

Ageism: Prejudice Against Our Feared Future Self

Todd D. Nelson

California State University-Stanislaus

For decades, researchers have discovered much about how humans automatically categorize others in social perception. Some categorizations—race, gender, and age—are so automatic that they are termed “primitive categories.” As we categorize, we often develop stereotypes about the categories. Researchers know much about racism and sexism, but comparatively little about prejudicing and stereotyping based on age. The articles in this issue highlight the current empirical and theoretical work by researchers in gerontology, psychology, communication, and related fields on understanding the origins and consequences of stereotyping and prejudicing against older adults. With the aging baby boomer demographic, it is especially timely for researchers to work to understand how society can shed its institutionalized ageism and promote respect for elders.

Walking down the street, you glance at people, which triggers an attending automatic categorization of each individual along three dimensions: race, gender, and age. This categorization is so well-learned and so fundamental to social perception that researchers refer to these dimensions as “primitive” or “automatic” categories (Bargh, 1994; Brewer, 1988; Fiske & Neuberg, 1990; Hamilton & Sherman, 1994). Indeed, for decades, researchers have studied extensively the influence of this automatic race categorization on impression formation (Dovidio & Gaertner, 1986; Jones, 1997; Schuman, Steeh, Bobo, & Krysan, 1997). The study of racism has been and continues to be a major focus of research (Nelson, 2002b; Plous, 2002; Schneider, 2004). Similarly, a tremendous number of studies have investigated prejudice based on gender (Swann, Langlois, & Gilbert, 1999). However, researchers have devoted comparatively little attention to prejudice based on age: ageism (Butler, 1969; Nelson, 2002a). As an illustration of this point, consider the results of a PsychINFO search I conducted minutes before writing

*Correspondence concerning this article should be addressed to Todd D. Nelson, Department of Psychology, California State University-Stanislaus, 801 W. Monte Vista Ave., Turlock, CA, 95382 [e-mail: tnelson@athena.csustan.edu].

Portions of this article are presented earlier elsewhere (Nelson, 2002a, 2002b).

this article. A search for “racism” yielded 3,111 documents, while a search for “sexism” yielded 1,385 documents, and a search for “ageism” produced only 294 documents.

Why have researchers essentially ignored one of the three critical dimensions upon which we categorize others in social perception? While a number of factors may account for this empirical imbalance, one reason may account for most of this disparity. Age prejudice in this country is one of the most socially-condoned and institutionalized forms of prejudice, such that researchers may tend to overlook it as a phenomenon to be studied (Nelson, 2002a; Palmore, 1999). For example, a cornerstone of the birthday greeting card industry is the message that it is unfortunate that one is another year older. While couched in jokes and humor, society is clearly saying one thing: getting old is bad. A recent survey found that approximately 90 million Americans each year purchase products or undergo procedures that hide physical signs of aging (National Consumer’s League, 2004). Why? Why does society view aging as a negative thing?

A Brief History of Ageism

The institutionalization of ageism has its roots in the increasingly negative way the United States (and to a lesser degree, other countries, see Ng, 2002 for a detailed review) views older adults. Older adults in the United States tend to be marginalized, institutionalized, and stripped of responsibility, power, and, ultimately, their dignity (Nelson, 2002a). It wasn’t always thus. In most prehistoric and agrarian societies, older people were often held in high regard. They were the teachers. By virtue of their age and greater experience, they were regarded as wise and they were the custodians of the traditions and history of their people. In biblical times, if one lived beyond age 50, it was believed he or she was chosen by God for a divine purpose (Branco & Williamson, 1982). However, attitudes toward older people began to shift dramatically with two major developments in civilization. First, the advent of the printing press was responsible for a major change in the status of elders (Branco & Williamson, 1982). The culture, tradition, and history of a society or tribe now could be repeated innumerable times, in exact detail through books, and the status and power elders once had as the village historians was greatly reduced and, in many cases, eliminated.

The second major development in society that led to a shift in attitudes toward the elderly was the industrial revolution (Stearns, 1986). The industrial revolution demanded great mobility in families—to go where the jobs were. In light of this new pressure to be mobile, the extended family structure (with grandparents in the household) was less adaptive. Older people were not as mobile as younger people. These jobs tended to be oriented toward long, difficult, manual labor, and the jobs were thus more suited to younger, stronger workers. Experience in a position was not as valued as the ability to adapt to changes and changing technology. Around

this time, great advances in medicine were taking place, extending life expectancy significantly. Society was not prepared to deal with this new large population of older adults. Society began to associate old age with negative qualities, and older adults were regarded as non-contributing burdens on society (Branco & Williamson, 1982). These negative attitudes have persisted in our society, and have in fact, only increased (Nelson, 2002a; Palmore, 1999). Older persons today are treated as second-class citizens with nothing to offer society and the negative attitudes about aging that give rise to ageism tend to manifest themselves in subtle ways in the daily life of the average older person.

