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Ageism in Interpersonal Settings

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Unlike sexism and racism, ageism continues to go largely unacknowledged in day-to-day life in the United States. The current social climate allows people to voice reservations freely about older people, in a way that would be patently unacceptable in discussions about race or gender. Ageism is so firmly embedded within the social fabric of U.S. culture that few people even question the fact that age is considered a legitimate reason for limiting access to health care and productive employment. Ironically, older people represent the only stigmatized group that, barring premature death, we all eventually join. Thus, ageism holds considerable relevance for all people, regardless of their current age. However, despite the clear demonstration of ageism evidenced in retirement and hiring policies, insurance practices, and other age-biased laws and policies, empirical evidence for ageist behavior in interpersonal settings is more elusive.

This chapter focuses on ageism as studied by the social sciences. We emphasize interpersonal behavior, but we touch on other aspects of ageism as well. First, however, we paint a broad picture of the elderly population

in an attempt to neutralize some common misperceptions about old age that our readers may share.

DEFINING OLD AGE AND AGEISM

The expression "old age is new" refers to the fact that only in recent history has it become normative to experience old age. Life expectancy at birth has increased by more than 30 years since the turn of the century, largely because improved sanitation and vaccination programs have reduced infant mortality. This has allowed most children born in industrialized countries to live out their entire life-span. As a result, the absolute and relative number of older people in developed countries has exploded during the 20th century, especially the "very old" group (see below). In 1900, 4% of the U.S. population was over the age of 65, but currently 12% of the population meets this age criterion; by the year 2020, 24% of the population will be over the age of 65 (Myers, 1990). Since the reduction in infant mortality has nearly reached its limit, the 21st century will not witness a continuation of this trend.

Who Are the Elderly?

Although it is beyond the scope of this chapter to provide a full description of the elderly population, one central feature should be noted: Older cohorts are more heterogeneous than any other age group, along virtually any dimension (Dannefer & Perlmutter, 1990). Whitborne (1987) refers to adult development as a process of differentiation; that is, people become increasingly individualized as they age. As a result, the elderly are a highly diverse group of people, including the wisest members of society as well as the most demented.

By convention, old age begins at age 65. The widespread use of this initially arbitrary age criterion has in some sense created its utility. That is, because most researchers use this cutoff, most studies of aging do describe people 65 years of age and older. Still, because aging is a gradual and cumulative process, the categorical term "old age" can be misleading. To address specific age groups more adequately, some scientists have come to refer to the "young-old" (65–75), the "old-old" (76–84) and the "very old" (over 85). However, individual variability is notable even within these smaller age categories.

The scientific study of aging has been largely a search for age-related decrement, from the slowing of mental processes to physical decline. In fact, one of the more subtle forms of ageism can be found in the way science has studied old age (Carstensen & Freund, 1994; Schaie, 1993). Given that

the quest has been focused on problems, it follows that gerontological researchers have primarily documented the problems older people face. But even though the search has been focused on decrement, it has had its surprises. Despite some common problems, older people appear in general to be doing quite well. For example, with the exception of the dementias, the prevalence of all other psychological disorders is lower among older people. Moreover, although dementia is a disease of late life, it occurs far less frequently than many imagine: Only 5% of people over 65 suffer from some form of dementia (Jorm, 1987). Although this percentage increases with age, the majority of people never suffer from dementia. Similarly, the image of the prototypical old person as a frail nursing home resident is misleading. Only 5% of older people live in nursing homes at any point in time; the vast majority of older people live independently in the community (American Association of Homes for the Aging, 1991).

Ageism

"Ageism" is not a precisely defined concept in the psychological literature or in everyday usage. Broadly, it may be defined as discrimination based on chronological age. In the social-psychological literature, ageism has typically been understood as including negative beliefs, attitudes, and stereotypes about elderly persons. Although ageist attitudes are relatively easy to identify, it is unclear how these attitudes translate into actual behavior. Without evidence for negative behavior, it is difficult to speak of interpersonal ageism, even with ample evidence of ageism at the level of public policy and legislation. Our current focus is on behavioral ageism rather than on ageist attitudes or structural ageism.

For our purposes, we define "ageist behavior" as behavior that discriminates on the basis of chronological age. Such discrimination can involve overtly hostile behavior, but it also includes behaviors that may appear quite positive but that ultimately serve to prevent elderly people from attaining their goals. Ageist behavior, then, must be contingent upon chronological age and must produce some sort of harmful impact.

In this chapter, we first address evidence for negative attitudes toward, beliefs about, and stereotypes of elderly people. We then examine the evidence for ageist behavior, both related and unrelated to ageist attitudes. We use the term "age-differentiated" to refer to behavior that differs as a function of the age of the target, but may or may not reflect negative overgeneralizations based on chronological age. We do so because much of the existing research is fraught with uncertainties regarding the nature of the documented behaviors. For example, many observed behaviors are not clearly negative or hostile. In addition, whether or not the behaviors were driven by negative expectations of the elderly targets is often unknown.

Indeed, in some cases, behavior distinctions could reflect respect or accommodations to genuine limitations of the target person. Finally, it is often unclear whether the observed behaviors constrain elders' desired goals—an uncertainty that stems largely from a failure to adequately address the impact of the age-differentiated treatment.

