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ORIGINAL PAPER

Ageism and Age Discrimination in the Family: Applying an Intergenerational Critical Consciousness Approach

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Abstract
Ageism and negative age stereotypes can be expressed unconsciously and consciously through microaggressions in interpersonal interactions, through social and cultural institutional messaging, and through exposure to and encounters with systems of law, government, employment and healthcare. The negative impact of age stereotypes on older adults has been well documented, yet the experience of older adults and ageism within the family has been understudied. This paper reviews theories and evidence on the manifestations of ageism and age discrimination, drawing from an ecological framework emphasizing the importance of structural systems, and then focuses on ageism in the family. A clinical case example illustrates this process and is analyzed through the lens of critical consciousness theory. The paper concludes with the implications for research, theory development and clinical practice.

Keywords Productive aging · Family caregiving · Ageism

Introduction

Ageism and ageist attitudes have been shown to have negative behavioral, psychological and cognitive consequences for older adults (Levy 2000, Levy 2003, 2009; Levy and Banjali 2002; Levy et al. 2011). Scholars increasingly view the problem of ageism with concern (Bennett and Eckman 1973; Palmore 1982; Polizzi and Millikin 2002a, b), especially in light of current demographic trends indicating an unprecedented growth of the older adult population in the U. S. (U.S. Census Bureau 2000). By the year 2030, one in every five Americans will be age 65 or older (U.S. Census Bureau 2000). "Ageism is a systematic stereotyping of and discrimination against people because they are old", and harms all of society by creating rifts between people and in communities (Butler 1969, 1989 p. 139). Ageism is structural, and permeates society from macro-level systems such as laws and policies affecting access to work for older adults (Gonzales et al. 2015a, b; Morrow-Howell et al. 2015), to micro-level healthcare decisions that negatively affect older adults with an excessive cost to society (Levy et al. 2018). In addition, ageism significantly impedes opportunities for productive aging (Gonzales et al. 2015a, b). Negative age attitudes lead to microaggressions, subtle or explicit insults that are commonly aimed at older adults and are produced by the ageism embedded in macro-structural systems. Federal, state and local policies can serve to bolster the dynamic between the dominant and subordinate groups, and this dynamic can shape healthcare, the workplace, communities and interpersonal interactions between colleagues, friends and family members (Marchiondo et al. 2017; Estes and DiCarlo 2019). Ageism within families has not yet been well studied; however, there are significant clinical implications to understanding ageism for the wellbeing of older adults and families. This paper takes the position that the problem of ageism in the family can be understood through the lens of larger social structural forces and provides theory, research and a case example to illustrate the problem and explore the use of critical consciousness therapy techniques as promising strategy to address ageism in the family.

The Concept of Ageism

Ageism refers to "the stereotyping and discrimination of people due to their chronological age or a perception that they are old, or elderly" (Butler 1969, p. 234). Ageism

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towards older adults is generally conceptualized as consisting of three interrelated components: affective, behavioral and cognitive. The affective component consists of feelings such as contempt for older adults or fears about the vulnerability inherent in the later years of life (Butler 2010). A sense of loathing younger people may feel toward older adults can be another manifestation of ageism, and serves to dehumanize older adults and deny them their rights to resources and participation in civil society (Estes and DiCarlo 2019). The behavioral component of ageism consists of age-based discrimination (Posthuma et al. 2012; Marchiondo et al. 2016). Butler compares age-based discrimination with the systematic discrimination against people based on race or gender. These forms of discrimination occur commonly and serve to prohibit or disallow certain people or groups from participating fully in society (1975). Age-based discrimination has been frequently documented, though it is often thought to be less offensive or damaging than other forms of prejudice such as racism or sexism (Deal et al. 2010; Levy and Banjali 2002; Marchiondo et al. 2016). Cognitive ageism refers to attitudes, schemas and stereotypes held about older adults that inform communication and interaction between older and younger individuals (Cuddy and Fiske 2002; Eagly and Chaiken 1993; Iversen et al. 2009; Levy 2001; Levy and Banjali 2002).

Theoretical Frameworks: The Ecological Framework

The ecological framework situates multiple levels of influence on behavior and organizes these levels from macro to micro, emphasizing the interrelatedness and reciprocity of influence across levels (Bronfenbrenner 1979). The framework emphasizes that the life of an older adult is embedded in a dynamic context of influences, as the older adult adapts to the confluence of macro-, meso- and micro- and chronological-level forces (Lawton and Nahemow 1973). Ageism and ageist policies and laws can have a negative influence on an older adult's quality of life, overall functioning and well-being. Applying the ecological framework to age discrimination helps to develop an understanding of the pathways through which structural or ideological conditions and forces, regulatory policies and programs, community-level supports, as well as relational and individual processes impact older adults (Norris et al. 2013).

The ecological framework contextualizes reciprocal relationships between aging and human development in the home, family, community and work. It provides a lens through which clinicians can examine the intergenerational relationships between adult children as caregivers and aging parents as care recipients (Schiamberg and Gans 1999, 2000). Use of the ecological framework in a clinical setting allows the clinician to see the context in which ageism and age discrimination occurs amidst the stressors and resilience factors influencing family behavior (Norris et al. 2013). Further, an ecological framework both provides a perspective from which to develop appropriate interventions, and helps the clinician develop a better understanding of the intergenerational factors influencing quality of life of older adults (Schiamberg and Gans 2000; Norris et al. 2013).

Structural Ageism

Viewed from an ecological framework, structural ageism is a process by which macro-level structural factors principally drive and reproduce ageist thoughts, feelings and behaviors at lower meso- and micro-levels. These macro-level influences include the system of policies, laws, societal attitudes, language and culture that shape institutional practices, as well as cultural representations that then reinforce ways that ageism and age-based discrimination are perpetuated (Estes and DiCarlo 2019; Ageism in America report). As with sexism and racism, "there is a significant structural component to ageism that is not captured by ideology alone" (McMullin and Marshall 2001, p. 113). Structural forces bring to bear the history of policy and laws and how this history creates and shapes messaging, which shapes communities and influences families (Estes and DiCarlo 2019). The workplace and healthcare settings are two notable places where structural ageism can be seen.

