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Anti-Ageism for Gerontologists

Nancy Morrow-Howell PhD[a], Suzanne Kunkel PhD[b], Tracey Gendron PhD[c], Shannon E. Jarrott PhD[d], and Carrie Andreoletti PhD[e]

[a]Brown School of Social Work, Washington University, St. Louis, MO, USA; [b]Scripps Gerontology Center, Miami University, Oxford, OH, USA; [c]Department of Gerontology, Virginia Center on Aging, Virginia Commonwealth University, Richmond, VA, USA; [d]College of Social Work, The Ohio State University, Columbus, OH, USA; [e]Department of Psychological Science, Central Connecticut State University, New Britain, CT, USA

ABSTRACT

We argue that gerontologists are products of our ageist culture and that we both perpetuate ageism and suffer from internalized ageism ourselves. We make ageist comments, deny our own age, fail to teach students to recognize and confront ageism, and use language that otherizes and categorizes older people. Gerontologists are in ideal positions to confront ageism through our scholarly work, teaching, and community engagement. However, we suggest that, despite our deep gerontological knowledge, we do not have enough awareness, knowledge, and skills for taking anti-ageism actions in these arenas of our professional lives. We offer some suggestions for confronting ageism, including self-study, increasing content on ageism in the classroom and beyond, pointing out ageist language and behaviors to colleagues and students, working with diversity, equity and inclusion offices on campus, and giving careful consideration to our research approaches and academic writing. To go forward, we must increase awareness about ageism and gain skills in promoting anti-ageism.

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Ageism is discrimination based on age, and it is a ubiquitous, largely invisible presence in our everyday lives (World Health Organization, 2021). From a young age, we are exposed to negative images and messages about what it means to age and be old. The dominant cultural narrative promotes a youth-centric ideal of beauty, vibrancy, and success, while old age is portrayed as something to be feared and avoided (Gendron, 2022; Levy, 2022).

Gerontologists strive to promote the well-being of people as they age, through research, education, practice, and the application of interdisciplinary knowledge of the aging process and the aging population (Gerontological Society of America, https://www.geron.org/about-us/our-vision-mission-and-values/). Colleagues from all disciplines contribute to this endeavor and there

CONTACT Nancy Morrow-Howell morrow-howell@wustl.edu Brown School of Social Work, Washington University, Campus Box 1196, and zip 63130, St. Louis, MO, USA

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is much diversity among professionals who identify as gerontologists. However, we all have something in common: we teach, write, conduct research, practice, and interact within a cultural context where ageism is pervasive. Although we received training on aging as a multidimensional, dynamic, and heterogeneous process, we have all been exposed to and perhaps even blinded to the negative meta-narrative about aging. Through our training and experience, we have gained some understanding that might loosen the grip of ageism on our attitudes and behaviors. For example, we understand the vast diversity within the aging population, and we know that generalizations are misleading. We know that social determinants of health play a more prominent role in late-life experience than chronological age itself. We recognize vitality across the life course, and we can articulate the possibilities of later life that are often overlooked in the public's narrative on aging. The gerontological knowledge we have gained and our experiences with older people as colleagues, community partners, students, and study participants give us a fuller picture of aging and later life. However, despite our academic training and our anti-ageism sensibilities, we too are influenced by the negative societal expectations of older people, the normalization of age-segregated institutions, and the internalized oppression that we feel as we get older.

In this paper, we argue that gerontologists are products of this ageist culture and that we both perpetuate ageism and suffer from internalized ageism ourselves. We provide examples of ageism that we see in ourselves and other gerontological researchers and educators. We acknowledge progress in our field; but we suggest that staying abreast of scientific advances within our areas of gerontological research does not necessarily enhance awareness, knowledge and skills for taking anti-ageism actions in teaching, writing, research, and advising roles. We offer some suggestions for confronting ageism in our professional lives as well as resources to support anti-ageism advocacy efforts. The authors of this paper continue to struggle individually and collectively with our ageist attitudes and behaviors. We have increased our awareness, but we all have much to learn. Our hope is that gerontology professionals will become stronger leaders in an anti-ageism movement toward an age-just society.