AGEIST ATTITUDES, BELIEFS, AND STEREOTYPES

Behavior that is ageist is often presumed to be associated with underlying negative conceptions of the old. Therefore, in this section we discuss evidence for ageism based on research that examines attitudes toward and beliefs about the elderly. As we review below, age is a dimension by which people categorize other people, and conceptions of the elderly include both negative and positive elements. However, conceptions of the old appear to be more negative than positive.

Several studies have found that age is a highly salient dimension along which people are categorized (Kite, Deaux, & Miele, 1991; Brewer & Lui, 1989). In fact, Kite et al. (1991) find that age is a more salient social category than gender. Not only is age a salient dimension, but shared stereotypes about elderly people exist (Brewer, Dull, & Lui, 1981; Brewer & Lui, 1989; Hummert, 1990). These include the "elder statesperson," the "senior citizen," and the "golden ager" (Brewer et al., 1981; Brewer & Lui, 1989; Hummert, 1990). Both young and old people share stereotypes of the elderly, although there are some differences in their categories. Most notably, older people appear to have more subcategories within the broad category "old" than do younger adults. Interestingly, stereotypes of the elderly often represent polar opposites or extremes, such as "wise" and "demented," "kind" and "grouchy," and "experienced" and "incompetent."

Although stereotypes of the elderly are both positive and negative, people appear to hold more negative than positive beliefs about aging (see Rubin & Brown, 1975; Heckhausen, Dixon, & Baltes, 1989). In one study, Heckhausen et al. (1989) asked young, middle-aged, and elderly adults to review a list of adjectives such as "dignified," "fair-minded," "shrewd," and "powerful," among others. Respondents rated each adjective for the degree to which it *increased* over the lifespan, the desirability of that increase, and the ages at which the increase began and ended. Heckhausen et al. concluded that people of different age groups share similar beliefs about adult development. Moreover, these beliefs are not unidirectional; aging is apparently perceived as a process involving gains (increases in desirable attributes, decreases in undesirable ones) and losses (increases in undesirable attributes, decreases in desirable ones). Despite the existence

of positive and negative beliefs, the ratio between gains and losses is thought to become more and more negative at older ages, as Figure 6.1 shows. For people in their early 80s, gains and losses are considered to be roughly equivalent, but the relative percentage of losses is thought to increase rapidly from that point on.

Just as beliefs and stereotypes about the elderly are ambivalent but tend to be negative, the attitude literature also reflects both negativity and ambiguity. Very early work by Tuckman and Lorge showed that a wide variety of people display negative attitudes toward the elderly (Tuckman & Lorge, 1952, 1958; Lorge, Tuckman, & Abrams, 1954). In fact, negative conceptions of the elderly can be documented as soon as children are able to discriminate age among adults (Looft, 1971). Despite these early findings, it is unclear just how negative people's attitudes toward the elderly

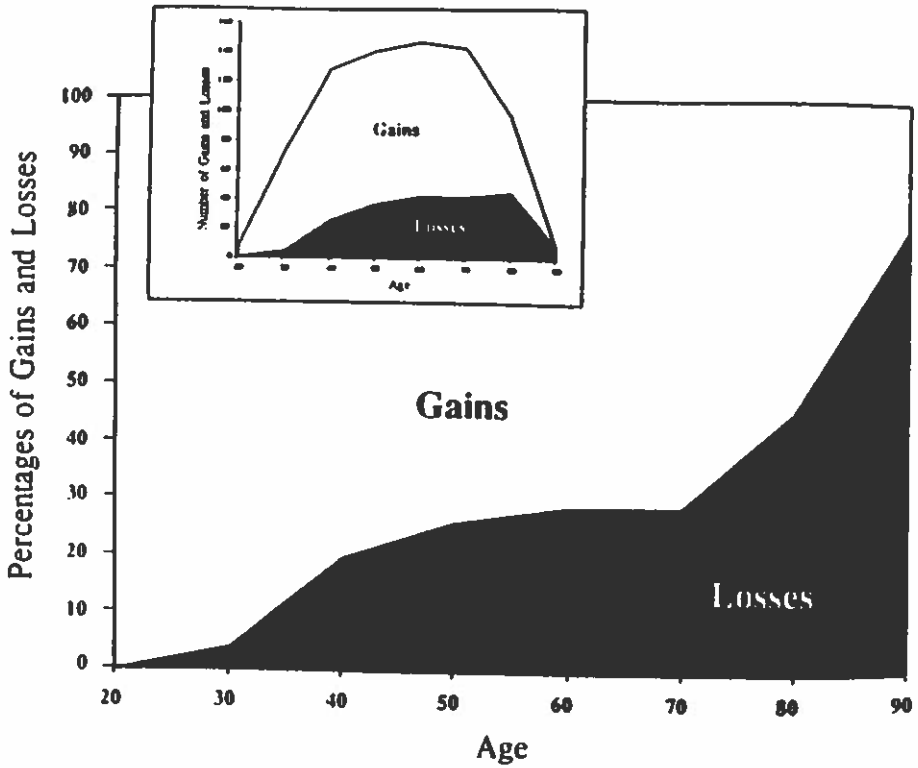

FIGURE 6.1. Quantitative relations of gains and losses across the adult lifespan: Percentages and absolute numbers (insert). From Heckhausen, Dixon, and Baltes (1989). Copyright 1989 by the American Psychological Association. Reprinted by permission.

are (Hummert, 1990; Brewer et al., 1981). For example, even though much of the literature shows that elderly people are viewed more negatively than the young, both groups are described on the positive side of neutral (Crockett & Hummert, 1987). In this sense, then, ageism may be relative rather than absolute.

