Abstract
The current study investigates older adults’ perceptions of ageism in the United States during the COVID-19 pandemic. Using tenets of Stereotype Embodiment Theory and the Behaviors from Intergroup Affect and Stereotypes Map framework, we sought to (a) examine whether older adults experienced ageism as self-relevant during the pandemic and (b) understand whether older adults experienced certain media messages and interpersonal behaviors during the pandemic and interpreted them as being motivated by potential paternalistic age stereotypes. Older adults aged 65 and older recruited from the community (n = 73) participated in a semi-structured interview about their perspectives on ageism toward older adults during the pandemic. Participants also completed an online survey about their experiences with a range of messages and interpersonal behaviors throughout the pandemic. We thematically analyzed interview data and identified three primary themes: self-relevance of age stereotypes; awareness of negative, overgeneralized portrayals of older adults; and defenses against self-relevance of age stereotypes. Survey responses were analyzed using descriptive statistics and frequency counts and suggest that participants attributed messages and behaviors potentially imbued with paternalistic ageism as motivated primarily by care and
concern for older adults. The findings add to the field’s understanding of older adults’ experiences and perceptions of ageism in the media and in interpersonal behaviors in the context of COVID-19.

INTRODUCTION

Ageism toward older adults—or negative age-based stereotypes, prejudice, and discrimination enacted toward older adults (Butler, 1969)—is a widely studied (Nelson, 2016), pervasive social problem, with pernicious effects on the mental health (Bai et al., 2016; Chrisler et al., 2016; Lyons et al., 2018), cognitive health (Cohn-Schwartz et al., 2022), physical functioning (Allen, 2016), and overall wellbeing (Kim & Jung, 2021; Sabik, 2015) of older adults. Concern about the ramifications of ageism toward older adults heightened in March of 2020 at the onset of the COVID-19 pandemic (Swift & Chasteen, 2021), as public health messaging stressed the significant risks of the virus to older adults with medical comorbidities (Morrow-Howell et al., 2020). This early concern was actualized, as researchers quantified the increased prevalence of ageist media messaging in relation to the virus (Jeong et al., 2020; Meisner, 2021), described unusual acts of ageism emerging in interpersonal interactions (e.g., “caremongering,” see Vervaecke & Meisner, 2021), and identified symbols of broad disregard for older members of the population (e.g., nursing home resident deaths dropped from total death counts; Fraser et al., 2020). In light of these initial findings, scholars have continued to investigate the scope of ageism toward older adults throughout the COVID-19 pandemic.

Central to understanding ageism directed toward older adults during the pandemic is examining older adults’ perceptions and experiences of ageism from their own perspective: did older adults perceive potentially ageist messaging and behaviors from others as relevant to themselves as individuals? Stereotype Embodiment Theory (SET; Levy, 2009) suggests that stereotypes about aging are embodied by older adults when they are integrated into an older adult’s identity from surrounding cultural cues in a way that negatively affects their health and wellbeing (Levy, 2009). Furthermore, a key component of SET proposes that stereotypes become more salient to older adults not simply when they are pervasive and commonly occurring, but when they are perceived as more relevant to the self (Levy, 2009). As one example, the “senior menu” at the local diner may become increasingly troublesome to a frequent patron who just celebrated their 65th birthday, even though senior menus were ubiquitous throughout their 40s and 50s: because that menu is now personally relevant to them as a person aged 65 or older, they are more likely to identify with other individuals aged 65 or older who also order from that menu (Levy, 2003). As another example, findings from Ng et al. (2016) indicate that holding positive stereotypes about physical and mental health in retirement years is associated with a significant survival advantage for older adults. Moreover, very recent research suggests that older adults who more greatly embody age-related stereotypes about sexuality and intimacy report lower engagement in intimate activities in their older adulthood (Syme & Cohn, 2021). Therefore, the extent to which older adults perceived any ageism that occurred in the context of the COVID-19 pandemic as relevant to the self may have shaped not only their lived experiences of ageism, but also their likelihood of experiencing long-term, negative consequences of that ageism (Levy, 2003, 2009).

A distinct, but equally critical step in elucidating the intersection between the COVID-19 pandemic and ageism toward older adults is understanding older adults’ explanations for increases
in ageism that were documented throughout the pandemic. In other words, if older adults were aware that their age group was being regarded and treated differently during the pandemic, to what did they attribute this differential regard and treatment? The Behaviors from Intergroup Affect and Stereotypes (BIAS) Map framework (Cuddy et al., 2007) outlines that discriminatory behavior (e.g., ageism) toward outgroups is indirectly shaped by stereotypes rooted in the outgroup’s perceived levels of warmth and competence. Importantly, the theory also suggests that emotions toward outgroup members mediates the relation between stereotypes and behaviors. As an outgroup, older adults are commonly regarded as warm, but lacking competence (Cuddy & Fiske, 2002). This paternalistic, high warmth-low competence stereotype profile of older adults (i.e., older adults are kind and friendly, but incapable of doing things for themselves; Fiske et al., 2002) often leads to helping behaviors being enacted toward them (e.g., grocery shopping for an older adult during the pandemic), mediated by feelings of pity. However, according to the BIAS Map framework, helping behaviors are also enacted toward groups perceived as having high warmth and high competence, mediated by feelings of admiration and respect. As a result, it is possible that members of a high warmth-low competence social outgroup (i.e., older adults) could be treated with the same behavior as members of a high warmth-high competence social outgroup, but with different emotions motivating each behavior (e.g., a college student visits their older grandparent during the pandemic because they feel bad for them, and they visit their best friend from high school because they genuinely want to spend time with them). Previous research conducted by Vauclair et al. (2016) indicates that older adults report having experienced more age discrimination when they believe that outgroup members feel pity toward them. Throughout the COVID-19 pandemic, most ageist behavior documented by scholars has been of the benevolent, paternalistic type (e.g., Fraser et al., 2020; Harper, 2020), or ageism motivated by patronizing stereotypes about older adults (e.g., older adults are kind, but also incompetent and helpless; Cuddy & Fiske, 2002) and possibly, feelings of pity. However, it is unknown whether older adults perceived ageism this way, or if they even perceived differential regard and treatment as rooted in ageism at all.

