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Age-Related Microaggressions: A Follow-Up Descriptive Study

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Abstract

Age-related microaggressions are forms of ageist discrimination that occur during day-to-day interactions. The aim of this study was to identify common types of age-related microaggressions as well as to determine how negative affect influences emotional reactions to microaggressions. Using an online survey, participants (n = 200) were asked if they had experienced any of the 20 most common examples of age-related microaggressions reported in previous research (Gietzen et al, 2022). Follow up questions inquired about the frequency, emotional reactions, and behavioral responses to these microaggressions. Participants also rated their physical health and completed the Positive and Negative Affect Scale (PANAS; Watson et al., 1988). The results indicated that participants were familiar with these microaggressions 53% of the time. Participants also reported having negative reactions to 43% of these microaggression. The frequency of negative emotional responses to microaggressions was significantly correlated with scores on the negative affect subscale of the PANAS (r = .34, p < .001) and with ratings of perceived physical health (r = -.32, p = .002). Finally, an analysis of the 20 survey items revealed that two items were “highly impactful” microaggressions, defined as microaggressions that older adults reported experiencing often and reported having a negative emotional reaction to at least one third of the time. The results of the study provide further insight into what age-related microaggressions look like, and how older adults experience these interactions.

Keywords: ageism, microaggressions, older adults

Introduction

Prejudice and discrimination have been targets of social movements since the twentieth century. The civil rights movement in the 50's and 60's fought for equality for African Americans. Equality for racial and ethnic minorities, women, and those of sexual minorities have also been the focus of social movements (Eitzen & Stewart, 2007). These movements have targeted the two greatest *isms* in our society: racism and sexism. The third greatest, however, is one that has become normalized despite its potential to impact everyone if they live long enough. Ageism has been considered the third greatest *ism* and has been described as "the ultimate prejudice, the last discrimination, the cruelest rejection" (Palmore, 2001, p. 572). This form of discrimination is also considered the most acceptable and most common form of discrimination (Allen et al. 2021). In fact, 80% of older adults report that they have experienced incidents of ageism (Palmore, 2004).

Ageism

The term ageism was coined in 1969 by psychiatrist, physician, and gerontologist, Dr. Robert Butler. Originally, he broadly defined ageism as "prejudice by one age group toward other age groups" (Butler, 1969, p. 243). However, he later adjusted his definition to incorporate older adults as victims, "[a] process of systematic stereotyping or discrimination against people because they are old, just as racism and sexism accomplish with skin color and gender" (Butler, 1975, p. 12). Recent scholars have critiqued this definition stating that it does not accurately describe the complexity of ageism, and inaccurately equates it to the other *isms*. Resultingly, Iversen et al. (2009) compiled 27 definitions of to create a modern definition of ageism: "Ageism is defined as negative or positive stereotypes, prejudice and/or discrimination against (or to the advantage of) elderly people on the basis of their chronological age or on the basis of a

perception of them as being ‘old’ or ‘elderly.’ Ageism can be implicit or explicit and can be expressed on a micro- or macro-level” (p. 15). This definition highlights the complexity of ageism in numerous ways. Firstly, this definition highlights that ageism can both either be implicit or explicitly delivered. Explicit ageism occurs when the deliverer is aware that they are acting in an ageist manor. In comparison, the ageist messages and beliefs are unconscious to the deliverer in implicit ageism. This is of value to consider in the expanding literature, as not all forms of ageism are overtly delivered (Iverson et al., 2009).

Secondly, unlike many definitions, this introduces the idea that ageism can both harm and help older adults. Age-related stereotypes that older adults are wise and full of experience serve as the foundation for positive ageism. In comparison, negative ageism is based in the belief that older adults are fragile, demented, and riddled with illness. There are inverse effects of either kind of ageism on older adults, as it may be to their advantage or harm (Sarabia-Cobo & Pfeiffer, 2015; Iversen et al., 2009; Palmore, 1999).

Consequences of Ageism

At times, ageism may benefit older adults. For example, there may be financial benefits built into social institutions such as Medicare/Medicaid, social security, and senior discounts. These benefits are the result of ageist beliefs that all older adults are not able to work due to their physical or cognitive impairments. The stereotype that with age comes wisdom may also benefit an older adult as they earn respect from those younger than them (Palmore, 1999). Largely, however, ageism negatively impacts the lives on older adults.

Conversely, a large body of research has also found evidence that ageism can negatively impact older adults’ psychological, physical, behavioral, and cognitive functioning. This may manifest as devaluation of older adult’s physical health problems by healthcare professionals,

leading to misdiagnosis, failure to provide treatment, or failure to test (Ouchida & Lachs, 2015; Levy et al., 2022). Additionally, Western culture has largely replaced multigenerational living arrangements with long-term care facilities, which has been associated with increased feelings of loneliness and rejection and lessened physical health (Levy et al., 2022; Chang et al., 2020). In addition, stereotype embodiment theory suggests that older adults may internalize these negative stereotypes, leaving older adults to think more poorly about themselves. Not only is this internalization associated with increased levels of mental health issues such as increased levels of anxiety and depression, but it can also have detrimental impacts on older adult's subjective memory. It has even been found that those who experience ageism are also at a higher risk for experiencing cognitive decline, a stroke, and dementia (Levy et al., 2022; Chang et al., 2020). Ageism has also found to be associated with a variety of other factors including exclusion from health research, devaluation of their own lives, lack of work opportunities, reduced longevity, poor quality-of-life, risky health behaviors, and poor social relationships (Chang et al., 2020). These findings demonstrate that ageism can impact nearly every aspect of older adult's lives at both a societal and personal level.

Everyday Ageism

Iverson's definition of ageism introduced the idea that ageism can occur at both a micro and macro level (2009). At a macro-level, ageism can manifest as societal norms such as ageist displays of older adults in the media or systematic discrimination (Iverson et al., 2009). Ageism at the micro-level describes the daily forms of discrimination experience in one-on-one interactions. There are two overlapping constructs that define these micro-level forms of ageism; everyday ageism (Allen et al., 2021), and age-related microaggressions (Gietzen et al., 2022).

A recent set of studies examined the prevalence of everyday ageism through the creation of the Everyday Ageism Scale (Allen et al., 2021; Allen et al., 2022). Everyday ageism is divided into three subtypes: exposure to ageist messages, ageism in interpersonal interactions, and internalized ageist beliefs. The Everyday Ageism Scale consists of 10-items which measures each of these subtypes (Allen et al., 2021). Overall, participants reported the most familiarity to internalized ageism, followed by ageist messages and interpersonal interactions (Allen et al., 2022). The related construct of age-related microaggressions focus on the forms of everyday ageism that occur within interpersonal interactions and can be further divided into three forms.

Microaggressions

The term microaggression was originally identified by physiatrist, Dr. Chester Pierce to describe covert and subtle manifestations of racism that occur in everyday life (Pierce, 1970). However, Dr. Derald Wing Sue, the leading researcher of microaggressions, has expanded upon this definition to capture the everyday forms of discrimination that carry negative messages to people who belong to a marginalized group of society (Sue et al., 2007). Microaggressions can take three forms: microassaults, microinsults, and microinvalidations.

Microassaults

Of the three forms of microaggressions, microassaults are often the most familiar. Microassaults are conscious forms of discrimination that are intended to hurt the individual because of one aspect of their identity (i.e., race, gender, age, etc.). These forms of overt discrimination can look like calling someone of color a derogatory name such as “oriental” or referring to a transgender individual by the wrong pronouns. A server refusing to serve someone of color, or a bouncer refusing to let a someone of color into a venue are other examples of microassaults (Sue et al., 2007).

Microinsults

In comparison to microassaults, microinsults are often implicit and unconscious to the deliverer. These forms of discrimination are often expressions of rudeness or insensitivity to the individual. Microinsults are often due to assumptions made based on one aspect of the victim's identity such as their race or gender. An example of a racial microinsult is when someone chooses to take the next elevator when they see a Black person because of the assumption that they are criminal. Another example of a racial microinsult may be assuming that an Asian person is very intelligent (Sue et al., 2007).

Microinvalidations

Like microinsults, microinvalidations are also often implicit and unconscious to the deliverer. Microinvalidations manifest as the invalidations of one's thoughts, beliefs, or experiences. Therefore, a declaration of color blindness to a person of color would be an example of a racial microinvalidation. Another example may be asking an American born person of color where they are from (Sue et al., 2007).

Age-Related Microaggressions

Age-related microaggressions represent the intersection of ageism and microaggressions. This construct overlaps with that of everyday ageism, but instead focuses on ageism which manifests during daily interactions rather than internalized ageist beliefs and exposure to ageist messages. Age-related microaggressions can be defined as "commonplace verbal or behavioral indignities, whether intentional or unintentional which communicate hostile, derogatory, or negative ageist slights or insults" (Gietzen et al., 2022, p. 5). A preliminary study on age-related microaggressions examined older adult's experiences with age-related microaggressions using a descriptive research design. This study asked participants to provide examples of age-related

microaggressions that they had experienced and a series of follow-up questions including the frequency of these experiences, their emotional response, and behavioral reaction. The results of this study suggested that microinsults were the most common form of microaggression that older adults experienced (54.3%). This was followed by microassaults (37.5%) and microinvalidations (8%). The participants of this study reported that microaggressions occurred frequently, with 1-2x per month being the most common response. Additionally, most participants reported feeling angry after these interactions (40%) and often avoided confronting the deliverer following a microaggression (37%). The results of this study provided foundation for the present study which aims to add to the current understanding of older adult's experiences with age-related microaggressions (Gietzen et al., 2022).

