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AN INVESTIGATION OF GERIATRIC MICROAGGRESSIONS, RELATIONS WITH
DEPRESSION IN LATER LIFE, AND THE MODERATING EFFECT OF COPING

A Dissertation

Submitted to the School of Education

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By

Lisa Zimmerman, M.Ed, N.C.C.

August 2017

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Lisa Zimmerman

2017

DUQUESNE UNIVERSITY
SCHOOL OF EDUCATION
Department of Counseling, Psychology and Special Education

Dissertation

Submitted in Partial Fulfillment of the Requirements
For the Degree of Doctor of Philosophy (Ph.D.)

Counselor Education and Supervision Program

Presented by:

Lisa Zimmerman

Kent State University, B.A., 2012
Kent State University, M.Ed., 2014

June 29, 2017

AN INVESTIGATION OF GERIATRIC MICROAGGRESSIONS, RELATIONS WITH
DEPRESSION IN LATER LIFE, AND THE MODERATING EFFECT OF COPING

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ABSTRACT

AN INVESTIGATION OF GERIATRIC MICROAGGRESSIONS, RELATIONS WITH DEPRESSION IN LATER LIFE, AND THE MODERATING EFFECT OF COPING

By

Lisa Zimmerman M.Ed., N.C.C.

August 2017

Dissertation supervised by Dr. Matthew Bundick

This quantitative study examined the relationships between experiences of geriatric microaggressions, mental health, coping, and demographic characteristics. Geriatric microaggressions are subtle forms of discrimination experienced by the older adult population based upon negative societal perceptions of aging. Previous research has found relations among other forms of microaggressions, such as racial and sexual orientation, and mental health and coping; however, age related microaggressions remain relatively unexplored. The present sample consisted of 163 adults, age 60 and older, who were recruited primarily from the Western Pennsylvania area. The results revealed significant demographic differences in regard to the experiences of geriatric microaggressions. The results also supported significant relationships between coping style, symptoms of depression, and experiences of geriatric microaggressions. These findings imply that experiences of geriatric microaggressions exist within our society and can potentially have meaningful consequences for older adults. Implications for counseling practice and education and recommendations for future research are presented.

DEDICATION

This dissertation is dedicated to my parents, Jim and Jane Zimmerman. You have believed in me through every success and hardship of my academic career. After all of these years of education, you still remain the best teachers I have ever had. You have taught me the most valuable lessons in life: acceptance, humility, and dedication. Your love and support throughout my journey has made this achievement possible. Thank you for my life and your love.

ACKNOWLEDGEMENTS

As I reflect upon this process, I recognize the number of people who has inspired, supported, and encouraged me along the way. I am grateful for my friends, family, coworkers, and clients who have made this journey possible. First and foremost, I would like to thank the older adults who participated in my study. I am grateful for your openness, honesty, and time. You are truly the ones who have made this study possible. I hope these findings provide insight into the experience of aging and facilitate change to combat ageism within our society.

I would like to thank my dissertation chair, Dr. Bundick, and the members of my dissertation committee, Dr. Gregoire and Dr. Zeleke. I am still convinced the only reason you agreed to be part of my team was for the beer! Words cannot express my appreciation of your encouragement and devotion to my professional development. You have made this process fun and exciting and have instilled in me a passion for research and advocacy.

Thank you to my friends and family. Your ongoing words of encouragement and support have motivated me throughout my academic career. You have always believed in me and saw my utmost potential, and for that reason I am where I am today. Although, we are scattered throughout, our times together have always brought me joy, laughter, and much needed rejuvenation when things get hard.

Finally, to my Pi Cohort, I never thought I would be lucky enough to be part of such an exceptional group of people. You set the bar high for counselors, educators, researchers, and most importantly, for just being good humans. I am truly grateful and proud to call you my friends first, and my colleagues second. See you at the Red Ring!

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Chapter I

Overview

Since the dawn of many human rights movements throughout the 20th century, it has become socially unacceptable for Americans to engage in overtly racist or discriminatory acts directed toward minority populations (Pager, 2008). Due to this social shift, many individuals deny that they are racist and assume that racism no longer exists within our society (D.W. Sue, 2010). Despite these attitudes, many individuals may still hold biases pertaining to race, ethnicity, and other identifiable characteristics. Often these biases are expressed subtly and unconsciously. This covert form of race based discrimination has been labeled as “new” or “modern racism” (Gaertner & Dovidio, 2006).

More recently, researchers have shifted their focus from blatant forms of discrimination to subtler forms of prejudice, known as microaggressions. The term microaggressions was popularized by Sue, Bucceri, Lin, Nadal, and Torino (2007) to describe the covert messages sent by perpetrators to target marginalized individuals. Studies have explored the potentially detrimental impact on the mental health of minorities who experience race-based microaggressions (Nadal, 2011; D.W. Sue, 2010). Researchers have also explored the experience of microaggressions on other minority populations, such as women, LGBTQ identifying individuals, and individuals with disabilities. Similar findings indicate a relationship between microaggressions and risk for poor psychosocial wellbeing and symptoms of mental health (Rivera, 2010; Herek, 2013; Bell, 2013).

Although ageism has been referred to as the third ism, following racism and sexism, there is a clear lack of research regarding discrimination as it pertains to the aging population (Butler, 1995). In a PsycINFO search for articles with the term “racism” in the title, 135,024 articles

were retrieved. 30,154 articles were retrieved when searching “sexism.” Yet, only 9,165 were retrieved when searching the term “ageism.” Too often have ageist beliefs been overlooked as a prejudice within the current body of literature. This study hopes to provide a breadth of data to illustrate the importance of investigating ageism in a similar fashion to the other *isms* that comprise the bulk of the existing literature. Additionally, this researcher intends to utilize a research platform to advocate for the older adult population and address the impact of negative societal perceptions of the aging process.

This study has three purposes: (a) to introduce a measure that allows researchers to assess microaggressions experienced by the older adult population, (b) to explore the relationship between perceptions of age-related microaggressions and the mental health of older individuals, and (c) to identify older individual’s coping methods and styles in relationship to mental health concerns regarding age discrimination.

Statement of the Problem

Social scientists often talk about the “Graying of America,” as the majority of the United States population enters their later years in life. The Administration on Aging reported in 2014 that older adults comprise 14.5% of the American population, about one in every seven Americans. Within the next 30 years, the number of older adults is expected to nearly double and will represent one-fifth of the American population. This will result in a dramatic shift in the age structure from 14.5% of the population aged 65 and older in 2014 to almost 22% in 2040.

Policy makers, health care providers, and families across the nation are beginning to anticipate the implications of this significant change in the population landscape. In a report brief release from The Institute of Medicine in 2012, it was stated that this population increase “holds profound consequences of the nation” (p.1). For example, the construction of senior

living facilities and retirement communities are on the rise to accommodate for age related housing needs. Government programs are being restructured to ensure medical and financial support for the aging population. Additionally, multigenerational households are increasingly common due to the growing cost of elder care.

Although the increase in the size of the older adult population would not numerically consider older individuals a minority group, negative societal perceptions and stereotypes of older adulthood have marginalized this population. More specifically, messages from the media perpetuate ageist perceptions and opinions of older adults in younger generations (Bell, 1992). Consider how the media portrays the aging process. During many television commercial breaks and within numerous magazine advertisement sections, viewers will take witness to the worldwide anti-ageing campaign. There are myriad products and techniques on the market that claim they can defy the natural and inevitable process of aging (National Consumer's League, 2004). Society continues to search for the fountain of youth, but the fact of the matter remains: everyone will make the transition from youth to old age over the course of their lifetime.

The media also often portrays ageing in the context of derogatory humor. Take for example a 2014 commercial for in the insurance company Esurance. The commercial starred an older woman named "Beatrice." Beatrice was so technologically inept that instead of posting her vacation pictures to her social media website, she physically posted them with tape to her living room wall. After a disagreement with her visiting neighbor about how much money she could have saved with Esurance, Beatrice announced that she "unfriended" her in retribution. Viewers all over the country just could not get enough of this hilarious white-haired woman. What was so funny about this commercial? The answer- it was Beatrice herself that was the joke. Her age along with her stereotypical geriatric behavior is what made the commercial funny. Indeed, "old

man,” “old-timer,” and “senile” are often themes and punchlines to well worn jokes.

Moreover, like race and gender, age was one of the most discussed attributes in the 2012 and 2016 presidential elections. Consider arguments from the opposition when John McCain, age 72, was the republican candidate for president in 2012. Often his running mate selection was scrutinized because, “as the vice president of the United States, she (Sarah Palin) would only be one heart beat away from the presidency.” John McCain’s health was frequently disputed as he would have been the oldest president in the United States to date (Kenski, 2010). Also, in the 2016 election, Hillary Clinton’s health was scrutinized as many in the opposition questioned her “stamina” and overall health in terms of her ability to lead the country. While little research exists examining the impact of age in presidential elections, it cannot be dismissed as an influential social factor.

So we are forced to confront the questions: What impact do these messages have on societal perceptions of the older adult population? And what impact do these perceptions have on the emotional and mental wellbeing of the older adult population?

Individuals’ beliefs and attitudes about others are well known to significantly impact their social interactions and behavior (Ferguson, 2004). The majority of studies on perceptions of aging report more negative attitudes toward older people than younger adults (Bell, 1973; Hummert, 1997; Kite, 2005). Older adults are typically described as fragile, senile, and physically and mentally disabled (McTavish 1971; Sue, 2010). Research provides a wealth of evidence that perceived discrimination based upon other facets of identify such as race, ethnicity, and sexual orientation, is linked with declines in self-reported health (Schulz, 2006), physical functioning (Gee, 2008; Mays, 2001), and mental health (Almeida, 2009; Huebner, 2007), and it is associated with increases in obesity (Hunte, 2009), chronic conditions (Gee, 2007), and

mortality risk (Barnes et al., 2004). Evidence also connects perceived discrimination with unhealthy coping behaviors (Burn, 2005; Chae, 2008), and physiological conditions, such as high blood pressure and pain (Lewis, 2009).

Age differs from any other social category. Across all racial and ethnic groups, genders, and socio-economic status, every person will become part of the older adult population—granted they live long enough (Butler, 1995). Conversely, little research focuses on age in comparison to other sources of discrimination, such as race, gender, and sexuality (Rivera, 2010; Herek, 2013; Bell, 2013). This is negligent of researchers when also considering the large number of reported age discrimination instances and legal claims of age discrimination within our society (McCann & Giles; 2002; Posthuma, 2009).

While little discrimination research has focused on age as a prejudice in comparison to other bases of discrimination, several studies have identified the existence of perceived discrimination based upon age within the older adult population (Luo, 2012). Research has linked perceived age discrimination to an increase in negative physical, cognitive, and emotional health symptoms (Sutin, 2015). However, the majority of these studies have been limited to the use of qualitative approaches to investigate perceptions of age related discrimination. Studies investigating other forms of discrimination, such as racism, sexism, and homophobia, have quantified experiences of perceived discrimination (Nadal, 2011; Swann, 2016). The limited use of quantitative methods along with the limited body of overall research investigating age discrimination, affirms the notion that ageism research has not followed the same trajectory as other more researched forms of discrimination.

In order to more fully understand the multidimensional nature of discrimination and prejudice, researchers have shifted their focus from blatant forms of discrimination to subtler

forms of prejudice, known as microaggressions. Microaggressions are a newly explored phenomenon that shed light on this covert discrimination. The bulk of the current literature that exists focuses primarily on assessing racial and ethnic microaggressions experienced by minority populations. Experiences of microaggressions base upon an individual's race, ethnicity, sexual orientation, gender, and ability, have been linked to a decline in individual's mental, physical, and emotional health (Mays, 2001). Existing literature has also linked mental health symptoms, suicidal ideation, and a lack of social connectedness to minority populations who experience microaggressions (Williams, 2009).

Microaggressions have been defined as, "everyday verbal, non-verbal, and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target a person based solely upon their marginalized group membership" (Sue, 2010, p. 5). Microaggressions are a subtle and covert form of discrimination that sends disparaging messages to marginalized groups. Their negative impact has been demonstrated for racial/ethnic groups, gender, sexual orientation, and mental illness. However, no current research exists on microaggressions as experienced by the older adult population.

Sue (2010) describes socially marginalized groups as, "Confined to existing on the margins of our social, cultural, political, and economic systems," resulting in "exclusion from mainstream life in our society, unequal treatment, and social injustice" (p. 34). With this definition in mind, the older adult population would clearly qualify as a marginalized population regarding whom microaggressions need to be studied.

