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Ageism and informal learning: Exploring care settings for older adults

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ABSTRACT

With the global trend of population aging, improving older adults' quality of life is increasingly urgent. While longevity should align with well-being, ageism remains a significant barrier. This study explores ageism in long-term care settings and its prevalence from a learning perspective. Grounded in a conceptualization of 32 variants of ageism and social representations theory, the ways in which the manifestations of ageism and their underlying social representations shed light on the informal learning processes within these settings are explored in this study. This study employed a convergent mixed-methods approach, combining qualitative and quantitative data. Data were triangulated from participant observation, interviews, and surveys, which enabled a comprehensive view of the phenomenon. For over three months, participant observation was conducted in four institutions in Portugal that offer residential and nonresidential services for older adults, yielding 32 field notes for analysis. In addition, four interviews were conducted with participants holding management responsibilities in these institutions. To examine social representations, 386 care workers from Portugal completed a nationwide survey including free word association and socio-demographic questions. The findings suggest that the social representation of older people held by professionals, alongside certain institutional practices, constitute positive and negative manifestations of ageism. Despite being different in nature, both result in older people's loss of autonomy, self-doubt, diminished confidence and self-reinforcing of negative stereotypes. As ageist beliefs and practices become naturalized within a long-term care culture, institutions may become a stage for learning processes that perpetuate rather than challenge ageism.

Introduction

The shift in demographic trends places older people as one of the fastest-growing populations in the world, particularly in developed countries (UNFPA, 2024). There is thus a need to evaluate how we can all live longer and better. Unfortunately, longevity is not synonymous with living longer and better lives for many people, and ageism is one of the threats to quality of life (Chang et al., 2020). Originally defined by Butler (1969, p. 243) as 'prejudice by one age group toward other age groups,' ageism can potentially be experienced by everyone if they live long enough (Palmore, 2015), despite being one of the least visible forms of discrimination (Nelson, 2005, 2009; Palmore, 1999). Long-term care (LTC) is one of the settings dedicated to catering to the needs of

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older people, yet it is common to find ageist attitudes toward older people in these settings (Band-Winterstein, 2015; de São José & Amado, 2017; Doyle, 2014; Natan et al., 2010; Post et al., 2010). This raises many concerns, namely the pressing need for interventions to fight this prejudice effectively.

Intergenerational approaches, such as Levy's (2018) PEACE model, combining positive education about aging with meaningful contact experiences, has demonstrated efficacy in reducing age prejudice (Del Carmen Requena et al., 2018; Kogan & Schoenfeld-Tacher, 2018; Lytle et al., 2020; Requena et al., 2018). These approaches highlight that quality interpersonal interactions disrupt discrimination and are aligned with the idea that the closer individuals' engagement in face-to-face situations, the further they are from the typification schemes in which others are apprehended and 'dealt with' in social encounters (Berger & Luckmann, 1991).

Both the importance of interpersonal interactions and learning opportunities in reducing ageism must be recognized, while there is still a puzzling prevalence of ageism in LTC, a dedicated platform for daily interactions with older people. We therefore argue for the importance of exploring the manifestations of ageism in these contexts and drawing inferences from the learning dimensions present in these settings, potentially contributing to this prevalence – a topic which remains underexplored.