Scant research has considered how ageism toward older adults in the context of COVID-19 was perceived and embodied by older adults throughout the first year of the pandemic in the United States. Furthermore, only a limited amount of research has examined older adults’ reactions to and interpretations of ageism during the pandemic, both in the United States and in Europe (Ayalon & Cohn-Schwartz, 2021; Cohn-Schwartz & Ayalon, 2021; Kornadt et al., 2021). Emerging research on this topic suggests that older adults in Europe were aware of their age group being represented as a homogeneous group throughout the pandemic, and that paternalism toward older adults during the pandemic may have shaped older adults’ perceptions of their identities (Hopf et al., 2021). Other recent work conducted in the United States suggests that older adults’ perceptions of ageism may have influenced social distancing and other protective health behaviors during the COVID-19 pandemic (Graf & Carney, 2021). However, investigating older adults’ explanations for why they were regarded and treated in such ways (i.e., how they experienced and interpreted ageism), as well as considering the extent to which they personally identified with the ageism that permeated our society throughout the COVID-19 pandemic, is a critical step for fully understanding the ramifications of ageism during a public health crisis in the United States. Furthermore, understanding older adults’ experiences and perceptions of ageism during the COVID-19 pandemic could inform educational initiatives, media messages, and social policies used in future public health crises.
The current study

The purpose of the current mixed-methods study was to understand older adults’ interpretations and experiences of ageism during the COVID-19 pandemic. We developed two primary aims and corresponding hypotheses for the current study, based on related, ongoing research about the intersection between older adults’ experiences of ageism and the COVID-19 pandemic (Hopf et al., 2021). We intentionally pursued these aims using a mixed-methods approach to (a) qualitatively examine the degree to which age salience for older adults was shaped in the context of the COVID-19 pandemic, then (b) quantitatively describe how older adults interpreted potentially ageist messages during the COVID-19 pandemic.

**Aim 1**: Qualitatively describe the ways in which older adults did or did not experience ageism as self-relevant (Levy, 2009) during the COVID-19 pandemic.

*Hypothesis*: Given that messaging about the dangers of the COVID-19 virus to all individuals over age 65 grew in both frequency and directness (e.g., Selyukh, 2020), participants will qualitatively describe an increase in the self-relevance of negative age stereotypes.

**Aim 2**: Quantitatively describe older adults’ experiences of messages and interpersonal behaviors potentially imbued with ageism during the COVID-19 pandemic within the context of the BIAS Map framework.

*Hypothesis*: Given the ambiguity of the high warmth-low competence stereotype profile outlined in the BIAS Map framework and the degree to which behaviors resulting from this stereotype profile (i.e., helping behaviors) resemble behaviors associated with a high-warmth high competence stereotype profile, older adults will report that potentially ageist messages and interpersonal behaviors were motivated by compassion toward older adults, but not pity.

METHODS

Participants

A sample of older adults in a metropolitan area of the midwestern United States was recruited between February and April of 2021. Individuals were eligible if they were aged 65 or older and living independently at home at the time of recruitment. The rate of new COVID-19 cases was declining overall between February and April 2021 in the region of interest, as was the rate of hospitalization in major hospitals throughout the area. On February 1, 2021, the average weekly rate of new cases was 50.4 per 100,000 in St. Louis City; the average weekly rate of new hospitalizations was approximately 18 per 100,000 (Centers for Disease Control and Prevention, 2022; City of St. Louis, 2022). On April 1, 2021, the average weekly rate of new cases was 24.1 per 100,000 in St. Louis City; the average weekly rate of new hospitalizations was approximately 9 per 100,000. Furthermore, throughout the recruitment period, the COVID-19 vaccine was being offered free of charge to all individuals who would have been considered eligible (Freed et al., 2021).

Participants were recruited from an ongoing longitudinal study of the impact of COVID-19 on older adults that began in the early summer of 2020. Individuals from the longitudinal study who indicated interest in completing an adjunctive study were contacted by phone to obtain consent. Of the 93 individuals who indicated interest in participating, 10 could not be reached by telephone, and three declined to participate after receiving additional study information. After providing consent, four participants did not complete the study, two participants’ audio recordings could
not be accessed, and one participant’s data was used for pilot testing purposes. Thus, the final sample included 73 participants ($M_{\text{age}} = 73.18$, $SD_{\text{age}} = 5.32$, range = 65–89; Table 1). The sample was predominately White (93.2%) and female (58.9%). All data for the current study were collected in March and April of 2021. To protect participant confidentiality, all participants were assigned a random ID number at the time of enrollment, and all data were tracked and stored using these ID numbers. The Washington University in St. Louis Institutional Review Board approved all study procedures.

### Procedure

Participants reported demographic information (i.e., age, gender, race/ethnicity) as part of the parent study. After obtaining consent over the phone, a research assistant conducted the qualitative interview. Within 24 h of the phone interview, the research assistant emailed the participant a link to the quantitative measures in Qualtrics. Participants who completed both the qualitative and quantitative portions of the study received a $10 Amazon gift card as compensation.

### Measures

#### Qualitative interview

Five interview questions included: (a) *How have older adults been portrayed in the media you’ve seen during the pandemic?* (b) *Do you think that messages in the media about COVID-19 and older people have made you think more about your age?* (c) *Do you think that messages in the media about COVID-19 and older people have made you feel more concerned about your health and well-being?* (d) *Do you think the COVID-19 pandemic has made you think more about your age?* and (e) *Do you think the COVID-19 pandemic has made other people think more about your age?* Interviewers probed participants’ responses using follow-up questions when appropriate (Wethington & McDarby, 2015). Interviews were conducted and recorded by five undergraduate research assistants. Interviews lasted on average 7 min 31 s ($SD = 2$ min 31 s, range = 2 min 51 s–14 min 39 s).
Quantitative measures

Age-focused media messaging
Participants were asked whether they had encountered five unique messages in the media during the pandemic (e.g., a message that advised older people not to leave their home at all because of COVID-19, see Supplementary materials). We developed these items based on work published during the pandemic (Jen et al., 2021) highlighting the ageism that imbued media coverage about older adults and the pandemic (Ayalon et al., 2021; Zhang & Liu, 2021). Any time participants were asked about messages in “the media,” we directed them to think about examples from all media sources, including newspapers, television, the internet, and the radio, as concurrent research to our own indicated that these messages were omnipresent across media sources internationally (Jen et al., 2021; Jimenez-Sotomayor et al., 2020; Meisner, 2021; Ng et al., 2022); however, we did not ask participants to specify in their responses where they had encountered a particular message. After reading each message, participants answered three follow-up questions related to perceived motivations behind that message. Specifically, we were interested in understanding whether messages potentially imbued with ageism were perceived as offensive by older adults, if older adults perceived these messages as rooted in kindness and compassion toward their age group, and if older adults regarded these messages as rooted in pity. As a result, participants first reported the degree to which they were offended by the message on a 5-point scale from 1 (strongly disagree) to 5 (strongly agree). Next, on a similar 5-point scale, participants reported whether they believed the message was said because people care about older adults. Lastly, participants indicated on the same 5-point scale whether they believed that the message was said because others feel bad for older people. For ease of analysis, responses to these questions were recoded as agree, disagree, or neither agree nor disagree. Any combination of responses to these three questions would offer insight into whether older adults believed such messages were motivated by high warmth-low competence or high warmth-high competence stereotypes toward their age group. It would also provide insight into whether older adults were negatively affected by the message.