Purpose and Research Questions

There are three societal factors that support the empirical importance of this investigation. First, the population of older adults in the United States is increasing rapidly. It is anticipated that by 2040, adults over the age of 65 will increase from 14.5% to 22% of the population, contributing to a drastic demographic shift. Second, researchers have identified a modern form of discrimination experienced by marginalized populations, termed microaggressions. The experience and impact of microaggressions have been examined among many minorities groups in terms of race, gender, and sexual orientation, whereas age has consistently been an aspect of identity that has been neglected in discrimination and microaggression literature. Thirdly, a consistent finding in the microaggression research is the prevalence of symptoms of negative mental health (such as depression) that result from perceived discrimination. While research has indicated an increased risk for symptoms of depression and thoughts of suicide for adults over the age of 65, no research has explored the role of microaggressions on older adult's mental health.

The purpose of this study is to quantitatively explore the relationships between perceptions of geriatric microaggressions, mental health, and methods of coping. Additionally, the overall purpose of this study is to fill a major gap in the existing body of age discrimination literature. This researcher will address the following questions provided from the data through quantitative inquiry:

1. What demographic differences are there among older adults in experiences of geriatric microaggressions?
2. What is the relationship between experiences of geriatric microaggressions and level of depression?

H₀2: The more often individuals experience geriatric microaggressions, the more severe their symptoms of depression will be.

3. What is the relationship between coping method and level of depression for individuals over the age of 60?

H₀3: Individuals who employ healthy coping mechanisms will experience fewer symptoms of depression.

H₀3: Individuals who employ unhealthy coping mechanisms will experience more symptoms of depression.

4. Is the relationship between experiences of geriatric microaggressions and level of depression moderated by degree of healthy or unhealthy coping?

H₀4: Perceptions of geriatric microaggressions are more strongly related to level of depression for those who engage in unhealthy coping practices.

Statement of Potential Significance

The literature has provided evidence to support the notion that prejudice and discrimination are complex and multidimensional in nature. Throughout the last three decades, many social scientists have devoted their work to investigating the experience and impact of discrimination as it pertains to race, ethnicity, gender, and sexuality (Sue, 2010). However, despite the reality that, barring premature death, every living person will at some point enter older adulthood, ageism continues to remain relatively under researched in comparison to other features of identity such as race, ethnicity, gender, and sexuality. The experience of ageism is underappreciated and is often overlooked as a prejudice (North & Fiske, 2012). Additionally, ageism is possibly even more prevalent than sexism and racism although it is typically much more difficult to detect (Banaji, 1999; Levy, 2002).

Nevertheless, these facts along with the rapid increase in the older adult population necessitates the need to explore the construct of ageism for both professionals working with the older adult population and society at large. Two recent meta-analytic studies on ageism have found that older individuals are generally perceived less favorably than younger generations (Gordon, 2004; Kite, 2004). Another reason the study of ageism is warranted is that recent research found that one in five older adults has a diagnosable mental health disorder (Stewart, 2012). These conditions are often comorbid with substance abuse and other health problems (Grant, 1996). These findings are insufficient without considering the impact perceived discrimination on older adult's mental health.

Opportunely, research has found that ageism can be reduced (Braithwaite, 2002; Chiu, 2001; Ragan & Bowen, 2001). Increasing awareness of the impact of ageism on individual's mental, physical and emotional health is critical. Better understanding the inaccuracy of ageist stereotypes is necessary to shift society's preference from anti-aging to anti-ageism. Finally, exploring older individuals healthy coping responses to ageism will help older adults utilize protective strategies to combat the negative effects of perceived ageism.

Coping refers to the things people do to protect themselves from being psychologically harmed by life strains (Pearling & Schooler, 1978). Experiencing ageism is likely to have pervasive effects on older individuals mental, physical, and emotional health. In previous studies researchers have investigated the strategies employed by individuals who experience racial microaggressions to manage negative mental, physical, and emotional health symptomology. Hernandez (2010) identified eight coping themes including identifying key issues in responding to racial microaggressions, self-care, spirituality, confrontation, support, documentation, mentoring, and collective organization. In order to reduce the negative impact of ageism, it is

important for researchers to understand the positive outcomes of coping strategies employed by older individuals who experience discrimination.

This study will expand the current body of discrimination literature to identify and investigate geriatric microaggressions as a modern form of discrimination. This study will be one of the first of its kind to explore and quantify the experience and impact of age-specific microaggressions on older individual's mental health. This study will also provide future ageism research with a quantitative tool for measuring geriatric specific microaggressions to explore the concept of ageism in more depth. This investigation will further provide insight into coping mechanisms employed by older individuals as a way to combat the effects of ageism. Additionally, this research hopes to challenge negative perceptions of aging and combat stigma associated with the aging process.

Theoretical Foundation and Conceptual Framework

This investigation was driven by three theoretical assumptions of discrimination:

1. Discrimination exists within the confines of American society,
2. Age is a social category in which older persons may be discriminated against/societal views of aging are negative, and
3. Microaggressions are a subtle form of discrimination that may have detrimental implications on marginalized individual's mental health.

This investigation conceptualized ageism from a functional perspective. From this perspective, ageism is understood as a defense mechanism applied by younger generations. Negative attitudes toward older adults and the aging process may serve as a protective function for younger adults (Snyder, 1994). It may be concluded that younger generations are able to reduce anxiety associated with end of life fears and mortality when considering older adults as a

group separate from themselves (Edwards, 1998). This study also utilized the life course perspective as a conceptual framework to understand aging as a life long process structured by institutions, roles, and norms. This perspective posits the experience of aging is defined in a social context. Societal institutions are age graded, therefore older adults are at a higher risk of exposure to ageism than others (Giles & Reed, 2005).

This investigation also addressed conflicting sociological theories of aging and considered the implications of these theories on societal perceptions of older adults and the aging process. In order to understand the multidimensional nature and complexity of ageism this investigation utilized Bronfenbrenner's Bio-Ecological Theory of human development to gain a holistic perspective of the human experience. This theory addresses forces from the micro, meso, macro, and exo-levels of society and their impact on societal perceptions of aging and older adults. In order to evaluate the effects of ageist stereotypes, the Looking Glass Self and The Stereotype Embodiment Theories allowed this researcher to understand the process of internalized stigma and antiaging beliefs (Cooley, 1902; Mead, 1930; Levy, 2009). Additionally, this investigation also incorporated modern theories of ageism, such as the Succession, Identity, and Consumption (SIC) Model of ageism (North & Fiske, 2013) and Rupp's model of ageism (Rupp, 2005). These theories of ageism provided further rationale to define and conceptualize ageism through a historical and contextual lens.

Summary of the Methodology

The experience of microaggressions by older adults was explored utilizing a quantitative approach to analyzing participant data. Participants were recruited by advertising participation in local senior living communities and via social media. Participants' data was collected using the online survey administration system SurveyMonkey. Participants were incentivized with the

chance to win a \$50.00 MasterCard gift card in a drawing at the end of the data collection phase. This researcher provided participants with informed consent agreements (see Appendix A). Participants completed a demographic questionnaire (see Appendix B) that collected information about the participant's gender, racial/ethnic identification, age, occupational status, level of education, and current residential setting. Participants then completed three self report questionnaires (see also Appendix B) to collect data pertaining to geriatric microaggressions, coping mechanisms, and symptoms of depression. These assessments are discussed in more detail in Chapter 3.

Data for this study were gathered by administering test packets consisting of a demographic face sheet, the Geriatric Microaggressions Scale, The BRIEF Cope Inventory, and the Center for Epidemiological Studies Depression Scale (CESD-R) to participants. The collection of assessments was estimated to take 15 minutes to complete. After the completion of the test packet, participant's identifying information was coded to ensure the protection of participant confidentiality. Participant demographic information and responses from the GMS, BRIEF Cope, and CESD-R were entered into SPSS statistical analysis software. This researcher employed multiple forms of inferential statistics, including t-tests, ANOVAs, and multiple regression analyses to test for relationships between scores on the questionnaire measures and demographic data.

Limitations

One potential limitation is that the current measure's development relied heavily on online samples. Though online data collection methods have been regarded as an inexpensive and reliable source of data collection (Buhrmester et al., 2011), other experts have indicated concerns about reduced quality of respondent data (Reips et al., 2012). Another limitation to the

current study is this researcher's delimited use of quantitative methods for data analysis. This study lacks the rich data provided in qualitative research. Additionally, this study relies heavily on local recruitment from senior living communities in the Western Pennsylvania region. Therefore, the generalizability of results may be limited with regard to the broader population of older adults.

Definitions of Key Terms

There are a number of key terms and concepts fundamental to the development and understanding of this study. These key terms are defined below.

Age Discrimination: the practice of treating individuals in an unfair way due to his or her age, most commonly in employment settings (Garstka, & Schmitt, 2004)

Ageism: the systematic discrimination of older persons, viewing them as senile, a burden, useless, and invisible (Butler, 1975; Palmore, 1999).

Microaggressions: Everyday verbal, non-verbal, and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target people based solely upon their marginalized group membership (Sue, 2010).

Microinsult: Implicit subtle snubs that convey insensitivity and rudeness to the target and are usually outside of the perpetrators conscious awareness" (Sue, 2007).

Microassault: Overt and explicit forms of discrimination which include verbal or nonverbal attacks that are intended to hurt the targeted individual (Sue, 2007).

Microinvalidation: Acts that exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of an individual based upon one facet of their identity (Sue, Bucceri et al, 2007).

Coping: the things people do to protect themselves from being psychologically harmed by life strains (Pearling & Schooler, 1978).

Older Adult: individuals who are over the age of 60.

Geriatric: relating to old age or to the process of getting older.

Chapter 2

An Introduction: Topics, Purposes, and Methods of the Literature Review

There were three goals of this literature review. The first aim was to provide a concise overview of literature that highlighted the key issues related to ageism, microaggressions, the relationship between discrimination and mental health, and coping responses to discrimination. The second goal was to clearly illustrate what gaps exist within the current body of literature surrounding ageism as a form of discrimination. The final goal was to introduce the theoretical framework of this investigation by providing a summary of theories of human development and models of ageism that have informed this study.

Description and Critique of Scholarly Literature

Ageism and Stereotypes of Older Adults

The term ageism was first identified by Butler in 1969 to describe the systematic discrimination of older persons, viewing them as senile, a burden, useless, and invisible (Butler, 1975; Palmore, 1999). Ageism has been referred to as the third *ism* following racism and sexism (Butler, 1995). Both positive (e.g., wise and experienced) and negative (e.g., senile, frail, and grumpy) stereotypes of the older adult population constitute ageism. Negative ageism often comes in two forms: hostile beliefs based upon stereotypes that older adults are incompetent, frustrating, and are a waste of resources, and benevolent beliefs based upon stereotypes that older adults are frail and need to be cared for.

Research has explored the impact of societal perceptions on aging process and older adults. For example, younger generations prefer to avoid contact with elders due to ageist beliefs and perceptions of older adults (North & Fiske, 2012). Societal shifts have facilitated this distancing by encouraging public policy for the development of special places for older adults

(e.g., “senior living” facilities), therefore institutionalizing age (Minichiello, 2000). Additionally, younger adults who have negative perceptions of older adults often expect older adults to be depressed about the aging process, which may normalize depression in later life (Gullette, 2004). Younger adults also prefer to engage in activities that exclude the older population. Younger adults reported beliefs that distinguished between youth activities and interests and older adult activities and interests. These beliefs facilitate the assumption that after a certain age, participation in certain activities is abnormal.

Stereotypes of older adults are not only portrayed negatively in popular culture, but also within the professional body of literature. Researchers found that over 50% of gerontological textbooks included a negative impression of aging (Robinson, Briggs, & O’Neill, 2012). This unintentional ageism has been demonstrated to carry over from textbooks to the perceptions and biases of professionals who work with older adults. For example, in a study by Chodosh (2000), physicians reported their immediate thoughts about older adult patients, which primarily related to death, disease and a decline in overall function. In another study, nurses reported that they preferred not to work with older adult patients, because they were “boring and repetitive” (Mckenzie & Brown 2014). These perceptions have led to an overwhelming preference of professional workers to work with younger populations (Grant, 1996).

Studies have also shown that mental health professionals are just as likely to have negative perceptions of older adults as the general public (Nelson, 2005). More often are older adults referred for drug therapies rather than counseling due to mental health provider’s beliefs that older clients will talk too little or too much in a counseling setting (Nelson, 2005). Across all health care professions, providers are less likely to explain details of their treatment to older adult clients than their younger clients, perhaps because they think that older adults would not

understand their treatment (Higashi et al. 2012).

Manifestations of ageism. When healthcare professionals do take the time to explain an older adult's treatment, they often use simple sentences or "baby talk" (Taylor, 2012).