The Current Study

In 2017, Dr. Scott Lilienfeld provided a critique of the current microaggression literature to strengthen the empirical evidence of microaggressions. Lilienfeld provided 18 recommendations for future microaggression research. Of note, he suggested to "ensure that microaggression items contain sufficient situational context to minimize the ambiguity of their interpretation," to "ascertain the approximate base rates of events (e.g., receiving poor service in restaurants) that are referenced in many microaggression items," "include measures of negative emotionality, especially those that assess the perception of oneself as a victim and hostile attribution bias," "examine behaviors and personality characteristics of microaggression deliverers as well as microaggression recipients", and to "use microaggression measures that do not confound the frequency of experience of microaggression experiences with the subjective distress associated with these experiences" (Lilienfeld, 2017, p. 161).

The current study aimed to address these recommendations made by Lilienfeld and to expand upon the literature on age-related microaggressions. Therefore, this study had three primary purposes; to validate the response of the preliminary descriptive study (Gietzen et al., 2022), to determine the types of age-related microaggressions that individuals over the age of 65 most often experience, and to understand the emotional responses connected to the examples given. It was hypothesized that the participants would report that they are familiar with a variety of the different microaggressions that were identified in Gietzen et al. (2022). To address Lilienfeld's recommendation concerning the importance of the trait of negative emotionality, it was hypothesized that individuals with higher levels of negative affect would report more negative emotional responses to an age-related microaggression. Finally, it was also hypothesized that individuals who perceive their physical health to be poor would more often report experiencing negative emotional reactions to age-related microaggressions.

Methods

Design

A quantitative descriptive study design was used to test the hypotheses and further explore older adults' experience of age-related microaggressions.

Participants

Participants were recruited using Prolific, an online service which provides researchers with a national participant pool. Participants (n = 200) were required be at least 65 years old. In this sample, participant ages ranged from 65-93 years old (M = 69.9). Concerning gender identity, 113 participants identified as females, and 87 participants identified as males. No discrepancies between gender identity and biological sex were reported. Regarding ethnicity, the sample was primarily white (n =185), followed by black/African American (n = 9),

Hispanic/Latino (n = 3), Asian (n = 1), and Native American (n = 1). Participants were also asked about their education level. Most participants held bachelor's degrees (n = 62), followed by master's degrees (n = 50), attended some college (n = 36), held a high school diploma (n = 25), held an associate degree (n = 15), and held a doctoral degree (n = 12). Participants were also asked about the region that they were born, where they had spent the most time, and where they currently reside. Participants were primarily born in the Midwestern United States (n = 68), spent the most time in the Southern United States (n = 75), and currently reside in the South (n = 91). Because the survey required for the study asked participants to rely upon their memory of previous social interactions, participants who had a diagnosis of a memory impairment were disqualified from the study (n = 2). Therefore, the final sample for this study consisted of 198 participants.

Procedure

This study was approved by the Minnesota State University, Mankato Institutional Review Board (IRBNet LOG# 1935027). Data collection was completed using an online Qualtrics survey. Participants were initially presented with an informed consent form (see Appendix A). Participants were then asked a variety of demographic questions as well as to rate their physical health, and memory (see Appendix B). Once these preliminary questions were answered, participants were asked to complete two measures.

Measures. Participants were asked to complete the 20-item Positive and Negative Affect Schedule (PANAS; Watson et al., 1988). This instrument contains 10 items which measure positive affect (PA; e.g., interested, strong, active, etc.) and 10 items that measure negative affect (NA; e.g., distressed, guilty, jittery, etc.). Participants are instructed to rate each item on a scale on the extent to which they have felt that way over the past week from 1 "very slightly or not at

all" to 5 "extremely". Scores on each subscale can range from 10-50. High scores on the PA subscale indicate high levels of PA whereas low scores on the NA subscale indicates low levels of NA. The PANAS was used to test the hypothesis that individuals who report higher levels of NA will report more negative emotional reactions to age-related microaggressions. This measure has a strong internal consistency reliability for both PA (α = .88) and NA (α = .85; Watson et al., 1988). Additionally, two separate confirmatory factor analyses completed with samples of older adults yielded two significant factors; positive and negative affect (Kawata, 2006; Kercher, 1992).

Participant then competed the age-related microaggression questionnaire (see Appendix B). After a short set of instructions, participants were then given 20 examples of commonly occurring age-related microaggressions based on previous research (Gietzen et al., 2022). Some examples included "Being told 'you look good for your age,'" "Applying for a job opening and being told that they are looking for a younger person, even though you are qualified," and "Being offered a senior discount." After each microaggression example, participants were asked how often they had experienced the microaggression. If they had experienced the microaggression, participants were then asked a variety of follow up questions regarding if they thought the microaggression was due to their age or another factor (e.g., race, gender), their emotional reaction to the scenario, where the interaction occurred (e.g., home, work, store), their relationship to the individual in the scenario (e.g., family member, waitress), and how they responded to the situation.

Analysis

Descriptive analyses and frequency distributions were used to summarize the responses to the multiple-choice questions, and to test the hypothesis that older adults would report being

familiar with a variety of different microaggressions identified in the literature (Gietzen et al., 2022).

A deductive thematic analysis was conducted to categorize responses to the question about behavioral reactions to microaggressions. Existing literature on reactions to microaggressions indicates four common behavioral reactions following a microaggressions: (a.) direct confrontation, (b.) indirect confrontation, (c.) passive coping, and (d.) did nothing. “Direct confrontation” refers to situations where the victim directly addressed the deliverer following the microaggression. “Indirect confrontation” described situations where the victim acted passive aggressively or contacted authorities following the interaction. In contrast, “passive coping” was used to define behavioral reactions in which the participant avoided the previous two types of behavioral reactions. Therefore, passive coping was used when the participant diffused, deflected, or removed themselves from the situation. For a behavioral response to be coded as “did nothing”, the participant had to be very explicit in that they did not have a behavioral response following a microaggression. Rather, they reported that they did not do anything following a microaggression (Gietzen et al., 2022, Nadal et al., 2014). Finally, the current study included a fifth reaction “not a coping response” to reflect a response in which the individual was unbothered or felt positively following the interaction.

Pearson *R* correlations were used to test the hypothesis that individuals who report having concerns regarding their memory or physical health will report more negative emotional response to age-related microaggressions. A correlational analysis was also used to test the hypothesis that individuals who report higher levels of general negative affect will report more negative emotional responses to age-related microaggressions.

Interobserver Agreement

A two-person coding team was used to complete the deductive thematic analysis of behavioral reactions to microaggressions. The first author trained a research assistant to identify the five different response categories using operational definitions and examples of the types of behavioral reactions from existing literature. Unlike previous research, this study asked participants to report their general experience during interactions as opposed to wording questions in such a way as to assume the interactions were negative. Therefore, it was possible participants would report positive or neutral reactions. As a result, behavioral reactions that are topographically the same may have produced very different internal reactions. Therefore, emotional responses were used when coding the behavioral reactions to provide context and meaning concerning ambiguous responses. Total interobserver agreement (IOA) for this item was 81% across the 1929 behavioral reactions that were provided.

Results

Age-Related Microaggressions

Participants provided information regarding their experiences with 20 examples of age-related microaggressions. This data was examined as a whole, and by microaggression form. Together, this provided a picture of not only how older adults experience age-related microaggressions, but how these experiences differed across the three forms of microaggressions (i.e., microinvalidation, microassault, and microinsult).

Frequency

Of the responses gathered regarding the 20 examples of age-related microaggressions (n = 3955, missing n = 5), 53% of the time, respondents endorsed experiencing these examples at least once a year. Therefore, 47% of the time, respondents indicated that they never experienced

the microaggression. The most reported frequency of participants who had these experiences was once a year (*n* = 899). See Figure 1 for the remaining frequencies.

Perceived Cause

When a participant endorsed experiencing a microaggression, they were then asked if they believed the microaggression concerned their age or another personal characteristic. Participants were able to give multiple responses per example, so the total number of responses (*n* = 2503) was higher than those who had experienced the microaggressions. Most participants indicated that they believed the interactions occurred because of their age (*n* = 1897). As seen in Figure 2, this was followed by gender (n = 459), ethnicity (n = 55), and other (n = 92). Examples of responses that were given in the other category included appearance, physical disabilities, personal characteristics (i.e., intelligence), or beliefs (i.e., religion, political affiliation).

When broken down by microaggression form, participants believed that the cause of these interactions was their age regardless of the form. Interestingly, however participants believed that they were the victim of microinsults because of their gender 26% of the time. A comparison of the percentage of perceived cause for each form of microaggression can be seen in Figure 3.

Setting

As seen in Figure 4, most often, these examples of age-related microaggressions were experienced in stores (*n* = 670), restaurants/bars (*n* = 374), healthcare settings (*n* = 414), and home (*n* = 409). Therefore, these interactions are not only occurring while older adults are in public but also are frequently occurring inside the safety of their own homes. Participants also gave other specific responses *(n* = 341). Responses within this category included on public transportation, virtually (i.e., online, or on TV), at a social gathering, or “everywhere.”

