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Ageist Attitudes: Youth Identity, Subjective Time to Become Older, and Impressions of the General Older Population's Physical and Mental Health

Abstract

Reduction in ageist attitudes is crucial to resolve intergenerational conflicts between older adults and other generations. As factors related to ageist attitudes, the extent to which people perceive themselves to be young should be the focus. The perceived link between older adults and illness also has a significant relationship with ageist attitudes. This study examines the relationship between ageist attitudes and youth identity (the extent to which people feel they belong to the young population as opposed to the older population), and impressions of the physical and mental health of the general older population. The results of an online survey of Japanese participants ($N = 474$) showed that those with higher youth identity held stronger ageist attitudes. While impressions of the physical health of the general older population were not associated with ageist attitudes, participants with more positive impressions of older adults' mental health had weaker ageist attitudes. Our model should be extended by adding factors that were not considered in this study.

Keywords: older people, youth identity, subjective time, physical health, mental health

Introduction

Background and Focus

The world's population is aging—people aged 65 years and older accounted for 5.1% of the population in 1950 and 8.3% in 2015, and this percentage will further increase to 17.8% by 2060 [21]. This trend is particularly pronounced in Japan, where those aged 65 years and older accounted for 28.7% of the total Japanese population in 2020 [6]. In aged societies, intergenerational conflicts between older adults and other populations are frequently seen in many workplaces and nursing care homes [5]. One of the major causes of such conflicts are ageist attitudes held by non-elderly people. Older adults are often perceived as incompetent

and stubborn [11]. Since such negative attitudes can lead to the neglect of older adults' will [16], it is important to identify factors associated with ageist attitudes.

In general, when negative attitudes are directed toward others, it is based on the perception that the target belongs to a different group from the self. Such social categorization influences the evaluation of targets and aversive behaviors. This occurs automatically in age-related contexts [9]. For example, a previous study presented Japanese participants with several sentences regarding a certain "speaker" and "number" and asked participants to memorize them [8]. Half of the participants were told that the number was the speaker's favorite number, and the others were told that the number was the speaker's age (which was set as older/younger than the participants' age). Consequently, when the numbers represented the speaker's age, inter-category errors regarding age were significantly less than intra-category errors. This is likely because age-related categorization automatically occurred [8].

As mentioned above, negative attitudes toward others are closely related to the cognition that separates others from the self as outgroup members. This study focuses on social identity theory [19] and disease avoidance mechanisms [15] to further examine ageist attitudes. Specifically, we will examine the relationship between ageist attitudes and (1) youth identity, which is the extent to which people feel they belong to the younger population as opposed to the older population, and (2) impressions of the general older population's physical and mental health. The following is a summary of previous research findings on these factors.

Youth Identity and Subjective Time to Become Older

According to social identity theory, people are more likely to view ingroup members positively and outgroup members negatively by attributing their identity to the ingroup [2, 19]. Everyone goes from being young to middle-aged as they get older. However, in modern society, people generally tend to place more value on being mentally and physically younger than their actual age [18]. In addition, people try to maintain their self-esteem by viewing ingroup identity

as a part of their identity [2, 19]. Therefore, even if one's age is far from the younger population, people may try to attribute their identity to the social group with a more ideal value of "youthfulness." Based on this, those who strongly perceive themselves as young and have a higher youth identity are likely to have stronger ageist attitudes.

A factor that can influence youth identity is the subjective time to become older (the perception of how long people feel it will be before they become old). People's sense of time has been reported to vary among individuals [7], and the subjective time to become older may vary from person to person [17]. For example, some people are middle-aged but may think that becoming old is still a long way off, while others who are young but may think that becoming old is in near future. Regarding the relationship between the subjective time to become older and youth identity, those who perceive the older population as an outgroup, as in "we are still a long way from becoming old," may have higher youth identity.

Impressions of the General Older Population's Physical and Mental Health

Disease avoidance mechanisms involve focusing on superficial cues, such as coughing or wearing a mask, to direct negative attitudes toward the target, regardless of whether the target is ill [12]. When the target is perceived to be associated with a disease, aversive reactions are automatically directed to the target [13]. Older adults are often perceived as related to disease due to weakened immunity and wrinkles [12]. This study focuses on impressions of the general health of older adults. From the perspective of disease avoidance mechanisms, the target perceived to be unhealthy will be judged to have a strong association with disease. Those who perceive the general older population to be unhealthy may have stronger ageist attitudes.

It has been pointed out that it is important to distinguish between physical and mental health when considering the health of the older population [14]. The physical and cognitive functions of older adults are prone to decline with age [1]. In contrast, unlike physical health, the mental health of older adults does not generally decline with age [22]. It is widely known

that a decline in physical health is physiologically inevitable, but people often do not understand the extent of decline in the general mental health of the older population [23]. However, even with such differences, negative impressions of the general older population's mental health will lead to ageist attitudes.