Infantilization and over accommodation can be experienced by elders as microaggressions that communicate a message of inferiority (Williams, Herman, Gajweski, & Wilson, 2009). Several studies have identified older adult's frustration of health care professionals who use patronizing language such as "sweetie," "young lady," or "dearie" (Cruikshank, 2008; Heintz et al. 2013; Leland 2008). This degree of ageism can result in the disrespectful treatment of older clients and discourage the utilization of healthcare services. Stewart (2015) found that age-related stigma predicted early termination and discontinued mental health services for older adults with depression. As a result, depression is undertreated in individuals over the age of 65 (Van Egeren, 2004).

Age discrimination has the potential to lead to internalized ageist perceptions that can become self-fulfilling prophecies and lead to barriers to seeking mental health treatment (Stewart, 2012). A qualitative study was conducted to explore perceptions of ageism in healthcare settings. In this study, a 75-year-old client reported, "sometimes you get the feeling that the doctor is thinking that because I am 75 I don't have much time left anyways, so why worry about me—I don't know if they really think that, but you certainly get that impression" (Tannebaum, Nasmith, & Mayo, 2003). Little research has explored the impact of perceptions of ageism on older adult's mental health and their ability to cope with age-related discrimination.

Ageism has also been linked to neglect, exploitation, and other abusive behaviors directed toward the older adult population (Quinn & Tomita, 1986). Rates of elder abuse and maltreatment have become a serious societal problem that only continues to increase as a large

portion of the population enters late adulthood (Hirsch, 2002). Often, elder abuse goes unreported due to professionals not being as well versed with elder abuse as they are with other forms of domestic violence. Only 25% of health professionals report having had training on elder abuse (Jones, 1997). Health professions do not receive adequate training on this topic, therefore older adults are at a great disadvantage as a marginalized population.

Ageism assessments. Efforts have been made to quantify the experience of discrimination in other marginalized populations. However, assessments of ageism are limited primarily to perpetrator perceptions. For example, early measures of age related attitudes have been developed to assess ageist perceptions and opinions about older people. Tuckman (1953) developed the Old People Questionnaire to assess misconceptions of stereotypical beliefs pertaining to the older population. Qualitative methods have explored general attitudes toward “old people” (Gold & Kogan, 1959). More recently the true-false questionnaire, The Facts on Aging Quiz developed by (Palmore, 1977) quantified participant’s knowledge regarding the aging process. Fraboni (1990) addressed ageism from a multidimensional perspective addressing cognitive components as well as antagonistic, discriminatory and avoidance attitudes toward aging. Older adults have reported being marginalized, institutionalized and stripped of responsibility, power and ultimately their dignity (Nelson, 2002). However, there is no existing quantitative tool to assess the concept age discrimination directly experienced by the older population.

More modern measures of ageism have explored the notion that ageism can operate without conscious awareness, control or intention to harm (Levy, 2002). Considering both the lack of explicit hatred toward older adults in comparison to other racial, ethnic and religious groups, and

the overall societal acceptance of negative perceptions of older adults, the role of implicit attitudes about aging is crucial to understand the components of ageism (Levy, 2002).

The Implicit Association Test (IAT) has been used to explore individual and group differences in unconscious attitudes, stereotypes, and identity as they relate to age (Greenwald, McGhee, & Schwartz, 1998). Levy (2002) suggests that all humans, to some degree, are implicated in the practice of implicit ageism. Interestingly, research has suggested that implicit age bias does not appear to vary as a function of the respondent's age. That is, older adults and younger adults both tend to have negative implicit attitudes toward older adults and more positive implicit attitudes toward younger persons (Greenwald, 2000).

Depression in Older Adulthood

According to the National Institute of Mental Health, depression is a serious mood disorder that causes severe symptoms that affect how individuals feel, think, and handle daily activities. The prevalence of depressive symptoms in later life is estimated to affect between 15-20% of Americans ages 65 and older (Cahoon, 2012). Depression in later life has been associated with cognitive impairment, physical disability and anxiety in older adults aged 55-85 (Beekman, 2000).

Depression in later life is often under recognized, misdiagnosed and undertreated with less than 3% of older adults receiving mental health treatment (Boltz et al., 2012). Many symptoms of depression, such as insomnia and loss of interest, are overlooked as risk factors among the older adult population (Rodda et al., 2011). Lack of training in the identification and diagnosis of depression in older adults may be a barrier to treatment (Aylaon, Fialova, Arian, & Onder, 2010). Older adults are more likely to display cognitive changes, somatic symptoms and loss of interest than younger adults (Pfaff & Almeida, 2005). Many older adults assume these

changes in mood are associated with the typical ageing process and do not report these symptoms to health care providers (Rodda et al., 2011).

Microaggressions Overview

The term “microaggression” was identified by Pierce in 1970 and was popularized by Sue, Bucceri, Lin, Nadal, and Torino in 2007. Microaggression have been defined as, “everyday verbal, non-verbal, and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target a person based solely upon their marginalized group membership” (Sue, 2010). Microaggression are a subtle and covert form of discrimination that sends disparaging messages to marginalized groups. Three manifestations of microaggression have been identified as: microassaults, microinsults, and microinvalidations (Sue et al., 2007.)

Microassaults are more overt and explicit forms of discrimination. Microassaults include verbal or nonverbal attacks that are intended to hurt a targeted individual. Examples of microassaults include name-calling, avoidant behavior, and blatant differential treatment due to an individual’s minority status. Although the perpetrator is deliberately and consciously attacking his or her victim, microassaults are still considered to be “micro” because they are conducted on an individual level. This private expression of prejudices allows the perpetrator some degree of anonymity (Sue et al., 2007).

Microinsults are defined as “implicit subtle snubs that convey insensitivity and rudeness to the target and are usually outside of the perpetrators conscious awareness” (Sue, 2007.)

Microassaults are indirect acts that convey hidden insulting messages. These messages demean an aspect of the recipient’s identity, such as their race or sexual orientation. For example, failure to incorporate images of people of color into public areas can minimize racially diverse person’s

experiences and send the message that that individual's identity is insignificant.

Microinvalidations are acts that, "exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality," of an individual based upon one facet of their identity (Sue, Bucceri et al., 2007). For example, when a Black American verbalizes an experience in which he or she was racially discriminated, he or she may be told that they are "being too sensitive," or provided a non-race-based explanation for the treatment they received. Therefore, the Black American's experience is negated and the importance of their experience is diminished (Sue, 2008). Another example of a microinvalidation is when Asian Americans are complimented for their English speaking ability. What might be intended as a compliment by the perpetrator, the message that is conveyed is that Asian Americans are perpetual foreigners in their own country of birth (Sue et al., 2007). Research in the area of microaggressions began by examining race specific microaggression and has since evolved and extended to examine the experiences of other marginalized and targeted groups. The negative impact has been demonstrated for other racial/ethnic groups, gender, sexual orientation, and mental illness.

Racial and ethnic microaggressions. The bulk of the current body of microaggression research has been conducted with racial and ethnic minority populations. Several studies have examined the impact of perceived racial microaggressions by African Americans (Sue, 2008), Latina/os (Rivera, 2010), Asian Americans (Sue, 2010), and indigenous peoples (Hill, 2011). In each study, researchers have found that racial and ethnical minorities who experience microaggressions in their everyday lives are at risk for negative and pervasive mental health symptoms and psychopathology (Nadal, 2011; Sue, 2008; Donovan, Galban, Grace, Bennett, & Felicié, 2013; Torres et al., 2010)

Sue et al. (2008) examined the perceptions and reactions of microaggressions as

experienced by Black Americans. Researchers also explored the short term and long term effects of these experiences. For example, Microassaults such as “you do not belong” and microinsults such as “you cannot be trusted” contributed to high degrees of stress for Black Americans. Participants also reported feeling powerless, invisible, and pressure to represent their racial group. Further, this study indicates that racial minorities experience of microaggressions have a powerful adverse long term impact (Sue, 2008). In another study examining the mental health effects of racial microaggressions, participants reported higher levels of feeling burdensome on others which in turn were associated with higher levels of suicidal ideation (Hollingsworth, 2016).

Rivera et al. (2010) explored the experiences of racial microaggressions of Latino/a Americans. The study was designed to test the categories of racial microaggressions initially proposed by Sue and Bucceri (2007). The study utilized qualitative methods to gather and analyze the data. Researchers revealed eight major themes including: ascriptions of intelligence, second class citizenship, pathologizing communication style/cultural values, characteristics of speech, alien in own land, assumptions of criminal status, invalidation of the Latino experience, and assumed inferior status (Rivera, 2010). Microassaults identified by participants included name calling and being forcefully told to leave the United States. Microinsults included statements overheard in the work place and educational settings that minimized the effort put forth by Latino/as.

Sue and Bucceri (2007) conducted a study to examine Asian Americans’ experiences of microaggressions. Researchers utilized focus groups to gain an “understanding of social interactions and events related to experiences of subtle racism directed toward Asian Americas by describing, comparing, contrasting, cataloguing, and classifying microaggressions” (Sue et

al., 2007). Eight microaggressive themes were identified: alien in own land, ascription of intelligence, denial of racial reality, exoticization of Asian American women, invalidation of interethnic differences, pathologizing cultural values/communication styles, second class citizenship, and invisibility (Sue et al., 2007). Additionally, this study also reveals that microaggressions have damaging consequences among minority groups. The majority of participants reported feeling belittled, angered, enraged, frustrated, and alienated as a result of their experiences (Sue et al., 2007).

Gender and sexuality microaggressions. Despite the advancements in legal protections and the overall social acceptance of LGBT individuals, prejudice against sexual minorities continues to persist within our society (Herek, 2013). While many instances of overt acts of violence and harassment are still reported, it may be that more covert acts of aggression toward this marginalized population occur more now than ever (Burn, Kadlec, & Rexer, 2005; Huebner & Davis, 2007; McCabe, Dragowski, & Rubin-son, 2013; Nadal et al., 2011).

A growing body of literature addresses microaggressions targeting women and LGBT individuals. The literature on sexual orientation and gender microaggressions follows the same general taxonomy as literature on racial and ethnic microaggressions (Nadal, 2010; Sue, 2010). For example, a study conducted by Nadal (2010) applied four of the 12 racial and ethnic microaggression categories previously proposed by Sue (2008) to examine sexual orientation microaggressions perceived by individuals identifying as gay, lesbian, or bisexual. The 12 categories included: second-class citizenship, traditional gender role prejudicing and stereotyping, use of heterosexist language, and assumptions of abnormality. Researchers then incorporated their review of existing literature to identify the nine themes of sexual orientation microaggressions as follows: “use of heterosexist terminology, endorsement of heteronormative

culture/behaviors, assumptions of universal LGBT experience, exoticization, discomfort of LGBT experiences, denial of societal heterosexism, assumptions of sexual pathology, denial of individual heterosexism, and environmental microaggressions” (Nadal, 2010).

One example of a sexual orientation microaggression would be using the phrase, “that’s so gay” in a derogatory way. This statement could be classified as a sexual orientation microassault. Exposure to this type of discrimination has been linked to increased feelings of isolation and psychological distress among a sample of LGBT participants (Woodford, Howell, Silverschanz, & Yu, 2012). Another example of an LGBT-specific microaggression is the heteronormative nature of gender roles typically portrayed in homosexual couples within the media. This could be considered a microinsult, with the assumption that traditional gender roles are the same within homosexual couples as heterosexual relationships. Additionally, assumptions made about a person’s interests and hobbies as a result of their gender expression may also be considered a gender and sexuality microinvalidation (Nadal, 2010). Perceptions of gender and sexual orientation microaggressions can lead to internalize sexist perceptions. Research has identified that the internalization of microaggressions contributes to symptoms of depression and self-harm particularly in this population (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009).

Coping with Discrimination

Discrimination has been identified as one of the most stressful experiences that contribute to negative mental health problems, such as depression (Kessler, 1999). Prior research on coping with stress as an outcome of discrimination has identified several coping responses. Studies have identified mechanisms of coping to include being persistent (Miller & Myers, 1998), using social skills, using humor (Cross & Stauss, 1998), or monitoring other’s verbal and nonverbal

cues to increase awareness (Frable, Blackstone, & Scherbaum, 1990). Romero (2008) identified disengagement as the most frequent coping mechanism utilized by a sample of Mexican adolescents experiencing racism. Researchers also indicated the risk of this approach to coping, as disengagement may worsen symptoms of depression in marginalized groups (Romero, 2008). More recently, researchers have explored the proactive coping styles in overweight women, resulting in positive intrapersonal outcomes (Mallett & Swim, 2006).

