

APA RESOLUTION on Ageism

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INTRODUCTION

Negative stereotypes of aging (ageism) continue to raise serious problems that lead to discrimination and unfair treatment of older adults. Since the adoption of the first APA Resolution on Ageism in 2002, there has been a wealth of empirical evidence documenting that ageism, including negative self-perceptions, are associated with a host of negative psychological and physical outcomes in older adults and societal impacts across health care, employment, education and training, and policy settings. While ageism is a construct that can impact individuals across the life span, and there is increased research attention to ageism directed toward younger people (e.g. Chasteen, Horhota, & Crumley-Branyon, 2020; Bratt, Abrams, & Swift, 2020), the focus of this resolution is the older adult population (defined as individuals 65 years and older). Although old age is defined differently across contexts such as housing, job discrimination, determination of eligibility for benefits, and across societies (O'Rand & Henretta, 2018), "older adults" typically refers to persons 65 years of age and older and is widely used by gerontological researchers, policy makers and in other APA policies, such as the Guidelines for Psychological Practice with Older Adults (APA, 2014).

WHEREAS ageism is stereotyping and discrimination against individuals or groups on the basis of their age (Butler, 1969); ageism can take many forms, including prejudicial attitudes, discriminatory practices, or institutional policies and practices that perpetuate stereotypical beliefs (Cuddy, Norton, & Fiske, 2005; World Health Organization, 2020); and

WHEREAS research has demonstrated the pervasive and institutionalized nature of prejudice against older persons in the United States (Nelson, 2015; Ng, Allore, Trentalange, Monin, & Levy, 2015) and globally (Chang, Kanno, Levy, Wang, Lee, et al. 2020; Lou & Dai, 2017); that expressions of ageism (and respect for older adults) can vary across cultural groups and societies (Hess et al, 2017; Peterson & Ralston, 2017); and that ageism remains prevalent with disregard to its effects (Donizzetti, 2019; Levy, 2001; Nelson, 2015); and

WHEREAS psychologists have documented the degree to which aging does (or does not) affect human behavior and performance, ageism's effects on age stereotypes, health status, treatment and outcomes, and the extent to which ageism is a factor in discriminatory practices and policies including discrimination in health care, workplace, criminal justice systems (Phelan & Ayalon, 2020), built environment, e.g. access to sidewalks and

alternatives to stairs (APA, 2020; Haselwandter, et al., 2015), education and training (Boswell, 2012; Eymard, & Douglas, 2012; Levy, 2018), and policy arenas (Lloyd-Sherlock, Ebrahim, McKee, & Prince, 2016; North, & Fiske, 2013); and

WHEREAS ageism is ubiquitous in the mass media in the United States (AARP, 2019) and promoted by stereotypes in advertisements, entertainment, greeting cards, and news stories that present older people as physically or cognitively disabled, lonely and depressed, or objects of ridicule (Levy, 2016; Cuddy, Norton, & Fiske, 2005; Kite, Stockdale, Whitley, & Johnson, 2005; Thayer & Laura, 2019); and

WHEREAS Stereotype Embodiment Theory (Levy, 2009) and related research has shown that older adults often assimilate negative age stereotypes from the surrounding culture, leading to negative self-definitions that have a detrimental effect for older individuals on a wide range of health outcomes, including increased risk for coronary heart disease, stroke, diabetes, chronic lung disease, chronic illness and, depressive symptoms (Jackson, Hackett, & Steptoe, 2019), increased prevalence of suicidal ideation, anxiety, and post-traumatic stress disorder in older adult veterans (Levy, Pilver, & Pietrzak, 2014); higher levels of biomarkers of Alzheimer's disease (Levy, Ferrucci, Zonderman, Slade, Troncoso, & Resnick, 2016), and decreased likelihood of engaging in preventative health behaviors (Levy & Myers, 2004); and, worse memory performance, functional health, will to live, and life expectancy (Levy, 1996; Levy, Ashman, & Dror, 2000; Levy, Slade, & Kasl, 2002; Levy, Slade, Kunkel, & Kasl, 2002; Meisner, 2012; Sargent-Cox, Anstey, & Luszcz, 2012); and

WHEREAS ageism may impact the health care older adults receive such as older adults being: less likely to receive a mental health evaluation and referral after being identified at risk for suicide in an emergency department compared to young adults (Arias et al., 2017); receiving less treatment, and encountering more limitations in life-sustaining treatments, even when controlling for severity of illness (Ayalon et al., 2020; Brandberg, Blomqvist, & Jirwe, 2013; United Nations, 2020); and being less likely to be included in clinical trials compared to younger adults due to medical complexity, even for diseases that disproportionately affect older adults such as cancer (Hurria et al., 2015), leading to knowledge gaps regarding the use and benefit of new treatments in older adults (Chang et al., 2020); and older adults with Alzheimer's disease and other dementias, and residents of nursing homes, are at particularly high risk for

stigma and devaluation of their lives (Evans, 2018; Lion et al., 2019; O'Connor & McFadden 2012) which is a global problem (Farina, Suemoto, Burton, Oliveira, & Frost, 2020; Małgorzata et al., 2019) and at risk for disrespect, mistreatment, and poor quality of care across diverse settings (Timmons et al., 2016; Williams et al., 2017; Zarowitz, Resnick, & Ouslander, 2018;); and