Overall, more negatively than positively valenced stereotypes about the elderly exist; negative beliefs about aging exist; and elderly people are evaluated more negatively than young people. Therefore, we can conclude that there is reasonable evidence for ageism in attitudes and beliefs about the old. A recent meta-analysis (Kite & Johnson, 1988) also supports the notion that general conceptions of people grow increasingly negative as the target group gets older.

Furthermore, a recent study using measures that were relatively immune to social desirability constraints suggests that people hold negative representations of the elderly, whether or not they consciously subscribe to that representation (Perdue & Gurtman, 1990). Perdue and Gurtman (1990) reasoned that an existing negative representation of the elderly should influence learning. Using an incidental-memory paradigm, they presented participants with a list of adjectives that were unequivocally positive or negative. Participants were asked to read each word and to make one of four judgments about it: (1) whether it was a desirable trait, (2) whether it described them, (3) whether it described an old person, or (4) whether it described a young person. Those who had been asked whether the word was typical of an old person recalled negative words more easily. Those asked whether the word was more typical of a young person recalled positive words more easily. A subsequent priming task in the same study demonstrated that this bias was unconscious, that is, respondents were unaware of their ageist responses. In other words, despite laudable conscious efforts to be egalitarian, people are likely to hold negative representations of the elderly.

In short, views of the elderly are predominantly negative, whether these are measured in terms of stereotypes, beliefs, attitudes, or learning. Although our particular focus is on the harmful behaviors that may result from negative attitudes and beliefs, negative attitudes may be harmful in their own right. According to Deaux's (1984) expectancy model of the effects of prejudice, stereotypes about the elderly will lead the elderly to develop specific expectations about their performance on particular tasks. That is, negative attitudes and stereotypes can influence the elderly's self-efficacy beliefs about task performance—beliefs that affect their actual performance (cf. Bandura, 1986, 1989). If people perform as they expect to perform on a given task, they attribute that performance to stable and internal causes. Thus, stereotype-consistent performance leads people to believe in and accept the specific implications of stereotypes about them.

For example, elderly people who are aware of the stereotypes about aging and memory may expect to perform poorly on memory tasks. If they do perform poorly, they assume that it is because they are old, and make an attribution that reinforces their expectations. Recent work suggests that elderly people who do not share widely held negative beliefs about aging do not show performance decrements on memory tasks (Levy & Langer, 1994).

Unfortunately, the literature on attitudes, beliefs, and stereotypes about aging leaves us quite ignorant about how people behave toward the elderly in day-to-day situations. There are several reasons why this may be the case. First, questionnaire methods are open to the biases of self-report (e.g., self-presentation), and often ask for global evaluations of elderly targets rather than for predictions of behavior toward the targets. As Perdue and Gurtman (1990) have shown, negative representations of the elderly are easily documented when other measures are used. It is unlikely that respondents in questionnaire studies can predict precisely how they would behave in actual situations. There is good evidence that people are not good at predicting their own behavior without knowing the particular constraints of the situation. Thus, the relationship between attitudes and behavior is known to be tenuous at best (Ajzen & Fishbein, 1977). Consequently, even if a person holds unambiguously negative attitudes toward the elderly, it is not clear that in a specific situation those attitudes would result in negative behavior.

In the next section, we review work that documents age-differentiated behavior in interpersonal settings, rather than ageist attitudes, beliefs, or stereotypes. We adopt a relatively open conception of behavior that includes actions such as referrals for psychological services (Gatz & Pearson, 1988), microanalytic approaches to linguistic behavior (Greene, Adelman, Charon, & Hoffman, 1986; Greene, Adelman, Charon, & Friedmann, 1989), and social attention contingent on dependent behavior (Baltes, Burgess, & Stewart, 1980; Baltes & Reisenzein, 1986). As previously mentioned, little work on interpersonal interaction with the elderly exists. The studies that we cite here are representative of what is known about interpersonal behavior toward the elderly.

EVIDENCE FOR BEHAVIORAL AGEISM

In considering the evidence for behavioral ageism, we begin with the relatively specific contexts of medical and institutional settings, and then move to more global everyday contexts in the community. Medical and institutional settings provide numerous examples of behavior that appear clearly ageist. In community contexts, the picture is less clear.

Medical Settings

Treatment and Referrals

Gatz and Pearson (1988) suggest that even though medical practitioners may not hold negative attitudes toward the elderly, they may possess specific biases regarding their treatment. For example, clinicians are more likely to prescribe drug treatments to elderly depressed patients than to refer them to psychotherapists. These biases stem from the misconception that elders are "stuck in their ways" and are incapable of introspection. The misconception persists despite ample evidence that psychotherapy works just as well for the depressed elderly as for depressed young people (Carstensen, 1988; Gatz & Pearson, 1988).

Physician–Patient Communication

Physician–patient communication can be a problem, regardless of the age of the patient. Studies of informed consent procedures suggest that patients, whether young or old, understand and recall very little of what doctors tell them (Mann, 1994). Explanations for this phenomenon vary; some blame patients for their anxiety and lack of medical knowledge, whereas others blame physicians for failing to use comprehensible language or to be receptive to patient concerns (Siminoff, 1989).