Ageism in the professional arena

As educators and researchers committed to combatting ageism, we continue to become more aware of our own ageist tendencies and can't help but notice them in others. We notice how often people make efforts to disguise or deny their age. For example, after being introduced as someone who has served the university for 30 years, a colleague remarks, "If I've been at this school for 30 years, I must have started when I was 12." Or someone might more directly say, "I would tell you about that experience, but it might date me." In general,

we demonstrate an aversion to claiming our own age. How many of us have said "thank you" after being told we don't look our age? We understand that revealing one's age can have negative repercussions in our ageist society; but often we don't tell our age simply out of embarrassment or desire to be considered younger than we are.

Even as gerontological scholars, we are not vigilant or precise about the language we use to describe older people. In our writing and presentations, we otherize older adults. We use the term *aging population* to mean older people when actually we are all aging our entire lives. We use language like *the elderly* or *seniors* — words that conjure negative stereotypes. Research shows that the terms *older people* or *older adults* elicit images that are more positive (Sweetland et al., 2017) – but it is hard to change our habits. In fact, it is more efficient to use labels than to use people-first language, which requires more words and more clarity about the specific population of our focus. Even the more preferable term *older adults* leaves too much to the imagination of the listener or reader. "Older than whom?" is a reasonable question to ask about that label. People-first language (such as people who are retired, people with functional limitations, people who are eligible for a particular service) is more complicated, but it minimizes stereotyping and requires the user to be clear about whom they are talking, and, ideally, why.

Similarly, it is more efficient to categorize people into large age groupings, such as people over the age of 60 (or 65), to describe a population or report our findings. Yet this standard practice masks the great diversity within an age range that can cover more than 50 years (from 60 to 110 years old), leading readers and listeners to oversimplify and overgeneralize. For example, about 8% of people over the age of 65 have a dementia; but that prevalence rate varies from 2% among people aged 65–69 to 33% among those aged 90 and older (Assistant Secretary for Planning and Evaluation, 2019). Presenting a single statistic on the large group of people over the age of 65 enables readers to connect 65+ and dementia; this habit also leads readers to think the condition is uniformly spread across this range. Similarly, we generalize across decades by reifying generational differences; and we accept generational profiling to such an extent that there are resources and consultants to help companies manage an intergenerational workforce, always beginning with what are presumed to be the universal defining characteristics of each generation.

How we choose to name and describe the groups of people we are studying or working with – whether generations or age groups – can reinforce negative stereotypes. For example, we often present our descriptive statistics in ways that highlight the existence of deficits. We report the percent of a certain older population who have a sensory impairment or a chronic condition or a limitation in a certain activity of daily living. We could report the number of people in our age categories that don't experience these challenges. That is, we could report the number of people with no functional limitations or

reporting no disability. What might it mean for an audience to learn that 81% of the US population over the age of 65 does not report any significant disability (Administration on Aging, 2021)? We show charts of the percent of people in certain age groups with cognitive impairment, and we see the trend upward with age; but we don't emphasize that most people, in fact, live their lives without experiencing dementia. This different perspective could reduce the fear and aversion that most of us feel about getting old.

Many of these apocalyptic data practices are tied to advocacy and policy strategies from the 1960s when federal legislation first addressed issues related to the aging of the U.S. population. During this era of compassionate ageism (Binstock, 1983), age was equated with need. Programs and policies were put into place to compensate for the losses that were presumed to be an inevitable component of aging. Unfortunately, this lens continues to be used today, reinforcing the age-as-deficit perspective, despite decades of gerontological research demonstrating the contrary. We acknowledge that we gain the attention of audiences and funders through the catastrophic framing, but it is at the expense of highlighting the success of population aging and increased longevity. This silver-tsunami framing engenders fear of aging, hopelessness about older societies, and generational tensions. Why do we continue to search for ways to extend human life, all the while bemoaning the consequences of this extension?

