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COMMENTARY

Aging is inevitable, nihilism is optional

Adult populations across the world are living considerably longer than previous generations. A child born in the United States today has a life expectancy beyond 85 years (Busetta and Bono, 2021). As life expectancy increases, individuals' concerns are focused on increasing quality, together with quantity, of life. Biological theories of aging suggest that aging is a complex process, in which changes at the molecular and cellular level lead to inevitable and inescapable decline in functioning. While advanced age is correlated with a reduction in functional health, chronological age alone is not an appropriate indicator of healthy aging (Lowsky *et al.*, 2014). Mere survival does not capture well-being. When it comes to aging satisfaction, self-perception is key.

An individual's cognitive and affective evaluation of their own life is regarded as an important indicator of their well-being (Diener, 2000). Self-perceptions of aging capture how individuals' attitudes toward their own aging and aging experiences influence their physical functioning as well as psychological well-being in later life. Irrespective of objective circumstances, self-perceptions operate to influence how hopeful or hopeless an individual may feel about their own aging and impact their longevity (Levy *et al.*, 2002).

Biological theories of aging attempt to explain individual differences in aging as stemming from genetic factors that are predetermined and nongenetic factors such as random events, environment, or lifestyle that interact throughout the entire lifespan to shape the course of adult development and aging. While physical health is invariably associated with aging satisfaction, medicalizing "aging" as a condition causing inevitable later-life disability, and further viewing "aging" as undesirable in and of itself, is problematic in terms of societal and individual impacts. One example is the nihilistic discourse of alleged economic burden of care being placed on younger generations by so-called "Baby Boomers," whose care needs will need to be met by those who follow (Meisner, 2020). Rather than celebrating the potential longevity dividend, this rhetoric may be reinforcing harmful stereotypes about age in terms of dependency and intergenerational discord.

Gerontologists and other aging experts may criticise biological theories of aging because of their failure to account for enormous interindividual variability and heterogeneity in later life and to recognize a major principle of life-span developmental theory in which age-related gains and losses occur simultaneously (Baltes and Carstensen, 1996). In addition, narrowing the aging process down to a physiological process and measuring "aging well" in terms of functional decline fails to capture cultural variability in older individuals' health (Levy, 2009) and their subjective experiences of the aging process.

More recently, the focus of gerontological research has shifted, from an emphasis on age-related vulnerabilities and inevitable decline to understanding and identifying certain behaviors that mediate age-related physiological and cognitive deterioration to support so-called successful aging. However, some critics rail against the term "successful aging," suggesting it implies an idealized state of aging, or *not* aging. The argument is that one cannot dictate what is the "norm" in terms of "successfully aging" and that *success* is not, and should not be, measured against one standard. Aging that is considered successful aging according to functional norms might not meet with ideal norms. For example, someone may live a healthy life, may live in objectively affluent circumstances, but may see aging as a burden, compared to someone who is aging and not living in an objectively ideal situation, but might be quite happy with where they are in life (Baltes and Carstensen, 1996). There is also a prevailing myth that older people become less satisfied and become more unhappy as they get older, but we do know that older people are more satisfied with their lives, compared to younger people, as well as compared to their younger selves (Baltes and Carstensen, 1996).

Ample research shows that self-perceptions of one's own aging exert a powerful influence on your later health and well-being. According to Baltes' SOC model (Baltes and Baltes, 1990), older adults are said to have reserves in capacity in relation to their functioning, however, their attitudes to their own aging affect how they use them. Positive self-perceptions and attitudes to own aging impact a variety of health outcomes (Levy and Myers, 2004; Levy *et al.*, 2000; Levy *et al.*, 2002). For example, possessing positive attitudes to aging has been linked with engaging in health preventative behaviors, such as exercise and a balanced diet (Levy and Myers,

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2004). Conversely, if someone holds a negative view of aging whereby decline is inevitable, they are less likely to engage in these health promoting behaviors. Negative aging perceptions have been shown to predict poorer functional health (Levy *et al.*, 2000) and shorten life expectancy by an average 7.5 years (Levy *et al.*, 2002). In addition, negative perceptions of aging may be internalized affecting various outcomes in later life.