Further research suggests that individuals experience racial discrimination as a psychological trauma (Carter, 2007). The race-based traumatic stress theory states that experiences of discrimination may elicit a response comparable to posttraumatic stress. Studies have examined the relationship between racial discrimination, coping, and common responses to traumatic exposure, such as dissociation. Researchers found that active coping styles were associated with lower levels of dissociative symptoms. Additionally, the more often individuals experienced racial discrimination the more often they reported symptoms of dissociation (Polanco-Roman, 2016).

The detrimental effects of racial discrimination have been well researched and consistently linked to poor physical and mental health outcomes (Pascoe, 2009; Williams, 2003). The mediating and moderating effects of coping on depression have also been examined in a sample individuals identifying as a sexual minority. Researchers reported that drug and alcohol use mediated the relationship between discrimination and depression (Ngamake & Walch, 2016). There is a growing body of literature suggesting that these detrimental effects of discrimination on individual's mental health may be minimized or exacerbated by various coping strategies (Brondolo, 2009; Pasco and Richman, 2009). However, little research exists that examines the relationship between coping and age discrimination.

Models of Ageism

The Succession, Identity, and Consumption (SIC) Model of aging will provide a theoretical framework from which to make sense of ageist perceptions of older adults and stigma associated with the aging process. The SIC Model is a three-factor scale of prescriptive ageism. The SIC Model has established convergent validity with other ageism and prejudice measures, such as the Fraboni Scale of Ageism (Fraboni, 1990). Additionally, the SIC model has affirmed divergent validity from other types of prejudice and discriminatory beliefs (North & Fiske, 2013). Components of the SIC Model are described below.

Succession factors are derived from societal expectations regarding enviable resources and social statuses. Realistically, younger generations rely on older individuals to step aside, or retire, in order to attain a sustainable career and lifestyle. It is socially expected for older individuals to retire at a particular age in order to allow those waiting to move into previously occupied positions (North & Fiske, 2013). Succession-based prescriptions help explain age discrimination in the work place.

Consumption-based stereotypes focus on the depletion of currently shared societal resources. Younger individuals hold the belief that elders reap more than their fair share of allotted societal resources, such as government money, health care, and shared public space (North & Fiske, 2013). Another aspect of consumption factors includes the fear that older adults will consume resources before others get there.

Identity factors represent a more symbolic element of aging, which assumes older adult participation in youth-oriented activities is abnormal (North et al., 2013). For example, going out on the weekend, having knowledge of current technology, or wearing youthful clothing would be youth specific activities that may exclude older adults. Research has supported the

notion of acceptable activities for old versus young people while older adults are often barred from youth culture (Greenberg, 2004).

Rupp (2005) identified a similar multidimensional nature of ageism. Rupp's model identified three components of ageism through a confirmatory factor analysis; antilocution, avoidance, and discrimination. Antilocution is defined as a dislike and aversion for older individuals fueled by misconceptions or myths about older adulthood. An example of the antilocution dimension may be the belief that all old people have dementia, are senile, or are stubborn. Avoidance is the second dimension of Rupp's model. Avoidance refers to younger individual's withdrawal of social contact with older adults. The third and final dimension of Rupp's model is discrimination. Discrimination refers to the inequality of political rights and the dissimilarity of older individuals in social settings and activities when compared to their younger counterparts (Rupp, 2005).

Theoretical Framework for Forthcoming Study

Bio-Psycho-Social Theories of Development

Conflicting theories of aging have the potential to send mixed messages to society and perpetuate stereotypes regarding what constitutes the "normal" aging process and "normal" age-specific behaviors. For example, roles theory labels aging as a transformative process in which older adults move from an "employee" to a "retiree" (Cottrell, 1942). This theory suggests that an older individual's routine, hobbies, and interests should inherently change with age. In turn, this theory may offer assumptions and stereotypes about what is appropriate behavior for an older individual.

Disengagement theory suggests that it is inevitable and natural for older adults and others in their environment to mutually disengage and withdraw from each other (Cumming, 1961).

This theory may normalize the isolation of older adults and may devalue the experience of depression as a result of loneliness in older age. Disengagement theory may also justify younger generation's preference to avoid contact with older adults. On the contrary, activity and continuity theories suggest the opposite. These theories state that positive aging is a result of staying active and resisting withdrawal from others and continuing to engage in positive activities (Lemon, 1972; Atchley, 1972).

Erik Erikson (1959) identified eight crises that individuals must resolve throughout the course of their lifetime for successful psychosocial development. The final stage, associated with late life resolution, provides a theoretical framework from which to conceptualize elderhood. This final stage, which entails addressing the psychosocial crisis of "integrity versus despair," involves reflecting on one's life to identify meaning and an overall sense of purpose and contribution to society. Failure to achieve ego integrity will result in feelings of bitterness, disappointment, and despair. Individuals who succeed are able to identify a summative life meaning will develop wisdom and acceptance of the inescapability of death (Clayton, 1975).

This researcher recognized that adult development is a multifaceted concept, therefore one model of development would not adequately capture the complexity of late life experiences (Hoare, 2009). Therefore, Bronfenbrenner's (2005) Bio-Ecological Theory of human development was utilized as a framework from which to consider psychological, sociological, and ecological factors. This theory considered the impact of messages sent to individuals from every level of society in terms of age related stereotypes, biases, perceptions, and attitudes. The Bio-Ecological Theory also allowed this researcher to methodologically consider the influence of contextual factors at each level of society.

Bronfenbrenner's Bio-Ecological Theory consists of three major levels of society. These three levels are the macro, exo and micro levels. The macro level represents the cultural and social context of an individual. At the macro level, an individual's socioeconomic status, ethnicity/race, age, gender, and sexual orientation can be explored through a cultural context that labels each aspect of one's identity as part of a dominant or minority group. The exo-level represents the interactions of various social settings in which the individual may or may not have a direct role. The micro level is the setting in which individuals have direct contact. Within the micro system, individuals will engage in regular social interactions with social agents, such as family members, friends, and coworkers. Bronfenbrenner's theory suggests that individuals not only receive information from the micro level, but that they also contribute to the construction of this environment.

The exo-level represents the greater societal context that includes a culture's social, political and public environments. For example, consider the United States' approach to meeting the needs of a rapidly growing older adult population through government funding to increase housing and medical security. At the macro-level, researchers will examine participant responses through a lens that considers societal myths and stereotypes about the older adult population. Macro-level analysis will also provide insight into younger generations attitudes and perceptions of older adults. Older adults are often labeled as senile, fragile, stubborn, and asexual. Finally, the micro-level will provide justification of the potentially detrimental impact of microaggressions on an older adult's mental health. The present study considered the impact of internalized beliefs stemming from the macro, meso and exo-systems on an older adult's wellbeing.

Self-Perception of Aging and the Mechanism of Ageism

The Looking Glass Self Theory is a sociological theory presented by Charles Horton Cooley in 1902. This theory delineates that our sense of self develops out of interpersonal interactions and the perceptions of others (McIntyre, 2006). As humans, our perceptions of other's beliefs and attitudes are often interpreted as true. Often, these perceptions are the result of stereotypes and misconceptions that generalize behaviors of groups of people based upon race, gender, sexual orientation, and age. This theory is particularly relevant in discrimination research. Our opinions of others are often fueled by stereotypical attitudes that exist within a cultural context. Frequently, these stereotypes suggest negative characteristics and qualities of marginalized populations.

Research has indicated that such disparaging messages have the potential to have a detrimental impact on marginalized individuals. These societal messages are often internalized by individuals who fall into minority statuses. For example, if society perpetuates the stereotype that all Black men are violent, Black men may internalize these messages and engage in violent behavior as a self-fulfilling prophecy and come to normalize their actions. For the purposes of this study, this researcher explored societal perceptions of older adults and aging processes through a lens guided by The Looking Glass Self Theory. Gaining an understanding of societal attitudes toward aging will provide insight into older individual's experiences of age discrimination. This theory also helped support the notion that perceived experiences of microaggressions may have a detrimental impact on older adult's health and wellbeing.

Additionally, stereotype embodiment theory further suggests the existence of a relationship between negative perceptions of aging and depression. According to this theory, the aging process is conceptualized as a social construct, therefore, individuals embody age

stereotypes across the lifespan and within a cultural context. These stereotypes can have a positive and negative impact on adults functioning and mental health (Levy, 2009). Further, this theory explains that if society views older adults as inferior or useless, older adults may also perceive themselves as unproductive and useless to society. Therefore, internalized ageism can negatively contribute to symptoms of depression.

Chapter 3

Overview of Methodology

The experiences of microaggressions by older adults was explored utilizing a quantitative approach to analyzing participant data. Participants were recruited by advertising participation in local senior living communities and senior centers. Participants were also recruited by using the online survey administration system SurveyMonkey via social media. Participants were incentivized to participate in this study with the chance to win a \$50.00 MasterCard gift card in a lottery drawing at the end of the data collection phase. This researcher provided participants with informed consent agreements (see Appendix A). Participants completed a demographic questionnaire (see Appendix B) that collected information about the participant's gender, racial/ethnic identification, age, relationship status, employment status, living environment, and religion. Participants then completed three self report questionnaires to collect data pertaining to geriatric microaggressions, coping mechanisms, and symptoms of depression. These questionnaires are discussed in more detail below (see also Appendix B).

Research Procedures

Participant Parameters

To increase the diversity of the sample, this researcher utilized the internet survey administration program SurveyMonkey to recruit participants online. Participants were also recruited from senior communities in the Tri-State Area of Western Pennsylvania, Northern West Virginia and Eastern Ohio. Senior living communities and retirement facilities were contacted via email. This research requested to post fliers on facility grounds and speak directly with residence about their interest in participating in this study. This researcher also utilized social media and professional platforms, such as Facebook, LinkedIn, and CESNET to recruit

participants. Additionally, in order to incentivize participation in this study, participants were informed of their chance to win a \$50.00 MasterCard gift card in a lottery style drawing at the end of the data collection phase.

Age. Participants were required to be over the age of 60. 60 years of age served as the operational definition of older adults for the purposes of this study. This criterion is consistent with other research on the older population. The term “older adult” is commonly used to refer to persons over the age of 60 by organizations such as The Administration on Aging (2006).

Demographic information. Both male and female participants were invited to participate in this study. There was no deterrence of other demographic factors such as race, ethnicity, or gender. Conversely, it was the intention of this researcher to employ a variety of recruitment methods to increase the diversity of this study’s sample population. For example, participants were recruited via social media, online and professional networking sites, and within the local community.

Instruments and Data Collection

Participants within this study were required to provide response data via online through SurveyMonkey, or by completing a paper copy of the administered assessment packet. After participants reviewed their informed consent form (see Appendix A) they completed a demographic questionnaire (see Appendix B). This questionnaire collected information about the participant’s gender, racial/ethnic identification, age, occupational status, level of education, and current residential setting (e.g., own home, with family, in a senior living community, with spouse). Following the completion of this demographic questionnaire, participants recorded their responses to three self report surveys and questionnaires.

The first questionnaire completed was the Geriatric Microaggressions Scale (GMS) adapted from the Racial and Ethnic Microaggressions Scale for the purposes of this study. The GMS provided insight into the type of age-related microaggressions experienced by older adults as well as the frequency of these experiences. The second survey participants completed was the Brief Cope Inventory. This tool collected data to provided insight into the specific coping mechanisms employed by older individuals who experience geriatric microaggressions. Finally, participants completed the CESD depression inventory. The depression inventory allowed this researcher to explore the impact of geriatric microaggressions on older adults' mental health.

Geriatric Microaggressions Scale (GMS). This researcher utilized preexisting assessments and scales of ageist beliefs and attitudes to adapt items of the Racial and Ethnic Microaggressions Scale (REMS) to reflect geriatric specific experiences. The Racial and Ethnic Microaggression Scale is a 45 item questionnaire developed to assess microaggressions experienced by racial and ethnic minorities. The REMS uses a dichotomous response format (1 and 0). Participants answer 0 if they do not experience a particular microaggression and 1 if they did experience a particular microaggression in the last six months. Developers of the REMS have identified six sub scales: 1) assumptions of inferiority, 2) second-class citizen and assumptions of criminality, 3) micro invalidations, 4) exoticization/assumptions of similarity, 5) environmental microaggressions, and 6) workplace and school microaggressions. The REMS has a Cronbach's alpha of .91 and subclass ranging in .78 to .87, and was validated by analyzing correlations with scales that measure modern racism (Nadal, 2011). This scale has also been validated with the LGBTQ population (Swann, 2016). The REMS served as a foundation and template for the development of the GMS.