Some research suggests that this phenomenon worsens when the patient is old. In a series of studies, physician–patient interchanges involving elderly and young patients were audiotaped during follow-up visits for earlier problems (Greene et al., 1986, 1989). Audiotapes were subsequently coded for topics raised, initiators of topic, reference to age, misattributions of symptoms to old age, compliments and social amenities, use of jargon, open-ended questions, doctor patience, doctor engagement, doctor egalitarianism, doctor responsiveness, patient assertiveness, patient tension, patient expressiveness, and patient friendliness. Physicians addressed elderly patients with less patience, engagement, and respect than they showed to young patients. Furthermore, young patients received more open-ended questions, more detailed information about their conditions, and more support from physicians (Greene et al., 1986)—factors that presumably contribute to better treatment. Although the elderly patients were sicker than the younger patients, all age effects remained significant even after illness severity was statistically controlled for. Finally Greene et al. (1989) examined the degree to which physicians and patients agreed about topics they discussed during office visits. There was less concordance between the reports of elderly patients and their physicians than between young patients and their physicians.

One possible explanation for this age-differentiated treatment is that

the elderly are more passive consumers of health care, and therefore do not seek or desire the same kind of treatment from doctors as young patients. However, in this study elderly patients were no less assertive, expressive, or friendly than younger patients, nor were they more tense (Greene et al., 1986). Despite the fact that there were no age differences in patient behaviors, physicians were less likely to respond to a topic raised by an elderly patient than to one raised by a young patient. This was particularly true when issues were psychosocial in nature, such as problems with family members or partners; concerns about health; or questions about tests, treatments, or procedures. Clearly, these findings suggest a lack of communication or understanding by physicians, patients, or both.

All told, the research of Greene and colleagues presents substantial evidence that physicians treat the elderly differently from the young. Age-differentiated behavior in physician–patient settings is particularly significant, because elders spend far more time in physicians' offices and far more dollars on health care than any other segment of the population (Kane & Kane, 1990). Thus, the physician–patient relationship may be increasingly important in later life.

Institutional Settings

Babytalk to Elderly People

A glaring example of age-differentiated behavior in nursing homes is provided by the literature on "babytalk" directed to older adults (Caporeal, 1981; Caporeal & Culbertson, 1986; Caporeal, Lukaszewski, & Culbertson, 1983; Ryan, Giles, Bartolucci, & Henwood, 1986). "Babytalk" is characterized by high, variable pitch and simplified content (Ryan et al., 1986). It is typical of parent–infant interactions, but is also found when people are addressing older children and retarded adults (DePaulo & Coleman, 1986).

Babytalk is clearly present in nursing homes. Caporeal (1981) audiotaped nursing home staff members as they performed their jobs. Utterances directed at a range of care receivers, aged 60 to 90 years, were transcribed and coded as either babytalk or nonbabytalk. Raters judged 22% of these verbal utterances as babytalk. When content-filtered, these same statements were indistinguishable from mother–infant speech.

How do elders perceive this babytalk? Babytalk may be quite pleasant to hear—for example, infants prefer it to other types of speech (Fernald & Mazzie, 1991). In fact, a second set of raters (viz., students) judged elder-directed babytalk to be more pleasant than normal adult speech. However, raters did not know to whom the talk was addressed; therefore, it is possible that they would have rated the speech as less pleasant had they known that it was directed toward adults rather than children. Thus, babytalk may be perceived as pleasant when addressed to children, but as condescending when addressed to competent adults.

Caporeal et al. (1983) set out to document the impact of elder-directed babytalk on residents of nursing homes. They asked residents to indicate their preferences for content-filtered statements that were either normal speech directed at adults (not residents), normal speech directed at elderly care recipients, or babytalk directed at elderly care recipients. Caregiving staff members were also asked to make judgments about the speech samples. They were asked to choose the voice that would be most preferred by elderly residents, and the voice that would be most effective for interacting with the residents. In addition, caregivers were asked about their expectations for various care receivers.

Most elderly people preferred adult-type speech to babytalk. There was a subset of elderly care recipients who preferred babytalk over adult-type speech; however, they were relatively lower in functional ability than the rest of the sample. Caregivers who had generally low expectations of the elderly thought that babytalk would be preferred by elderly and be more effective in dealing with the elderly. These findings suggest that staff members' expectations of elders, rather than the elders' individual characteristics, predict staff members' use of babytalk (Caporeal, 1981; Caporeal et al., 1983). Although Caporeal et al. (1983) did not measure these staff members' actual use of babytalk, their findings have important implications for the use of babytalk. Elderly persons may perceive babytalk as communicating the speaker's low expectations for their abilities. For high-functioning elders, the discrepancy between these expectations and their own (as high-functioning adults) may have detrimental effects (see Deaux, 1984). Low-functioning elders, on the other hand, may prefer babytalk to adult-type speech because the use of babytalk communicates expectations that are more consistent with their own.