Manifestations of Ageism in Daily Life

Patronizing Language

Paradoxically, people with positive attitudes toward older people often seem to communicate with older people according to negative stereotypes about older persons. Two major types of negative communication have been identified by researchers: *overaccommodation* and *baby talk*. In *overaccommodation*, younger individuals become overly polite, speak louder and slower, exaggerate their intonation, have a higher pitch, and talk in simple sentences with elders (Giles, Fox, Harwood, & Williams, 1994). This is based on the stereotype that older people have hearing problems, decreasing intellect, and slower cognitive functioning (Kite & Wagner, 2002). *Overaccommodation* also manifests itself in the downplaying of serious thoughts, concerns, and feelings expressed by older people (Grainger, Atkinson, & Coupland, 1990). In one study (Kemper, 1994), caregivers at a nursing home were found to speak in simple, short sentences. They repeated their sentences and spoke slower to older adults. Interestingly, this pattern did not vary as a function of the cognitive state or physical health of the individual. What seemed to trigger this overaccommodating speech style was simply the age of the individual. That is, all older persons were treated this way, which suggests a strong influence of a negative stereotype influencing the behavior of these caregivers.

A more negative, condescending form of *overaccommodation* is what is termed *baby talk* (Caporael, 1981). *Baby talk* is a “simplified speech register. . . [with] high pitch and exaggerated intonation” (Caporael & Culbertson, 1986). As the term implies, people often use it to talk to babies (termed *primary baby talk*) but such intonation is used, also, when talking to pets, inanimate objects, and adults (termed *secondary baby talk*). In one of the first experiments on this phenomenon, Caporael (1981) filtered out the content of *secondary baby talk* directed to adults and had young adults attempt to differentiate it from *primary baby talk*. Participants were unable to distinguish between the two types of *baby talk*, which indicates that the only thing that distinguishes *secondary baby talk* from *primary baby talk* is the content. The exaggerated tone, simplified speech and high

pitch of the talk are virtually identical. How do older people respond to this type of treatment? The evidence is mixed. Some data (Edwards & Noller, 1993; O'Connor & Rigby, 1996) shows that some older people have a positive attitude toward this talk, and in fact, they feel better about themselves when they receive more frequent baby talk. Other research shows that older people resent baby talk and negatively evaluate people who speak that way toward them (Ryan, Hamilton, & See, 1994). Caporeal, Lukaszewski, and Culbertson (1983) found that older people who have lower functional abilities preferred secondary baby talk to other types of speech, because it conveys a soothing, nurturing quality. This is interesting because older persons who have higher cognitive and social functioning regard secondary baby talk as disrespectful, condescending, and humiliating (Giles et al., 1994). In addition to these features, secondary baby talk is ageist and insulting because it connotes a dependency relationship (i.e., the target of the secondary baby talk is dependent on the speaker; Caporael & Culbertson, 1986). The use of this type of speech appears to be associated with the stereotype of all older persons as having deficits in cognitive abilities, and therefore needing special communication at a slower, simpler level. Cross-cultural research also indicates that both primary and secondary baby talk appear to be universal, occurring in small preliterate societies as well as modern industrialized cities (Caporael & Culbertson, 1986).

Effects of Pseudopositive Attitudes on Older People

According to Arluke and Levin (1984), infantilization creates a self-fulfilling prophecy in that older people come to accept and believe that they are no longer independent, contributing adults (they must assume a passive, dependent role; Butler, Lewis, & Sunderland, 1991). The acceptance of such a role and the loss of self-esteem (that one derives from feeling like a useful, valued member of society) in an older individual occurs gradually over his/her life, as he/she is continually exposed to society's subtle and not-so-subtle infantilization of older people (Ansello, 1978; Rodin & Langer, 1980). When older people come to believe and act according to these age myths and stereotypes, it then reinforces the maintenance of such stereotypes and treatment of older persons (Grant, 1996).