A review of the literature surrounding topics related to attitudes and perceptions of older adults, ageism, and age discrimination was conducted to guide the formulation of geriatric-specific items for the Geriatric Microaggression Scale. A prominent example of an ageist beliefs assessment is the Facts on Aging Quiz (Palmore, 1998). Other instruments focus more directly on prejudicial attitudes pertaining to the older adult population. Two early scales- Tuckman and Lorge's (1953) Attitudes Toward Old People measure and Negative Attitudes Toward Old People Scale (Kogan, 1961) The Aging Semantic Differential (Rosencranz & McNevin, 1969) organized descriptive statements into three overarching constructs. The three-factor Fraboni Scale of Ageism (FSA) aimed to measure the affective component of ageist attitudes (Fraboni, 1990). The FSA includes both attitudinal beliefs (via descriptive antilocution items, such as "Many old people just live in the past"), and discriminatory behavior (such as "I sometimes avoid eye contact with old people when I see them"). Together these assessments and scales assisted this research in the development of age related microaggression statements.

The initial 25-item version of the GMS was constructed based upon common themes and perceptions of older adults identified in in the literature review of preexisting ageism assessments. A focus group was conducted with a panel of five counselor education and supervision doctoral candidates from Duquesne University to critique items on the initial version of the GMS. The feedback provided from the focus group was incorporated into the first revision of the scale. For example, the initial version of the GMS included a number of items that were double barreled, awkwardly worded, and repetitive. Feedback from the focus group was used in the first revision of the GMS. The GMS was then administered to four professionals and experts within the counseling and human development fields. Professional's expertise varied in microaggression research, older adult demographics, age discrimination, and scale construction.

Feedback from the four professional evaluations was utilized to revise the final version of the GMS used in this study. Examples of feedback from professional's evaluations included combining similar items and modifying the terminology used within some items. The final version consisted of 22 items designed to assess the frequency and nature of geriatric microaggressions experienced by a sample of the older adult population.

Brief COPE. The Brief COPE measure was constructed to measure coping strategies by Carver (1997). It is a 28-item tool developed to assess 14 different dimensions of coping. The dimensions are: 1) active coping, 2) planning, 3) use of instrumental support, 4) use of emotional support, 5) venting, 6) behavioral disengagement, 7) self-distraction, 8) blame, 9) positive reframing, 10) humor, 11) denial, 12) acceptance, 13) religion, and 14) substance use. Carver (1997) reported good psychometric properties for the scale, including an alpha of .56 across the 14 subscales. Additionally, exploratory factor analysis yielded 9 factors that accounted for 72.4% of the variance (Carver, 1997). The Brief COPE has been translated into both French and Spanish, which have also been found to have good psychometric properties (Perczek, 2000; Muller, 2003). Finally, the Brief COPE is a flexible measure that can be tailored to fit the needs of individual studies, as has been done for this study. The Brief COPE has been utilized in a similar study exploring the mechanism of coping related to the experience of racial microaggressions in school psychology students (Ortiz-Frontera, 2013).

For the purposes of this study, this researcher examined differences in healthy and unhealthy coping styles. This researcher categorized the 14 subscales of the Brief COPE into healthy and unhealthy coping groups. Active coping, planning, use of instrumental support, use of emotional support, self-distraction, positive reframing, humor, acceptance, and religion were identified as healthy coping styles. Venting, behavioral disengagement, blame, denial, and

substance use were identified as unhealthy coping styles. This categorization of healthy versus unhealthy coping styles is consistent with the current body of coping literature (O'Donnell, 2008; DeShields, 2015).

The Center for Epidemiological Studies Depression Scale (CESD-R). The Center for Epidemiological Studies Depression Scale (CESD-R) was first published in 1977 by Radloff and later revised in 2004 by William Eaton. The CES-D is a 20-item self administered depression inventory that measures symptoms of depression in nine different groups as defined by the American Psychiatric Association Diagnostic and Statistical Manual, fifth edition (American Psychiatric Association, 2013). These symptom groups are: sadness, loss of interest, appetite, sleep, thinking and concentration, guilt, fatigue, movement, and suicidal ideation. Response options range from “not at all” to “nearly every day for two weeks” on a 5-point scale. The CESD-R is one of the most widely used instruments in the field of psychiatric epidemiology. The scales application is suitable for typically undercounted populations, such as older adults (Murphy, 2002). Researchers have demonstrated this measures ability to screen for depression among older adults (Lewinsohn, 1997).

Analysis Plan

The number of participants targeted for recruitment was based on two forms of a priori power analysis. The first is Green's (1991) power guidelines for regression analyses in which the sample size N is greater or equal to $50 + 8m$, with m being the number of predictors. For the current study, there were 5 predictors (i.e., GMS average, Brief COPE average, healthy coping score, unhealthy coping score, and CES-D average.) By this method, a minimum of 90 participants was needed for the study. This researcher also conducted an a priori G*Power 3.1 analysis (Faul, Erdfelder, Lang, & Buchner, 2009) with an alpha level of .05, an effect size of .35

based on existing literature (Nadal, 2014), and 5 predictor variables. A sample size of 147 was determined by these G*Power parameters. In order to account for incomplete questionnaires or missing item responses, this researcher planned to have a sample size of $N > 150$. A total of 163 participants participated in this study after eliminating incomplete test packets and responses from individuals who did not meet the required age parameter.

In the first phase of statistical analysis, *t*-tests and analyses of variance were conducted to examine the variation in scores on the three instruments depending on categorical demographic factors (e.g., gender, age, race/ethnicity, marital status, current living environment, and religious preference). In the second phase of statistical analysis, correlation analyses were conducted to examine the relations between geriatric microaggressions, healthy and unhealthy coping, and level of depression. This researcher then calculated two interaction terms of geriatric microaggressions and coping by centering the predictor (geriatric microaggressions score) and moderator variables (healthy and unhealthy coping scores) using the grand mean centering methods.

In the third phase of statistical analysis, multiple linear regression analyses were conducted in SPSS to test for moderation. Two separate regression analyses were conducted to answer the final research question. The first regression analysis examined the the relationships between frequency of experienced geriatric microaggressions, unhealthy coping style and level of depression. The second regression analysis explored the relationship between frequency of experienced geriatric microaggression, healthy coping style, and level of depression. Geriatric microaggressions, depression, and coping were standardized to control for multicollinearity (Aiken & West, 1991; Baron & Kenny, 1986).

Human Participants and Ethics Precautions

This investigation complied with the Principles of Respect of Persons, Beneficence, and Justice defined by Duquesne University's Institutional Review Board for the protection of human subjects involved in all forms of research. Subjects voluntarily participated in this investigation with the discretion of the primary investigator. Participants who met the parameters of this study were provided an informed consent document prior to data collection. The informed consent defined subject's voluntary participation in this study, privacy rights, and protections of identifiable information.

Assumptions. This study was guided by the assumption that microaggressions are a modern form of discrimination that exist within the current social environment of our society. Microaggressions are experienced by marginalized populations and have the potential to have detrimental effects on individual's mental health and wellbeing. Additionally, the older adult population is recognized as a marginalized population in this investigation due to society's negative perceptions of aging and stereotypically beliefs associated with older adults.

Delimitations

Several delimitations were addressed for the purposes of this study. First, the sample of this study was limited in that it was a sample of convenience. 118 participants had computer access and completed the survey online via survey monkey. The 45 participants who completed hard copy versions were primarily from the western PA area. Due to convenience sampling, the internal validity of this study is lessened. In addition to this limitation of convenience sampling, the demographics of this sample lacked diversity. The majority of the sample was Caucasian and Christian, with a mean age of 68. Secondly, this researcher's use of self report questionnaires is a disadvantage because they are open to distortions, reflecting a response bias (Heppner et al,

2008). The researcher attempted to mitigate this effect by stressing the notion of confidentiality in the informed consent document. However, the possibility of participants responding as what they perceive as socially acceptable remains a concern. Finally, this study was limited in the exclusive use of quantitative approaches to data collection. The lack qualitative response data excludes the richer and more detailed information generated from individual responses.

Chapter 4

Results

This chapter presents descriptive statistics, a summary of the statistical analyses performed, and the results of the current study. The analyses are presented in both tabular and narrative format. Each research question is explored based on the results of various correlation analyses, t-tests, analyses of variance, and regression analyses.

Descriptive Analysis of Sample

The current study represents a data sample of 163 older adults over the age of 60. Participants completed a demographic questionnaire, The Geriatric Microaggressions Scale (GMS), The Brief Coping, and The Center for Epidemiological Studies Depression Inventory (CESD-R). Descriptive statistics were used to report the number of valid responses (N=163). The sample is composed of 95 women and 68 men with an overall average age of 68.26 ranging from 60 years to 94 years of age. 118 participants responded to the online questionnaire and 45 completed a hard copy of the test packet. Of the 163 participants 30 resided alone, 98 with a spouse or partner, 24 in a senior living facility, and 11 with a family member. 142 participants identified as Caucasian and 21 reported an ethnicity/race other than Caucasian. 111 participants reported being married or partnered, 22 identified as widowed, 20 identified as divorced, and 10 identified as single. 75 participants reported being Christian, 64 reported being Catholic, 19 reported no religious affiliation, and 5 reported practicing another religion. 35 participants reported currently working full time, 23 reported working part time, 101 reported being retired and 4 reported being unemployed (see Table 1).

Table 1

Descriptive Analysis of Demographic Information

<u>Variables</u>	<u>Frequency</u>	<u>Percent of Participants</u>
Gender		
Male	68	41.7
Female	95	58.3
Relationship Status		
Married or partnered	111	68.1
Widowed	22	13.5
Divorced	20	12.3
Single	10	6.1
Ethnicity		
Caucasian	142	87.1
Non Caucasian	21	12.9
Living Environment		
Alone	30	18.4
With a spouse or partner	98	60.1
With a family member	11	6.7
Senior or nursing facility	24	14.7
Employment Status		
Employed, working full time	35	21.5
Employed, working part time	23	14.1
Retired	101	62.0
Unemployed	4	2.5
Religion		
Christian	75	46.0
Catholic	64	39.3
Nothing in particular/non believer	19	11.7
All other religions	5	3.1

Note N= 163

Table 2

Descriptive Statistics for GMS, Brief Cope, and CESD Scores

	<i>N</i>	<i>M</i>	<i>SD</i>	<i>Min</i>	<i>Max</i>
GMS	163	4.00	3.97	0.00	17.00
Unhealthy Coping	163	1.84	.46	1.00	3.33
Healthy Coping	163	1.41	.67	1.00	3.00
CESD	163	13.95	9.94	0.00	44.00

Test for statistical assumptions. An analysis was conducted to determine any violations of assumptions for the analyses conducted in this study. Green and Salkind (2014) identify three overarching assumptions for running both univariate and multivariate analyses:

1. The variables are normally distributed in the population.
2. The population variances are dependent of each other.
3. The cases represent a random sample from the population and the scores on variables are independent from other scores on the same variable.

The first assumption of variables being normally distributed was violated. The scores on the GMS, unhealthy coping and healthy coping scales were not normally distributed in the population. In order to satisfy this assumption, this researcher transformed scores on the unhealthy and healthy scales by using the Lg10 transformation (Tabachnick, 2007; Howell, 2007). This transformation is used for positively skewed data and data that does not include negative number or zero's. The Lg10 transformation was also used to transform scores on the GMS. Prior to this transformation this researcher added a constant of "1" due to some scores equaling zero. The second assumption, equal population variances, is satisfied. The Levene's

Test assessed the equality of variance of the population sample in this study (Green & Salkind, 2014, 261).

Regarding the third assumption of multiple regression, the sample of older adults 60 years of age or older was not a random sample. Participants were recruited online using the survey administration system, SurveyMonkey, and from two senior living facilities in the Greater Pittsburgh area. It will be recommended that future research studies analyzing experiences of geriatric microaggressions will utilize random sampling techniques. The second assumption also addresses the independence of scores. If independence is violated, the likelihood of a type I error increases (Stevens, 2009). For the current study, no participant who completed the survey was influenced by other participants. There was no collaboration among the older adults as they completed their respective test packets. Therefore, the independence assumption was not violated.

To counteract the potential of a type I error due to multiple analyses with the same dependent variable, an adjustment was made to the alpha level used for the statistical tests conducted to answer the first research question (Mertler, 2013). The Bonferroni-type adjustment was used to account for this issue. The Bonferroni-type adjustment sets a more stringent alpha level for the tests of each dependent variable so that the cumulative alpha does not exceed the critical value (Tabachnick & Fidell, 2007). For the purposes of this analysis with 8 dependent variables, each univariate test will be conducted at $\alpha = .006$ because $.05/8 = .00625$.

Research Questions and Hypotheses

Four research questions were proposed for examination in this study. The first research question explored differences in older adult's number of reported experiences of geriatric microaggressions when compared to their demographic information. The aim of the second

research question was to determine if there is a relationship between experiences of geriatric microaggressions and level of depression. The third research question explored the relationships between unhealthy and healthy coping styles and level of depression. The goal of the final research question was establishing if healthy and unhealthy coping strategies were predictors of depression for older adults who experience geriatric microaggressions. All tests in this study were conducted at the 0.05 alpha level because this is a commonly used measure in the behavioral sciences (Cohen, Cohen, West, & Aiken, 2003).