Age-focused interpersonal behaviors
Participants reported whether nine behaviors had been enacted toward them by another individual during the COVID-19 pandemic (e.g., Somebody advised me not to leave my home at all because of COVID-19, see Supplementary Materials). If the participant indicated that they had experienced the behavior, they then answered three follow-up questions related to perceived motivations behind that behavior. Similarly, we were interested in understanding whether interpersonal behaviors imbued with ageism were perceived as offensive, rooted in compassion, and/or rooted in pity; however, we were also interested in knowing whether older adults believed such behaviors were enacted toward them exclusively because of their age. Therefore, participants first reported the degree to which they were offended by the behavior on a 5-point scale from 1 (strongly disagree) to 5 (strongly agree). Next, using the same 5-point scale, participants reported whether they believed the behavior was enacted because people care about older adults. Participants also indicated on the same 5-point scale whether they believed that the behavior was enacted because others feel bad for older people. Lastly, using the same scale anchors, participants reported whether they believed that the behavior had been enacted towards them because of their age. For ease of analysis, responses to these questions were recoded as agree, disagree, or neither agree nor disagree. Any combination of these responses would offer insight into whether
older adults attributed such behaviors as motivated by high warmth-low competence or high warmth-high competence stereotypes toward their age group.

**Data analysis**

Audio recordings of the semi-structured interviews were transcribed into text documents. We conducted a thematic analysis of the interviews, using an inductive coding approach and identifying themes at the semantic level (Braun & Clarke, 2006). Our bottom-up analysis was shaped by the authors’ preexisting knowledge about and interest in SET (Levy, 2009) and the BIAS Map Framework (Cuddy et al., 2007), or, in other words, our “theoretical and epistemological commitments” (Braun & Clarke, 2006, p. 84). However, our analytic method relied squarely on participant responses to guide the identification of themes. Therefore, our organization and understanding of themes in these data is often consistent with previous research and reflects an effort to integrate our findings into the literature in a parsimonious and efficient manner, not to constrain participant responses by preformed hypotheses. All coding was conducted manually: each coder received clean, electronic copies of the interview transcripts and used the comment function in Microsoft Word to make notes and assign codes in the text of each transcript. The research team carefully adhered to standards put forth for conducting and reporting qualitative research (O’Brien et al., 2014).

First, three members of the research team (MM, CHJ, MCP) independently read the first five transcripts in full. Each team member took notes about each transcript (e.g., recurring ideas, similarities in language across participants) and identified potential themes for exploration. The team met as a group to discuss notes about the transcripts and preliminary codes. A set of 14 preliminary codes was established and recorded in a codebook as a provisional coding scheme (Miles et al., 2014). This provisional coding scheme was reviewed with author BDC to ensure agreement with the plan and coding scheme. Next, authors CHJ and MCP applied the full provisional coding scheme to the five transcripts which had already been read and coded, then met again to confirm consistency of the coding approach. The same two coders repeated this process again a second time: five new transcripts were coded using the provisional coding scheme, then a meeting was convened to discuss new observations, resolve discrepancies in how codes had been applied, consider new emergent themes, and confirm that the codebook had been utilized consistently by each coder. Again, the coding scheme was updated and reviewed in full by both coders, then finalized. All 10 transcripts that had been coded using the preliminary coding scheme were reviewed and confirmed for consistency with the final coding scheme. The remaining 63 transcripts were coded by CHJ and MCP in sets ranging between 10 and 19. Coders met weekly after coding each set to resolve discrepancies and confirm that the codebook had been applied consistently by both coders. Any minor discrepancies in coding were resolved between the two coders before moving onto coding the next set. No major instances of coder drift were noted by coders throughout the coding process.

After coding was complete, three members of the study team (MM, CHJ, MCP) met three times to complete thematic analysis and to determine how individual codes coalesced into subthemes and themes. At that point in the coding process, we referenced and discussed our knowledge of the field’s understanding of ageism toward older adults, then applied this knowledge in our final conceptualization of primary theme categories. Ultimately, the thematic analysis suggested three primary themes in our data, with subthemes assigned to each primary theme.
We used descriptive statistics to determine the frequency and prevalence with which study participants encountered messages and interpersonal behaviors imbued with ageism. We also calculated descriptive statistics to examine participants’ impressions of the motivation behind ageist messages and behaviors.

RESULTS

Qualitative perspectives on COVID-19 and aging

Our thematic analysis suggests three primary themes in the data: self-relevance of age stereotypes in the context of COVID-19; awareness of negative, overgeneralized portrayals of older adults; and defenses against self-relevance of age stereotypes. Each theme was further organized into several subthemes reflecting common beliefs and experiences across participants.

Theme 1: self-relevance of age stereotypes in the context of COVID-19

The following four subthemes illustrate several ways participants felt that their age was brought to the forefront during the COVID-19 pandemic and became increasingly salient, or self-relevant.

Subtheme 1: self-aware of age

Participants commented that since the COVID-19 pandemic, they had become more aware of their age, or that they had paid more attention to their age because of messaging about older adults’ increased risk of contracting or dying from COVID-19:

I’m 69, and so age has never really been something that I’ve focused on. But now since it puts me in a higher rate for getting COVID, I’ve certainly become more aware of my age. (Participant 20, 69 years old, female, White)

Participants also stated that prioritizing COVID-19 vaccinations for older age groups made age much more salient in their lives:

Paying attention to “where’s my age and where’s my history and what does that make me in getting vaccinated?” . . . so that was all based on age . . . It may be I’m more aware of my age because a lot of the procedures for getting a vaccination were age things. (Participant 47, 69 years old, male, White)

Subtheme 2: changes in feelings and beliefs about age

While some participants indicated simply being more aware of their age, other participants reported “feeling older” because of the COVID-19 pandemic. Participants referenced changes in appearance related to aging, such as several participants who mentioned that they were not able
to visit hair salons because of the pandemic and could not color their hair, making them feel significantly older: “My hair [was] gaining so much length and I wasn’t coloring it. I just started to look old.” (Participant 50, 70 years old, female, White).

Participants also commented that since the pandemic began, they had increasingly felt like a member of the older adult age group: “You know, it hit me like a brick that I’m getting older than the general population. You know, I never felt that old until I started seeing all these stories about older people” (Participant 19, 69 years old, male, White). These participants voiced a realization that a group they had once perceived as an outgroup was suddenly their ingroup: “Don’t [sic] have to be afraid of this until our kids said, ‘You are that group now,’ which has made us more aware of our age than we were before” (Participant 7, 69 years old, female, White).

