2022

Age-Related Microaggressions: A Descriptive Study

Luke J. Gietzen
Minnesota State University, Mankato

Age-Related Microaggressions: A Descriptive Study

By

Luke J. Gietzen

A Thesis Submitted in Partial Fulfillment of the

Requirements for the Degree of

Master of Arts

In

Clinical Psychology

Minnesota State University, Mankato

Mankato, Minnesota

May 2022

04.28.2022

Age-Related Microaggressions: A Descriptive Study

Luke J. Gietzen

This thesis has been examined and approved by the following members of the student's committee.

X _____

Jeffrey Buchanan, PhD (Advisor)

X _____

Angelica Aguirre, PhD, BCBA-D (Committee Member)

X _____

Aaron Hoy, PhD (Committee Member

Table of Contents

Age-Related Microaggressions: A Descriptive Study

Luke J. Gietzen

A Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree Of
Master of Arts in Clinical Psychology

Minnesota State University, Mankato
Mankato, Minnesota
May 2022

Abstract

The aim of this study was to expand the literature on ageism and microaggressions by defining a novel concept called an age-related microaggression. Participants (n = 51) were presented with explanations of gender and racially charged microaggressions and then were asked whether they had ever had an experience like that but related to their age. Participants described experiences of age-related microaggressions and were further guided through a series of questions via an online survey to determine the topography of the age-related microaggressions, emotional and behavioral reactions to being victimized, perpetrators and settings of the attacks, and perceived intent. A thematic analysis (Braun & Clarke, 2006) was conducted on the responses. The results are grim and closely parallel previous research on racial and gender microaggressions. Our hope is this descriptive study will spark motivation to, and serve as a foundational framework for, conducting future exploration of age-related microaggressions and their effects on society and older adults.

Keywords: age-related microaggression, ageism, microaggression, qualitative method, older adults.

Introduction

Upon the arrival of human rights movements, overt racism, sexism, or any outright discriminatory acts toward minority and marginalized populations have been deemed socially unacceptable. Although much work has been done through the civil and women's rights movements to eradicate racism and sexism, it seems these forms of prejudice and discrimination have been *altered* rather than *eradicated* (Thompson & Neville, 1999, Glick & Fiske, 1996). And, despite society's negative discernment toward racism and sexism, negative attitudes held by individuals pertaining to race and gender remain prevalent (Lee et al., 2019; SteelFisher et al., 2019). It seems the manifestations have turned subtle; this form of minute, covert discrimination has been conceptualized and re-packaged in the form of the microaggression (Pierce, 1970)—since popularized by Sue et al. (2007).

When considering stereotypes, prejudices, and discrimination, racism and sexism are likely the automatic associations. It has been suggested *ageism* is the "ultimate prejudice, the last discrimination, and cruelest rejection... [ageism] is the third great *ism* in our society, following racism and sexism," (Palmore, 2001, p. 572; See Butler, 1995). Generally speaking, *isms* have been condemned in American society. There is a push to expand the literature on ageism because fully understanding ageism as a social construct is the first step toward eliminating it as an issue older adults are forced to face. This call-to-action is exemplified by this statement from the World Health Organization ([WHO], 2021):

> World Health Organization, Office of the High Commissioner for Human Rights, United Nations Department of Economic and Social Affairs, and United Nations Population Fund, calls for urgent action to combat ageism and better measurement and reporting to expose ageism for what it is – an insidious scourge on society (para. 2).

Furthermore, the American Psychological Association ([APA], 2020) released a resolution, calling for a better understanding of ageism to proactively deter it in research and clinical care. Thus, in accord with the resolution, this paper should be used as a resource to facilitate the procurement of competencies surrounding how professionals understand ageism. This knowledge should be translated into practice—because professionals across disciplines can serve as active change agents in the reduction of marginalization of older adults (APA, 2020).

Moreover, Levy and Macdonald (2016) called for the "…casting [of] a wider net in assessing ageism" (p. 13). This paper hopes to provide a theoretical foundation for further studies on understanding the imperative connection between two constructs—ageism and microaggressions.

Ageism

The term *ageism* was coined in 1969, by the United States gerontologist, psychiatrist, and inaugural director of the National Institute of Aging, Robert N. Butler as, "prejudice by one age group toward other age groups... [a] deep seated uneasiness on the part of the young and the middle-aged – a personal revulsion to and distaste for growing old, disease, disability; and fear of powerlessness, uselessness, and death" (Butler, 1969, p. 243) and "a process of systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this with skin color and gender" (Butler, 1975, p. 12).

Ageism is a term used to describe the systematic discrimination of members of the older population, stereotypically seeing the elderly as senile, poor, a financial and familial burden, useless, disabled, incompetent, and invisible (Butler, 1995). Over the half century since the advent of ageism as a construct, various other researchers have expanded on Butler's 1969 definition to better encompass the complexity of ageism as well as its diversity as compared to

other, more well-known, forms of prejudice. Iversen et al. (2009) conducted a concept analysis on 27 of the most popular definitions of ageism and offered the most complete definition to date:

> Ageism is defined as negative or positive stereotypes, prejudice and/or discrimination against (or to the advantage of) elderly people on the basis of their chronological age or on the basis of a perception of them as being 'old' or 'elderly.' Ageism can be implicit or explicit and can be expressed on a micro-, meso- or macro-level. (p. 15).

While examining the exact prevalence of ageism is difficult, numerous studies that have measured ageist attitudes indicate ageist beliefs are extremely common (Wilson et al., 2019). Of even greater concern, the findings of Wilson et al. (2019) indicated, "ageism is experienced almost universally by older people and younger adults commonly acknowledge holding ageist views and/or having done ageist actions" (p. 82).

Locating Ageism in Society at Large

Although ageism can be located in all domains of daily lives of older adults, research suggests it is most prevalent and has devastating effects in the mass media (Thayer & Skufca, 2020), health care (Buttigieg et al., 2018), workplaces (Perron, 2018), and in the criminal justice system (Goodwin & Landy, 2014).

There exists a large body of literature pointing to evidence for the presence of ageism in healthcare systems (Ouchida & Lachs, 2015). This evidence includes the fact that few providers specialize in aging (Holveck & Wick, 2018), providers communicate less effectively with older adults, older adults are often over and undertreated (Feliu et al., 2021), and they are often not included in medical clinical trials (Herrera et al., 2010).

In the workplace, it is suggested three out of five older workers have experienced or witnessed age discrimination in their workplace (Perron, 2018). Workplace-related ageism has

many negative consequences such as, older adults are less often selected for job interviews and are less often the chosen candidate (Abrams et al., 2016). Furthermore, perceived age discrimination may be related to low levels of engagement at the workplace (James et al., 2013).

The media is highly laced with ageism that perpetrates stereotypical depictions of age-related health conditions (Fraser et al., 2016) and most of the ageism perpetrated in the media is negative in fashion (Marier & Revelli, 2017). For example, the images and representations in media reflect and reinforce the societal/cultural belief that we should try to maintain a youthful physical appearance (Richards et al., 2012). The implicit message of these portrayals is that old age is something to be feared, avoided, or concealed (Smirnova, 2012). Ageism is so commonplace, even Google's *autocomplete* function has recently been found to perpetrate ageist predictions (Roy & Ayalon, 2020).

Ramifications of COVID-19

It has been suggested the COVID-19 pandemic has exacerbated ageism-related problems (Meisner, 2020). Across social media, during the pandemic, there were examples of ageist catchphrases for the virus such as the "Boomer Remover," the "Boomer Doomer," the "Elder Repeller," and the "Senior Deleter." These phrases, coupled with the WHO's (2020) blanket statement that people who are, "60+ and those with underlying health conditions" are to be especially careful in their efforts to not catch the virus, convey the message that all older adults are same, and they are fragile. Meisner (2020) said it best, "These campaign messages depict an oversimplification of both "age" and the risks of COVID-19 associated with "age", which represents and reinforces ageism (para. 4)."

Furthermore, adults 60+ who contract COVID-19 present worse symptoms with significantly higher mortality than younger individuals (Centers for Disease Control and

Prevention, 2021; Chan et al., 2020; Zhou et al., 2020), which is framed as less important because older adults have, "lived full lives," they are "close to death anyways," and "we need to thin the herd."

Other Timely Examples

Still, ageism goes largely unrecognized in everyday life, the media, research, and in as many as 88% of over 300 educational textbooks on geriatrics (Robinson et al., 2012). In 2020, we faced a presidential election consisting of the two oldest candidates in history, Donald Trump (74 years old) and Joseph Biden (77 years old). The presidential race was deeply devoted to focusing on chronological age as a detrimental factor in the race. Donald Trump referred to Joseph Biden as *sleepy Joe* and attempted to refer to Joseph Biden's stuttering (a speech disorder he has dealt with for most of his life), as a sign of *dementia*. For example, BBC News (2020) said, "The fact that the president [Donald Trump] has been seriously ill has reminded the public they have the two oldest presidential candidates in history [Donald Trump and Joseph Biden]." This statement implies that older people are sickly, more prone to sickness, and/or weak. The article also insinuated Americans should take a closer look at the vice-presidential candidate because those candidates have an increased chance at becoming president during their tenure.

Older adults are often exposed to sayings like, "old-timer's disease" and "senior moments." Younger people may begin believing that older adults are incapable of making decisions on their own, they require assistance with simple actions/tasks, they are dependent, they need help with finances, simply because of chronological or perceived age. All of these relate to the assumption older individuals are *less capable* and/or *cognitively/physically impaired.*

Evidence also suggests younger people talk to older adults differently, by overaccommodating their speech, and speaking humorously, or slowly (Chen et al., 2017). Elderspeak is defined as the adjustment of speech patterns, such as speaking more slowly and/or more loudly, shortening sentence length, or using limited/less complex vocabulary, that are sometimes made by younger people when communicating with older adults (VandenBos, 2015). These simplified speech patterns are implicitly held and express the assumption that older individuals are cognitively impaired or incapable of understanding normal speech.

Other examples of ageism in the daily lives of older adults include family members calling grandma/pa, “cute,” “silly,” “grumpy,” “wise,” family members avoiding eye contact, or not including older family members during conversations or activities.

Consequences of Ageism

The number of negative health outcomes related to experiencing ageism and/or being ageist is staggering and well documented in the literature. It has been suggested ageism can lead to negative behavioral, psychological, and cognitive consequences in older individuals (Levy, 2000; Levy, 2003; Levy et al., 2011; Chang et al., 2020). Adverse health outcomes due to ageism have been reported in 95.5% of the 1,159 ageism-to-health associations examined in the literature (Chang et al., 2020). Some of the adverse health outcomes examined in this systematic review included: denial of access to health services and treatments, lack of work opportunities, mental and physical illness, exclusion from health research, poor quality-of-life and well-being, risky health behaviors, poor social relationships, reduced longevity, cognitive impairment, and the subjective devaluation of their lives.

It has been suggested experiencing ageism is strongly related to negative outcomes on variables such as depressive and anxious symptoms, and general stress (Lyons et al., 2017).

Ageism may also be a determinant of short and long-term physiological health consequences such as increased blood pressure, heart rate, and skin conductance (Levy et al., 2000; Levy et al., 2008). Furthermore, frequent rises in blood pressure may lead to hypertension, heart disease, stroke, obesity, diabetes, and kidney disease (Go et al., 2013; Julius et al., 2000; Lago et al., 2007)—all of which could be caused by exposure to ageism. It has even been suggested younger individuals who hold more negative aging stereotypes have higher rates of cardiovascular events later in their lives (Levy et al., 2009). Moreover, individuals with more negative age stereotypes earlier in life had increases counts of Alzheimer's disease biomarkers upon brain autopsies (Levy et al., 2016). Cognitively, having a younger subjective age has been linked to better episodic memory and executive function after a 10-year period (Stephan et al., 2014).

We have described many of the manifestations of ageism as well as ageism's detrimental consequences. But, to deeply understand ageism, we must fully understand the various levels on which ageism presents. As Iversen et al. (2009) described in their thorough definition of ageism, special attention should be paid to micro- meso- and maro-levels. To date, no such undertaking has occurred in the realm of micro-level forms of ageism. A starting point to this consideration is to examine and make the connection between ageism and other common forms of mico-level stereotypes, prejudice, and discrimination. As such, microaggression research creates this bridge.

The Microaggression

Of the examples of ageism provided above, many suggest ageism is prevalent in many meso- and macro- levels. When ageism is exhibited as part of daily interactions between individual younger and older adults, the essence of the interaction parallels a concept called microaggressions. Microaggressions have been studied since the 1970's, when Chester Pierce (1970) coined the new term to describe covert and subtle manifestations of racism that occur in

everyday life. Microaggressions are described as being "put-downs, done in an automatic, preconscious or unconscious fashion" (Pierce, 1974, p. 515).