Everyday informal learning

Since a central element of this study is the learning dimensions present in these institutions, it is essential to clarify the learning perspective that informs the research, i.e. the theoretical lenses through which the findings of study are interpreted. Malcolm et al. (2003) challenge the traditional categorization of learning as formal, informal, or non-formal and propose a framework of attributes – *location, process, content, and purpose* – to reflect the complexity of learning. They mention that 'formality and informality are not discrete types of learning, but represent attributes of it' (Malcolm et al., 2003, p. 29) and we agree that the tripartite perspective of learning can be re-conceptualized. Drawing on the author's framework of attributes (Malcolm et al., 2003) but keeping the tripartite terminology for consistency with the literature, we adopt a multifaceted concept of informal learning as follows: (i) its *process* is contextual and related to human activity, interdependent between the individual and the social practice (Billett, 2002); (ii) it is life-wide (Reischmann, 2014), which means it is not constricted to a particular *location*; (iii) it is often unintentional, and the level of awareness or *purpose* does not impact the educational outcome and; (iv) the nature of learnt curriculum or *content* is a product of the dynamics of power differentials that influence how individuals relate to and understand each other in social interactions. In this study, the ways in which these learning dimensions unfold in LTC settings are investigated, proposing these environments as pivotal learning contexts for and about ageism.

Long-term care settings as learning contexts

According to a sociology of knowledge perspective, 'all human "knowledge" is developed, transmitted and maintained in social situations' (Berger & Luckmann, 1991, p. 15). We thus propose to analyze both the social situations and the 'knowledge' of LTC settings to discuss the learning dimensions of these contexts – a principle that, we argue, should be considered when researching educational interventions[1] as an effective strategy against ageism. This is because while anti-ageism interventions targeting undergraduates may influence LTC practices, it is equally plausible that these settings reinforce ageist norms.

First, we will explore the conceptualization of ageism to identify the different manifestations of the phenomenon, i.e. social situations. Then, we will draw on social representations theory to understand the representational structure that informs those manifestations, i.e. the 'knowledge' of LTC settings. These two contributions will give us insights into the learning dimensions in LTC settings.

The conceptualization of ageism

Ageism was originally coined by Butler in 1969 and has since been further conceptualized to capture its complexity. In this study, we adopted a definition by de São José and Amado (2017) which is, in turn, an adapted version of Iversen et al. (2009) and includes five dimensions, represented in Figure 1, below, that we define as: (1) polarity; (2) components; (3) level of awareness; (4) directionality and (5) contextual scale. It is important to note that ageism is manifested toward individuals regarding their chronological or subjectively perceived age, which is not exclusive to older people. However, since this research is focused on an older cohort of the population, we will only refer to them in this conceptualization.

With regards to the dimension of polarity, ageism can be described as positive or negative. These two attributes are identified as such depending on whether ageism is expressed in favor or in disfavor of individuals. While the mainstreaming of negative ageism is more common, positive ageism is usually recognized in the form of beliefs (e.g. stereotypes such as kindness or wisdom) or actions (e.g. attributing special discounts to people over 65 years old) (Palmore, 1999).

Additionally, ageism is conceptualized around three components: cognitive (perceptions, concepts and beliefs), affective (feelings) and behavioral (overt actions) – following the tripartite model of attitudes, a framework widely attributed to Rosenberg and Hovland (1960). Since attitudes are predispositions to respond in a particular way toward social objects and are not measurable, they need to be inferred from types of response that fall into the three above-mentioned categories, usually through verbal statements (Rosenberg & Hovland, 1960). Therefore, studying how we '1) think of, 2) feel for, 3) and act on the aging human being' (Iversen et al., 2009, p. 15) is an important dimension of the conceptualization and operationalization of ageism, particularly because of the interrelation of these components.