The frequency distributions for settings at which microaggressions occurred varied by form. The most common settings at which the forms occurred were healthcare settings (microinvalidations), the workplace (microassaults), and stores (microinsults). These differences may be attributed to the specific items in the survey. For example, a microinsult described in the survey was "being offered a senior discount" which exclusively occurs within a retail setting (such as a store or restaurant). Figure 5 provides a further comparison of the settings at which the forms of microaggressions took place.

Relationship to Deliverer

Participants were then asked what their relationship to the deliverer of the microaggressions was. Participants provided a total of 2,360 responses for their relationship with the deliverer. Most often, these examples were committed by a stranger to the participant (n = 980) or a service provider (n = 524). As seen in Figure 6, other common responses included family members (n = 325), friends (n = 258), and coworkers/employers (n = 202). Other specific responses were also given (n = 75). Some examples of the relationships that fell within this category included "an acquaintance," "my neighbor," or "students."

When examining the relationship to the deliverer by microaggression form in Figure 7, strangers remain the most common deliverer for all three forms. Interestingly, however, family member remains in the top three relationships for each form. Therefore, it seems that these interactions are being committed by both those who older adults are closest to, as well as those with whom they do not have a relationship.

Emotional Response

Data was collected on the participants' emotional responses to the examples given. Participants were given the opportunity to provide multiple emotional responses to each

example, with a total of 2983 responses provided. Participants reported having negative emotional reactions (i.e., angry, embarrassed, insulted, isolated/rejected, anxious, sad) 43% of the time, followed by having positive emotional reactions (i.e., comforted, appreciative) 27% of the time, and feeling neutral (i.e., indifferent, surprised) 26% of the time. A breakdown of frequencies by individual emotional reactions can be seen in Figure 8.

The proportion of emotional reactions varied by microaggression form. Participants reported experiencing negative emotional reactions most frequently following a microassault (70%), followed by microinvalidation (44%), and microinsult (33%, see Figure 9). Conversely, participants most often reported experiencing a positive emotional reaction following interactions which can be interpreted as compliments or acts of kindness (i.e., microinsults (42.5%), and microinvalidations (26.9%)).

Behavioral Reaction

Participants were also asked how they responded to the microaggressions. Of the 1,929 responses given from this open-ended question, 255 responses were removed due to vagueness (i.e., “respected”), not making sense (i.e., “I wiped the toilet seat”), or not being a behavioral reaction (i.e., “I appreciate it when someone says I look younger than my age. Let's face it, most of the time they're just being nice”). Therefore, there was a remaining total of 1,674 behavioral reactions. Of these, most responses were not considered coping responses (n = 898). As described previously, emotional responses were also considered when coding these data, so behavioral reactions that were topographically the same could be coded into two separate categories. The responses that fit within the category of “not a coping response” included instances when the participant reported having a positive emotional reaction to the example in addition to a positive behavioral reaction (i.e., having an emotional reaction of feeling

appreciative and responding “thank you, I try to do good for myself”), or when they had a neutral emotional reaction in addition to a positive behavioral reaction (i.e., having an emotional reaction of feeling indifferent and responding “thank you”).

The second most common response was “did nothing” (*n* = 271). This was coded when participants had either a neutral or negative emotional response to the example, but did not have a behavioral reaction (i.e., “I didn’t respond,” “I didn’t,” or “I said nothing”). The third most common behavioral reaction was “direct confrontation” (*n* = 208). This code was used when participants had a negative or neutral emotional reaction and a response in which they confronted the deliverer. For example, one participant said “I said ‘Hey, hey, I am right here. What do you want me to know?’ and ‘What's going on’? I try to nip this kind of thing in the ‘bud.’” While another said, “I told them that I understood completely and to stop making assumptions.” Passive coping was the next most commonly occurring behavioral response (*n* = 203). A response was coded as passive coping when the participant had a negative emotional reaction while avoiding confrontation with the deliverer. Examples of responses that were passive coping included “I responded by moving aside so they could go around,” and “just left embarrassed, later angry.” The last category was “indirect confrontation” (*n* = 94). This category was used when participants had negative or neutral emotional responses, and either acted passive aggressively towards the deliverer, or went to their superior or authorities after the interaction. Some examples include “I slowed down even more,” and “called the manager to complain.” See Figure 10 for the frequency distribution.

In most cases following a microinsult, participants did not report having a coping response. However, when coping responses were reported, participants most often directly confronted the deliverer. Of note, participants reported that they directly confronted the deliverer

following a microassault nearly one fourth of the time, while direct confrontation was used less frequently following microinvalidations (8.5%) and microinsults (12.4%). As seen in Figure 11, participants rarely used indirect confrontation regardless of the microaggression form. Passive coping was reported to have occurred more frequently following a microinvalidation (15.9%) and microassault (21%) compared to microinsults (5.5%).

Survey Item Analysis

An analysis of all 20 survey items was conducted to determine the frequency of each potential microaggression as well as the emotional reactions that occurred. This analysis was conducted to determine if specific upsetting microaggressions were highly prevalent in the lives of older adults. Table 1 shows the how frequently each item was reported to have occurred and Table 2 show the frequency of positive, negative, and neutral emotional reactions for each survey item. Using data from Tables 1 and 2, "highly impactful" microaggression were identified using the following criteria: 1) the survey item was endorsed by half of the participants *(n* = 99), and 2) more than a third of participants reported experiencing negative emotional reactions associated with the item. Two of the twenty microaggressions in the survey met these criteria, both of which were microinvalidations. The first was item 12 ("Being told your medical issues [for example, arthritis, diabetes] or physical issues [for example, poor eyesight/hearing] are not bad because they are expected at your age"). The second was item 14 ("Being told that you do not qualify for a survey after entering your age").

Emotional Response and Negative Affect

A Pearson's *R* correlation was run to determine if levels of negative affect as measured by the PANAS was related to the frequency of negative emotional reactions following an age-related microaggressions. The result of this correlational analysis suggests that there is a

relationship (r = .34, p <.001). These results indicate that individuals who had higher scores on the NA scale of the PANAS also reported a higher frequency of negative emotional responses following a microaggression. Conversely, those who scored lower on the NA scale of the PANAS reported a lower frequency of negative emotional responses following a microaggression.

Emotional Response and Perceived Physical Health

The hypothesis that perceived physical health would be related to emotional response was tested using a Pearson's *R* correlation. The results of this analysis indicated that poorer ratings of perceived physical health were associated with a greater frequency of negative emotional reactions (r = -.21, p = .002).

Discussion

This study examined older adult's experience with commonly reported examples of age-related microaggressions (Gietzen et al., 2022). The results of the present study indicated that older adults were familiar with these interactions about half the time. This finding is consistent with the literature on the overlapping construct of everyday ageism. Specifically, a study found that older adults were familiar with ageism in interpersonal interactions 44.9% of the time (Allen et al., 2022).

When participants reported that they had experienced these interactions, they experienced them infrequently (i.e., 1-4 times a year). This finding differs from previous research in which participants reported having these experiences 1-2 times a month. This difference is likely due to the difference in methodologies. The previous study asked open-ended questions requiring participants to provide examples of age-related microaggressions that they had experienced, which likely prompted individuals to provide the most salient and memorable examples and

produced a wide array of examples of microaggressions. Conversely, the current study asked participants about their experience with a specific set of examples of microaggressions. It is possible individuals in the current study had frequently experienced some forms of microaggressions in their daily lives, just not the ones present in the survey.

Of the twenty examples given, over half of the participants were familiar with ten items. Of these, four were microinsults, five were microinvalidations, and one was a microassault. It is unsurprising that older adults reported having more familiarity to microinsults and microinvalidations, as these are covert, often unconscious displays of ageism. Similarly, when examining the emotional reactions to these examples, participants primarily reported feeling positively following these examples. The examples in which participants reported having positive emotional reactions are those in which can be interpreted as compliments or acts of kindness. For example, item 7 (being offered a seat in a public place), item 15 (being offered a senior discount), item 1 (being told "you look good for your age), and item 19 (when someone suggests that you are doing well for your age) were all examples in which many participants reported having experienced, but also felt positively following the interactions. This result differs with that of the previous study in that participants in the previous study largely reported feeling negatively after these interactions (Gietzen et al., 2022). The difference in results is likely due to methodological differences. Participants in this study still reported feeling negatively after these interactions. It is of value to further examine why this disparity exists.

It can be hypothesized that these differences may occur because some older adults may perceive that they are being offered assistance because the deliverer assumes they are unable to do so independently due to the perception of them as being an older adult. In contrast, other older adults may perceive this as an act of kindness. Similarly, one older adult may perceive the

comment that they are functioning well for their age as a compliment. In contrast, another older adult may feel that they are nullifying their thoughts and experiences as an older adult (Gietzen et al., 2022). Therefore, it seems that the topography of the interaction is not of importance, but rather one's perception of the meaning of the interaction, and the intention behind it. This finding presents an important implication for future research in that age-related microaggressions cannot be defined by topography alone. Rather, the recipient's interpretation of these interactions must be examined as well.

