2010

Ageism and psychological well-being in older adults

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AGEISM AND PSYCHOLOGICAL WELL-BEING IN OLDER ADULTS

A Dissertation

Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment of the
requirements for the degree of
Doctor of Philosophy

in

The Department of Psychology

by
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August 2010

DEDICATION

I would like to dedicate my dissertation research to my late uncle, Jerry Young. Jerry lived a life that inspired everyone who came in contact with him. This was never more apparent than when an entire town came together to celebrate his life. A headline in the local paper summed it up best by saying, “Jerry Young loved life and lived it to the fullest.” He was so many things to so many people, and he is constantly missed by everyone who knew him. To me, he was a loving uncle who constantly challenged me and helped me to become the person I am today.

Jerry had the ability to be completely easygoing and challenging all at the same time. His easygoing nature put everyone at ease and made every conversation fun and enjoyable. Those conversations were always full of challenging questions, and it was these questions that helped me learn to think critically about whatever I was working on. I don’t think I fully appreciated how valuable and wonderful those conversations were until he was gone, and I miss them so much. I am thankful to have had the time with him that I did, and I am especially grateful for all that he taught me about how to think and, more importantly, about how to live.

Jerry loved to give me a hard time about trying to break the family record for the longest amount of time spent in school. Even though I broke his record with years to spare, I know that no one would be prouder of me for accomplishing all of my goals than Uncle Jerry.

ACKNOWLEDGEMENTS

I would like to thank a number of people for their support throughout the process of conducting my dissertation research as well as throughout my graduation education. First and foremost, I would like to thank my parents, Jane and Kevin Denver, and my brother, Jon Kevin Denver. My parents and my brother have been a constant source of love and support throughout my life, and that love and support has been particularly steadfast and unconditional during my time in graduate school. To my parents and brother, thank you for enduring all of the highs and lows, for never giving up on me, and for never allowing me to give up on accomplishing my goals. To my other family members, Faith, Cathy, Steve, Jay, the Kyzer family, and so many others, thank you for your support and for making our family so special and wonderful and fun. To my friends, thank you for being tireless cheerleaders. Annie, Jenn, Anna, Lar, Jeremy, Emily, Doug, and so many others—thank you for having confidence in me when I had trouble having it in myself. Jeremy, thank you for providing daily support this last year as well as for providing a lot of tough love; your love and encouragement helped me to not only survive the past year, but to also become a stronger person both mentally and emotionally. To all of my family and friends, thank you for being the most important part of my life.

I must also acknowledge Dr. Katie Cherry without whom my graduate education at LSU and this dissertation research would not have been possible. Dr. Cherry, thank you for welcoming me into your lab and for sticking with me throughout the last five years. I have learned so much from you about the field of psychology and aging, and I am so grateful for all of the time and energy you have invested in my education and training. I would also like to thank my dissertation committee members, Dr. Lilly Allen, Dr. Sean Lane, Dr. Kevin Grobman, and Dr. Frances Lawrence. Drs. Allen, Lane, Grobman, and Lawrence, thank you for all of your help

and guidance throughout the challenges of my general exams and the dissertation process. Thanks, too, to Traci Lilley, Elizabeth Routon, and Denise Chaisson of the LSU School of Social Work for making it possible to complete the Master of Social Work program concurrently with my doctoral research. Additionally, I would like to thank Betsy Wilks and Kathy Vilas, my social work internship supervisors, for providing excellent clinical training and supervision in flexible and caring settings. Last but not least, I would like to thank my friend and colleague, Emily Boudreaux, for her help with everything from acclimating to a new city to maintaining sanity throughout graduate school. Em, I am quite sure I would not have made it through the program without your support, your willingness to listen, or your wicked sense of humor.

I would also like to thank all of the participants who made this research study possible. Thank you to Marilyn Munday and the Rhea Richland Senior Neighbors group of Dayton, Tennessee, Dr. Gwen Moore and the residents of St. James Place Continuing Care Retirement Community in Baton Rouge, Louisiana, Sandy Harrison and the residents of Alexian Grove Retirement Community in Chattanooga, Tennessee, the members of the LSU Lagniappe Studies Unlimited program in Baton Rouge, Louisiana, and to all of the other older adult acquaintances who participated in the present research study. These participants made the study what it is in so many ways, and I truly enjoyed meeting with them throughout the data collection process. Additionally, I must thank Kelli Broome, Claire Leerkes, and Kayla Holland who worked as research assistants throughout the data collection and data entry process—they are incredibly hard-working and conscientious people, and I am very grateful to have had their help.

To my family, friends, colleagues, advisor, committee members, supervisors, and research assistants, thank you for all of your help along the way. I am so very grateful for all of your support these last five years.

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ABSTRACT

Despite being faced with difficulties, such as declining physical health and negative stereotypes, older adults are often able to maintain a positive sense of well-being in the face of such challenges (Mroczek & Kolarz, 1998). This finding is known as the *paradox of well-being.* The present study examined this phenomenon as it relates to the experience of ageism, reactions to aging as interpreted through identity process theory, and psychological well-being. The study is an exploratory examination of these factors in a sample of 137 community-dwelling older adults. It was hypothesized that 1) a greater experience of ageism would be associated with declines in psychological well-being, 2) at least one identity processing style would be associated with declines in psychological well-being, and 3) participants' experience of ageism and favored identity processing style would be associated with different outcomes for psychological well-being. Results indicated that the majority of participants reported fairly low experiences of ageism. Ageism scores were not related to any of the dimensions of psychological well-being. As predicted, participants' use of the identity balance processing style was positively related with all dimensions of well-being, while use of the identity accommodation processing style was negatively related with all of the dimensions. It was not possible to examine the interaction between the experience of ageism and identity processing styles because of the low experience of ageism within the present sample. These results contribute to the relatively small body of research on identity process theory and represent one of the first attempts to examine the relationships among ageism, identity process theory, and psychological well-being.

CHAPTER ONE: INTRODUCTION

As the Baby Boom generation enters older adulthood, the world's population of older adults is expected to increase rapidly. According to U.S. census data in 2008, older adults 65 years and older made up approximately 12% of the population in the United States. By 2030, the percentage of people 65 and older is expected to account for 20% of the population (Kinsella & He, 2009). Further, people are living longer than ever, and adults 80 years and older (the oldest-old) are the fastest growing segment of the population. With people living longer, the quality of life in a person's later years will be a prominent issue for well-being (Kinsella & He, 2009).

Negative stereotypes about aging along with actual or perceived age-related health declines have contributed to the overall negative view of older adulthood. Given this bleak picture of the aging process, it may seem that overall declines in well-being would be inevitable. However, considerable research suggests that in many cases well-being is maintained or even improved with age (e.g., Carstensen, 1995; Rowe & Kahn, 1997; Whitbourne & Sneed, 2002). This potentially counterintuitive finding has been called the *paradox of well-being* and refers to "the presence of subjective well-being in the face of objective difficulties or other sociodemographic or contextual risk factors that intuitively should predict unhappiness" (Mroczek & Kolarz, 1998, p. 1333).

Researchers have offered a number of theories as a means of explaining the paradox of well-being (e.g., Brandstadter & Graeve, 1994; Carstensen, 1992; Kite & Smith Wagner, 2002). These theories generally focus on one of two paths; one approach views the older adult as having a sense of control over his or her environment, while the other approach views the older adult as being self-oriented (Sneed & Whitbourne, 2005). Identity process theory, which typifies a self-oriented approach, attempts to explain the paradox of well-being based on processes that older

adults engage in when they encounter age-related physical or social changes (Whitbourne & Sneed, 2002). According to Whitbourne and Sneed (2002), older adults play an active part in shaping their own experience, which allows them to maintain a positive sense of self across time. Identity process theory targets the approaches older adults may use to protect their sense of self in the face of objective difficulties such as the negative views associated with aging (Whitbourne & Sneed, 2002).

As the Baby Boom generation approaches older adulthood, fears about the possible social problems associated with their large numbers and increasing life expectancy have propagated a negative view of aging and older adults (Longino, 2005). However, negativity toward older adults is not a concept unique to the boomer generation. In 1969, Butler coined the term *ageism* to describe these attitudes and behaviors, which has been defined as any form of stereotype, prejudice, or discrimination based on a person's or group's perceived chronological age (Butler, 1969; Levy & Banaji, 2002). The majority of older adults express that they have been on the receiving end of ageist behaviors (Palmore, 2001). Furthermore, older adults are also subject to the development of "self-stereotypes" in which their previous negative attitudes about aging are directed at themselves (Levy, 2001).

Although most older adults have experienced ageism and may even continue to endorse negative age stereotypes themselves, theories of successful aging suggest that well-being does not decline in older adulthood in the face of such difficulties (Mroczek & Kolarz, 1998). Researchers have examined the impact that negative attitudes toward aging have on a number of health-related issues, but minimal attention has been given to how the experience of ageism relates to psychological well-being specifically. The present study utilizes a cross-sectional design and takes an exploratory approach to the study of ageism and psychological well-being.

The current study presents an examination of the relationships among the experience of ageism, the approaches older adults take in an attempt to maintain six specific components of psychological well-being. In the sections that follow, the concepts of psychological well-being, reactions to aging, and ageism will be discussed in turn.

PSYCHOLOGICAL WELL-BEING

Psychological versus Subjective Well-Being

Psychological well-being, sometimes referred to as subjective well-being, has been defined in a number of ways. Well-being can be viewed in terms of the quantity or quality of the components that people think make up "the good life," or it can be viewed in terms of how people evaluate their lives (Diener, 2000, p. 34). Subjective well-being falls primarily under the latter view and refers to the fact that people are able to determine whether or not they have achieved the good life based on their own criteria for success. It has been suggested that there are multiple components that make up well-being, and in the past, researchers often studied only one component or used only one item to measure each component (Diener, 2000). These components have typically been related to satisfaction and happiness (Ryff, 1989a; 1995). Evaluations of these components have been global (e.g., life satisfaction) and domain-specific (e.g., work satisfaction), as well as multidimensional (e.g., positive affect v. negative affect) in nature (Diener, 2000).

Although the terms *subjective* and *psychological* are often used interchangeably when paired with well-being, Keyes, Shmotkin, and Ryff (2002) suggested that they do in fact refer to two empirically different constructs. Keyes et al. stated that subjective well-being encompasses the more traditional view that well-being is the "evaluation of life in terms of satisfaction and balance between positive and negative affect" (p. 1007); further, subjective well-being is viewed

in terms of happiness, achievement of pleasure, and avoidance of pain (Ryan & Deci, 2001). Keyes et al. stated that psychological well-being is the "perception of engagement with existential challenges of life" (p. 1007); in this area, psychological well-being is viewed in terms of meaning, self-realization, and level of functioning (Ryan & Deci, 2001). The study of well-being has generally taken one approach versus the other (Keyes et al., 2002; Ryan & Deci, 2001; Ryff & Singer, 2008).

In an attempt to better understand and evaluate psychological well-being, Ryff (1989a; 1995) created a multidimensional model that would provide a theory-driven representation of well-being. Ryff's model was developed in response to the view that prior studies had failed to truly assess well-being (Ryff, 1989a). Given the difficulties associated with determining which aspects should be identified as the essential features of positive psychological well-being in an already "hopelessly value laden" area of research, Ryff (1989a, p. 1070) conducted a comprehensive assessment of well-being. Ryff (1989a) turned to research from developmental and clinical psychology, as well as general research on mental health. Pulling from perspectives such as Erikson's theory of psychosocial development, Neugarten's work on personality change in older adulthood, and Allport's views on maturity, Ryff (1989a) identified six dimensions of psychological well-being. These six dimensions were ultimately based on theory associated with positive functioning and include autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance (Ryff, 1989a; 1995).

Ryff's (1991) dimensions of psychological well-being provide a more well-rounded view of psychological well-being and how people can vary on each dimension. The dimension of autonomy is characterized by how a person handles social pressures and evaluates him or herself. Someone who is high on this dimension is self-determining and independent, while someone low

would be concerned about others' opinions of him or her. The dimension of environmental mastery is characterized by a person's ability to manage his or her environment. A person with a high sense of environmental mastery would feel competent navigating his or her environment and activities, while someone with a low sense of mastery would have difficulty managing affairs and have a low sense of control. The dimension of personal growth is characterized by a person's sense of continued development. Someone high on this dimension would have a feeling of continued development in life while someone low would feel bored, uninterested, or stagnant in life. The dimension of purpose in life is characterized by a person's goals in life and what gives his or her life meaning. A person with a high sense of purpose in life would have a strong sense of direction in life, while someone with a low sense of purpose would have few goals and feel that life lacked meaning. The dimension of positive relations with others is characterized by a person's interaction with others and whether or not he or she engages in trusting relationships. A person who is high on this dimension would have satisfying relationships with others, while someone low on this dimension would have few close relationships and lack trust in others. The dimension of self-acceptance is characterized by one's attitude toward the self and his or her life's path. A person high on the dimension of self-acceptance would have a positive, realistic view of self, while a person low on this dimension would feel disappointment in him or herself and life in general.

Research on the six dimensions of psychological well-being has been conducted along with measures designed to assess subjective well-being. Such research has shown that the dimensions of positive relations with others, autonomy, purpose in life, and personal growth were not related to the earlier instruments (e.g., affect balance, life satisfaction, self-esteem, morale locus of control, depression), which suggests that they represent aspects of well-being

that have not previously been incorporated into assessments of well-being (Ryff, 1989a). For further review of the psychometric properties of Ryff's Scales of Psychological Well-Being (SPWB), see Ryff and Singer (2006). Considerable research using the SPWB has been conducted as a means of taking a more thorough theory driven approach toward the assessment of well-being. These studies are discussed in greater detail next.

Previous Research on Psychological Well-Being

In the past, studies of well-being took a more subjective approach and generally used broad measures of happiness or life satisfaction to assess well-being (Ryff, 1995). In an attempt to provide a more in depth assessment of psychological well-being, Ryff's (1995) scales were developed as a means for examining several components of the good life rather than just measuring one factor such as happiness (p. 100). Research on psychological well-being using the SPWB has shown that older adults experience a decrease in their sense of purpose in life and sense of personal growth; this pattern has been shown consistently across studies (Ryff & Singer, 2008). Research has also shown that when older adults were asked to report their future expectations for psychological well-being, their responses were generally lower than younger and middle-aged adults (Ryff, 1991). Despite this picture of age-related declines in psychological well-being, several theories have suggested that older adults develop ways to combat possible negative outcomes related to the aging process, and in turn protect their sense of well-being (e.g., Carstensen, 1992; Whitbourne, 1996).

Ryff, 1989a and Ryff, 1989b

In 1989, Ryff conducted two different examinations of psychological well-being across several different age groups. One study focused on quantitatively examining the six dimensions of well-being included in the SPWB (1989a), while the other study focused on qualitative

interviews with adults about their personal views on positive psychological functioning (1989b). The studies were designed to further examine psychological well-being by using a theoretically driven measure as well as by gaining information directly from those people who were capable of reflecting on well-being in later life. Overall, their convergent findings suggested that older adults are not unhappier than other age groups nor are they more likely to suffer from low self-esteem.

Given that previous research on psychological well-being was only very loosely based in theory, Ryff's 1989a study was conducted to provide a theory-driven empirical examination of psychological well-being using the SPWB. Participants included 321 young, middle-aged, and older adults who had mean ages of 19.5 years, 49.8 years, and 74.9 years, respectively. All participants reported fairly high levels of education, predominantly good or excellent self-reported health, and financial stability. Participants were asked to complete the SPWB as well as earlier measures of well-being, including those that assessed affect balance, life satisfaction, self-esteem, morale, locus of control, and depression. Responses from these measures were examined for possible age differences.

In regard to age effects, Ryff (1989a) found that middle-aged adults scored higher than older adults on the purpose in life scale, and higher than young adults on the autonomy scale. Further, Ryff found that both middle-aged and older adults scored higher than young adults on the environmental mastery scale. Both young and middle-aged adults scored higher than older adults on the personal growth scale. There were no differences among age groups for the positive relations with others and self-acceptance scales. In regard to the previous measures of well-being, younger adults scored lower than middle-aged and older adults on the affect balance scale and the locus of control measure, as well as lower than the middle-aged adults on the morale

scale; older adults scored higher than the other two age groups on the depression measure. There were no age differences for the measures of life satisfaction and self-esteem. Overall, Ryff's findings present a mixed view of psychological well-being across different age groups. The lack of age differences on a number of the scales, along with the areas in which older adults reported higher scores than other age groups, implies that older adults are not unhappier than other age groups. However, the increase in depression reported by the older adult group along with the decreases in purpose in life and personal growth might suggest a different picture of psychological well-being later in life. As a whole, Ryff suggested the importance of noting that even well-educated, physically healthy, and financially stable older adults may face major challenges as they attempt to maintain aspects of psychological well-being in later adulthood.

In addition to conducting the quantitative study of well-being in 1989, Ryff (1989b) also conducted a qualitative examination to better understand how it is that middle age and older adults actually define positive functioning. Ryff provided a thorough rationale for the importance of conducting the qualitative assessment, with particular emphasis on the need to examine how it is that older adults' views on well-being do or do not match up with research conceptions. In order to examine psychological well-being in later life through the eyes of those living that experience, the author asked participants about their evaluations of life, past life experiences, conceptions of well-being, and their thoughts on the aging process. Participants included 171 middle age (mean age = 52.5 years) and older adults (mean age = 73.5 years) who were well educated, physically healthy, and financially stable. The results showed that middle age adults provided more elaborate responses to the questions than did the older adults, while women reported more differentiated responses than did men. While older adults placed a greater emphasis on health issues, middle age adults expressed more concern about their jobs. Of

particular interest was the finding that older adults frequently reported that there was little they were unhappy about with their lives and that they were not interested in changing their lives. However, Ryff noted that there is difficulty associated with determining whether such positive assessments actually reflect life getting better with age or rather that older adults are skilled at adapting to age-related changes.

Ryff, 1991

Previous research on psychological well-being had participants rate themselves on the dimensions of well-being at the present time. In her 1991 study, Ryff examined participants' perceptions of psychological well-being over time using self-representations and self-narratives (i.e., an attempt to understand one's path over time, which can be stable, progressive, or regressive). Participants were asked to complete the SPWB based on assessments of themselves at the past, present, and future as well as based on ideal versions of themselves. Ryff's study was designed to examine age differences in self-narratives. Participants included 308 young (mean age = 19.3 years), middle-aged (mean age = 46 years), and older adults (mean age = 73.4 years) who were well educated, physically healthy, and financially stable. Participants were asked to complete the SPWB four times including once for how they perceived themselves at the present, once for their ideal self, once for how they thought they were in the past, and once for how they thought they would be in the future. The results of the study provide useful information about how the participants compared to previous studies in which psychological well-being was examined using assessments of self at the present, as well as information about how participants perceive themselves over time.

In general, the findings from the study were consistent with previous research in that older adults scored lower than young and middle-aged adults on the scale of personal growth.

Middle-aged adults scored higher than the young adults on the autonomy scale, and the middle-aged and older adults scored higher than the young adults on the environmental mastery scale. There were no age differences for the positive relations with others scale or the self-acceptance scale; further, there were no age differences for the purpose in life scale, which is inconsistent with previous research that has found declines in purpose in life for older adults.