The cumulative effect of hearing from others that one is "old" will eventually bring about "older" behavior and an "older self-image" in the older individual via a basic self-fulfilling prophecy effect. In a series of studies, Giles and his colleagues (Giles et al., 1994; Giles, Fox, & Smith, 1993) found that elder adult targets of overaccommodation appear (to independent raters) to "instantly age" in that they look, talk, move, think, and sound older than control participants (those with no overaccommodation). Harris, Moniz, Sowards, and Krane (1994) reported that when undergraduates believed they were making a teaching video for an older partner (in another room) were more overtly anxious, and showed signs of withdrawal and negative affect. Students who watched this videotape answered

fewer questions correctly, rated the teacher less positively and felt worse about their own performance. These data represent indirect evidence for the notion that anxiety and negative expectancies directed toward an older target lead that target to also feel anxiety, generalized negative affect (about oneself and one's young interaction partner), and suffer performance deficits as a result.

Ageism in the Helping Professions

One might think that if there was any person who would be least likely to hold stereotypes about and be prejudiced against older persons, it would be those whose job it is to help older persons. Sadly, research has shown that counselors, educators, and other health professionals are just as likely to be prejudiced against older people as other individuals (Pasupathi & Lockenhoff, 2002; Troll & Schlossberg, 1971). For example, Reyes-Ortiz (1997) suggested that many physicians have a negative or stereotypical view of their older patients. Specifically, older patients are often viewed by doctors as “depressing, senile, untreatable, or rigid” (p. 831). Physicians may feel frustrated or angry when confronted with cognitive or physical limitations of older people, and may approach treatment with a feeling of futility (Wilkinson & Ferraro, 2002). Levenson (1981) argued that “medical students’ attitudes have reflected a prejudice against older persons surpassed only by their racial prejudice” (p. 161). He suggests that the medical community implicitly trains doctors to treat patients with an age bias, putting little value on geriatrics in the medical school curriculum. Levenson further suggests that in their medical training, medical students learn to approach the treatment of older people with a noticeable degree of apathy or even disdain. According to Levenson, doctors all too often think that because old age is unstoppable, illnesses that accompany old age are not that important, because such illnesses are seen as a natural part of the aging process.

Curiously, the perpetuation of the myth of aging as a state of continual physical and cognitive decline leads to the continued treatment focus on disease management, versus prevention. Much evidence suggests that many of the “usual” disease processes associated with aging (e.g., osteoporosis, diabetes, blood pressure) can be changed and addressed proactively (Grant, 1996). Indeed, the expectation that older people have cognitive and physical deficits, can be debilitating to the older individual in terms of self-esteem and performance. Avorn and Langer (1982) found that when nursing home residents were helped with a jigsaw puzzle versus simply encouraged, they rated the task as more difficult, believed themselves to be less able, and their performance on the puzzle was much poorer.

Treatment for older people by psychologists shows evidence of stereotypes and ageist views also. Many therapists are what Kastenbaum (1964) calls a “reluctant therapist” when it comes to older clients, because of many pervasive stereotypes therapists may have about older people (e.g., older people don't talk much, or they

talk too much; Garfinkel, 1975). Even when presenting with the same symptoms, older persons are less likely than younger clients to get referred for psychiatric assessments (Hillerbrand & Shaw, 1990). Some evidence suggests that this may be due to the perception by some therapists that the problems of older patients are not as serious or as important as when those identical concerns are expressed by younger patients (Ivey, Wieling, & Harris, 2000). As an indicator of the presumption of a poorer prognosis for the older client, Ford and Sbordonne (1980) found that psychiatrists were more likely to recommend drug therapy rather than psychotherapy for the treatment of depression. In a survey of 350 psychiatrists, Ray, Raciti, and Ford (1985) found that females, and those of a psychoanalytic orientation held the most negative views toward older patients. Gatz and Pearson (1988) suggest that this may not reflect "professional ageism," but rather a tendency to exaggerate the competency and excuse the failings of older clients (in an effort to be non-discriminatory). However, there is a lack of compelling evidence to support this speculation. Because of methodological problems and mixed evidence for ageism in psychological services to older people (e.g., Dye, 1978, found no ageism in diagnoses of depression), it is unclear whether there is a strong ageist bias among mental health professionals. Rather, it may be the case that therapists are more influenced by misconceptions about normal aging processes, and as such, ageist thinking can be addressed in clinical training with increased emphasis on understanding the normal and abnormal aspects of the aging process (Gatz & Pearson, 1988).