Similarly, as suggested by Lilienfeld, personal characteristics of the recipient may also impact how they respond to these interactions (2017). The present study found that high levels of negative affect and low ratings of perceived physical health were correlated with a higher frequency of negative emotional responses. Because neuroticism is a trait which describes increased experiences of negative emotionality, it makes sense that those with high levels of negative affect may also negatively evaluate social interactions. Similarly, negative affect has been associated with poor subjective health (Watson & Pennebaker, 1989). Therefore, if an older adult is more sensitive to their physical health, they may be more likely to interpret the presence of implicit ageist messages in their social interactions. Studies have found a positive correlation between self-rated physical health and exposure to age-related discrimination (Kornadt et al., 2021; Vauclair et al., 2015). It is unclear, however, if exposure to ageist messages decreases one's self-rated physical health, or if lower ratings of physical health is related to an increased interpretation of ageist messages.

The behavioral reactions reported by older adults aligned well with the categories that were identified by Nadal and colleagues (2014), with the addition of the category "did nothing," which was identified in previous research (Gietzen et al., 2022), as well as a new category to

encapsulate when an older adult was unbothered by the interaction. When examining the frequency of behavioral reactions, the previous study (Gietzen et al., 2022) suggested that older adults were most likely to respond by passively coping following an age-related microaggression. The results of this study, however, suggested that when an older adult felt negatively following an interaction, they were most likely to do nothing (n = 271). This was followed by direct confrontation (n = 208), passive coping (n = 203), and indirect confrontation (n = 94). As with emotional responses, these differences may be the result of differences in methodology. Specifically, the examples provided may not have been as personally relevant to the participants, so the emotional reactions were not as strong, and the behavioral reactions were less direct.

When examining behavioral reaction by form, participants were overall more likely to directly confront the deliverer of microassaults. It may be that explicit and egregious manor of most microassaults is more likely to evoke a direct response when compared to the other two forms (i.e., microinsults and microinvalidations).

Overall, strangers were most likely to deliver age-related microaggressions. This was true across the three forms of microaggressions. Service providers were the second most reported deliverer of age-related microaggressions and were most likely to be the deliverer of microinvalidations. This finding is consistent with previous research, which suggested service providers and strangers are the most common deliverers of age-related microaggressions (Gietzen et al., 2022). It can be hypothesized that strangers to older adults may be more likely to act based upon ageist stereotypes and thus more likely to commit an age-related microaggression. In comparison, those close to the older adult (i.e., family members, friends) see them as an individual, rather than a stereotype.

Participants most often endorsed that age-related microaggressions occur in stores. This finding matches that of the previous study (Gietzen et al., 2022). When looking at the most common response by form, microinvalidations most often occurred in healthcare settings, microassaults most often occurred at work, and microinsults most often occurred in stores. These results are likely due to the examples of the microaggressions given. For example, item 15 (being offered a senior discount) is categorized as a microinsult and almost exclusively occurs in retail settings such as stores. Similarly, item 6 (applying for a job opening and being told that they are looking for a younger person, even though you are qualified) is categorized as a microaggression and exclusively occurs at a desired place of work. Therefore, the variability observed in responses to questions regarding settings is likely explained by survey items that could potentially occur in a variety of settings (e.g., item 20, "having the door held open for you", could occur in any place with an entrance.

Limitations/Future Directions

The study of age-related microaggressions is in its infancy. Resultingly, there are countless directions for future research. As mentioned previously, it seems that older adults may interpret topographically identical social interactions differently. Therefore, future studies should aim to continue to identify age-related microaggressions that are most frequently experienced and negatively interpreted by older adults. To do this, a replication of the initial study (Gietzen et al., 2022) with a larger, more diverse sample size should be completed. Additionally, per the recommendation of Lilienfeld (2017), future studies should make use of focus groups to provide a deeper understanding of older adult's experiences with these types of interactions. These are required steps to strengthen the current age-related microaggression literature as it continues to grow as a construct.

The current literature on age-related microaggressions primarily consists of samples of heterosexual, Caucasian older adults. Future studies should aim to recruit a nationally representative sample. This data would provide valuable information on how older adults of other marginalized groups experience age-related microaggressions. Future studies should also aim to recruit a balanced proportion of older adults in the youngest-old, middle-old, and oldest-old to determine if the types of microaggressions experienced as well as their impact vary based on age.

Furthermore, this study recruited participants through an online service which provides researchers with a participant pool. Individuals must be signed up for this service to be recruited to participate in studies. As a result, these participants are required to have a certain level of technological knowledge. Therefore, this study did not capture the experiences of older adults who are not technologically inclined, or do not have access to a computer. To reach this population, studies should use other data collection procedures which include mail or in-person sampling.

As speculated by Lilienfeld (2017), the present study indicates that there is variation in how older adults perceive the same topographically similar interactions. In other words, the same microaggression may be interpreted in very different ways depending on several factors. This study identified perceived physical health, and presence of negative affect as being potential moderators of this relationship. Future studies however should further examine this relationship, as well as to identify other potential moderators for this relationship.

Finally, studies have suggested that due to their physical or cognitive disabilities, older adults in long-term care settings may be at a greater risk being the victim of ageism (Dobbs et al.,

2008). Therefore, studies should expand recruitment to examine the form and prevalence of age-related microaggressions both from the perspective of residents and staff.

Conclusion

This study aimed to add to the existing foundational literature on age-related microaggressions (Gietzen et al., 2022). Overall, it was found that older adults were familiar with these examples of age-related microaggressions, however, participants did not always feel negatively following these examples. In fact, participants reported experiencing both positive and negative emotional reactions to microinsults and microinvalidations. It was found that the perception of the interaction influences how the older adult responds to an age-related microaggression. The results suggested that the personal characteristics of the older adult such as their level of negative affect, and perceived physical health may explain this difference in perception.

The result of this study adds to the literature regarding what kinds of age-related microaggressions are the most prevalent and impactful in the lives of older adults. Knowing this information can hopefully lead to the development of targeted interventions designed to increase awareness and reduce prevalence of microaggression. This study points to several lines of future research examining age-related microaggressions. Additionally, the results of this study should be used as an educational tool to decrease the high prevalence of ageism (Palmore, 2004) and to lessen the negative health impacts that ageism has on older adults (Levy et al., 2022; Chang et al., 2020).

