get older, you can’t fight it. But racism…sometimes I think if you’re treated badly because of that, you can say something. But if you’re older, you’re just getting older.

Othering or Discrimination

This umbrella theme includes participants’ experiences of being categorized, avoided, tokenized, or otherwise “othered” due to ageism and racism.

Ignoring or Discriminating Against Others Perceived as Different Due to Discomfort

This sub-theme refers to quotes where participants describe being ignored or discriminated against because other people feel uncomfortable due to perceived differences. As James, a 69 year-old man who originally identified as Black but later emphasized not wanting to be labeled, said: “People put you in a category because they want to feel comfortable with you.” Lorena, a 61 year-old Hispanic woman, agreed that ignoring others can be a similarity between ageism and racism because:

If you look at the way people dress, and the way they speak, if it’s not something you’re used to, it makes you uncomfortable…They don’t know the life that person has lived. And because it’s different, they don’t talk to them.

Black Eagle, a 63 year-old Black woman, expounded upon others’ discomfort as a factor in discrimination during interviews for jobs and PhD programs:
The thing that I’ve noticed, especially in some of the interviews that I’ve had in different positions; I feel like I create a threat. I cause discomfort and I create a threat because I see myself as I don’t fit the stereotypes of my level of intelligence.

**Hate and Violence**

This sub-theme refers to participants explicitly stating that the intersection of racism and ageism involves hate or contempt or where participants share examples of being the target of violence. Lilly, a 63 year-old African American woman, shared: “To me, ageism is based on pity. Racism is based on hate.” When sharing this quote with all participants through the member checking process, Black Eagle, a 63 year-old Black woman, stated: “I need to add the word “contempt” when looking at the intersection of ageism/racism. Racialized ageism is not based on pity; it is based on contempt and hate.” During the full interview, Black Eagle also described an encounter of hate/violence with a customer at her workplace, where the customer “puts his hands on my shoulder and grips my shoulders…telling me what I will and will not do.” Black Eagle emphasized this was an example of racialized ageism because the customer treated her, an older Black woman, with this violence, while a White co-worker half her age was standing right next to her and did not receive the same treatment.

**Unspoken Bias**

This sub-theme refers to examples where verbal communication may not be present, but the participant describes a palpable sense of being watched/followed or
suspects that others may be talking in a denigrative way about them behind their backs.

Lilly, a 63 year-old African American woman, described the following experience:

When I go shopping…I’ve experienced being followed around. And I’m looking, and I’m like, ‘Really? Why are you following me around?’ So I can’t tell anymore. When I was younger and it happened, obviously I knew it was racism. But now, I don’t know if they’re following me around because they think I’m going to need help because of age or if they just think I’m going to be stealing something because of racism and age.

Devyn, a 66 year-old gender fluid Filipino, also shared:

I’ve very aware that they’re looking at me, that I’m different. So I feel that you get the hackles going up on the back of your neck, where just be ready for anything. So I feel my body becoming tense…just being ready for any kind of confrontation.

**Language Barriers**

This sub-theme refers to when older people are treated differently because of a language barrier. For example, Lorena, a 61 year-old Hispanic woman, shared: “I’ve seen a lot of the older people. They barely make it because their English is broken. People don’t help them as much.”
Microaggressions

This umbrella theme includes examples of participants experiencing intentional or unintentional comments or actions expressing a prejudicial attitude which have a derogatory and harmful effect.

Questioning or a Reaction of Surprise at Intelligence/Ability

This sub-theme refers to examples where participants describe that another person questions their intelligence/ability or seems surprised to learn about the amount of knowledge, skills, or experience the older adult has. For example, Black Eagle, a 63 year-old Black woman, described how a customer at work was very surprised by her use of vocabulary: “He was just so stunned and astonished at how much I knew…And I was using different jargon…and he was just flabbergasted…he was just so stunned that I could talk like that.” Black Eagle shared not only how this was a form of ageism, but how racism may be at play due to racist stereotypes of Black people as physically strong but lacking intelligence.

Slurs

This sub-theme refers to harmful, denigrating, hateful verbal comments made related to age and/or race. Although the exact language need not be repeated here, the examples often involved racist tropes and stereotypes meant to discriminate or convey hatred, as well as ageist stereotypes intended to mock one’s competence or to infantilize older people.
Discussion and Implications