Subtheme 3: mortality salience and limited time horizon

In addition to being more aware of their age and feeling older because of the COVID-19 pandemic, participants described feeling as though they had a limited amount of time to live and that they were running out of time to enjoy with friends and family. Participants reported that lost time with loved ones was a direct trade-off of isolating themselves to protect against the COVID-19 virus: it “just changed life for a year, put everything on hold, and there aren’t that many years left . . . we’re both losing out on the time we could’ve had closer to our kids” (Participant 7, 69 years old, female, White). On the other hand, some participants reported that because risk of death from COVID-19 was especially high for older adults, thinking about the possibility of death enabled them to appreciate life more fully:

I’m 66 years old, and I’ve been retired for a few years, and it really gave me a different perspective on life because, like, I could get this thing and die. All of the things I wanted to do, I never got to do again, and I need to basically start really enjoying what I want to do and all the things on my bucket list that I keep saying, “Well, I’ll do that next year.” You know, I’ve gotten a totally different outlook now. (Participant 2, 66 years old, female, White)

Subtheme 4: perceptions of others

Participants also discussed the effects of age salient discourse during the COVID-19 pandemic in terms of their interactions with other people. For instance, participants reported that other people had treated them differently due to the intersection of the pandemic and their age. Participants described others offering to help them with activities such as grocery shopping, and many stated that they had friends and family call to check in on them. Sometimes, participants appreciated these changes:

You know, so there were people that had me on their list to make sure I had those things, and that felt good. It didn’t seem extreme. But, you know, there were people willing to help. And so they were aware of the fact—they put me on the list of people to check in on . . . that was very nice. (Participant 22, 76 years old, female, White)

Other times, participants did not appreciate others offering to help, or even felt offended:
[They're] just trying to control what I do so that they think I'm going to be more protected. “You don’t need to go out and do this, I'll get it for you,” that type of thing. And I’m very big on doing what I can for myself—I’m handicapped—and I try and keep my self-worth by not asking others to help me. (Participant 11, 68 years old, male, White)

Theme 2: awareness of negative, overgeneralized portrayals of older adults

In response to questions regarding the media’s coverage of the COVID-19 pandemic, participants said that when older adults were described as a social group, they were often portrayed negatively and with little variability, as exemplified in the subthemes below.

Subtheme 1: exaggeration

Participants described feeling as if the media focused too extensively on COVID-19 throughout the pandemic. Moreover, some stated that the media embellished information and only reported negative news:

You know, I think they try to make a story out of everything and therefore they sensationalize a whole lot of things, scaring people, quite frankly, to death and just really overdoing the whole thing. I know this is a serious, serious story, but it doesn’t have to be this old story on the news all the time. They have to find the negative thing to say. Whether it has to do with older adults or whatever. They gotta find something big or it’s not a news story. So they overload us with bad news. (Participant 51, 74 years old, male, White)

Participants also highlighted the media’s attention to worst case scenarios that did not accurately portray the impact of the pandemic for most people. Consequently, some participants noted feeling more fearful about the virus, like Participant 52, who stated, “They always take the worst-case scenario, and so it makes me think that just because—even though I’m in excellent health, that I could be vulnerable to this” (74 years old, female, White). Overall, participants believed that the media overstated the effects of the pandemic in a way that was out of proportion to the actual threat of the virus.

Subtheme 2: homogeneous group

Participants also reported a tendency for the media to portray all adults over the age of 65 as a single, monolithic group. They felt as if the media focused too extensively on the older end of the age spectrum, with little acknowledgement of different age ranges:

I do feel like they’ve put more emphasis on the older people like in 80s and 90s when, you know, people between 65 and 80, they kind of are ignoring us. It’s like they have
one view of older people and it’s the extremely old. (Participant 9, 70 years old, female, White)

Participants also commented on the media’s focus on older adults in vulnerable health states, such as those living in skilled-nursing settings:

Most of [the older adults shown on television] have been in nursing homes, but in person, I know that’s not true. But that’s basically all you saw, people that were in nursing homes . . . what I’m saying is most of the older people that you saw and the ones first getting the vaccinations—this was on TV—have been residents of nursing homes or assisted living places. It was those people I saw. I know, I personally know that’s not—I know there’s other places but that’s all they basically—the ones on TV that’s all I saw. (Participant 37, 71 years old, female, White)

Participants saw the need for greater diversity in the media’s portrayal of the older adult population.

Subtheme 3: vulnerability

Participants also commented that the media portrayed all older adults as vulnerable and susceptible to adverse outcomes should they contract the virus:

[The media] claims that [older adults] are more susceptible and they’re more susceptible to death. Mainly what I’m seeing, especially when the pandemic first started, is the fact that the elderly [sic] were very vulnerable, in that I believe they were trying to say that if you get it, you would probably die, is the way I took it. Because they were saying older adults don’t do well with it. (Participant 76, 72 years old, female, White)

Moreover, participants suggested that the media portrayed the heightened risk for older adults through images shown on television news programming:

Most [of the older adults shown on television] are hospitalized. Look as if they’re in dire straits, many of them are intubated. There’s also comments about people being isolated, which is certainly true. Loneliness, depression . . . I haven’t seen anything good about older people in the pandemic, that’s for sure. (Participant 84, 83 years old, female, White)

Overall, participants stated that the media portrayed all older adults as at risk for the most adverse health outcomes should they contract COVID-19.

Subtheme 4: helpless

Some participants reported that messages in the media portrayed older adults as second-class citizens or unable to keep up with the times. Participants reported that these messages depicted older adults as unable to think for themselves: “They treat them as a third party, as not as quite
equal in their intelligence” (Participant 5, 84 years old, male, White). Others commented that some older adults’ hesitancy to adopt technological innovation led to challenges in finding and adopting behaviors to lessen their risk of getting COVID-19:

In some cases [the media portrayed older adults as] not being able to work the system. All of the stuff—so much of it was online. You know to hunt for vaccines and to register to get them and to even find out where they were being given and a lot of older people are not that hip online. (Participant 47, 69 years old, male, White)

**Theme 3: defenses against self-relevance of age stereotypes**

In contrast to the previous themes, some participants said the COVID-19 pandemic had not led to greater salience of age (either positive or negative). Subthemes reflect the range of ways in which participants described feeling shielded from ageism and negative age stereotypes in the context of the pandemic.