Ageism in the Workplace

Given estimates that by 2020 one in four U.S. workers will be age 55 or older (Hayutin et al. 2013) and one in three U.K. workers will be over age 50 (Department for Work and Pensions 2013), the prevalence of and tolerance for ageism is concerning, as more workers may become targets. In a report based on unemployment rates and duration of unemployment, Miller (1966) found that when older workers lose their jobs, they have more difficulty finding new jobs when compared with younger workers. Older workers show higher unemployment rates and longer durations of unemployment (Miller 1966; Neumark 2009).

Significant evidence shows workplace inequities, where employers and others, exhibit stereotyping of older adults, resulting in negative attitudes about older workers (Cuddy et al. 2005; Posthuma and Campion 2009; Marchiondo et al. 2016). Negative age stereotypes held by employers, managers and employees in the workplace include beliefs that older workers have a lower level of competence, decreased performance capacity, (Krings et al. 2011; Loretto and White 2006), limited physical and mental capacity to perform at

work (Finkelstein et al. 2013; Karpinska et al. 2013; Loretto et al. 2013), and inflexibility and resistance to change (Chiu et al. 2001; Redman and Snape 2002).

Management decisions based on negative beliefs that older workers are less competent or more difficult to train in the use of technology can result in age discrimination in the workplace (Posthuma and Campion 2009). Negative age stereotypes also influence managers' subjective decision-making in hiring and job performance evaluations of older workers (Sterns and Alexander 1988; Posthuma et al. 2012). These stereotypes result in less frequent hiring of older workers, failure to select older workers for training, or targeting older workers for layoffs (Posthuma et al. 2012).

The Workplace Age Discrimination Scale (WADS) is a tool designed to measure the perceptions of workers' overt and covert discriminatory experiences (Marchiondo et al. 2016). As the researchers note," perceived age discrimination within the workplace is associated with higher rates of depression, compromised self-rated health, job dissatisfaction and an increased motivation to retire earlier" (Gonzales et al. 2019a, b; Marchiondo et al. 2016; Marchiondo et al. 2017 p. 2). Further, the negative consequences of perceived age discrimination are related to a deterioration of mental health, lower self-rated health and the hastening of physical health problems and and a decrease in job satisfaction (Marchiondo et al. 2017).

Ageism in Healthcare

Specific medical concerns related to age are generally addressed by physicians specializing in geriatric medicine. The lack of access many older adults have to geriatric physicians is a fundamental challenge in the healthcare of older adults. The principles guiding geriatric medicine, such as patient-centered care, management of chronic illness, and attention to a patient's goals and functioning, are those at the forefront of care for all people (Tinetti 2016). However, the number of physicians choosing to specialize in geriatrics is far below demand of the burgeoning older adult population (Kane 2002). As a group, geriatricians have not been consistently strong champions of the case for geriatric medicine, and themselves have professed ageist attitudes about their specialty. "Rather than promoting the benefits of working with the older adult population, geriatricians accentuate and lament careers focused on caring for older adults as burdensome and financially unattractive. Every year we publicize the number of unfilled geriatric fellowship slots. Then we wonder why trainees don't want to join our club" (Tinetti 2016, p. 1401). Financial reimbursement for time spent in office with older adults is low, and Kane and Kane (2005) argue that ageism is the reason that geriatrics pays relatively poorly compared to other medical specialties. Cost and medical effectiveness of the geriatric assessment has been demonstrated, yet geriatric assessment is poorly reimbursed under Medicare to the point that such activities must be subsidized by other more cost-effective procedures. Medicare payments are heavily biased toward such procedures (Hsiao et al. 1988).

A dearth of geriatric physicians means that older adults seeking geriatric primary care and geriatric psychiatric care are often seen by physicians who lack an understanding of the aging process and who believe that continual decline is inevitable. In many cases this leads to a disease-management focused approach rather than a proactive supportive approach, and can result in such problems as polypharmacy, whereby older adults with multiple comorbidities are provided redundant prescriptions or medications that interact negatively with one another, leading to the development of more serious yet avoidable conditions (Hajjar et al. 2007).

Ageist behavior by physicians and other healthcare professionals has been well documented. Such behaviors include: reports of physicians minimizing concerns of older adults, and ascribing them only to their age and not to actual medical conditions (Greene et al. 1989; Adelman et al. 2000; Williams et al. 2007; Ambady et al. 2002); a lower likelihood of physicians using preventive methods to treat either medical or psychiatric problems (Cobbs et al. 1999; Greenfield et al. 1987; Adelman et al. 2000); use of derogatory names when speaking about older patients, and spending less time listening to older patients (Adelman et al. 2000; Ambady et al. 2002); and physicians considering older patients difficult and less pleasant to deal with (Adelman et al. 1991, 2000).

Ageist bias has been identified particularly in cancer screening, diagnosis and treatment. Studies reveal that although more than 55% of all cancers and over two thirds of all cancer mortalities occur in the 65-plus age group, older adults are less frequently diagnosed at an early stage, even when standard screening procedures exist. In addition, older adults are underrepresented in clinical cancer drug trials, and are less likely to be informed of such trials by their physicians and to receive treatments that are considered definitive or potentially curative (Townsley et al. 2005; Turner et al. 1999; Goodwin et al. 1988).

Ageism in the Family

For many older adults, family relationships are their longest surviving connections and family relationships often "act as a buffer against negative self-views and negative mental and physical health outcomes in older persons" (Nelson 2016 p. 278). Knowing that a supportive family member is present, reliable and consistent whether close by or afar, can have a positive impact on an older adult's attitude and expectations

about their own mental and physical health and can also provide older adults with a sense of hope and control of their future aging trajectory (Nelson 2016; Ramirez and Palacio-Espinoza 2016).