To our knowledge, this is the first study to explore the intersectionality of ageism with racism from the perspective and lived experience of diverse older adults. The findings speak to varied and nuanced perspectives from the lived experience of racially diverse older adults with implications for scholars and practitioners. “Compounding oppression” and “intersection of disparities” align with the theory of cumulative advantage/disadvantage, which posits that advantages or disadvantages may widen and accumulate across the life course (Melo et al., 2019). In the present study, participants described how racism was often clearly to blame for experiences of discrimination or oppression earlier in life, while ageism adds another layer of oppression in later life that may not always be clear or easy to recognize. This is indicated by representative quotes from the themes of both “compounding oppression” and “blurred lines.” Additionally, “racism and ageism: overt or covert?” highlights how racism may seem easier to distinguish for some older adults due to its constant influence, while in other cases ageism may be described as increasingly “overt” in later life. Additionally, some participants described feeling an increasing sense of disrespect in general as they age, including examples of how this disrespect may intersect with experiences of racism. While varied experiences were described by participants in this study, the findings overall describe how ageism adds an insidious layer of oppression on top of existing experiences of racism in later life.
One prevalent description of the intersectionality of ageism with racism in this study involved examples of older adults feeling categorized, ignored, othered, or tokenized in some way due to others’ discomfort. Some older adults reflected more generally about how people may be more uncomfortable being around others perceived as different. Other examples were more visceral, such as when Black Eagle shared: “I feel like I create a threat. I cause discomfort and I create a threat because I see myself as I don’t fit the stereotypes of my level of intelligence.” This example highlights an example of how ageism may be racialized through stereotypes that can be used based both on age and/or race, depending on the circumstance. For example, stereotypes based on mental capacity have been documented as ageist when older adults are devalued and viewed as “ineffective, unproductive, and dependent due to age-related reduced physical and mental capacity” (Jönson & Taghizadeh Larsson, 2019, p. 2). In regard to racism, as one prevalent racist stereotype depicts Black people as physically strong yet mentally incapable (Collins, 2000). Therefore, stereotype threat theory is one conceptual framework that could be applied in future scholarship on racialized ageism (Steele & Aronson, 1995). Black Eagle also described her experience of being ignored at work when a customer walked right past her to seek assistance from a younger, White co-worker, but exhibited violence and hate during interactions with her, an older, Black woman. Only very recently has the case been made to classify instances of ageism as a hate crime (Goosey, 2021). We contend that much further work is needed to explore the impact of and response to hate crimes from an intersectional lens, particularly as it relates to the intersectionality of ageism with racism.
The fact that all the examples under the theme “blurred lines” described the intersectionality of ageism with racism at a structural level is striking. Examples from throughout the interviews highlight the insidious and unclear experience of ageism, such as when David stated “I don't know if I know a true example of what that [ageism] looks like because I'm in it. Kind of hard to see yourself swimming when you're in the pool.”

However, the “blurred lines” theme may also demonstrate how the intersectionality of ageism with racism is particularly insidious at the structural level. Some of the structural settings described in this study match prior literature on ageism, such as discrimination in the workplace (e.g., Naegele et al., 2018), technology-rated stereotyping (e.g., Ivan & Cutler, 2021), and discrimination in healthcare settings (São José et al., 2017). Yet, other settings/experiences brought up by older adults in this study such as profiling and being followed in public places like shopping centers may demonstrate one way that ageism is racialized. For example, prior research depicts anti-Black bias in retail settings by describing Black shoppers’ experiences navigating racial hierarchies and being (racially) perceived as shoplifters (Pittman, 2020). This mirrors the experience of Lilly in the present study, who shared how she is sometimes followed around while shopping, and it is difficult for her to discern whether these experiences are due to ageism (i.e., someone trying to help her due to her age/paternalistic ageism) or racism (i.e., someone assuming she is trying to steal something due to racism). While racial profiling during interactions with the police has received considerable attention in both scholarship (e.g., Legewie, 2016) and mainstream media (e.g., Balko, 2020), limited attention has been given to racial profiling among older adults. David, a 66 year-old Black man in the present study,
described his perception that police may view him as less of a threat than when he was younger. However, experiences of racial profiling among older Black men should be explored more fully as the primary focus of future studies.

Although ableism was not the focus of the present study, the themes related to physical appearance may point toward the intersectionality of both ageism and racism with ableism. Ageism and ableism often intersect because ageism often manifests through physical or disability-related stereotypes such as frailty, dependence, or mental incapacity (Gibbons, 2016). Future research should explore how both ageism and ableism may be racialized in older adults’ lived experience. The themes related to physical appearance may also indicate one way older adults try to rationalize or cope with intersectional experiences of ageism and racism. There were many examples in the interviews of older adults minimizing or denying experiences of ageism. However, when older adults in this study described how the color of their skin does not age (or appear to age) as quickly as older adults with a different skin color, this may indicate a coping response related to the intersectionality of ageism with racism that future research should explore further.

The theme of “microaggressions” opens up a critical and largely underexplored topic. While some scholarship addresses the impact of ageist language (e.g., Nussbaum et al., 2005), Gendron et al. (2016) conducted a search across three databases (JSTOR, Ebscohost, and PsycInfo), findings 302 articles based on the keyword “microaggression,” with only one of these articles related to age. To our knowledge, literature on ageist microaggressions remains very sparse. The present study helps builds the knowledge base not only related to ageist microaggressions but adds an intersectional lens in better
understanding how ageist microaggressions may be racialized. For example, similar to previous examples, the “questioning intelligence/ability” theme may reflect both ageist and racist stereotypes of mental incapability that could be wielded to cause harm based on either age, race, or as a means of racializing ageist microaggressions, depending on the case. Future studies should explore the impact of ageist microaggressions within specific settings such as the workplace, healthcare settings, classroom settings, families, social media environments, and more. The negative impact of microaggressions on psychosocial well-being is well documented, as research indicates an association between microaggressions and traumatic stress symptoms such as depression (Torres & Taknint, 2015), anxiety, anger, confusion, hopelessness, paranoia, and fear (Williams, 2020). While this study helps build our knowledge of the experience of racialized ageist microaggressions, much further research is needed to examine additional intersectionalities (e.g., sexism, classism, microaggressions toward LGBTQ older adults, etc.), as well as the specific health impacts of racialized ageist microaggressions.