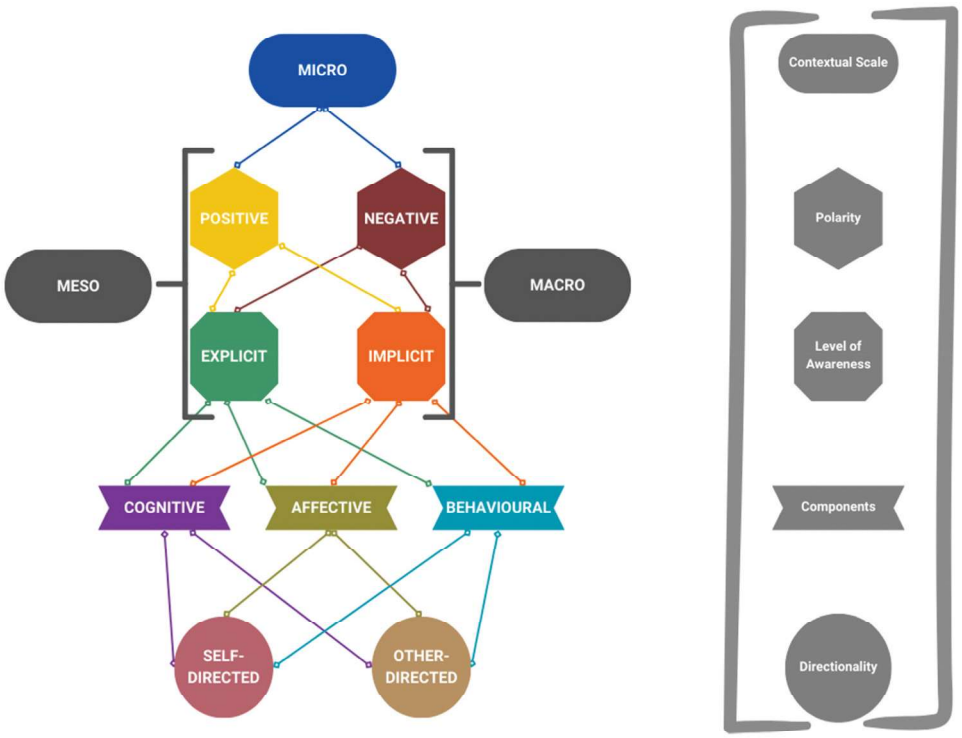


Figure 1. Ageism conceptualization. Visual representation created by the authors, based on the conceptualization by de São José and Amado (2017), which is itself an adaptation of Iversen et al. (2009).

Moreover, ageism can be implicit or explicit, if one considers the different levels of awareness in manifestations of ageism. This understanding has been gaining popularity in ageism studies, particularly after the contribution from Levy and Banaji (2002). These authors focus on the implicit expressions of ageism and explain how negative thoughts and feelings about older people can exist and operate without conscious awareness, intention, or control. This contribution is particularly important as it broadens the concept but also brings up additional challenges in research because, contrary to explicit manifestations, implicit ageism 'cannot be easily assessed through verbal self-report' (Levy & Banaji, 2002, p. 51). As seen above, this is crucial in inferring cognitive, affective and behavioral types of attitudinal responses (Rosenberg & Hovland, 1960).

So far, we have presented three dimensions (polarity, components and level of awareness) that conceptualize ageism in terms of 'how' it is manifested; however, similarly important is answering the questions 'by whom' and 'where.' These two dimensions are seen slightly differently by de São José and Amado (2017) and Iversen et al. (2009). First, the understanding that ageism can be either self-directed (toward oneself or one's own age group) or other-directed (toward individuals in a different age group) is not part of Iversen et al. (2009) definition of ageism. This idea of directionality is not new to the literature (Ayalon & Tesch-Römer, 2017; Levy, 2001) but it is not part of the definition of the concept before de São José and Amado (2017). Finally, manifestations of ageism are conceptualized at the micro, meso and macro level and it is at the meso level that de São José and Amado (2017) and Iversen et al. (2009) differ since they rely on different authors. We adopt de São José and Amado (2017) conceptualization, so we define the contextual levels considering Turner (2005) approach. According to the author, while the micro level is understood as interpersonal, i.e. episodes of face-to-face interaction, the meso level is comprised of corporate and categoric units, i.e. comprised by a structure and its related culture organized to pursue goals or ends (corporate), and by a social category which makes a difference in terms of how people act and are treated by others (categoric). Moreover, at the macro level we find the relationship of a population with its social and biophysical environments, i.e. institutional systems. To clarify, in the context of LTC, ageism manifestations can be observed at: (i) the micro level (in-person interactions between social actors), (ii) the meso level (organizational norms and rules affecting different age cohorts or social roles), and (iii) the macro level (public policies on LTC).