Research Question 1. What demographic differences are there among older adults in experiences of geriatric microaggressions.

A Pearson correlation coefficient was calculated for the relationship between participant's age and experiences of geriatric microaggressions. A positive moderate correlation was found ($r(161) = .447, p < .001$), indicating a significant linear relationship between the two variables. The older adults in the present sample of those aged 60 and above reported experiencing more geriatric microaggressions.

An independent-samples t test comparing the mean scores of males and females found no significant differences between the two groups ($t(161) = .931, p = .35$). The mean score of women ($M = .60, SD = .34$) was not significantly different from the mean of score of men ($M = .55, SD = .29$) (see Table 3).

Due to a small number of responses from ethnicities other than Caucasian (i.e., African American, Asian, Latino/a, Middle Eastern, and Native American) these ethnic groups were collapsed into one ethnicity which was recoded as "non Caucasians." An independent-samples t test comparing the mean GMS scores of Caucasian participants to non Caucasian participants did not find significant differences between the two groups ($t(161) = 2.408, p = .017$), given the

Bonferroni-adjusted p -level. The mean scores of Caucasian participants ($M = .5581$, $SD = .31$) was not significantly different from the mean score of non-Caucasian participants ($M = .7359$, $SD = .33$) (see Table 3).

Table 3

<i>Demographic variables t tests with GMS Scores</i>			
	<i>n</i>	<i>M</i>	<i>SD</i>
Male	68	.55	.29
Female	95	.60	.34
Caucasian	142	.59	.31
Non Caucasians	21	.74	.33

A one-way ANOVA comparing number of geriatric microaggressions of participants who resided in one of four living environments was conducted. A significant difference was found among the four living environments ($F(3,159) = 8.939$, $p < .001$). Tukey's HSD was used to determine the nature of the differences between living environments. This analysis revealed that participants who reside alone ($M = .61$, $SD = .33$) experienced fewer geriatric microaggressions than participants residing in a senior facility ($M = .86$, $SD = .32$). Participants who reside with a spouse or partner ($M = .51$, $SD = .28$) experienced fewer geriatric microaggressions than participants residing in a senior facility ($M = .86$, $SD = .32$). There were no significant differences found between participants living alone ($M = .61$, $SD = .33$) and with a spouse or partner ($M = .51$, $SD = .28$), living alone ($M = .61$, $SD = .33$) and with a family member ($M = .59$, $SD = .35$), living with a spouse or partner ($M = .51$, $SD = .28$) and with a family member ($M = .59$, $SD = .35$), or living with a family member ($M = .59$, $SD = .35$) and in a senior facility ($M = .86$, $SD = .32$) (see Table 4).

A one-way ANOVA comparing number of geriatric microaggressions of participants who are in four different relationship statuses was conducted. A significant difference was found among the four relationship statuses ($F(3,159) = 11.013, p < .05$). Tukey's HSD was used to determine the nature of the differences between the relationship statuses. This analysis reveals that participants who are married ($M = .52, SD = .29$) experience fewer geriatric microaggression than participants who are widowed ($M = .91, SD = .28$). Participants who are widowed ($M = .91, SD = .28$) experience more geriatric microaggressions than participants who are divorced ($M = .60, SD = .39$). Participants who are single ($M = .48, SD = .21$) experience fewer geriatric microaggressions than participants who are widowed ($M = .91, SD = .28$). There were no significant differences found between participants who are married ($M = .52, SD = .29$) and divorced ($M = .60, SD = .39$), participants who are married ($M = .52, SD = .29$) and single ($M = .48, SD = .21$), or participants who are divorced ($M = .60, SD = .39$) and single ($M = .48, SD = .21$) (see Table 4).

A one-way ANOVA was conducted comparing the number of geriatric microaggressions experienced by participants in four different employment statuses. No significant differences were found among the four employment statuses ($F(3,159) 2.27, p = .08$) (see Table 4).

A one-way ANOVA was conducted comparing the number of geriatric microaggressions experienced by participants in four different religious affiliations. There were no significant differences among the four religious affiliations ($F(3,159) 1.65, p = .57$) (see Table 4).

Table 4

Demographic Variables ANOVA with GMS Scores

	<i>df</i>	<i>F</i>	η^2	<i>p</i>
Living Environment	3	8.39	.14	.000
Relationship Status	3	11.01	.17	.000
Employment Status	3	2.27	.04	.08
Religion	3	.68	.01	.57

Research question 2. What is the relationship between perceptions of geriatric microaggressions and level of depression?

H₀2: The more often individuals experience geriatric microaggressions, the more severe their symptoms of depression will be.

A Pearson correlation coefficient was calculated for the relationship between participant’s experiences of geriatric microaggressions and level of depression. A positive moderate correlation was found ($r(161) = .479, p < .001$), indicating a significant linear relationship between the two variables. Individuals who experience more geriatric microaggressions tend to report higher levels of depression.

Research question 3. What is the relationship between coping method and level of depression for individuals over the age of 60?

H₀3: Individuals who employ positive coping mechanisms will experience lower levels of depression.

H₀3: Individuals who employ negative coping mechanisms will experience higher levels of depression.

A Pearson correlation coefficient was calculated for the relationship between participant's degree of unhealthy coping and level of depression ($r(161) = .689, p < .001$). A positive high correlation was found indicating a significant linear relationship between the two variables. Older adults who employ unhealthy coping strategies reported higher levels of depression.

A Pearson correlation coefficient was calculated for the relationship between participant's degree of healthy coping and level of depression ($r(161) = .464, p < .001$). A positive moderate correlation was found indicating a significant linear relationship between the two variables. Older adults who employ healthy levels of coping report higher levels of depression.

Research question 4. Is the relationship between perceptions of geriatric microaggressions and level of depression moderated by degree of unhealthy or healthy coping?
H₀4: Experiences of geriatric microaggressions are more strongly related to level of depression for those who engage in unhealthy coping practices.

A multiple linear regression was calculated to test for moderation by predicting level of depression with geriatric microaggressions scores, unhealthy coping scores, and their interaction. Results from this regression analysis indicated that unhealthy coping scores ($b = 35.950, SE = 11.750, \beta = .459, p = .003$) and GMS scores ($b = 2.241, SE_b = 3.118, \beta = .072, p = .473$) were not associated with CESD scores (see Table 4), and the interaction between unhealthy coping and experiences of geriatric microaggressions was not significant ($b = 17.315, SE_b = 15.820, \beta = .213, p = .275$). The lack of a significant interaction term suggests that unhealthy coping does not moderate the relationship between experiences of geriatric microaggressions and level of depression among older adults (see Table 5).

Table 5

Summary of Moderation Analysis: Frequency of unhealthy coping strategies as a moderator between GMS and CESD scores

	<i>B</i>	<i>SE B</i>	β
(Constant)	6.293	1.659	
Unhealthy	35.950	11.750	.459
GMS	2.241	3.118	.072
Interaction Term	17.315	15.820	.213

A multiple linear regression was calculated to predict participants' level of depression based on their experience of geriatric microaggressions and healthy coping score. Results from this regression analysis indicated that healthy coping scores ($b = 12.280$, $SE_b = 8.331$, $\beta = .203$, $p = .142$) and GMS scores ($b = 7.234$, $SE_b = 1.095$, $\beta = .233$, $p = .086$) were not associated with CESD scores (see Table 6).

The interaction between healthy coping and experiences of geriatric microaggressions was not significant ($b = 12.687$, $SE_b = 13.534$, $\beta = .193$, $p = .350$) suggesting that healthy coping does not moderate the relationship between experiences of geriatric microaggressions and level of depression among older adults (see Table 6).

Table 6

Summary of Moderation Analysis: Frequency of healthy coping strategies as a moderator between GMS and CESD scores

	B	SE B	β
(Constant)	4.843	1.095	
GMS	7.234	4.193	.233
Healthy	12.280	8.331	.203
Interaction Term	12.687	13.534	.193

Summary of Results

The results of the analyses conducted in this study suggest significant relationships between several demographic variables and scores on The Geriatric Microaggression Scale. Specifically, results showed a significant moderate positive relationship between age and scores on the GMS, and significantly higher GMS scores for non-Caucasian participants relative to Caucasian participants. However, results suggested no significant differences in GMS scores between males and females. Results from ANOVA analyses indicated significant differences in participants living environments and GMS scores and relationship statuses and GMS scores. ANOVA results indicated that there were no differences in GMS scores comparing religious affiliations or employment statuses. The results furthermore provided evidence of relations among depression and GMS as well as both unhealthy and healthy coping styles in older adults; however, neither healthy nor unhealthy coping strategies were found to moderate the relationship between experience of geriatric microaggressions and level of depression.

Chapter 5

Discussion

This chapter presents a summary of the study, a conclusion of the results, and a consideration of the limitations of this research. Provided is also a discussion of recommendations for future research and implications for practice and curriculum development.

Summary of the Study

The purpose of this study was to investigate the relationships between experiences of geriatric microaggressions, mental health and coping style. Specifically, this study explored differences among demographic information in relationship to experiences of geriatric microaggressions, and examined possible predictors of experiences of geriatric microaggressions in relationship to mental health.

In order to measure experiences of geriatric microaggressions, this researcher adapted the Racial and Ethnic Microaggressions Scale to reflect age specific microaggressions. This was done by conducting a review of the literature surrounding societal perceptions of aging and age discrimination. Items of the REMS were reconstructed to reflect geriatric specific microaggressions. The Brief Cope scale was utilized to measure and categorize participant's preferred methods of coping into healthy and unhealthy categories. Finally, The Center for Epidemiological Study Depression Inventory was used to measure participant's level of depression experienced within the past 6 months. Scores from each measure along with a demographic questionnaire were analyzed using SPSS statistical analysis software. A series of multivariate and univariate tests were conducted to examine the relationships among demographic data and the scores on the three measures.

Major Findings

Research question 1. The results of the analyses conducted exploring differences among demographic data and scores on the Geriatric Microaggression Scale indicated significant differences among several variables. Older individuals reported more experiences of geriatric microaggressions than their younger counterparts. This is consistent with existing literature intimating a linear increase in experiences of age discrimination (Palmore, 2001). Old-older adults experience age discrimination more frequently than young-older adults when comparing young-old to old-old age categories (Duncan, 2004). An explanation for this finding could be that younger aged older adults are still engaging in many of the same activities as younger individuals. Within the United States the retirement age is increasing. More individuals between the ages of 60 and 70 are remaining in the work force (Duggan, 2005). Extending the working age of older adults maintains the identities of older adults who associate with younger individuals in the work place. Societal perceptions of individuals who are employed are typically positive, viewing working individuals as healthy and productive members of society (Gaertner, 1989). Additionally, positive perceptions of work have been linked to positive physical and mental health outcomes (Hakansson, 2011). According to the Looking Glass Self Theory, older adults who are viewed by society as productive and healthy are more likely to have similar self perceptions (McIntyre, 2006). Older adults who continue to stay active with youth orientated activities may view themselves as being more productive members of society than older adults who are no longer engaging in youth oriented activities.

Significant differences were also found between individual's living environments when comparing the mean scores of individuals residing alone, with a spouse or partner, and in senior living facilities. Research suggests that older adults are being institutionalized by constructing

senior living facilities and senior centers that limit older adult's interactions with the younger population and label them as "frail" (Rockwood, 1996). A consequence of living in a senior living facility or nursing home or involvement with a senior center is that older adults are typically categorized on a daily basis primarily on their age. Stereotype embodiment theory suggests that exposure to negative stereotypes may lead to internalization and a negative self perception (Levy, 2009). Previous research has linked low self esteem and self efficacy to depression in older adults (McAuley, 2005). Therefore, older adults who have negative self-perceptions or low self esteem may be sensitive to other's perceptions. Consequently, older adults with a negative view of self may interpret their interactions with others as being discriminatory.

Participant's experiences of geriatric microaggressions also varied among relationship statuses. Individuals who were married reported fewer experiences of geriatric microaggressions compared to individuals who were widowed. Older adults who were widowed reported experiencing more geriatric microaggressions than those who were divorced and single. These findings could be explained by the possible lack of support systems of family and friends for individuals who are widowed. Research has linked loneliness and lower perceptions of togetherness to symptoms of depression in older adults (Tiikkainen, 2004). Older adults may be more likely to report experiences of geriatric microaggressions due to a lack of a support system. Conversely, support systems may function as a protective factor for older adults. Older adults who lack supports are in turn more affected by experiences of geriatric microaggressions.