It is important to discuss that there were examples in the present study of cultural respect for elders serving as a supportive buffer for experiences of ageism within the White, dominant community. However, this does not align with prior quantitative research, which has found ageism to be a universal phenomenon with higher prevalence in more collectivistic cultures (Chang et al., 2020; North & Fiske, 2015). It is possible that the qualitative interviews in this study may have facilitated an environment where participants felt comfortable openly sharing about cultural strengths, as each interview began with open-ended questions about the participants’ family, culture, and values.
Further qualitative work is needed to explore how respect for elders in collectivistic cultures may serve as a support for experiences of both ageism and racism. Scholars will need to further investigate if seemingly opposing findings continue to manifest in quantitative as compared with qualitative studies.

Despite the strengths of this study, there are a few limitations which are important to discuss. First, while the sample was racially diverse overall, there were a low number of Indigenous elders. Future research should explore intersectional experiences of ageism and racism specifically among Indigenous elders, which may provide opportunity to further explore how cultural respect for elders may serve as a buffer for intersectional experiences of racism and ageism. Additionally, the participants in this study were highly educated. Therefore, the intersectional experiences of ageism and racism described in this study may not reflect the experiences of older adults with lower levels of education or lower socioeconomic status. In terms of age, while two participants were in their 90’s, the remainder were in their 60’s or early 70’s. Scholarship indicates that age discrimination is perceived differently at different ages in later life (i.e., early midlife, late midlife, young old, oldest old) (Giasson et al., 2017). Therefore, future research should explore intersectional experiences of ageism and racism specifically among adults in their 80’s, 90’s, and 100’s. Finally, while this study focuses on the intersectionality of ageism with racism, some participants expressed how their experiences could not be disentangled from sexism. Thus, while we report findings within the scope of our research question, the lived experience of older adults involved in this study is certainly much more nuanced and multi-faceted than the present study is positioned to articulate.
In conclusion, this study presents rich, nuanced perspectives on the intersectionality of ageism with racism from the lived experience of diverse older adults. The themes from this study can be applied by gerontological scholars and practitioners to advance initiatives which are both intentionally anti-ageist and anti-racist (Gonzales et al., 2021). Given the “blurred lines” between ageism and racism expressed by many participants in this study, anti-ageism/anti-racism initiatives should focus on providing education with clear examples of ageism and racism, particularly at the structural level. The findings from this study can also be applied toward interventions to reduce ageism and racism experienced among older adults from an intersectional lens. For example, future researchers can incorporate stereotype threat theory (Steele & Aronson, 1995) through interventions aimed at intentionally reducing racialized ageist stereotypes such as mental incapability. Ultimately, policy solutions will be needed to address issues such as racial profiling and hate crimes targeting older adults of color. Future research should more fully explore the experience of racialized ageist microaggressions, as well as the impact of intersectional experiences of ageism and racism upon specific health outcomes.
References


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Table 3.1

Sample Characteristics (n=20)

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<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Gender</th>
<th>Self-Identified Race and Ethnicity (if different)</th>
<th>Education</th>
<th>Employment</th>
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<td>Jacob</td>
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<td>PhD</td>
<td>Retired professor</td>
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<td>Bachelors</td>
<td>Social worker</td>
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Appendix

Table 3.2

Interview Questions

1. Have you ever felt that you were treated differently by others because of your age? Is there a specific example of a time you felt that way you could share with me?
   • Possible probe: How has ageism impacted your life?
   Note: Define ageism for participants. Ageism has been defined as any bias, stereotype, prejudice, or discrimination toward an individual solely based on that person’s age (Nelson, 2002).
2. Are there any examples you would like to share about how your race, ethnicity, or culture has influenced your life?
   Note: Encourage participants to define race, ethnicity, and culture based on their own perspective and experience.
   • Possible probe: Have you ever felt that you were treated differently by others because of your racial or ethnic background? Is there a specific example of a time you felt that way you could share with me?
   • Possible probe: How has racism impacted your life?
3. Have you ever felt that you were treated differently by others because of both your age and racial/ethnic background at the same time (or it was difficult to tell the difference)? Is there a specific example of a time that you felt that way you could share with me?
   • Possible alternative question for White participants: In your experience, can you think of any examples of how your race or ethnicity may have influenced your experience of aging?
4. How does your experience of ageism look similar or different from your experience of racism?
5. How has your experience of racism changed over the course of your life?
6. In what settings have you most encountered ageism and racism?
7. Is there anything you feel is particularly misunderstood about ageism and/or racism in larger society?
8. How have you responded to ageism and racism in your life? Are there ways you have found to cope or find support for the impacts of ageism and racism?
9. What solutions do you recommend for ageism and racism and how these issues intersect to impact people’s lives?
### Table 3.3