**Subtheme 1: perseverance**

Participants reported that they continued to feel or behave the same way throughout the pandemic, despite warnings about the detrimental effects of COVID-19 for older adults. This perspective was showcased in disregard for the general public’s concern about older adults:

I mean, I know that COVID-19 supposedly is much more deadly for old people, and I’m certainly an “old people” in terms of my age, and that’s what it is. I’m not going to worry about it. (Participant 43, 77 years old, male, White)

Other participants’ responses demonstrated that they pursued life in many of the same ways as they had prior to the pandemic, and that they were determined not to let the pandemic preclude them from meaningful activities despite their age:

I’ll put it this way: we didn’t cloister ourselves. We went back to work in May last year, and we travelled in the summer, and we travelled in the fall. But after a while, you just say, hey, get on with life. (Participant 16, 72 years old, male, White)

**Subtheme 2: increasing self-relevance of other identities**

When asked whether media messages about COVID-19 and older adults had made them more concerned about their health and wellbeing, participants suggested that sometimes they thought about aspects of their identity other than age when thinking about the pandemic. For example, participants stated that previous experiences in the workforce had shaped their concerns toward the pandemic: “The majority of my work has been hospitals, so I see the importance . . . of patient care . . . that it just, it just really impacts everyone” (Participant 58, 70 years old, female, Black). Similarly, other participants cited their professional identities as shaping their approach to messaging about the pandemic, like Participant 64, who worked as “a microbiologist, so I’ve always
been very careful about, like, washing my hands, not touching things . . . it’s just kind of my—I guess my training more than anything” (70 years old, female, White).

Subtheme 3: lesser concern about age during COVID-19 due to other concerns

Participants reported that concerns about other chronic and life-limiting illnesses had superseded concerns about COVID-19: “There’s one thing that makes me think about my age, and it wasn’t COVID-19. I’ve got arthritis . . .” (Participant 37, 71 years old, female, White). As another example, one participant emphasized her general experiences with aging and physical deterioration, stating, “I’m already concerned about my age physically because every day there’s something new. Like right now, I’m having a problem with one of my knees, so you know, I don’t think COVID has made any difference” (Participant 59, 89 years old, female, White).

Subtheme 4: distancing from age stereotypes

In contrast to participants for whom the pandemic had made their age seem more salient, others reported a distancing from other members of their age group. One manifestation was the tendency to speak about older adults in the third person: “I feel like they have been downgraded in the sense that they have no sense to make decisions for themselves” (emphasis added; Participant 14, 70 years old, female, White). Participants also commented that they did not uniformly consider themselves to be a member of the older adult category. As one example, some participants noted the discrepancy between how older adults were referenced in the media and how participants felt about their age:

They’ve blocked all people 65 and older into so called “elderly,” and I walk two miles a day and I am on zero medication, so I feel like my health is excellent and I don’t feel old! But those kinds of messages, where they lump everybody in together as, ‘you’re elderly,’ and I’m like, so I look in the mirror, I don’t see elderly! (Participant 66, 65 years old, female, White)

Experiences with and perceptions of media messages

Nearly all participants encountered messages in the media stating that older adults were more likely to contract COVID-19 (n = 71, 97.3%), were more likely to die from COVID-19 (n = 71, 97.3%), and should receive the COVID-19 vaccine (n = 70, 95.9%) (Table 2). A large majority of participants (n = 62, 84.9%) also reported having encountered a message in the media that people should be more careful around older adults. Just over half of participants (n = 43, 58.9%) reported having encountered a message that older adults should not leave their homes at all. By and large, however, participants attributed these media messages to care and concern for older adults. Depending on the message, between 59.2% and 77.1% of participants indicated perceiving messages in the media as being motivated by care and concern for older adults. Overall, few participants reported that they were offended by age-related media messaging: depending on the message, between 12.9% and 18.6% of participants described feeling offended by each message.
| Media message | Experienced (yes) | Occurred because I am old | Message or behavior offended me | Occurred because people care about older adults | Occurred because people feel bad for older adults |
|---------------|-------------------|---------------------------|----------------------------------|-----------------------------------------------|-----------------------------------------------|
| N (%)         | N (%)             | N (%)                     | N (%)                            | N (%)                                         | N (%)                                         |
| OAs have higher likelihood of getting COVID-19 | 71  97.3 | – – | 10  14.1 | 49  69.0 | 15  21.1 |
| OAs more likely to die from COVID-19 | 71  97.3 | – – | 12  16.9 | 42  59.2 | 15  21.1 |
| OAs should get the COVID-19 vaccine | 70  95.9 | – – | 10  14.3 | 54  77.1 | 15  21.4 |
| People should be more careful around OAs | 62  84.9 | – – | 8  12.9 | 41  66.1 | 16  25.8 |
| OAs should not leave their home at all | 43  58.9 | – – | 8  18.6 | 28  65.1 | 10  23.3 |

| Interpersonal message/Behavior | Experienced (yes) | Occurred because I am old | Message or behavior offended me | Occurred because people care about older adults | Occurred because people feel bad for older adults |
|-------------------------------|-------------------|---------------------------|----------------------------------|-----------------------------------------------|-----------------------------------------------|
| N (%)                        | N (%)             | N (%)                     | N (%)                            | N (%)                                         | N (%)                                         |
| Someone told me that I have a higher likelihood of getting COVID-19 | 47  64.4 | 38  80.9 | 6  12.8 | 44  93.6 | 6  12.8 |
| Someone told me that I needed to get the COVID-19 vaccine | 47  64.4 | 28  59.6 | 3  6.4 | 41  87.2 | 4  8.5 |
| Someone “checked in on me,” without me asking, to see how I was doing | 46  63.0 | 25  54.3 | 2  4.3 | 46  100.0 | 7  15.2 |
| Someone told me they needed to be more careful around me because they might give me COVID-19 | 35  47.9 | 24  68.6 | 0  0.0 | 32  91.4 | 5  14.3 |
| Someone told me not to leave home at all | 23  31.5 | 16  69.6 | 4  17.4 | 20  87.0 | 3  13.0 |
| Someone acted surprised that I was still doing an in-person activity | 25  34.2 | 10  40.0 | 5  20.0 | 20  80.0 | 2  8.0 |
| Someone told me that I am more likely to die from COVID-19 | 18  24.7 | 14  77.8 | 2  11.1 | 13  72.2 | 4  22.2 |
| Wasn’t included in/invited to a social event | 19  26.0 | 9  47.4 | 1  5.3 | 17  89.5 | 3  15.8 |
| Someone assumed I was feeling depressed, anxious, or lonely | 13  17.8 | 7  53.8 | 2  15.4 | 11  84.6 | 7  53.8 |

Note: OAs = older adults.
To understand whether participants believed that certain messages were rooted in mixed stereotypes about older adults as a group (e.g., high warmth-low competence), we examined participant endorsement of more than one explanation for a certain message (Table 3). Most participants agreed that media messaging related to the COVID-19 pandemic and older adults was only rooted in feelings of care toward older adults (39.1%–53.6%). A smaller proportion of participants reported that the messages were linked to feelings of both care and pity toward older adults (13.0%–17.6%). Approximately 20% of participants indicated that they did not believe a specific media message to be rooted in care or pity, and that they did not find the message offensive. 