It would be useful to focus on the concept of controllability and to investigate the difference between impressions of physical and mental health. It is assumed that those who have negative impressions of older people's physical health will attribute the cause of deteriorating physical health to physiological phenomena with less controllability due to aging. However, those who have negative impressions of the older adults' mental health may attribute the cause of deteriorating mental health to the personality, such as "older adults are selfish or have lost their purpose in life," and view the cause as controllable. In general, more negative attitudes are held toward targets with highly controllable and negative aspects [24]. Therefore, people with negative impressions of the mental health of the general older population may have stronger ageist attitudes.

Hypothesis

The hypotheses are as follows: (1) participants with higher youth identity have stronger ageist attitudes, (2) participants with a longer subjective time to become older have higher youth identity, and (3) participants with more positive impressions of the physical and mental health of the general elderly have weaker ageist attitudes, and a stronger relationship is seen in the case of impressions of mental health.

Method

Participants

The result of a sensitivity analysis was posted on the Open Science Framework (OSF) (https://osf.io/p97u4/?view_only=77b81ff11a20427ab12575af134967bd). We recruited 474 Japanese participants (aged 18–64 years old) using the crowdsourcing service CrowdWorks,

which has the largest number of registered users in Japan [3]. The participants were 197 men and 277 women, with a mean age of 39.42 years ($SD = 9.57$). While we believe that the participants were drawn from a wide range of regions in Japan, the limitation of the sampling will be discussed later.

Measures

Ageist attitudes. These were measured by the Japanese short version of the Fraboni Scale of Ageism [4] containing 14 items: three on antilocution (privately expressed prejudice; $\alpha = .68$), six on aversion/discrimination ($\alpha = .76$), and five on avoidance ($\alpha = .84$). Responses were rated on a five-point Likert scale. Mean scores were calculated, with higher scores indicating stronger ageist attitudes.

Youth identity. It was measured using the Japanese version of the Group Identification Scale [20], containing seven items ($\alpha = .86$). Responses were rated on a seven-point Likert scale. Mean scores were calculated, and higher scores indicated a stronger youth identity.

Subjective time to become older. It was measured using a single item, “I think I am still a long way away from becoming an older person.” Responses were rated on a seven-point Likert scale, with higher scores indicating longer subjective time to become older.

Impressions of the physical and mental health of the general older population. Impressions of older people’s physical health were measured using four items ($\alpha = .72$). Similarly, impressions of their mental health were measured using four items ($\alpha = .68$). Responses were rated on a five-point Likert scale. Mean scores were calculated, and higher scores indicated better impressions of the general older population’s physical and mental health.

Demographics. Participants provided information such as gender, age, and nationality.

Procedure and Analysis

This study was conducted in June 2021. Participants responded to an online survey about ageist attitudes, youth identity, subjective time to become older, impressions of the general

older population's physical and mental health, and demographics. The software R (ver. 4.1.0) was used for analysis, and the statistical significance was set at $\alpha = .05$. The scale items, data, and R scripts were posted on OSF.

Results

Table 1 shows the means, standard deviations, and correlation coefficients of each indicator. No ceiling and floor effects were observed (see OSF). To test the hypotheses, we examined a model in which subjective time to become older predicts youth identity, and youth identity and impressions of the physical and mental health of the older people predict ageist attitudes. We also assumed covariate relationships among the three sub-categories of ageist attitudes (antilocution, aversion/discrimination, and avoidance) and between impressions of the physical and mental health of older adults. Structural equation modeling was conducted by controlling for participants' age and gender (Figure 1), and showed a sufficient goodness of fit ($\chi^2(7) = 11.43, p = .12, RMSEA = .04, CFI > .99, AGFI = .96$).

Participants with higher youth identity had stronger aversion/discrimination; thus, Hypothesis 1 was supported. Participants with longer subjective time to become older had a higher youth identity; Hypothesis 2 was supported. While impressions of the physical health of older adults were not associated with ageist attitudes, participants with positive impressions of the mental health of older adults had weaker antilocution, aversion/discrimination, and avoidance; Hypothesis 3 was partially supported.

Discussion

In this study, participants with higher youth identity had stronger aversion/discrimination, probably because they were more sensitive and directed negative attitudes toward older adults as an outgroup that could threaten their identity. Moreover, older adults may have been viewed as an inferior group that did not possess youthfulness, a value considered important in modern society [18]. Although youth identity was negatively correlated with participants' age, it was

not overly biased toward lower scores among older participants; a floor effect did not occur (see OSF). In examining ageist attitudes, the concept of youth identity has not received sufficient attention and needs further examination.

Participants with a longer subjective time to become older, had a higher youth identity. Each of these variables was affected by the participants' age. Younger participants tend to have both longer subjective time to become older and higher youth identity. Conversely, as we controlled for participants' age in the analysis, the relationship between the subjective time to become older and youth identity was significant. Determinants and functions of subjective time to become older have not received sufficient attention in gerontological and psychological research aimed at reducing ageism [17]. Thus, they require further investigation.