Overall, the results showed that compared to young and middle-aged adults, older adults had fairly different views of themselves when asked to reflect on their present, past, future, and ideal selves. Young and middle-aged adults viewed the life span story as one in which they were getting better over time for all of the dimensions of psychological well-being; young and middle-aged adults' future ratings generally indicated expectations for improvement. Older men and older women, however, had a more varied picture of themselves across the dimensions of well-being, and their responses across all intervals showed stability, progress, or decline depending on the dimension (older men reported perceptions of stability for dimensions like autonomy, positive relations with others, and environmental mastery, progress for self-acceptance, and decline for purpose in life and personal growth; older women reported perceptions of stability for dimensions like purpose in life and personal growth, and progress for self-acceptance, environmental mastery, and positive relations with others). In general, the older adults' future scores were lower than the young and middle-aged adults' scores on all of the dimensions of well-being and their ratings indicated expectations of stability or decline rather than improvement. These findings suggest that older adults' future expectations are more negative than young and middle-aged adults' expectations. Given that the older adults in the sample are well educated, physically healthy, and financially secure, it is difficult to determine whether their expectations reflect views that are realistic, pessimistic, or possibly just protective. As Ryff

(1991) notes, this distinction is particularly critical to understand because views that are unnecessarily pessimistic may lead to "a lack of motives and goals for future selves, which may in turn translate to defeatist behaviors" (p. 293).

Ryff & Keyes, 1995

Ryff and Keyes' (1995) study was conducted to examine the multidimensional model of well-being originally proposed by Ryff (1989a) using a nationally representative sample. The study was also conducted as a means of examining age and sex differences as they compared to previous research using the SPWB, as well as to further examine the dimensions of psychological well-being as they compared to previously researched dimensions of subjective well-being. Ryff and Keyes' examination of age differences is highlighted in the present review. Participants included 1,108 adults who were grouped by age as young, middle-aged, and older. Participants were asked to complete a 20-item version of the SPWB over the phone along with a few items about life satisfaction and happiness. Consistent with previous research, Ryff and Keyes found that the older adults scored significantly lower than the young group on the scales of personal growth and purpose in life, while the two older groups scored higher than the young adults on the environmental mastery scale. Although previous research had shown that there were no age differences in participants' scores on the positive relations with others scale, Ryff and Keyes found that older adults scored higher than both of the younger groups. Overall, their findings provided support for the six factor multidimensional model to be used for the empirical assessment of psychological well-being; however, they recommended the use of observational methods as a means of further examining psychological well-being without relying on self-report.

Other Research Using the SPWB

The SPWB is frequently used as part of the Midlife in the U.S. (MIDUS) research, and as such has been used in numerous studies since its development to assess psychological well-being (see http://www.midus.wisc.edu/findings). Among other issues, the SPWB has been used to examine psychological well-being for groups such as cancer patients (Costanzo, Ryff, & Singer, 2009) and people going through a life transition (Bardi & Ryff, 2007), as well as for topics such as vocational issues (Strauser, Lustig, & Ciftci, 2008) and family cohesion (Uruk, Sayger, & Cogdal, 2007). A number of studies have focused on the links between psychological well-being and factors such as personality (Keyes et al., 2002; Schmutte & Ryff, 1997), life experiences (Ryff & Heidrich, 1997), and role involvement (Chrouser Ahrens & Ryff, 2006). Research on role involvement has shown that the more roles (i.e., involved) a person has, the more likely he or she is to have greater access to things such as resources, social links, and emotional support (Chrouser Ahrens & Ryff, 2006).

Research related to subjective well-being and productive activities of older adults has also suggested support for the relevance of role involvement to well-being (Baker, Cahalin, Gerst, & Burr, 2005). Although Baker et al.'s study did not employ the SPWB in their research, their examination of the link between subjective well-being (taking into account life satisfaction, happiness, and depressive symptoms) and the activity involvement of older adults provides results similar to Chrouser Ahrens and Ryff (2006). Baker et al. found that as older adults increased the amount of time committed to activities, their happiness and life satisfaction increased and that as the number of activities increased, so did happiness.

Summary

Research has shown that factors related to the dimensions of the SPWB are important for well-being (e.g., Mroczek & Kolarz, 1998). Research on older adults in long-term care settings has shown that factors such as autonomy, environmental mastery, and relationships with others may be critical to promoting well-being and quality of life (e.g., Baker et al., 2005; Kane, 2005; Zeisel, Silverstein, Hyde et al., 2003). Additional research has shown that having more roles can have positive implications for improved resources, power and prestige, and social and emotional connections (Chrouser Ahrens & Ryff, 2006). Developmental research on the SPWB has suggested that compared to other age groups, older adults experience declines in their sense of purpose in life and personal growth (Ryff, 1989a; Ryff & Keyes, 1995), as well as declines in their expectations for future well-being (Ryff, 1991). However, research has also shown that middle-aged and older adults generally score higher than young adults on the dimension of environmental mastery (Ryff & Keyes, 1995). Although the reports of decline are in contrast to the paradox of well-being phenomenon, they represent only a small amount of research; additional research is needed to more fully understand age-related changes in psychological well-being. The present study examined ageism's impact on older adults' psychological well-being using the SPWB; to date, it does not appear that the SPWB has been used in a study related to the experience of ageism in older adults.

REACTIONS TO AGING

Theories of Successful Aging

Although the common stereotypes of older adults present images of a person who is frail or sick, lonely, and unable to cope with age-related declines, considerable research has demonstrated that such images represent myth rather than reality (Cooley, Deitch, Harper et al.,

1998; Sneed & Whitbourne, 2005). Despite these negative stereotypes about aging and the occurrence of age-related declines, older adults manage to live positive and fulfilling lives. While some theories of aging continue to focus on issues of impairment, other theories have focused on *successful aging*, which highlights the importance of "personal control and the self's organizing function" (Sneed & Whitbourne, 2005, p. 378). Rowe and Kahn (1997) make the distinction between people who are aging in either a *usual* (non-pathological, but a higher risk) or *successful* (better overall functioning and a smaller risk) manner in order to shift attention from viewing aging as simply a pathological versus non-pathological process.

In an attempt to shift the focus of aging theories from one of impairment or decline to one of positive growth, Rowe and Kahn (1997) presented a three-part definition of successful aging. Rowe and Kahn's definition encompasses three inter-related components necessary for successful aging to occur. These components include a low probability of disease and disability, high cognitive and physical functional capacity, and continued active engagement in life, and each of the three components also includes subparts. In particular, a subpart for the tenet on actively engaging with life focuses on the importance of maintaining relationships and for continuing to be involved in productive activities; this emphasis is consistent with the findings on psychological well-being and the importance of role and activity involvement (Baker et al., 2005; Chrouser Ahrens & Ryff, 2006).

In a sense, theories of successful aging target the paradox of well-being because they are focused on explaining how it is that older adults are able to lead happy lives in the face of age-related changes in their health and an abundance of negative stereotypes about aging (Sneed & Whitbourne, 2005). There are two types of theories under the general umbrella of successful aging theories (Sneed & Whibourne, 2005). Personal control theories emphasize an individual's

sense of control over his or her environment (Sneed & Whitbourne, 2005). Theories such as the life-span theory of control (Heckhausen & Schulz, 1995), model of the aging self (Brandstadter & Greve, 1994), and socioemotional selectivity theory (Carstensen, 1992) are examples of personal control theories (Sneed & Whitbourne, 2005). On the other hand, self-oriented theories (or self-theories) place emphasis on an individual's ability to handle challenges that may conflict with his or her sense of self (Sneed & Whitbourne, 2005). Self-theories include the model of possible selves approach (Markus & Nurius, 1986), self-discrepancy theory (Higgins, 1987), and the theory of the relational self (Andersen & Chen, 2002). One additional self-theory is identity process theory (Whitbourne, 1996), and it is this theory that is of particular relevance to the present study. **Table 1** provides more information on several of the personal control and self-oriented theories.

Table 1. Theories of Successful Aging

Theory	Premise
Self-Oriented Theories	
Identity process theory (Whitbourne, 1996)	Age-related changes in adulthood are perceived and interpreted using the processes of IAS, IAC, and IBL; individuals use all three processes, but may be more inclined to use one approach more often than the others; assimilation is used prior to accommodation
Social identity theory (Kite & Smith Wagner, 2002)	The ability to maintain a positive identity is linked to group identity; elevating one's group above another promotes a positive group identity and in turn a positive self-identity
Model of possible selves (Markus & Nurius, 1986)	Cognitive self-conceptions motivate future-oriented behavior as a means of achieving "ideal selves" and avoiding "dreaded selves;" affect is influenced by one's ability to achieve the ideal self (i.e., positive affect results from achieving the ideal self, while negative affect stems from an inability to do so)

(continued on the next page)

Self-discrepancy theory (Higgins, 1987)	Discrepancies between the actual versus ideal self influence one's emotions as well as form "self-guides" or standards for being
Theory of the relational self (Andersen & Chen, 2002)	The self is shaped by interactions with important people in one's life, which are represented as relational exemplars in long-term memory; based on the process of transference and behavior motivated by the need for belonging and attachment
Control Theories	
Socioemotional selectivity theory (Carstensen, 1992; 1995)	Affect becomes more important to people as they age, but emotions are regulated better; better emotion regulation leads to improved well-being (higher positive, lower negative affect)
Life-span theory of control (Heckhausen & Schulz, 1995)	Personality is driven by the desire to control one's interactions with the environment; based on processes of primary control (behaviors designed to generate effects in the environment) and secondary control (shaping cognitive, motivational, and emotional states related to interactions with the environment); with age, older adults place more emphasis on secondary control as a means of maintaining positive well-being
Model of aging self (Brandstadter & Greve, 1994)	The ability to maintain a positive sense of self is due to older adults shifting from assimilative coping strategies to accommodative strategies; the use of accommodative strategies prevents older adults from being faced with their limitations
Vaillant, 1993	Older adults use mature defense mechanisms (e.g., humor, altruism) to handle emotional challenges
Haan, 1977	Coping strategies and defense mechanisms develop across the life span, with positive coping strategies (e.g., mature emotional expression) increasing with age and defense mechanisms (e.g., processes that lack conscious cognitive mediation and distort reality) decreasing with age
Labouvie-Vief & Blanchard-Fields, 1982	Affect and cognition restructure and become more cohesive with age, which leads to better emotion regulation and allows older adults to maximize positive affect and minimize negative affect
Environmental docility hypothesis (Lawton, 1996)	Older adults become more skilled at managing their affect over time; these gains result from personality factors and adapting to social contexts and life events

(table compiled from Mroczek & Kolarz, 1998; Sneed & Whitbourne, 2005; Whitbourne & Sneed, 2002)

Identity Process Theory

Identity process theory (IPT) is a self-oriented theory of successful aging, which offers one possible explanation for how it is that older adults maintain a positive sense of well-being even in the face of objective difficulties. Identity itself is defined as a broad definition of self that is made up of an individual's self-representation, which is based on numerous areas such as physical functioning and cognitive ability (Whitbourne, Sneed, & Skultety, 2002). IPT is centered on the notion that experiences are interpreted through a person's self-schema or identity (Whitbourne & Sneed, 2002). IPT proposes that older adults handle age-related changes through the processes of identity assimilation (IAS), identity accommodation (IAC), and identity balance (IBL) (Sneed & Whitbourne, 2003). IAS reflects a person's ability to maintain his or her sense of self, IAC is associated with making changes in the self, and IBL reflects the ability to maintain a sense of self while also being able to make changes to the self when necessary. IPT posits that use of IAS and IAC is "time-dependent" and that IAC is utilized only when IAS has failed (Sneed & Whitbourne, 2003). IPT also suggests that the concept of IBL reflects a "dynamic equilibrium" between IAS and IAC and that IBL is the most adaptive approach to take when dealing with age-related changes (Sneed & Whitbourne, 2003).

IPT suggests that all people utilize both the process of assimilation and the process of accommodation in order to negotiate age-related changes (Sneed & Whitbourne, 2005); however, it is possible that older adults may be categorized by identity process type because they may predominantly use one process over another (Sneed & Whitbourne, 2003). Although it is possible to classify older adults as IAS, IAC, or IBL, such classification is not recommended because most people typically use each style to some extent.

Several example scenarios have been offered as a means of further defining the identity processing styles (e.g., Whitbourne & Sneed, 2002). When using an IAS approach, people attempt to fit their experiences into their current identities, particularly when the experience goes against their current views of themselves; people may use coping mechanisms such as denial, with extreme use of IAS resulting in people potentially denying the fact that they are actually aging (Whitbourne & Sneed, 2002). When using an IAC approach, people may be more likely to allow their identities to be more easily shaped by their experiences and be more likely to believe the negative stereotypes about aging; people using an IAC approach might prematurely accept that they are in a steady state of decline that cannot be reversed (Whitbourne & Sneed, 2002). Ideally, older adults will adopt an IBL approach, which is characterized by having the flexibility to assimilate new experiences, while still maintaining a strong sense of self so as not to be overly accommodative and let every new experience change their identity (Sneed & Whitbourne, 2005). Previous research has shown that an IBL approach is most beneficial to successful aging (Sneed & Whitbourne, 2003). Although the IBL approach is most beneficial to successful aging, IPT suggests that older adults maintain subjective well-being in the face of objective difficulty by using IAS increasingly more frequently with age.

IPT is centered on the processes of IAS, IAC, and IBL as they contribute to a person's ability to maintain a positive sense of self over time. More specifically, IPT addresses the paradox of well-being through the Identity Assimilation Effect (IAE). The IAE suggests that older adults shape their own aging process to fit with their identities, and that use of this process increases with age for some domains (Sneed & Whitbourne, 2001; Whitbourne & Collins, 1998; Whitbourne & Sneed, 2002). More specifically, the IAE is a "product of the older adult's desire to preserve a positive sense of self in the face of increasingly threatening images of aging as a

negative state of existence" (Whitbourne & Sneed, 2002, p. 255). The IAE reflects the relationship between age and self-esteem that is accounted for by the relationship between age and the use of IAS (Whitbourne & Sneed, 2002). In other words, when older adults are presented with an age-related challenge, they will engage in the process of IAS in order to handle any negative consequences (Sneed & Whitbourne, 2005). Previous research has shown that the IAE may be domain-specific to physical and cognitive changes, but not to personality (Sneed & Whitbourne, 2001; Whitbourne & Collins, 1998). Within the scope of IPT, the manner in which older adults cope with ageism will be influenced by how they choose to make sense of it in light of their own identities (Whitbourne & Sneed, 2002).

Previous Research on Identity Process Theory

Whitbourne & Collins, 1998

Whitbourne and Collins (1998) conducted an exploratory study to examine how people reacted to specific age-related physical changes. They also examined the relationships among identity processes and self-esteem as a means of investigating the possible link between identity processes and an individual's view of self. Participants included 242 adults who ranged in age from 40-95. Participants completed the Identity and Experiences Scale—Specific Aging, which is a version of the IES that is specific to age-related changes. Participants were also asked to complete a measure designed to assess physical and cognitive change, which included components such as appearance, competence (e.g., mobility, muscle strength, etc.), basic functions (e.g., bladder control, dentures, etc.), and cognition and perception (e.g., hearing, vision, memory, balance, etc.); participants were also asked to complete a measure assessing self-esteem. Overall, Whitbourne and Collins found that participants of all ages were sensitive to age-related changes. Younger adults were more sensitive to changes in appearance while older

adults were more sensitive to changes in competence and basic functions. Both groups were equally sensitive to age-related changes in cognition. Younger adults used the IAS approach the most, particularly so for cognitive functioning. Older adults had high scores on the IBL approach as it related to basic functions. IAS was positively related to self-esteem for appearance for both age groups, as well as positively related to cognitive functioning for younger adults; these findings suggest that use of IAS is linked to a more positive sense of self. IAC was negatively related to self-esteem for appearance and cognition for both age groups, as well as negatively related to competence for younger adults; these findings suggest that use of IAC is linked to a less positive sense of self. Whitbourne and Collins suggested that these findings supported the identity process model and the IAE because they showed that IAS is a healthy approach toward maintaining a positive sense of self in light of age-related changes.

Sneed & Whitbourne, 2001.

Sneed and Whitbourne (2001) conducted a study to examine the relationships among age, identity processes, and self-esteem. They also wanted to further examine possible findings associated with the IAE. Recall that the IAE is the finding that, with age, older adults use the process of IAS more frequently in some domains in order to maintain a positive sense of self. Participants included 242 adults who ranged in age from 40-95. Approximately 2/3 of the sample was female, and all participants were fairly well educated. Participants were asked to complete the Identity and Experiences Scale and a self-esteem questionnaire. The results showed that IBL and IAS were positively related to self-esteem, while IAC was negatively related to self-esteem. IAS was positively correlated with age. Previous research showed that use of IAS increases with age in regard to physical and cognitive functioning, which is known as the IAE (Whitbourne & Collins, 1998). Sneed and Whitbourne examined interaction effects between age and identity

processing styles as a means of assessing the IAE as it related to the domain of personality. However, there were no significant interactions between age and identity processing styles; as older adults perceive age-related threats to personality, they do not necessarily use the process of IAS more frequently in order to maintain a positive sense of self. Sneed and Whitbourne suggested that the IAE may be domain-specific to physical and cognitive functioning.

Whitbourne et al., 2002.

Whitbourne et al. (2002) conducted a study to examine the relationships among IAS, self-esteem, and defensive processes. Participants included 147 adults who had a mean age of 59.6 years. They were asked to complete the Identity and Experiences Scale – General, along with measures designed to assess self-esteem and defense mechanisms. The authors chose to use a categorization process in which participants were grouped by their dominant identity processing type. The authors reported that their findings were limited as a result of this categorization and suggested that correlational data were more appropriate for examining identity process styles. Whitbourne et al. found that high self-esteem scores for women categorized as identity accommodators reflected a defense mechanism that was being used to cover underlying fear and anger. The authors suggested that IAC is linked to self-handicapping and an inability to deny or rationalize negative experiences.

Sneed & Whitbourne, 2003

Sneed and Whitbourne (2003) conducted a study to examine the relationships among identity processes and self-consciousness variables such as public self-awareness and the two components that make up private self-awareness, self-reflection and internal state awareness. Public self-consciousness is associated with scoring higher on measures such as depression and neuroticism, while both internal state awareness and self-reflection are associated with being

more open to new experiences; however, self-reflection is also positively associated with greater levels of neuroticism. Participants included 173 adults who ranged in age from 42-85, who were divided evenly as being younger or older than 60. They were asked to complete the IES-G and a scale designed to measure public and private self-consciousness. Sneed and Whitbourne found that IAS was positively associated with age and somewhat negatively associated with self-reflection; the authors suggested that this finding supports research related to the importance of minimizing negative aspects of the self while enhancing positive aspects in later adulthood. IAC was negatively related to age and internal state awareness, but positively related to self-reflection and public self-awareness; this suggests that use of IAC in general is negatively related to processes that promote psychological health. IBL was the only process to be positively related to internal state awareness (the process deemed psychologically healthy). Sneed and Whitbourne (2001) suggested that this finding was similar to the finding that IBL was positively associated with self-esteem (Sneed & Whitbourne, 2001). Taken together, these findings provide support for the suggestion that the ability to incorporate age-related changes within identity while maintaining a positive sense of self is the best approach for successful aging.