WHEREAS ageism in the workplace (e.g., 3 in 5 older workers have either seen or experienced age discrimination in the workplace [Perron, 2018]) has negative consequences for older adults including being less likely to be selected for job interviews and training opportunities than younger adults (Abrams, Swift, & Drury, 2016; Harris, Krygsman, Waschenko, & Laliberte Rudman, 2017); being less likely to be recruited or supported in service roles, such as Teach for America (Morrow-Howell, Gonzales, James, Matz-Costa, & Putnam, 2018), experiencing age-based discrimination compared to younger workers (Shippee, Wilkinson, Schafer, & Shippee, 2019); the US Supreme Court in *Babb v. Wilkie* (2020) has affirmed the importance of protecting older workers from age discrimination; and experiencing age-based discrimination compared to younger workers (Shippee, Wilkinson, Schafer, & Shippee, 2019); and concerns about age discrimination in the workplace are global problems (Harada, Sugisawa, Sugihara, Yanagisawa, & Shimmerl, 2019); and

WHEREAS ageism is also a serious concern in the criminal justice system, with many older adults being victims of elder abuse (Phelan & Ayalon, 2020; Pillemer, Burnes, Riffin, & Lachs, 2016) and financial exploitation (Lichtenberg, 2016), and having poorer outcomes when they are victims of civil and criminal offenses, which are often not investigated or taken seriously due to undue skepticism about their testimony (Pittman, Togli, Leone, & Mueller-Johnson, 2014) or viewed as less serious because of factors such as the denigration of the value of older adults' lives (Callan, Dawfry, & Olson, 2012; Goodwin & Landy, 2014); and

WHEREAS, social norms generally include sanctions for statements of prejudice and discrimination based on race or sex, yet ageist statements often go unchallenged such as the growth of older people portrayed as a threat, e.g. as a "Silver Tsunami" or natural disaster (Chrisler, Barney, & Palatino, 2016; Frameworks Institute, 2015); and

WHEREAS causes of ageism are diverse and have been explained by multiple theoretical mechanisms (Lev, Wurm, & Ayalon, 2018) that include Terror Management Theory (Bodner, 2009; O'Connor, & McFadden, 2012); and Social Identity Theory (Chonody, & Teater, 2016); and

WHEREAS ageism is a stressor that may chronically activate the physiological system with adverse health effects, and has been shown as a mediator between income inequality and older people's self-rated health (Vauclair et al., 2015, 2016); and

WHEREAS ageism intersects with sex, race, ethnicity, gender identity and expression, sexual orientation, disability, health, socioeconomic status, social class, and multiple devalued identities accumulate to create compounded disadvantages (Ferrer, Grenier, Brotman, & Koehn, 2017; Purdie-Vaughns & Eibach, 2008); and individuals with multiple stigmatized identities face greater risk for poor health outcomes due to multiple types of marginalization (Adelman, Greene, & Ory, 2000); and contexts such as rural/urban setting, and access to and familiarity with technology can heighten such disadvantages (Skoufalos, Clarke, Ellis, Shepard, & Rula, 2017); and

WHEREAS ageism negatively affects older adults with disabilities whose needs are multifaceted, and older people with disabilities are often ostracized, made to feel ashamed, and unequal when others define them by their health condition versus as individuals (Larsson & Jönson, 2018; Sheets, 2005); and

WHEREAS older adults with disabilities are at risk for double jeopardy (the combined effects of age and disabilities) (Shaw, Chan & McMahon, 2021) and at grave risk for experiencing institutional ageism, which impedes older adults from securing similar rights and accommodations given to younger people with disabilities in order to be full participants in their society (Larsson & Jönson, 2018); and

WHEREAS gendered ageism, or the combination of ageism and sexism, results in double jeopardy: Older women are discriminated against both because they are women and because of their age (e.g., Krekula, Nikander, & Wilińska, 2018), with many studies showing greater ageism toward older women compared to older men (Barrett & Von Rohr, 2008; Chonody, 2015; Chrisler et al., 2016; Clarke, & Korotchenko, 2016; Calasanti, King, Pietilä, & Ojala, 2016). However, while some men are relatively immune to ageism (Calasanti, King, Pietilä, & Ojala, 2018; Clarke, & Korotchenko, 2016), research on cultural images of men's aging has shown that aging men often lose their power and status due to retirement and a loss of bodily performance (Kornadt, Voss, & Rothermund, 2013); and

WHEREAS racial and ethnic minority older adults also face a double jeopardy, due to the additive effects of age and race, resulting in far poorer health for older African-American and Hispanic older adults compared to White older adults, with this difference magnified compared to results in younger adults (Carreon, & Noymer, 2011), and that across the lifespan, African-American and Hispanic older adults face a health insurance double jeopardy that leaves them uninsured for longer periods through their lives compared to White older adults (Kirby & Kaneda, 2013); and