Nursing Homes and Dependency

In nursing homes, age-differentiated treatment exists in the reinforcement of specific behaviors that promote dependency. Although residence in a nursing home setting implies some degree of dependency, elderly residents can typically engage in a considerable amount of independent behavior. Doing so should improve their sense of efficacy in multiple domains (Rodin, 1986). However, in some cases, the cost of behaving independently may be the loss of social support. Over the years, Baltes and her colleagues have studied the ways in which nursing home staff members respond to self-care behaviors from residents. Baltes et al. (1980) developed a systematic coding system in which residents' self-care behaviors (e.g., brushing teeth, dressing) are coded as either independent (performed without assis-

tance) or dependent (requiring assistance). Staff responses are coded as either dependence-supporting, independence-supporting, no response, or other response. Dependence-supporting behaviors include staff assistance in self-care behaviors, praise for the acceptance of help, or discouragement of independent self-care behavior. Independence-supporting behaviors include encouragement and praise for independent self-care behavior, and discouragement of requests for assistance. Baltes et al.'s findings showed reliably that when residents engaged in independent acts, staff members did not respond to them. In contrast, when dependent behaviors were displayed, the staff responded consistently and positively. Thus, a nursing home appears to be an environment where dependence is reinforced and independence is ignored.

To determine whether this phenomemon could be attributed to age or to institutional settings, Baltes and Reisenzein (1986) used a similar paradigm to compare the treatment of institutionalized children and institutionalized elderly people. They found that twice as much support was given to the elderly for dependent behaviors as for independent behaviors, whereas the reverse pattern was true for children. Thus, institutionalization per se is not the cause of the dependence-supporting environment observed in nursing homes. Although these two populations are not entirely comparable, it is at least clear that in institutional contexts, the elderly are treated very differently from children.

The above-cited studies demonstrate that elderly people are treated differently and rather negatively by health care professionals in a variety of settings. As we discuss below, although dependency may not be a completely negative outcome, and babytalk may communicate warmth as well as expectations of incompetence, all of the age-differentiated treatment we have listed thus far could be considered ageist. Of course, in all of the studies cited, this age-differentiated treatment occured in the context of pre-existing power imbalances (physicians and nursing home staffs hold a great deal of power in comparison to patients and residents, regardless of age) and with relatively frail elders. These studies do not adequately address how interpersonal ageism influences social interactions with healthy, community-dwelling elderly persons. In this population, age-differentiated behavior also exists; however, it is more difficult to determine whether such behavior is ageist.

Community Settings

Dependency in the Community

To examine the generalizability of their findings, Baltes and Wahl (1992) examined interactions between community-dwelling elderly and their social partners, and compared them with those between nursing home residents and staff members. Elders' behaviors were coded as sleeping, constructively engaged, destructively engaged, nonengaged, independent self-care behavior, or dependent self-care behavior. Social partners' responses were coded as dependence supporting, independence-supporting, engagement-supporting, nonengagement-supporting, nonresponse, or leaving. With regard to dependent behaviors, both the community elderly and nursing home residents were treated similarly by their social partners—that is, social partners responded to elders' dependent behaviors in a dependence-supporting manner. With respect to independent self-care behaviors, however, the two elderly groups differed. In the nursing home, as in previous work, independent behaviors were for the most part ignored by staff members. In the community, however, independent behaviors received a variety of responses. For one-third of the time, social partners responded in an independence-supporting way; for the remainder of the time, independent behaviors received dependence-supporting responses.

Thus, the work of Baltes and Wahl (1992) suggests that although there may be similarities between institutional and noninstitutional settings, there also may be differences. As they note, these differences may arise from the ambiguous nature of social interactions in noninstitutional settings. For example, in medical and institutional settings, social interactions entail clear goals regarding the treatment of patients. In contrast, the goals of social partners in more casual social settings are less clear. Consequently, ambivalent responses that reflect a complicated mixture of ageist attitudes, desires to assist elders, and goals of promoting their independence may result. In any case, these behaviors differ from those toward the young. What about interactions between the young and the old? We now turn to interpersonal communications in a variety of contexts.

Intergenerational Communication

The findings from studies on intergenerational communication are mixed; some suggest no or little age-differentiated behavior, whereas others document robust age-differentiated behavior. In one early study (Rubin & Brown, 1975), college students were asked to rate the competence of people of various ages across a variety of cognitive skills, some of which are stereotypically believed to decline in old age (e.g., memory), and others of which are believed to increase (e.g., wisdom). In general, students rated people's competence in these domains as curvilinear—increasing until middle adulthood, and then decreasing. They were then asked to explain a game to a hypothetical listener of a particular age. The listener was represented by an ink drawing that was suggestive of a particular age. Students spoke fewer words per utterance when speaking to children,

adolescent, and elderly "listeners" than when speaking to young and middle-aged adult "listeners." The number of words per utterance was considered a rough index of the complexity of the explanation. Thus, the elderly received both simple explanations and lower competency ratings; in fact, they were treated like children and adolescents rather than like competent adults. Unfortunately, this study did not examine actual interpersonal interaction. It is possible that had Rubin and Brown employed real listeners rather than drawings in their design, the explanations given by the students would have differed. Real listeners give signals that indicate their comprehension and allow the speaker to move on, or signals indicating lack of comprehension and asking for further detail; in the absence of such signals, speakers have difficulty (Krauss, Garlock, Bricker, & McMahon, 1977).

Another project examined the behavior of children as they interacted with elderly people (Isaacs & Bearison, 1986). Children aged 4, 6, and 8 were first asked about their ageist attitudes. Four-year-olds did not demonstrate ageist attitudes, whereas 6- and 8-year-olds did. Each child was then brought into a room with a child-sized table, chairs, and two jigsaw puzzles. The experimenter and an adult confederate were in the room. Confederates were either elderly adults (approximately 75 years old) or young adults (approximately 35 years old). All confederates were healthy, were fashionably dressed, and had professional experience working with children. Each child was asked to work on the puzzle with the confederate. Behaviorally, the children were quite discriminating: They sat farther away from, made less eye contact with, spoke fewer words to, initiated less conversation with, and asked for less help from aged confederates. However, children's attitudes correlated with only some of their behaviors. Ageist attitudes were strongly correlated with the age of a child. Ageist behavior, on the other hand, was less related to a child's age. Thus, although 4-year-olds asked for assistance more often overall and sat closer to the elderly confederates than their older peers did, on all other measures children of all ages behaved similarly.