**Codebook**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Exemplar Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demographic/Personal Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Age</td>
<td>Demographic identifier of age</td>
<td>“64”</td>
</tr>
<tr>
<td>1.2 Self-Identified Gender</td>
<td>Demographic identifier of gender</td>
<td>“Female”</td>
</tr>
<tr>
<td>1.3 Self-Identified Race</td>
<td>Demographic identifier of race</td>
<td>“African-American”</td>
</tr>
<tr>
<td>1.4 Self-Identified Ethnicity</td>
<td>Demographic identifier of ethnicity</td>
<td>“Hispanic”</td>
</tr>
<tr>
<td>1.5 Education Background</td>
<td>Self-described background of educational experiences</td>
<td>“I have a Bachelors degree”</td>
</tr>
<tr>
<td>1.6 Employment Background</td>
<td>Self-identified employment experience</td>
<td>“I've worked in human services, human resources, criminal justice, public health and now I'm in healthcare.”</td>
</tr>
<tr>
<td>2. Values</td>
<td>Any description of values which may connect to the lived experience of the intersectionality of ageism and racism (may be personal, family, cultural, community, or any other relevant values)</td>
<td>“It was expected that I go to college, and that I get myself educated. There was never a question about it. So that was always very important. In fact, my grandpa, they had one son and I think four daughters, and all of them had degrees. They all went to college and they all had degrees. That was something that the family was very proud of.” (Interview 13)</td>
</tr>
</tbody>
</table>
3. Ageism

Ageism has been defined as any bias, stereotype, prejudice, or discrimination toward an individual solely based on that person’s age (Nelson, 2002). May include examples in the U.S. and outside of the U.S.

3.1 Ageism: Self

When a participant shares about their own experience with ageism (may include minimizing or denying experience with ageism)

“I have a colleague who, whenever we go for walks, she's constantly telling me to look out for curb cuts or the sidewalk and I'm like, “I can see that just as well as you can,” and I walk just fine... She wants to hold my elbow. I'm like, really? I'm healthier than you are. I don't need it.” (Interview 18)

“In my last workplace, before the one I'm in right now, I was having difficulty learning how to use a certain computer program, and setting up PowerPoint on my own without help. It just was a little confusing for me, but, oh my gosh, you'd have thought that I was the dumbest person in the world. Now, I worked on that job for 16 years. I couldn't have been that stupid. And I had a number of accomplishments while doing so.” (Interview 18)
3.2 Ageism: Others

When a participant shares about other people’s experiences related to ageism (how they perceive others’ experiences)

“Interviewer: Are there particular settings where you feel that ageism or racism are most encountered?
Participant: Out in the public more, like at the grocery store. Everybody has to go to the grocery store. Then the little old lady doesn't know how to do the stupid machine. What is it called? The self checkout. Yet none of the aisles are open for her. So you have got to suck it up and help them. God, it makes you feel so good. People don't realize that it's not just the lady who's blocking the aisle. She needs help, and doesn't hurt to help. But I think that's a perfect example of where you see that. They don't know how to do this technology stuff. I already know my computer's going to stop. So I have to wait. But they don't. They don't understand. They have their little debit cards or whatever, but they don't know how to use them. That's a perfect example of where that happens.”
(Interview 12)
3.3 Ageism: Intergenerational Relationships

Any description of how intergenerational relationships, connections, encounters, or potential intergenerational differences impact the experience of ageism

“My son is 25 right now, and when he said, "Oh, you guys, you old people, you like to be together. I don't want to join you guys. You're old," and all this, like what? You know? And I don't think he really feels like he offended us, that he was saying anything mean to us. He's just, I guess, being honest, and I never thought about that, right?” (Interview 12)

3.4 Internalized Ageism

When a participant may (unconsciously) reflect the social norms that devalue or marginalize older people

“Interviewer: So as you have progressed through your career and now retired, have you ever felt that you've been treated differently based on your age? Participant: No, because I act like I'm 14.” (Interview 13)

“I don't want to be treated as aging, you know? Like I'm aging, I'm an old person. I don't like to be treated like that... I mean, it's just inevitable that people get old, but I just don't like that idea. So at this point, I'm resisting it” (Interview 12)

3.5 Structural Ageism

Any reference to policies, practices, or procedures of societal institutions that

“I've seen my mom and her husband, like the insurance. Because they got older, their insurance
discriminate against older people went up, even if they had no accidents. So that's always bothered me a little bit. Because they're going through that now, and they're both retired. Instead of being rewarded for being good drivers, they've sort of been, I don't know. It hasn't been as great for them.” (Interview 13)

4. Influence of Race on Aging

This code is intended for participants who identify as White. Given that the research team does not feel that White people experience racism, this code exists to label examples when White older adults describe any way that their race may have influenced their experience of aging.

“I don't want anyone to ever think that I think that my experience is simpler to someone of color, because it isn't. It is a micro... I mean, it is a minuscule amount of what somebody of color experience. I think it's on [inaudible 00:47:48] It's on a spectrum. And so it's on the very beginnings of just like... of people my age that suddenly we are not [inaudible 00:48:16]. So people in my age group, they suddenly become a group, which is what people of color have always been. Right? If you're a white person, you're an individual. You're not seen as a group at all. You're seen as an individual until you hit a certain age. [inaudible 00:48:42] We've never [inaudible 00:48:43] we don't have that experience.

Participant:
People of color have always had that experience. They're part of a group. They are a group of people [inaudible 00:49:02] and so people have a... After a certain age, and I'm not sure what that age is, and I'm not sure how young people identify us as a certain age, but we become a certain age and we become part of a group that is generally not liked and is seen as we have certain characteristics all of a sudden. I'm not sure what those characteristics are, but they're not very likable. It's just amazing to me. It is so funny to me to become a part of this group, because I've never been seen that way before. I've always been an individual people [inaudible 00:49:59] I've never been seen as part of any group.” (Interview 10)

5. Racism

Racism has been defined as: “1) A belief that race is a fundamental determinant of human traits and capacities and that racial differences produce an inherent superiority of a particular race, 2) a: The systemic oppression of a racial group to the social, political, and economic advantage of
another (may include examples in the U.S. and outside the U.S.), b: a political or social system founded on racism and designed to execute its principles.” (Merriam-Webster, n. d.) See https://www.merriam-webster.com/dictionary/racism.