Aging self-stereotypes represent an implicit form of self-perceptions of aging and can exert a powerful influence on health and well-being. Stereotype embodiment (Levy, 2009) explains the process. Stereotyped views of aging develop across the lifespan, operate on an unconscious level, become more salient as they become self-relevant (Levy, 2009), and may be consistent and fixed (Fawsitt and Setti, 2017; Swift *et al.*, 2017). They operate via inter- and intraindividual pathways—from society to individual and from early to late development, acting as a kind of self-fulfilling prophecy with adverse effects (Levy, 2009).

Awareness is considered a major driving force for adaptational efforts, associated with psychological and physical health, and life engagement outcomes (Diehl and Wahl, 2010). The construct of "awareness of age-related change," as described by Diehl and Wahl (AARC; 2010) does not refer to objective age-related changes as such, but rather becoming aware of changes. The conceptual framework described positive (AARC-Gains) and negative (AARC-Losses) valences, measured across five behavioral domains: Health and Physical, Cognitive, Social-Cognitive and Social-Emotional functioning, Interpersonal Relations, and Lifestyle and Engagement (Diehl and Wahl, 2010). A given example is an individual who interprets their subjective forgetfulness to a developing dementia, yet objective measures would show that person is well within normative functioning (Diehl and Wahl, 2010). Brothers *et al.* (2019) extended the research by creating the multidimensional AARC-50 questionnaire to assess AARC across the five behavioral domains.

The paper on "Exploring Awareness of Age-Related Changes among over 50s in the UK: Findings from the PROTECT study" (Sabatini *et al.*, 2022) in this issue of *International Psychogeriatrics* makes an important contribution to the expanding topic of AARC. Specifically, the authors investigate what contributes to making people aware of positive and negative age-related change using quantitative and qualitative methods. The findings of this mixed methods study provide promising explanations for potential links between AARC and later life health outcomes.

Sabatini *et al.* (2022) used secondary data collected as part of the UK PROTECT study on aging. The PROTECT study, a major initiative of the University of Exeter and Kings College London, in partnership with the NHS, is open to UK residents aged over 50 years with no clinical diagnosis of dementia (at time of recruitment). AARC was measured using the short form AARC-10 (Kaspar *et al.*, 2019). A total 14,757 respondents completed the AARC-10 SF online during 2019. Of these, 609 participants (M age = 67.9; SD = 7.6), predominantly female (81.1%) responded to both the AARC-10 SF and an additional open-ended question.

A feature of the paper is its focus on both qualitative and quantitative assessments of AARC. Respondents indicated on a five-point scale how much they agreed or disagreed with each of five items measuring gains and five items measuring losses. Additionally, respondents' thoughts about AARC were analyzed alongside their ratings via an open-ended question at the end of the survey that instructed: "*If you wish, please add any additional information or comments for this section in the box below.*" These open responses were content analyzed with several categories identified. Based on these categories, t-tests were used to compare the mean AARC gains and losses scores to determine whether there was a difference between respondents' whose comments were assigned to a particular category against those whose comments were not.

The findings advance existing evidence through identification of novel potential contributors to AARC. While several of the categories discovered were in line with variables defined by the Diehl and Wahl (2010) conceptual framework, novel contributions included engagement in activities that were purpose-driven or that distracted from age-related thoughts. The authors relate the findings to potential ways of intervening to improve an individual's subjective aging experience, such as motivating healthy lifestyle behaviors through awareness of age-related change. Further, AARC may have elicited a kind of age-based stereotype threat for the small proportion of participants whose coping strategy was to favorably compare themselves to peers who were experiencing more negative changes than themselves. However, while this type of downward social comparison may be a useful coping strategy, it may also reflect a type of anxiety about aging and failure.

In the context of the pandemic, it is likely that failing health and mortality have become self-relevant for older people. We need only look to the "vulnerability" and "burden" narratives identified in COVID-19-related discourses (Cohn-Schwartz and Ayalon, 2020) for examples. These widely embedded portrayals of older people as being dependent, incompetent, and in need of saving; versus dispensable and expendable; may act to reinforce negative self-stereotypes, resulting in negative

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health outcomes for older people (Ayalon, 2020; Meisner, 2020; Pachana *et al.*, 2020; Swift *et al.*, 2017) and may detrimentally affect their ability to seek and receive medical health support (Scott *et al.*, 2019). Positive aging self-stereotypes may motivate meaningful action while conversely negative self-stereotypes may impose inaction. Intervening to improve an individual's self-perceptions of own aging is key to improving their later life health and well-being.

Conflict of interest

The author has no conflict of interest to report.

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