This conceptualization helps to operationalize the definition of ageism, and it also indicates how challenging comprehensive research in this field can be. Although the ways in which ageism is manifested in settings or among professional groups is one of the main focuses of the literature in this field of research, ageism in LTC is, nevertheless, an emerging field (de São José & Amado, 2017).

The naturalization of ageism: theoretical contributions

The literature shows that age stereotypes are internalized from an early age (Burke, 1981) and therefore, seem to be intertwined with socialization processes since they are part of the intersubjective world which individuals share (Berger & Luckmann, 1991).

Considering the importance of this shared 'knowledge' that mediates interpersonal encounters, we argue the importance of social representations theory since 'cognitive biases, subjective distortions, [and] affective tendencies exist in relation to a model or rules considered as the norm' (Moscovici, 2007, p. 30). The social representation of older persons is, then, a vital element for ageism studies as they constitute an 'organised set of opinions, attitudes, beliefs, and information related to an object or a situation' which are 'determined simultaneously by the individual themselves (their history, their experiences), by the social and ideological system in which they are embedded, and by the nature of the connections they maintain with that social system' (Abric, 2001a, p. 156). Within this theory, the structural perspective introduced by Abric (2001b) states that all social representation is organized around a central core, providing a global and consensual meaning and incorporating the elements which are most resistant to change (Abric, 2001a). A peripheral system also forms the flexible part of the structure, determined by the individual and context (Bertoni & Galinkin, 2017; Wachelke, 2012);

however, it is the central core that is fundamental for this study as it represents the stabilized meanings that group members associate with the object of representation. Hence, it will support our understanding of the shared 'knowledge' present in LTC settings as it shapes the ways in which both professionals and older adults navigate and make sense of their interactions with each other.

Methodology

The study was carried out in Portugal, the country with the fourth highest percentage of people aged 65 or over in the world (22.3%) (United Nations, 2023). It explores how manifestations of ageism and social representations about older people in LTC shape informal learning processes in these settings. While carried out in the Portuguese context for convenience, the study also responds to its social and scientific relevance. Here, the primary social responses for older people are care homes (Estrutura Residencial para Pessoas Idosas – E.R.P.I.), day centers for older adults (Centro de Dia – C.D.) and domiciliary care (Serviço de Apoio Domiciliário – S.A.D.) (GEP/MTSSS, 2024). While an E.R.P.I. is collective accommodation for people aged 65 or older with social support activities and nursing care, C.D. and S.A.D. are designed to provide care and services in the institution's premises or in-home, respectively. C.D. service users and residents share some spaces, activities and routines within the institution, but S.A.D. service users are usually not present on the institution's premises; therefore, they only interact with the caregiver or a small team of professionals that provide services at home. In this study, the focus was on the settings that provided the three services, exploring it mainly at micro and meso level.

Since we did not seek representativeness or statistical inferences, we conducted what is called a purposive (or purposeful) sampling strategy (Cohen et al., 2018; Creswell, 2003; Creswell & Poth, 2018; Newby, 2014), i.e. we intentionally selected our sample among the total universe of Portuguese institutions ($n = 2582$) that met the criteria of the study. To obtain a comprehensive view, we triangulated different data types using a convergent mixed-methods approach (Creswell, 2003) (interviews, questionnaires and participant observation), which will be detailed next. We targeted professionals employed in at least one of the services described above (E.R.P.I., C.D. or S.A.D.) on a nationwide scale for participation in the questionnaire. The other two data collection tools were administered in institutions (located in the same district as researchers, for convenience), offering all the three services described above. Participation, both individual and at the institutional level, was the result of self-selection processes, i.e., given the opportunity to participate, the participants chose to do so.