May include examples in the U.S. and outside of the U.S.

5.1 Racism: Self
When a participant shares about their own experience with racism (may also include minimizing or denying experience with racism)

“I think I was one of only two black girls that were a part of the group. And we were walking on the campus to go to one of the classes and a girl behind me, white girl, said to me, "Oh, I love your tan." But she was with a group of her friends. They walk past, she looks back at me and she snickers. Because she knew darn well I didn't have a tan.” (Interview 18)

5.2 Racism: Others
When a participant shares about other people’s experiences related to racism (how they perceive others’ experiences)

“My parents, they grew up in the south, so they seen a lot more of open racism” (Interview 1)

5.3 Racism: Intergenerational Relationships
Any description of how intergenerational relationships, connections, encounters, or potential intergenerational differences impact the experience of racism

“I was the only black in a lot of things that I associated with. And again, and my thought is I've really not been in a culture where I wasn't the only black person or one of few black people, and that's a total different situation where, for
instance, my son is planning on moving to Atlanta, and he's very excited about the aspect of being in an area in Atlanta. The pseudonym for Atlanta is Chocolate City, at least that's what we called it back in the day, because of the high concentration of black people that live there. So to move to Chocolate City is a big thing. He's just glad it's not just... Here, it's Green Valley Ranch and Montbello, and maybe Five Points, which Five Points is becoming more gentrified, but I digress again. His point was that there weren't just small sectors of black community there, there were volumes of communities that were black, and then it got into a point of social economic rather than black people just being whatever. There's certain areas of Atlanta you may not want to go to because it's a little less economically, and then there's the high-class black people living in Marietta, and those other areas, suburbs, and so forth. So he's excited, and I'm excited for him to have that exposure. I never
experienced that. And so with regard to that, it caused, for me, to be a certain way and to act a certain way, and I thought about it again, and thinking about today it's like, "If I was placed into an all black environment today, how would I fare with that? How would I live with that? How would I adjust to that?"

<table>
<thead>
<tr>
<th>5.4 Internalized Racism</th>
<th>When a participant may (unconsciously) devalue/reflect bias or oppression toward themselves or their own racial group</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.5 Structural Racism</td>
<td>Any reference to the cumulative and compounding effects of an array of societal factors, including the history, culture, ideology and interactions of institutions and policies that systematically privilege white people and disadvantage people of color.</td>
</tr>
</tbody>
</table>

“I think we're held back, which is our own fault for being quiet and staying away from the limelight.” (Interview 14)

“We were moving from [name of midwestern US city] to [name of western US state], we went by train. And we of course had to be in a specific area of the train. Black people weren't allowed to just sit wherever you want. As children, we wouldn't have understood that.” (Interview 18)

“But as a kid, I just rolled with it. It was a part of assimilation. Assimilation is a big part. Most black people, probably anywhere, but I'll just say in America, because that's where I live is America, and

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assimilation and fitting in and making people feel comfortable and being edged upon that. It's an interesting thing”

(Interview 19)

“I belong to an accountability group and I'm the only black on the group. We all started together and we stuck together and we talk about our finances and our businesses. She was telling me how she could just go and get a credit card against her business. I could never do that. I tried, but it isn't that I don't have the credit. I have a house, I have ... And the thing about it is, she did it without using her personal finances. They wanted to attach it to my house. No, I'm not doing that. I don't want a credit card for my house. I want it for my business, and so I did not get a credit card, but she did. She had no collateral at all. I don't know why. Yeah. That kind of stuff. When we were talking ... We actually had a whole meeting on racism, which is kind of cool that I could talk, that they were able to talk to me about it. She explained what she did to get her
credit card. I did the same thing. She has no more ability. Her credit's no better than mine, but she got the card. I didn't. I don't know. Do people take the time to look that up? To go online, to see what you look like, to see whether they're going to ... I don't know. It just baffles me, but I never tried anymore. I just said that I'd rather not have a debt anyway, and I just let it go” (Interview 1)

6. Intersectionality
Any example of the intersection of ageism and racism in a participant’s experience

“When I go shopping, which I don't do often anymore because I can do it online, so I don't have to go into a store, but the very few times that I will go into the store, I've experienced being followed around. Now, mind you, they know nothing about it. It's not as if I'm dressed in a certain way. It doesn't matter how I'm dressed. But they'll follow me around in the store. And I'm looking and I'm like, really? Why are you following me around? So I can't tell anymore. When I was younger and it happened, obviously I knew it was racism. But now, I don't know if they're following me around because they
think I'm going to need help because of age or if they just think I'm going to be stealing something because of racism and age. I remain the same kind of indignant, especially if they bother me. But I just don't know.” (Interview 18, line 166)

“With ageism, it's in and out, racism is constant and that's consistent. I live with that all the time on a daily basis.”

“I try not to let things like that bother me. It's not worth it. It's too insignificant in my life, that I will not let it make my life miserable, or think that it's so important that I have to really kind of think about it, make my life miserable. It's absolutely not worth it.” (Interview 12)

“Every now and then I'll get somebody who will treat me as an old person. And I think, for me, it's not so much that I feel negative towards it, but then I start to feel well, I'm going to have to prove that I'm better than a 66-year-old or your typical 66 year-old.”