We usually do not offer more complete definitions of aging to include growth, adaptation, maintenance and decline in biopsychosocial spiritual domains. Most often, we use biological decline as the definition of aging; and then we fail to explain that biological aging per se is not usually the root cause of challenges we face in later life. Biological aging influences risk for some physiological changes and disease processes, but none of these outcomes are inevitable or universal based solely on aging. By failing to make the distinctions among biological aging, disease, and social determinants of health, we contribute to the perception that age alone equals disease and nothing can be done about it. As noted above in the discussion of people-first language, oversimplification and problematic communication habits are at work here. It is more efficient to talk about "older people" than differentiate people with limited digital skills, or with sensory impairments, or with limited range of motion, or with cognitive impairment. When we simulate chronic conditions with foggy glasses or rubber gloves, we aren't careful to teach about the diseases that cause these conditions or to distinguish the specific disease from the process of aging itself. We have our students undertake this exercise to increase empathy with older people, not a person with a specific health condition, which only reinforces the stereotypes we strive to ameliorate.

Unacknowledged and unintentional ageism also shows up in our teaching. The topics we choose to include and the way we approach the topics often promote ageism. As examples, we aim to teach about transportation in an

aging society and then focus on driving and deficits associated with age without acknowledging that most older adults are safe drivers and that adults of all ages may experience an inability to continue driving. We teach about sexuality and then focus on intimate partner relations and cognitive decline when cognitive function is not the most common sexual concern. Despite the reality that older adults generally have more mental well-being than younger people (Thomas et al., 2016), we teach about mental health in later life and then focus on depression and suicide. These aspects of reality are surely important to us as practitioners and advocates; but focusing on a certain "side of the story" reinforces ageist beliefs and increases fear of aging itself. We should strive to approach topics in more balanced ways to include the diverse realities of older people, which overlap with the realities of young and middle-aged adults.

We sometimes allow students to be ageist, even in their training to be gerontological professionals. In an effort to promote a comfortable classroom, we do not always challenge students who use suboptimal language (the elderly) or images of demographic cliffs in presentations. Students are in training settings where elderspeak, simplified speech that sounds like baby talk (Shaw & Gordon, 2021), goes unchallenged; and compassionate ageism arguments are used to justify policies and practices. All of these ageist behaviors present opportunities for education, skill development, and behavior change, but we don't always have the confidence, time, or specific strategies to take corrective actions.

Ageist tendencies are deeply engrained and not always visible to even those professionals who are leading the way in promoting age-inclusivity and more positive views of later life. For example, we continue to use language that "others" those in older age, such as the phrase "age-friendly." Age-friendly has paternalistic undertones and could easily be replaced by using more neutral terminology such as "age inclusive." Further, age-friendly initiatives can be rather superficial and not fundamentally alter explicit and implicit biases toward older people. For example, a health care provider could embrace the 4-M framework of the age-friendly health systems initiative and recognize the important of what matters, medication, mentation, and mobility (Fulmer & Pelton, 2022). Providers can following evidence-based practices in these arenas and continue to view and treat older patients in age-biased ways.

We continue to accept that universities embody "age diversity" if they include lifelong learning programs or intergenerational programming rather than meaningfully embrace how learners of all ages can be supported and integrated in all aspects of university life. We continue to promote the inclusion of training on generational differences in the workplace despite limited empirical support of the validity of generational differences (Rudolph et al., 2020). We know that ageism is also experienced by young adults who are often stereotyped in negative ways; and reifying generational differences promotes ageism against both younger and older people. Reframing the issue requires

disrupting the "othering" of people based on age and generational group. Gerontology has the theoretical foundation of life course (Elder et al., 2003) and life span theories (Baltes et al., 1980) that can be used to counter the dominant narrative claiming that cohorts of people share common traits and characteristics that distinguish them from other cohorts.

Striving to do better

As gerontologists, we must strive to acknowledge, address, and prevent ageism in our own lives. We can and should advocate for anti-ageism training in our own institutions and in organizations with whom we partner. We should be motivated to do this work by the growing evidence produced by our colleagues: ageism has negative consequences. External and internal ageism are associated with negative physical, cognitive and emotional health (e.g., Levy, 2022; Mikton et al., 2021). Age discrimination has financial consequences for individuals and organizations (AARP, 2020). Generational profiling exacerbates the perception of generational conflict; and ageism prevents the attainment of social and economic justice (Gendron, 2022). In these numerous ways, ageism threatens the potential of achieving long and healthy lives.

Here are some ideas for gerontological researchers and educators to confront ageism within our profession and beyond. We organize these suggestions by arenas of interpersonal and institutional practices, research, and teaching.