This study showed that impressions of the general older population's mental health had a stronger association with ageist attitudes than impressions of physical health. This may be because the decline in physical health with aging is widely known to the public, however, there is a lack of understanding of the decline in mental health [23]. Specifically, those who had negative impressions of older adults' physical health did not show strong ageist attitudes because they viewed older adults' deterioration as less controllable. However, those who had negative impressions of older adults' mental health, showed stronger ageist attitudes because they attributed the cause of deterioration to more controllable and personality aspects, such as "older adults are selfish or have lost their purpose in life" [24]. Such an interpretation is only hypothetical, and we cannot fully discuss the study's data because we did not measure the participants' evaluation of controllability. Therefore, the reason why impressions of the general older population's mental health were strongly related to ageist attitudes, should be re-examined in future empirical studies.

Although the above findings were obtained, there are three limitations. First, it is possible that participants viewed "mental health" in multiple ways. We assumed that the concept of

mental health was a state of high subjective well-being, consisting of emotional vitality and positive functioning [10]. However, this was not made clear to participants and our results should be re-examined in future by conducting a survey with clarifying the definition of mental health. Second, participants were limited to registered users of CrowdWorks. We believe that participants were drawn from wide regions in Japan, but there may have been some bias in their occupation and family structure. It would be necessary to conduct another larger-scale survey using random sampling. It is also necessary to measure and control the demographics such as social status, marital status, and educational level when examining the model. Third, we only examined ageist attitudes rather than behavioral indicators toward older adults. We cannot fully examine whether variables used in this study are also associated with behavioral indicators such as helping behavior. Thus, further empirical studies are required.

Conclusion

This study focused on social identity theory and disease avoidance mechanisms to deepen the investigation of the cognition that separates older adults from the self as an outgroup. Participants with higher youth identity and with less positive impressions of older adults' mental health held stronger ageist attitudes. It is important to extend our model by adding factors that were not considered in this study, such as the relationship between participants' calendar age and the idea of the age when old age occurs.

Declarations

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Conflicts of Interests: The authors have no conflicts of interest to declare relevant to the contents of this article.

Ethics Approval: This study was performed in accordance with the principles of the Declaration of Helsinki. Approval was granted by the Ethics Committee of the University of Tokyo (UTSP-21003).

Consent to Participate: Informed consent was obtained from all participants in the study.

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Tables

Table 1

The means, standard deviations, and correlation coefficients for each indicator

	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7
1 Antilocution	3.13	0.75	—						
2 Aver/disc	2.22	0.66	.51 **	—					
3 Avoidance	2.98	0.79	.48 **	.66 **	—				
4 Youth identity	3.61	1.03	.09 *	.14 **	-.01	—			
5 Subjective time	3.96	1.59	.12 **	.14 **	.10 *	.35 **	—		
6 Physical health	3.11	0.61	-.20 **	-.08	-.11 *	.02	-.05	—	
7 Mental health	3.24	0.56	-.21 **	-.17 **	-.14 **	.13 **	.02	.52 **	—
8 Age	39.42	9.57	-.14 **	-.14 **	-.12 *	-.29 **	-.56 **	.16 **	-.02

Note. Aver/disc represents aversion/discrimination. * $p < .05$, ** $p < .01$.

Figures

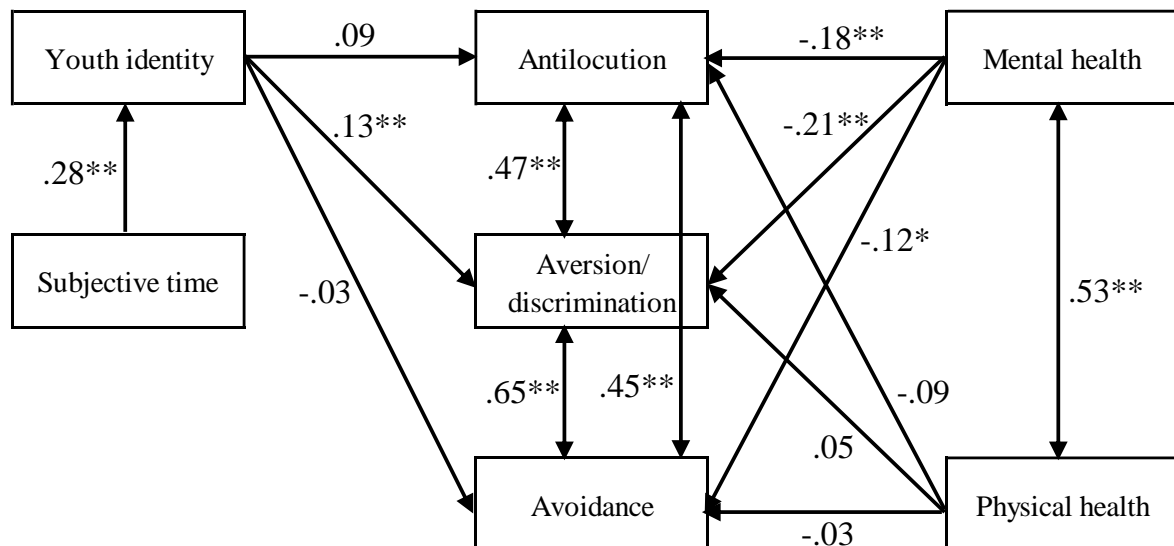


Figure 1. The results of structural equation modeling. * $p < .05$, ** $p < .01$.