7. Coping

Ways that the individual attempts to manage/deal with the impacts of ageism or racism
### 8. Support

Examples of the individual reaching out to others to deal with the impacts of ageism or racism

“Definitely my husband and I will talk. We share our experiences and he's had many, because he's darker complected, very dark. So we lean in on each other. We'll share with our siblings and friends. But typically each other and our siblings, we'll talk about it. Sometimes I'll talk to friends about it because they've experienced it. Yeah, that's the only thing you can do.”

(Interview 18)

### 9. In-Vivo Interesting Quotes

“To me ageism is based on pity. Racism is based on hate.” (Interview 18, line 176)

### 10. Miscellaneous

Any example that seems to be relevant to the research question, but the researcher is unsure which code it would be most appropriate.

“Education. Education, I mean, even if they don't want to learn another language that's fine but just have an open mind. It's largely like the LGB group or any other groups or seniors or whoever. Everything falls in the same category. Learn and get... Learn from all these different groups so we can be more open and more productive as individuals, as a country, because this is a great country and I have done here what I could never achieve in my country. And we come here, ready
to work like crazy. For many years, I cannot tell you, [name], years and years that I never had a day off. I work the seven days, three jobs, and going to school as a single mom and I did not ask for any public benefits. I just made sure that I pay my rent and I will even go to food banks if I needed food but we're willing to put the work. Because at the end of the day, we live good. We live better than in our countries. So for us, we're not afraid to work which is…” (Participant 4, line 103)
Table 3.4

Audit Trail

Step 1: Prepare transcripts
  • Remove any names or other identifying information

Step 2: Develop coding process as a team for first four interviews

Part A
  • All team members code interviews 13 and 18 (use in vivo and open coding).
  • Meet as full team for how the coding process went, discuss team approach to coding, comparison of codes, and critical discussion of these first 2 interviews by date TBD.
  • First author will combine coding work into one Atlas.ti file in follow up.

Part B
  • All team members code interviews 3 and 12 (use in vivo and open coding).
  • Meet as full team for comparison of codes and critical discussion of these two interviews by date TBD.
    o First author conduct initial member checking/peer debriefing
    o First author combine coding work into one Atlas.ti file in follow up.
    o There may be some initial codes to work with at this point, but this will continue to be updated throughout the process.

Step 3: First coding cycle: Double code eight interviews
  • Use in vivo and open coding methods
  • First and second authors double code 2 interviews (19 and 14); third and fourth authors double code 2 interviews (20 and 11). Second and fourth authors double code 2 interviews (15 and 4). First and third authors double code 2 interviews (5 and 17). Meet as pairs for in-depth comparison of codes and critical discussion. Date TBD.
  • Discuss agreement before and after discussion. Resolve any disagreement and reach a consensus.
  • Meet as full team for in-depth comparison of codes and critical discussion of these eight additional interviews.
  • First author conduct initial member checking.
  • First author update team Atlas.ti file.
Step 4: Group codes/develop tentative codebook

- Discuss tentative codes and develop tentative codebook as a team (first, second, third, and fourth authors).
- Draft codebook, staying open to the possibility of adding new codes throughout the process and returning to prior transcripts to see if these codes were present before new codes were added.

Notes from meeting on 12/14/2021 (After initial four interviews coded and team double coded eight interviews)

Question—When other intersectionalities are discussed (e.g. ageism and sexism), should we code “intersectionality”?
- It was agreed that no, we would not. We would only code the ageism aspects of this, since sexism is not a focus of this project.

Question—Should we code when people talk about racism or ageism in other countries?
- The team agreed that yes, we should code this, but we should update the code definitions for ageism and racism to specify that this may include experiences within and outside the U.S.

Question—Should we add a “family background” code in addition to the “values” code?
- The team was unsure, especially as many of the “values” codes refer to family values/background in particular. After consultation with faculty mentor, it was decided to keep a broad “values” code rather than also adding a “family background” code.

Question—Is there any confusion about the difference between coping and support? Should we combine these codes?
- It was decided that coping and support are distinct constructs, and we should keep these as separate codes. The team conceptualizes coping as more of an individual action, but support as reaching out to others.

Question—Is the intersectionality code redundant since intersectionality may be captured in the separate ageism and racism codes as is?
- The team discussed how our process has looked similar, as everyone was coding both specific codes for “ageism” and “racism” as well as sections where both ageism and racism seem to be present as “intersectionality.” We agreed that this process was working and is a good process to continue.

Question—When participants minimized or denied experiences of ageism or racism, should we still code this as ageism: self or racism: self?
- The team agreed that yes, we should code minimizing/denial as ageism: self or racism: self and to ensure the definitions for these codes
specify that these include both that participants experience these issues but also examples of when they minimized or denied experiencing these issues.

Question- Should we have a code specifying experiences of racism in other countries (since this may look different)?

- The team agreed that we should update the codebook definition to indicate that both ageism and racism could include examples from within the U.S. and outside the U.S.

Step 5: Code remaining interviews

- First and fifth authors go back to code first four transcripts (13, 18, 3, 12) now that there is an agreed-upon codebook.
- Meet for comparison of codes and critical discussion for additional transcripts.
- Discuss disagreement, reach consensus.
- First author codes remaining eight interviews (1, 2, 6, 7, 8, 9, 10, 16), applying decisions reached through prior team consensus.