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Figures

Figure 1

Frequency of Age-Related Microaggressions

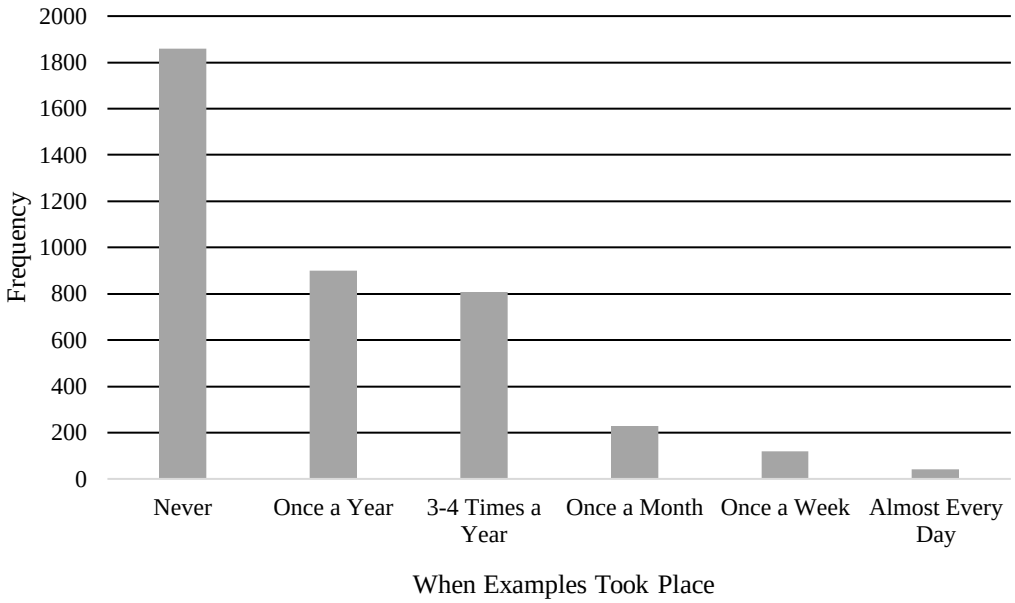


Figure 2

Perceived Cause of Age-Related Microaggressions

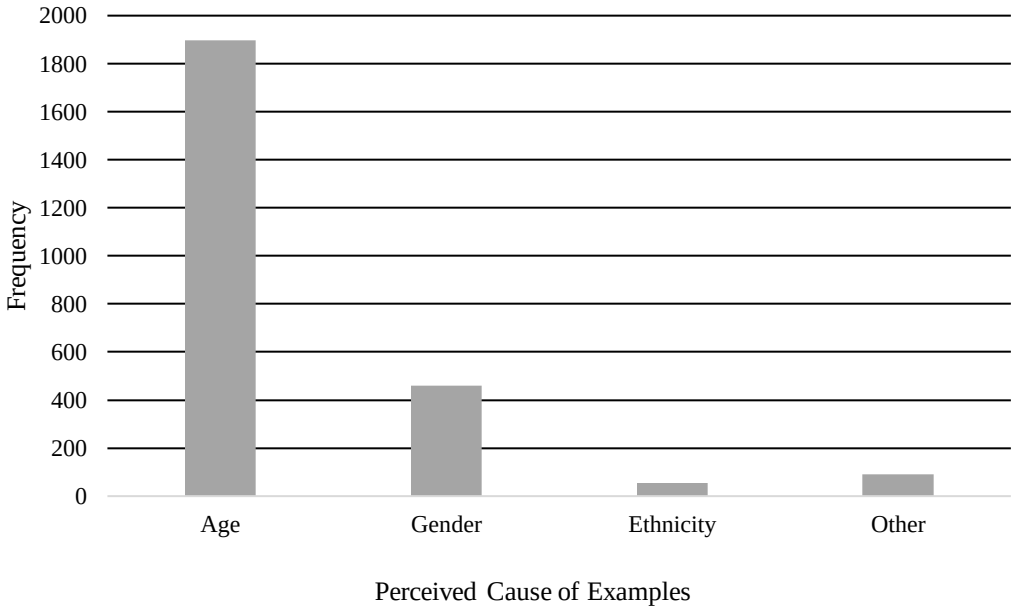


Figure 3

Perceived Cause of Age-Related Microaggressions by Form

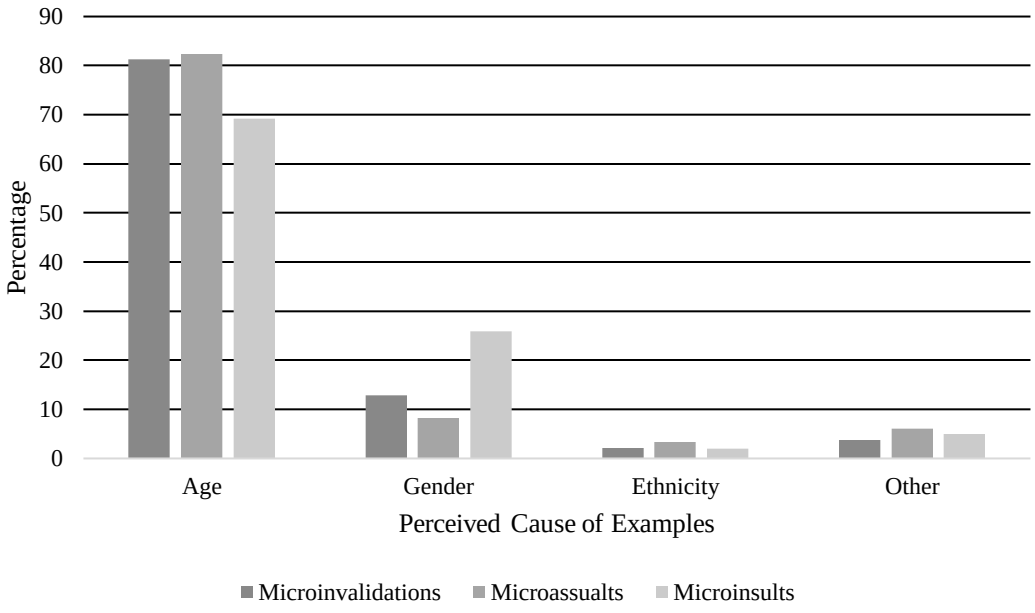


Figure 4

Setting at which the Age-Related Microaggressions Occurred

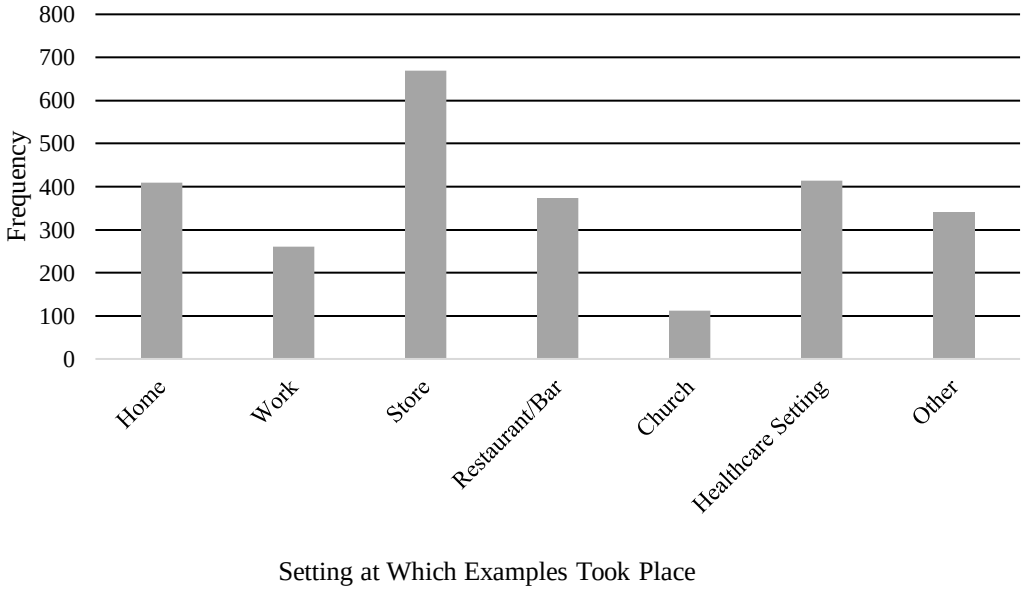


Figure 5

Setting at Which Age-Related Microaggressions Occurred by Form

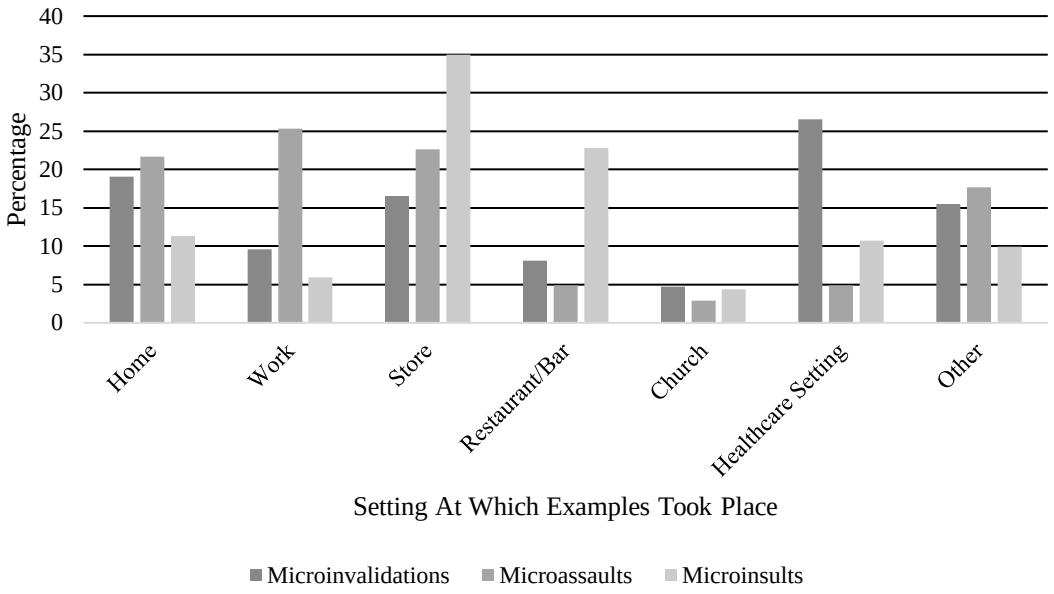