Skultety & Whitbourne, 2004

Skultety and Whitbourne (2004) conducted a study in order to test a theory of gender differences in identity processes and self-esteem. Participants included 222 adults who ranged in age from 40-84; participants were well educated and primarily Caucasian. As with previous research, participants were asked to complete the IES-G and a measure of self-esteem. The authors found that women scored higher on IAC than men. Older adults scored higher than middle-aged adults on IAS, but lower than them on IBL. IAC was negatively associated with self-esteem for both men and women. IAS was positively associated with self-esteem for

women, while IBL was positively related to self-esteem for both men and women. Age was positively related to IAS for both men and women, which suggests that use of IAS increases with age. Overall, these findings are in line with previous research in that they show use of IBL is associated with a more positive sense of self.

Weinberger, 2009.

Weinberger (2009) conducted a study to examine the relationship between depressive symptoms and identity process theory. Participants included 123 younger and older adults who were asked to complete the IES-G as well as a measure of depression. Weinberger examined a mediation model as well as a moderation model. In the mediation model, he examined whether or not identity processes mediated the relationship between age and depression and between gender and depression. The results showed that identity processes mediated the relationship between age and depression such that older adults' use of IAS decreased the likelihood of reporting depressive symptoms, while use of IAC increased the likelihood. In the moderation model, Weinberger examined whether age and gender moderated the relationship between identity processes and depression. The results showed that the relationship between identity processing styles and depression was moderated by age but not by gender. These findings are in line with previous research showing that use of IAS is positively associated with positive functioning, while use of IAC is negatively associated with it.

Summary

Although research on IPT and the corresponding identity processing styles is in the early stages, there have been several consistent findings across studies. The majority of earlier studies have focused on examining the links between identity processing styles and perceptions of self (e.g., self-esteem, self-consciousness). These studies have generally shown that use of IAC is

associated with declines in healthy perceptions of self, while use of IAS and IBL are generally associated with stability or improvements in healthy perceptions of self; this same pattern was shown to be true for the relationship between identity processing styles and depression. Given that previous research has focused primarily on examining the relationships among identity processing styles and perceptions of self, there has been minimal attention paid to the possible link between identity processing styles and psychological well-being.

AGEISM

Defining Ageism

There are numerous conceptualizations and definitions of ageism in the extant literature today. There have been several derivations from Butler's (1969) original definition of ageism as well as considerable debate over what exactly constitutes ageism (Palmore, 2003). Butler's (1969) original definition included any form of prejudice or discrimination that occurred based on a person's age. More recently, Palmore, Branch, and Harris (2005) have suggested that the definition of ageism can have numerous parts. Palmore et al.'s definition encompasses stereotypes, prejudice, and discrimination against people because of their age; their definition also emphasizes the finding that these components of ageism can be both positive and negative. Palmore et al. note that not all ageist behaviors may be bad, and that "the concept of ageism has an implicit evaluative connotation that all ageist beliefs and behaviors are bad" (p. 97).

Levy and Banaji (2002) define ageism as "an alteration in feeling, belief, or behavior in response to an individual's or group's chronological age," and call specific attention to the fact that ageism may take place "without conscious awareness, control, or intention to harm" (p. 50). In that regard, Levy and Banaji's (2002) research is focused on implicit ageism, a term they use to encompass implicit age stereotypes and implicit age attitudes; these terms are defined in the

same manner as the multi-part definitions laid out by Palmore et al.'s (2005) work, save for the fact that they focus on forms of ageism that occur automatically or unconsciously. Palmore et al. (2005) also suggest that there are specific types of ageism, including individual, institutional, and cultural. Individual ageism refers to a person's own stereotypes and prejudices against older people. Institutional ageism is seen most often in the workplace and other programs, and it can be positive (e.g., tax breaks or discounts for older adults) or negative (e.g., mandatory retirement policies). Cultural ageism is largely responsible for individual and institutional ageism, and it can be seen in everything from language and literature to humor and mass media. Research has shown that people of all ages freely admit to engaging in positive ageist behaviors (Allen, Cherry, & Palmore, 2009; Cherry & Palmore, 2008). Further, research has shown that older adults do hold self-stereotypes about aging (e.g., Levy, 1996; Levy, Slade, & Kasl, 2002). Given the prevalence of ageism in everyday life, it is not all that surprising that people develop and maintain age stereotypes, which can then become self-stereotypes with age (Levy & Banaji, 2002). The social cognitive perspective along with views on implicit ageism provide means for understanding how it is that people first develop stereotypes and then how those stereotypes may ultimately get turned inward.

Age Stereotypes: Social Cognitive Perspective

The social cognitive perspective is centered on understanding the ways in which people make sense of themselves and others in their day to day lives (Blanchard-Fields & Hess, 1999). Within the social cognitive perspective, age stereotypes are viewed as person perception schemas that are based on organized structures of prior knowledge (Hummert, 1999). Rather than being inherently negative, these schemas simply provide a means of processing and interpreting new information (Hummert, 1999).

Ageism, as viewed within the social cognitive perspective, might then be used as a means of understanding how it is that people can be both the victims and the culprits of ageist attitudes and behaviors. Previous research has shown that people of a variety of ages and educational and occupational backgrounds readily admit to engaging in positive ageist behaviors (Allen et al., 2009). If people are using these person perception schemas about aging in order to interpret social situations, it seems unlikely that they are aware of how their attitudes and behaviors are in fact ageist. Whether these behaviors are out of courtesy or perhaps coping, they reflect ingrained societal views on aging that can have potentially detrimental effects on those whom ageism affects (Lachman, 2000, Levy et al., 2002). Research within the area of implicit social cognition has attempted to examine the ways in which unconscious negative attitudes toward older adults may manifest in overt attitudes and behaviors.

Self-Stereotypes about Age: Implicit Ageism

Implicit theories of cognition encompass the idea that thoughts and feelings can occur outside of conscious awareness (Levy & Banaji, 2002; Perdue & Gurtman, 1990). These theories address the ways in which people come to have inherent beliefs about aging. The phrase *implicit ageism* refers to automatic or unconscious stereotypes, which are "thoughts about the attributes and behaviors of the elderly that exist and operate without conscious awareness, intention, or control" (Levy & Banaji, 2002, p. 50). Several explanations have been offered for how it is that people have these implicit stereotypes. It has been suggested that implicit social cognition may actually begin in explicit form but become automatic over time through repeated activation (Bargh, 1997, as cited in Levy & Banaji, 2002). Similar to the broader view of the social cognitive perspective, it has been suggested that automatic stereotypes may serve a functional purpose in that they are generalizations people can use to simplify new encounters (Levy &

Banaji, 2002); such generalizations allow people to quickly and easily interpret new experiences by grouping them into existing schemas.

If implicit stereotypes are in fact acquired early in life, it stands to reason that there are functions working to maintain or even enhance these beliefs over time. Once age stereotypes have been formed, it is likely that they will be activated when a person encounters an older adult, which further contributes to the automaticity of the stereotype (Levy & Banaji, 2002). On the other hand, encountering evidence that would seemingly refute the stereotype does not work to decrease or diminish the stereotype; rather, people view these instances as exceptions (Levy & Banaji, 2002). Implicit stereotypes may be perpetuated by repeated activation or by ignoring evidence in contrast to the stereotype, as well as by avoidance altogether (Levy & Banaji, 2002).

There are a variety of factors contributing to the perpetuation of negative age stereotypes, both implicit and explicit in nature. Given the prevalence and salience of age stereotypes in today's society, there is a "reciprocal nature…between stereotypes and self-stereotypes" (Levy & Banaji, 2002, p. 62); self-stereotypes may be activated by stereotypes endorsed by society, which may then be perceived by others. These negative self-stereotypes may lead a person to develop negative expectations or predictions about his or her own aging, which may eventually become a self-fulfilling prophecy (Levy, 1996; Levy et al., 2002). Considerable research has shown that older adults have self-stereotypes about aging, and that these beliefs can affect their cognitive and physical functioning (e.g., Levy, 1996; Levy et al., 2002).

In a review of her work as well as others', Levy (2003) suggested that self-stereotypes of aging have distinguishable characteristics. First, aging stereotypes are internalized in childhood and then reinforced in adulthood. Second, stereotypes and self-stereotypes can be unconscious. Lastly, the stereotypes people hold about aging will become self-stereotypes as they age. These

steps help illustrate the concepts of in-groups and out-groups. In-groups (or "us") refer to the groups that people identify as their own, while out-groups (or "them") refer to the groups that people do not see themselves as belonging to and often view as less valuable than their own (Kite & Smith Wagner, 2002; Nelson, 2002). These concepts are of particular interest because older adulthood is the only out-group that will eventually become an in-group for many people.

Ageism as an "ism"

Ageism has been viewed as being similar to racism and sexism because it reflects prejudice or discrimination against an entire group of people (Palmore, 2001). However, ageism differs from racism and sexism because it is discrimination against a group that everyone has the potential to join (Palmore, 2001). Further, there are no hate groups that explicitly target older adults (Levy & Banaji, 2002). At least one author has suggested that ageism may exist only as a "social myth" because researchers have perpetuated negative attitudes and assumptions about older adults through their work (Schonfield, 1982). On the other hand, older adults do qualify as a minority group in that the majority group (i.e., younger and middle-aged adults) holds negative stereotypes about them, identifying characteristics with status-role expectations are present, and discrimination exists in some areas (Palmore, 1999).

One feature that separates ageism from racism and sexism is that, in many cases, people may not even be aware that there is such a construct as ageism (Nelson, 2002). This deficiency is most likely due to the fact that many ageist attitudes and behaviors are still considered socially acceptable (Nelson, 2002). Further, ageism can be expressed explicitly and implicitly, making it possible that a person who is opposed to ageism may still be influenced by implicitly ageist attitudes (Levy, 2001).

Ageism can be both positive and negative in nature (Palmore, 2001). It has been suggested that negative ageist attitudes and behaviors may be more easily recognized as "ageist," whereas positive items may be so engrained in our culture that we view those attitudes and behaviors as "courteous" or as a coping mechanism rather than "ageist" (Cherry & Palmore, 2008). Although research has shown that people of all ages freely admit to endorsing positive ageist attitudes and behaviors, it is still not clear what factors lead to such endorsement (Allen et al., 2009; Cherry & Palmore, 2008). Current investigations of attitudes toward aging often examine attitudes about physical health, mental health, cognitive function, personality issues, and activities and interests. Research has shown that attitudes toward aging or perceptions of aging can affect the health and well-being of older adults (e.g., Levy, 2003; Moor, Zimprich, Schmitt, & Kliegel, 2006; Ron, 2007).

Previous Research on Ageism

The impact of ageism on older adults has been studied via longitudinal studies (e.g., Levy et al., 2002) and using a variety of populations and settings (e.g., older adults, social workers, workers in long-term care facilities, etc.) and through numerous variables (e.g., functional health, cognitive functioning, socioeconomic status, subjective well-being, etc.). Levy and her colleagues have shown that ageism can be detrimental to older adults' performance on everything from memory tasks to cardiovascular responses to stress (Levy, 2001). Further, the experience of ageism can also lead older adults to develop a more negative sense of self (Levy et al., 2002). In that same sense, it has been suggested that older adults "buy-in…to the intrinsic devaluation" of older adults by society (Cohen, 2001, p. 576). Levy et al. (2002) found that the way older adults viewed themselves in the aging process had an effect on their functional health.

However, ageism's impact on the psychological well-being of older adults has only been examined minimally.

Previous research on ageism has examined the construct several ways. The Ageism Survey (AS; Palmore, 2001) has been used to examine the experience of ageist attitudes and behaviors, while measures such as the Fraboni Scale of Ageism (FSA; Fraboni, Saltstone, & Hughes, 1990) and the Relating to Older People Evaluation (ROPE; Cherry & Palmore, 2008) measure the endorsement of ageist attitudes and ageist behaviors, respectively. Although, Palmore's (2001) initial assessment using the AS did not reveal any age or gender differences in the sample of older adults, the study did note some differences associated with education level; participants with lower education reported more instances of ageism. More recently, McGuire, Klein, and Chen (2008) administered the AS to older adults and found that over 2/3 of the sample experienced two or more instances of ageism. McGuire et al. also found that items characterized by disrespect toward older adults were frequently experienced. Similar findings are evident throughout research that has used the AS and are discussed more fully in the following sections.

Palmore, 2001

In his 2001 report, Palmore presented the first findings for the Ageism Survey. Palmore developed the AS in hopes of addressing three specific concerns including, 1) the prevalence of ageism in the U.S. and other societies, 2) the most prevalent types of ageism, and 3) the subgroups of older adults who report a greater experience of ageism. The survey was developed based on information contained in the research literature on ageism, Palmore's discussions with colleagues, and the experiences of older adults. Palmore reported that the survey was based on a typology he developed, which stipulated that ageism can be both positive and negative and that

there is a distinction between prejudice (stereotypes and attitudes) and discrimination (personal acts and institutional policies); however, Palmore noted that while only negative items were included in the AS, there were items indicative of stereotypes, attitudes, and personal and institutional discrimination.

In his study, Palmore (2001) asked a convenience sample of 84 participants over the age of 60 to complete the AS; participants had a mean age of 75 years. Palmore reported that the AS had satisfactory reliability and high face validity. Results of the study showed that over 77% of participants had experienced one or more of the ageist items. The item most frequently reported was related to hearing a joke that makes fun of old people. Other frequently reported items included those characterized by disrespect such as being given a birthday card making fun of old people, being ignored, being called an insulting name, being patronized or talked down to, or being treated with less dignity and respect all because of one's age. Items that suggested chronological age caused disease, frailty, or disability were also reported frequently; these items included those related to a doctor or nurse assuming health problems were age-related, others stating that a person was too old for some behavior, and others making an assumption that an older adult could not hear or understand well. These 10 items were most frequently reported in this study as well as in subsequent studies using the AS. The least frequently reported items were related to being refused rental housing, having a home vandalized, and being victimized by a criminal; Palmore reported that the reliability of the AS would be increased if these items were omitted from the survey. Palmore (2001) also examined possible differences in AS scores as a result of age, sex, and education. There were minimal differences between men and women in their responses on the AS. Participants with less education reported more experiences of ageism than did those with higher education. Palmore suggested that people with less education may be

more at risk for experiencing ageism, but noted that the study was unable to determine what might be the effects of education versus perceived financial wellness level.

Based on this research, Palmore (2001) determined that the AS was a reliable measure of ageism with high face validity; he also suggested that such an explicit measure was potentially more useful than other measures designed to examine prejudice and discrimination because it did not require participants to admit that they themselves had committed ageist acts. However, Palmore also reported several problems with interpreting such ambiguous findings as those garnered by the AS. It is difficult to ascertain whether participants simply experienced the item, if they experienced the item and correctly perceived it as ageist, or experienced something that was not ageist but was perceived as such as a result of being hypersensitive to prejudice or discrimination. Further, a person might have experienced an ageist item but failed to report it because they did not want to admit having had that experience. Lastly, given that many people are not even aware that ageism exists, others may have experienced an item but not known to recognize it as ageist. Palmore recommended the use of qualitative interviews, focus groups, and other experiments as a means of further examining ways to measure the experience of ageism.

Palmore, 2004

Following Palmore's (2001) initial findings using the AS, subsequent research was conducted comparing AS results between a sample of Americans and Canadians in hopes of determining the prevalence of ageism in both countries (Palmore, 2004). Participants included 152 Americans over the age of 60 and 375 Canadians over the age of 50. Participants were asked to complete the AS and mail it back to the author. Palmore (2004) found that 91% of Canadians and 84% of Americans had experienced one or more incidents of ageism. As with Palmore's (2001) earlier research, the most frequently reported item was related to hearing a joke that

makes fun of older people; this was true for both the American and Canadian participants. Although the order of the most frequently reported items was varied, the same 10 items were most commonly reported by both samples. Overall, Canadians reported more ageist experiences than did Americans. Palmore noted that it was difficult to determine if Canadians actually experienced more ageism, or if Canadians possibly had a greater awareness of ageism itself and therefore recognized more instances of ageism than did Americans. Interestingly, Palmore reported that several participants questioned whether the humorous items were actually considered ageist in nature, and he also noted that a number of participants denied experiencing any forms of ageism; Palmore suggested that those who denied experiencing ageism may have done so to avoid being categorized as an old person who might be subjected to ageism.

McGuire et al., 2008

McGuire et al. (2008) conducted a study utilizing the AS to assess the prevalence of ageism reported by older adults in East Tennessee. Participants included 247 community-dwelling older adults from both urban and rural areas who were over the age of 60. Participants had a mean age of 74 years; the sample was predominantly female and most had a high school education or less. McGuire et al. found that 84% of participants had experienced one instance of ageism and 71% had experienced two or more instances. The most frequently reported item was, like the previous studies, being told a joke that makes fun of old people. The top 10 most frequently reported items were the same 10 items most often identified in previous studies using the AS (listed in the Palmore, 2001 section). McGuire et al.'s findings provide support for previous findings; however, as with earlier studies, the authors caution interpretation based on these findings. They called attention to the idea of "ageism by invisibility," which they suggested was an unintentional form of ageism that occurs when older adults are left out of advertising and

educational materials (McGuire et al., 2008, p. 15); it is ageist because, in many cases, these materials present opportunities to promote positive images of aging and older adulthood. Ultimately, McGuire et al. emphasized the importance of educating the public about the aging process so that people will be informed that growing older can be a time of continued development and fulfillment.

Anderson & Yon, 2010

More recently, Anderson and Yon (2010) conducted a study utilizing the AS to further examine Palmore's (2004) finding that Canadians report a greater experience of ageism than Americans. Participants included 815 community-dwelling older adults who were over the age of 55. Participants were asked to complete the AS and return it to the researchers directly or via mail. As with previous research, the most frequently reported item was being told a joke that pokes fun at old people. Anderson and Yon reported that this humorous item was the "most contested" form of ageism, which they learned was a result of participants including written comments on the AS (p. 68). The most frequently reported items were the same 10 items as in previous studies (listed in the Palmore, 2001 section). Anderson and Yon included a useful means of categorizing the items included in the AS. In particular, they suggested that the most frequently reported items fell into categories such as *humor*, *health/assumed competency*, and *personal rejection*; less frequently experienced items fell into categories such as *victimization* and *employment*. The study's findings provide support for previous research using the AS. The authors offered several possible explanations for why the ageist items were problematic as well as why people may be inclined to participate in an ageist act.

In regard to humor, they suggested that these items are ageist because they can be hurtful, but noted that people may engage in such acts as a means of releasing anxiety about internalized

negative images about aging. In regard to health and assumed competency, the authors suggested that such acts are dangerous because health-related assumptions may result in poorer care for an older adult (e.g., assuming an ailment is age-related when it is not); however, they suggested that people (health professionals in particular) may make such assumptions because they have been trained to pair age with deterioration. The authors suggested that forms of personal rejection were problematic because they represented "attempts to marginalize and demean older persons" (p. 70). Further, such attempts have the possibility of affecting a person's self-evaluation and self-esteem, which could have implications for how older adults interact with others in the future. Overall, Anderson and Yon's research provides support for previous studies using the AS, as well as provides general categories for the items on the AS, which help to facilitate future discussion of the experience of ageism as it is measured by the AS.

Summary

Numerous studies have examined the impact of ageism or age stereotypes on various health-related functions in older adults. Research has shown that ageism can have a detrimental impact on cognitive and physical functioning (Levy, 1996; Levy et al., 2002) and potentially on longevity (Levy, Zonderman, Slade, & Ferrucci, 2009). In many cases, people may not realize that ageism exists, and further, they may freely engage in certain types of ageism that have been culturally reinforced as courteous behaviors (Cherry & Palmore, 2008; Nelson, 2002). Similarly, as people may not realize they are being ageist (Nelson, 2002), they also may not realize instances where they have turned their ageist views upon themselves (Levy, 2001; 2003). Research using the AS has shown that ageism is widespread and frequently reported, with items related to humor, health and assumed competency, and personal rejection being the items cited most often. The prevalence of ageism and the possibility of self-stereotypes present a risk for

older adults; more research is needed in order to better understand the ways that ageism may relate to older adults' overall sense of well-being.