Ethical approval was waived in light of the planned research design; however, informed consent was obtained from both survey and interview participants, as well as from the institutions where the research took place, ensuring that participation was confidential and voluntary.

Data collection tools and procedures

The study involved three data collection instruments: (1) a nationwide survey applied to professionals in residential and nonresidential care settings for older people that included a free word association technique and socio-demographic questions; (2) field notes resulting from three months of participant observation conducted in four institutions in Portugal; and (3) interviews with participants holding management responsibilities in these institutions.

Survey

The research included collecting data concerning social representations of professionals in Portuguese residential and nonresidential care settings. A total of 386 participants were recruited through purposive sampling (358 women and 26 men; $M = 42.27$ years, $SD = 10.70$) (Cohen et al., 2018). A link to the Qualtrics© survey was emailed to a universe of 2582 residential institutions, requesting individual participation by sharing the link with their employees so that the participants could

complete the survey independently. The instrument is divided into two sections. The first includes socio-demographic questions such as gender, age, nationality, education, role and type of care service provided. The second section uses a free word association question: 'Write up to five words that come to mind spontaneously when you think about older people.' The survey included other questions; however, they were not relevant to this study.

The data collected from the survey was analyzed using Iramuteq (version 0.7 alpha 2). We conducted a prototypical analysis – an exploratory method (Moliner & Abric, 2015) developed by Vergès (1992) – to investigate the representation's structure. This analysis uses words or expressions evoked by participants in response to an inducing term (e.g. 'older people'), and so it focuses on the verbal material collected (Wachelke & Wolter, 2011), combining quantitative data – evocation frequencies – and qualitative data – the order of evocation. Words that come to mind most frequently and rapidly form the central core of the social representation and this is what we focused on. The raw data collected, in the form of words or expressions, were subject to reduction rules commonly used in this technique, such as verbs changing to infinitives and adjectives changing to nouns, for consistency (Rosenberg & Jones, 1972). For example, 'life experience' was reduced to 'experience,' and 'vulnerable' was changed to 'vulnerability.' Also, we grouped responses by semantic criteria, classifying them according to shared meaning and keeping the word with higher frequency, e.g. love, pampering, or hug, under affection. Three judges performed this data treatment independently and then cross-checked to reach a consensus.

Participant observation and interviews

As per the objective of the study, it encompassed collecting qualitative data to identify contextualized manifestations of ageism. In the attempt to include 'thick descriptions' (Geertz, 1973) of these manifestations, we conducted participant observation in four institutions over a period of three months (20 hours exclusively dedicated to observation in each institution). An e-mail was sent to 35 institutions in the researchers' district requesting participation, and four agreed and consented to participate. The participating institutions shared homogeneous characteristics, including their status as private social solidarity institutions (IPSS), the provision of the three types of care services (E.R.P.I., C.D. and S.A.D.), a religious foundation, and operation under the same regulatory framework. Given this homogeneity, it was concluded that it was unnecessary to expand the study beyond the four selected institutions, as this sample was considered not too large to hinder the extraction of thick, rich data nor too small to prevent data saturation in line with Onwuegbuzie and Leech (2007, p. 242).

The focus of observation was mainly the 'interactional setting' (Morrison, 1993, as cited in Cohen et al., 2018), i.e., encounters between residents/users and professionals (intra- and intergroup) for which we followed an 'observer-as-participant' approach (Cohen et al., 2018) characterized by a clear but unobtrusive researcher role. Due to the qualitative and unstructured nature of our observation, data was descriptively recorded in field notes after each moment of observation. This writing process during the observational period, in the form of field notes, resulted in inferences annotated using NVivo. These annotations were very important because 'for descriptions to be 'thick' requires inclusion not only of detailed observational data and data on meanings, participants' interpretations of situations and unobserved factors' (Cohen et al., 2018, p. 289).