Participant's scores on the Geriatric Microaggression Scale also differed depending on place of residence. Older adults residing alone experienced fewer microaggression than those residing in a senior living facility. Participants living with a spouse or partner also reported

fewer experiences of microaggressions than those residing in a senior living facility. Research has revealed that older adults residing in senior living facilities or nursing home are at risk for feelings of loneliness which could be linked to symptoms of depression (Russell, 1997). Increased feelings of loneliness and a lack of social support may provide an environment where older adults are more affected by experiences of geriatric microaggressions.

The results of this research revealed no significant relationships between individual's religion, ethnicity or employment status and their experiences of geriatric microaggressions. One explanation for the lack of significant findings among these variables could be that, in the present sample, the demographic categories of religion, ethnicity and employments status lacked diversity. Both religion and ethnicity had to be collapsed and recoded into variables that contained fewer categories. An explanation for the lack of significant findings between employment statuses and experiences of geriatric microaggressions could be that perceptions of ageism have been reported by both retired and employed individuals (Rupp, 2006; Tougas, 2004).

Bronfenbrenner's Bio-Ecological Theory of human development can be applied to the overall findings of Research Question 1. According to Bronfenbrenner's theory, demographic differences must be explored within a cultural context that labels each aspect of a person's identity as a dominant or minority group. It is understood that individuals' identities are multidimensional and are a sum of factors such as gender, age, ethnicity, sexual orientation and socioeconomic status. It could be assumed that various combinations of these factors produce different life experiences and perceptions of the world. For example, individuals residing in senior living facilities are exposed to different types of people, environments, and situations, compared to those residing in their own homes. This exposure may or may not have a direct role

on their experiences of geriatric microaggressions, symptoms of depression, and coping preference.

Research Question 2. Results from the statistical analyses conducted to answer Research Question 2 found that the more often individuals experience geriatric microaggressions, the more likely they are to report more severe levels of depression. This finding is consistent with the literature surrounding experiences of microaggressions based upon race, ethnicity, gender, and sexual orientation (Sue, 2008, Nadal, 2011, Herek, 2013). Self-reported depression has also been linked to perceived discrimination among older adults (Bai, 2016).

Stereotype embodiment theory may explain the connection between depression and experiences of geriatric microaggressions. Older adults who are treated differently and assumed to be inferior or less capable than their younger counterparts may internalize these perceptions. According to many psychosocial theories of ageing many factors linked to depression, such as isolation and inactivity, have been normalized for the older adult population (Cumming, 1961; North, 2013; Greenberg, 2004). As a consequence of this stereotyping, the expectation for older adults to “act their age” could put them at risk for developing symptoms of depression.

Additionally, Erikson identified his final stage of psychosocial development as integrity versus despair. According to Erikson, individuals who do not resolve this conflict will consequently, result in feelings of bitterness, disappointment, and despair. Many of these feelings are similar to negative assumptions made of older adults. It could be that failure to resolve this psychosocial conflict puts older adults at a risk of experiencing geriatric microaggressions.

Research Question 3. The results from the correlations conducted for Research Question 3 produced significant findings, though one in an unexpected direction. The first hypothesis that older adults who employ unhealthy coping strategies will report higher levels of depression was supported. The second hypothesis that older adults who employ healthy coping strategies will report lower levels of depression, however, was not confirmed. In fact, individuals who employ healthy coping strategies also reported higher levels of depression.

The results from the first correlation supporting the hypothesis that older adults who employ unhealthy coping strategies will report higher levels of depression is supported by the existing literature. For example, older adults who engage in self neglecting behavior, such as excessive drinking, are more likely to experience symptoms of depression (Hansen, 2016).

The finding associated with healthy coping strategies also being linked to higher levels of depression is not consistent with the literature. Research has linked healthy coping strategies, such as praying and seeking emotional support, to lower symptoms of depression among the older adult population (Pieper, 1992; Pargament, 2000). For example, older adults who engage in regular physical activity are at a reduced risk for subsequent depression (Strawbridge, 2002). One reason these findings may contradict existing literature is that items on the Brief Cope were categorized into “healthy” versus “unhealthy” coping styles, which was not the originally intended use, though there is precedent for it (O’Donnell, 2008; DeShields, 2015). Examining the previously established subscales within the Brief Cope in relationship to levels of depression may yield results that are more nuanced and discernably in line with the previous research. An alternative explanation for this finding could be that older adults who report engaging in coping strategies, regardless of being healthy or unhealthy, are doing so because they have already experienced some form of adversity other than age discrimination. Conversely, older adults who

report low levels of both healthy and unhealthy coping may reflect that they are at a lower risk of experiences that may negatively impact their mental health.

Research Question 4 The results of the moderation analyses conducted for Research Question 4 were not significant. The interaction of healthy and unhealthy coping strategies and experiences of geriatric microaggressions were not associated with level of depression, suggesting no significant moderating effect of either form of coping between experiences of geriatric microaggressions and depression. One explanation for this finding could be that there are other variables that should be examined, such as demographic variables, that may moderate the relationship between experiences of geriatric microaggressions and depression. Another explanation could be that the moderating effects between these variables are in the opposite direction of what was hypothesize. That is, coping style moderates the relationship between depression and experiences of geriatric microaggressions.

That being said, there is a lack of literature surrounding the interactions of microaggressions, coping, and mental health. However, one study investigating the moderating effects of coping between experiences of racial microaggressions and distress reported similar findings. In the study, the researcher established that coping style did not moderate the relationship between experiences of racial microaggressions and level of distress (Alejandro, 2014). This implies that other moderating variables should be explored in future studies.

Bronfrenbrenner's (1979) bioecological model provides a framework for understanding macrosystemic factors such as cultural stereotypes, myths, and beliefs, about older adults. Negative societal views of aging and the older adult population have the potential to negatively impact older adult's emotional and physical health (Stewart, 2012; Swift, 2017); the present study provides first-of-its-kind evidence that such negative societal views can and do take the

form of geriatric microaggressions, and that these forms of microaggressions do have negative mental health consequences to older adults. Bronfenbrenner's theory also accounts for individual and environmental factors that contribute to human development (Ryan & Deci, 2000). In that regard, the demographic variables included in this study were included to account for the roles that both individual factors—such as race and gender—and environmental factors—such as living environment and employment status—might play in the experiences of geriatric microaggressions in older adults. By incorporating these variables into this study, the findings suggest that ageism is much more complex and multidimensional than simply traditionally understood overt forms of discrimination against older adults in general.

Limitations

The current study has several limitations to consider. One major limitation is the sample. This study utilized convenience sampling methods, primarily recruiting older adults in the Western Pennsylvania region. Based upon the descriptive statistics of the sample, participants reflect a relatively homogenous group of older adults. Most participants were Caucasian, in their early 60's, and Christian or Catholic. With such a lack of diversity in the sample, the results may not be generalizable to the larger population.

A second limitation is the use of self-report questionnaires. Using self reported information in data analysis poses a threat for response bias. Considering the societal stigma associated with both aging and mental health, some participants may have responded dishonestly or inaccurately rated their experiences. It may have been useful to incorporate qualitative methods of data collection, such as interviews, focus groups, or observation. This would allow researcher to gain a deeper subjective understanding of geriatric microaggressions, mental health, and coping, experienced by older adults.

Although the Geriatric Microaggressions Scale (GMS) included the three forms of microaggressions (i.e. microinsults, microassaults, and microinvalidations) running additional analyses with these subcategories would call for a much larger sample size than the present study has included. This study is limited by not exploring these subcategories of microaggressions. Other discrimination literature pertaining to race, ethnicity, gender, and sexual orientation has investigated the interactions and relationships between these subcategories and symptoms of depression (Sue et al., 2010; Nadal et al., 2007). The present study presents a foundation for broadly examining experiences of geriatric microaggressions in the older adult population; however, future studies must include the subcategories of geriatric microaggressions to more fully understand the complexity of experiences of ageism within our society.

The use of technology also presented a challenge, which may have influenced the participation in this study. Those who were recruited online had to have some degree of technological awareness to navigate the survey administration system. The majority of participants in this study were recruited by online methods which lend the assumption that those individuals have computer access and are computer literate.

Finally, no existing research explores age discrimination in such a way as the present study. This researcher relied on existing measures of race/ethnicity and sexual orientation microaggressions to develop a tool to measure experiences of geriatric microaggressions. Although this research manages to shed light on ageism as a detectable form of discrimination, age remains a unique social category spanning across all other demographic categories. Everyone, granted they live long enough, is at risk of age discrimination at one point in his or her life, regardless of other demographic factors. Due to this element of aging, experiences of

ageism may not be best explored by relying so heavily on previous studies investigating other forms of discrimination.

Implications for practice

The results of this study provide implications for counseling practice and education. These results contribute to professional counselor's understanding of age related experiences and depression in later life. Older adult specific interventions, particularly designed for individuals reporting experiences of microaggressions, can be developed from further examination of these findings. Results of this study may also aid in the future development of educational trainings and workshops designed to enhance understanding of cultural sensitivities pertaining to the older adult population.

Counselors may incorporate the topic of age discrimination into their work with older adults. Although many older adults may not experience geriatric microaggressions, inviting the topic into a therapeutic setting may offer an opportunity to address these negative experiences and their effects. Counselors would be better able to develop specific treatment goals and interventions pertaining to the detrimental effects of experiences of ageism. For example, cognitive and behavioral counselors may engage clients with a thought mapping activity designed to uncover negative thinking patterns associated with experiences of geriatric microaggressions. Clients would gain insight into internalized ageism and link these internalizations to symptoms of depression. Counselors would then aid the client in developing thought challenging techniques to combat such negative thinking patterns.

Incorporating the findings of this study into multicultural and life span courses will expand student's understanding of diversity beyond race, gender, and sexual orientation. As counselors, we conceptualize our client's identities as being multidimensional and as a sum of all

parts. Emphasizing age related identities to the same degree as other demographic factors will provide students with a more comprehensive understanding of individual's identities.

Additionally, false perceptions of older adults could lead to misdiagnosis and mistreatment.

Considering age as part of one's identity will provide new perspectives and considerations for the treatment of older adults.

The findings of the current study could also be used to inform employees of senior institutions regarding age discrimination. Social service agencies typically provide training for working with marginalized populations; however, older adult trainings are not mandated and are infrequently offered. For example, an informative training could be developed from the findings of this study to address the impact of experiences of geriatric microaggressions. Attendees would be provided a working definition of geriatric microaggressions and asked to reflect upon their own biases pertaining to the older adult population. Further suggestions for these trainings might be to include confronting stereotypes of the older adult population and age related microaggressions in the work place, as well as provide educational material to challenge societal perceptions of older adults.

Recommendations for Future Research

This study provides a foundation for the future exploration and research of experiences age discrimination in the older adult population. Future studies may incorporate a more representative sample of older adults with more diverse cultural factors. This would allow researchers to explore the relationships between demographic variables, such as, educational level, number of children, and income level to scores on the GMS. Comparing more groups such as these will facilitate a deeper understanding of the experiences of geriatric microaggressions.

Due to the need for a much larger sample size, this investigation did not explore the potential presence of three subtypes of microaggressions found in research related to other forms of microaggressions; microinsults, microassault, and microinvalidations. Future examination of the subcategories of microaggressions experienced by older adults is essential for continuing to move age discrimination research along the same trajectory as other forms of discrimination. Without exploring each type of microaggression, the current study is limited in understanding geriatric specific microaggressions to the same degree as other microaggressions. Also due to a small sample size, this study did not explore specific subscales of coping identified in the Brief Cope as the measure was intended. Conducting a study with a larger sample size would enable researchers to scrutinize more closely what specific coping methods older adults employ and how coping is related to experiences of geriatric microaggressions.

Future research may also investigate other moderating relationships involving geriatric microaggressions, mental health and coping. Researchers might consider the possibility of older adults who report high levels of depression as being “predisposed” to experiences of geriatric microaggressions based upon their coping styles. Such a study would allow researchers to investigate the directionality of moderating relationships among these variables. Also, the effects of experiences of age discrimination on other psychological factors, such as quality of life, and biological factors, such as chronic pain, should be further investigated.

Future studies must also consider the multidimensional nature and complexity of individual’s identity. Discrimination and identity literature suggests that it is nearly impossible to examine one aspect of an individual’s identity independently (Jones & McEwen, 2000; Reynolds & Pope, 1991). Future research must consider the intersection of other social identities, such as race, gender, and sexual orientation, with age. Without considering these intersecting circles

surrounding an individual's core identity, the current study is not able to examine the effects of having multiple minority statuses. For example, individuals who reported experiences of geriatric microaggressions may also be experiencing microaggressions based upon their race, gender, and/or sexual orientation. Future research may be concerned with examining the compounding effects of experiences of microaggressions due to more than one aspect of an individual's identity. Researchers might investigate how individuals determine which aspect of their identity is being targeted at a given time. Researchers might also explore the exacerbated or reduced outcomes on an individual's mental health due to experiencing multiple of microaggressions.