WHEREAS the Institute of Medicine (IOM, 2012) identifies older LGBTQI adults as an at-risk and under-served population and older sexual minority adults, compared to their heterosexual peers, have a higher risk of disability, worsened mental health,

and poorer health behaviors (Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013); and

WHEREAS, older adults living with HIV experience intersecting or layered stigmas due to their sexual orientation, age, race and ethnicity, gender identity/expression, disability, or drug use (Earnshaw, Bogart, Dovidio, & Williams, 2013; Stangl, Lloyd, Brady, Holland, & Baral, 2013); and

WHEREAS socioeconomic status can compound experiences of ageism, with the common perception that older people are not contributors to society, together with a societal context characterized by income inequality, is likely to increase older people's vulnerability to age prejudice (Abrams, Russell, Vauclair, & Swift, 2011; Garstka, Schmitt, Branscombe, & Hummert, 2004); and

WHEREAS the ageist views that pervade society decrease trainee interest in pursuing careers focused on older adults, leading to gross workforce shortages (IOM, 2008; IOM 2012; Whitbourne & Montepare, 2017), including in psychology where less than 2% of psychology health service providers specialize in Geropsychology (APA, 2016) and these shortages have a notable negative impact on older adults' ability to receive care that adequately meets their unique needs; and

WHEREAS ageism can also become formalized and adopted as a part of public policy and it has been argued that focusing healthcare policy on "premature mortality," defined by the World Health Organization as deaths that occur between the ages of 15 and 70, devalues lives of people over this arbitrary age of 70; thus such institutionalized devaluation of older individuals may perpetuate negative attitudes about older people and the value of their lives in policy discussions (Lloyd-Sherlock, et al., 2016) including the failure of any comprehensive federal response to the growing challenges of older adults in areas of caregiving, funding for long-term care, and Medicare reimbursements for end of life services (Belluck, 2015; Blancato & Ponder, 2015; United Nations, 2020); and

WHEREAS similar to other forms of bias and discrimination, effective interventions, including professional education about aging (Brown, Kother, & Wielandt, 2011; Chonody, 2015), intergenerational contact with older adults that can reduce prejudice (Abrams, et al., 2006; Levy, 2018; Lytle & Levy, 2019; Mellor, McCabe, Rizzuto, & Gruner, 2015), and implicit-age-stereotype interventions (Busso, Volmert, & Kendall-Taylor, 2019; Levy, et al. 2016), exist to reduce ageist beliefs, and counteract ageist myths (e.g., myths that all older people are the same and most older adults experience significant cognitive decline that jeopardizes their everyday function, including job performance) and the impact of ageist stereotypes (Burns, et al., 2019).

THEREFORE BE IT RESOLVED that the American Psychological Association continues to reject ageism in all its forms and commits to support efforts to eliminate it from our society.

BE IT FURTHER RESOLVED that the American Psychological Association:

Recognizes age as a risk factor for discrimination and includes consideration of ageism within all discussions of equity, diversity and inclusion; bias, stigma, and discrimination; and health disparities and health equity.

Maintains a commitment to combating ageist language in all its communications, including with the public, through adherence to the Bias-Free Language Guidelines of its Publication Manual and condemn the continued and willful use of ageist language and/or images.

Encourages its Offices, Boards, Committees, Divisions, as well as State, Provincial and Territorial Psychological Associations to educate their colleagues about research and interventions to combat ageism and promotes psychology and aging as an important career path within the profession.

Scrutinizes its own practices to assure that older members of the Association are treated with fairness and dignity.

Encourages the inclusion of aging content and a lifespan developmental focus in curricula across levels of psychology training, including education on the contributions of older adults to society, a balanced view of aging (vs. deficit- and disease-focused), and the prevalence and negative effects of ageism in order to reduce discrimination based on personal characteristics. Training should also include aspects of history, culture, and intersectionality that might magnify the effects of ageism.

Encourages students and psychologists to become familiar with resources that provide accurate and science-based information on the aging process and evidence-based practice such as the *APA Guidelines for Psychological Practice with Older Adults*, and *Age and Health-related Changes: Reality vs. Myth*.

Encourages psychology training in the intersection of age with sex, race, gender, sexual orientation, disability, health and socioeconomic status, social class, and other stigmatized identities and encourages psychologists to be informed about the implication of these intersections for mental health and strategies for appropriately addressing their impact through relevant literature and trainings.

Encourages the development of resources and tools to cultivate age-supportive practices and proactively deter ageism in research and clinical care including training for health care professionals and psychologists that includes supervised experience with older adults where relevant.

Promotes and facilitates psychologists' acquisition of competencies with respect to how they can be active agents of change to reduce the marginalization of older adults via ageist beliefs.

Encourages a more productive public narrative about the heterogeneity of older adults and positive benefits of longer lifespans that addresses systemic occurrences of ageism across multiple societal settings (e.g., employment and healthcare).

Supports appropriate interdisciplinary and inter-organizational collaborations to address entrenched ageism.

Encourages APA to work with government agencies and private funding sources to promote research and prevention and intervention efforts to counter ageism and its impact.

Supports appropriate legal and policy interventions to fight age discrimination across diverse settings including healthcare, employment, education and criminal justice.

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