Interpersonal and institutional practices

- Seek to recognize/identify our own ageist beliefs and behaviors. Catch ourselves when we say, or thank others for saying to us: "You look good for your age" or "I can't believe you are 75!" We are ageist toward ourselves when we say "I am too old for this" or "I'm dating myself when I tell you I was around when . . . ." We are ageist toward younger people when we say "you are too young to understand this." Alternatively, we could tell someone "you look terrific," or tell ourselves "this is harder for me than it used to be, especially if I don't practice as much." When someone tells us we don't look our age, instead of thanking them, we could say, "This is what 60 (or 70 or 80) looks like."
- Point out ageist comments and ideas expressed by our colleagues. This is hard because we don't want to be confrontational or disrespectful. We might try to ask for clarification or share a different perspective. For example, when a colleague comments that they feel "too old" to be dealing with a complicated situation, we might offer: "Your experience is invaluable to untangling this issue. Is there some other reason you might not want to take this on?" The question can open the door for a discussion about ageist attitudes, behaviors, and values.

- Increase awareness about how the larger academic environment where many of us work reinforces ageism. Review practices in our own departments or work groups that might discriminate against older colleagues, who often feel under pressure to retire to make room for new or lower-paid faculty. Review the eligibility requirements of university-level professional development opportunities, and look at the range of awards and funding opportunities that have explicit or implicit bias (e.g., the Young Scholar Award for researchers who are less than 5 years post-degree). There is a trend toward removing dates on CVs or resumes; and some universities are removing dates from applications in the hiring process to reduce age biases in hiring decisions. (See for example, Connecticut's Public Act No. 21-69, making it illegal for employers to require information that reveals an applicant's age.)
- Lead your university in joining the international learning collaborative, the Age-Friendly University Global Network (https://www.geron.org/programs-services/education-center/age-friendly-university-afu-global-network). This organization advances principles, including encouraging the participation of older adults in all core activities of the university, promoting personal and career development across the life course, and facilitating intergenerational learning. The GSA and its Academy for Gerontology in Higher Education have developed "Tools for Advancing Age Inclusivity in Higher Education" and offers a monthly newsletter to share information.
- Connect with diversity, equity and inclusion (DEI) offices on campus. Offer to develop content to include ageism training into existing DEI programming. DEI efforts have developed across organizations with scant attention to age as an identity issue (Morrow-Howell & Gonzales, 2020); persistent and skillful relationship building with DEI personnel will be key, given the resistance that many of us have experienced (Morrow-Howell et al., 2022). It may be useful to emphasize the intersection of age with other identities and the cumulative impact that all forms of discrimination pose to educational attainment and well-being. Offer ideas to increase age diversity and age inclusion in all aspects of campus life (Silverstein et al., 2019).

Research and dissemination

- Become aware of how we talk about older study participants or clients or stakeholders as *them*, and try to use inclusive language, like *all of us*. Instead of discussing transportation as a challenge for older people, talk about transportation challenges that affect all of us.
- Avoid catastrophic language to garner attention in publications and grant proposals. Find more inclusive and accurate language to get your point

across. Talk about the population of older people instead of the aging population or the silver tsunami. Avoid equating age with deficit by using people-first language. Take care not to imply that diseases associated with advanced age are inevitable. Also acknowledge that ableism is a cousin of ageism and can stigmatize differently-abled people. Start from a position of commitment to honor the dignity of all people, regardless of age, ability or need; if your message includes any explicit or implicit reference to those pitiful/greedy/needy/selfish/dependent old people, it is not respectful or inclusive.