Including qualitative or mixed methods approaches to data collection would facilitate a deeper understanding of experiences of geriatric microaggressions and age discrimination as experienced by older adults. Incorporating data collection methods such as interviews, focus groups, and observations, would provide rich and detailed data to continue to expand the literature surrounding these topics. For example, having a focus group of older adults over the age of 60 discuss personal experiences related to age discrimination and geriatric microaggressions would create a safe environment where individuals could openly share their experiences. Having such an environment may contribute to more self disclosure and discussion pertaining to the negative impact of experiencing age discrimination.

Future research may also utilize interviews as a form of data collection. Participants would be able to identify sources of age discrimination, verbalize opinions about ageism, and discuss more specific coping strategies utilized to combat negative societal perceptions of aging. Lastly, future researchers could utilize field observations to collect data. For example, researchers could observe the interactions of older adults in senior living facilities or senior

centers. Observations could be made about the interactions between older adults and staff and within groups of older adults socializing. This information would provide insight into observable occurrences of geriatric microaggressions as well as older adults physical and emotional reactions to such experiences.

Conclusion

This chapter provided a discussion of the basic findings and results of the present study. This chapter also provided limitations to the present study and implications for future research, practice and education.

The current body of literature surrounding age discrimination is limited in comparison to more commonly researched topics such as race, ethnicity, gender and sexual orientation. This study is one of the first to explore age discrimination as a significant form of discrimination in the form of microaggressions. Geriatric microaggressions should be investigated and considered as detrimental to one's health as other forms of discrimination. This is particularly important considering a large portion of the United States population will be entering older adulthood in the coming years.

In conclusion, the results from this study will contribute to the existing literature surrounding age discrimination, mental health, and coping, considering these relationships have not been previously examined. The results from this study highlight the importance of addressing age related discrimination when researching experiences of microaggressions within our society. These findings will also facilitate future research exploring the impact of everyday age discrimination on older adult's mental health and wellbeing. Further, future investigation is needed to explore sources of experiences of geriatric microaggressions and strategies to combat negative societal perceptions of aging.

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CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE:

An Investigation of Geriatric Microaggressions, Relations with Depression in Later Life, and the Moderating Effect of Coping

INVESTIGATOR:

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SOURCE OF SUPPORT:

This study is being performed as partial fulfillment of the requirements for the doctoral degree in the Executive Counselor Education and Supervision Program and Duquesne University.

PURPOSE:

You are being asked to participate in a study that is intended to examine the relationships between experiences of age discrimination, depression, and coping style. In order to qualify for participation, you must be: over the age of 60.

PROCEDURE:

To participate in this study, you will be asked to: read and sign the informed consent form to acknowledge your rights and responsibilities as a participant in this study. You will then complete a demographic form and complete three questionnaires related to your experiences with age discrimination, mental health, and coping. The estimated time to complete this study is 30

minutes. You may complete the test packet online or in hard copy form in a location of your convenience. You will be required to complete the demographic form and all three questionnaires consecutively. These are the only requests that will be made of you.

RISKS AND BENEFITS:

The risks associated with this study are minimal, and may include feeling sadness or discomfort upon completion of testing materials. However, these risks are not believed to exceed those that may be encountered throughout your daily life. Although you may not experience immediate or personal benefits from this study, this research will help to provide information that will help others better understand the important issues related to experiences of ageism and mental health.

COMPENSATION:

All questionnaires must be completed for participants to be eligible to enter into a lottery style drawing. Upon completion of all assessment questionnaires, you may choose to enter your email address or phone number for the chance to win a \$50.00 MasterCard gift card. The drawing will take place after data collection has been completed. The winner of the lottery style drawing will be contacted via email or phone. Participation in this project will require no monetary cost to you.

CONFIDENTIALITY:

Your participation in this study and any personal information that you provide will be kept confidential at all times and to every extent possible. Your name will never appear on any survey or research instruments unless you choose to enter your contact information into the drawing. Once data collection is complete and the winner of the drawing is identified, all contact information will be destroyed. All written and electronic forms and study materials will be kept secure in an encrypted file on a password protected computer. Your responses will be coded and only appear in statistical data summaries. Any study materials with personal identifying information will be maintained for three years after the completion of the research and then destroyed.

RIGHT TO WITHDRAW:

You may withdraw from this study at any time prior to the completion of the study. You do not have to provide any explanation for your decision to withdraw. If you choose to withdraw, all coded information gathered from you as part of this study will be destroyed including your contact information for the lottery style drawing.

SUMMARY OF RESULTS:

A summary of the results of the study will be available to you at the completion of the study at no cost to you, upon request.

VOLUNTARY CONSENT:

I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project. I understand that should I have any further questions about my participation in this study, I may call the primary investigator, Lisa Zimmerman or the advisor, Dr. Matthew Bundick at, (412) 396-6110. Should I have any questions regarding protection of human subject issues, I may contact Dr. David Delmonico, Chair of the Duquesne University Institutional Review Board, at (412) 396-1886.

_____ Date
Participant's Signature

_____ Date
Researcher's Signature

Appendix B

Demographic Questionnaire

Age: _____

Gender:

- Female
- Male
- Other or not listed above *Please specify if desired _____

Race/Ethnic self- identification: (Check all that apply)

- African, African American, or Black
- Asian, Asian American
- Caucasian, European American or White
- Latina/o, Latina/o American
- Middle Eastern
- Native American, American Indian
- Other or not listed above *Please specify if desired _____

Current living environment:

- Alone in own home
- With spouse in own home
- With a family member
- Senior living community
- Assisted living
- Nursing facility

What is your marital status?

- Married or living with partner
- Widowed
- Divorced
- In a relationship
- Single, never married

Employment Status

- Working full time
- Working Part time
- Retired
- Unemployed

Religious preference: _____

Geriatric Microaggression Scale (GMS)

Lisa Zimmerman, M.Ed., N.C.C

Respondents are instructed to indicate true or false if they have experienced each of the following in the past 6 months.

	True	False
I was told I shouldn't drive anymore because of my age.	<input type="radio"/>	<input type="radio"/>
I was told I complain about my age too much.	<input type="radio"/>	<input type="radio"/>
Someone told me I was overreacting when I talked about a negative experience I had because of my age.	<input type="radio"/>	<input type="radio"/>
Someone assumed I cannot take care of everyday tasks because of my age.	<input type="radio"/>	<input type="radio"/>
Someone assumed I had dementia because of my age.	<input type="radio"/>	<input type="radio"/>
Someone assumed I was less productive than younger people.	<input type="radio"/>	<input type="radio"/>
Someone spoke in a loud voice when addressing me.	<input type="radio"/>	<input type="radio"/>
Someone avoided eye contact with me because of my age.	<input type="radio"/>	<input type="radio"/>
Someone avoided talking with me because of my age.	<input type="radio"/>	<input type="radio"/>
Someone has told me "an old dog can't learn new tricks."	<input type="radio"/>	<input type="radio"/>
Someone once referred to me as "cute" because of my age.	<input type="radio"/>	<input type="radio"/>
I was told that I "live in the past."	<input type="radio"/>	<input type="radio"/>
I was told I am "too old" to participate in an activity.	<input type="radio"/>	<input type="radio"/>
I was told that I look good for my age.	<input type="radio"/>	<input type="radio"/>
Someone assumed I was stingy with my money because of my age.	<input type="radio"/>	<input type="radio"/>
I get the impression that I am a burden on my family.	<input type="radio"/>	<input type="radio"/>
I get the impression that others feel depressed when they are around me because of my age.	<input type="radio"/>	<input type="radio"/>
Someone assumed I would not be educated or informed of present day knowledge because of my age.	<input type="radio"/>	<input type="radio"/>
Someone acted surprised at my physical capabilities because of my age.	<input type="radio"/>	<input type="radio"/>
Someone assumed I was mentally impaired because of my age.	<input type="radio"/>	<input type="radio"/>
Someone assumed I was physically impaired because of my age.	<input type="radio"/>	<input type="radio"/>
I was told I was stubborn because of my age.	<input type="radio"/>	<input type="radio"/>

Brief COPE (Carver, 1997)

These items deal with ways you have been coping with experiences of age discrimination identified in the previous set of questions. There are many ways to try to deal with problems. Obviously, different people deal with things in different ways, but I'm interested in how *you've* tried to deal with it. Each item says something about a particular way of coping. I want to know to what extent you've been doing what the item says, how much or how frequently. Do not answer on the basis of whether it seems to be working or not—just whether or not you're doing it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

	I haven't been doing this at all	I've been doing this a little bit	I've been doing this a medium amount	I've been doing this a lot
I've been turning to work or other activities to take my mind off things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been concentrating my efforts on doing something about the situation I'm in.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been saying to myself "this isn't real."	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been using alcohol or other drugs to make myself feel better.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been getting emotional support from others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been giving up trying to deal with it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been taking action to try to make the situation better.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been refusing to believe that it has happened.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been saying things to let my unpleasant feelings escape.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been getting help and advice from other people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been using alcohol or other drugs to help me get through it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been trying to see it in a different light, to make it seem more positive.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been criticizing myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been trying to come up with a strategy about what to do.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I've been getting comfort and understanding from someone.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been giving up the attempt to cope.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been looking for something good in what is happening.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been making jokes about it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been accepting the reality of the fact that it has happened.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been expressing my negative feelings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been trying to find comfort in my religion or spiritual beliefs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been trying to get advice or help from other people about what to do.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been learning to live with it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been thinking hard about what steps to take.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been blaming myself for things that happened.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been praying or meditating.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been making fun of the situation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Healthy items (18)

Self-distraction, items 1 and 19
Active coping, items 2 and 7
Use of emotional support, items 5 and 15
Use of instrumental support, items 10 and 23
Positive reframing, items 12 and 17
Planning, items 14 and 25
Humor, items 18 and 28
Acceptance, items 20 and 24
Religion, items 22 and 27

Unhealthy items (10)

Denial, items 3 and 8
Substance use, items 4 and 11
Behavioral disengagement, items 6 and 16
Venting, items 9 and 21
Self-blame, items 13 and 26

The Center for Epidemiological Depression Scale (CESD-R)

Below is a list of ways you may have felt or behaved. Please tell me how often you have felt or behaved this way in the last week

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
I was bothered by things that usually don't bother me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I did not feel like eating my appetite was poor.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt that I could not shake off the blues even with help from my family or friends.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt I was just as good as other people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I had trouble keeping my mind on what I was doing.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt depressed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt that everything I did was an effort.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt hopeful about the future.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I thought my life had been a failure.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt fearful.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My sleep was restless.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was happy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I talked less than usual.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt lonely.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
People were unfriendly.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I enjoyed life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I had crying spells.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt sad.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt that people dislike me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I could not get "going."	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Appendix C

Recruitment Email

Hello,

I am writing to let you know about an opportunity to participate in a research study investigating the relationships among coping, mental health and discrimination in older adults over the age of 60. This study is being conducted by Lisa Zimmerman, M.Ed., NCC, at Duquesne University for the doctoral program requirements in the Counselor Education and Supervision doctoral program.

The study will require participants to complete an assessment packet consisting of a demographic questionnaire and three separate surveys. The test packet will take participants approximately 30 to 45 minutes to complete. These surveys will collect participant data related to mental health, coping styles, and experiences of discrimination based upon age. Participants who complete the assessment packet and voluntarily submit their email addresses upon completion of the test packet will be entered into a lottery style drawing for the chance to win a \$50.00 MasterCard gift card upon the completion of data collection.

Participating in this study will contribute to the much needed body of research regarding later life experiences and aging. The findings of this study will also benefit your organization by offering insight into residents' experiences and sense of wellbeing. These insights may foster future program development opportunities based upon information directly gathered from your residents. I hope to discuss this opportunity with your organization further if you will contact me at your earliest convenience. Thank you!

Sincerely,

Lisa Zimmerman, M.Ed., NCC
Duquesne University Doctoral Candidate
zimmerm8@duq.edu

RESEARCH OPPORTUNITY

Duquesne University

Are you 60 years of age or older?

Do you have 30 minutes to participate in a research study?

****In this study you will answer three surveys and a demographic questionnaire. Each survey will address topics of age discrimination, mental health, and coping style. ****

Purpose of the study: to explore the relationships between age discrimination, mental health and coping



Come join me and participate for your chance to win a \$50.00 MasterCard Gift Card upon completion of 3 surveys!