In contrast to the abundance of evidence of the positive impact of family support for older adults, very little attention has been given to the issue of ageism and age discrimination in families. Ageism and ageist attitudes, rooted in both positive and negative stereotypes, can have a significant impact on older adults and their family relationships (Palmore 1999). Positive ageism in the family might take the form of family members calling grandma "cute", speaking to her slowly and in a tone of voice with which adults would normally address a child, or grabbing her hand at a crosswalk to ensure that she crosses the street safely (Chonody 2016). These stereotypes and behaviors appear to be compassionate, but they are often paternalistic in nature and serve to support behaviors that place older adults as needy and childlike. These behaviors are detrimental as they cause older adults to question their own capabilities and strengths and lower self-esteem (Kemper et al. 1995; Gendron et al. 2016). Negative ageism takes the form of well-intentioned family members who portray older adults as less capable of making decisions for themselves and fail to afford them privileges of adulthood, solely because of their age. (Estes and DiCarlo 2019). Often, these families are not aware that their attention to older relatives can be viewed as ageist and support a limited view of older adulthood. "Even though at face value these behaviors appear to be deferential to age, they have the potential to undermine the status and treatment of older persons in society" (Cherry and Palmore 2008, p. 857).

Microaggressions

The term "microaggression" is a particularly useful concept to advance our understanding of ageism in the family as it focuses on discrimination at the interpersonal level, and refers to an "everyday verbal, non-verbal or environmental slight, snub or insult" directed at a target person or persons who are members of an oppressed group (Sue 2010, p. 5, 2004; Sue et al. 2018). Microaggressions can be insidious, slight or subtle, and may be intentionally made to marginalize people or make them feel inferior (Sue 2004, p. 5). Such statements may "invalidate group identity, demean someone on a personal level or communicate that they are lesser human beings, and suggest they do not belong to the majority group" (Sue 2010, p. 3).

Sue (2010) proposes that microaggressions fall into three different categories: microassaults, which are often unconscious and convey rudeness and insensitivity toward a person because of their heritage, microinsults, which are often conscious and are explicitly derogatory verbal or non-verbal attacks with the intention of causing harm to a person, and microinvalidations, which are often unconscious and cause a person to question their own thoughts, feelings or experiences. The concept of microaggressions was first employed by Pierce (1974), and has only recently been employed in the literature on older adults by Sue (2010) for example, when referring to "elderspeak" (p. 113), or the use of a microaggressive label such as "sweetie" that belittles or infantilizes an older adult.

Ageism in the family can be seen in the form of microaggressions such as a remark a family member might make about the older adult rendering their less than adequate competence or capability in performing certain tasks due to their age (e. g. in using technology, seeing or hearing well, remembering details or performing a job). Sometimes it can be difficult to discern the difference between a microaggression toward an older adult in the family and a statement of concern about them. Generally, a statement of concern about a family member is about the person's well-being and has the person's overall functioning in mind. A concern focused on the health, or behavior of a family member can be followed up by a visit to a physician, to have the issue of concern evaluated. A microaggression about age is not meant to be followed up with any clarification or action; rather, it is an opinion statement about the older adult and has little or no positive benefit to the older adult. The following case example illustrates how ageism in the form of microaggressions manifest in the micro-level system within a family.

Mr. Franco: A Case Study

A case study is a useful tool to illustrate examples of behavior discussed in this paper. The author presents this fictional case study, one based on several similar cases from their clinical social work practice (Strong et al. 2018).

Mr. Franco is a 76 year-old middle-class Italian American man in good health, living on his own in an apartment in New York City, where he has lived for 45 years. He has been divorced for 25 years and maintains an active life, volunteering in a neighborhood school, and working part-time at a local bookstore. He has two adult children: a 43 year-old son AJ, who lives uptown, and a 53 year-old daughter Amanda, who lives in a suburb of New Jersey, an approximately 45-min car ride from her father. Mr. Franco has developed close connections with his neighbors, people of all ages. He considers many of them close friends and socializes with them about every other week. He is particularly close with one neighbor, and this young man has a spare set of keys to Mr. Franco's apartment.

On a recent walk home from his part-time work, Mr. Franco stopped at the grocery store to purchase some food. Carrying his two medium-sized grocery bags home from the

store, he became distracted by several dogs playing across the street and did not see a cracked area of the sidewalk. Mr. Franco tripped on the sidewalk and fell in front of his apartment building. He later reported that this particular area of raised sidewalk was a well-known problem, and it had been slated for improvement the following week. The doorman of the building confirmed that Mr. Franco was not the first person to trip in that spot. As Mr. Franco's neighbors were leaving the building, they saw him fall and called 911, waiting with him until an ambulance arrived. Mr. Franco was met by paramedics and was rushed to the hospital in an ambulance.

Mr. Franco's adult children met him at the hospital and stayed with him while the doctor conducted a thorough examination, taking an X-ray of his knee and a CT scan of his brain. His children requested the brain CT scan as they were concerned that Mr. Franco might have hit his head when he fell. Mr. Franco reported his knee was in pain, and badly bruised. The X-ray showed he had no broken bones, and the CT scan indicated nothing unusual. After many hours of tests and observation, Mr. Franco was discharged from the emergency room, and both AJ and Amanda accompanied their father home in a taxi. When they arrived, they found that Mr. Franco's neighbors had left his two bags of groceries right outside his door. The three family members entered the apartment, prepared and ate a meal together. The adult children then left their father just before he was ready to go to bed. The next morning AJ called Mr. Franco to check on him and informed him that he and Amanda and their spouses would be coming over to see him that evening and would bring dinner. After dinner ended, AJ announced that "it was time to have a talk" with Mr. Franco, who agreed to sit and engage in conversation. AJ began by saying that he and Amanda and their spouses were very worried about their father, and that they had decided it was time for Mr. Franco to leave his apartment and move into an assisted living facility with greater support and supervision, one located in Amanda's suburban neighborhood in New Jersey. Amanda told Mr. Franco that this is what all of her friend's parents are doing and this would be "the best option" for Mr. Franco who "clearly needed more supervision than he was getting" at home in New York City. Amanda then announced as she and AJ were leaving, that she had visited a certain facility with an excellent reputation and had already put down a deposit to save two different units until Mr. Franco was able to get to the facility to choose which unit he prefers.