Additionally, interviews were conducted with the four technical directors who agreed to be interviewed as part of the institution's participation in the study. The interviews had an approximate duration of 1 hour. They included questions whose aim was to understand the organization's foundation and structure, to characterize staff and residents/service users, to question whether these institutions are seen as learning contexts, and to explore the concept of agency toward promoting human rights identified as important in old age.

Verbatim transcripts of the interviews, alongside the researcher's field notes, were analyzed and coded manually in NVivo (15) software. After initial coding identifying ageism manifestations, we systematized and categorized the data using the ageism conceptualization that served as the theoretical framework (de São José & Amado, 2017). Like de São José and Amado (2017) we only

compartmentalized the components (cognitive, affective and behavioral) and directionality (self or other-directed) dimension at the micro level to avoid excessive fragmentation, which results in the 32-variant framework. The analysis resulted, therefore, from a inductive – deductive logic process (Creswell & Poth, 2018) performed independently by two judges that went 'through the data set more than once to ensure consistency, refinement and modification' (Cohen et al., 2018, p. 669). Assigning data to specific categories during this process was challenging, particularly concerning the explicit/implicit and positive/negative distinctions. This difficulty arose because what might appear to be positive discrimination often had negative consequences, and what seemed conscious was frequently naturalized and, thus, unconscious. The complexity of the concept resulted in the need to set clear questions for each dimension, establishing the criteria for categorization. To ensure consistency, a grid with specific questions was developed to guide the allocation of each manifestation of ageism to the appropriate category, as detailed in Table 1 in the findings section.

Findings

Social representation of older people

The following findings are based on survey data analyzed using the prototypical analysis method. The words most evoked by participants in the sample (358 women and 26 men; $M = 42.27$ years, SD = 10.70) were 'Affection' ($n = 306$), 'Wisdom' ($n = 143$), 'Care' ($n = 136$), 'Experience' ($n = 121$) and 'Loneliness' ($n = 94$), as seen in Figure 2, below.

'Wisdom' and 'Experience' refer to positive stereotypes of older people, while 'Loneliness' refers to negative ones. 'Care' seems directly connected to the relationship between these participants and older people, as all participants provide care services, regardless of the exact role – even though most participants held either direct operational roles, e.g., caregiver ($n = 120$) or held direct management roles ($n = 145$). The most cited word, 'Affection,' might be related to the sociological and familial caring practices, mainly because most participants are women and care roles are traditionally associated with this gender.

The prototypical analysis (Figure 2), using word frequency and evocation order criteria from the free word association technique, facilitated the identification of the abstract and symbolic elements of the representational structure – specifically, the central core, which reflects the group's values, norms, and history and holds significant consensus among its members (Moliner & Abric, 2015). The most frequent words (≥43.61) are part of the central core because they also have the lowest order of evocation (≤2.91), which means they were accessed in participants' consciences more rapidly.

Prototypical analysis with reference to the Inductive Term "older people" (n = 386)

Low Rank ≤ 2.91

High Frequencies ≥ 43.61 — Central Core	Frequency	Average Rank
Affection	306	2.8
Wisdom	143	2.2
Care	136	2.9
Experience	121	2.5
Loneliness	94	2.9
Respect	89	2.5
Dependence	86	2.8
Frailty	85	2.3

Figure 2. Prototypical analysis with reference to the inductive term 'older people'.

Table 1. Manifestations of ageism in long-term care settings identified through qualitative analysis of interview and observation data.