Experiences with and perceptions of interpersonal messages and behaviors

Most participants had been told by another person that they had a higher likelihood of contracting COVID-19 and that they should get the COVID-19 vaccine. More than 60% of participants also reported that somebody had checked in on them, without them asking, during the pandemic. Generally, participants believed these messages and behaviors were motivated by feelings of care and concern. The percentage of participants who attributed interpersonal messages and behaviors to care and concern toward older adults ranged but was consistently an overwhelming majority (82.2%–100.0%). Furthermore, by and large, participants did not report feeling offended by these messages and behaviors. Across interpersonal messages and behaviors, very few participants (0.0%–20.0%) viewed those messages and behaviors as offensive. See Table 2 for complete details. We also examined whether participants perceived interpersonal messages and behaviors as rooted in mixed stereotypes toward older adults as a group, any participants agreed that these messages and behaviors had been enacted toward them because of their age, but also because the people saying and doing them cared about older adults as a group (29.2%–61.7%). A similar proportion of participants reported that these messages and behaviors had been enacted toward them simply out of a place of care for older adults. Participants reported a sense that these messages and behaviors had been enacted toward them simply out of a place of care for older adults. Participants reported a sense that these behaviors stemmed from mixed stereotypes toward older adults (e.g., care and pity) relatively infrequently. See Table 4 for complete results.

DISCUSSION

The purpose of this mixed-methods study was to elucidate older adults’ experiences with ageism in media messaging and interpersonal behaviors in the United States during the COVID-19 pandemic. Specifically, we were interested in understanding, qualitatively, whether older adults felt that their age had become more salient during the pandemic, as Stereotype Embodiment Theory (SET; Levy, 2009) suggests that age stereotypes are embodied when they increase in self-relevance, then become more salient. We also sought to understand whether older adults connected the increases in ageism reported throughout the pandemic (Vervaecke & Meisner, 2021) to feelings of pity, informed by paternalistic age stereotypes held by outgroup members (Cuddy et al., 2007). Our qualitative findings suggest that older adults felt more aware of their age throughout the COVID-19 pandemic and that they were increasingly aware of the media’s tendency to portray older adults as a homogeneously frail and vulnerable group when it came to the virus. Our qualitative results simultaneously suggest that, for several reasons, some older adults were shielded
| Completed all three items | Offend, Care, Pity | Offend, Care | Offend, Pity | Care, Pity | Offend | Care | Pity | None |
|---------------------------|--------------------|--------------|--------------|------------|--------|------|------|------|
| N                         | N                  | (%)          | N            | (%)        | N      | (%)  | N    | (%)  |
| OAs have higher likelihood of getting COVID-19 | 68 | 1 | 1.5 | 5 | 7.4 | 0 | 0 | 12 | 17.6 | 4 | 5.9 | 29 | 42.6 | 2 | 2.9 | 15 | 22.1 |
| OAs more likely to die from COVID-19 | 69 | 1 | 1.4 | 3 | 4.3 | 2 | 2.9 | 10 | 14.5 | 6 | 8.7 | 27 | 39.1 | 2 | 2.9 | 18 | 26.1 |
| OAs should get the COVID-19 vaccine | 69 | 4 | 5.8 | 3 | 4.3 | 1 | 1.4 | 9 | 13.0 | 2 | 2.9 | 37 | 53.6 | 1 | 1.4 | 12 | 17.4 |
| People should be more careful around OAs | 61 | 3 | 4.9 | 3 | 4.9 | 1 | 1.6 | 10 | 16.4 | 1 | 1.6 | 24 | 39.3 | 2 | 3.3 | 17 | 27.9 |
| OAs should not leave their home at all | 43 | 1 | 2.3 | 2 | 4.7 | 1 | 2.3 | 6 | 14.0 | 4 | 9.3 | 19 | 44.2 | 2 | 4.7 | 8 | 18.6 |

Note: OAs = older adults; Offend = Message or behavior offended me; Care = occurred because people care about older adults; Pity = occurred because people feel bad for older adults.
| Completed all three items | Completed Old, Offend, Care, Pity | Completed Old, Offend, Care | Completed Old, Offend, Pity | Completed Old, Care, Pity | Completed Old, Offend | Completed Old, Care | Completed Offend, Care |
|--------------------------|----------------------------------|-----------------------------|-----------------------------|--------------------------|----------------------|---------------------|----------------------|
| N                       | N (%)                           | N (%)                       | N (%)                       | N (%)                    | N (%)                | N (%)               | N (%)                |
| Someone told me that I have a higher likelihood of getting COVID-19 | 47 1 2.1 | 2 4.3 | 0 0 | 4 8.5 | 0 0 | 0 0 | 29 61.7 | 3 6.4 |
| Someone told me that I needed to get the COVID-19 vaccine | 45 1 2.2 | 0 0 | 0 0 | 3 6.7 | 0 0 | 0 0 | 21 46.7 | 1 2.2 |
| Someone “checked in on me,” without me asking, to see how I was doing | 46 1 2.2 | 0 0 | 0 0 | 4 8.7 | 0 0 | 0 0 | 20 43.5 | 1 2.2 |
| Someone told me they needed to be more careful around me because they might give me COVID-19 | 35 0 0 | 0 0 | 0 0 | 5 14.3 | 0 0 | 0 0 | 18 51.4 | 0 0 |
| Someone told me not to leave home at all | 21 1 4.8 | 2 9.5 | 0 0 | 2 9.5 | 0 0 | 0 0 | 9 42.9 | 0 0 |
| Someone acted surprised that I was still doing an in-person activity | 24 1 4.2 | 0 0 | 0 0 | 1 4.2 | 0 0 | 0 0 | 7 29.2 | 2 8.3 |
| Someone told me that I am more likely to die from COVID-19 | 18 1 5.6 | 1 5.6 | 0 0 | 2 11.1 | 0 0 | 0 0 | 7 38.9 | 0 0 |

(Continues)
| Completed all three items | Old, Offend, Care, Pity | Offend, Care, Pity | Old, Offend, Care | Offend, Care | Old, Offend | Old, Care | Offend, Care |
|---------------------------|-------------------------|-------------------|------------------|-------------|------------|----------|-------------|
| N                         | N (%)                   | N (%)             | N (%)            | N (%)       | N (%)      | N (%)    | N (%)       |
| Wasn’t included in/invited to a social event | 19 | 1 | 5.3 | 0 | 0.0 | 0 | 0 | 1 | 5.3 | 0 | 0.0 | 0 | 0.0 | 7 | 36.8 | 0 | 0 |
| Someone assumed I was feeling depressed, anxious, or lonely | 13 | 1 | 7.7 | 0 | 0.0 | 0 | 0 | 1 | 7.7 | 0 | 0.0 | 0 | 0.0 | 4 | 30.8 | 0 | 0 |

| Completed all three items | Old, Pity | Offend, Pity | Care, Pity | Old | Offend | Care | Pity | None |
|---------------------------|---------|-------------|----------|-----|-------|------|------|------|
| N                         | N (%)  | N (%)       | N (%)    | N (%) | N (%) | N (%) | N (%) | N (%) |
| Someone told me that I have a higher likelihood of getting COVID-19 | 47 | 0 | 0.0 | 0 | 0.0 | 1 | 2.1 | 2 | 4.3 | 0 | 0 | 4 | 8.5 | 0 | 0.0 | 1 | 2.1 |
| Someone told me that I needed to get the COVID-19 vaccine | 45 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 2 | 4.4 | 1 | 2.2 | 14 | 31.1 | 0 | 0.0 | 2 | 4.4 |
| Someone “checked in on me,” without me asking, to see how I was doing | 46 | 0 | 0.0 | 0 | 0.0 | 2 | 4.3 | 0 | 0 | 1 | 2.2 | 17 | 37.0 | 0 | 0.0 | 0 | 0.0 |