SPECIFIC AIM AND HYPOTHESES

Despite increasing amounts of research on the effects of ageism, there are still a number of questions remaining about the impact that ageism may have on the psychological well-being of older adults. First, whether or not ageism impacts psychological well-being has yet to be determined. Research has shown that negative attitudes toward aging have detrimental effects on older adults' functional health (Levy, 1996), perceived health (Moor et al., 2006), cognition and will to live (Levy, 2003). The present study attempted to determine if the experience of ageism had a similarly negative relationship with psychological well-being in older adulthood. Second, research on subjective well-being has shown that older adults typically maintain a positive sense of self even when they are faced with age-related declines or difficulties (Mroczek & Kolarz, 1998). Identity process theory presents one attempt to explain how it is that older adults approach age-related changes and in turn maintain a positive sense of well-being (e.g., Carstensen, 1992; Whitbourne, 1996). Given that research on identity process theory is in its infancy, the relationship between identity processing styles and psychological well-being has not been thoroughly explored. The present study attempted to examine the relationship between identity processing style and psychological well-being. Lastly, minimal research, if any, has examined the relationships among the experience of ageism, identity process theory, and components of psychological well-being. The present study examined these relationships in a sample of community-dwelling older adults. The research questions motivating the present research and associated hypotheses tested in this study are summarized next.

Hypothesis 1

What is the relationship between ageism and psychological well-being? It was predicted that older adults who have a greater experience of ageism would have a decreased sense of well-being on at least one of the dimensions of psychological well-being. It was suggested that higher ageism scores would be negatively related to one or more of the dimensions of psychological well-being.

Hypothesis 2

Does psychological well-being vary depending on the different approaches older adults may adopt when dealing with age-related changes (i.e., different identity processing styles)? It was predicted that psychological well-being would vary by different reactions to aging or identity processing styles. It was suggested that IAS and IBL approaches would be positively related to one or more components of psychological well-being, while an IAC approach would be negatively related to one or more components of psychological well-being.

Hypothesis 3

Will the relationship between ageism and psychological well-being differ by identity processing style? It was predicted that the experience of ageism on psychological well-being will vary by identity process style (see **Figure 1**). Older adults who are more inclined to take an IAS or IBL approach and have a lesser experience of ageism will have a better sense of psychological well-being than will older adults who have a greater experience of ageism and are more inclined to take an approach of IAC.

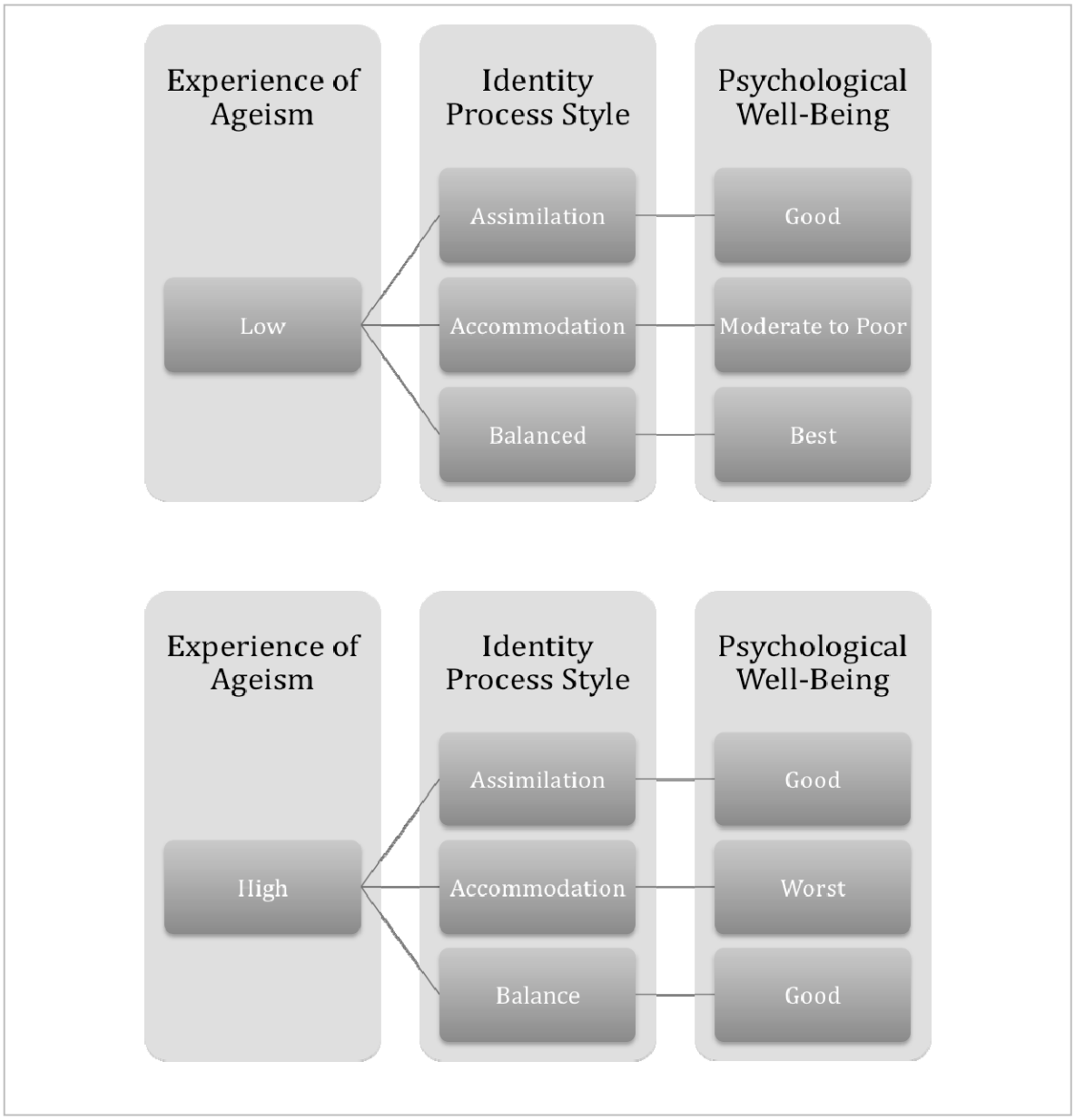

Figure 1. Hypothesis model: Predicted relationships among experience of ageism, identity processing styles, and psychological well-being

CHAPTER TWO: METHOD

PARTICIPANTS

A power analysis determined that a total of 129 participants would be appropriate for the present study (Faul, Erdfelder, Lang, & Buchner, 2006); see **Appendix A** for details of the power analysis. In all, 137 participants residing in the southeastern part of the United States were included in the study. All participants were community-dwelling older adults over the age of 60. Inclusion and exclusion criteria were listed on the informed consent form, and participants were asked if they met either set of criteria prior to starting the data collection session. Inclusion criteria for the study required that participants have visual and auditory capability. Exclusion criteria for the study required that participants not have a history of stroke, adult dementia, or another neurological impairment. Participants were offered $10 as compensation for their participation; upon completion of the study, participants' contact information was submitted to the LSU Office of Accounting Services and payment was mailed to their homes.

Participants were recruited from four general groups including older adult acquaintances of the research group (OAA; N = 43), members of senior centers (SC; N = 26), members of Lagniappe Studies Unlimited, a continuing education group for older adults (LS; N = 37), and residents from the independent living section of St. James Place, a continuing care retirement community (SJP; N = 29).

Given that the participants were recruited from several different groups, it was important to examine any possible group differences. In particular, we examined group differences for participants' age, level of education of self, one question pertaining to perceived financial wellness ("How difficult is it for you to pay for basic items?"), one question of self-reported

health ("How would you rate your health at the present time?"), ADL total score, and IADL total score (see **Table 2**).

The OAA group (*M* = 70.9 years, *SD* = 8.2) included people over the age of 60 who were acquainted with a member of the Adult Development Lab at Louisiana State University. This group was significantly younger than participants in the SJP and SC groups. These participants continue to live in their own homes and reside in states throughout the southern United States including Louisiana, Tennessee, Georgia, Florida, Virginia, and Texas. The SC group (*M age* = 77.2 years, *SD* = 8.8) included people over the age of 60 who were members of a local senior group; they were significantly younger than participants in the SJP group but significantly older than participants in the OAA group. The LS group (*M age* = 74.8 years, *SD* = 7.5) is a continuing education group for older adults in Baton Rouge, Louisiana; these participants were significantly younger than those in the SJP group. The SJP group (*M age* = 84.5 years, *SD* = 4.0) reside in the independent living section of a continuing care retirement community located in Baton Rouge, Louisiana; these participants were significantly older than all of the other groups.

Table 2. Means and Standard Deviations on Selected Demographic Variables by Data Collection Site/Group

	Older Adult Acquaintances (*N*=43)	Senior Centers (*N*=26)	Lagniappe Studies Unlimited (*N*=37)	St. James Place (*N*=29)
	M (SD)	*M (SD)*	*M (SD)*	*M (SD)*
Age in years**	70.9 (8.2)	77.2 (8.8)	74.8 (7.5)	84.5 (4.0)
1-Perceived financial wellness*	1.47 (.78)	1.77 (.86)	1.15 (.37)	1.31 (.54)
2-Education**	2.40 (1.51)	1.21 (.88)	3.13 (1.04)	3.34 (.97)

(continued on the next page)

3-Self-Reported Health	1.95 (.80)	2.20 (.71)	1.78 (.63)	1.79 (.56)
4-Activities of Daily Living (ADLs)	5.93 (.34)	5.92 (.27)	5.97 (.16)	6.00 (.00)
5-Instrumental ADLs	7.53 (1.20)	7.27 (1.25)	7. 85 (.59)	7.72 (.59)

*denotes significance, $p < .01$; **denotes significance, $p < .001$
1-lower scores denote a more secure sense of financial stability; 2-higher scores denote higher education; 3-lower scores denote better self-reported health; 4-higher scores denote higher functional ability; 5-higher scores denote higher functional ability

Group Differences

In order to examine possible group differences on sociodemographic variables, several univariate Analysis of Variance (ANOVA) tests were conducted on the variables for age, education, perceived financial wellness, self-reported health, and functional ability**.** We selected self-reported health and functional ability because they are suggestive of the level of support participants may need to accomplish daily activities; the level of support needed has implications for the experience of ageism. We selected education and perceived financial wellness because they are suggestive of the socioeconomic status (SES) of participants; SES has implications for disability rates, and in turn the need for additional support and the experience of ageism. Given that participants' functional ability and SES may vary by group, it was important to examine these possible differences prior to conducting analyses in which the participants comprise a single group.

The analyses related to self-reported health and functional ability revealed that there were no significant group differences in self-reported health, F (3, 129) = 2.23, p = .09, η_p^2 = .05, overall ADL scores, F (3, 133) = .73, p = .53, η_p^2 = .02 or IADL scores, F (3, 133) = 2.10, p =

.10, η_p^2 = .05. Using education and perceived financial wellness as available indicators of SES, we found that there was a significant between-groups difference in education, F (3, 130) = 17.97, p < .001, η_p^2 = .29. The Tukey HSD test was used to conduct post-hoc comparisons. The post-hoc findings revealed that the SJP group was significantly more educated than the OAA and SC groups, while the SC group was significantly less educated than all of the groups; there was no significant difference between the SJP and LS group or between the LS and OAA group. There was also a significant between-groups difference in participants' reported ability to pay for their basic needs, F (3, 133) = 4.95, p < .01, η_p^2 = .10. Post-hoc comparisons revealed that participants in the SJP and LS groups reported that it was significantly easier for them to pay for the basics than it was for the SC group.

Given that there were no differences in participants' self-reported health or functional ability as indicated by the ADL and IADL checklists, the different subject samples were collapsed into one group for all analyses that follow. While the findings related to SES revealed a few differences between the groups, it is important to note that all groups reported fairly high education and perceived financial wellness levels. When asked how difficult it was to pay for the basic necessities, the mean scores for all groups suggested that it was either "not difficult at all" or "not very difficult" to pay for the basics. When asked to report the highest level of education they completed, the mean scores for all groups showed that participants had a high school education or higher. Participants in the OAA group had some college or higher, while participants in the LS and SJP group had a Bachelor's degree or higher. In general, these findings suggest that the present sample represents a single group of older adults who are healthy, functional, educated, and financially stable.

Present Sample

Participants ranged in age from 61-95 years. Participants' mean age was 76.1 years old (*SD* = 8.9). Participants were tested primarily in Louisiana (52.6%) and Tennessee (42.3%), although seven participants were from various other states in the southern United States (5.1%). The sample was predominantly female (71.5%) and Caucasian (95.6%). Additional characteristics of the sample are presented in **Table 3.**

In addition to gathering information about participants' age, sex, and location, the present study gathered information about several additional sociodemographic variables. Participants reported their martial status, religious preference, and self-reported physical health, as well as their level of education (and their spouse's level of education if applicable) and perceived financial wellness. Participants' functional ability was also examined via questions about their activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Information about participants' self-reported health is presented in **Table 3**, while information about functional ability is presented in **Table 4**. Information about living environment, relationship status, education, and participants' perceived financial wellness is presented in **Table 3**.

In regard to their current relationship status, the majority of the sample reported that they were married (50.3%) or widowed (34.3%). The majority of the sample identified Protestantism as their religious affiliation (73.5%); 19.9% of participants identified themselves as Catholic. When asked how they would rate their health at the time of their interview, 84.2% reported that their health was good or excellent. When asked how much health troubles stood in the way of doing what they wanted to do, 37.6% reported "not at all" while 54.9% stated that health troubles only interfered "a little" with what they wanted to do. When asked if their health was better, the same as, or worse than most people their age, 69.1% stated that it was better while 26.1% stated

Table 3. Demographic Characteristics

Self-Reported Health				
	Excellent	Good	Fair	Poor
How would you rate your health at the present time?	26.3%	57.9%	13.5%	2.3%
	Not at all	A little (some)	A great deal	
How much do health troubles stand in the way of your doing things you want to do?	37.6%	54.9%	7.5%	
	Better	The same as	Worse	
Do you think your health is better, the same as, or worse than most people your age?	69.4%	26.1%	4.5%	

Living Environment, Relationship Status, Education, and Religion						
	I live in my home	I live in a retirement community				
Living Environment	72.3%	26.3%				
	Single	Married	Partner/Sig Other	Divorced	Widowed	
Relationship Status	5.2%	53%	<1%	6.7%	34.3%	
	< High School	High School/GED	Some College/Associate's	Bachelor's	Master's	Doctoral/ Professional
Education	8.2%	16.4%	17.9%	29.9%	20.1%	7.5%
Spouse's Education	7%	15.8%	14%	30.7%	17.5%	14.9%

(continued on the next page)

	Catholic	Protestant	Jewish	Non-religious	Other
Religious Affiliation	19.9%	73.5%	2.2%	1.5%	2.9%

Perceived Financial Wellness				
	Not difficult at all	Not very difficult	Somewhat difficult	Very difficult
How hard is it to pay for the basics?	70.1%	20.4%	8.8%	<1%

	Not at all adequate	Can meet necessities only	Can afford some of the things I want	Can afford everything I want	Can afford everything I want and still save
To what extent do you think your income is enough for you to live on?	1.5%	8.1%	35.3%	25%	30.1%

	<$1000	$1000-2000	$2000-3000	$3000-4000	$4000-5000	$5000-6000	>$6000	Don't know
Approximate overall monthly income level after taxes	9.5%	12.7%	18.3%	11.9%	11.1%	7.9%	19%	9.5%

Table 4. Functional Ability Proportion Scores	
Activities of Daily Living (ADLs)	
Bathing	.99
Dressing	.99
Toileting	1.00
Transferring	.98
Continence	1.00
Feeding	1.00
Total	5.96
Instrumental Activities of Daily Living (IADLs)	
Use the telephone	1.00
Shopping	.93
Food preparation	.92
Housekeeping	1.00
Laundry	.95
Mode of transportation	.96
Responsibility for medications	.99
Ability to handle finances	.99
Total	7.61
Note: All scores are based on a 0 or 1 coding scheme	

that their health was the same as other people their age.

Participants reported their own level of education as well as their spouse's level of education in addition to items about their current financial status. More than half of the participants had a Bachelor's degree or higher (57.5%), as did their spouses (63.1%). Participants were also asked several questions about their financial situation. Approximately 90.5% stated that it was not very difficult or not difficult at all to pay for the very basic items (e.g., food, shelter, clothing, etc.). Thirty-five percent of participants stated that they could afford some of the things they wanted but not all, 25% stated they could afford all that they wanted, and 30.1% stated they could afford all that they wanted and still save money.

MATERIALS

Participants provided information about a number of sociodemographic variables including their age, sex, race, level of education, marital status, religion, perceived financial wellness, residence type, and self-reported physical health (see **Appendix B**). They also completed a measure assessing functional ability, which included questions about ADLs, and IADLs. Additionally, participants completed a measure designed to screen for depression so that affective status could be examined in the study. Lastly, participants completed one measure designed to examine their experience of ageism, one measure designed to assess identity process styles, and one measure designed to assess six dimensions of psychological well-being.

Functional Ability

Participants completed questionnaires designed to assess their ability to complete ADLs and IADLs. ADLs refer to the basic activities a person typically performs on his or her own, and include bathing, dressing, toileting, moving from a bed or a chair, eating, and caring for incontinence (Katz, Down, Cash, & Grotz, 1970; Wallace & Shelkey, 2006). IADLs typically

include actions such as light housework, preparing meals, taking medications, handling finances, using the telephone, shopping, laundry, and transportation (Graf, 2007; Lawton & Brody, 1969). Participants' ADLs were measured using the Katz Index of Independence in Activities of Daily Living (Katz ADL; Katz et al., 1970; Wallace & Shelkey, 2006), and IADLs were measured using the Lawton Instrumental Activities of Daily Living Scale (Lawton IADL; Graf, 2007; Lawton & Brody, 1969). Both functional ability questionnaires were presented within a two-page questionnaire (see **Appendix C**).

The Katz ADL is a questionnaire commonly used to measure functional status in older adults. The measure has been deemed most useful and effective for assessing functional ability in older adults, and it is suitable for use in a variety of care settings (Wallace & Shelkey, 2006). The Katz ADL examines six functions of daily living including bathing, dressing, toileting, transferring, continence, and feeding (Wallace & Shelkey, 2006). Participants are asked to state whether they are capable of completing the activity independently (scored as 1) or if they require assistance (scored as 0). A score of 6 represents full functional ability, while a score of 4 represents some or moderate impairment, and a 2 or less reflects significant functional limitations.

While the Katz ADL measures overall ability to perform basic daily functions, the Lawton IADL is targeted at measuring functions associated with independent living (Graf, 2007). These functions are considered to be more complex than the basic daily functions since they are activities generally required for a person to live on his or her own (Graf, 2007). The Lawton IADL consists of eight scales including ability to use the telephone, shopping, food preparation, housekeeping, laundry, mode of transportation, responsibility for own medications, and ability to handle finances. Similar to the Katz ADL, participants are asked to rate whether

they can complete the activity relatively independently (scored as 1) or if they require assistance (scored as 0); however, unlike the Katz ADL, participants are provided several levels of ability rather than having to make a binary decision about whether or not they are able to complete a task. Total scores can range from 0 to 8, with 8 reflecting high functional ability or independence.