In an attempt to sort out his feelings and communicate with his children about their demand that he move, Mr. Franco contacted a social worker and stated that although he was shocked by his children's quick rush to move him, he also felt a good measure of warmth and appreciation over their concern for him. He later stated that he had begun to feel angry and disappointed in his children for not discussing directly with him their plans for his future, and for thinking that his opinion did not matter or should be overruled. He reported feeling deeply insulted, misunderstood and belittled, as though he had been made to feel like a child himself and was being "duped by his kids", and stated that "right now, I can't trust my children to act in my best interest."

Mr. Franco contrasted his feelings about his children with the more positive feelings he had towards his friends and neighbors. He reported that when his friends and neighbors noticed that he seemed down, they rallied around him, bringing him meals and "cards with nice messages". They communicated to Mr. Franco how much they appreciated his friendship and how much he added to the building and to the neighborhood. Mr. Franco declined the invitation to go and see the assisted living facility and stated that he had no intention of moving out of his apartment.

Analysis of the Case of Mr. Franco: Structural Ageism

The interactions among Mr. Franco and his children, Amanda and AJ, can be understood from their embeddedness in larger macro- and meso-level contexts of structural ageism. Amanda's and AJ's decision to act to secure a placement for Mr. Franco in an assisted living facility without receiving his prior consent can be placed in the context of a proliferation of private for-profit assisted living options in the United States (Grabowski et al. 2012). The growth of such facilities is, in part, a result of the lack of broad public commitment to and an attendant lack of allocation of resources by policy makers to support middle-class older adults in their own homes and in their communities. Large gaps exist between funding allocated through the Older Americans Act, and the critical needs of older adults (Estes 1979), particularly those in the middle class, whose life expectancy has increased without savings to keep apace. Private independent and assisted living facility chains can be viewed as representatives of an "aging-industrial complex", a shrewd profit-driven solution to fill a void in publicly supported housing for older adults. Large corporations, driven by their financial bottom-line, operate across multiple states and are not governed by federal regulations. Each state asserts its own system of rules and regulations regarding staffing and environment in private (non-Medicaid) assisted living facilities (Hodlewsky 2001). These large facility chains direct their advertising for independent and assisted living communities toward families like Mr. Franco and his children in order to effectively populate their facilities. Often it is the adult children who, influenced by advertising and without other options, influence their parents to leave their home. A study by Reinardy and Kane (2003) explored decision making within families in a move from home to assisted living. The study indicates that two-thirds of older adults

were influenced by family members to make the decision to move to assisted living. While some older adults do choose to live in an assisted living facility and enjoy their programming and social opportunities, the majority of older adults prefer to age in place, in their own homes and communities (Wiles et al. 2012). Amanda and AJ did not explore or consider any of the community options that might assist their father in aging in his own home, because they did not know of such programs.

It is common for adult children to present the option of assisted living out of concern for their parents without investigating the full scope of services available to age in place in the community, and the financial commitment and services available. Looking at the case example through a meso-level lens, Amanda and AJ failed to consider the community context and institutions Mr. Franco is involved in prior to a rush to move him to an unfamiliar assisted living facility. For example, he works part-time at a local bookstore and volunteers part-time at a local elementary school. These organizations value Mr. Franco and his daily contributions. Since he has worked at each of these institutions for over ten years, he has become a well-known and well-loved community member, and his knowledge of literature, and skills with young children are highly valued. If he were to leave his apartment and move to an assisted living facility, it would be difficult for him to find equivalent experiences there. As noted previously, biases against older adults in the workplace are likely to present difficulties for Mr. Franco in seeking to secure similar part-time positions if he were to move to an assisted living facility.

Ageism in the family on the micro-level often manifests in microaggressions that create inequities and distance between family members. Age-based microaggressions are covert or overt manifestations of the marginalization of older adults and in many cases an unconscious attempt to wrest power away from them (Sue 2010). Amanda and AJ's attempts to assert control over his future was initially perceived by Mr. Franco as an act of caring and genuine concern of his children for his well-being. However, over time, when Mr. Franco felt otherwise and mentioned he did not intend to move out of his apartment, his daughter became angry. In an awkward attempt to help their father and assume a role as caregiver, AJ and Amanda's microaggressive action was ultimately viewed by their father as an attempt to take his power away. This action informed their family dynamic and reshaped their relationship. Researchers in productive aging have looked at ageism in the workplace and in healthcare, but have not yet examined ageism in the family, especially in the form of microaggressions (Gonzales et al. 2015a, b).

Perpetrators of microaggressions are often unaware of the insult and the marginalization they convey, and often are only subtly aware of the damage that can be wrought by a microaggression (Sue 2010). In the case of Mr. Franco, who was excluded from the decision-making process about his own life, his livelihood, and his home, he reported that he felt deeply insulted, misunderstood, and belittled, as though he had been made to feel like a child himself. Often the intention of a microaggression, or in this case a microinvalidation, is not immediately perceived by the receiver of the insult, especially when occurring in conversation between family members, and when portrayed as an expression of concern. Microaggressions and microinvalidations "allow the expression of biased opinions while freeing the perpetrator of a thin veil of doubt concerning the intentionality of the action, comment or behavior" (Van Sluytman 2013, p. 1).