The mixed data on the issue of ageism among psychological therapists has led some researchers to the conclusion that the bias observed in the delivery of psychological services indicates not ageism, but *healthism* (stereotypes about individuals who are in poor physical health; Gekoski & Knox, 1990; James & Haley, 1995). In their national survey of doctoral-level psychologists, James and Haley (1995) found that psychologists continue to rate the psychological prognosis of older individuals as worse than younger clients presenting with the same symptoms. These authors also found that psychologists gave worse interpersonal ratings for persons with poor physical health than those with no health problems. In a similar design with undergraduate raters, Gekoski and Knox (1990) found that only people in poor health were rated negatively on personality measures. This is a problem however, because there is no reason why, for example, people in poor physical health should be rated worse on personality dimensions (e.g., introverted-extraverted). Because older adults frequently present with health problems, this may bias psychologists in assessing the presence and extent of any mental health problems (Grant, 1996; James & Haley, 1995). Grant suggests several ways that elements of age bias (and healthism) among medical and psychological health care providers can be changed. Professionals need to (a) continually assess their own attitudes toward older people, (b) confront ageism and healthism where it arises, (c) institute geriatrics programs in hospitals and mental health practices, and (d) integrate into

their training a thorough knowledge of healthism and ageism, as well as become well versed on what happens when humans age.

Elder Abuse

The negative attitudes that lead to ageist behavior also make it easier for the perceiver to regard the welfare and humanity of older adults as less important than that of younger adults. As such, ageism may indeed be a contributing factor that leads some younger adults to neglect, exploit, or otherwise abuse older adults (Quinn & Tomita, 1986). The maltreatment of older adults has become a serious, increasingly common problem that has only recently (i.e., within the last 20 years) received attention from researchers (Hirsch & Vollhardt, 2002). There are many different ways older adults can be (and are) abused. This abuse can take the form of neglect by the caregiver, outright violence, fraud, or exploitation. One reason why this form of abuse is so often underreported is that physicians are not as well acquainted with the problem as they are with other forms of domestic violence. Jones, Veenstra, Seamon, and Krohmer (1997) conducted a survey of American emergency room physicians and found that only 25% of the respondents had training on elder abuse, while 63% had training on spouse abuse, and 87% had training on child abuse. Another reason why the incidence elder abuse is often underestimated is that elder victims of abuse are often afraid to disclose their abuse for fear of retaliation by the abuser (Quinn & Tomita, 1986; Steinmetz, 1983). Abuse against elders is not just an American phenomenon. Researchers have found dramatic increases of elder abuse in Puerto Rico (Sanchez, 1999) and Japan (Tomita, 1999). In Japan in particular, the problem is vastly underreported in large part because the culture leads elders to endure suffering in silence and elders often are not aware that their maltreatment would be classified as abuse (Tomita, 1999). This growing problem, affecting so many older adults, needs much more empirical attention directed toward a better understanding of the incidence rates, the factors that give rise to the various forms of abuse, and prevention and treatment models that effectively address the problem.

Theoretical Perspectives

Researchers have put forth several different views that could account for the origin of ageism in a particular society. Two related approaches have received the most attention, and these show much promise in understanding the genesis and maintenance of age prejudice.

Functional Perspective

This approach holds that negative attitudes toward older adults serve an ego-protective function for the stereotyping individual (Snyder & Meine, 1994).

In other words, these stereotypes help younger persons deny the self-threatening aspects of old age (e.g., that one will become frail, and die eventually). Edwards and Wetzler (1998) found evidence to support this view. Their data showed that when people encounter others who represent a threat to their self, their perceptions of and behaviors toward the threatening person tend to be more negative. It may be the case that by doing this, younger participants were able to reduce anxiety associated with considering older people as a future ingroup.

Terror Management

Terror Management Theory (TMT; Greenberg, Pyszczynski, & Solomon, 1986; Solomon, Greenberg, & Pyszczynski, 1991) suggests that culture and religion are creations that impose order and meaning on the world, and this buffers frightening thoughts of one's own mortality and the seemingly chaotic nature of existence. As we grow up, we learn that being good means being protected (parental approval and protection). Therefore, self-esteem becomes an anxiety buffer in that it helps people deny their mortality. Because older people tend to be associated with death, younger persons may adopt ageist attitudes and behaviors to distance themselves from older people. This may include blaming the older person for their state (e.g., external indicators of aging). Doing this may allow the younger person to deny the reality that they too will eventually become part of that outgroup. TMT represents a fascinating and useful perspective on ageism, and much more research is warranted on the application of this theory to our understanding of age prejudice (Greenberg, Schimel, & Martens, 2002).