In the early 2000's, microaggression-related research exploded, spearheaded by the work of Derald Wing Sue. Like Pierce's description of microaggressions over 30 years earlier, Sue et al. (2007) describes microaggressions as, "everyday verbal, non-verbal, and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostility, derogatory, or negative messages to target a person based solely upon their marginalized group membership" (Sue et al., 2007; Sue, 2010, p. 5, Sue & Spanierman, 2020, p. 8). Sue and colleagues (2007) explained that although microaggressions are often brief, covert and outside of consciousness, they always communicate some level of hostility to marginalized groups. Sue et al. (2007) also made the invaluable contribution of describing three forms of microaggressions: microassaults, microinsults, and microinvalidations. In 2010, D. W. Sue published an all-encompassing book on microaggressions, expanding on the 2007 article, and provided an all-encompassing, comprehensive description of microaggressions and their forms. By February 2017, the *Merriam-Webster Dictionary* added the word *microaggression*—thereby shifting the term from academic jargon to an everyday word. Then, in 2020, Sue and Spanierman published the second edition of the 2010 text, which included updated statistics, revisions, and crucial addendums.

Interestingly, Sue (2010, p. 113) discussed elderspeak as being one form of an age-related microaggression and noted another example of an age-related microaggression might include a salesclerk who, "assumes the older customer does not know how to work a computer." Unfortunately, unlike the first edition, Sue and Spanierman (2020) does not discuss age-related microaggressions in any way—discussions on elderspeak are gone, and age-related

microaggressions are no longer mentioned anywhere. Although concerning, it is possible that Sue and Spanierman (2020) neglected age-related microaggression due to the lack of research on the subject since the 2010 edition.

The foundational work to solidify the three common taxonomies of microaggressions (i.e., microassaults, microinsults, and microinvalidations; Sue et al., 2007) has provided a springboard for research on varying topics surrounding microaggressions.

Microassaults

The microassault is characterized by overt and deliberate, subtle, or explicit, biased attitudes, behaviors, and beliefs that target some marginalized group (Sue & Spanierman, 2020). They are perpetrated as attacks to consciously harm or hurt the victim/s. Race and sex-charged verbal microassaults include referring to women as “cunts” or “bitches,” members of the LGBTQIA+ community “fags” or “homos,” African Americans as “n*****s,” Chinese Americans as "chinks,” and Japanese Americans as “Japs” (Sue, 2010; Sue & Spanierman, 2020). Microassaults are intentional and convey the message that members of these marginalized communities are lesser human beings.

Telling an individual who is transgender they cannot use a multiple-stalled restroom, or rejecting their entrance into a restroom, would be a microassault. Microassaults are also characterized as avoidant behavior and the explicit differential treatment of people based on their group membership, much like traditional forms of discrimination (Sue & Spanierman, 2020). Although these are explicit and conscious in fashion, microassaults are, generally, expressed in more private situations, allowing for some degree of secrecy of the offender (Sue et al., 2007).

Microinsults

Microinsults are communications that convey rudeness, stereotypes, and/or insensitivity on interpersonal or environmental levels and they are often subtle unconscious messages communicated to a marginalized group (Sue & Spanierman, 2020). They are communications that demean someone's identity (Sue et al., 2007; Sue & Spanierman, 2020). An example of a racial microinsult provided by Sue et al. (2007) includes asking a person of color how they got their job, conveying they are not qualified, or they must have obtained the position because of some affirmative action or quota program. Another microinsult would include using the phrase, "that's so gay," when referring to something you do not agree with or something that is odd, strange, undesired, or uncommon.

Nonverbally, microinsults, occur when a white supervisor does not make eye contact, or seems uninterested when an employee of color is talking to them, conveying people of color do not have important contributions (Sue et al., 2007). Simply put, microinsults are indirect acts that convey some hidden message that is insulting to the victim.

Microinvalidations

The third form of a microaggression is microinvalidations. These can be characterized as interpersonal communications, or other cues in the environment, that work to negate, nullify, and/or exclude the experiential realities, thoughts, and/or feelings of marginalized groups of individuals (Sue et al., 2007; Sue & Spanierman, 2020). It is suggested microinvalidations may be the most destructive of the three manifestations of microaggressions due to the direct and insidious denial of an individuals' identity (Sue & Spanierman, 2020).

A common example of a microinvalidation is when a person of color expresses that they feel they were targeted by someone because of their race and they are, in turn, told they are

"being overly sensitive" (Sue et al., 2007). Another example may be assuming *all* gay individuals had a difficult experience "coming out." Essentially, the feelings of the targets are ignored, not believed, invalidated, or unimportant to the perpetrator. According to Sue and Spanierman (2020), one of the most common microinvalidations is when an individual states they are *color blind* or they "do not see color." While the intent of the perpetrator is often to appear as a non-racist, the victim may interpret this message as a denial of their individual racial experiences.

Negative Impact of Microaggressions

In consideration of microaggressions being classified as a form of stress, like the negative health outcomes associated with experiencing ageism, it can be surmised that similar adverse health outcomes would be identified in individuals who have experienced prolonged periods of age-related microaggressions. Thus, models of stress, such as Selye's (1956; 1982) general adaptation syndrome model of stress, can be applied when considering the negative impact of stress on individuals who experience microaggressions.

Psychological and Physical Health Outcomes

It is apparent that experiencing microaggressions may lead to negative impacts on physical health (Nadal et al., 2017). Specifically, there is evidence that experiencing racial microaggressions is associated with poorer sleep quality and shorter sleep duration (Ong et al., 2017). The exposure to chronic stressors, such as microaggressions, may lead to an increased susceptibility of contracting disease, and could increase the speed of progression (Miller et al., 2007). Along these lines, microaggressions as a stressor may negatively affect immune functioning (Dhabhar, 2014). Moreover, Sue & Spanierman (2020) report on the findings that the

physical health outcomes of experiencing microaggressions may include direct physiological reactions like increases in blood pressure and heart rate.

The negative impacts of microaggressions and stress have also been linked to poor cognitive, emotional, and behavioral health. Ong et al. (2013) demonstrated that individuals who experience more microaggressions also report poorer psychological adjustment; somatic symptoms rise because of anticipating being a victim of a microaggression; and have decreased affect and overall well-being. Sue et al. (2007) reported on a multitude of responses that involve "feelings of belittlement, anger, rage, frustration, alienation, and of constantly being invalidated" (p. 77). Furthermore, experiencing microaggressions has been linked to increased anxiety, increased perceived stress, a decrease in self-esteem and a decrease in identity pride (Woodford et al., 2014). Furthermore, Sue and Spanierman (2020) reported other psychological health effects of microaggressive stressors include: lowered life satisfaction, increased cultural mistrust, feelings of alienation and loss, anxiety, helplessness, and rage.

Emotionally, microaggressions have been linked to depressive symptoms such as sadness and hopelessness in Nadal et al., (2011), where the researchers refer to experiencing microaggressions as a "death by a thousand cuts." Lilly et al. (2018) reported that depressive symptoms significantly increased after a sample 325 racial minority graduate students were exposed to microaggressions. In response to microaggressions, Hall and Fields (2015) reported Black adults reported feeling fearful. Sue and Spanierman (2020) discuss at length other ways in which microaggressions are experienced. Emotionally, they suggest, individuals experience anger, fear, rage, depression, and anxiety. And, after being a victim of microaggressions, people become hypervigilant and skeptical, leading them to disengage and become avoidant, tired, and hopeless (Sue & Spanierman, 2020).

It may also be the case that these negative side-effects of microaggressions may permeate throughout society, leading to a ubiquitously negative existence for older adults. One of the most moving statements Pierce (1974) provides can be paraphrased as follows; the accumulation of continual microaggressions creates and contributes to the pervasive effect on the "stability and peace of this world" (p. 515).

Microaggressions and Aging

Microaggressions directed toward older adults have only recently been acknowledged in relation to elderspeak (Sue, 2010, p. 113). As previously mentioned, experts agree the time is right for an expansion of microaggression research, and we feel this expansion should include gerontology. Microaggressions, as a construct, overlaps with existing concepts. For example, as we have outlined, research over the past 50 years has firmly established that ageism is quite prevalent and has widespread negative effects on older adults. However, as with other forms of discrimination, open and overt manifestations of ageism are less socially acceptable, so these acts have likely become more subtle as time progresses.

Ageism is an umbrella term which can be further broken down into other subcategories—like racism and sexism. Unfortunately, unlike racism and sexism, ageism has received much less attention; barring the fact every individual will gain membership to this marginalized population if they live long enough. Moreover, those identifying as members of racial, gender, or sexual minority groups will eventually have to endure the struggles of the intersection between multiple marginalized identities. Thus, much like how racism has been broken down into sub-constructs by D. W. Sue and colleagues for many years, ageism can be done in much the same way. This will ultimately lead to a better understanding of how ageism manifests, while simultaneously expanding upon the microaggression literature.

Elderspeak and microaggressions also overlap (Sue, 2010). Elderspeak and other forms of patronizing speech serve as microaggressions because the speaker often unintentionally conveys, on the micro level, the older adult is less competent and incapable. Although elderspeak is a relevant example of one kind of microaggression (a microinsult), it is just that, one example.

Overall, it is clear microaggressions represent a unique phenomenon worthy of study because they represent a timely consideration of discrimination that, while being more subtle and frequent in nature, also have the potential to be very destructive to the victims. In addition, it has been suggested microaggressions provide a particularly useful construct for advancing the literature and research on ageism because of its specific focus on discrimination taking place on an interpersonal, in an often unconscious and non-verbal level (Gordon, 2020).

Purposes of the Current Study

Most of the research on microaggressions has been conducted with racial and ethnic minority populations in mind. Microaggressions targeting gender and sexuality minorities have been explored following the same general taxonomies outlined in Sue et al., 2007. Recently, there has been a growing body of literature on microaggressions targeting other marginalized populations such as refugees (El-Bialy & Mulay, 2020), individuals with physical and psychological disabilities (Conover et al, 2021; Kattari, 2020), sexual/gender minorities (Swann et al., 2020), individuals who stutter (Coalson et al., 2022); and people who have highly stigmatized diseases, like HIV/AIDS (Eaton et al., 2020).

One marginalized group that has gone unrecognized in the microaggression literature is the older adult population. Therefore, the time is ripe to explore microaggression as a facet of ageism; particularly given the percentage of the world's population over 60 years will double, from 12% to 22%; an expected increase from 900 million to 2 billion people (WHO, 2018).

Because no research has been conducted on specifically defining age-related microaggressions, this area of inquiry is wide open for empirical investigation.

Research must start with addressing the fundamental question of, "What do microaggressions directed at older adults typically look like?" The current study has been designed to begin to answer this fundamental question by creating a compendium of commonly experienced microaggressions. Another goal is to categorize these examples (i.e., microassaults, microinsults, and microinvalidations) and investigate the general themes underlying these common microaggressions.

Method

Design

A qualitative descriptive research design was utilized, which allowed the researcher to explore, identify, and understand participants' subjective experiences with age-related microaggressions (Sandelowski, 2010; Kim et al., 2017). With the dearth of literature on age-related microaggressions, it was determined that a qualitative research design was the most appropriate approach to generate a foundational base of knowledge to uncover the topography and taxonomies of microaggressions (Sue & Spanierman, 2020).

Participants

Participants (n = 51) were required to be 65 years of age or older. Participant recruitment and compensation was completed using a nationwide Qualtrics research panel. A majority of the sample was 65-84 years old (n = 48), with a small percentage of participants being 85+ years old (n = 3). Although participants were not limited to reporting binary gender categorizations, respondents predominantly identified being female (n = 35) with the remaining (n = 16) reporting being male. Regarding ethnicity, the sample was largely homogeneous with 86.3% of

participants identifying as being white (*n* = 44). Other reported ethnicities included: Asian (*n* = 2), black/African American (*n* = 2), Hispanic/Latino (*n* = 1), and mixed (*n* = 2). Finally, regarding educational attainment, the distribution was relatively even with 23.5% being high school graduates (*n* = 12), 23.5% with some college (*n* = 12), 10% with a 2-year degree (*n* = 5), 21.5% with 4-year degree (*n* = 11), and 21.5% beyond a 4-year degree (*n* = 11).

Procedure

Customary sampling and data collection approaches in qualitative research include purposive samples, focus groups, and individual interviews (Sue & Spanierman, 2020). Social distancing restrictions due to the COVID-19 pandemic limited the ability to gather data in person. Moreover, to preserve the health of the researchers and participants, all data was collected via an online Qualtrics survey.

The survey began with an informed consent form followed by the microaggression survey. The survey began with definitions and examples of microaggressions related to race and gender (Nadal, 2019; Sue et al., 2007). Examples of racial and gender microaggressions were provided as education, in an attempt not to lead participants to specific age-related examples they may have experienced. Following the brief education, participants were asked if they have ever experienced anything like those examples but related to their age. If they positively responded, they were directed, "In as much detail as possible, describe what was said or done by the individual/s that you considered an age-related microaggression."

Follow-up questions included probes to elicit further details about the experience:

1. Roughly how long ago did you experience the *age-related* microaggression?
2. What is/was the relationship between you and the person/s who used the age-related microaggression?

3. Where did the age-related microaggression occur?
4. How did you feel when you experienced the age-related microaggression?
5. Rate how strong this reaction was.
6. Do you think the individual/s did this on purpose or was it a mistake/accident?
7. What did you do in response to the age-related microaggression?
8. How often do you estimate you experience age-related microaggressions like the one you just described?
9. Please describe an example of an age-related microaggression you have heard about or witnessed that was not directed towards you.

See Appendix A for the informed consent used and Appendix B for the survey implemented.