In the case of Mr. Franco, his adult children made a decision without his permission and announced their decision to him, in an attempt to get him to do what they thought was best for him. Whether consciously or unconsciously, Mr. Franco's children minimized his self-agency by attempting to assert dominance over him. Even well-meaning interactions between family members can be perceived as demoralizing by older adults; communicating excessive care can promote dependence rather than autonomy (Nussbaum 2005). Patronizing behavior by a family member is often excused as a well-intentioned display of concern rather than recognized as controlling behavior. Older adults may come to expect family members to provide social support when needed, and may therefore come to tolerate family members' efforts to exercise social control and dominance (Hummert and Mazloff 2001; Rook and Ituarte 1999). Mr. Franco, however, perceived his children's attempt to dislodge him from his home as upsetting and one he could not consent to, and therefore their intervention backfired.

Through this experience, Mr. Franco called into question fundamental beliefs about his relationships with his children, thereby distancing himself from his children. The support he received from his friends and neighbors helped to boost Mr. Franco's sense of himself and served to remind him of his strong connections to his community and the support he had to remain in his apartment. Numerous studies have examined how implicit ageism negatively affects older adults. Such negative consequences can begin with self-doubt, but can further result in "worsening memory performance, self-efficacy, handwriting and the will to live" (Levy 2001, p. 579; 1996; 2000; Levy et al. 1999). However, Nelson has found that the "negative effects of the negative age-related stereotypes can be mitigated or even eliminated if older adults perceive a mismatch between the stereotype and how they perceive themselves in the future" (Nelson 2016, p. 3). Ultimately Mr. Franco felt bolstered by his neighbors and friends in the community, but still at odds with his children.

Applying a Critical Consciousness Approach

From a clinical standpoint, the challenge in addressing ageism in the family context, such as in the case of Mr. Franco, emerges from the fact that the source of such bias derives from outside the family itself, in the macro-structural and meso-level influences that shape attitudes and behaviors towards older family members. Here, the notion of developing "critical consciousness" can assist the clinician in addressing such a dilemma. Linking the larger social context to problems found in the family, a critical consciousness approach links structural ageism deriving from the macro-system to ageism occurring within the family. Critical consciousness examines family interactions within their societal context and analyzes how family members are valued according to identity characteristics. "Family interactions with patterns of inequality are too often unacknowledged and unchallenged" (Hernandez et al. 2005, p. 107).

Developing a critical consciousness in families involves identifying ageist attitudes, behaviors and cognitions within each family member and connecting these with their macro-level origins. In the case of Mr. Franco and his adult children (and their partners), the clinician might explore aspects of structural ageism, and encourage them to engage in a group discussion of how ageism is perpetuated by macro-level structures such as social policies and the aging industrial complex, that reproduce ageist attitudes and age-discrimination within the family. The clinician might include a discussion of how age is portrayed in the media, how anti-aging products are sold to keep people from appearing old, and ask the adult children to think about how each of them feels in relation to their own aging. The clinician could then explore the negative consequences of ageism for older adults and for younger people, presenting facts about the known negative consequences of ageism. One key point to stress is how significant it is to their own aging that they come to terms with their own feelings about older people as they too are aging and will one day be old like their father.

Another piece of critical consciousness development would be an analysis of how the adult children made the decision to impose their own will on their father's living arrangements without considering his thoughts or feelings. This might include an exploration of why they might have thought this would be acceptable, and why they did not think to discuss with their father, and plan with him. Anxiety about aging and about caregiving may need to be explored, since one natural consequence of being an adult child of an older parent is that at some point the parent will have care needs. Engaging the adult children in a discussion about concern for their father's safety is important. Reframing the adult children's concern for his safety as a concern for helping their father figure how he would like to plan for the future would be empowering for Mr. Franco. Once a plan is in place, Mr. Franco's family members can provide help in the role they have been designated by their father, according to his wishes.

Conclusion

By using a framework supported by the critical consciousness approach, clinicians can encourage older adults and family members to examine their own internalized ageism and the impact of microaggressive interactions with older adults in the family. Clinicians can further empower family members by teaching critical gerontological perspectives that encourage a deepening of their knowledge of structural ageism and the social construction of age and how societal expectations of older adults "encourage their dependence on systems that serve to enrich others, at their own expense" (Estes and DiCarlo 2019). Supporting the development of a critical consciousness with respect to ageism can normalize and place in context the challenges and joys of older adulthood. Promoting such consciousness can also support the productive aging of older family members in ways that encourage their inclusion and active contribution in society (Gonzales et al. 2015a, b). In so doing, clinicians can simultaneously support the empowerment, dignity and self-esteem of older adults, and optimally encourage their aging well and productively. More needs to be learned about the resilience of older adults when confronting microaggressions and ageism in the family, and it is hoped that growing awareness of ageism in the family will lead to further theory development and evidence that promotes more age-inclusive and affirming clinical practice in the field.

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References

Adelman, R. D., Greene, M. G., & Charont, R. (1991). Issues in physician-elderly patient interaction. *Ageing and Society, 11*(2), 127–148. https://doi.org/10.1017/S0144686X00003974.

Adelman, R. D., Greene, M. G., & Ory, M. G. (2000). Communication between older patients and their physicians. *Clinics in Geriatric Medicine, 16*(1), 1–24. https://doi.org/10.1016/S0749-0690(05)70004-5.

Ambady, N., Koo, J., Rosenthal, R., & Winograd, C. H. (2002). Physical therapists' nonverbal communication predicts geriatric patients' health outcomes. *Psychology and Aging, 17*(3), 443. https://doi.org/10.1037/0882-7974.17.3.443.

Bennett, R., & Eckman, J. (1973). *Attitudes toward aging: A critical examination of recent literature and implications for future research*. Washington, DC: American Psychological Association.

Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge: Harvard University Press.

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

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

Butler, R. (1989). Dispelling ageism: The cross-cutting intervention. *The Annals of the American Academy of Political and Social Science, 503*, 138–147. https://doi.org/10.1177/0002716289503001011.

Butler, R. N. (2010). *The longevity prescription: The 8 proven keys to a long, healthy life*. New York: Penguin.

Cherry, K. E., & Palmore, E. (2008). Relating to Older People Evaluation (ROPE): A measure of self-reported ageism. *Educational Gerontology, 34*, 849–861. https://doi.org/10.1080/03601270802042099.

Chonody, J. M. (2016). Positive and negative ageism: The role of benevolent and hostile sexism. *Affilia: Journal of Women and Social Work, 31*(2), 207–218. https://doi.org/10.1177/0886109915595839.

Chiu, W. C. K., Chan, A. W., Snape, E., & Redman, T. (2001). Age stereotypes comparison. *Human Relations, 54*(5), 629–661.

Cobbs, E. L., Duthie, E. H., Murphy, J. B., (eds): *Geriatrics review syllabus, 4th ed: A core curriculum in geriatric medicine*. Iowa: Kendall/Hunt.

Cuddy, A. J., & Fiske, S. T. (2002). Doddering but dear: Process, content, and function in stereotyping of older persons. *Ageism Stereotyping and Prejudice Against Older Persons, 3*(1), 26.

Cuddy, A. J., Norton, M. I., & Fiske, S. T. (2005). This old stereotype: The pervasiveness and persistence of the elderly stereotype. *Journal of Social Issues, 61*(2), 267–285. https://doi.org/10.1111/j.1540-4560.2005.00405.x.

Deal, J. J., Altman, D. G., & Rogelberg, S. G. (2010). Millennials at work: What we know and what we need to do (if anything). *Journal of Business and Psychology, 25*(2), 191–199. https://doi.org/10.1007/S10869-010-9177-2.

Eagly, A. H., & Chaiken, S. (1993). *The psychology of attitudes*. San Deigo: Harcourt Brace Jovanovich College Publishers.

Estes, C. L. (1979). *The aging enterprise* (pp. 98–102). San Francisco: Jossey-Bass.

Estes, C. L., & DiCarlo, N. B. (2019). *Aging A-Z: Concepts Toward Emancipatory Gerontology*. London: Routledge.

Finkelstein, L. M., Ryan, K. M., & King, E. B. (2013). What do the young (old) people think of me? Content and accuracy of age-based metastereotypes. *European Journal of Work and Organizational Psychology, 22*(6), 633–657. https://doi.org/10.1080/1359432X.2012.673279.

Gendron, T. L., Welleford, E. A., Inker, J., & White, J. T. (2016). The language of ageism: Why we need to use words carefully. *The Gerontologist, 56*(6), 997–1006. https://doi.org/10.1093/geront/gnv066.

Gonzales, E., Marchiondo, L., Ran, S., Brown, C., & Goettge, K. (2015). *Age discrimination in workplace and its association with health and work: Implications for social policy*. Boston, MA: Boston University.

Gonzales, E., Matz-Costa, C., & Morrow-Howell, N. (2015). Increasing opportunities for the productive engagement of older adults: A response to population aging. *The Gerontologist, 55*(2), 252–261. https://doi.org/10.1093/geront/gnu176.

Gonzales, E., Lee, K., & Harootyan, B. (2019). Voices from the field: Ecological factors that promote employment and health among low-income older adults with implications for direct social work practice. *Clinical Social Work Journal*. https://doi.org/10.1007/s10615-019-00719-x.

Gonzales, E., Shen, H. W., Perry, T. E., & Wang, Y. (2019). Intersections of home, health, and social engagement in old age: Formal volunteering as a protective factor to health after relocation. *Research on aging, 41*(1), 31–53. https://doi.org/10.1177/0164027518773125.

Grabowski, D. C., Stevenson, D. G., & Cornell, P. Y. (2012). Assisted living expansion and the market for nursing home care. *Health Services Research, 47*(6), 2296–2315. https://doi.org/10.1111/j.1475-6773.2012.01425.x.

Greene, M. G., Hoffman, S., & Charon, R. (1987). Psychosocial concerns in the medical encounter: A comparison of the interactions of doctors with their old and young patients. *The Gerontologist, 27*, 164–168. https://doi.org/10.1093/geront/27.2.164.

Greenfield, S., Blanco, D. M., Elashoff, D. M., & Ganz, P. (1987). Age related breast cancer therapy. *Journal of the American Medical Association, 257*, 2766–2770. https://doi.org/10.1001/jama.1987.03390200106023.

Goodwin, J. S., Hunt, W. C., Humble, C. G., Key, C. R., & Samet, J. M. (1988). Cancer Treatment Protocols: Who Gets Chosen? *Archives of Internal Medicine, 148*(10), 2258–2260. https://doi.org/10.1001/archinte.1988.00380100106022.

Hajjar, E., Cafiero, A. C., & Hanlon, J. T. (2007). Polypharmacy in elderly patients. *The American Journal of Geriatric Pharmacotherapy, 5*(4), 345–351. https://doi.org/10.1016/j.amjopharm.2007.12.002.

Hayutin, A., Beals, M., & Borges, E. (2013). The aging US workforce: A chartbook of demographic shifts. Stanford Center on Longevity. Retrieved from https://longevity.standford.edu/financial.security.

Hernández, P., Almeida, R. V., & Dolan-Dei Vecchio, K. (2005). Critical consciousness, accountability, and empowerment: Key processes for helping families heal. *Family Process, 44*, 105–130. https://doi.org/10.1111/j.1545-5300.2005.00045.x.