Depression

The Geriatric Depression Scale (GDS; Yesavage, Brink, Rose et al., 1983), a widely used screening measure for depression symptoms in older adults, was included to account for a possible influence of depressive symptoms on participants' responses on the primary measure of interest in the study. The full-length version of the GDS has 30 items, while the short form has 15. The present study required participants to complete the 15-item version of the GDS in order to limit the time spent on each item within the session (see **Appendix D**). Participants are asked to report how they have felt over the past week. They are presented with 15 statements and are asked to state "yes" or "no" to each statement. Each response receives a score of 0 or 1. Ten of the items are negatively phrased, while the other five are positive in tone. Given that higher scores represent higher levels of depressive symptoms, "yes" responses to negative items and "no" responses to positive items were scored as 1.

Ageism

The experience of ageism was measured by having participants complete the Ageism Survey (AS; Palmore, 2001), which is a 20-item measure of the experience of ageism. The AS includes examples of negative stereotypes, attitudes, and discrimination, and participants were asked to state the frequency with which they have experienced each item; participants were asked to state whether they have experienced each item *never, once,* or *more than once*.

Participants were also provided with additional options in order to estimate *how many times* they had experienced items they already reported as occurring *more than once*. In the event participants reported that they had experienced an item *more than once*, they were then asked to estimate how often they had experienced the item since turning 60. Participants were asked to report if they had experienced the item *a few times*, *quite a bit*, or *all the time*[1]. This addition to the AS is unique to the present study and was included in order to gain a slightly more informative picture of the frequency with which participants experienced the ageist items (see **Appendix E** for an example of the AS including the additional response option).

The AS was designed to examine the prevalence of ageism, the types of ageism that are most prevalent, and which groups of people report a greater experience of ageism (Palmore, 2001). The AS has been shown to have adequate reliability (Cronbach's alpha = 0.81) and high face validity; however, the author stated that reliability could be improved by omitting three of the items that were rarely experienced by participants (Palmore, 2001). These items related to discrimination in leadership, rental housing, and employment; the author elected to retain these items since they represent more serious forms of ageism (Palmore, 2001). In keeping with the original author's suggestion, all 20 items were included in this study. Participants' responses were scored as 0 (never), 1 (once), or 2 (more than once), and these scores were used to calculate an overall sum score.

Identity Process Styles

Identity process styles were assessed by having participants complete the Identity and Experiences Scale-General (IES-G; Whitbourne et al., 2002). The IES-G was designed to assess the relationship between identity and adult experiences, while examining the identity processing

[1]Although, participants were asked to complete an extended version of the Ageism Survey (i.e., for items they reported experiencing more than once, they were asked to report whether they had experienced the item a few times, quite a bit, or all the time), the majority were confused by this additional option and filled out this portion of the survey incorrectly. As a result of the high number of unusable responses, we elected not to include results from this part of the Ageism Survey.

types of identity assimilation (IAS), identity accommodation (IAC), and identity balance (IBL). The IES-G is a self-report questionnaire that incorporates items designed to assess IAS, IAC, and IBL (Sneed & Whitbourne, 2003). Each processing style has a unique set of 11 items on which participants are asked to report how much they are like the statement in question using a 1 to 7 with 1 representing *not like me at all* and 7 representing *completely like me*. These scores are used to calculate sum scores for each dimension. The 33 items are mixed to form a single measure.

Each of the three scales was designed to thoroughly examine the underlying identity process style (Sneed & Whitbourne, 2003; Whitbourne et al., 2002). The IAS scale assesses how people interpret new experiences and the extent to which they resist modifying their identity. The IAS scale has been shown to have an internal consistency of .72 (Sneed & Whitbourne, 2003). The IAC scale assesses how people interpret new experiences and the extent to which they are willing to allow themselves to be shaped by that experience. The IBL scale assesses how people interpret new experiences and the extent to which they are able to maintain a consistent sense of identity while still being willing to recognize and accept instances that may require them to modify their sense of self to some degree. Both the IAC and IBL scales have been shown to have an internal consistency of .86 (Sneed & Whitbourne, 2003). Although it is possible to categorize participants by their dominant processing style, Sneed and Whitbourne (2003) suggest that it is more accurate and useful to examine the scale scores (see **Appendix F** for an example of the IES-G).

IES-G Correction

During the data collection process, it was discovered that one item on our version of the IES-G was duplicated. Item #6 (“I often wonder how my life could be different than it is”)

appeared as #6 as well as #8; the original item #8 ("I often wonder whether others like me") was omitted on a portion of the IES-G forms. Both items #6 and #8 were part of the identity accommodation scale. Sixty participants received the correct version of the IES-G while 76 received the incorrect version; one participant failed to complete the IES-G. For those participants who received the correct version, scores for each of the three scales were summed, which is the standard scoring procedure; in the event that an item was randomly omitted by a participant, the response was treated as missing data and no correction/completion process was implemented. For those participants who received the incorrect version, the identity-assimilation and identity-balance scales were summed using the same process as was used for the correct version.

For the identity accommodation scale, two different processes were used to account for the missing data. The first method was a process suggested by the author of the measure (Whitbourne et al., 2002). In order to account for missing data, Whitbourne et al. suggested calculating an average score of the total number of items on the scale and then multiplying that number by 11 (the total length of the scale). In the case of the identity accommodation scale in the present study, a mean score was created using the 10 items, which was then multiplied by 11 to arrive at the corrected sum score. Using this technique, the mean score for the identity accommodation scale was 31.30 (*SD* = 12.08). The second method involved a statistical process designed to replace missing data known as "substitution of the linear regression trend value for that point"; in other words, the missing value was replaced with the predicted value (Statistical Package for the Social Sciences). This process was used in order to add the predicted value for item #8 to the other ten items of the identity accommodation scale. Once these values were added, the total score for the identity accommodation scale was summed. The mean score for the

scale was 31.37 (*SD* = 11.35). Given that the mean scores for the identity accommodation scale did not differ significantly depending on which method was used, we elected to use the method suggested by Whitbourne et al.; this decision was made out of deference to the measure's author rather than based on further statistical analyses of the two methods used for correcting for missing data. Multiple imputation offered an additional process for addressing the missing data, however, we elected not to conduct this analysis after obtaining very similar results using the first two processes described above.

Psychological Well-Being

Participants' completed Ryff's Scales of Psychological Well-Being (SPWB; Ryff, 1989a), which include six dimensions designed to assess psychological well-being in a variety of populations. The six dimensions include autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance. The dimension of autonomy is characterized by how a person handles social pressures and evaluates him or herself. The dimension of environmental mastery is characterized by a person's ability to manage his or her environment. The dimension of personal growth is characterized by a person's sense of continued development of his or herself. The dimension of positive relations with others is characterized by a person's interaction with others and whether or not he or she engages in trusting relationships. The dimension of purpose in life is characterized by a person's goals in life and the things that give his or her life meaning. The dimension of self-acceptance is characterized by one's attitude toward the self and his or her life's path.

Each of the six dimensions has a separate corresponding scale, and each scale consists of 7 items designed to measure the construct. The SPWB offers several length options for administration. Ryff and her colleagues have employed the original 14-item scale in several of

their studies, while the Wisconsin Longitudinal Study uses the 9-item scale. Ryff and Keyes (1995) developed a 3-item scale for use in large-scale telephone studies, although Ryff strongly cautions against the use of this version. More recently, Ryff and colleagues have been using a 7-item version in the MIDUS (Midlife in the U.S.) study, which is a national study of American adults (C.D. Ryff, personal communication, October 28, 2009). The present study utilized the 7-item version in order to limit the time and energy required of participants (see **Appendix G**).

The items from each of the six SPWB scales are mixed to form a single measure, and the 7-item questionnaire has a total of 42 questions. Each item contains a statement related to one of the six dimensions, and participants are asked to rate their level of agreement with the statement using a 1 to 7 scale with the numbers corresponding to whether the participants *strongly agree, somewhat agree, a little agree, neither agree nor disagree, a little disagree, somewhat disagree,* or *strongly disagree* with each item. Sum scores are calculated for each dimension (positively framed items are reverse-scored), with higher scores representing higher ratings on the dimensions. Scores for each dimension can range from 7 to 49. Previous research has provided support for this multidimensional view of psychological well-being; factor analyses have shown that a model featuring the six main factors linked together by one higher order factor is representative of the best fit (Ryff & Keyes, 1995, p. 724).

PROCEDURE

Each of the measures along with an information sheet (see **Appendix H**), a cover sheet (see **Appendix I**), and a consent form (see **Appendix J**) were compiled into one data packet; see **Appendix K** for the order of administration within the data packet. Participants' data packets were collected both in person and via mailings. They were collected individually as well as within group settings. All participants were provided with a step-by-step instruction sheet (see

Appendix L). Participants were allowed to complete the packet at their own pace. The researcher and research assistants were available for any questions participants had. Participants' time to completion ranged from 20-90 minutes to complete the packet, with most participants taking approximately 40 minutes to finish.

Prior to the start of data collection, participants were informed of the purpose of the study and asked to sign a consent form. Participants were offered $10 as compensation for their involvement in the study. In order to receive payment, participants were asked to provide their Social Security number; in the event that participants did not want to disclose their Social Security number, they were informed that they would not be paid but that they could still participate in the study is they so desired. Upon completion of the packet, participants were given a brief disclosure statement (see **Appendix M**) for instructions and debriefing statement), thanked for their time, and asked if they had any remaining questions. Participants were informed that they would be mailed a brief summary of the study's findings once it was completed.

Throughout the data collection process, every effort was made to make the procedure as uniform as possible. Regardless of whether packets were collected in person or via mail, all participants received a step-by-step instructions sheet in their data packet. In the event that the researcher or research assistants collected the data packet in person, an instructions script was utilized (**Appendix L**). All participants were allowed to complete the packet at their own pace and were instructed to take a break if they needed one. Although the participants were all community-dwelling older adults and the administration was the same, each of the groups' settings for data collection differed slightly.

OAA Group

Older adults who were acquainted with the members of the Adult Development Lab at LSU were asked to participate in the study. These participants were given packets to complete in their own time and at their own pace. Many were administered and collected in person, although a portion were sent and received via mail.

SC Group

The SC groups included the Senior Neighbors group and an activities group at Alexian Grove. These groups represent social groups that meet daily for activities such as having coffee, discussions, exercising, or lunch. These participants were tested on January 4, 2010 at 9:00am (Senior Neighbors) and February 15, 2010 at 1:00pm (Alexian Grove). Each group was provided with a brief overview of the study. Participants were invited to participate but were told that it was not mandatory. Participants were given packets and told to work at their own pace.

LS Group

The researcher attended an information meeting of Lagniappe Studies Unlimited, which is a continuing education program for older adults. Participants were provided with a brief overview of the study; those who were interested in participating filled out a response card. The researcher or a research assistant then contacted the people who were interested in participating in order to schedule an appointment for the participant to come to the Louisiana Healthy Aging Study lab in the Student Research and Training Center located on LSU's campus. Participants were tested individually or in small groups of 2 to 3 between the first week of February 2010 and the first week of March 2010.

SJP Group

The researcher contacted the Community Liaison staff member at St. James Place and established two days during which residents could attend a data collection session. These sessions were scheduled for February 15 and 16, 2010 from 1:00pm to 3:00pm. Flyers advertising the sessions were posted around the community. Residents from the independent living community who were interested in participating were asked to come to the Duplantier Room in the Duplantier Building. Participants typically arrived between 12:50pm and 1:30pm; all participants were allowed to complete a packet regardless of arrival time.

CHAPTER THREE: RESULTS

Before testing the primary hypotheses of the study, we first examined the findings from each individual measure. A brief examination of the paradox of well-being hypothesis as it relates to physical health and functional ability is presented followed by basic descriptive statistics for each measure. These findings are followed by a more detailed examination of the primary hypotheses.

PARADOX OF WELL-BEING

The present research was designed to examine the paradox of well-being as it pertained to the experience of ageism, which in turn, was hypothesized to challenge psychological well-being. These findings will be presented later on when interrelationships among variables are discussed. Another way to look at the paradox of well-being is to examine the relationship between participants' self-reported health and psychological well-being. We used each of the three self-reported health variables to represent subjective health; for each variable, participants were categorized as having *low* or *high* subjective health. The three main self-reported health items asked participants to 1) rate their health at the present time as excellent, good, fair or poor (excellent, good = high; fair, poor = low), 2) report how much health troubles stand in the way of what they want to do as not at all, a little, or a great deal (not at all, a little = high; a great deal = low), and 3) to compare their health to the health of other people their age as better, the same as, or worse (better, the same as = high; worse = low).

We conducted three independent samples *t*-tests in order to examine the possible impact of self-reported health on overall well-being scores. Overall, results from the *t*-tests revealed that participants in the low self-reported health group had lower well-being scores than those in the high self-reported health group. There was a significant difference between participants based on

ratings of health at the present time, t (131) = 5.15, $p < .001$; participants in the high self-reported health group had significantly higher overall well-being scores than those in the low self-reported health group. There was also a significant difference between participants based on their ratings of how much health troubles stood in their way, t (131) = 2.45, $p < .05$; participants in the high self-reported health group had significantly higher overall well-being scores than participants in the low self-reported health group. There was not a significant difference between participants' comparisons of their own health and the health of others their age. However, in keeping with the paradox of well-being, the majority of participants had overall well-being scores of 200 or higher regardless of self-reported health. Overall well-being scores could range from 49 to 294, with higher scores indicating better well-being. **Table 5** shows mean overall well-being scores by self-reported health variables; note that despite significant differences based on self-reported health ratings, all mean well-being scores are 200 or higher. Although participants who were in the low self-reported health group had lower overall well-being scores than those in the high self-reported health group, the relatively high well-being scores across health ratings provide some support for the presence of well-being even in the face of objective difficulties.

Table 5. Differences in Overall Psychological Well-Being by Self-Reported Health

	Mean (SD)		*t*	*p*
	High	Low		
How would you rate your health at the present time?	235.36 (27.29)	200.86 (32.71)	5.15	.000
How much do health troubles stand in the way of your doing things you want to do?	231.91 (30.18)	207.70 (29.17)	2.45	.016

(continued on the next page)

Do you think your health is better, the same as, or worse than most people your age?	230.77 (30.93)	210.17 (16.49)	1.62	.11

PSYCHOLOGICAL WELL-BEING

Psychological well-being was measured using the SPWB, which includes 42 items that asks participants to rate how much they agree with each item using a 1 to 7 scale. The measure consists of six scales with seven items per dimension/scale. Dimension scores were summed and could range from 7-49, while the total score was summed across dimensions and could range from 49-294. Means and standard deviations for the total score for each dimension on the SPWB can be found in **Table 6** along with the total score for all dimensions combined. Overall, dimension scores ranged from 33.95 (*SD* = 5.81) for the Purpose in Life scale to 41.70 (*SD* = 6.46) for the Positive Relations with Others scale; the overall mean score for all dimensions combined was 229.66 (*SD* = 31.18).

Table 6. Overall Score and Dimension Scores for the Scales of Psychological Well-Being

	Mean	Standard Deviation
Autonomy	38.03	6.80
Environmental Mastery	39.15	7.47
Personal Growth	40.01	6.74
Positive Relations with Others	41.70	6.46
Purpose in Life	33.95	5.81
Self-Acceptance	36.82	6.19
Total	229.66	31.18

IDENTITY PROCESS THEORY

Identity processing styles were measured using the IES-G, which is a 33-item measure that asks participants to rate how much they are like each of the items using a 1 to 7 scale. The measure consists of three scales, with 11 items on each scale. Scale scores were summed and could range from 11-77; no total score across scales is created with the IES-G. Means and standard deviations for each overall scale score on the IES-G can be found in **Table 7**.

Table 7. Scale Scores for the Identity and Experiences Scale – General

	Mean	Standard Deviation
Identity Balance	58.73	11.08
Identity Accommodation	31.30	12.08
Identity Assimilation	44.21	10.92

AGEISM

Ageism was measured using the AS, which is a 20-item measure that asks participants to indicate how often they have experienced each item by reporting that the item occurred never, once, or more than once for them. The 20 items make up a single measure, and the total score is summed across all items; scores can range from 0-40. Participants in the present study had a mean score on the AS of 6.78 (*SD* = 5.86), which is a fairly low overall score. Frequency scores for each of the items on the Ageism Survey can be found in **Table 8**. Items that were frequently endorsed as "never" having been experienced are highlighted in grey. Item rank with respect to frequency of experience is included in **Table 8**. In general, items related to humor (e.g., receiving a birthday card joking about age) and disrespect (e.g., being ignored or not taken seriously because of age) were reported as being experienced most often. Previous research

categorized the items on the AS as a means of more easily examining the types of ageism that were most prevalent (Anderson & Yon, 2010). Similar to Anderson and Yon's findings, participants' most frequently reported experiences fell in the categories of humor, health/assumed competency, and personal rejection.

As is depicted in **Table 8**, 90% or more of the sample reported that they had never experienced the item for 10 of the 20 items. The author of the measure had originally reported that several of the items were rarely experienced by participants and that the reliability of the measure would be enhanced without these items. However, the author reported that these items were kept in the final version of the measure because they represent "the more serious types of ageism" (Palmore, 2001, p. 573). These 10 items, in which 90% or more of participants reported that they had never experienced the item, were dropped in the analyses that follow[2]. Incidentally, these 10 items that were dropped were also the least frequently reported items in a number of previous studies using the AS (e.g., Anderson & Yon, 2010; McGuire et al., 2008; Palmore, 2001; 2004). Cronbach's alpha for the revised 10-item version of the AS was .80, which suggests that the revised measure has satisfactory internal reliability. Using the revised version of the AS, participants had a mean total score of 6.14 (*SD* = 4.65). Approximately 83% of participants reported two or more experiences of ageism. Frequency scores for the 10-item version of the AS are presented in **Table 9.**

The previous analyses of the AS were conducted based on the 0 (never), 1 (once), or 2 (more than once) scoring method. However, it was apparent that participants primarily reported that they had experienced an item "never" or "more than once." As such, it seemed useful to examine these data based on a 0 (never) or 1 (at least once) scoring method. We conducted the same correlation and regression analyses using this scoring method for both the 10-item and 20-

[2]Analyses were first conducted using the 20-item version of the AS followed by the 10-item version of the AS. The results did not differ as a result of the version used, and we elected to report the results using the 10-item version in which the least frequently endorsed items were omitted.