Organization of This Issue

This issue is divided into three sections. The first group of articles focuses on factors that contribute to the origin and maintenance of age prejudice in society. Section two highlights articles on the experience of ageism from the perspective of elders who are targets of that prejudice. Finally, ageism is examined in a group of theoretical articles.

Foundations of Ageism

The first article, by Martens, Goldenberg, and Greenberg (this issue), discusses the fruitful application of Terror Management Theory to understanding the origin of age prejudice. Martens and his colleagues make a compelling argument (backed by some data) that our thoughts of our own mortality spark feelings of intense anxiety (tied to our fear of dying) and that we will try to distance ourselves from anything (or any person/group) that reminds us of our mortality. In so doing, the

young perceiver convinces him/her self that such a fate is not in his/her own future, thus alleviating the anxiety.

The last major meta-analysis of attitudes toward older and younger adults was published over 14 years ago (Kite & Johnson, 1988). Since then, the analysis techniques and questions asked have grown more sophisticated. In the next article, Kite, Stockdale, Whitley, and Johnson (this issue) describe the results of a new meta-analysis, based on 232 studies, compared with Kite and Johnson's 43 studies. Also, Kite and her colleagues break this down further by examining separate components of the attitude (evaluation, stereotype, competence). The results of their meta-analysis suggest that, indeed, people evaluate older adults more negatively than younger targets. Interestingly, Kite et al. found that older adults were more ageist than younger people, and the data revealed a complex picture when the sex of the target is evaluated, along with age. These results give researchers a much clearer picture of the current state of our understanding of the attitudes younger and older adults have about each age group.

Cuddy, Norton, and Fiske (this issue) discuss data bearing on their stereotype content model (Fiske, Cuddy, Glick, & Xu, 2002). This model suggests that people stereotype others along the dimensions of warmth and competence. Cuddy and Fiske (2002) showed that older adults in the United States are perceived as warm, but incompetent. In the present issue, Cuddy, Norton, and Fiske examine the prevalence of that conceptualization with a cross-cultural sample of six countries. Results confirm that the warm/incompetent stereotyped view is held quite universally, showing no differences between collectivist and individualistic cultures. Cuddy et al. also show that this stereotype results in random discrimination (older persons are sometimes helped, sometimes neglected). Finally, Cuddy and her colleagues discuss the results of two experiments designed to increase perceptions of competence of older persons, showing that such manipulations were essentially ineffective. Cuddy et al. suggest that the stereotype of older persons is stronger than previously thought, and it poses a special challenge for researchers to further explore the nature of this cross-cultural, stubbornly-held, negative attitude toward older persons. With future studies such as this, we can come closer to finding ways to reduce ageism.

Experiencing Ageism

Like most prejudice research, research on ageism has tended to focus on understanding the factors that lead the perceiver to develop prejudiced attitudes against older adults. This follows from the commonsense notion that if prejudice is a problem that originates in the perceiver, then efforts to understand it and to find a way to reduce or eliminate that prejudice ought to focus on the perceiver. However, comparatively little attention has been devoted to understanding how the targets of prejudice are affected by their stereotyped position. This skewed research

emphasis is only recently changing (see Swim & Stangor's [1998] excellent volume). Researchers know very little about how older adults perceive ageism. Nussbaum and his colleagues (this issue) discuss current theory and data on the significant impact that ageist communication and ageist language have on the older person, and the relationships the older individual has with others. Nussbaum et al. also highlight how such ageism can have detrimental consequences for the older person in his or her work setting. Despite the literature on the pernicious effects of ageist language on the older person more attention needs to be brought to understanding how ageism pervades the health care context. This article by Nussbaum and his colleagues provides a much-needed focus on this issue, highlighting the devastating consequences that ageist attitudes among health care workers can have on the care of the older patient.

Researchers have documented the prevalence of ageism in television shows (e.g., Bell, 1992), and because seniors tend to spend much of their leisure time watching television (Davis & Davis, 1985), Donlon, Ashman, and Levy (this issue) speculated that the more an older person is exposed to these negative portrayals of elders, he/she will develop a more negative view of aging. Donlon et al. also designed an intervention to encourage older adults to think critically about the ageism present in each program they are watching. Older adults in the intervention condition were less likely to "buy into" ageist views of themselves and other older adults. Their results confirm their hypotheses, and highlight the importance of such interventions in improving the quality of life of older adults.