To obtain a broader sample of microaggressions, participants were given the opportunity to provide three separate examples of age-related microaggressions they were victims of and three examples of age-related microaggressions they witnessed that they were not victims of. The average time to complete the survey was (M = 23.70 minutes, SD = 13.01 minutes).

Analysis

A combination of inductive and deductive thematic analysis (TA) (Braun & Clarke, 2006) was carried out following the collection of data to identify meaningful patterns within the responses. The process of coding was iterative and aligned with Braun and Clarke's (2006) six-phase process of conducting TA. The steps were as follows: (a) familiarization with the data that was collected through the Qualtrics survey, (b) generating initial codes present in responses, (c) searching for themes that cut across the responses, (d) reviewing themes to include a list of main

and subthemes, (e) defining and naming themes both inductively and deductively, and (f) producing the report.

A three-member coding team was formed, which included the primary student investigator and another researcher well-versed in microaggressions, as well as a fellow researcher familiar with aging research, but unfamiliar with age-related microaggressions. The third member served the crucial role to assess and control for observer-drift.

A data-driven, inductive, TA was utilized for questions related to (a) the relationship of the perpetrator, (b) where the microaggression took place, and (c) emotional reactions of the participants. Thus, responses were coded without trying to fit the data into a preexisting coding paradigm.

Conversely, a theory-driven deductive TA was conducted for (a) microaggression examples and (b) behavioral responses to experiencing a microaggression. Examples of microaggressions were deductively coded based on Sue et al.'s (2007) taxonomies of racial-microaggressions (i.e., microassaults, microinsults, and microinvalidations). This top-down data analysis approach was conducted to determine if the three commonly used classifications of microaggressions generalize to age-related microaggressions. Finally, behavioral reactions to microaggressions were coded deductively based on Nadal et al.'s (2014) study and included four themes, (a) direct confrontation, (b) indirect confrontation, (c) passive coping, and (d) did nothing.

The remaining survey questions were formatted as multiple-choice questions, so descriptive statistics and frequency distributions were used to summarize these data across participants.

Interobserver agreement

Methodological rigor of the qualitative analysis was ensured primarily using multiple independent reviewers of all participant responses. Disagreements that arose were discussed among the research team to determine a consensus. If a consensus could not be made, a third independent reviewer broke the tie.

The three members of the coding team were all provided the same materials to train them in the operational definitions and examples of the *a priori* taxonomies of microaggressions (i.e., microassaults, microinsults, and microinvalidations; Sue et al., 2007, Sue & Spanierman, 2020) and behavioral responses to microaggressions (i.e., direct confrontation, indirect confrontation, and passive coping; Nadal et al., 2014).

To ensure adequate operational definitions were created for themes, and to confirm the training was clear, a pilot interobserver agreement (IOA) check was conducted on a random sample of 10 microaggression examples given by participants with a resulting categorization exact agreement of 90% between the first and second authors. Because the pilot IOA demonstrated high reliability in categorizing examples into the three forms of microaggressions, the third member of the coding team was trained and IOA on 30% of the sample responses was conducted. Interobserver agreement was 91% between the first and second authors, 89% between the first author and third independent reviewer, and 84% between the second author and third independent reviewer. These high IOA statistics strengthen the study because they demonstrate reliable categorization of microaggression examples into the three common taxonomies of microaggressions. Furthermore, the addition of the third independent reviewer as a probe ensured the coding of microaggression examples remained reliable.

To further strengthen confidence in the quality of the data, the first and second authors independently coded *all* responses to ensure an unbiased categorization of responses into microaggression categories. When all responses were coded by the first and second authors, discrepancies were noted. Then, any conflicts in coding were discussed and if a decision could not be determined, the pair consulted the third member of the coding team to break the tie. Across the n = 153 examples of age-related microaggressions provided, and n = 153 additional examples (i.e., examples of times when participants witnessed an age-related microaggression), the total exact agreement IOA was 93.46%.

Interobserver agreement between first and second authors was also calculated for four additional survey questions. Interobserver agreement for these four questions ranged from 97-99% (see Table 1).

Table 1

Interobserver Agreement

Question	Exact Agreement (0-100%)
1. What is/was the relationship between you and the person/s who used the age-related *microaggression*?	97%
2. Where did the age-related microaggression occur?	99%
3. How did you feel when you experienced the age-related microaggression?	98%
4. What did you do in response to the age-related microaggression?	99%

Note. Exact agreement was calculated between the first and second authors.

Findings

Age-Related Microaggressions

Overall, there were *n* = 306 examples of age-related microaggressions reported by participants that were coded (i.e., *n* = 153 where the participant was the victim; *n* = 153 where the participant was not the victim). Across both categories, *n* = 74 (24.2%) were excluded from the analysis because the examples given were either too vague to accurately code, the example given was not a microaggression, or the microaggression example was not related to age (e.g., race or gender motivated). The remaining *n* = 232 examples of age-related microaggressions were used as the final sample. See Figure 1 for a frequency distribution of microaggression categories.

Microinsults

Of the *n* = 232 reported examples of age-related microaggressions, *n* = 126 were examples of age-related microinsults. Within microinsults, five general subthemes were identified. First, it was common for older adults to report being offered assistance by younger individuals, one respondent said, “I have chronic lung issues and I'm on oxygen and people often assume I'm unable to do things like grocery shopping and I'm often talked down to...like my breathing difficulties caused my IQ to drop!” Or, individuals assume older adult require assistance, “I have been asked, "Do you still live by yourself" and "Who checks on you, does your shopping, etc.”

Participants also reported being the target of elderspeak, “[I was] being referred to as “young lady” by someone obviously decades younger than me.” Another explained, “Some kids talk loud because they thought an older gentleman couldn't hear them,” and, “People constantly

talking loud like I can't hear them, patting me on back and saying aren't you precious, like I am a puppy."

Another common subtheme within microinsult experiences included being ignored, "When I was having lunch with my daughter, the waiter seemed to think she was speaking for me and addressed all questions to her [daughter]." Being offered a senior discount was also commonly reported and included as a microinsult, "Because I look older than I really am, I frequently get told that, "I'm Giving you the Senior Discount" when I purchase food at fast food places."

Finally, assumptions regarding the ability (i.e., intellectual and physical) of older adults were also commonly reported examples, "My own family members will say things like, "Well, you wouldn't understand" when speaking about technical matters," "[I was] told that I was too old to understand how today's kids are taught in school," and "Let me help you, you are too old to lift that." .See Appendix C and D for a summary and breakdown of themes identified with the categories of microinsults, microassaults, and microinvalidations.

Microassaults

Of the n = 232 examples of age-related microaggressions reported, n = 87 were examples of age-related microassaults. Older adults reported physical forms of microassaults such as being pushed and rushed, "I wasn't fast enough going through a door to suit Ms. Executive, and she grabbed my arm and shoved me in, then pushed me aside to pass me." Another reported, "[I] was not fast enough to get out of the way. This person rammed the shopping cart into me." Name-calling and verbal assaults were also common:

> I was riding my bicycle in the street, following the traffic laws. Guy behind me was in a hurry, but I had no safe place to pull over on that narrow street. When I did, he slowed

down beside me and called me a stupid old hag and yelled that, I should get off the street, go home and die, that I was too old to pedal fast enough.

One older adult reported, “I commented on her [a student] dissertation, she casually turned to me and said be quiet old lady.” Another explained, “While teaching a speech class, I was told by a student "Okay, Boomer!" Obviously, he felt I was an ancient person trying to explain something I didn't know what I was talking about.”

Moreover, other older adults commented on discrimination that occurs in the workplace, “I applied for a job opening and was told they were looking for a younger person, even though I was well qualified,” and “…pharmacist friends have been terminated… because of the age factor.” (See Appendix C and D for further definitions/descriptions and breakdowns).

Microinvalidations

Only n = 16 of all microaggression reported were examples of age-related microinvalidations. One participant reported medical concerns are often minimized, “Friends tell me their doctors say it’s not bad for you to have this [medical concern] because you are older, and you can expect this to happen.” The emotional invalidation of older adults’ thoughts, experiences, or feelings emerged in this example provided, “A speaker made the statement, ‘Everyone raise their hand if you have done this, Senior Citizens do not raise your hand, you don't count.’”

The most reported age-related microinvalidation related to age-related “compliments.” One older adult commented, “I don’t like when someone says u look good for your age then ask, how old r you?” Another participant explained, “People tell me I'm good at pickleball for my age. Although I'm 75, I do not appreciate the intended compliment.”

Identified Subthemes

To reiterate, after becoming highly acquainted with the obtained data, it became clear that within each of the three previously identified forms of microaggressions, there were apparent subthemes. Within the microinsults, there were four inductively identified subcategories of responses; (1) elderspeak; (2) assumptions regarding ability; (3) senior discounts; and (4) offering assistance. Microassaults were further broken down into three subcategories; (1) name-calling; (2) rushing older adults; and (3) workplace discrimination. Finally, there were three subcategories of microinvalidations recognized; (1) minimization of problems; (2) emotional nullification; and (3) age-related "compliments" (See Appendix C and D for further definitions/descriptions and breakdowns).

Recency of Microaggressions

After providing examples of age-related microaggressions, participants rated when the event took place on a Likert scale ranging from *within the last week* to *more than one year ago*. Most commonly, the experiences took place on opposite ends of the spectrum—either within the last week (n = 25), or more than one year ago (n = 25). See Figure 2 for a detailed breakdown of data related to this question.

Frequency of Occurrence of this Type of Microaggression

Participants were also asked how often they have been a victim of an age-related microaggression like the one they had just described. The self-report scale ranged from *daily* to *less than once per year*. The results indicated that the most common answer was *1-2 times per month* (n = 34). For a breakdown of responses, see Figure 3.

Relationship to Perpetrator

A total of $n = 119$ responses were analyzed regarding the question about perpetrators of microaggressions. There were $n = 35$ responses coded as *not applicable* because they were either too vague or corresponded to an example coded as *not applicable.* An inductive analysis suggests there are at least six common perpetrators: service providers, strangers, family members, friends, coworkers/employers, healthcare workers. There were *other* specific examples provided such as neighbor, church members, students, customers, educators, and one person said, "everyone." Responses categorized as service providers were the most common provided offenders of age-related microaggressions. Examples included cashiers, waiters, and salespersons.

The second most common categorization was strangers. Responses grouped into this category included, "Anyone who does not know me well," "stranger," "no relationship at all," and "people I have never met." Combined, service providers and strangers comprised 53% of offenders ($n = 63$). A breakdown of the frequency of perpetrators can be seen in Figure 4.

Setting of Age-Related Microaggression Experiences

A total of $n = 124$ responses were analyzed concerning the question about the setting in which microaggressions occurred. There were $n = 29$ responses coded as *not applicable* because they were either too vague or corresponded to an example coded as *not applicable.* An inductive analysis suggests there are at least six common settings where age-related microaggressions may take place: stores, restaurants, at home, work, in the community, and at a hospital/clinic. *Other* specific responses included: "while driving," "on the phone," "online," "at the other person's house," "anywhere and everywhere," and "church." Responses related to stores (e.g., "At the

corner store," "grocery store," "retail store," "liquor store," "pharmacy," "shopping mall," and "driver's license office") more than doubled that of other responses (See Figure 5).

Emotional Reactions to Experienced Age-Related Microaggressions

The analysis of emotional reactions became complex because multiple older adults reported more than one emotional reaction in their response. Of the potential $n = 153$ responses, $n = 35$ were removed because they were either too vague or corresponded to an example coded as *not applicable.* This left the team $n = 118$ responses to analyze. Of this sample, $n = 29$ responses had multiple emotions, with a range of two to five emotional reactions. Therefore, a total of $n = 146$ emotional responses were coded.

An inductive analysis suggests there are at least 10 common emotional reactions older adults experience because of being the victim of age-related microaggressions: anger, insult, unbothered, sad, embarrassed, isolated/rejected, surprised, resignation, other negative emotion, and anxious. *Other Negative Emotion* specific examples included: "I didn't like it," "I didn't like the action at all," and "I felt bad."

By far the most common emotional reaction to being the victim of an age-related microaggression was found to be *anger*, accounting for 40% of the responses analyzed ($n = 59$). Examples of responses categorized as anger included: "It made me angry," "pissed off," "I wanted to hit them in the face," "I walked out because it pissed me off and I said to myself they won't get my money," "frustrated," "annoyed," and "angry and ready to fight."

There were several responses that expressed individuals felt *insulted* ($n = 24$). There were also $n = 13$ responses that indicated the older adult was *unbothered* by experiencing the microaggression: "I could not have cared less," "It didn't really bother me," and "I refuse to let it get to me and I am very good at dealing with people." There was an interesting theme that

surfaced, which we called *resignation*, examples that were categorized as resignation included, "I've learned to live with it, and I just accept it," I'm used to it, so I don't let it bother me," and "I am getting used to it figure it goes with getting OLD."

See Figure 6 for a complete listing of all emotional reactions as well as how frequently each was reported.

Intensity of Emotional Responses

After providing examples of age-related microaggression, participants were asked how intense their emotional reaction was to the microaggression using a Likert scale ranging from *not strong at all* to *extremely strong*. The most common intensity reported was *moderately strong* (*n* = 64); followed by *extremely strong* (*n* = 41), and *not strong at all* (*n* = 20) (See Figure 7).