Table 8. Percentage of Participants Experiencing Items on the Ageism Survey

	Never	Once	More than Once	At Least Once	Rank
1. I was told a joke that pokes fun at old people	15.7	3.1	81.1	84.2	1
2. I was sent a birthday card that pokes fun at old people	29.5	7.8	62.8	70.6	2
3. I was ignored or not taken seriously because of my age	66.7	8.5	24.8	33.3	4
4. I was called an insulting name related to my age	87.3	3.7	9.0	12.7	10
5. I was patronized or "talked down to" because of my age	66.9	9.0	24.1	33.1	5
6. I was refused rental housing because of my age	98.5	0.8	0.8	1.6	19
7. I had difficulty getting a loan because of my age	97.8	0.7	1.5	2.2	16
8. I was denied a position of leadership because of my age	91.7	4.5	3.8	8.3	11
9. I was rejected as unattractive because of my age	93.9	2.3	3.8	6.1	13
10. I was treated with less dignity and respect because of my age	84.8	4.5	10.6	15.1	9
11. A waiter or waitress ignored me because of my age	94.0	0.7	5.2	5.9	15
12. A doctor or nurse assumed my ailments were caused by my age	59.2	10.8	30.0	40.8	3
13. I was denied medical treatment because of my age	97.8	0.7	1.5	2.2	16
14. I was denied employment because of my age	92.4	3.8	3.8	7.6	12
15. I was denied a promotion because of my age	93.9	3.8	2.3	6.1	13
16. Someone assumed I could not hear well because of my age	77.3	5.3	17.4	22.7	7

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17. Someone assumed I could not understand because of my age	82.0	6.8	11.3	18.1	8
18. Someone told me, “You’re too old for that.”	70.7	12.8	16.5	29.3	6
19. My house was vandalized because of my age	97.8	1.5	0.7	2.2	16
20. I was victimized by a criminal because of my age	99.3	0.7	--	0.7	20

--Grey-shaded items represent those in which 90% or more of the sample reported that they had never experienced the items

Table 9. Percentage of Participants Experiencing Items on the 10-Item Version of the Ageism Survey

	Never	Once	More than Once	At Least Once	Rank
1. I was told a joke that pokes fun at old people	15.7	3.1	81.1	84.2	1
2. I was sent a birthday card that pokes fun at old people	29.5	7.8	62.8	70.6	2
3. I was ignored or not taken seriously because of my age	66.7	8.5	24.8	33.3	4
4. I was called an insulting name related to my age	87.3	3.7	9.0	12.7	10
5. I was patronized or “talked down to” because of my age	66.9	9.0	24.1	33.1	5
10. I was treated with less dignity and respect because of my age	84.8	4.5	10.6	15.1	9
12. A doctor or nurse assumed my ailments were caused by my age	59.2	10.8	30.0	40.8	3
16. Someone assumed I could not hear well because of my age	77.3	5.3	17.4	22.7	7
17. Someone assumed I could not understand because of my age	82.0	6.8	11.3	18.1	8
18. Someone told me, “You’re too old for that.”	70.7	12.8	16.5	29.3	6

item versions of the AS. The mean score for the 10-item version was 3.84 (*SD* = 2.54), while the mean score for the 20-item version was 4.53 (*SD* = 3.80). The 10-item version of the AS was not significantly correlated with any of the dimensions of well-being (*r* = -.01 to .10) nor was the 20-item version (*r* = -.002 to .10). The AS total score did not account for a significant portion of the variance for any of the well-being scores.

DEPRESSION

Depressive symptoms were screened for using the GDS, which is a 15-item measure asking participants to report how they have felt in the past week. Scores of "yes" on the negatively worded items were awarded 1 point, as were scores of "no" on the positively worded items. Scores of 6 or higher represent participants who are "mildly depressed." Participants in the present sample had a mean depression score of 1.71 (*SD* = 2.49); 9 participants (6.6%) reached criteria to be considered mildly depressed[3]. It should be noted that the GDS is designed to be used as a screening measure rather than a measure that should be used for clinical diagnosis, so interpretive caution is warranted.

Although the majority of our sample reported levels of depression that fell below the criterion set for mild depression, several analyses revealed that depression scores were accounting for a significant portion of the variance in well-being scores. As such, depression was included as a control variable in the first step of the hierarchical regression models when examining the well-being variables. Depression accounted for a significant portion of the variance in overall well-being as well as all six of the individual dimensions of well-being; these findings are reported more thoroughly in the following sections.

INTERRELATIONSHIPS AMONG VARIABLES

In order to test the hypotheses of the present study, we conducted correlation analyses as

[3]Analyses were conducted with and without these 9 participants who met criteria to be considered mildly depressed. The results were unchanged as a result of these participants being included in the sample.

a means of examining the relationships among the experience of ageism, identity processing styles, and psychological well-being. Correlation analyses are presented in **Table 10.** A series of hierarchical regression analyses were conducted to more specifically examine the three main hypotheses concerning the relationship between ageism and psychological well-being, the relationship between identity processing styles and psychological well-being, and the relationships among all three sets of variables.

Hypothesis 1

The first hypothesis of the study was made in regard to the relationship between the experience of ageism and psychological well-being. Specifically, we predicted that as the experience of ageism increased, one or more dimensions of psychological well-being would decrease. As predicted, correlation analyses showed that scores for autonomy, environmental mastery, personal growth, positive relations with others, self-acceptance, and overall well-being decreased as the experience of ageism increased (r = -.01 to = -.19); however, none of these relationships was statistically significant. Correlation analyses are presented in **Table 10**.

Several multiple regression analyses were conducted using the total score on the AS as the predictor variable, each of the six dimensions of psychological well-being and the overall well-being score as outcome variables, and depression as a control variable. An examination of the results from the regression analyses revealed that depression scores accounted for a significant portion of the variance in all of the well-being scores. However, the AS total score did not explain a significant portion of the variance for the overall well-being score or for the dimensions of autonomy, environmental mastery, personal growth, positive relations with other, or purpose in life. The AS total score explained 2% of the variance for the dimension of self-

acceptance after controlling for depression (β = -.13, p = .08). Results from these analyses are presented in **Table 11**.

Hypothesis 2

The second hypothesis was made in regard to the relationship between identity processing styles and psychological well-being. Specifically, we predicted that scores on the IBL and IAS scales would be positively related with one or more scores on the dimensions of well-being. We predicted that scores on the IAC scale would be negatively related with one or more scores on the dimensions of well-being. Correlation analyses showed that the relationships between identity processing styles and overall well-being, autonomy, environmental mastery, positive relations with others, and self-acceptance were in the predicted direction; as IBL and IAS scores increased, well-being scores decreased, while as IAC scores increased, well-being scores decreased. For the dimensions of personal growth and purpose in life, the relationships between IBL and IAC scores and well-being scores were in the predicted direction; however, IAS scores were negatively correlated with well-being scores. Correlation analyses are presented in **Table 10**.

In order to examine the relationship between the three identity processing styles and psychological well-being, we conducted several hierarchical regression analyses. The first analysis examined the relationship between the three identity processing styles (predictors) and the total SPWB score (outcome variable) while controlling for depression; subsequent analyses were conducted using the three identity processing styles as predictors and each of the six SPWB dimension scores as outcome variables while controlling for depression.

Results from the regression analysis using the scores from the identity processing scales as predictors and the overall SPWB score as the outcome revealed that IBL and IAC scales

Table 10. Correlation Analyses

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.
1. Ageism Survey	--	-.10	.05	-.06	-.14	-.06	-.13	.00	-.01	-.19	-.11	.11
2. Identity-Balanced		--	-.12	.35**	.50**	.51**	.48**	.30**	.40**	.44**	.56**	-.33*
3. Identity Accommodation			--	.27**	-.51**	-.50**	-.49**	-.47**	-.41**	-.58**	-.62**	.53**
4. Identity-Assimilation				--	.08	.09	-.06	-.11	.00	.05	.02	.09
5. Autonomy					--	.60**	.56**	.37**	.47**	.58**	.76**	-.38**
6. Environmental Mastery						--	.65**	.54**	.61**	.55**	.85**	-.56**
7. Personal Growth							--	.66**	.49**	.55**	.83**	-.62**
8. Purpose in Life								--	.50**	.44**	.73**	-.45**
9. Positive Relations w/Others									--	.59**	.77**	-.42**
10. Self-Acceptance										--	.78**	-.56**
11. Overall SPWB Score											--	-.63**
12. Depression												--

*denotes significance, $p < .01$; ** denotes significance, $p < .001$

Table 11. Relationship between Ageism and Psychological Well-Being, Controlling for Depression					
		ß	R^2	ΔR^2	*F*
Overall Well-Being	Step 1: Depression	-.634**	.402		90.88
	Step 2: Ageism Survey	-.040	.404	.002	45.40
Autonomy	Step 1: Depression	-.378**	.136		22.47
	Step 2: Ageism Survey	-.099	.140	.010	12.04
Environmental Mastery	Step 1: Depression	-.559**	.307		61.28
	Step 2: Ageism Survey	.007	.302	.000	30.42
Personal Growth	Step 1: Depression	-.624**	.385		86.10
	Step 2: Ageism Survey	-.059	.384	.003	43.35
Purpose in Life	Step 1: Depression	-.452**	.199		34.75
	Step 2: Ageism Survey	.052	.196	.003	17.53
Positive Relations with Others	Step 1: Depression	-.419**	.170		28.80
	Step 2: Ageism Survey	.039	.165	.002	14.44
Self-Acceptance	Step 1: Depression	-.564**	.313		62.98
	Step 2: Ageism Survey	-.127*	.324	.016	33.60
*denotes significance, $p < .10$; **denotes significance, $p < .001$					

explained 27% of the variance in overall psychological well-being even after controlling for depression, (β = .41, p < .001 and β = -.43, p < .001, respectively). Results from the subsequent regression analyses showed that the IBL and IAC scales accounted for a significant portion of the variance (11% to 31% depending on the dimension of well-being) in each of the six dimensions of well-being even when accounting for depression. Examination of the results showed that the IBL and IAC scores were significant predictors of each dimension of well-being (p < .01 for all comparisons); as IBL scores went up so did scores on the dimensions of well-being, while increases in IAC scores was associated with a decrease in scores on the dimensions of well-being. **Table 12** includes the results from these analyses.

Table 12. Relationship between Identity Processing Styles and Psychological Well-Being, Controlling for Depression

		ß	R^2	ΔR^2	F
Overall Well-Being	Step 1: Depression	-.643**	.410		94.64
	Step 2: IP Styles		.671	.267	69.91
	IBL	.411**			
	IAC	-.433**			
	IAS	.017			
Autonomy	Step 1: Depression	-.385**	.142		23.35
	Step 2: IP Styles		.441	.309	27.63
	IBL	.428**			
	IAC	-.471**			
	IAS	.066			

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		ß	R^2	ΔR^2	F
Environmental Mastery	Step 1: Depression	-.566**	.317		63.76
	Step 2: IP Styles		.498	.190	34.42
	IBL	.339**			
	IAC	-.337**			
	IAS	.094			
Personal Growth	Step 1: Depression	-.636**	.400		91.09
	Step 2: IP Styles		.516	.125	36.95
	IBL	.349**			
	IAC	-.213*			
	IAS	-.083			
Purpose in Life	Step 1: Depression	-.457**	.203		35.47
	Step 2: IP Styles		.296	.108	15.20
	IBL	.214*			
	IAC	-.311*			
	IAS	-.079			
Positive Relations with Others	Step 1: Depression	-.421**	.172		28.95
	Step 2: IP Styles		.291	.134	14.86
	IBL	.319**			
	IAC	-.278*			
	IAS	-020			

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		ß	R^2	ΔR^2	F
Self-Acceptance	Step 1: Depression	-.568**	.317		63.75
	Step 2: IP Styles		.510	.202	36.10
	IBL	.272**			
	IAC	-.438**			
	IAS	.099			

*denotes significance, $p < .01$; **denotes significance, $p < .001$

Hypothesis 3

We hypothesized that a low experience of ageism and an increased use of IBL and/or IAS processing styles would be associated with better psychological well-being scores. We also hypothesized that a high experience of ageism and an increased use of the IAC processing style would be associated with poorer psychological well-being scores. However, ageism was not significantly related to any of the identity processing styles or any of the dimensions of well-being so it was not possible to examine an interaction effect. In an attempt to further investigate the experience of ageism, we conducted exploratory analyses using subsets of the AS. However, even with the more condensed versions of the AS, we were not able to detect a significant relationship between the experience of ageism, the identity processing styles, or the scales of psychological well-being.

CHAPTER FOUR: DISCUSSION

The present study was designed to examine the finding that older adults report subjective well-being in the face of objective difficulty, otherwise known as the paradox of well-being, by investigating the relationships among the experience of ageism, identity processing styles, and psychological well-being. Generally speaking, the participants included in the present study were a healthy, functionally able, non-depressed, highly educated, and financially secure sample of older adults. Overall, participants reported a low experience of ageism, used the best or most positive approaches for dealing with age-related changes (IBL), and had high well-being scores on all of the dimensions of psychological well-being. As such, the examination of the paradox of well-being was particularly challenging because the sample essentially reported little to no objective difficulty (at least as far as difficulty was measured by the selected variables). However, the patterns that emerged from these data were, for the most part, in the directions predicted by the main hypotheses. The next section addresses the findings and implications for each of the main variables followed by the findings and implications associated with the interrelationships between these variables. Lastly, limitations of the present study are discussed along with recommendations for future research.

PSYCHOLOGICAL WELL-BEING

Previous research on psychological well-being has shown that older adults generally score lower on the dimensions of personal growth and purpose in life when compared to young and middle-aged adults (Ryff, 1989a; Ryff & Keyes, 1995). Older adults have also been shown to expect declines in the future on most all areas of psychological well-being (Ryff, 1991). Older adults have been shown to score higher or more consistently than younger adults on the dimensions of environmental mastery and autonomy (Ryff, 1991; Ryff & Keyes, 1995). In

general, previous research suggests that older adults' scores on the dimensions of psychological well-being are, for the most part, stable or declining rather than showing progress. This finding appears to be true even when healthy, educated, and financially secure older adults are assessed. Further, these findings are somewhat in contrast to research on subjective well-being that has shown older adults are as happy as any other group and generally satisfied with their lives (Ryff, 1989b). Although the results from the present study did not make comparisons between a variety of age groups or make multiple comparisons over time, our findings did show similarities with previous research.

Results from the present study revealed that participants' mean scores on the dimensions of psychological well-being were relatively similar compared to those reported by previous research (e.g., Ryff, 1989a; Ryff, 1991; Ryff & Keyes, 1995). Consistent with previous research, participants' scored lowest on the dimension of purpose in life. Similar to Ryff and Keyes (1995), participants in the present study scored fairly high on the positive relations with others dimension, which was the highest score of all the dimensions. Contrary to previous research, participants' second highest score was for the personal growth dimension; previous research has shown that older adults tend to score lower on this dimension than on other dimensions (Ryff, 1989a; Ryff, 1991; Ryff & Keyes, 1995). It is important to note that one subset of participants in the present study was recruited from a continuing education program for older adults, which may play some part in the high scores on the personal growth dimension; these participants may be more inclined than others to seek out means of improving themselves. Further, the majority of the sample was recruited from subsets that facilitated positive relations with others via activities and shared environments (e.g., senior center, retirement community, etc.). However, having a desire for personal growth and being a part of groups that facilitate positive relations with others

does not help explain why a group of vibrant older adults would have lower scores in their views on purpose in life. Overall though, participants in the present study scored on the higher end for all of the scales of psychological well-being.

IDENTITY PROCESSING STYLES

Previous research related to identity process theory has primarily focused on the relationships between identity processing styles and perceptions of self. Earlier studies have examined the link between identity processing styles on factors such as self-esteem and self-consciousness as well as affective factors such as depression (e.g., Sneed & Whitbourne, 2001; 2003; Weinberger, 2009). Across these areas, the research has shown that the use of IAS and IBL processing styles generally has a positive association with the variables in question; use of these approaches is related to positive outcomes such as better self-esteem. The use of IAC, on the other hand, has typically had a negative association with the variables in question; use of this approach is related to declines in positive function. These findings are in keeping with Whitbourne's premise that the paradox of well-being is attained through the use of IAS and that the use of IBL is the most conducive to aging successfully (e.g., Sneed & Whitbourne, 2003).

Results of the present study support previous findings and are in the direction predicted based on earlier research. The use of IBL was positively associated with psychological well-being, while the use of IAC was negatively associated with psychological well-being; this pattern of results was true for all six dimensions of well-being and the overall sum score. For the most part, the use of IAS was associated with psychological well-being in the predicted positive direction; however, the relationship between IAS and the dimensions of psychological well-being was minimal and did not account for any of the variance in the well-being variables.

Findings from the present study support the tenets of IPT given the positive relationship between use of the IBL approach and all of the dimensions of psychological well-being.

AGEISM

Previous research on ageism has taken several approaches such as examining implicit forms of ageism and the types of ageist attitudes and behaviors that people commonly endorse (e.g., Levy & Banaji, 2002; Cherry & Palmore, 2008). However, less attention has been given to examining the actual experience of ageism as it pertains to those who are currently in later adulthood. Research designed to examine the experience of ageism has largely been conducted using the AS (Palmore, 2001). Previous research using the AS has consistently shown that the majority of participants report experiencing at least one incident of ageism included in the AS (McGuire et al., 2008; Palmore, 2001; Palmore, 2004). Previous research has also shown that despite including 20 items, 10 items were consistently cited as the most frequently experienced items (Anderson & Yon, 2010; McGuire et al., 2008; Palmore, 2001; Palmore, 2004). Using Anderson and Yon's (2010) descriptions, these events typically fall into categories such as humor, health, assumed competency, and personal rejection.

Overall, participants in the present study reported a generally low or less frequent experience of ageism. Despite the low occurrence of ageism overall, the present study's findings were in accordance with previous research. Like the earlier studies, we found that the same 10 items were the most frequently reported items. We also found that the results of the analyses were unchanged when using a 10-item version of the AS compared to using the 20-item version; as such, we elected to report findings about the overall experience of ageism using a total score summed from the 10-item version of the AS. In regard to the frequency with which these items were reported, the pattern of findings for the present study were identical to those reported by

McGuire et al. (2008) and extremely similar to those reported by Anderson and Yon (2010) and Palmore (2001; 2004). Participants cited humorous events most frequently followed by items characterized by health, assumed competency, and personal rejection. Although the present sample's participants had a relatively low experience of ageism, these findings provide support for previous research using the AS.

HYPOTHESIS 1

When examining the three main hypotheses of the study, it became evident that the examination of the relationship between ageism and psychological well-being was precluded by the low experience of ageism reported in this sample. Contrary to the study's hypothesis, the experience of ageism was not significantly related to any of the dimensions of well-being; this finding was true despite using several different techniques to analyze scores on the AS. However, the pattern of responses was in the predicted direction; as the experience of ageism increased, scores on the dimensions of well-being decreased.

It is difficult to navigate the interpretation of null results in any case, but particularly so when previous research has also had difficulty in coming to terms with results from the AS. Specifically, there is ambiguity associated with understanding participants' motivation in reporting or failing to report their experiences. Palmore (2001) suggested that participants might be unaware that ageism even exists and therefore unable to perceive such experiences as ageist, or that some participants might not want to admit to experiencing ageism. Palmore (2004) also suggested that participants might deny ageist experiences because it would place them in the category of "old people."

In line with these questions are issues associated with the items on the AS themselves. While many people may be aware that ageism exists, they may not deem certain items on the AS

to actually be ageist. Palmore (2004) reported that participants frequently wrote notes in the margin questioning whether the humorous items (e.g., being told a joke about an old person; being sent a birthday card joking about age) were in fact really instances of ageism; Palmore argued that such jokes and cards were based on negative stereotypes and in turn fit the definition of ageism. Anderson and Yon (2010) also commented on the humorous items by first calling to attention the fact that scholarly analysis of such birthday cards largely tell older women that they are "disgusting and hideous" (p. 69); further, they note that any attempt to object to the sentiments in such cards is typically met with judgment that one has no sense of humor. That said, Anderson and Yon (2010) noted that humorous banter is often part of the interactions between friends and that "joking may be an outlet for older persons who have internalized the ageist cultural values about themselves and are releasing anxiety in a relatively safe environment" (p. 69). From a research point of view, the items on the AS clearly fit the description for ageist items; however, it is possible that the definition and understanding of what constitutes ageism may differ somewhat for those who are actually experiencing life as an older adult. The AS was developed primarily based on the available literature on ageism and discussions with other gerontology colleagues (Palmore, 2001). As Palmore (2001) previously suggested, now may be a critical time to further examine the experience of ageism using qualitative interviews and focus groups as a means of better understanding how older adults themselves perceive ageism.