Figure 6

Relationship to Deliverer of Age-Related Microaggressions

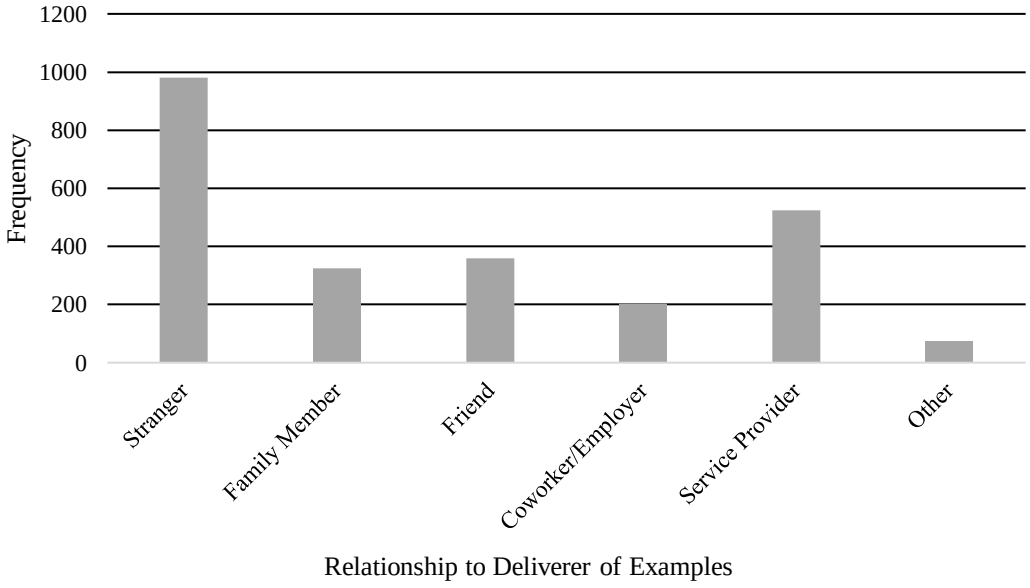


Figure 7

Relationship to Deliverer of Age-Related Microaggression by Form

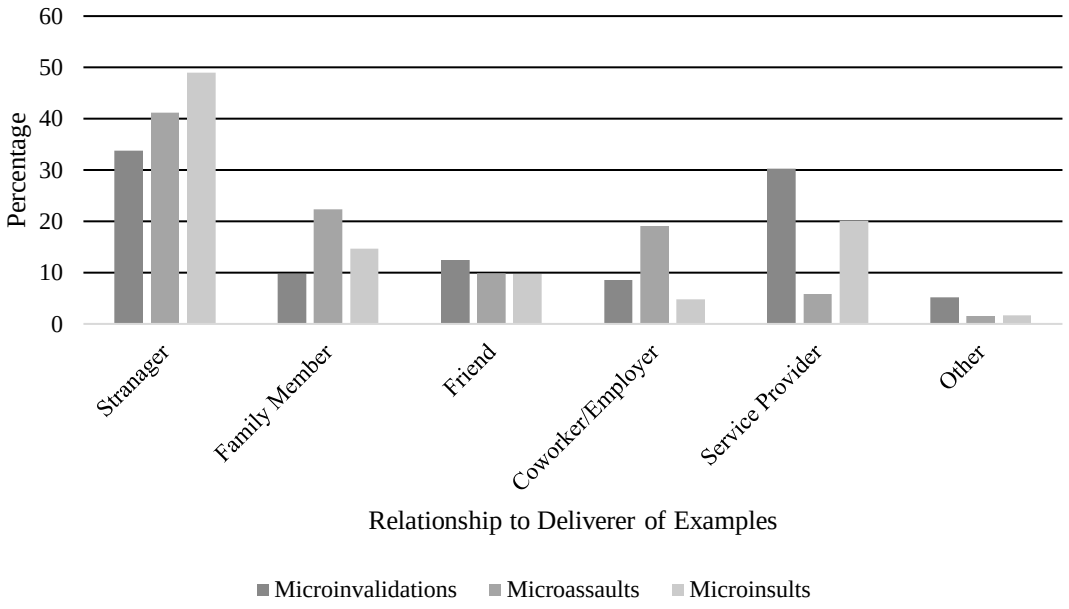


Figure 8

Emotional Response to Age-Related Microaggressions

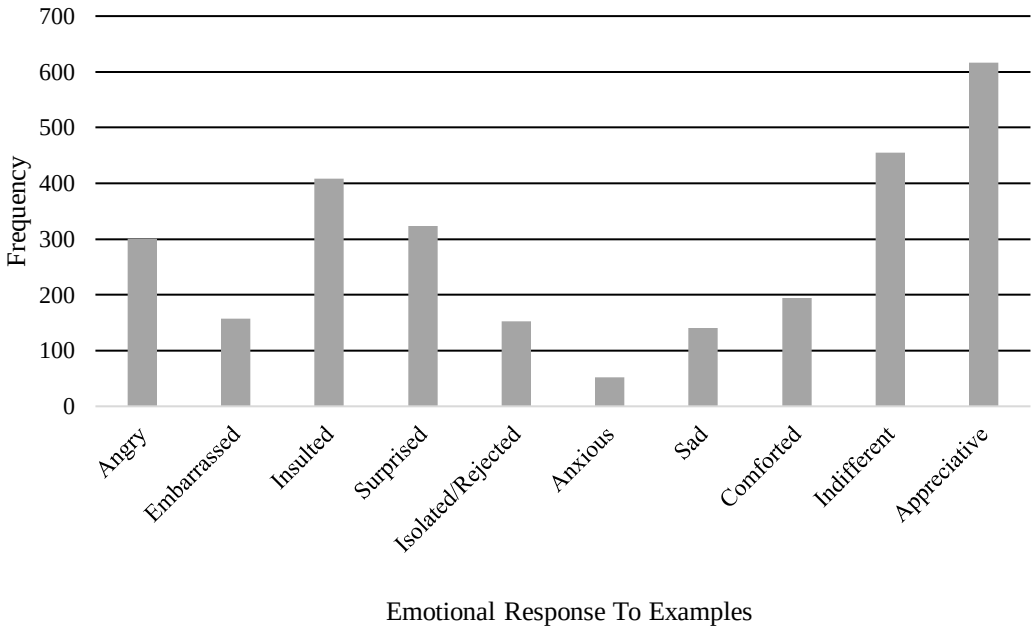


Figure 9

Emotional Response to Age-Related Microaggressions by Form

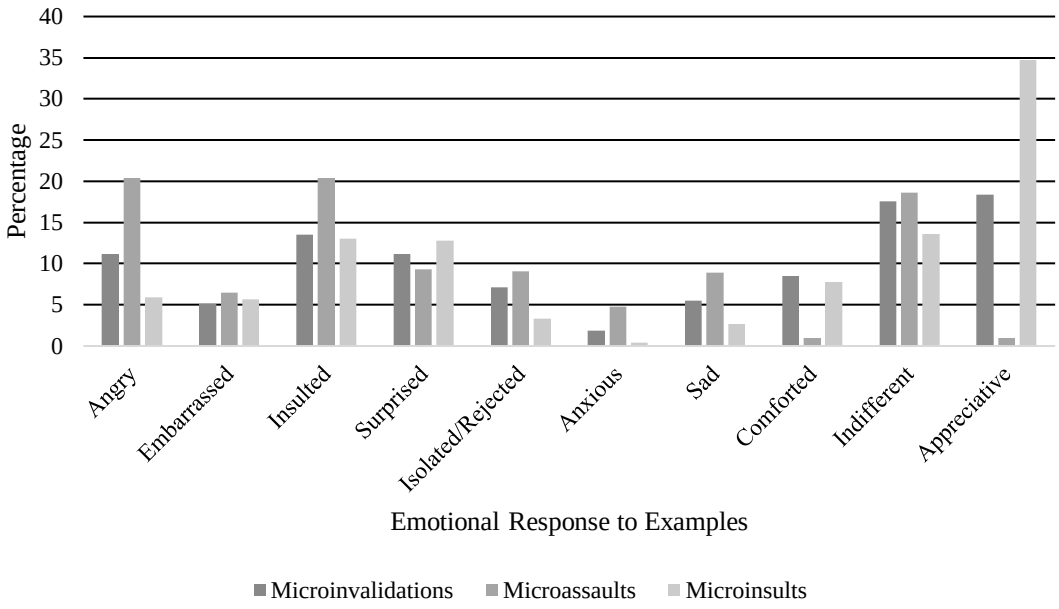


Figure 10

Behavioral Reaction to Age-Related Microaggression

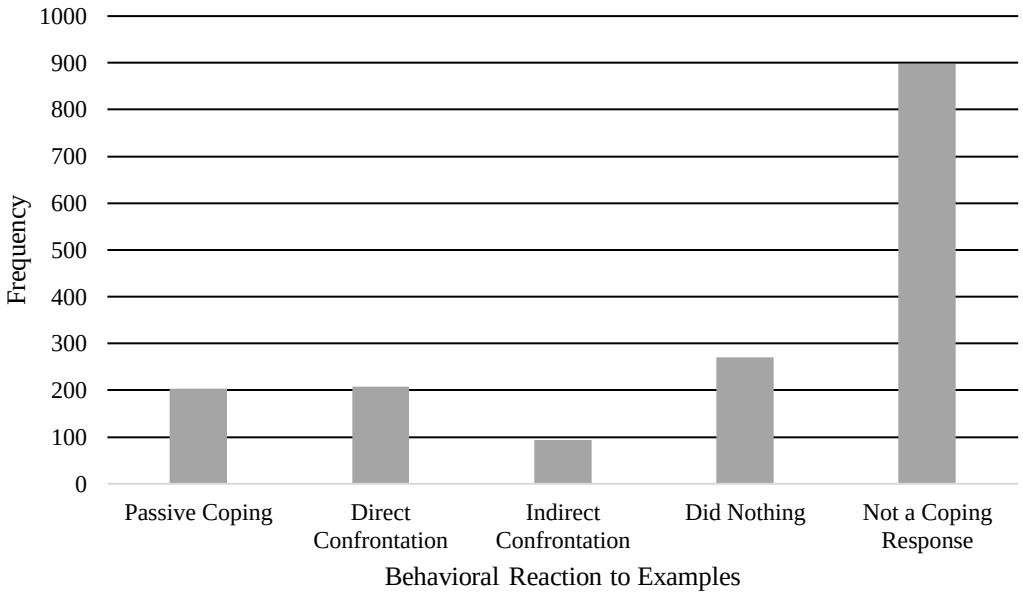
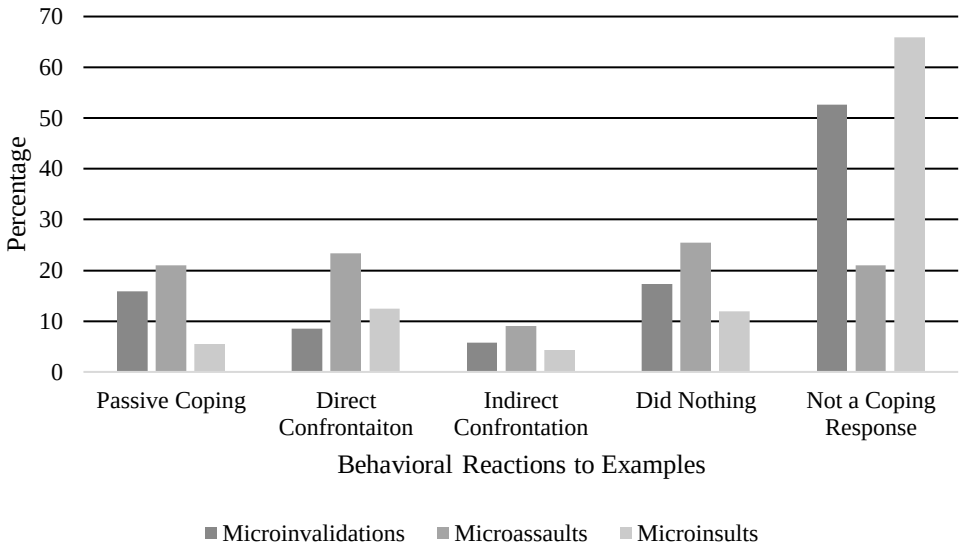