Behavioral Responses to Experienced Age-Related Microaggressions

A total of *n* = 123 responses were analyzed regarding the question about behavioral responses to being a victim of age-related microaggressions. There were *n* = 30 responses coded as *not applicable* because they were either too vague or corresponded to an example coded as *not applicable.* A deductive analysis based on Nadal et al.'s (2014) common behavioral reactions to microaggressions suggests three behavioral responses to experiencing a microaggression: direct confrontation, indirect confrontation, and passive coping. Our analysis suggested one additional behavioral response not captured in Nadal et al.'s (2014) study—*doing nothing* in response to experiencing an age-related microaggression. The frequency of each behavioral response is presented Figure 8.

Passive coping was the most common behavioral response (*n* = 46). Passive coping was defined as any reaction that included an avoidance response, diffusion, deflection, acting in a way to make others happy, removing themselves from the situation, or intentionally avoiding

direct or indirect confrontation of the perpetrator (Nadal et al., 2014). One older adult commented, “I just gave them a state and said, ‘thank you.’ I have never wanted to get into any confrontation-that is not me.” Others said, “I turned my back and allowed things to defuse,” “I acted like I didn't notice it,” and “It has happened so many times I am learning to ignore it.” Other common passive coping responses included participants mentioning, “I just smiled,” “I walked away and ignored them,” and “Laughed it off.”

Direct confrontation was also a common behavioral response (n = 38). Direct confrontation was defined as any reaction where the older adult confronted the perpetrator of the microaggression (Nadal et al., 2014). Moreover, Nadal et al. (2014) describes that direct confrontation commonly includes verbal assertion, sometimes educating the perpetrator, and often incorporates calling-out the microaggression for what it is. One older adult commented, “I told her I had a sprained ankle, not dementia, and if she needed to know something about me, she needed to ask me, not my friend.” Other responses that older adults provided that embody direct confrontation included, “I explained to her she was wrong in so many ways,” “I replied that age is just a number,” “I told them to shut up,” and:

> I responded, I have gray hair and that does not mean I don't know how to use a computer, I have been using a computer since 1974 and part of my job is to teach people how to use a computer, I was using a computer before you and your parents were born. Stop assuming peoples’ age and cognitive abilities based on gray hair.

Beyond passive coping and directly confronting offenders, there was a large proportion of older adults who reported *doing nothing* after being victimized (n = 29): “I did nothing, I was afraid and vulnerable. If you complain there is always retribution.” Others responded, “Very

little, I acted as if it didn't bother me," "I did not like it, but I swallowed and lumped it," and "I just let it slide and laughed it off. After all, that is what fathers do ...right..."

Finally, there was a small subset of participants who reported responses categorized as indirect confrontation (n = 10). Indirect confrontation was operationally defined as being responses that included contacting authorities or superiors/supervisors, allowing someone else to handle the situation, or being passive aggressive (Nadal et al., 2014). One older adult had this response after being a victim of an age-related microaggression, "I demanded to speak to the store manager immediately." Others reported, "We called for a manager to have him handle it," "Complained via email," and:

> I regretted not saying more at the time it happened, but I received a survey about my visit, and I explained what happened (in detail) to the extent of using the person's name. I was highly disappointed that there was absolutely no follow up on this survey.

Perceived Intent

Participants were asked to rate whether they felt the age-related microaggression directed toward them felt like a mistake or intentional. Results indicated the age-related microaggressions were perceived as being intentional 82% of the time (n = 95; See Figure 9).

Discussion

The results of this study provide unambiguous evidence of the existence of micro-level forms of ageism occurring in the everyday lives of older adults—age-related microaggressions. We purposed to identify if older adults can relate to, and remember, a time they were a victim of a subtle attack or received the message from a younger person conveying a negative message due to the perception of them being an older adult. Participants were introduced to racial and gender-charged microaggressions and were subsequently asked if they have ever had experiences like

the ones described but related to their age. Thus, we attempted to capture older adults' recollections of specifically being a victim of an age-related microaggression. The results were clear; older adults commonly recalled being the victims of age-related microaggressions.

We also determined how age-related microaggressions manifest and what the topography of age-related microaggressions look like. Using a combination of inductive and deductive TA techniques (Braun & Clarke, 2006), we were able to utilize existing frameworks of microaggressions (Sue et al., 2007) and behavioral responses to microaggressions (Nadal et al., 2014), and we reliably determined common trends and themes of various other questions using a bottom-up approach.

Finally, we were able to respond to calls for the expansion of the understanding of ageism using qualitative and observational data (Levy & MacDonald, 2016). We also created a framework for future research on age-related microaggressions, which will assist in combating and deterring ageism (APA, 2020).

Our methods captured over 300 potential age-related microaggressions. However, nearly one quarter of the responses were not age-related or were unclear. This result is somewhat expected, as this was likely the first occasion participants were exposed to this novel concept. Moreover, in the United States, ageism is one of the most socially condoned and institutionalized forms of prejudice (Palmore, 1999; Angus & Reeve, 2006), which may lend to individuals underreporting the true frequency of the phenomenon.

Of the true examples of age-related microaggressions, over half of the examples provided were exemplars of microinsults. It is our hypothesis this might be the case for at least three reasons; (1) microassaults clearly occur, but because they are often socially unacceptable due to their harmful intent, they occur at a lower frequency; (2) the general concept of

microinvalidations is sometimes difficult to explain, and our lack of comprehension checks in the survey made it unable for us to ensure participants understood the general nature of this form of microaggressions. Therefore, due to uncertainty, participants opted to report *clearer* examples of age-related microaggressions (i.e., microassaults and microinsults). (3) The true nature of age-related microaggressions is that microinsults occur at a higher rate than other forms of age-related microaggressions.

Most commonly, older adults reported experiencing age-related microaggressions more than one year ago, and within one week ago. But, overall, the responses were distributed relatively evenly across time-points. This result suggests is there are commonplace age-related microaggressions manifesting throughout society, targeting older adults. However, there are some microaggressions which are so salient and impactful to older adults, that they are remembered over a year after they occur; microassault examples were commonly identified as happening over one year ago; “she grabbed my arm and shoved me in, then pushed me aside to pass me.”

Moreover, age-related microaggressions are also perpetrated at a high frequency according to the older adults in this study. There were $n = 12$ individuals who reported age-related microaggressions happen daily, according to participants. Examples include, (1) being too old to remember events; (2) being told they [older adult] wouldn’t understand; (3) getting yelled at for being too slow or being confused about something; and (4) assumptions of limited physical ability. While the intention of some perpetrators might be benign, the conveyed and received message is degrading and hurtful to the victims of these communications.

Often, it was reported microaggressions are occurring one-to-two times per month, giving unambiguous evidence of the common occurrence of these often-harmful interpersonal

communications. This finding further supports the notion that ageism is socially acceptable and therefore perpetrated at a high rate.

Our analysis of who commits microaggressions supports the sentiments described in Sue & Spanierman (2020) in their discussion of microaggression perpetrators; "To some degree, all dominant members in society are likely to commit microaggressions" (p.147). We saw a wide variety of different perpetrator-to-victim relationships endorsed, and thus, we can confirm anyone can commit an age-related microaggression—whether intentionally or not. Interestingly, we found the most common perpetrators were *service providers* and *strangers*. It is our position this is the case due to the level of personal familiarity with the victim. Individuals who have had little to no prior contact or understanding of the victim may be more likely to depend upon their implicitly held biases based on the unconscious schemas aroused by the exposure to the individual. Thus, when communicating with an older adult, strangers and service providers often base their interaction on the commonly negative implicit biases about older adults—leading them to commit age-related microaggressions.

This notion is further supported by the finding that coworkers, employers, friends, family members, etc., all have a higher degree of familiarity with the victim and therefore, we see a lower frequency of microaggressions.

We postulate the findings on the setting of the age-related microaggression are best predicted by the perpetrator of the age-related microaggression. Consequently, if we see service providers are the common perpetrator, we can predict, and we see, the common setting of the microaggressions is in stores and restaurants.

Sue and Spanierman (2020) discuss at length the harmful effects of microaggressive stress described in the current literature. They describe the most common emotional reactions to

microaggressions are anger, rage, anxiety, depression, or hopelessness. Our findings of emotional reactions to age-related microaggressions confirm anger/rage as being a common emotional reaction—which supports other previous literature as well (Nadal, et al., 2014). Sadness, isolation, and embarrassment were also common emotions reported in this study, which all tend to describe the larger constructs of depression and hopelessness.

Interestingly, our inductive analysis identified other common emotional reactions not described by Sue and Spanierman (2020), such as feeling *insulted*. This may allude to a difference in the emotional impact of age-related microaggressions, as compared to microaggressions with a focus on other marginalized populations.

Feelings of anxiety were minimally endorsed by victims of age-related microaggressions, whereas literature on other forms of microaggressions suggest it is a common emotional reaction (Sue & Spanierman, 2020; Blume et al., 2012). Further research should confirm the finding that anxiety as an emotional effect of age-related microaggressions truly manifests at a lower rate than it does for microaggressions targeting other victims.

Finally, there were $n = 13$ emotions reported that suggested the victim was *unbothered* by being victimized which was a very intriguing result. This finding should be further examined to determine what protective factors are at play in these individuals. Upon a deeper analysis, we noticed some responses starkly paralleled learned helplessness. One older adult wrote, “I’ve learned to live with it and just accept it.” It was response like this which were coded as *resignation*. While this may be an adaptive response, we feel further investigations into these responses are warranted to determine if these individuals are experiencing learned helplessness or if they are exhibiting an adaptive level of cognitive flexibility.

Regarding the intensity of the emotional reactions experienced, we found most individuals who reported an emotional reaction also endorsed moderate to extreme levels of intensity. Several participants (n = 20) reported a level of intensity that was not strong at all. However, considering n = 13 participants reported being unbothered by being victimized, it is expected those reactions correlate with the n = 20 responses indicating the reaction was not strong at all.

The results of this study further confirm the findings of Nadal et al., (2014); we found that direct and indirect confrontations, and passive coping were all common behavioral responses to being a victim of an age-related microaggression. We did, however, implement an additional categorization to capture the responses indicating they *did nothing* in response to being a victim. Passive coping was the most common behavior response, indicating older adults typically are not "making the invisible, visible" (Sue & Spanierman, 2020, p. 261). Moreover, nearly 25% of older adults reported doing nothing—also meaning they are not bringing the age-related microaggression into the awareness of the perpetrator (i.e., "making the invisible, visible").

Ultimately, we discovered 61% of the time, older adults are not disarming the microaggression, shedding light on the microaggression, educating the offender, or seeking support—behaviors coined *microinterventions* (See Sue & Spanierman, 2020, pp. 261-274). A deeper investigation to uncover barriers to direct confrontation of perpetrators should be conducted in the future.

Fortunately, we discovered direct confrontation is possible. Of the n = 123 behavioral responses coded, n = 38 gave examples of direct confrontation and n = 10 gave examples of indirect confrontation. Both forms, suggest there are factors leading to victims feeling empowered to engage in a microintervention—future research must be conducted to determine

why some individuals engage in a form of confrontation and why some do not. Our preliminary analysis suggests an element of fear plays into the analysis of determining whether to act or ignore. Something of note, is much of the sample were white individuals. We believe race influenced the larger than expected frequency of direct confrontation. It is hypothesized a more heterogeneous sample would display a lower rate of direct confrontation due to other marginalized populations being less likely to directly confront perpetrators because of fear of retaliation.

Finally, our results on perceived intent suggest victims subjectively evaluate the perpetrators' intent as intentional at least 82% of the time. This is extremely problematic because microaggressions commonly manifest on an unconscious level for the perpetrator (Sue, et al., 2007). Moreover, while the intent is often benevolent, the perceived intent of the victim is that the perpetrator is intentionally attacking them because of their chronological or perceived age.

Other Future Directions/Limitations

Our intent is to provide a foundational framework for future research on age-related microaggressions. We are striving to cultivate momentum for researchers to further identify a compendium of commonly experienced microaggressions, which opens the door for categorizing these examples (i.e., microassaults, microinsults, and microinvalidations), investigating the general themes underlying these common microaggressions, and developing a psychometrically sound self-report instrument for measuring microaggressions.

Furthermore, additional research must be explicitly directed at determining how frequently older adults typically experience diverse types of age-related microaggressions, the environmental circumstances under which they most frequently occur, how older adults respond to the age-related microaggressions when they occur, and common behavioral and emotional

reactions to age-related microaggressions. Once these fundamental questions are answered, future research should focus on: (a) long-term physical and psychological effects to exposure to microaggressions; (b) better understanding why age-related microaggressions occur from the perspective of younger and older adults; (c) the kinds of microaggressions experienced by older adults that belong to other marginalized groups (e.g., gender and ethnic minorities); (d) how factors such as socioeconomic status, health status, self-esteem, or the presence of psychological distress predict the effects of microaggressions on the victims; and (e) efforts to increase awareness of microaggression and their effects on older adults.