HYPOTHESIS 2

Turning to the study's second hypothesis, we examined the relationship between older adults' identity processing styles and psychological well-being. Based on previous research, we predicted that IBL and IAS would be positively associated with at least one dimension of

psychological well-being, while IAC would be negatively associated with at least one dimension of psychological well-being. Results from the present study supported two of the three predictions. The use of an IBL approach was positively associated with all of the dimensions of psychological well-being; however, the use of IAS was not associated with any of the dimensions of wellbeing. The use of an IAC approach was in fact negatively associated with all of the dimensions of psychological well-being. The use of IBL and IAC approaches accounted for a significant portion of the variance in scores on all of the dimensions of well-being including the overall sum score across dimensions. These findings are particularly interesting because IBL and IAC accounted for significant portions of the variance even when controlling for depression. These findings are consistent with previous research on identity processing styles and provide support for both identity process theory and the use of the IES-G as a measure of identity processing styles. Previous research using the IES-G has largely been conducted to examine the associations between identity processing styles and perceptions of self. To our knowledge, the present study represents one of the first attempts to examine the associations between identity processing styles and psychological well-being.

HYPOTHESIS 3

The last of the main hypotheses was related to examining how an interaction between the experience of ageism and identity processing styles might be related to psychological well-being. We predicted that a low experience of ageism and an increased use of an IBL approach would be associated with the best sense of psychological well-being. On the other end, we predicted that a high experience of ageism and an increased use of the IAC approach would be associated with the worst sense of psychological well-being. Given that our participants had a relatively low experience of ageism overall and that the total ageism score was not significantly related to any

of the dimensions of well-being, we had difficulty examining this hypothesis in the manner predicted. Given that participants' mean total score on the AS did not reveal a floor effect, we investigated the possibility that the experience of ageism was related to psychological well-being by examining the AS scores in several different ways. Despite examining the scores using smaller subsets of the AS as well as rescoring the items to reflect an "all or nothing" experience of ageism, we were unable to obtain statistical evidence showing a link between ageism and psychological well-being. Although the present study was unable to find an association between the experience of ageism and psychological well-being, the lack of floor effects in the total AS score suggests that further examination of ageism is needed.

It is impossible to make any real claims about how these data apply to this particular hypothesis, but it is interesting to note that the entire sample seems to embody at least one part of the hypothesis. As a whole, participants in the present study had a low experience of ageism, used an IBL approach more often than the other approaches, and had high scores on all dimensions of well-being and on the overall well-being score. Again it is important to note that we are unable to make any sort of causal claims about these data, but the patterns that became evident suggest that this hypothesis is worth further examination in the future.

LIMITATIONS AND RECOMMENDATIONS

The present study was designed as an exploratory examination of the relationships among the experience of ageism, identity processing styles, and psychological well-being. Several limitations emerged that warrant discussion. It is important to note that there were limitations associated with the sample of older adults included in the present study. There were also some limitations evident with at least one of the measures included in the study.

The present study experienced some limitations associated with the sample of older adults who participated in the study. In order to recruit the 129 older adults deemed necessary by a power analysis, the research team used a convenience sample. Older adults were recruited through a continuing care retirement community, a continuing education group for older adults, senior centers, and community-dwelling older adults who were acquainted with members of the research team. In each case, at least one member of the research team had prior experience with the site, group, or individual. In addition to the sample being one of convenience, it also reflected a group of older adults who were considerably healthier, wealthier, and better educated than a group of older adults who might have been randomly sampled from the community. It is possible that such a wealthy, high functioning group may in some way be "protected" from the negative experiences of ageism by the privileges to which they have access. Despite the likelihood that the sample was biased toward high functioning older adults, it does seem worth noting that several of the predicted patterns were evident presumably even in a group of successful agers. Future research should focus on examining the present study's hypotheses in a more diverse group of older adults, and particularly those with a more varied socioeconomic background.

An additional limitation the present study faced was potential difficulties associated with using the AS in order to measure the experience of ageism. Although it is currently the only measure offered for assessing the experience of ageism, current and previous research has found problems with gaining a clear understanding of the prevalence and frequency with which ageism is experienced by older adults. It is impossible to ascertain the motivations underlying participants' decisions to report or not report their experiences, and as a result, it is very difficult to determine whether the AS provides an accurate estimation of an older adult's experience of ageism. When using the 20-item version, there were 10 items in which 90% or more of the

sample reported that they had never experienced the item. Omission of these 10 items did lead to a more full range of scores, but a low experience of ageism was obviously still evident. Further, the overall findings for the AS were unchanged even when smaller subsets of items were examined and items were rescored. Future research should take a more qualitative approach to examining the experience of ageism; in turn, it is possible that such qualitative findings could aid in the enhancement of the AS or the construction of a new quantitative measure designed to more accurately assess the experience of ageism.

IMPLICATIONS

The present study represents an examination of the relationships among the experience of ageism, reactions to age-related changes as viewed through identity process theory, and six dimensions of psychological well-being. We found that ageism was not significantly related to psychological well-being, but that the use of certain identity processing styles was significantly related to well-being. Within identity process theory, the IBL and IAS processes have been shown to be better strategies for maintaining a positive sense of self when faced with age-related changes. On the contrary, use of the IAC process has been shown to be a less effective strategy at maintaining a positive sense of self with age. We found that use of IBL was associated with higher psychological well-being scores, while use of IAC was associated with lower well-being scores.

The present study has implications for the practices and measures used for assessing the experience of ageism. Given the low experience of ageism reflected in the present study, future research is needed to qualitatively examine how ageism is actually perceived by older adults. Although it is possible that participants in the present study had a genuinely low experience of ageism, it is also possible that they simply did not perceive the items on the AS to be ageist.

Further, several participants suggested they did not allow themselves to be bothered by such experiences—to the point that they perhaps failed to report the experience altogether. In addition to studying the actual construct of ageism more closely, future research should also develop other ways to examine the possible effects associated with the experience of ageist attitudes and behaviors.

The present study provides support for the basic tenets of identity process theory and extends research using this theory to the study of psychological well-being. The study also provides some support for previous research on psychological well-being and represents one of the first studies to examine psychological well-being as it is potentially influenced by the experience of ageism. Further, participants in the present study used the IBL approach most frequently, which is the approach that has been shown to be most conducive to successful aging. Overall, participants in the present study serve as exemplars of the successful aging paradigm because they have high levels of physical and cognitive functioning and continue to maintain an active engagement with life (Rowe & Kahn, 1997). Although we are possibly left with the question of "which came first?"—did participants utilize the IBL approach, which resulted in high psychological well-being, or did they have high psychological well-being, which allowed them to more easily utilize the IBL approach—there do seem to be implications for promoting the use of an IBL approach when navigating age-related changes. With the increasing numbers of adults entering older adulthood and an increasing emphasis on quality of life, it will be important to parse out these components in future research on ageism as well as other age-related challenges that older adults may face.

As the Baby Boom generation ages and the potentially negative views surrounding programs such as Social Security and Medicare come to the forefront, it is unlikely that ageist

views will decrease in the near future (Longino, 2005). There may be a lack of awareness about ageism as a construct as well as a shortage of programs or campaigns designed to reduce ageism. As such, targeting the ways that people negotiate age-related changes may be a useful approach to not only lessen the impact of ageism on psychological well-being, but potentially address ageism as well. More specifically, presenting people of all ages with positive information about the aging process may lead to decreases in negative age stereotypes and increases in the use of positive strategies for handling age-related changes. This area represents interesting possibilities that await further research.

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APPENDIX A – POWER ANALYSIS

In order to determine the appropriate sample size, a power analysis was conducted using the G*Power program. The following information was entered into the program, which resulted in a suggested sample size of 129 participants.

Input Parameters		Output Parameters	
Test family	F tests	Noncentrality parameter λ	19.35
Statistical test	Multiple regression omnibus (R^2 deviated from 0)	Critical F	2.44
Type	a priori-computer ample size	Numerator df	4
Effect size	0.15	Denominator df	124
α error probability	0.05	Total sample size	129
Power (1 - β error probability)	0.95	Actual power	0.951
Number of predictors	4		

APPENDIX B – DEMOGRAPHIC QUESTIONNAIRE

Please complete the following questionnaire to the best of your ability.

For all of the items below, please circle one response.

HOW WOULD YOU RATE YOUR HEALTH AT THE PRESENT TIME?

1. Excellent 2. Good 3. Fair 4. Poor

HOW MUCH DO HEALTH TROUBLES STAND IN THE WAY OF YOUR DOING THINGS YOU WANT TO DO?

1. Not at all 2. A little (some) 3. A great deal

DO YOU THINK YOUR HEALTH IS BETTER, THE SAME AS, OR WORSE THAN MOST PEOPLEYOUR AGE?

1. Better 2. The same as 3. Worse

I CURRENTLY LIVE: *(please circle one)*	RELATIONSHIP STATUS: *(please circle one)*
1. in my home	1. Single
2. independently, in a retirement community	2. Married
3. with a family member	3. Partner/Significant Other
4. in assisted living	4. Divorced
5. in a nursing home	5. Widowed

PLEASE CIRCLE THE HIGHEST LEVEL OF EDUCATION **YOU** COMPLETED	PLEASE CIRLCE THE HIGHEST LEVEL OF EDUCATION **YOUR SPOUSE** COMPLETED
0 Less than high school	0 Less than high school
1 High school/GED	1 High school/GED
2 Some college/Associate's degree	2 Some college/Associate's degree
3 Bachelor's degree	3 Bachelor's degree
4 Master's degree	4 Master's degree

5 Doctoral/professional degree	5 Doctoral/professional degree

WHAT, IF ANY, IS YOUR RELIGIOUS AFFILIATION *(please circle one)*	*If Other, please specify. Please feel free to specify denomination or group.*
1. Catholic 2. Protestant 3. Jewish 4. Other Religions of the World 5. Non-religious/Agnostic/Secular 6. Other 7. Atheist or non-applicable	

HOW HARD IS IT FOR YOUR TO PAY FOR THE VERY BASICS LIKE FOOD, HOUSING, MEDICAL CARE, AND HEATING? *(please check one)*

____ Not difficult at all

____ Not very difficult

____ Somewhat difficult

____ Very difficult

TO WHAT EXTENT DO YOU THINK YOUR INCOME IS ENOUGH FOR YOU TO LIVE ON? *(please check one)*

____ Not at all adequate

____ Can meet necessities only

____ Can afford some of the things I/we want but not all that is wanted

____ Can afford to buy everything I/we want

____ Can afford about everything I/we want and still save money

PLEASE INDICATE YOUR APPROXIMATE OVERALL MONTHLY INCOME LEVEL AFTER TAXES? *(please check one)*

____ Less than $1,000 a month (up to $12,000 per year)

____ Between $1,000 and $2,000 a month ($12,000 to $23,999 per year)

____ Between $2,000 and $3,000 a month ($24,000 to $35,999 per year)

____ Between $3,000 and $4,000 a month ($36,000 to $47,999 per year)

____ Between $4,000 and $5,000 a month ($48,000 to $59,999 per year)

____ Between $5,000 and $6,000 a month ($60,000 to $71,999 per year)

____ More than $6,000 a month ($72,000 or more per year)

____ Don't know

Please feel free to include any questions, comments, or concerns in the space provided below. We appreciate your feedback! Thank you again for your participation!

APPENDIX C – FUNCTIONAL ABILITY QUESTIONNAIRE

Functional Ability	ID#	Date

For the following activities, please state whether you are able to complete the task on your own or if you require some form of assistance.

	Activity	**On My Own**	**With Help**
1	Bathing	o	o
2	Dressing	o	o
3	Toileting	o	o
4	Transferring	o	o
5	Continence	o	o
6	Feeding	o	o

For the following activities, please check the activities that you are capable of performing

1	**Use telephone**	***Check all that apply***
	Operate telephone on own	o
	Dial a few well-known numbers	o
	Answer telephone but do not dial	o
	Do not use telephone at all	o

2	**Shopping**	***Check all that apply***
	Take care of all shopping needs on own	o
	Shop independently for small purchases	o
	Need to be accompanied on trips	o
	Completely unable to shop	o

3	**Food preparation**	***Check all that apply***
	Plan, prepare, and serve meals	o
	Prepare adequate meals if supplied with ingredients	o
	Heat, serve, and prepare meals but don't maintain an adequate diet	o
	Need to have meals prepared and served	o
4	**Housekeeping**	***Check all that apply***
	Maintain house alone or with occasional help	o
	Perform light daily tasks such as dishwashing	o
	Perform light daily tasks but cannot maintain acceptable level of cleanliness	o
	Need help with all home maintenance tasks	o
	Do not participate in any housekeeping tasks	o
5	**Laundry**	***Check all that apply***
	Do personal laundry completely	o
	Launder small items; rinses stockings, etc.	o
	All laundry must be done by others	o
6	**Mode of transportation**	***Check all that apply***
	Travel independently on public transportation or drive own car	o
	Arrange own travel via taxi, but do not otherwise use public transportation	o
	Travel on public transportation when accompanied by another	o

	Travel limited to taxi or automobile with assistance of another	o
	Do not travel at all	o

7	**Responsibility for own medications**	***Check all that apply***
	Responsible for taking medication in correct dosages at correct time	o
	Take responsibility if medication is prepared in advanced in separate dosage	o
	Not capable of dispensing own medication	o

8	**Ability to handle finances**	***Check all that apply***
	Manage financial matters independently (budgets, writes checks, pays rent, etc.), collect and keep track of income	o
	Manage day-to-day purchases, but need help with banking, major purchases, etc.	o
	Not capable of handling money	o

APPENDIX D – GERIATRIC DEPRESSION SCALE

GDS - Short Form **Date _____ ID _____**

*We would like to ask you some questions about how you have felt over the **PAST WEEK**. Please circle **YES** if a statement is true for you and **NO** if it does not apply to you.*

1	Are you basically satisfied with your life?	Yes	No
2	Have you dropped many of your activities and interests?	Yes	No
3	Do you feel that your life is empty?	Yes	No
4	Do you often get bored?	Yes	No
5	Are you in good spirits most of the time?	Yes	No
6	Are you afraid that something bad is going to happen to you?	Yes	No
7	Do you feel happy most of the time?	Yes	No
8	Do you often feel helpless?	Yes	No
9	Do you prefer to stay at home, rather than going out and doing things?	Yes	No
10	Do you feel that you have more problems with memory than most?	Yes	No
11	Do you think it is wonderful to be alive now?	Yes	No
12	Do you feel pretty worthless the way you are now?	Yes	No
13	Do you feel full of energy?	Yes	No
14	Do you feel that your situation is hopeless?	Yes	No
15	Do you think that most people are better off than you are?	Yes	No

APPENDIX E – AGEISM SURVEY

Aging Survey		**ID _____**		**Date _____**			
		Please select one of the following to indicate how often you have experienced the item.			*If you HAVE experienced the item, please select how often you have experienced the item **SINCE TURNING 60.***		
	Statement	**Never**	**Once**	**More than once**	**A few times**	**Quite a bit**	**All the time**
1	I was told a joke that pokes fun at old people	o	o	o	o	o	o
2	I was sent a birthday card that pokes fun at old people	o	o	o	o	o	o
3	I was ignored or not taken seriously because of my age	o	o	o	o	o	o
4	I was called an insulting name related to my age	o	o	o	o	o	o
5	I was patronized or "talked down to" because of my age	o	o	o	o	o	o
6	I was refused rental housing because of my age	o	o	o	o	o	o
7	I had difficulty getting a loan because of my age	o	o	o	o	o	o
8	I was denied a position of leadership because of my age	o	o	o	o	o	o

9	I was rejected as unattractive because of my age	o	o	o		o	o	o
10	I was treated with less dignity and respect because of my age	o	o	o		o	o	o
11	A waiter or waitress ignored me because of my age	o	o	o		o	o	o
12	A doctor or nurse assumed my ailments were caused by my age	o	o	o		o	o	o
13	I was denied medical treatment because of my age	o	o	o		o	o	o
14	I was denied employment because of my age	o	o	o		o	o	o
15	I was denied a promotion because of my age	o	o	o		o	o	o
16	Someone assumed I could not hear well because of my age	o	o	o		o	o	o
17	Someone assumed I could not understand because of my age	o	o	o		o	o	o
18	Someone told me, "You're too old for that."	o	o	o		o	o	o
19	My house was vandalized because of my age	o	o	o		o	o	o
20	I was victimized by a criminal because of my age	o	o	o		o	o	o

APPENDIX F – IDENTITY AND EXPERIENCES SCALE – GENERAL

Identity & Experiences Scale - General **Date** **ID**

Please choose the response that reflects how much each statement below is like you.