- Use the new publication guidelines from our professional associations. From the American Medical Association (2020): Avoid othering terms like seniors, elderly, aged, aging dependents, old-old, young-old, or other similar phrases. From the American Psychological Association (2020): Avoid fatalistic attitudes about aging, such as age or aging societies being an obstacle to overcome. The Gerontological Society of America's publication guidelines (2022) suggest avoiding terms that imply helplessness of people with diseases (ex: instead of "suffering from arthritis" say "diagnosed with arthritis"). The Associated Press Style book (2020) suggests aiming for specificity when space allows (ex: "Delivery man charged in fatal attack on woman, 89" rather than "Delivery man charged in fatal attack on elderly woman." Or perhaps leave out any reference to age at all.
- Critically examine ageism embedded in constructs and research questions. For example, the construct of subjective age asks participants to reflect on how *old* they feel, implying that feeling younger is better, and that *old* is something that can be easily defined. Further, the question is most likely translated as how physically old (frail, weak, unhealthy) one feels, promoting a one-sided view of being old as a state of decline. In our long history of caregiving research, we have focused on caregiver burden, contributing to a dominant view of caregiving as a unidirectional process that leads to burnout and burden rather than a bidirectional process that includes reciprocity and joy. This narrative contributes to ageism by perpetuating the concept of older care recipients only as a drain on resources. We could also do more to document strengths and opportunities in our community-based needs assessments.

Teaching

- Proactively teach students to use different language in speaking and writing. Give instructions on preferred language in the beginning of the semester; then it will be easier to point out when these guidelines are not being followed. Explain elderspeak, its negative effects, and how to address elderspeak in fieldwork settings (McLaughlin, 2020).

- Include content on ageism in the classroom. It is important to define it and describe its prevalence, including ageism directed toward young people. Provide examples and discussion around how it occurs in medical, educational, and work settings as well as in the media. Describe the outcomes of ageism to individuals, organizations, and society. Review interventions that have shown to reduce ageist attitudes and behaviors.
- Engage with the rich resources available to us. The GSA's Reframing Aging initiative is a long-term social change effort aimed at addressing ageism by changing communications – how we talk about and portray aging and older adults (https://www.reframingaging.org/). It is an educational effort aimed at all types of audiences, and there are numerous infographics, downloadable slides, and videos to use in classroom, professional and community presentations. Additionally, GSA offers training to become a facilitator to lead educational sessions on reframing aging strategies. The World Health Organization has the Global Campaign to Combat Ageism, with reports, infographics, and videos available (https://www.who.int/publications/m/item/global-campaign-to-combat-ageism-toolkit). There are curricula to adopt in classroom and community trainings, including AARP's Disrupt Aging Classroom (https://www.aarp.org/disrupt-aging/about-us/classroom) and GSA's Ageism First Aid (https://www.geron.org/programs-services/education-center/ageism-first-aid).

Conclusions

We all have a stake in eliminating ageism because it discriminates against our current and future selves. Further, as gerontologists, our stake in eliminating ageism stems from the reality that the full benefits of our policy and program interventions will not be realized until ageism is eliminated. Interventions intended to address inequities and maximize opportunities are thwarted in their implementation by implicit and explicit ageist actions of administrators, law-makers, and practitioners. For example, the limits of the Age Discrimination in Employment Act are revealed in reports from the EEOC (Lipnik, 2018) that 60% of people reported age discrimination in the workplace, yet only 3% of these persons made formal complaints. And we know that the attitudes and behaviors of supervisors and colleagues undermine efforts to make organizations of any type more age-just.

In sum, we know that we are not immune from being ageist just because we are gerontologists. In our roles as researchers, educators, and advocates, we too often pass on our ageist beliefs, whether conscious or not, and perpetuate the problem. To go forward, we must recognize that we are all ageist, increase awareness about ageism and age stereotyping, and gain skills in promoting anti-ageism among students, colleagues, and community partners. We wrote this editorial as a call to action and hope that it will motivate those who work

in the field to critically evaluate their own work, beliefs, and behaviors and commit to make changes that will foster a more age inclusive society.

Key points

- Despite our training, gerontologists perpetuate ageism and suffer from internalized ageism.
- Gerontologists can continue building knowledge and skills specific to recognizing and confronting ageism and intentionally applying these to our scholarship, teaching, and community engagement more actively than we currently do.
- There is a growing collection of resources to support these anti-ageism efforts.
- Until ageism is eliminated, the full benefits of policies and programs will not be realized.

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ORCID

Nancy Morrow-Howell PhD http://orcid.org/0000-0002-8146-9323
Tracey Gendron PhD http://orcid.org/0000-0001-8975-2302
Shannon E. Jarrott PhD http://orcid.org/0000-0002-0612-4245
Carrie Andreoletti PhD http://orcid.org/0000-0002-9068-5992

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