Furthermore, research on age-related microaggressions should be expanded to include focus groups, a more diverse sample, and individuals who are members of multiple marginalized populations. Other areas of inquiry include, (a) a deeper investigation of the most common forms of age-related microaggressions (i.e., microinsults), and (b) an investigation on microinterventions for age-related microaggressions.

This study limited by the novelty of the concept under investigation. We were also bound by the fact all participants must have had access to the internet and Qualtrics. All participants also had a good command on written communication. Like we mentioned the sample was very homogenous and therefore limits the generalizability of these findings to other demographics.

One particular limitation was that a portion of the data was unintentionally deleted by Qualtrics. Qualtrics only provided the data for *fully completed* surveys. Thus, any survey which had five, rather than the required six age-related microaggression examples to be considered *fully completed*, were deleted by the Qualtrics team, and were rendered unretrievable. Thus, many may have noticed we had an astounding 100% full completion rate. This is not an error on our

part, but rather an error due to the unintentional omission of data by the Qualtrics data management team.

Future investigation should implement focus groups to capture participants who are not comfortable with internet, technology, or written communication.

Conclusion

The current study aimed to build the connection between ageism and microaggressions—the age-related microaggression. The call for the expansion of the concept of ageism (APA, 2020; Levy & Macdonald, 2016; WHO, 2021) was answered in this study by expanding the research to investigate how older adults experience microaggressions that relate to their age—which concurrently furthered the microaggression literature. Thus, in solidarity with the APA resolution on ageism (APA, 2020), this paper should serve as an educational tool to broaden competencies surrounding how to interact with older adults properly and effectively; it should also be used as an educational tool to inform future research on the topic.

Overall, we found that age-related microaggressions exist and commonly manifest as microinsults perpetrated by service providers and strangers. They lead to strong emotional reactions like anger, insult, and sadness. And, while most older adults perceive the attacks as intentional, unfortunately, most older adults passively cope or do nothing about the attacks due to fear of retribution or learned helplessness.

References

Abrams, D., Swift, H. J., & Drury, L. (2016). Old and unemployable? How age-based stereotypes affect willingness to hire job candidates. *Journal of Social Issues, 72*(1), 105-121. https://doi.org/10.1111/josi.12158

American Psychological Association. (2020). *APA resolution on ageism*. https://www.apa.org/about/policy/resolution-ageism.pdf

Angus, J., & Reeve, P. (2006). Ageism: A Threat to "Aging Well" in the 21st Century. *Journal of Applied Gerontology, 25*(2), 137-152. http://dx.doi.org/10.1177/0733464805285745

BBC News. (2020, October 8). *Kamala Harris v Mike Pence: Why this vice-president debate matters*. https://www.bbc.com/news/election-us-2020-54423497

Blume, A. W., Lovato, L. V., Thyken, B. N., & Denny, N. (2012). The relationship of microaggressions with alcohol use and anxiety among ethnic minority college students in a historically White institution. *Cultural Diversity and Ethnic Minority Psychology, 18*(1), 45-54. http://dx.doi.org/10.1037/a0025457

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. http://dx.doi.org/10.1191/1478088706qp063oa

Butler, R. N. (1969). Age-ism: Another form of bigotry. *The Gerontologist, 9,* 243-246. https://doi.org/10.1093/geront/9.4_Part_1.243

Butler, R.N. (1975). *Why survive? Being old in America.* New York: Harper and Row.

Butler, R. N. (1995). Ageism. In G. Maddox (Ed.), *The Encyclopedia of Aging, 2*, 38– 39. New York, NY: Springer.

Buttigieg, S.C., Ilinca, S., de Sao Jose, J.M.S., Larsson, A.T. (2018). Researching ageism in health-care and long term care. In: Ayalon, L., Tesch-Römer, C. (eds) *Contemporary*

Perspectives on Ageism. International Perspectives on Aging, vol. 19. Springer, Cham. https://doi.org/10.1007/978-3-319-73820-8_29

Centers for Disease Control and Prevention. (2021). *COVID-19 risks and vaccine information for older adults.* https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html

Chan, J. F. W., Yuan, S., Kok, K. H., To, K. K. W., Chu, H., Yang, J., . . . Yuen, K. Y. (2020). A familial cluster of pneumonia associated with the 2019 novel coronavirus indicating person-to-person transmission: A study of a family cluster. *The Lancet, 395,* 514–523. http://dx.doi.org/10.1016/S0140-6736(20)30154-9

Chang, E.-S., Kannoth, S., Levy, S., Wang, S.-Y., Lee, J. E., & Levy, B. R. (2020). Global reach of ageism on older persons' health: A systematic review. *PLoS ONE*, *15*(1), 1–24. https://doi.org/10.1371/journal.pone.0220857

Chen, C.-Y., Joyce, N., Harwood, J., & Xiang, J. (2017). Stereotype reduction through humor and accommodation during imagined communication with older adults. *Communication Monographs, 84*(1), 94–109. https://doi.org/10.1080/03637751.2016.1149737

Coalson, G. A., Crawford, A., Treleaven, S. B., Byrd, C. T., Davis, L., Dang, L., Edgerly, J., & Turk, A. (2022). Microaggression and the adult stuttering experience. *Journal of Communication Disorders, 95*, 1-18. http://dx.doi.org/10.1016/j.jcomdis.2021.106180

Conover, K. J., Acosta, V. M., & Bokoch, R. (2021). Perceptions of ableist microaggressions among target and nontarget groups. *Rehabilitation Psychology, 66*(4), 565-575. http://dx.doi.org/10.1037/rep0000404

Dhabhar F. S. (2014). Effects of stress on immune function: the good, the bad, and the beautiful. *Immunologic research, 58*(2-3), 193–210. https://doi.org/10.1007/s12026-014-8517-0

Eaton, L. A., Allen, A., Maksut, J. L., Earnshaw, V., Watson, R. J., & Kalichman, S. C. (2020). HIV microaggressions: a novel measure of stigma-related experiences among people living with HIV. *Journal of Behavioral Medicine, 43*(1), 34–43. https://doi.org/10.1007/s10865-019-00064-x

El-Bialy, R., & Mulay, S. (2020). Microaggression and everyday resistance in narratives of refugee resettlement. *Migration Studies, 8*(3), 356–381. https://doi.org/10.1093/migration/mny041

Feliu, J., Espinosa, E., Basterretxea, L., Paredero, I., Llabrés, E., Jiménez-Munárriz, B., Antonio-Rebollo, M., Losada, B., Pinto, A., Gironés, R., Custodio, A. B., Muñoz, M.,Del Mar, Gómez-Mediavilla, J., Torregrosa, M. D., Soler, G., Cruz, P., Higuera, O., & Molina-Garrido, M. (2021). Undertreatment and overtreatment in older patients treated with chemotherapy. *Journal of Geriatric Oncology, 12*(3), 381-387. http://dx.doi.org.ezproxy.mnsu.edu/10.1016/j.jgo.2020.10.010

Fraser, S. A., Kenyon, V., Lagacé, M., Wittich, W., & Southall, K. E. (2016). Stereotypes associated with age-related conditions and assistive device use in Canadian media. *Gerontologist, 56*(6), 1023–1032. https://doi.org/10.1093/geront/gnv094

Glick, P., & Fiske, S. T. (1996). The ambivalent sexism inventory: Differentiating hostile and benevolent sexism. *Journal of Personality and Social Psychology, 70*(3), 491-512. https://psycnet.apa.org/doi/10.1037/0022-3514.70.3.491

Go, A. S., Mozaffarian, D., Roger, V. L., Benjamin, E. J., Berry, J. D., Borden, W. B... Turner, M. B. (2013). Heart disease and stroke statistics–2013 update: A report from the American Heart Association. *Circulation*, 127 (1), e6–e245. https://doi.org/10.1161/CIR.0b013e31828124ad

Goodwin, G. P., & Landy, J. F. (2014). Valuing different human lives. *Journal of Experimental Psychology: General, 143*(2), 778–803. https://doi.org/10.1037/a0032796

Gordon, S. (2020). Ageism and age discrimination in the family: Applying an intergenerational critical consciousness approach. *Clinical Social Work Journal, 48*(2), 169–178. https://doi.org/10.1007/s10615-020-00753-0

Hall, J. M., & Fields, B. (2015). "It's killing us!" Narratives of black adults about microaggression experiences and related health stress. *Global Qualitative Nursing Research, 2*. https://doi.org/10.1177/2333393615591569

Herrera, A. P., Snipes, S. A., King, D. W., Torres-Vigil, I., Goldberg, D. S., & Weinberg, A. D. (2010). Disparate inclusion of older adults in clinical trials: Priorities and opportunities for policy and practice change. *American Journal of Public Health, 100*(1), S105–S112. https://doi.org/10.2105/AJPH.2009.162982

Holveck, C. A., & Wick, J. Y. (2018). Addressing the Shortage of Geriatric Specialists. *The Consultant Pharmacist: The journal of the American Society of Consultant Pharmacists*, *33*(3), 130–138. https://doi.org/10.4140/TCP.n.2018.130

Iversen, T. N., Larsen, L., & Solem, P. E. (2009). A conceptual analysis of ageism. *Nordic Psychology, 61*(3), 4-22. https://doi.org/10.1027/1901-2276.61.3.4

James, J. B., McKechnie, S., Swanberg, J., & Besen, E. (2013). Exploring the workplace impact of intentional/unintentional age discrimination. *Journal of Managerial Psychology, 28*(7-8), 907–927. https://doi.org/10.1108/JMP-06-2013-0179

Julius, S., Valentini, M., & Palatini, P. (2000). Overweight and hypertension: A 2-way street? *Hypertension*, 35 (3), 807–813. https://doi.org/10.1161/01.HYP.35.3.807

Kattari, S. K. (2020). Ableist Microaggressions and the Mental Health of Disabled Adults. *Community Mental Health Journal, 56*(6), 1170–1179. https://doi.org/10.1007/s10597-020-00615-6

Kim, H., Sefcik, J. S., & Bradway, C. (2017). Characteristics of Qualitative Descriptive Studies: A Systematic Review. *Research in nursing & health*, *40*(1), 23–42. https://doi.org/10.1002/nur.21768

Lago, R. M., Singh, P. P., & Nesto, R. W. (2007). Diabetes and hypertension. *Nature Clinical Practice Endocrinology and Metabolism, 3*(10), 667. https://doi.org/10.1038/ncpendmet0638

Lee, R. T., Perez, A. D., Boykin, C. M., & Mendoza-Denton, R. (2019). On the prevalence of racial discrimination in the United States. *PloS one*, *14*(1), e0210698. https://doi.org/10.1371/journal.pone.0210698

Levy, B. (2000). Handwriting as a reflection of aging self-stereotypes. *Journal of Geriatric Psychiatry, 33*(1), 81—94.

Levy, B. R., Hausdorff, J. M., Hencke, R., & Wei, J. Y. (2000). Reducing cardiovascular stress with positive self-stereotypes of aging. *The Journal of Gerontology, Series B: Psychological Sciences and Social Sciences, 55*(4), P205–P213. https://doi.org/10.1093/geronb/55.4.P205

Levy, B. R. (2003). Mind matters: Cognitive and physical effects of aging self-stereotypes. *Journal of Gerontology, Series B: Psychological Sciences and Social Sciences, 58*(4), 203—211. https://doi.org/10.1093/geronb/58.4.P203

Levy, B. R., Ryall, A. L., Pilver, C. E., Sheridan, P. L., Wei, J. Y., & Hausdorff, J. M. (2008). Influence of African American elders' age stereotypes on their cardiovascular response to

stress. *Anxiety, Stress, and Coping, 21*(1), 85–93. https://doi.org/10.1080/10615800701727793

Levy, B. R., Zonderman, A. B., Slade, M. D., & Ferrucci, L. (2009). Age stereotypes held earlier in life predict cardiovascular events in later life. *Psychological Science, 20*(3), 296–298. https://doi.org/10.1111/j.1467-9280.2009.02298.x

Levy, B. R., Zonderman, A. B., Slade, M. D., Ferrucci, L. (2011). Memory shaped by age stereotypes over time. *Journals of Gerontology: Series B, 64*(4), 432-436. https://doi.org/10.1093/geronb/gbr120

Levy, B. R., Ferrucci, L., Zonderman, A. B., Slade, M. D., Troncoso, J., & Resnick, S. M. (2016). A culture–brain link: Negative age stereotypes predict Alzheimer's disease biomarkers. *Psychology and Aging, 31*(1), 82–88. https://doi.org/10.1037/pag0000062

Levy, S. R., & Macdonald, J. L. (2016). Progress on understanding ageism. *Journal of Social Issues, 72*(1), 5–25. https://doi.org/10.1111/josi.12153

Lilly, F. R. W., Owens, J., Bailey, T. C., Ramirez, A., Brown, W., Clawson, C., & Vidal, C. (2018). The influence of racial microaggressions and social rank on risk for depression among minority graduate and professional students. *College Student Journal, 52*(1), 86-104.