An examination of how different age groups are perceived reveals that older and younger people are perceived with more stereotypes and less power than middle aged persons (Nelson, 2002b). In their article, Garstka, Hummert, and Branscombe (this issue) hypothesized that the way each group cognitively frames their competition for scarce economic resources may influence their perception of age discrimination. In their experiment, Garstka et al. found that, indeed, different ways of framing competition (in terms of economic status and legitimacy of that status—fair or unfair) influence the way age discrimination is perceived. Specifically, older and younger persons perceived more age discrimination against their groups, than did middle-aged persons. Interestingly, when the economic advantage of the middle-aged group was portrayed as illegitimate, middle-aged participants perceived more age discrimination (against young and older persons). Garstka et al. discuss how this may be a way for the middle aged group to minimize the inequality between the groups.

Theoretical Perspectives

This final section takes a broader view of the issue of ageism, examining problems in the way researchers have conceptualized age, and how they make comparisons across categories (Bytheway, this issue), linkages between individual

ageism and societal, institutionalized ageism (Hagestad & Uhlenberg, this issue), and the apparent paradox between the fact that most older adults live happy, satisfying lives, and the negative stereotypes about aging (Sneed & Whitbourne, this issue).

The way that society carries certain expectations for behaviors for people of various ages (sometimes called the “social clock” or “age grading”) is ageist in that it segregates younger and older people into “us and them.” This argument, by Hagestad and Uhlenberg, posits that the institutionalization of age grading is so thorough that it permeates all aspects of culture and society, and this complete separation of age groups provides fertile ground for the origin of ageism. The authors, further, make a compelling case that micro-level instances of ageism (prejudice against older individuals) lead to segregation and this leads to macro-level ageism on a societal level. What is needed, Hagestad and Uhlenberg argue, in order to break this link is to understand the intermediate linkages at the “meso” level. By exploring these links, their article advances our understanding of the operation of ageism at these various levels.

In his article, Bytheway points out that our current conceptualization of ageism is based on the assumption that age-specific categories exist. This assumption, modeled upon ideas about sexism and racism (more categorizations), has had a tremendous impact on gerontology, and on the way that researchers and policy-makers think about older adults. Bytheway presents a compelling argument (with data) that suggests that researchers ought to adopt a different perspective, one that doesn't rely on simple age categories, but rather “age differentials” and each person's subjective experience of aging.

Sneed and Whitbourne make the case that previous models of lifespan development, which tended to be goal-oriented, tend to reflect an ageist view of older adults in that these models assume older adults are essentially unable to significantly influence their environment. Sneed and Whitbourne argue that Whitbourne's Identity Process Theory is best suited to reflect the development of the individual throughout his or her later life, and the authors present data to support this assertion. Only by regarding development from a dynamic process model, incorporating stability via identity assimilation and accommodation, can researchers best avoid ageist stereotypes that are inherent in many of the previous (goal-oriented) models of development.

In a final epilogue article, Giles and Reid (this issue) use the present collection of articles to identify lacunae in the research literature, and they articulate useful new directions for future research on ageism.

Conclusion

Our understanding of the far-reaching influence of age prejudice on the lives of older adults is nascent, and much more empirical attention needs to be brought

to bear on ageism. While it is beyond the scope of this issue to comprehensively address the many complex factors that give rise to age prejudice (for reviews, see Kite & Wagner, 2002; Nelson, 2002b; Palmore, 1999), the distinguished contributors to this issue will highlight current research on prejudice against older adults, and in doing so, they will help bring this important issue to the forefront of the research agenda for social scientists. The U.S. Census Bureau (2000) estimates that by the year 2030, the number of people over age 65 will double. Around the year 2009, the first wave of the “baby boomer” demographic will hit retirement age, and for the next 20 years thereafter, the United States will experience an unprecedented shift in its population, in what some have termed the “graying of America.” As the boomers become “senior citizens,” society must be prepared to accommodate the enormous transformation of its complexion. Thus, the purpose of this issue is to showcase our current understanding of the causes and consequences of ageism, and to highlight the many more unanswered and important questions about ageism that remain, so that social scientists can help shine much-needed light on this important problem, which so dramatically affects everyone in society. In so doing, we may help policy makers, legislators, health professionals, and society in general become more sensitive to age prejudice, thereby enhancing the quality of life for older adults.

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TODD D. NELSON is the Gemperle Foundation Distinguished Professor of Psychology at California State University-Stanislaus. His research focuses on the impact of ageism on older persons. Specifically, he is interested in understanding and how age prejudice, stereotyping, and discrimination at the individual and societal level influence how older people feel about themselves and the future.

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