	Micro						Meso	Macro
	Cognitive		Affective		Behavioural			
	Self-Directed	Other-Directed	Self-Directed	Other-Directed	Self-Directed	Other-Directed		
Explicit Negative	Beliefs such as having reached the "end of the line" and being incapable of doing things. Self-perception of being dependent and pitiable ("Poor is the one who needs help"). Perceived power imbalance ("The director is now my mother" / "You're the ones in charge").	Older adults are perceived as uninterested in technology, disengaged, lazy, inherently vulnerable, "difficult", and resistant to change. Also depictions of being overly focused on health concerns and suspicious of others ("They stole from me"). Assumptions that all older adults have hearing impairments, get easily tired and are prone to various risks ("they need to be constantly supervised because they are at risk of falling, of everything!"). Belief that older adults need authoritative behaviour like children ("People might even call this violence, but they need to respect us! They're like children!")	Feelings of helplessness and unworthiness. Unwillingness to mingle with other older adults and refusal to self-identify as such. Fear of failure, particularly during activities ("I used to be able to do it. I even finished primary school with top marks, but now I'm afraid").	Feeling depressed and unmotivated to work with or for older adults due to perceptions that they are "mean" or that ageing is a regressive process (unlike working with children).	Perceived limitations as barriers to participation ("It wasn't me. If it were, I wouldn't have done it like that, but I have poor eyesight.").	Providing care with no concern for privacy (e.g., during hygiene routines) or entering rooms without permission. Rushed and impersonal care practices. Speaking loudly to older adults. Displays of indifference or impatience, sometimes in the context of refusing to attend to requests ("I just changed your diaper a while ago, I'm not going to change it again now!"). Use of commanding tones ("Let's get this over with," "Move," "Help yourself"). Patronising language (residents addressed informally as "you" or "kid"). Close monitoring of movements ("Where do you think you're going?").	Among staff, older adults are objectified as care recipients to be managed rather than individuals with unique needs and identities ("How about you entertain them, or do I have to do it?" / "This one goes to bed, this one too, that one goes downstairs…"). Older adults' choices are not a concern ("What they are told to do, they must do").	Public policies fail to provide specialised care, and institutions operate as generalised spaces for all older adults, regardless of their diverse needs or conditions.

(*Continued*)

Table 1. (Continued).

	Micro							
	Cognitive		Affective		Behavioural			
	Self-Directed	Other-Directed	Self-Directed	Other-Directed	Self-Directed	Other-Directed	Meso	Macro
Implicit Negative		Mistrust and assumptions of incompetence, i.e., older adults are often mistrusted based on the assumption that their cognition is impaired ("She said there's no one here! She's already 95, the poor thing"). Also, there is a presumption of incompetence, such as an inability to manage finances or drive.			Reliance on authority figures for approval, frequently seeking validation during tasks.	Participation in activities is often assumed rather than voluntary. If older adults are present in the activities' room, staff may take their participation for granted without seeking their input. Residents with less autonomy are neglected when it comes to engaging in activities. They are often left in separate rooms.	Loss of decision-making rights in care settings, i.e., upon admission to a care centre, older adults are frequently deprived of decision-making rights, including financial management and personal preferences ("He doesn't need wine, a regular haircut, or even coffee every day"). These decisions are often directed by family members, with institutions colluding through unspoken norms, leaving these matters unchallenged and within the "private" sphere of the family. Institutional environment reinforcing depersonalisation (The physical layout of care homes often reinforces feelings of depersonalisation and control, as spaces are designed more for efficiency than for comfort or social interaction).	

(*Continued*)

Table 1. (Continued).