Lyons, A., Alba, B., Heywood, W., Fileborn, B., Minichiello, V., Barrett, C., ... Dow, B. (2017). Experiences of ageism and the mental health of older adults. *Aging & Mental Health, 7863*(11), 1–9. https://doi.org/10.1080/13607863.2017.1364347

Marier, P., & Revelli, M. (2017). Compassionate Canadians and conflictual Americans? Portrayals of ageism in liberal and conservative media. *Ageing and Society, 37*(8), 1632-1653. https://doi.org/10.1017/S0144686X16000544

Meisner, B. A. (2020). Are you ok, boomer? Intensification of ageism and intergenerational tensions on social media amid COVID-19. *Leisure Sciences, 43*, 56–61. https://doi.org/10.1080/01490400.2020.1773983

Miller, G. E., Chen, E., & Zhou, E. S. (2007). If it goes up, must it come down? Chronic stress and the hypothalamic-pituitary-adrenocortical axis in humans. *Psychological bulletin, 133*(1), 25–45. https://doi.org/10.1037/0033-2909.133.1.25

Nadal, K. L., Issa, M., Leon, J., Meterko, V., Wideman, M., & Wong, Y. (2011). Sexual orientation microaggressions: "Death by a thousand cuts" for lesbian, gay, and bisexual youth. *Journal of LGBT Youth, 8*(3), 234-259. http://dx.doi.org/10.1080/19361653.2011.584204

Nadal, K. L., Davidoff, K. C., Davis, L. S., & Wong, Y. (2014). Emotional, behavioral, and cognitive reactions to microaggressions: Transgender perspectives. *Psychology of Sexual Orientation and Gender Diversity, 1*(1), 72–81. https://doi.org/10.1037/sgd0000011

Nadal, K. L., Griffin, K. E., Wong, Y., Davidoff, K. C., & Davis, L. S. (2017). The injurious relationship between racial microaggressions and physical health: Implications for social work. *Journal of Ethnic & Cultural Diversity in Social Work: Innovation in Theory, Research & Practice, 26*(1-2), 6–17. https://doi.org/10.1080/15313204.2016.1263813

Nadal, K. L. (2019). Measuring LGBTQ microaggressions: The Sexual Orientation Microaggressions Scale (SOMS) and the Gender Identity Microaggressions Scale (GIMS). *Journal of Homosexuality, 66*(10), 1404-1414. http://dx.doi.org/10.1080/00918369.2018.1542206

Ong, A. D., Burrow, A. L., Fuller-Rowell, T. E., Ja, N. M., & Sue, D. W. (2013). Racial microaggressions and daily well-being among Asian Americans. *Journal of counseling psychology, 60*(2), 188–199. https://doi.org/10.1037/a0031736

Ong, A. D., Cerrada, C., Lee, R. A., & Williams, D. R. (2017). Stigma consciousness, racial microaggressions, and sleep disturbance among Asian Americans. *Asian American Journal of Psychology, 8*(1), 72–81. https://doi.org/10.1037/aap0000062

Ouchida, K. M., & Lachs, M. S. (2015). Not for Doctors Only: Ageism in Healthcare. *Generations: Journal of the American Society on Aging*, *39*(3), 46–57. https://www.jstor.org/stable/26556135

Palmore, E. B. (1999). *Ageism: Negative and Positive*. New York: Springer

Palmore, E. B. (2001). The forum. The Ageism Survey: First findings. *Gerontologist*, *41*(5), 572–575. https://doi.org/10.1093/geront/41.5.572

Perron, R. (2018). The value of experience: AARP multicultural work and jobs study. Washington, DC: AARP Research. https://www.aarp.org/research/topics/economics/info-2018/multicultural-work-jobs.html

Pierce, C. (1970). Offensive mechanisms. In F. B. Barbour (Ed.), *The black seventies* (pp. 265–282). Boston, MA: Porter Sargent.

Pierce, C. M. (1974). Psychiatric problems of the Black minority. In S. Arieti (Ed.), American handbook of psychiatry (pp. 512–523). New York, NY: Basic Books.

Richards, N., Warren, L., & Gott, M. (2012). The challenge of creating 'alternative' images of ageing: Lessons from a project with older women. *Journal of Aging Studies, 26*(1), 65–78. https://doi.org/10.1016/j.jaging.2011.08.001

Robinson, S., Briggs, R., & O'Neill, D. (2012). Cognitive aging, geriatric textbooks, and unintentional ageism. *Journal of the American Geriatric Society, 60*, 2183–2185. https://doi.org/10.1111/j.1532-5415.2012.04217.x

Roy, S., & Ayalon, L. (2020). Age and gender stereotypes reflected in Google's "autocomplete" function: The portrayal and possible spread of societal stereotypes. *Gerontologist, 60*(6), 1020–1028. https://doi.org/10.1093/geront/gnz172

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing & Health, 33*(1), 77-84. https://doi.org/10.1002/nur.20362

Selye, M. (1956). *The stress of life*. New York, NY: McGraw-Hill

Selye, M. (1982). Stress: Eustress, distress, and human perspectives. In S. B. Day (Ed.), *Life Stress* (pp. 3-13). New York, NY: Van Nostrand Reinhold.

Smirnova, M. H. (2012). A will to youth: The woman's anti-aging elixir. *Social Science & Medicine, 75*(7), 1236–1243. https://doi.org/10.1016/j.socscimed.2012.02.061

SteelFisher, G. K., Findling, M. G., Bleich, S. N., Casey, L. S., Blendon, R. J., Benson, J. M., Sayde, J. M., & Miller, C. (2019). Gender discrimination in the United States: Experiences of women. *Health Services Research*, *54*(2), 1442–1453. https://doi.org/10.1111/1475-6773.13217

Stephan, Y., Caudroit, J., Jaconelli, A., & Terracciano, A. (2014). Subjective age and cognitive functioning: A 10-year prospective study. *The American Journal of Geriatric Psychiatry, 22*(11), 1180—1187. http://dx.doi.org/10.1016/j.jagp.2013.03.007

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical

practice. *American Psychologist, 62*(4), 271-286. http://doi.org/10.1037/0003-066X.62.4.271

Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation*. John Wiley & Sons, Inc.

Sue, D. W. & Spanierman, L. B. (2020). *Microaggressions in everyday life* (2nd ed.). John Wiley & Sons, Inc.

Swann, G., Stephens, J., Newcomb, M. E., & Whitton, S. W. (2020). Effects of sexual/gender minority- and race-based enacted stigma on mental health and substance use in female assigned at birth sexual minority youth. *Cultural Diversity & Ethnic Minority Psychology, 26*(2), 239–249. https://doi.org/10.1037/cdp0000292

Thayer, C., & Skufca, L. (2020). Media Image Landscape: Age Representation in Online Images. *Innovation in Aging*, *4*(Suppl 1), 101. https://doi.org/10.1093/geroni/igaa057.332

Thompson, C. E., & Neville, H. A. (1999). Racism, mental health, and mental health practice. *Counseling Psychologist, 27*(2), 155-223. https://doi.org/10.1177/0011000099272001

VandenBos, G. R. (2015). *APA dictionary of psychology.* (2nd ed.). Washington, DC: American Psychological Association.

Wilson, D. M., Errasti-Ibarrondo, B., & Low, G. (2019). Where are we now in relation to determining the prevalence of ageism in this era of escalating population ageing? *Ageing Research Reviews, 51*, 78–84. https://doi.org/10.1016/j.arr.2019.03.001

Woodford, M. R., Kulick, A., Sinco, B. R., & Hong, J. S. (2014). Contemporary heterosexism on campus and psychological distress among LGBQ students: The mediating role of self-acceptance. *American Journal of Orthopsychiatry, 84*(5), 519-529. http://dx.doi.org/10.1037/ort0000015

World Health Organization. (2018). *Ageing and Health*. https://www.who.int/news-room/fact-sheets/detail/ageing-and-health

World Health Organization. (2020). *Coronavirus disease (COVID-19) advice for the public.* https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public

World Health Organization. (2021). *Ageism is a global challenge: UN*. https://www.who.int/news/item/18-03-2021-ageism-is-a-global-challenge-un

Zhou, F., Yu, T., Du, R., Fan, G., Liu, Y., Liu, Z., . . . Cao, B. (2020). Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: A retrospective cohort study. *The Lancet, 395,* 1054–1062. http://dx.doi.org/10.1016/S0140-6736(20)30566-3

Figures

Figure 1

Overall Occurrence of the Three Categorizations of Microaggressions

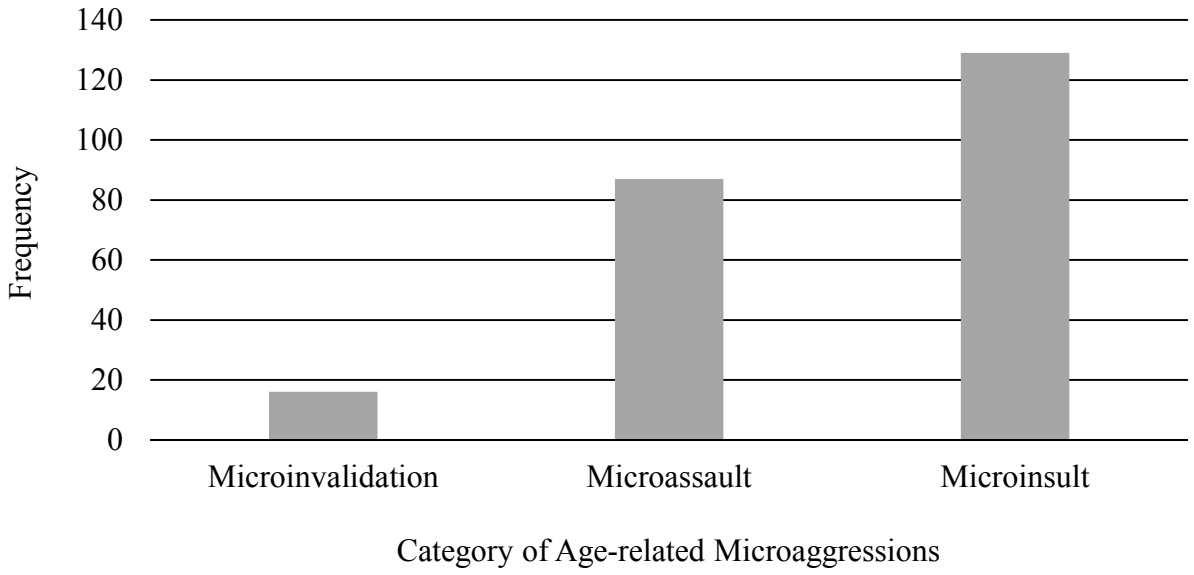
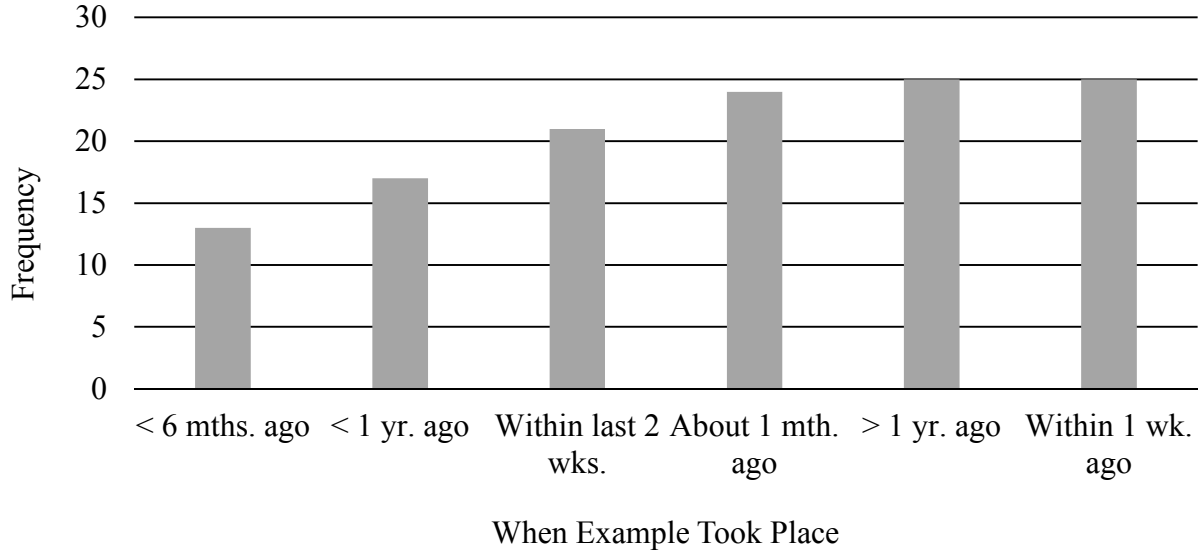


Figure 2

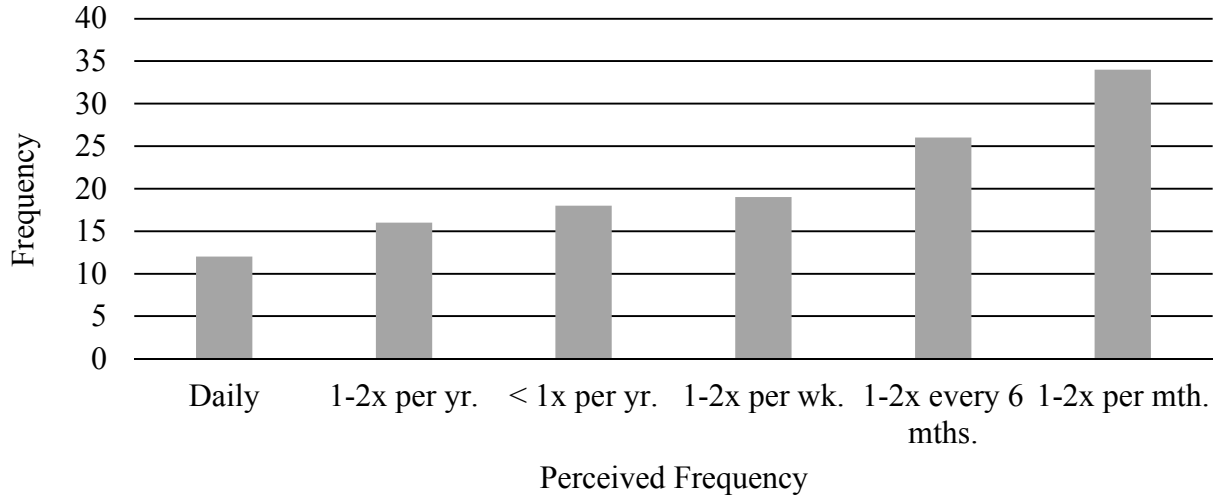
When Age-related Microaggression Took Place



Note. 28 responses were removed because they corresponded to an example coded NA.