Notes from meeting on 2/5/22 with first and fifth authors

The first and fifth authors met to code the first four interviews (3, 12, 13, 18) that were initially coded tentatively when developing our codebook. The fifth author brought some great perspectives on the codes. For example:

1. There is a code for “Ageism: Intergenerational Relationships,” but there are examples in the transcripts where participants reference intergenerational relationships but not necessarily ageism. We were unsure if these should be coded. For now, since the focus of this project is the experience of “the intersectionality of ageism and racism,” the first author suggested not coding these if it seems ageism is not part of what has been shared. However, it is possible that these sections could fall under the “values” code, which the team had already decided would be applied in some cases and in other cases not; only if the values relate to the research question of “What is the lived experience of the intersectionality of ageism and racism?”

2. Another perspective the fifth author shared relates to the coping code. The fifth author highlighted some examples the first author had missed where participants were helping others and this seemed to be a way that they were coping with ageism or racism.

3. Related to the “Internalized Racism” or “Internalized Ageism” codes, the fifth author shared the perspective of coding examples where a participant appears to share about an experience related to racism or ageism that troubles them, yet they cannot exactly define why it is racism or ageism. The fifth author argued that this could be an example of internalized racism or ageism. An example was for Participant 3, [40:13]: “At [university
in U.S. Mountain West], there was only one guy that I was very suspicious about. He had deserted during the Second World War from the Russian Army and joined the German Army. And he was a professor of library science. He objected to the things I did. He did not like the fact that I seemed to favor women, from his point of view. And, oh, I did things like get a faculty course evaluation [inaudible 00:41:19] created one. A fellow named [name 00:41:23] at Michigan was the dean of research for the area.” The fifth author’s note is that: “This person perceived his encountering with this guy as racism though this guy didn’t do anything that can be identified as racism.”

Step 6: Update original codebook (step 4)
- Create new code groups and definitions for the code groups
  - A new code of “influence of race on aging” was added primarily for White participants.

Step 7: Second coding cycle
- The first author prints out all “intersectionality codes” and cuts into paper scripts, placing in large, secure-seal manila envelope.
- The first and second authors meet in person, sorting the “intersectionality” codes in separate rooms (on separate tables) through an inductive process of grouping based on commonalities.
- First and second authors engage in critical discussion to reach consensus on umbrella themes.

Step 8: Third coding cycle
- The first author sorts the individual quotations under each umbrella code to identify (tentative) sub-themes.
- The first author consults with the second author and two faculty mentors regarding the sub-themes. Critical feedback is incorporated to adapt the sub-themes.

Notes from meeting on 2/14/2022

The first and second authors met in person to sort the “intersectionality” codes into umbrella themes and engaged in critical reflection/discussion of disagreements to reach consensus on these umbrella themes. The “intersectionality” codes were the focus since the research question is “What is the lived experience of the intersectionality of ageism and racism among diverse older adults?” The first author consulted with two senior faculty mentors, gaining confirmation that other future projects can focus on other codes related to coping/support, intergenerational relationships, or the intersectionality of internalized ageism & racism. After critical discussion, the first and second authors agreed upon the following umbrella themes:

1) Racism experienced differently based on age,
2) Ageism or aging experienced differently based on race,
3) Blurred lines (where participants described both ageism and racism, but it was hard to distinguish the difference or the “line” between them),
4) Comparing/contrasting experiences of ageism and racism,
5) Othering or discrimination,
6) Microaggressions (intentional or unintentional comments or actions expressing a prejudiced attitude with a derogatory, harmful effect)

Step 9: Member checking/peer debriefing
- The first author shared a table of both the umbrella and sub-themes with two senior scholars with extensive experience in qualitative, gerontological research through a process of peer debriefing.
- For member checking, an in-vivo interesting quote (“Ageism is based on pity, racism is based on hate”) and the table of umbrella and sub-themes is shared with all participants. Seven participants engaged in member checking by email or phone.
- Feedback is incorporated through both peer debriefing and member checking to adapt the themes and manuscript as needed.

Step 10: Write manuscript
Conclusion

These three manuscripts enhance our understanding of and response to ageism in methodologically and substantively distinct ways. The conceptual model in the first manuscript offers a road map for gerontological practitioners and scholars to conceptualize and test activities and interventions which may reduce internalized ageism and enhance psychosocial health for older adults. This manuscript also addresses the need for future research and practice to focus on how macro-level policies may influence internalized ageism and psychosocial well-being. There has long been an emphasis in the field of gerontology on individual-level pursuits toward healthy outcomes in aging. The theories of successful and productive aging, which emphasize individual lifestyle activities such as exercise, diet, and volunteering, reflect this individualism and may contribute toward potential biases in this conceptual model. Yet, the conclusion of the first manuscript connects our efforts to reduce internalized ageism with efforts to reduce other social justice issues, such as racism. Epidemiologist Camara Phyllis Jones (2000) emphasized that if institutional racism if addressed first, impacts on interpersonal and internalized racism would follow. Therefore, this dissertation argues that gerontological scholars and practitioners should shift away from the focus on individual-level approaches to healthy aging, and focus on structural-level policies,
such as amendments to the Age Discrimination in Employment Act or age friendly workplace policies, in order to reduce internalized ageism and enhance psychosocial well-being for aging adults.