Other studies of intergenerational interaction include Montepare, Steinberg, and Rosenberg's (1992) examination of college students' speech to their grandparents and their parents. Speech directed at grandparents had a higher pitch and was more feminine, deferential, and unpleasant than speech directed toward parents, according to observers' ratings. Interestingly, it was not more simple than speech directed toward parents. The authors suggest that these characteristics reflected the greater deference and lesser intimacy college students felt toward their grandparents compared to their parents. In addition, they conclude that age-differentiated speech is not a reflection of negative attitudes, although their rationale is unclear.

Further evidence of age-differentiated behavior in intergenerational interactions is provided by a second study, conducted in a less naturalistic setting (Coupland, Coupland, Giles, Henwood, & Wiemann, 1988). Elderly adults and nonelderly adults were paired once with same-aged peers, and once with partners of a different age; in each case, partners were instructed to get to know each other. Sessions were videotaped, and conversations between partners were transcribed and coded for painful self-disclosure, operationalized as the discussion of loneliness, disengagement, and other troubles. Overall, elderly participants were found to engage in painful self-disclosure more often than younger participants. Moreover, young adults appeared to be influenced by their partners' age, whereas the elderly adults were not. Elderly adults disclosed to young and old social partners alike, whereas young adults were more likely to disclose to same-age peers.

In our laboratory, we examined intergenerational interaction in two groups: European-Americans and Chinese-Americans (Tsai & Carstensen, 1991). These groups were chosen because the ethnographic literature suggests that Chinese Americans may hold fewer ageist attitudes than do European-Americans (Chang, Chang, & Shen, 1984; Cheung, 1989; Lee, 1986). Studying both groups afforded a chance to look at attitude–behavior relationships, as well as to examine behavior in a group that is purportedly not ageist. Participants aged 18–21 years were paired with other women of the same ethnicity, who were either the same age or elderly. Pairs were instructed to come to agreement on a topic about which they held opposite opinions (as assessed by previously administered questionnaires). Topics ranged from "mothers' employment outside the home" to the "use of the military to combat drugs."

Raters gauged the respectfulness, politeness, patience, responsiveness, comfort, and directiveness of participants toward their partners. Both similarities and differences in the behavior of participants were identified as a function of their social partners' age. Participants were comparably patient, comfortable, and responsive toward both young and old social partners. However, compared to those interacting with young partners, those interacting with older social partners were more respectful, polite, and directive, and changed their opinions more *during* the interaction (but returned to their initial opinions after the interaction). In addition, participants paired with elderly partners moved their chairs closer to their partners (as measured by the distances between the partners' chairs). Thus, as in previous work, we found ample evidence for age-differentiated behavior on the part of young adults. Interestingly, no differences between the two ethnic groups were found: Despite different expressed attitudes towards the elderly, both European-Americans and Chinese-Americans behaved differently toward partners who were older.

Existing Research: Limitations

The existing research on ageist behavior spans a variety of settings and paradigms. Although most studies do show age-differentiated treatment of social partners, the interpretation of findings is hampered by various limitations.

One limitation involves apparent reliability of effects. For example, Isaacs and Bearison (1986) found that children sat further from elderly partners, whereas Tsai and Carstensen (1991) found that young adults sat closer to elderly partners. The inconsistency of these findings suggests that researchers should consider not only characteristics of the elderly targets of age-differentiated behavior, but also characteristics of their social partners. Although this point seems obvious, much of the existing literature has not varied the characteristics of social partners, such as their age, ethnicity, and/or gender. Moreover, most of the work we have reviewed examines strangers interacting. When familiar partners are examined, findings may be altered—for example, Montepare et al. (1992) found that speech to grandparents and parents was similar in complexity, whereas Rubin and Brown (1975) found that speech to elderly targets was simplified. Familiar or intimate others—people who constitute an elderly person's inner social network—may behave very differently toward the elderly individual than strangers may.

Clearly, the social context is important as well, and it rarely receives the attention it deserves. For example, behavior that is appropriate in one setting may be inappropriate in another; therefore, researchers attempting to document ageist, sexist, or racist behavior must consider the possibility that the social context both inhibits and alters the expression of behavior. For example, increased politeness of young adults toward elderly confederates may serve as a socially acceptable way of distancing from an elderly person. Alternatively, it may be an attempt to follow a rule of respect for elders. Similarly, disclosing painful events to elderly people may violate norms of "not burdening" the older persons with the insignificant troubles of youth. Because perceptions of the social context are often unaddressed, it is difficult to interpret findings of age-differentiated behavior.

Another limitation of the existing literature is its failure to address the interplay among factors such as sexism, racism, homophobia, and ageism. Sometimes referred to as "double jeopardy," "triple jeopardy,", or "multiple jeopardy," the intersection of old age with other stigmatized characteristics represents largely uncharted territory, particularly in the domain of interpersonal interaction. Because the majority of elderly people are women, sexism must be addressed. And because the combined proportion of minority elderly is expected to double by the next century, the intersection of ageism and ethnicity is clearly important to understand (National Academy on Aging, 1994).