Figure 11

Behavioral Reaction to Age-Related Microaggressions by Form



Tables

Table 1

Frequency by Microaggression Example

Frequency/Example	Never	Once a Year	3-4 Times a Year	Once a Month	Once a Week	Almost Every Day	*Total*
Microinsults							
Item 2	129	42	19	4	1	2	197
Item 4	106	45	34	8	3	2	198
Item 5	114	47	30	5	1	1	198
Item 7	68	77	41	9	2	1	198
Item 9	75	57	49	12	4	1	198
Item 10	121	38	30	6	1	1	197
Item 15	14	47	86	28	18	4	197
Item 20	12	17	70	58	28	12	197
Total	639	370	359	130	58	24	1580
Microinvalidations							
Item 1	32	58	74	24	8	2	198
Item 11	158	21	14	3	2	0	198
Item 12	70	77	44	5	1	1	198
Item 14	28	37	68	29	27	9	198
Item 17	86	51	53	4	3	1	198
Item 18	123	34	31	7	2	0	197
Item 19	67	70	53	7	1	0	198
Total	564	348	337	79	44	13	1385
Microassaults							
Item 3	108	47	36	2	3	2	198
Item 6	158	28	10	1	1	0	198
Item 8	153	26	16	3	0	0	198
Item 13	162	28	7	0	0	1	198
Item 16	75	52	44	15	12	0	198
Total	656	181	113	21	16	3	990

Table 2

Emotional Response by Microaggression Example

Frequency/Example	Positive	Neutral	Negative	*Total*
Microinsults				
Item 2	11	27	34	72
Item 4	0	31	100	131
Item 5	4	16	73	93
Item 7	116	29	11	156
Item 9	32	68	55	155
Item 10	3	44	60	107
Item 15	168	58	15	241
Item 20	147	26	3	176
Total	481	299	351	1131
Microinvalidations				
Item 1	116	62	29	207
Item 11	0	8	47	55
Item 12	22	60	116	198
Item 14	1	96	163	260
Item 17	74	54	12	140
Item 18	0	14	124	138
Item 19	107	48	35	190
Total	320	342	526	1188
Microassaults				
Item 3	0	20	72	92
Item 6	0	7	69	76
Item 8	1	13	68	82
Item 13	1	10	76	87
Item 16	8	88	62	158
Total	10	138	347	495

Appendix A

Informed Consent

Informed Consent for Participation in Research

Title: The title of this research study is: "Age-Related Microaggressions: A Follow-up Descriptive Study."

Investigators: This study is being conducted by Hannah Lewis under the direct supervision of Jeffery Buchanan, PhD, of Minnesota State University Mankato's Department of Psychology.

Purpose: The purposes of this study are to determine the types of age-related microaggressions (which are subtle forms of discrimination based on age) that individuals over the age of 65 most often experience and to understand the emotional responses connected to the examples given.

Participants: You have been asked to participate because you are 65 years of age or older.

Procedure: You will be asked to complete an online survey that will take approximately 20 minutes to complete. This survey will first ask you several questions about yourself and then will present examples of microaggressions. You will then be asked a series of questions regarding your opinions about these examples and if you have experienced similar situations. The study will end when all questions have been answered, and you close your browser.

Risks: The risks you will encounter as a participant in this research are not more than experienced in your everyday life. It is possible you may experience emotional discomfort

related to describing experienced microaggressions. Should this occur, you may choose not to answer any of the survey questions, and you have the option to end your participation at any time by exiting out of the survey. The researchers strongly encourage you to use a secure internet connection and to participate in the study from a location where you would have privacy from others so they cannot view your computer or mobile device's screen.

Benefits and Compensation: The results of this study will provide a deeper understanding of how older adults experience subtle forms of ageism, in the form of microaggressions. Prolific will compensate you $5.00 for your participation.

Confidentiality: The findings of this study will be completely confidential. Confidentiality will be protected in that your name will not be included on any records. All information collected during this study will be used for research purposes only and will only be accessible to the principal investigator, Jeffrey Buchanan PhD and the student investigator Hannah Lewis. If you would like more information about the specific privacy and anonymity risks posed by online surveys, please contact the Minnesota State University, Mankato IT Solutions Center (507-389-6654) and ask to speak to the Information Security Manager.

Right to Refuse or Withdraw: Participation in this study is voluntary. You may choose not to answer any of the survey questions, or you may end your participation at any time by closing the web browser. Your decision whether or not to participate will not affect your relationship with Minnesota State University, Mankato, and refusal to participate will involve no penalty or loss of benefits.

Questions: If you have any questions, you are free to ask them. If you have any additional questions, you may contact the office of the principal investigator, Jeffrey Buchanan, PhD at (507) 389-5824. If you have questions about participants' rights and for research-related injuries, please contact the Administrator of the Institutional Review Board at (507) 389-1242.

Closing Statement: Submitting the completed survey will indicate your informed consent to participate and indicate your assurance that you are at least 65 years of age.

Please print a copy of this consent form for your records.

Minnesota State University, Mankato IRBNet LOG # 1875121

Q1 Do you consent to participating in this survey?

- ○ Yes (1)
- ○ No (2)

Appendix B

Qualtrics Survey

Prolific What is your Prolific ID?

_____

Q2 What is your age?

Q3 What sex were you assigned at birth, on your original birth certificate?

- Male
- Female

Q4 How do you describe yourself?

- Male
- Female
- Transgender
- Do not identify as female, male, or transgender

Q5 Which of the following best describes your race/ethnicity?

- ○ White or Caucasian
- ○ Black or African American
- ○ Native American or Alaskan Native
- ○ Asian or Pacific Islander
- ○ Hispanic or Latino
- ○ Multiracial or Biracial
- ○ I prefer not to answer
- ○ Another race/ethnicity not listed (please specify) _____

Q6 What is your highest level of education achieved

- ○ Less than a high school diploma
- ○ High School Diploma/GED
- ○ Some College
- ○ Associates Degree/Certificate
- ○ Bachelor's Degree
- ○ Master's Degree
- ○ Doctoral Degree

Q7 What state were you born in?

▼ Alabama (1) ... Wyoming (50)

Q8 What state have you spent most of your life in?

▼ Alabama (1) ... Wyoming (50)

Q9 What state do you reside in now?

▼ Alabama (1) ... Wyoming (50)

Q10 Overall, would you say your health is...

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

Q10 Do you have concerns about your memory?

- ○ Yes
- ○ No

Q11 Have you been diagnosed with any memory impairments?

- ○ Yes
- ○ No

Q12 Indicate the extent you have felt this way over the past week

	Very slightly or not at all	A little	Moderately	Quite a bit	Extremely
Interested	○	○	○	○	○
Distressed	○	○	○	○	○
Excited	○	○	○	○	○
Upset	○	○	○	○	○
Strong	○	○	○	○	○
Guilty	○	○	○	○	○
Scared	○	○	○	○	○
Hostile	○	○	○	○	○
Enthusiastic	○	○	○	○	○
Proud	○	○	○	○	○
Irritable	○	○	○	○	○
Alert	○	○	○	○	○
Ashamed	○	○	○	○	○
Inspired	○	○	○	○	○
Nervous	○	○	○	○	○
Determined	○	○	○	○	○

Attentive	○	○	○	○	○
Jittery	○	○	○	○	○
Active	○	○	○	○	○
Afraid	○	○	○	○	○

Directions For the next set of questions, you will be given a scenario followed by a list of questions. Please reflect on your own experience with these scenarios to the best of your ability.

Item 1 Being told "you look good for your age" .

Q1 Do you think this interaction was related to your... (check all that apply)

- ☐ Age
- ☐ Gender
- ☐ Ethnicity
- ☐ Other (please specify)

Q2 How often have you experienced a scenario of this type?