The second manuscript applies the conceptual model by testing the real-world application of volunteering as one activity at a meso-level which may reduce internalized ageism and enhance psychosocial health for adults 50+. This study is based in a community-engaged partnership between the dissertator and a community non-profit that was ongoing for three years. Older volunteers were instrumental in drafting and adapting survey questions, as well as responding to evaluation results through an iterative process of feedback that sought to center the experiences of adults 50+ years of age engaged in community volunteerism. The ongoing impacts of the COVID-19 pandemic at the time of data collection, which include potentially increased social isolation and negative ageist messaging, are relevant to the study design and interpretation of findings. These factors informed the selection of the dependent variable of social connectedness as a positive outcome, as opposed to social isolation, in order to promote positive contributions and outcomes among older adults during the pandemic. Additionally, the finding that volunteering is associated with increased internalized positive age stereotypes was unexpected, yet offers additional insights about how positive age stereotypes may function as a form of esteem for some older adults. Future researchers should continue to grapple with how ageism was originally conceptualized as having both negative and positive components (Palmore, 1999), yet internalized positive age stereotypes may lead to more positive psychosocial health outcomes.
Also critical for reflecting upon and interpreting the findings from Manuscript 2 is acknowledging the privilege of the sample. The fact that 92% of the sample was White and over half the sample has a Masters or Doctorate degree must be taken into account. In addition, it is possible that internalized positive age stereotypes (e.g., terms such as “capable” and “active”) may not function as a form of esteem, but rather may be problematic for older adults living with disabilities or functional limitations. Future research should explore informal volunteering among communities which are more racially, educationally, and economically diverse.

The third manuscript intentionally recruited a racially diverse sample of older adults and explores the lived experience of the intersectionality of ageism with racism. The fact that, to our knowledge, the intersectionality of ageism with racism has yet to be taken up in scholarship or highlighted in mainstream discourse may point toward the insidious effect of White supremacy culture (Okun, 2021). For social work scholars and practitioners alike, it is critical to take a critical eye to social justice issues by asking “Who, and what intersectionalities, have been left out of the conversation?” This qualitative project, then, attempts to center the lived experience of diverse older adults by exploring intersecting experiences of ageism and racism through an open-ended and inductive approach.
In the qualitative findings, themes of compounding oppression and intersecting disparities align with the theory of cumulative advantage/disadvantage, suggesting that advantages or disadvantages may widen and accumulate across the life course (Melo et al., 2019). Therefore, future scholarship should intentionally focus on the intersectionality of ageism with racism while incorporating the theories of cumulative advantage/disadvantage and the life course perspective (Hutchison, 2005). Some of the examples shared by participants also relate to acts of hate or violence. Therefore, strategies that are known to be effective in combatting hate crimes and violence should be applied in order to respond to intersectional hate and violence based on both ageism and racism. These may include advocacy from civil rights groups, hate crime laws, public awareness campaigns, and intergroup contact programs (Cramer, 2020). It appears that one of the ways ageism may be racialized is via stereotypes which may function as ageist and/or racist such as mental incapability. Intergroup contact hypothesis (Allport, 1954; Pettigrew & Tropp, 2006) could be applied in future scholarship and practice to combat racialized ageist stereotypes, as this has been demonstrated to successfully reduce ageist stereotypes, as well as ethnocentrism, sexism, and racism (Burnes et al., 2019; Pettigrew & Tropp, 2006; Gonzales et al., 2021). The findings of the qualitative manuscript also demonstrate how intersectional ageist and racist stereotypes can be manifest through racialized ageist microaggressions. Ageist microaggressions have received very little attention in scholarship to date (Gendron et al., 2016), and future research focused on exploring the phenomenon and impacts of racialized ageist microaggressions is warranted.
The fact that all the examples shared under the “blurred lines” theme were structural may also point toward the insidious effects of both ageism and racism at a structural level. Future scholarship and community-engaged practice should focus on interventions at the structural level which are intentionally anti-ageist and anti-racist. This also aligns with the recommendation from Manuscript 1, which emphasized the need to focus on anti-ageism policies in reducing internalized ageism and enhancing psychosocial health for older adults. Therefore, the primary recommendation from this dissertation as a whole is for gerontological scholars and practitioners to focus on macro, structural-level policies and practices to combat internalized and racialized ageism to support the well-being of older adults. Social workers are uniquely fit to respond to these needs given the profession’s focus on social justice and systems-level change (National Association of Social Workers, 2017; Schirmer & Michailakis, 2019). In order to do this, advocates of anti-racism and anti-ageism initiatives will need to collaborate in their efforts. Public awareness campaigns need to include education about both ageism and racism in the same messaging. Policies such as the Age Discrimination in Employment Act and age-friendly workplace policies should also intentionally integrate anti-racist approaches such as unconscious bias training and resources for Black and Indigenous employees and their families. Community-engaged scholarship should explore “informal” volunteering and other healthy individual or community-level activities in low-income, predominately Black and Brown communities so that understanding of healthy aging is not limited to primarily privileged, White and highly educated older adults.
While this dissertation explores present gaps in our understanding of and response to ageism, it also opens doors to many needs and opportunities that lie ahead.


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World Health Organization. (2021, March 18). *Ageism is a global challenge: UN.*

Ageism is a global challenge: UN (who.int)