SUMMARY AND CONCLUSIONS

The literature provides ample evidence that people treat the elderly differently from younger people in medical, institutional, and community settings. However, we caution against the automatic conclusions that age-differentiated behavior represents ageism. Recall that according to the definition of ageist behavior we have proposed earlier, ageist behavior must be based on chronological age and must have harmful effects. Harmful effects can derive from overtly hostile behavior or from behavior that blocks an elderly person's desired goals. Very little of the age-differentiated behavior we have detailed above can be clearly categorized as hostile or negative. Some of it may even be construed quite positively, such as increased politeness (Tsai & Carstensen, 1991). Perhaps one way we can identify whether such behavior is positive or negative is by incorporating the perspectives of the elderly in the work. Another way of better understanding such behavior is to examine its impact via other measures: For example, would elderly people negotiating with younger adults perform better or worse when sitting closer or farther away from their partners? Unfortunately, a central limitation of the existing literature is its failure to address harmful impact by either of these criteria.

Social science research on attitudes toward the elderly suggests that people hold ambivalent views of the elderly, believing that the elderly are wise as well as demented, grouchy as well as kind. The literature on behavior toward the elderly appears similar. It seems that old age encompasses both positive and negative stereotypes, and that the elderly are the recipients of differential treatment that is sometimes positive and sometimes negative. People treat the elderly with more respect, but are also more directive of a conversation with an elderly person (Tsai & Carstensen, 1991). In the community, people treat the independent behavior of the elderly with ambivalence—sometimes rewarding such behavior, sometimes discouraging it (Baltes & Wahl, 1992). This ambivalence makes it difficult to characterize ageist behavior.

Not only is age-differentiated behavior frequently ambivalent, but the problem of interpreting such behavior is exacerbated by the fact that aging is associated with genuine changes that may require accommodation by social partners. Unlike race and gender, aging is associated with some predictable deficits, most notably losses in sensory perception and in short-term memory functioning (Zarit & Zarit, 1987). Consider the following scenario: An elderly adult woman, in good health but with some hearing loss, is instructed to get acquainted with a young adult woman. The young adult, when talking to peers, tends to speak quite rapidly. However, as the young adult begins a conversation with the elderly adult, the young speaker slows her speech dramatically. Why? Is she ageist? Or

is she accommodating to the needs of the listener? Perhaps the elderly listener was initially having difficulty hearing the young woman, and gave subtle cues to this effect. In fact, it could be argued that *failing* to respond to an elderly person's need for accommodation constitutes ageism.

Not all elderly adults have hearing deficits, of course. We expect that actual age-related changes do not account for all, or even most, of the age-differentiated treatment that we have documented. Rather, age-differentiated treatment is likely to stem from an overgeneralization of the homogeneity and magnitude of real age-related changes. Many elderly adults (about 28%) experience significant hearing loss (Zarit & Zarit, 1987), but not all elderly people have hearing difficulties. The young adult who overgeneralizes assumes *a priori* that all elderly adults, including her present social partner, are hard of hearing. The young adult may further assume that the magnitude of the hearing loss (often reasonably small) is large, requiring overaccommodation through shouting—a strategy that is ineffective even when the social partner does have hearing loss! We would argue that that scenario is clearly ageist.

There is substantial evidence for ageist behavior in medical and institutional settings. The treatment of elderly nursing home residents and of elderly patients is likely to produce poorer outcomes along multiple measures, ranging from satisfaction with the institution to physical health. In the community, the picture is less clear, but our intuition is that many of the age-differentiated behaviors we have reported do hold negative consequences for elderly persons, even when they appear to be superficially positive. Being held at a distance from others, even through excessive politeness—particularly at a time of life when emotional exchange may be placed at a premium (Carstensen, 1993)—may result in significant costs, despite the best intentions. These costs have not been documented in the current literature.

Further research on ageism is vitally important. We will all eventually become old, and we will also be the recipients of differential treatment based on our age. Whether we label this treatment "ageist" or "age-differentiated," it is crucial to understand its impact and potential for harm. As long as we treat the problem of ageism as "someone else's," we are guilty of making the elderly into "them" rather than "us." Such a dichotomy is false, and can only make our own aging an unneccessarily fearsome and arduous process. Speaking particularly of women, Barbara MacDonald (1991) notes the irony of our attitudes toward the elderly:

> We are the women we once saw as boring. We are the women we didn't want to look at. We are the women we expected should sit on the sidelines always loving and admiring us. And we are the women we were once told we must have "respect" for, this admonition to prevent our taunting, our jeers, our ignoring—to prevent our showing contempt for old women. (p. 58)

POLICY IMPLICATIONS OF AGEISM

Again, in everyday life, there is substantial evidence of ageism at the level of institutions. Some institutional policies and some behaviors toward the elderly are clearly ageist (i.e., they are based on chronological age rather than an individual's abilities, stem from hostile and negative feelings, and constrain the desired opportunities of elders). Most of these policies and behaviors occur in the workplace and in medical settings, and in these cases we strongly advocate policy reform. Ageist behavior in less formal settings, however, is more ambiguous; therefore, recommendations for reform are more difficult to suggest. We believe that in general, ageism exists because of gross misconceptions about the elderly—overgeneralizations of age-related changes and overestimations of their magnitude. Therefore, to combat ageism more broadly, we advocate policies intended to prevent ageism via education.