(Continues)
**TABLE 4**  (Continued)

| Completed all three items | Old, Pity | Offend, Pity | Care, Pity | Old | Offend | Care | Pity | None |
|---------------------------|-----------|--------------|------------|-----|--------|------|------|------|
| N | N (%) | N (%) | N (%) | N (%) | N (%) | N % | N (%) | N (%) |
| Someone told me they needed to be more careful around me because they might give me COVID-19 | 35 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 1 | 2.9 | 0 | 0.0 | 9 | 25.7 | 0 | 0.0 | 2 | 5.7 |
| Someone told me not to leave home at all | 21 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 2 | 9.5 | 1 | 4.8 | 4 | 19.0 | 0 | 0.0 | 0 | 0.0 |
| Someone acted surprised that I was still doing an in-person activity | 24 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 2 | 8.3 | 8 | 33.3 | 0 | 0.0 | 3 | 12.5 |
| Someone told me that I am more likely to die from COVID-19 | 18 | 1 | 5.6 | 0 | 0.0 | 0 | 0.0 | 2 | 11.1 | 0 | 0.0 | 2 | 11.1 | 0 | 0.0 | 2 | 11.1 |
| Wasn’t included in/invited to a social event | 19 | 0 | 0.0 | 0 | 0.0 | 1 | 5.3 | 0 | 0.0 | 0 | 0.0 | 7 | 36.8 | 0 | 0.0 | 2 | 10.5 |
| Someone assumed I was feeling depressed, anxious, or lonely | 13 | 0 | 0.0 | 1 | 7.7 | 4 | 30.8 | 1 | 7.7 | 0 | 0.0 | 1 | 7.7 | 0 | 0.0 | 0 | 0.0 |

*Note: Old = occurred because I am old; Offend = Message or behavior offended me; Care = occurred because people care about older adults; Pity = occurred because people feel bad for older adults.*
from over-identifying with potentially ageist commentary and behaviors which occurred during the pandemic, reporting that rather than (or in addition to) focusing on their age, they leaned into other parts of their identities or life experiences throughout the pandemic. Our survey results revealed that while most of the sample had encountered media messages or interpersonal behaviors potentially imbued with ageist undertones, they attributed these messages and behaviors to concern for older adults during the COVID-19 pandemic: they rarely perceived these messages and behaviors as rooted in pity toward their age group, and they were almost never offended by them. Although participants in the current study were aware of fearmongering rooted in stereotypes about their age group throughout the COVID-19 pandemic, they did not universally identify ageism in media messaging, identify with ageism that was present in media messaging, or report feeling offended by behaviors that may have been enacted toward them because of their age.

In Aim 1, we hypothesized that participants would describe increased self-relevance of negative age stereotypes during the COVID-19 pandemic. In the context of SET, our qualitative findings underscore that older adults' increased awareness of ageism toward older adults during the COVID-19 pandemic often, but not always, had the effect of increasing the self-relevance of negative age stereotypes (Levy, 2009). This finding partially supports our hypothesis about the self-relevance of age to older adults during a time when ageist messages and behaviors about all people over age 65 were increasingly commonplace in the United States. However, according to participants' responses, older adults—whether consciously or unconsciously—still deployed strategies, like psychological distancing from their identity as an older adult (Schimel et al., 2000) and prioritizing other aspects of their identity (Siebert et al., 1999), which seem to have partially buffered against the potential damaging effects of negative age stereotypes. Indeed, Thoits’ (1983) framework of identity relevance suggests that the stress associated with certain identities (e.g., older age) is less threatening and damaging to individuals who associate less so with that identity. As a result, it is possible that this strategy served as a protective mechanism for older adults in our study sample, shielding them from an overwhelming self-relevance of age. Importantly, based on the SET framework, this approach taken by older adults, whether consciously or unconsciously, could have protected older adults from more detrimental consequences of negative age stereotypes embodiment throughout older adulthood (Levy et al., 2009).

In Aim 2, we hypothesized that older adults would report that potentially ageist messages and interpersonal behaviors were motivated by compassion toward older adults, but not pity. Although the BIAS Map framework suggests that behaviors enacted toward outgroup members who are stereotypically viewed as being high in warmth but low in competence are often motivated by pity (Bye & Herrebroden, 2018), our quantitative findings indicate that older adults did generally interpret COVID-19-related messages and behaviors as arising from compassion toward older adults, and less so from pity. Even when we examined the degree to which participants perceived messages and behaviors arising from mixed stereotypes (e.g., care and pity), we observed that the tendency was for participants to perceive these messages and behaviors as motivated by primarily by care, even when they also believed they occurred due to their old age. Furthermore, older adults did not frequently say that they were offended by the messages and behaviors imbued with ageism that they encountered in the media or in interactions with other people. These results partially support our hypothesis: older adults seem to have realized that they were the subject of paternalistic attitudes and stereotypes throughout the pandemic, but they were not overtly bothered by being regarded in this way. In other words, even when they recognized that society was treating them differently during the COVID-19 pandemic, they were not overly concerned about whether it was coming from a place of paternalism. These results represent a clear extension of the BIAS Map framework in terms of outgroup members’ attributions of the emotions underlying
behaviors directed toward them. Though there is clear, replicable evidence that feelings of pity mediate the relation between the high warmth-low competence stereotype profile and helping behaviors (Sadler et al., 2015), outgroup members on the receiving end of those helping behaviors may be squarely focused on the function of the behavior itself, and less so on attributes of themselves that motivated the behavior in the first place.

Our results also point to an interesting dichotomy between the ways in which older adults may have interpreted the sentiments behind media messages differently than interpersonal messages and behaviors. A subset of participants reported that they did not perceive various media messages as offensive, motivated by care, or motivated by pity: instead, these older adults possibly perceived such messages as motivated by something unrelated, or as neutral, and occurring due to the media’s typical approach to reporting news. On the other hand, far fewer participants reported the same response profile when it came to interpersonal messages and behaviors. In other words, participants more frequently perceived interpersonal messages and behaviors as motivated by one or more of the constructs of interest in our investigation compared to media messages. This finding raises additional questions about the extent to which media messages imbued with ageism were detrimental to the wellbeing of older adults if some older adults did not universally identify them as motivated by perceptions of older adults as warm—but lacking competence—and did not find them offensive.