Figure 3

Occurrence of Perceived Frequency



Note. 28 responses were removed because they corresponded to an example coded NA.

Figure 4

Occurrence of Relationship to Perpetrator

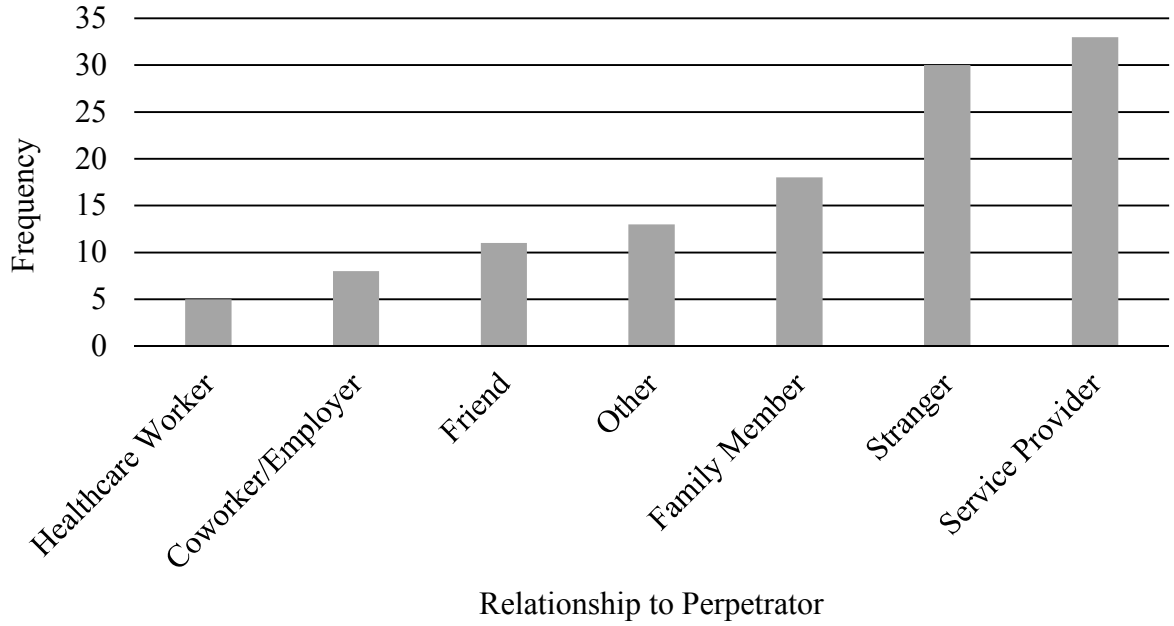
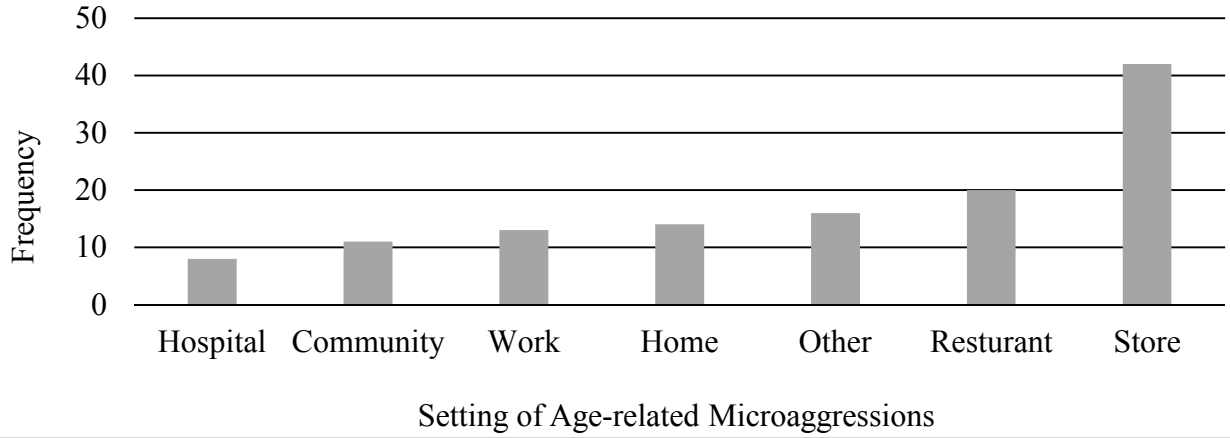


Figure 5

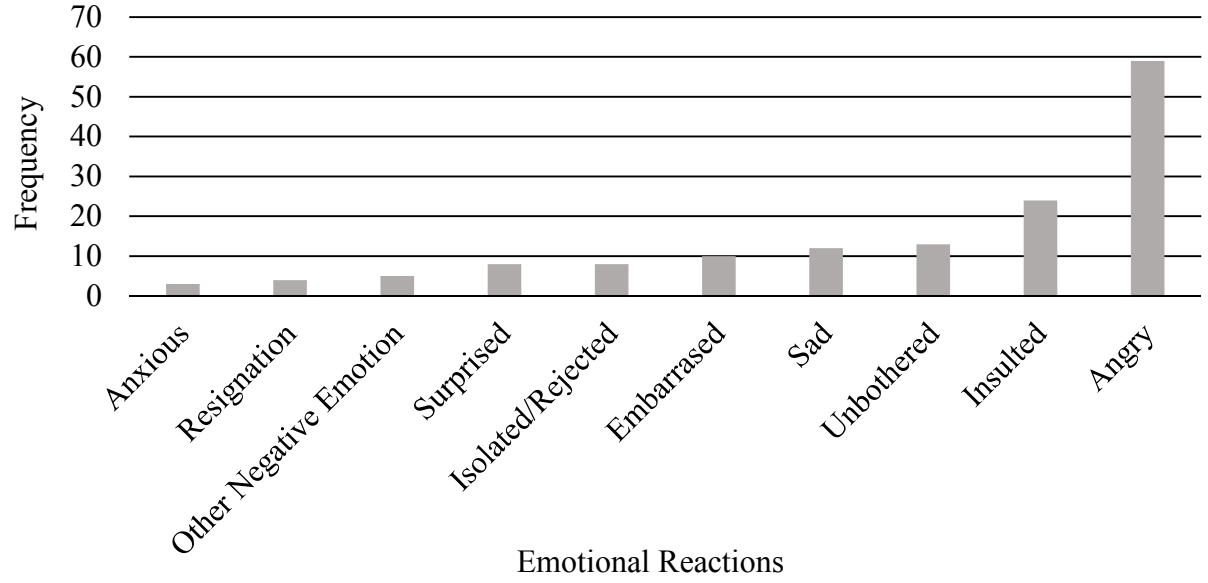
Occurrence of Specific Settings of Microaggressions



Note. Other included: "while driving," "on the phone," "online," "at the other person's house," "anywhere and everywhere," and "church."

Figure 6

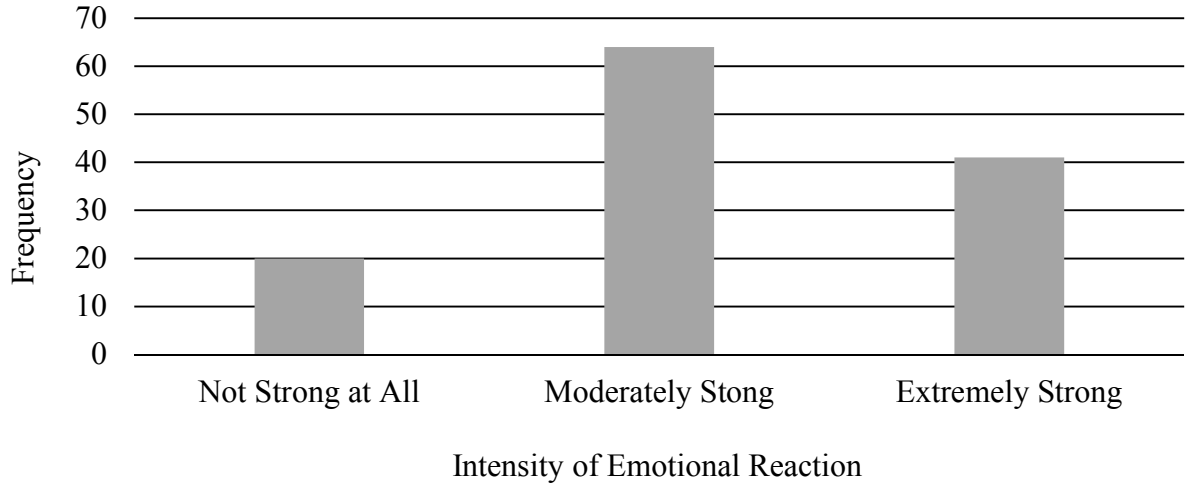
Occurrence of Specific Emotional Reactions to Experienced Microaggressions



Note. Other Negative Emotion specific examples included: "I didn't like it," "I didn't like the action at all," and "I felt bad."

Figure 7

Occurrence of Emotional Reaction Intensity



Note. 28 responses were removed because they corresponded to an example coded NA.

Figure 8

Occurrence of Behavioral Responses to Experienced Microaggressions

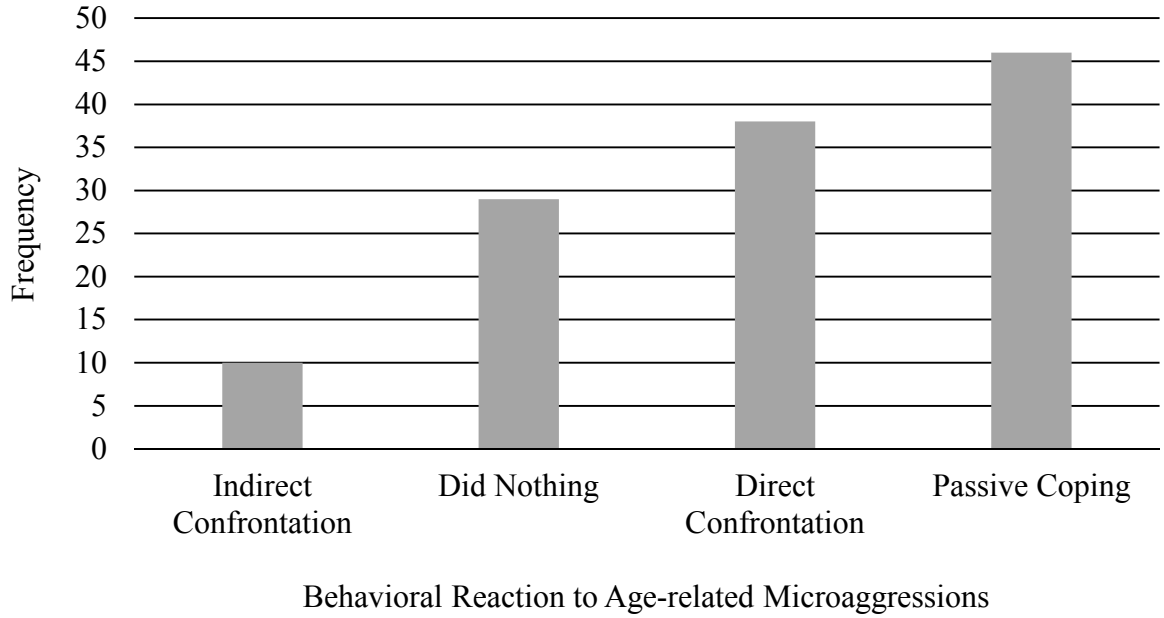
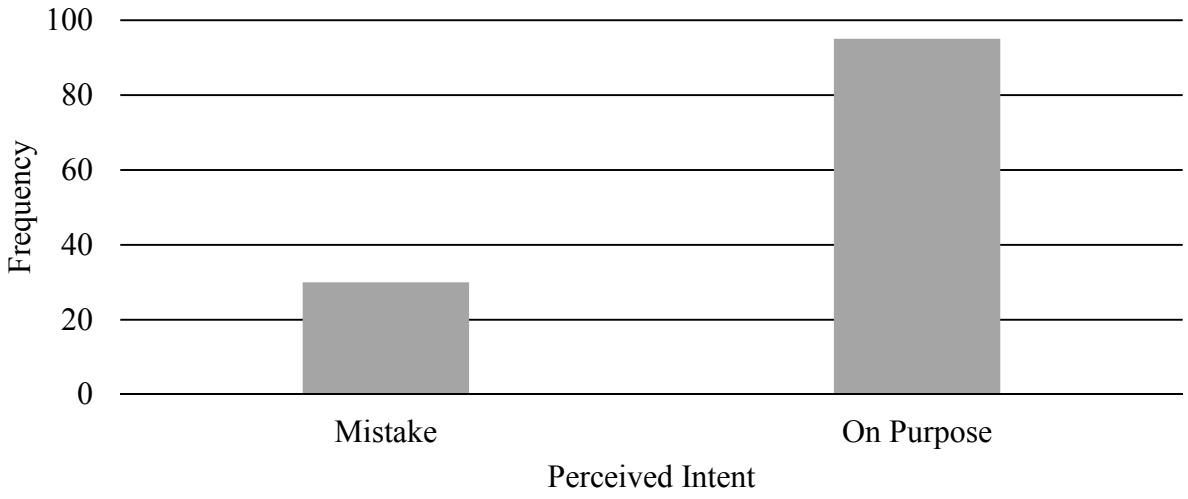


Figure 9

Occurrence of Perceived Intent



Note. 28 responses were removed because they corresponded to an example coded NA.