		Not at all like me	***Completely like me***
1	I am not very interested in advice from others	1-------2-------3-------4-------5-------6-------7	
2	I spend little time wondering "why" I do things	1-------2-------3-------4-------5-------6-------7	
3	I have many doubts and questions about myself	1-------2-------3-------4-------5-------6-------7	
4	I have very few doubts or questions about myself	1-------2-------3-------4-------5-------6-------7	
5	I don't spend much effort reflecting on "who" I am	1-------2-------3-------4-------5-------6-------7	
6	I often wonder about how my life could be different than it is	1-------2-------3-------4-------5-------6-------7	
7	I am very influenced by what others think	1-------2-------3-------4-------5-------6-------7	
8	I often wonder whether others like me	1-------2-------3-------4-------5-------6-------7	

9	I try to be flexible but also try to maintain my goals	1-------2-------3-------4-------5-------6-------7
10	I generally try to avoid change in my life or how I see myself	1-------2-------3-------4-------5-------6-------7
11	I don't think very deeply about my goals because I know what they are	1-------2-------3-------4-------5-------6-------7
12	At times, I seriously question "who" I am	1-------2-------3-------4-------5-------6-------7
13	I behave according to what I think others want from me	1-------2-------3-------4-------5-------6-------7
14	I feel that it's hard to decide on which course I want in life	1-------2-------3-------4-------5-------6-------7
15	I prefer to think only about the "good" in myself	1-------2-------3-------4-------5-------6-------7
16	I like to see myself as stable, consistent, and unlikely to change	1-------2-------3-------4-------5-------6-------7
17	I am challenged but not overwhelmed by change	1-------2-------3-------4-------5-------6-------7
18	I need people to tell me they like me	1-------2-------3-------4-------5-------6-------7
19	I feel I can handle disappointments about myself	1-------2-------3-------4-------5-------6-------7

20	I try to keep a steady course in life but I am open to new ideas	1-------2-------3-------4-------5-------6-------7
21	I try not to get into situations that cause me to question myself	1-------2-------3-------4-------5-------6-------7
22	I have had my share of experiences in which I've learned about myself	1-------2-------3-------4-------5-------6-------7
23	I rely on others because I lack confidence in my judgments	1-------2-------3-------4-------5-------6-------7
24	I wonder what others will think of my behavior	1-------2-------3-------4-------5-------6-------7
25	I often change my mind as I consider different alternatives in life	1-------2-------3-------4-------5-------6-------7
26	I feel confident in "who" I am but I am willing to learn more about myself	1-------2-------3-------4-------5-------6-------7
27	I don't think about my mistakes or shortcomings	1-------2-------3-------4-------5-------6-------7
28	When it comes to understanding myself, I'd rather not look too deeply	1-------2-------3-------4-------5-------6-------7
29	I often take stock of what I have or have not accomplished	1-------2-------3-------4-------5-------6-------7
30	I have a clear sense of my goals but I am willing to consider alternatives	1-------2-------3-------4-------5-------6-------7

31	I am always looking for ways to improve myself	1-------2-------3-------4-------5-------6-------7
32	I am not afraid to confront my failures	1-------2-------3-------4-------5-------6-------7
33	I am influenced by my experiences but I also feel I can control my life	1-------2-------3-------4-------5-------6-------7

APPENDIX G – SCALES OF PSYCHOLOGICAL WELL-BEING

Scales of Well-Being **Date _____ ID _____**

	The following set of questions deals with how you feel about yourself and your life. Please note how much you agree or disagree with each statement.	Strongly Agree	Somewhat Agree	A Little Agree	Neither Agree or Disagree	A little Disagree	Somewhat Disagree	Strongly Disagree
1	I am not afraid to voice my opinions, even when they are in opposition to the opinions of most people	1	2	3	4	5	6	7
2	In general, I feel like I am in charge of the situation in which I live	1	2	3	4	5	6	7
3	I am not interested in activities that will expand my horizons	1	2	3	4	5	6	7
4	Most people see me as loving and affectionate	1	2	3	4	5	6	7
5	I live life one day at a time and don't really think about the future	1	2	3	4	5	6	7

6	When I look at the story of my life, I am pleased with how things have turned out	1	2	3	4	5	6	7
7	My decisions are not usually influenced by what everyone else is doing	1	2	3	4	5	6	7
8	The demands of everyday life often get me down	1	2	3	4	5	6	7
9	I think it is important to have new experiences that challenge how you think about yourself and the world	1	2	3	4	5	6	7
10	Maintaining close relationships has been difficult and frustrating for me	1	2	3	4	5	6	7
11	I have a sense of direction and purpose in life	1	2	3	4	5	6	7
12	In general, I feel confident and positive about myself	1	2	3	4	5	6	7

13	I tend to be influenced by people with strong opinions	1	2	3	4	5	6	7
14	I do not fit very well with the people and the community around me	1	2	3	4	5	6	7
15	When I think about it, I haven't really improved much as a person over the years	1	2	3	4	5	6	7
16	I often feel lonely because I have few close friends with whom to share my concerns	1	2	3	4	5	6	7
17	I don't have a good sense of what it is I'm trying to accomplish in life	1	2	3	4	5	6	7
18	I feel like many of the people I know have gotten more out of life than I have	1	2	3	4	5	6	7
19	I have confidence in my own opinions, even if they are different from the way most other people think	1	2	3	4	5	6	7

20	I am quite good at managing the many responsibilities of my daily life	1	2	3	4	5	6	7
21	I have the sense that I have developed a lot as a person over time	1	2	3	4	5	6	7
22	I enjoy personal and mutual conversations with family members or friends	1	2	3	4	5	6	7
23	My daily activities often seem trivial and unimportant to me	1	2	3	4	5	6	7
24	I like most aspects of my personality	1	2	3	4	5	6	7
25	It's difficult for me to voice my own opinions on controversial matters	1	2	3	4	5	6	7
26	I often feel overwhelmed by my responsibilities	1	2	3	4	5	6	7

27	For me, life has been a continuous growth process of learning, changing, and growth	1	2	3	4	5	6	7
28	People would describe me as a giving person willing to share my time with others	1	2	3	4	5	6	7
29	I enjoy making plans for the future and working to make them a reality	1	2	3	4	5	6	7
30	In many ways, I feel disappointed about my achievements in life	1	2	3	4	5	6	7
31	I tend to worry about what other people think of me	1	2	3	4	5	6	7
32	I have difficulty arranging my life in a way that is satisfying to me	1	2	3	4	5	6	7
33	I gave up trying to make big improvements or changes in my life a long time ago	1	2	3	4	5	6	7

34	I have not experienced many warm and trusting relationships with others	1	2	3	4	5	6	7
35	My attitude about myself is probably not as positive as most people feel about themselves	1	2	3	4	5	6	7
36	I judge myself by what I think is important, not by the values of what others think is important	1	2	3	4	5	6	7
37	I have been able to build a home and a lifestyle for myself that is much to my liking	1	2	3	4	5	6	7
38	I do not enjoy being in new situations that require me to change my old familiar ways of doing things	1	2	3	4	5	6	7
39	I know that I can trust my friends, and they know they can trust me	1	2	3	4	5	6	7
40	Some people wander aimlessly through life, but I am not one of them	1	2	3	4	5	6	7

41	When I compare myself to friends and acquaintances, it makes me feel good about who I am	1	2	3	4	5	6	7
42	I sometimes feel as if I've done all there is to do in life	1	2	3	4	5	6	7

APPENDIX H – INFORMATION SHEET

Ageism & Psychological Well-Being Study – Information Sheet

Name: _____

Mailing Address: _____

City _____ State _____ Zip Code _____

Phone Number : ( ) _____

Date of Birth: _____

ITEM CHECKLIST *-- (for in-office purposes only)*

Item	**Completed**	
Informed Consent Form	SIGNED	NOT SIGNED
Cover Sheet	YES	NO
Scales of Well-Being	YES	NO
Identity & Experiences Scale – General	YES	NO
Aging Survey	YES	NO
Functional Ability questionnaire	YES	NO
Demographic Questionnaire	YES	NO
GDS – Short Form	YES	NO
Informed Consent Letter	YES	NO
Social Support Questionnaire	YES	NO

For in-office purposes only	*Date*
Social Security Number Received:	
Check Requested:	
Check Mailed:	
Check Received:	

APPENDIX I – COVER SHEET

Louisiana State University
Ageism and Psychological Well-Being Study
Cover Sheet

Name _____

Age _____

Gender
(please circle one) Male Female

Race/Ethnicity
(please check one)

_____ African American or Black
_____ American Indian or Alaska Native
_____ Asian
_____ Caucasian or White
_____ Hispanic or Latina/Latino
_____ Multiracial
_____ Native Hawaiian or other Pacific Islander
_____ Other

Please select one of the following options:

_____ I would like information about the results of the study mailed to me.

_____ I **do not** want information about the results of the study mailed to me.

Thank you for your time and participation!

For questions or concerns, please contact:

Jenny Y. Denver, M.S. | (423) 605.7245 Katie E. Cherry, Ph.D. | (225) 578.4099

The study has been discussed with me and all my questions have been answered. I may direct additional questions regarding study specifics to Dr. Katie Cherry, LSU Department of Psychology (225) 578-4099. If I have questions about subjects' rights or other concerns, I can contact Dr. Robert Mathews, Chairman, LSU Institutional Review Board, (225) 578-8692. I agree to participate in the study described above and acknowledge that I have been given a copy of the consent form.

APPENDIX J – INFORMED CONSENT FORM

CONSENT FORM

1. Study Title: Ageism and Psychological Well-Being in Older Adults

2. Performance Sites: The Adult Development Lab on the LSU campus, Baton Rouge, LA., and participants' homes

3. Contacts: *(available Monday through Friday between 10:00am and 4:00pm)*

Principal Investigator:	Katie E. Cherry, Ph.D.	Tel: (225) 578-8745
Co-Investigators:	Jenny Y. Denver	Tel: (225) 578-8745
	Kelli Broome	Tel: (225) 578-8745

4. Purpose of the Study: The investigators seek to examine factors that influence quality of life in adulthood. We will examine relationships among factors including everyday routines and social activities, psychological well-being and the experience of ageism.

5. Subjects:

Inclusion Criteria: 18 years of age or older; visually and auditorily capable

Exclusion Criteria: history of stroke, adult dementia, or other neurological impairment

Maximum number of subjects: 1000 persons

6. Study Procedures: The study will be conducted in one or more sessions where I will be asked to complete a series of paper and pencil questionnaires that ask about my experiences, everyday activities, psychological well-being, and other background characteristics about me (educational attainment, etc.).

7. Benefits: The benefits I may expect from participating in this project include: an opportunity to learn about quality of life in adulthood, an opportunity to contribute to scientific research, and a modest honorarium.

8. Risks/Discomforts: There are no anticipated risks/discomforts during participation in this project. If signs of minor stress are apparent, the session will be discontinued immediately.

9. Measures taken to reduce risk: The investigators will be well trained in administering the surveys and will be vigilant to potential signs of risk/distress. Participants' data sheets will be coded by number to preserve complete anonymity.

10. Right to Refuse: Participation in this project is entirely voluntary. I can withdraw my consent at any time and have the results of the participation returned to me, removed from the experimental records, or destroyed.

11. Privacy: All response forms will be will be kept in a secure location housed within a limited access, locked research room. Results of the study may be published; however, we will keep your name and other identifying information private. Your identity will remain confidential unless law requires disclosure.

12. Financial Information: not applicable

13. Withdrawal/Removal: There are no consequences of withdrawing from the project. I may discontinue my participation at any time by informing the investigator. I will not be removed from the study without my consent

14. Health Insurance Portability and Accountability Act (HIPAA): Records that you give us permission to keep, and that identify you, will be kept confidential as required by law. Federal Privacy Regulations provide safeguards for privacy, security, and authorized access. Except when required by law, you will not be identified by name, social security number, address, telephone number, or any other direct personal identifier in screening records disclosed outside of Louisiana State University (LSU) and kept in study archives.

The study has been discussed with me and all my questions have been answered. I may direct additional questions regarding study specifics to Dr. Katie Cherry, LSU Department of Psychology (225) 578-4099. If I have questions about subjects' rights or other concerns, I can contact Dr. Robert Mathews, Chairman, LSU Institutional Review Board, (225) 578-8692. I agree to participate in the study described above and acknowledge that I have been given a copy of the consent form.

_____

Signature of Participant Date

_____

Signature of Investigator Date

APPENDIX K – ORDER OF ADMINISTRATION

1. Informed consent form
2. Information sheet
3. Cover sheet
4. Scales of Psychological Well-Being
5. Identity & Experiences Scale – General
6. Ageism Survey
7. Functional Ability Questionnaire
8. Demographic Questionnaire
9. Geriatric Depression Scale

APPENDIX L – IN-PACKET INSTRUCTIONS SHEET

Order of Tasks & Instructions

Thank you for agreeing to participate in the current research study!

We realize that your time is important, and we appreciate your willingness to fill out the forms in this packet. As a gesture of appreciation, we will be paying all participants $10. In order for you to receive the check from Louisiana State University, we will need to submit your name, address, and social security number to LSU's Office of Accounting Services. Your social security number will only be paired with an ID number and the information will be shredded immediately after it has been submitted in order to protect your privacy. Thank you for your assistance!

STEP	TASK	INSTRUCTIONS
Step 1	Consent Form	Please read the consent form. Please sign one copy and return it to the researcher. Please keep the other copy for your records.
Step 2	Cover Sheet	Please fill out all of the information on the cover sheet.
Step 3	Scales of Well-Being	Please circle the number (1 to 7) that corresponds with how much you agree or disagree with each statement. Please respond to all items to the best of your ability.
Step 4	Identity & Experience Scale	Please circle the number (1 to 7) that corresponds with how much you think each item is like you or not like you. Please respond to all items to the best of your ability.
Step 5	Aging Survey	Please select "Never," "Once," or "More than once" to represent how often you have experienced each item. If you choose "More than once," please review the second column of response options, and select how often you have experienced the item.
Step 6	Functional Ability Questionnaire	Please read each item and select the response option that best represents your current functional ability.
Step 7	Demographic Form	Please fill out all of the information on the demographic form. Please feel free to include any comments, questions, or concerns in the space provided.
Step 8	GDS-Short Form	Please circle Yes or No to represent whether or not you have experienced each item in the <u>past week</u>.
Step 9	Information Letter	Please read the letter, which will provide more information about our research lab's ongoing social support research.
Step 10	Social Support Questionnaire	This questionnaire asks a variety of questions about the social support system in your life. Please respond to each item to the best of your ability.

APPENDIX M – INSTRUCTIONS AND DEBRIEFING STATEMENT

AGEISM & PSYCHOLOGICAL WELL-BEING STUDY

Please arrive at the Energy Center 30 minutes prior to the scheduled session.

Greet participants when they arrive, introduce yourself, and ask if they would like a bottle of water.

Explain that the study is interested in examining the psychological well-being of healthy older adults and that you will be asking them to fill out some surveys. Thank them for their participation and ask if there are any questions before you begin going through the protocol.

Explain that we will work with them over the course of 30 minutes to an hour and that they should feel free to take a break if/when they feel they need one. When you are ready to begin, read the following instructions verbatim.

PROCEDURE

Thank you again for agreeing to participate in this research study.

This research study is related to quality of life issues in older adulthood. You will be asked to complete several questionnaires. Basically, the questionnaires are all about you! The questionnaires ask general questions about your thoughts, feelings, opinions, and experiences. We will go over the basic instructions together, but you will be free to work at your own pace. Please feel free to ask questions at any point as we go along.

At the very beginning, you will see a place for your social security number. We need this information in order for LSU to pay you your $10 participation fee. Every precaution will be taken to ensure your privacy is protected. The little green card where you will write your social security number will be destroyed as soon as your information has been submitted to the LSU Office of Accounting Services. If you would prefer not to include your social security number, you will not receive the $10 payment, but you may still participate in the study. Is this okay with everyone? *Wait for participants to either nod/give approval that they understand or to ask questions. Should someone be unwilling to provide their social security number and unwilling to participate without compensation, please thank them for their time and tell them they are free to leave.*

The next page that you will see is a step-by-step instructional guide. Each questionnaire will have instructions at the beginning, but please feel free to reference this guide if you need additional help.

After the instructional sheet, you should find 2 copies of an informed consent form. This form explains the entire study, including any risks or benefits of participation. One copy is for our records while the other copy is for you to keep for your records. Please take a moment to read through the consent form. Please let me know if you have any questions about the consent form. If you agree to participate, please sign and date the consent form.

Next, you will be asked to fill out a cover sheet followed by questionnaires about well-being, your experiences in general, and several age-related experiences. You will also be asked about your current functional ability, basic demographic information (such as self-reported health, education, etc.), and how you've been feeling during the past week. Lastly, you will find a letter to participants and a questionnaire about social support. Please review the letter and fill out the social support questionnaire. Once you have completed this measure, you will be finished.

Are there any questions? *Wait to see if there are any questions before moving on.* Please feel free to work at your own pace. Also, please feel free to take a break at any point if you need to. If there are no other questions, you may begin.

**If possible, keep track of all questions that participants ask throughout the data collection session.*

If you need to answer questions about individual items in the packet, please refer to the statements below:

1. Consent form: In your packet, you should have two copies of the consent form. One is for you to keep and the other one is for our records. Please read through the consent form and sign at the bottom. Once you have read and signed the consent form, please put our copy back in the folder. Thank you.

**Make sure that participants have placed one signed consent form back in the folder before moving on.*

2. Cover Sheet

3. Scales of Well-Being: *The next survey includes statements about how you feel about yourself and your life. Please note how much you agree or disagree with each statement as it relates to you and your own life. For each item, you may select whether you STRONGLY AGREE, SOMEWHAT AGREE, AGREE A LITTLE, NEITHER AGREE OR DISAGREE, DISAGREE A LITTLE, SOMEWHAT DISAGREE, OR STRONGLY DISAGREE with the statement. There are 42 items in all. Please complete each item to the best of your ability and feel free to ask questions at any time.*

Are there any questions about the Scales of Well-Being survey?

4. Identity & Experiences Scale: *The next survey includes statements about how a person might feel about his or herself. For each item, you can select how much each statement is like you. You can rate how much the item is like you using a scale of 1 to 7, with 1 suggesting the statement is NOT AT ALL LIKE YOU and 7 suggesting the statement is COMPLETELY LIKE YOU. A response of 4 would suggest that the statement is neither like you nor is it unlike you.*

There are 33 items in all. Please complete each item to the best of your ability and feel free to ask questions at any time.

Are there any questions about the Identity and Experiences Scale?

5. Aging Survey: *The next survey asks questions about behaviors you may have experienced as a result of your age. For each item, please select whether you have NEVER experienced it, experienced it ONCE, or have experienced MORE THAN ONCE. In the event that you HAVE experienced an item, please select how often you have experienced it SINCE TURNING 60. There are 20 items in all. Please complete each item to the best of your ability and feel free to ask questions at any time.*

Are there any questions about the Aging Survey?

Once you have completed the Aging Survey, please feel free to take a short break to get up and move around, grab a bottle of water and a snack, or use the restroom. If you would like to continue on with the surveys, please feel free to do so.

6. Functional ability form: *The next survey asks questions about your functional ability. For the first 6 items, please check whether you are able to complete the task on your own or if you require some form of assistance. The following 8 items are related to the ability to use the telephone, go shopping, prepare food, perform housekeeping tasks, do laundry, use transportation, take medications, and handle finances. For each of these items, select all items that you are capable of performing. For example, if you have no problem using the telephone under normal circumstances, please select "operate telephone on own." There are 14 items in all. Please complete each item to the best of your ability and feel free to ask questions at any time.*

Are there any questions about the functional ability form?

7. Demographic form: Let's move on to the next form. After the consent forms, you should find a form called the "Demographic Questionnaire." This form will help us get to know a little bit more about you. The form consists of two pages and asks questions about basic information like your age, where you live, and so on. Please complete each item to the best of your ability and feel free to ask questions at any time.

8. GDS: *The last survey includes statements about how you have felt over the PAST WEEK. Please read each item carefully and select YES if you have felt that way in the past week or NO if you have not felt that way in the past week. There are 15 items in all. Please complete each item to the best of your ability and feel free to ask questions at any time.*

Are there any questions about the GDS?

VITA

Jenny Young Denver is a native of Chattanooga, Tennessee. In 2003, she received a Bachelor of Science degree in psychology from the University of Tennessee at Chattanooga, where she was a member of the University Honors program and Chi Omega Fraternity. Her departmental honors research thesis was conducted under the supervision of Dr. Amye Warren and was entitled, *Age and Cohort Differences in Flashbulb Memory*. In 2005, Jenny received a Master of Science degree in psychology with a concentration in research from the University of Tennessee at Chattanooga. During her graduate work at the University of Tennessee at Chattanooga, Jenny worked with Dr. Amye Warren and Dr. Rich Metzger, and her thesis research was entitled, *Predicting Health Changes Using Cognitive Measures: The Case for Cancer Diagnosis*. In 2010, she received a Master of Social Work degree from Louisiana State University and was invited to become a member of Alpha Delta Mu Honor Society in Social Work. While at Louisiana State University, Jenny worked with Dr. Katie Cherry, Distinguished Professor of Psychology and Director of the LSU Life Course and Aging Center, and was a member of the LSU Life Course and Aging Center and Sigma Phi Omega Honor Society in Gerontology. Jenny's research is related to cognitive and social aspects of aging, with an emphasis on aspects such as episodic memory of the oldest-old and quality of life issues in later life. Over the past seven years, Jenny has presented her research at several conventions including the Association for Psychological Science, Cognitive Aging Conference, Society for Applied Research on Memory and Cognition, Southeastern Psychological Association, Louisiana Psychological Association, and the LSU Life Course and Aging Center's annual community partners luncheon. Jenny currently resides in Chattanooga, Tennessee.