Work Settings

In work settings, ageist policies such as mandatory retirement laws abound. Mandatory retirement laws are based on the misconceptions that age is a good predictor of competence, and that competence invariably decreases in later life. In fact, age is a poor predictor of competence in most areas, including the workplace. Moreover, some people believe that without mandatory retirement laws, employees over 65 will continue to work past their capabilities. In fact, this may not be cause for concern. Even without mandatory laws, adults usually retire. For example, at the University of Wisconsin–Madison, there has not been a mandatory retirement age for 10 years; however, the average age of retirement has remained unchanged (Goodman, 1994). Of course, there are a number of possible explanations for the lack of change. Despite the dissolution of mandatory retirement laws, subtle pressures to retire at certain ages may still exist. Similarly, retirement at a certain age may be such a strong social norm that individuals voluntarily retire at the appropriate age. However, it is also possible that elders are deciding for themselves when to retire. Given the importance of self-efficacy for health and the fact that there is great variability in terms of when elders need to retire, we believe that it is important for elders themselves to make this choice. To combat the ageist policy of mandatory retirement, we recommend that competence assessed on the basis of actual job performance, rather than age, be the basis of retirement decisions.

Medical Settings

In medical settings, elderly people are frequently treated in ageist ways—sometimes as a matter of policy and sometimes not. For example, cancer-

screening programs often ignore adults over 65, despite the increased cancer risk of those in this group (Derby, 1991). Furthermore, the withdrawal of food and hydration from terminally ill patients is sometimes based upon age (Uddo, 1986). Finally, physicians may "slow-code" elderly patients, resulting in treatment that is given too slowly or in dosages that are too low to be effective (Uddo, 1986). Such practices are based on the idea that elders' lives are not worth saving, since they are on the brink of death in any case. To combat such ageist beliefs, we recommend that clinical work with elders and education about treatment issues of the elderly be incorporated into standard medical training. In addition, students must be informed of the potential for and consequences of treating elderly patients differently from young patients.

Informal Settings

Ageism also exists in less formal settings, although it is much harder to demonstrate. Age-differentiated behaviors such as secondary babytalk and dependency-supporting behaviors may have a harmful impact by reducing an elderly person's sense of self-efficacy. However, in some cases they may be desired by elderly people. Because the impact of these behaviors is ambiguous, targeting such behavior with legislation is premature. Furthermore, policies that legislate the interpersonal behavior of citizens may be at odds with principles of freedom and personal privacy. Therefore, as suggested earlier, we argue for an educational policy that exposes children to people of all ages in positive ways. For example, having elderly tutors in the classroom (Cartensen, Mason, & Caldwell, 1982), and including elderly characters in teaching materials, might serve to improve intergenerational interaction by simply altering the notion that the elderly are different from most others.

Multiple Jeopardy

In addition to policies such as mandatory retirement, which are clearly ageist, there are policies that contribute to multiple jeopardy for elderly women and ethnic minority elderly. Women are less likely to receive retirement benefits, and their received benefits are generally lower than men's. Because of discriminatory Social Security laws (Carstensen & Pasupathi, 1993), the different career patterns of men and women result in lower benefits for women (Patterson, 1994). Of course, existing gender inequalities in pay for equal work also contribute to later-life disadvantage for women. Elderly people from other disadvantaged groups, who worked in lower-status jobs with no pension benefits, are similarly at high risk for poverty in late life. Clearly, policies that are generally ageist require consideration. But policies that exert disproportionate negative effects on certain groups of elderly people should also be revised.

A Final Caution

We have distinguished among work, medical, and informal settings, believing that in work and medical settings ageist policies should be reformed, whereas in informal settings more discretion should be used. We assume this stance for two reasons: (1) Ageism may be more ambiguous in informal settings than in work and medical contexts; and (2) policies that attempt to regulate the behavior of people in informal settings imply that the elderly cannot deal with unpleasant people as well as young people can—that is, that the elderly cannot adequately select social partners who do not discriminate against them. The evidence from studies of social partner choice among the elderly suggest that, if anything, the opposite is true (Cartensen, 1993). The elderly appear quite capable of handling their social worlds to their own satisfaction. In work and medical contexts, however, the elderly are comprised in their abilities both to choose their social environments, and to interact selectively with staff members. Because the elderly in work and medical settings have already lost some freedom of choice about their interpersonal experiences, they are most in need of protection against ageism.

But regardless of the setting, we must not forget that aging is a human process, and consequently that ageism is a human problem affecting us all. Combating ageism hurts no one, and helps everyone.

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7

Multiple Variables in Discrimination

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In recent years, several multidimensional approaches to social stratification have emerged (e.g., Jeffries & Ransford, 1980). These models recognize that U.S. society is stratified not only along the dimension of social class, but also along several additional dimensions such as age, gender, race/ethnicity, and other factors. Theoretically, stratification along each of these dimensions is similar, because each is characterized by these six features:

1. The ruling group (e.g., men, Whites, the upper class) possesses greater power, privilege, and prestige than the subordinate (disadvantaged) group (e.g., women, racial/ethnic minorities, the poor).
2. The ruling group attempts to maintain its privileged status at the expense of the subordinate group through a variety of means (e.g., self-serving legislation and discrimination at the various levels detailed by Lott, Chapter 2, this volume).