Appendix A

Informed Consent

Informed Consent for Participation in Research

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

Investigators:

This study is being conducted by Luke J. Gietzen under the direct supervision of Jeffery Buchanan, PhD, of Minnesota State University Mankato's Department of Psychology.

Purpose:

The purposes of this study are to determine whether individuals over the age of 65 have experienced age-related microaggressions (which are subtle forms of discrimination based on age) and to understand what these age-related microaggressions look like.

Participants:

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

Procedure:

You will be asked to complete an online survey that will take approximately 30 minutes to complete. This survey will first ask you several questions about yourself and then will present some definitions and examples microaggressions. You will then be asked a series of questions about instances of microaggressions that you have experienced related to your age. The study will end when all questions have been answered, and you may close your browser.

Risks:

The risks you will encounter as a participant in this research are not more than experienced in your everyday life. It is possible you may experience emotional discomfort related to describing experienced microaggressions. Should this occur, you may choose not to answer any of the survey questions, and you have the option to end your participation at any time by exiting out of the survey. The researchers strongly encourage you to use a secure internet connection and to participate in the study from a location where you would have privacy from others so they cannot view your computer or mobile device's screen.

Benefits and Compensation:

The results of this study will provide a deeper understanding of how older adults experience subtle forms of ageism, in the form of microaggressions. Qualtrics will compensate you approximately $10.00 for your participation.

Confidentiality:

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

Right to Refuse or Withdraw:

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

Questions:

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

Closing Statement:

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

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

Minnesota State University, Mankato IRBNet LOG # 1732958

Do you consent to participate in this study?

o Yes (1)

o No (2)

Skip To: End of Block: If Do you consent to participate in this study? = No

Appendix B

Qualtrics Survey

1. Age

o below 65 (4)

o 65-84 (5)

o 85+ (6)

Skip To: End of Survey If Age = below 65

2. Gender

o Male (1)

o Female (2)

o Trans (3)

o Non-binary / third gender (4)

o Prefer not to say (5)

o Other: Please Specify (6) _____

The **purpose of this survey** is to gain an understanding about how individuals ages 65 and older experience age-related microaggressions in their day-to-day lives.

What are **microaggressions**?

Microaggressions are brief and commonplace, verbal, behavioral, or situational embarrassments/shames/disgraces/humiliations directed towards members of various

marginalized social groups. Microaggressions can be intentional and obvious but are often unintentional and covert.

There are three types of microaggressions.

a) Microassaults
b) Microinsults
c) Microinvalidations

Microassaults: Verbal and non-verbal acts that are intended to harm the targeted individual. Microassaults look a lot like traditional acts of discrimination.

Examples:

a) A white family is deliberately served at a restaurant before a black family.
b) An individual uses racial slurs or refers to individuals in marginalized groups by offensive names (e.g., "queer").
c) Someone deliberately avoids being around members of a marginalized community.
d) A person displays a swastika flag outside their home.

Microinsults: Often unconscious verbal, nonverbal, or environmental communications that express rudeness and insensitivity. Messages could include subtle statements that imply you are not a member of the dominant group.

Examples:

a) A white manager does not acknowledge a Hispanic employee during a work meeting.
b) A white store worker being overly observant of a black customer.

c) A female physician is mistaken as a nurse in a hospital.

Microinvalidations: Often unconscious verbal, nonverbal, or environmental communications that subtly contradict or invalidate your thoughts, feelings, or reality because of your minority/marginalized group membership.

Examples:

a) When Asian Americans are told they, “Speak good English”; despite the fact they were born and raised in America.
b) When people say things like: “I’m not racist. I have several Black friends.” “As a woman, I know what you go through as a racial minority."
c) When an individual of a marginalized group expresses that they feel they were targeted by someone because of their race or gender and they are, in turn, told they are “being overly sensitive.”

3. Think about a time when you may have experienced a microaggression related specifically to your age. Have you ever experienced something like the microaggressions described above that related specifically to your age?

o Yes (1)

o No (2)

Skip To: End of Block If Think about a time when you may have experienced a microaggression related specifically to your age = No

4. To learn more about this, we would like to walk you through some questions related to your experience. In as much detail as possible, describe what was said or done by the individual/s that you considered an age-related microaggression.

5. Roughly how long ago did you experience the age-related microaggression?

- o Within the last week. (1)
- o Within the last 2 weeks. (2)
- o About 1 month ago. (3)
- o Less than 6 months ago. (4)
- o Less than 1 year ago. (5)
- o More than 1 year ago. (6)

6. What is/was the relationship between you and the person/s who used the age-related microaggression?

Some examples could include a friend, brother, doctor, child, waitress, partner, etc.

7. Where did the age-related microaggression occur?

Some examples could include at home, a store, a restaurant, medical office, hospital, etc.

8. How did you feel when you experienced the age-related microaggression?

9. Rate how strong this reaction was.

- o Not Strong At All (1)

o Moderately Strong (2)

o Extremely Strong (3)

10. Do you think the individual/s did this on purpose or was it a mistake/accident?

o On Purpose (1)

o Mistake (2)

11. What did you do in response to the age-related microaggression?

12. How often do you estimate you experience age-related microaggressions like the one you just described?

o Everyday (1)

o 1-2 times per week. (2)

o 1-2 times per month. (3)

o 1-2 times every 6 moths. (4)

o 1-2 times per year. (5)

o Less than once per year. (6)

13. Do you think other people over the age of 65 have experienced age-related microaggressions like the one described?

o Yes (1)

o No (2)

Display This Question: If Do you think other people over the age of 65 have experienced age-related microaggressions like the one described = Yes

14. Please describe an example of an age-related microaggression you have heard about or witnessed that was not directed towards you.

15. Can you think of another example of an age-related microaggression you have experienced?

o Yes (1)

o No (2)

If Q15 was answered Yes, then the participant would repeat Q4-Q15 up to two more times.

Appendix C

Age-Related Microaggressions: Key Terms and Definitions

Age-Related Microaggression: Brief, commonplace, verbal, or behavioral indignities, whether intentional or unintentional, which communicate hostile, derogatory, or negative ageist slights and insults due to chronological or perceived age of the target/victim.

(1) Microinsult: Often unconscious verbal and nonverbal interpersonal exchanges conveying ageist stereotypes, rudeness, and insensitivity and demean an individual's identity due to their chronological or perceived age.

(i) Elderspeak: Speaking to an older adult in an infantilizing manner.

(ii) Assumptions Regarding Ability: Assuming an older adult lacks the intellect to answer questions or contribute to a conversation or lacks the physical ability to do physical tasks.

(iii) Senior Discount: Assuming an individual qualifies for a benefit/discount due to the perception of them being an older adult.

(iv) Offering Assistance: Assuming an individual requires assistance due to the perception of them being an older adult.

(v) Ignoring:

(2) Microassault: Commonly conscious, explicit ageist derogations characterized primarily be a violent verbal or behavioral attack meant to harm the intended victim due to their chronological or perceived age.

(i) Name-Calling: The use of culturally offensive descriptions with the intent to belittle or humiliate an individual due to the perception of them being an older adult.

(ii) Rushing: The conscious communication, verbally or behaviorally, to an older adult they are not fast enough.

(iii) Workplace Discrimination: Refusing to hire, firing, or undue questioning of qualified and able individuals, based solely on their chronological or perceived age.

(3) Microinvalidation: Often unconscious comments or behaviors which exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of an individual due to their chronological or perceived age.

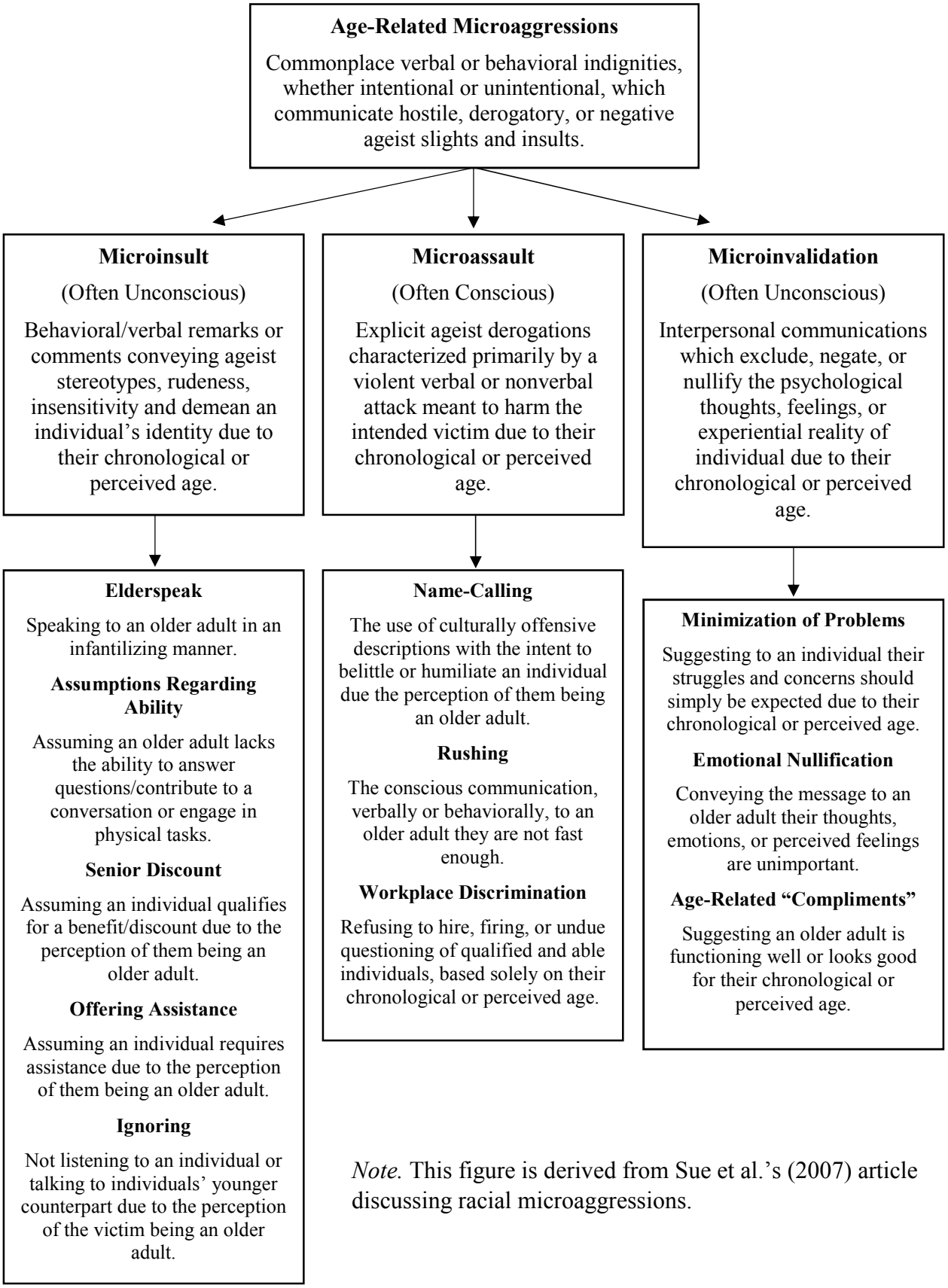
(i) Minimization of Problems: Suggesting to an individual their struggles and concerns should simply be expected due to their chronological or perceived age.

(ii) Emotional Nullification: Conveying the message to an older adult their thoughts, emotions, or perceived feelings are unimportant.

(iii) Age-Related "Compliments": Suggesting an older adult is functioning well or looks good for their chronological or perceived age.

Appendix D

Categories of and Relationships Among Age-Related Microaggressions



Note. This figure is derived from Sue et al.'s (2007) article discussing racial microaggressions.