Hodlewsky, R. T. (2001). Staffing problems and strategies in assisted living. In S. Zimmerman (Ed.), *Assisted living: Needs, practices, and policies in residential care for the elderly* (pp. 78–91). Baltimore: Johns Hopkins Press.

Hsiao, W. C., Braun, P., Yntema, D., & Becker, E. R. (1988). Estimating physicians' work for a resource-based relative-value scale. *New England Journal of Medicine, 319*(13), 835–841. https://doi.org/10.1056/NEJM198809293191305.

Hummert, M. L., & Mazloff, D. C. (2001). Older adults responses to patronizing advice: Balancing politeness and identity in context. *Journal of Language and Social Psychology, 20*(1–2), 168–196. https://doi.org/10.1177/0261927X01020001008.

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

Kane, R. L. (2002). The future history of geriatrics: Geriatrics at the crossroads. *The Journals of Gerontology: Series A, Biological Sciences & Medical Sciences, 57*(12), M803–M805. https://doi.org/10.1093/gerona/57.12.m803.

Kane, R. L., & Kane, R. A. (2005). Ageism in healthcare and long-term care. *Generations, 29*(3), 49–54.

Karpinska, K., Henkens, K., & Schippers, J. (2013). Hiring retirees: impact of age norms and stereotypes. *Journal of Managerial Psychology, 28*(7/8), 886–906. https://doi.org/10.1108/JMP-07-2013-0223.

Kemper, S., Vandeputte, D., Rice, K., Cheung, H., & Gubarchuk, J. (1995). Speech adjustments to aging during referential communication task. *Journal of Language and Social Psychology, 14*, 40–59. https://doi.org/10.1177/0261927X95141003.

Polizzi, K. G., & Millikin, R. J. (2002a). Attitudes towards the elderly: Identifying problematic usage of ageist and

overextended terminology in research instructions. *Educational Gerontology, 28*(5), 367–377. https://doi.org/10.1080/03601270290081344.

Krings, F., Sczesny, S., & Kluge, A. (2011). Stereotypical inferences as mediators of age discrimination: The role of competence and warmth. *British Journal of Management, 22*(2), 187–201. https://doi.org/10.1111/j.1467-8551.2010.00721.x.

Lawton, M. P., & Nahemow, L. (1973). Ecology and the aging process. In C. Eisdorfer & M. P. Lawton (Eds.), *The psycholgy of adult development and aging* (pp. 619–674). Washington, DC: American Psychological Association.

Levy, B. (1996). Improving memory in old age through implicit self-stereotyping. *Journal of Personality and Social Psychology, 71*(6), 1092.

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

Levy, B., Ashman, O., & Dror, I. (1999). To be or not to be: The effects of aging stereotypes on the will to live. *OMEGA-Journal of Death and Dying, 40*(3), 409–420. https://doi.org/10.2190/Y2GE-BVYQ-NF0E-83VR.

Levy, B. R. (2001). Eradication of ageism requires addressing the enemy within. *The Gerontologist, 41*(5), 578–579. https://doi.org/10.1093/geront/41.5.578.

Levy, B., & Banaji, M. R. (2002). Implicit ageism. In T. Nelson (Ed.), *Ageism: Stereotyping and prejudice against older persons* (pp. 49–75). Cambridge, MA: MIT Press.

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

Levy, B. (2009). Stereotype embodiment: A psychosocial approach to aging. *Current Directions in Psychological Science, 18*(6), 332–336. https://doi.org/10.1111/j.1467-8721.2009.01662.x.

Levy, B. R., Zonderman, A. B., Slade, M. D., & Ferrucci, L. (2011). Memory shaped by age stereotypes over time. *Journals of Gerontology: Series B, 67*(4), 432–436. https://doi.org/10.1093/geronb/gbr120.

Levy, B. R., Slade, M. D., Chang, E., Kannoth, S., & Wang, S. Y. (2018). Ageism amplifies cost and prevalence of health Conditions. *The Gerontologist, 20*, 1–8. https://doi.org/10.1093/geront/gny131.

Loretto, W., & White, P. (2006). Employers' attitudes, practices and policies towards older workers. *Human Resource Management Journal, 16*(3), 313–330. https://doi.org/10.1111/j.1748-8583.2006.00013.x.

Loretto, W., Lain, D., Vickerstaff, S., Fuertes, V., Egdell, V., & McQuaid, R. (2013). Extending working lives: Age management in SMEs. *Employee Relations*. https://doi.org/10.1108/014254513111320477.

Marchiondo, L., Gonzales, E., & Ran, S. (2016). Development and validation of the workplace age discrimination scale. *Journal of Business and Psychology, 31*, 493–513. https://doi.org/10.1007/s10869-015-9425-6.

Marchiondo, L. A., Gonzales, E., & Williams, L. J. (2017). Trajectories of perceived workplace age discrimination and long-term associations with mental, self-rated, and occupational health. *The Journals of Gerontology: Series B, 74*(4), 655–663. https://doi.org/10.1093/geronb/gbx095.

McMullin, J. A., & Marshall, V. W. (2001). Ageism, age relations, and garment industry work in Montreal. *The Gerontologist, 41*(1), 111–122. https://doi.org/10.1093/geront/41.1.111.

Morrow-Howell, N., Gonzales, E., Matz-Costa, C., & Greenfield, E. A. (2015). *Increasing productive engagement in later life* (Grand Challenges for Social Work Initiative Working Paper No. 8). Cleveland: American Academy of Social Work and Social Welfare.

Miller, D. (1966). Age discrimination in employment: The problem of the older worker". *New York University Law Review, 41*, 383–424.

Nelson, T. D. (2016). Promoting healthy aging by confronting ageism. *American Psychologist, 71*(4), 276–282. https://doi.org/10.1037/a0040221.

Neumark, D. (2009). The age discrimination in employment act and the challenge of population aging. *Research on Aging, 31*(1), 41–68. https://doi.org/10.3386/w14317.