Social policy implications

Throughout the pandemic, ageism was prominent in messaging about the risks of the COVID-19 virus to older adults in the United States. Ageism rooted in paternalistic stereotypes was front and center in news articles (e.g., “Seniors are the most vulnerable during coronavirus. You can help them”) (Beachum, 2020) and political efforts to protect older adults, such as the “Stay Home. Save Lives. Check In.” campaign (Office of Governor Gavin Newsom, 2020). In reality, the risks of the COVID-19 virus were largest for individuals with comorbid health conditions (Liu et al., 2020). There is, objectively, a high degree of overlap between the older adult population and the population of individuals with chronic, life-limiting health conditions (e.g., diabetes, heart failure), which undoubtedly strengthened the public’s association between the two (Mozaffarian et al., 2016). However, because these two categories of individuals are not mutually exclusive (i.e., there are very healthy older adults, and there are very young people with chronic health conditions), messaging about the virus was not only patronizing, but also misleading for older adults. As a result, our findings point to a need to carefully reexamine our approach to “communication campaigns” targeting specific populations that overlap significantly with other populations (Rogers & Storey, 1987). Media messaging outlets should consider strategies developed in the context of other public health crises, like AIDS (Horner et al., 2008; Myhre & Flora, 2000) to facilitate information exchange that is less stigmatized and more informed in terms of the actual risks to certain populations.

Similarly, but perhaps more importantly, the current study sheds light on how we can do better in terms of how we message about social issues that sometimes, but not always, have dangerous consequences for older adults. As one example, several participants in our study encountered messages that “older adults” should stay home but noted that the images associated with these messages depicted older adults in nursing facilities. It is true that some participants interpreted these messages with a grain of salt, in light of discordant images (i.e., older adults in nursing facilities, who are in poor health, and who have multiple comorbidities, should stay home), but some
did not. Therefore, public health experts should consider the nuances of language in their messaging about the pandemic by framing warnings and agendas in ways that are more specific to the group that is truly at risk. For example, instead of reserving “senior shopping hours” for older adults only, retail stores could label their initiative something like “shopping hours for people with increased vulnerability to the COVID-19 virus.”

Finally, the COVID-19 pandemic produced an overwhelmingly strong public health response in defense of older adult health and wellbeing. However, there are numerous social issues for which older adults are truly at disproportionately increased risk which receive very little coverage in the public health arena. Take the example of suicide, a condition for which men over age 75 are at increased risk (Hedegaard et al., 2021). There is very little public health messaging which draws attention to this serious social issue, and the messaging that does exist about risk of suicide tends to highlight young adults as victims at particularly elevated risk (e.g., Brody, 2019; Miles & Tonsall, 2021). Moreover, there is limited infrastructure in place to combat this known risk factor for men over age 75: Medicare continues to offer low reimbursement rates for older adults seeking psychotherapy from a licensed clinical psychologist (Centers for Medicare and Medicaid Services, 2021). Therefore, the findings of our current work emphasize the importance of prioritizing social and public health issues with known serious consequences for older adults, potentially reevaluating how time, resources, and messaging are allocated in the context of emerging public health crises.

Limitations

Our investigation was limited in a number of ways. First, the demographic characteristics of our sample limit the generalizability of our findings. Our sample was comprised of healthy older adults who were mostly White and non-Hispanic/Latino. As a result, future work should address similar research questions in more diverse samples of older adults, drawing on the perspectives of other groups of older adults with identities that may have further intersected with the COVID-19 pandemic (e.g., Black older adults, indigenous older adults, older adults with physical disabilities). For example, it is possible, yet unknown, whether older adults with other marginalized identities (e.g., Black) perceived those other identities as more or less self-relevant during the COVID-19 pandemic compared to their age (Chatters et al., 2020).

Second, because we recruited any older adult above age 65, our sample is comprised of a somewhat heterogeneous group of “older adults” (e.g., members of the young-old, old-old, and oldest-old; Ortman et al., 2014). Due to the nature of our analyses and the cell sizes required to conduct analyses by age group, our findings cannot credibly speak to differences in the experiences of ageism from members of different age groups. Future work should ensure adequate representation of different age subgroups in study samples to expand potential analyses.

Third, and in terms of methodological limitations, we did not include any qualitative questions or quantitative measures about participants’ ratings of subjective age, or how old they feel they are, irrespective of their biological age (Kotter-Grühn et al., 2016; Terracciano et al., 2021). In the current study, it is possible that collecting ratings of subjective age would have augmented our understanding of the mechanisms underlying participants’ reactions to age-related messages, especially because research conducted in Israel during the COVID-19 pandemic suggests that older adults’ subjective age was related to their psychological experiences throughout the pandemic (Shrira et al., 2020). Expansions of the current work should consider including straightforward, quantitative questions that address this topic (e.g., How old do you feel like you
are (in years)?) in addition to qualitative inquiries (e.g., *What makes you feel like you are younger/older than you actually are? Do you feel like you are younger/older compared to your peers and friends, or to older adults who you see represented in other places?*). Our quantitative results are also potentially constrained by our methodological decision to ask participants whether they perceived each media message or interpersonal behavior as offensive prior to asking whether they perceived the message or behavior as motivated by pity or compassion. The fact that this question appeared before others could have produced demand characteristics for participants and potentially could have suggested a reason for them to rate the message as offensive. Future work should consider phrasing questions in a less direct way so as not to sway participant responses or influence participant appraisals of messages and behaviors.

Finally, our sample was too small to investigate associations between the perpetrator of an interpersonal behavior imbued with ageism (e.g., family member, friend, colleague, stranger) and how participants experienced that behavior. It is certainly possible that the same remark (e.g., You shouldn’t leave your house at all) would be perceived significantly differently if coming from a cherished child or a condescending coworker. Future similar investigations should sample purposively to examine these potential differences more carefully.

**CONCLUSIONS**

Ageism toward older adults was present throughout the COVID-19 pandemic. Our findings highlight the unique ways in which older adults experienced this increase in ageism during the pandemic and underscore the importance of looking to the victims of ageism to understand the true implications of that ageism. Although participants in our sample acknowledged the extent to which old age was increasingly salient throughout the pandemic, many participants also cited an internal resistance to overidentifying with ageist rhetoric, and, more crucially, an internal resistance to overemphasizing the intersection between their age and risks to their health and wellbeing. Above all, our work calls attention to the importance of including the voices of older adults in research about ageism toward older adults, as it is not simply ageism on its own, but how ageism is interpreted and embodied, that shapes the lived experiences of older adults.

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**SUPPORTING INFORMATION**

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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