- ○ Never
- ○ Once a year
- ○ 3-4 times per year

- ○ Once a month
- ○ Once a week
- ○ Almost every day

Q3 How did this scenario make you feel?

- ☐ Angry
- ☐ Embarrassed
- ☐ Insulted
- ☐ Surprised
- ☐ Isolated/Rejected
- ☐ Anxious
- ☐ Sad
- ☐ Comforted
- ☐ Indifferent
- ☐ Appreciative
- ☐ N/A

Q4 Where did this occur?

- [ ] Home
- [ ] Work
- [ ] Store
- [ ] Restaurant
- [ ] Church
- [ ] Healthcare setting
- [ ] N/A
- [ ] Other (please specify)

Q5 What is your relationship to this individual?

- [ ] Stranger
- [ ] Family Member
- [ ] Friend
- [ ] Coworker/Employer
- [ ] Service Provider
- [ ] N/A

☐ Other (please specify)

Q6 How did you respond?

_____

Item 2 Being patted on the back by someone while saying something similar to “aren’t you precious,” or aren’t you cute.”

Item 3 Being rushed for not being fast enough (for example, being bumped or pushed)

Item 4 Someone suggesting that perhaps you are not well versed in technology (for example, saying “well, you wouldn’t understand” when speaking about technical matters).

Item 5 Someone talks about you without involving you even when you are present.

Item 6 Applying for a job opening and being told that they are looking for a younger person, even though you are qualified.

Item 7 Being offered a seat in a public place (for example, on a bus, or in a waiting room).

Item 8 Hearing a person say something indicating *that the world would be better off if older people just went away to make room for younger people* (For example, “it will be good when old people just die off”, or “I wish more older people would retire.”)

Item 9 Being referred to as “young lady/man” by someone who is younger than you.

Item 10 Being told that you are too old to understand what it is like for kids these days.

Item 11 Getting the impression that you should not share your opinions (for example, “be quiet old lady/man”).

Item 12 Being told your medical issues (for example, arthritis, diabetes) or physical issues (for example, poor eyesight/hearing) are not bad because they are expected at your age.

Item 13 Believing you were not hired for a position because you do not look young enough.

Item 14 Being told that you do not qualify for a survey after entering your age.

Item 15 Being offered a senior discount.

Item 16 Being called or referred to as “old.”

Item 17 Having someone suggest that you are being dishonest about your age (for example, “I can’t believe you’re 80, you don’t look a day over 60”).

Item 18 Feeling as if you are being ignored or dismissed by others because of your age (for example, you say something, and no one responds to you).

Item 19 When someone suggests that you are doing well for your age (for example, a dentist saying that your teeth are good for your age; someone remarks that, “you get around well for your age.”)

Item 20 Having the door held open for you

Appendix C

Age-Related Microaggressions: Key Terms and Definitions

Ageism: Age-related stereotypes in the form of prejudice or discrimination towards someone based upon their chronological age or the perception of them being old.

Microaggression: Commonplace verbal or behavioral indignities, whether intentional or unintentional, which communicate hostile, derogatory, or negative slights and insults.

Microinsult: Behavioral/verbal remarks or comments conveying stereotypes, rudeness, insensitivity and demean an individual's identity.

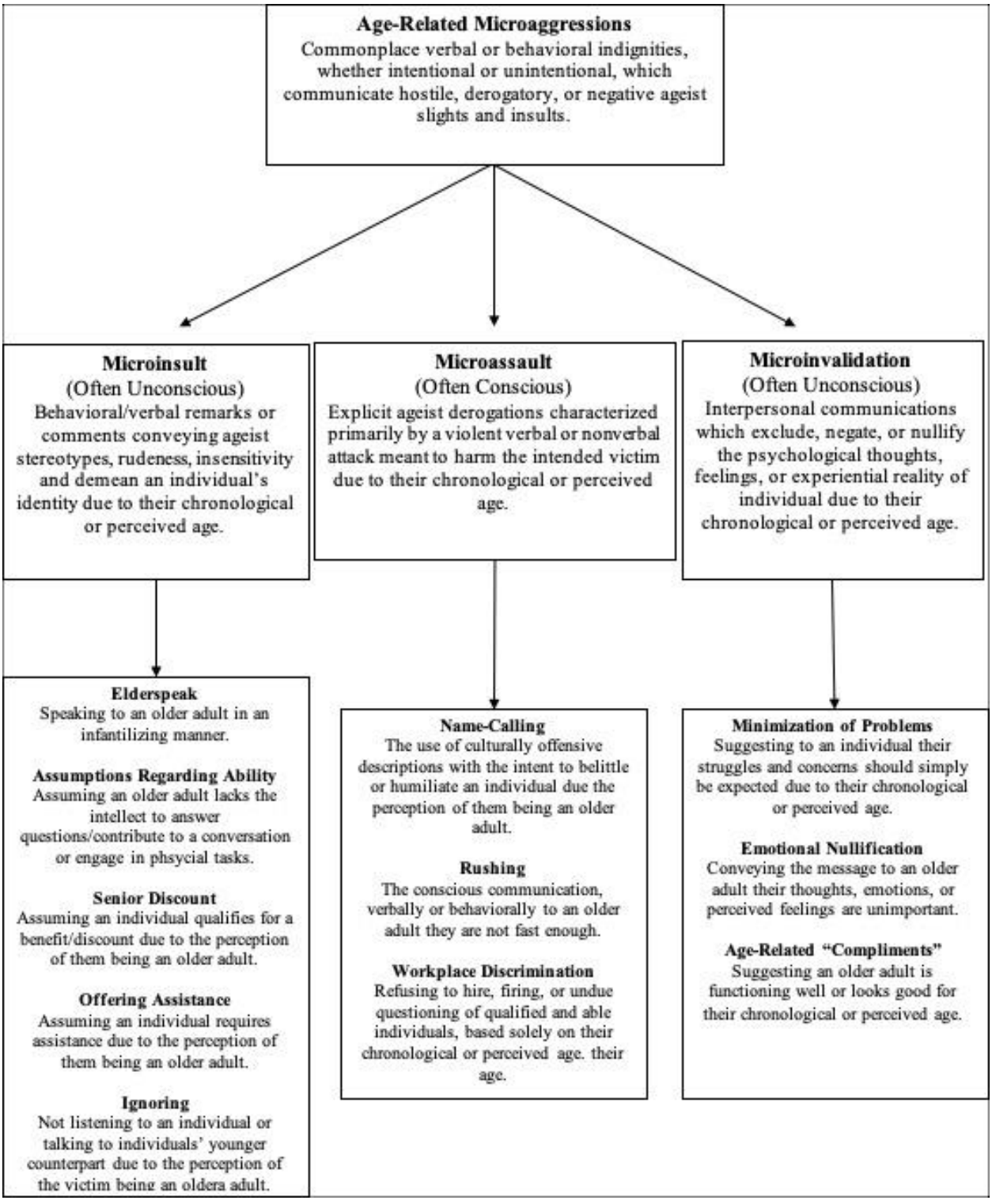
Microinvalidation: Interpersonal communications which exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of individual.

Microassault: Explicit derogations characterized primarily by a violent verbal or nonverbal attack meant to harm the intended victim.

Age-Related Microaggression: Commonplace verbal or behavioral indignities, whether intentional or unintentional which communicate hostile, derogatory, or negative ageist slights or insults.

Appendix D

Categories of and Relationships Among Age-Related Microaggressions


Age-Related Microaggressions
Commonplace verbal or behavioral indignities, whether intentional or unintentional, which communicate hostile, derogatory, or negative ageist slights and insults.
Microinsult
(Often Unconscious)
Behavioral/verbal remarks or comments conveying ageist stereotypes, rudeness, insensitivity and demean an individual's identity due to their chronological or perceived age.
Microassault
(Often Conscious)
Explicit ageist derogations characterized primarily by a violent verbal or nonverbal attack meant to harm the intended victim due to their chronological or perceived age.
Microinvalidation
(Often Unconscious)
Interpersonal communications which exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of individual due to their chronological or perceived age.
Elderspeak
Speaking to an older adult in an infantilizing manner.
Assumptions Regarding Ability
Assuming an older adult lacks the intellect to answer questions/contribute to a conversation or engage in phsycial tasks.
Senior Discount
Assuming an individual qualifies for a benefit/discount due to the perception of them being an older adult.
Offering Assistance
Assuming an individual requires assistance due to the perception of them being an older adult.
Ignoring
Not listening to an individual or talking to individuals' younger counterpart due to the perception of the victim being an oldera adult.
Name-Calling
The use of culturally offensive descriptions with the intent to belittle or humiliate an individual due the perception of them being an older adult.
Rushing
The conscious communication, verbally or behaviorally to an older adult they are not fast enough.
Workplace Discrimination
Refusing to hire, firing, or undue questioning of qualified and able individuals, based solely on their chronological or perceived age. their age.
Minimization of Problems
Suggesting to an individual their struggles and concerns should simply be expected due to their chronological or perceived age.
Emotional Nullification
Conveying the message to an older adult their thoughts, emotions, or perceived feelings are unimportant.
Age-Related "Compliments"
Suggesting an older adult is functioning well or looks good for their chronological or perceived age.