Norris, D., Fancey, P., Power, E., & Ross, P. (2013). The critical-ecological framework: Advancing knowledge, practice, and policy on older adult abuse. *Journal of Elder Abuse & Neglect, 25*(1), 40–55.

Nussbaum, J. F., Pitts, M. J., Huber, F. N., Krieger, J. L. R., & Ohs, J. E. (2005). Ageism and ageist language across the life span: Intimate relationships and non-intimate interactions. *Journal of Social Issues, 61*(2), 287–305. https://doi.org/10.1111/j.1540-4560.2005.00406.x.

Palmore, E. B. (1982). Attitudes toward the aged: What we know and need to know. *Research on Aging, 4*(3), 333–348. https://doi.org/10.1177/0164027582004003004.

Palmore, E. (1999). *Ageism: Negative and positive*. New Yok: Springer Publishing Company.

Pierce, C. (1974). Psychiatric problems of the Black minority. In S. Arieti (Ed.), *American Handbook of Psychiatry* (pp. 512–523). New York: Basic Books.

Polizzi, K. G., & Millikin, R. J. (2002). Attitudes toward the elderly: Identifying problematic usage of ageist and overextended terminology in research instructions. *Educational Gerontology, 28*(5), 367–377. https://doi.org/10.1080/03601270290081344.

Posthuma, R. A., & Campion, M. A. (2009). Age stereotypes in the workplace: Common stereotypes, moderators, and future research directions. *Journal of Management, 35*(1), 158–188. https://doi.org/10.1177/0149206308318617.

Posthuma, R. A., Wagstaff, M. F., & Campion, M. A. (2012). Age stereotypes and workplace age discrimination. In W. C. Borman & J. W. Hedge (Eds.), *The Oxford handbook of work and aging* (p. 298). New York: Oxfod University Press.

Ramírez, L., & Palacios-Espinosa, X. (2016). Stereotypes about old age, social support, aging anxiety and evaluations of one's own health. *Journal of Social Issues, 72*(1), 47–68. https://doi.org/10.1111/josi.12155.

Redman, T., & Snape, E. (2002). Ageism in teaching: Stereotypical beliefs and discriminatory attitudes towards the over 50s. *Work, Employment and Society, 16*(2), 353–369. https://doi.org/10.1177/095001702400426884.

Reinardy, J. R., & Kane, R. A. (2003). Anatomy of a choice: Deciding on assisted living or nursing home care in Oregon. *Journal of Applied Gerontology, 22*(1), 152–174. https://doi.org/10.1177/073346402250477.

Rook, K. S., & Ituarte, P. H. (1999). Social control, social support, and companionship in older adults' family relationships and friendships. *Personal Relationships, 6*(2), 199–211. https://doi.org/10.1111/j.1475-6811.1999.tb00187.x.

Schiamberg, L. B., & Gans, D. (1999). An ecological framework for contextual risk factors in elder abuse by adult children. *Journal of Elder Abuse & Neglect, 11*(1), 79–103. https://doi.org/10.1300/J084v11n01_05.

Schiamberg, L. B., & Gans, D. (2000). Elder abuse by adult children: An applied ecological framework for understanding contextual risk factors and the intergenerational character of quality of life. *The International Journal of Aging and Human Development, 50*(4), 329–359. https://doi.org/10.2190/DXAX-8TJ9-RG5K-MPU5.

Sterns, H., & Alexander, R. (1988). *Performance appraisal of the older worker: Fourteen steps in managing an aging work force* (pp. 85–93). Lexington, MA: Lexington Books.

Strong, J. D., Crowe, B. M., & Lawson, S. (2018). Female veterans: Navigating two identities. *Clinical Social Work Journal, 46*(2), 92–99. https://doi.org/10.1007/s10615-017-0636-3.
Sue, D. W. (2004). Whiteness and ethnocentric monoculturalism: Making the "invisible" visible. *American Psychologist, 59*(8), 761. https://doi.org/10.1037/0003-066X.59.8.761.
Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation*. New York: Wiley.
Sue, D. W., Capodilupo, C. M., Nadal, K. L., Rivera, D. P., & Torino, G. C. (2018). *Microaggression theory: Influence and implications*. New York: Wiley.
Tinetti, M. (2016). Mainstream or extinction: Can defining who we are save geriatrics? *Journal of the American Geriatrics Society, 64*, 1400–1404. https://doi.org/10.1111/jgs.14181.
Townsley, C. A., Selby, R., & Siu, L. L. (2005). Systematic review of barriers to the recruitment of older patients with cancer onto clinical trials. *Journal of Clinical Oncology, 23*(13), 3112–3124. https://doi.org/10.1200/JCO.2005.00.141.
Turner, N. J., Haward, R. A., Mulley, G. P., & Selby, P. J. (1999). Cancer in old age—is it inadequately investigated and treated? *BMJ, 319*(7205), 309–312. https://doi.org/10.1136/bmj.319.7205.309.
U.S. Census Bureau. (2000). *Population Profile of the United States: 2000 (Internet Release) THE NEXT FOUR DECADES, The Older Population in the United States: 2010 to 2050,* 2010, Retrieved from https://www.census.gov/prod/2010pubs/p25-1138.pdf.
Van Sluytman, L. G. (2013). MicroAggressions. *Encyclopedia of Social Work*. https://doi.org/10.1093/acrefore/9780199975839.013.987.
Wiles, J. L., Leibing, A., Guberman, N., Reeve, J., & Allen, R. E. (2012). The meaning of "aging in place" to older people. *The Gerontologist, 52*(3), 357–366. https://doi.org/10.1093/geront/gnr098.
Williams, S. L., Haskard, K. B., & DiMatteo, M. R. (2007). The therapeutic effects of the physician-older patient relationship: Effective communication with vulnerable older patients. *Clinical Interventions in Aging, 2*(3), 453–467.

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