	Micro							
	Cognitive		Affective		Behavioural			
	Self-Directed	Other-Directed	Self-Directed	Other-Directed	Self-Directed	Other-Directed	Meso	Macro
Explicit Positive	Older adults acknowledge wisdom and life experience.	Older adults are perceived as reliable, honest, resilient and capable of learning, particularly when interacting with younger people, provided they do not have cognitive impairments. Their rights and agency are acknowledged.			Older adults challenge demeaning labels such as being called "oldies" by their peers ("We are not old. I am not old. We are experienced!" / "We are graduates of life!"). Older adults may display high compliance, unquestioningly following instructions given by authority figures ("What they tell us to do is for our own good"). Some older adults assist others whom they identify as needing assistance, without a request.	Staff in management positions assume responsibilities such as handling older adults' finances and safeguarding funds for essential expenses, including institutional fees ("We have to smooth things out"). Expressions of concern and unsolicited help are common, e.g., tidying up residents' rooms without request. Some staff members, with perceived authority, intervene with families for the elderly person's well-being, such as giving money to the resident or influencing decisions like allowing a drink ("At this age, are we going to take away their comfort?").	Although obtaining consent for administering medication is a legal requirement, the common practice is to bypass it to prevent refusal from older adults under care. The use of incontinence products is widely promoted. Activities that are encouraged tend to focus on cognitive, physical, or occupational aspects, e.g., time orientation exercises, mobility, or colouring. When an output of an activity is produced, service users are encouraged to take it home to show their family.	Most older adults accessing care services in non-profit institutions (such as the institutions participating in the study) receive help from the welfare system to cover the costs of these services.

(*Continued*)

Table 1. (Continued).

	Micro							
	Cognitive		Affective		Behavioural			
	Self-Directed	Other-Directed	Self-Directed	Other-Directed	Self-Directed	Other-Directed	Meso	Macro
Implicit								
Positive						Infantilisation is implicitly present in some caring, affective or protective interactions and can be expressed in favour of older adults, for example: Healthy practices are often encouraged, such as hydration, eating or exercise ("Everybody drink water, it's very important!" / "Let's get pedalling – I want 50!") It also appears in affectionate interactions ("my little boy" / "blue-eyed girl"/ "my little ducks"). Condescending tones are frequently used ("poor thing" / "Oh dear, look at the mess you're making!"/ "Well done, you!").		

Micro - *Does it describe interpersonal encounters?*
Meso - *Does it describe an organization's norms and practices?*
Macro - *Does it describe public policies?*
Cognitive - *It it expressed as a perception, concept or belief?*
Affective - *Is it expressed as a feeling?*
Behavioural - *Is it expressed as an action?*
Self-Directed - *Is it expressed towards oneself or one's own age group?*
Other-Directed - *Is it expressed towards individuals in another age group?*
Explicit - *Is it expressed as a conscious, deliberate action or statement?*
Implicit - *Is it expressed as a practice or assumption that is naturalised and unspoken?*
Negative - *Is it expressed in disfavour of aged individuals?*
Positive - *Is it expressed in favour of aged individuals?*

Manifestations of ageism

As showed in Table 1, below, various manifestations of ageism in LTC were identified in this study, consistent with several qualitative studies analyzed by de São José and Amado (2017). Themes such as holding negative stereotypes about older persons' capacities and conditions, providing care in a rigid and rushed manner, requesting older adults to undertake childish activities, not giving an older person enough privacy or the organizational policy of discouraging autonomy and independence, were common between the literature and our study.

Also, similar to other studies (de São José & Amado, 2017) the categories of other-directed explicit ageism and ageism at the meso level seem to be more prevalent; however, our study also shows manifestations of self-directed and implicit ageism, as well as explicit and implicit positive ageism. This broad perspective allows us to gain deeper insight into these manifestations and draw inferences on the possible interconnectedness between the various dimensions.

Our research suggests that the three components of attitudes toward older people – stereotypes, emotions, and behaviors – are deeply intertwined. For instance, when older adults internalize the belief that they lack capabilities (negative, cognitive, self-directed), they may experience distress and fear of failure during activities (negative, affective, self-directed), increasing the likelihood of withdrawal from participation (negative, behavioral, self-directed). Similarly, staff assumptions that all older adults have hearing impairments (negative, cognitive, other-directed), lead to systematic behaviors, such as speaking loudly to them regardless of their individual needs (negative, behavioral, other-directed). Another example is the use of commanding tones and patronizing language (negative, behavioral, other-directed) which might be related to the belief (negative, cognitive, other-directed) that older adults are akin to children and therefore require authoritative oversight to ensure compliance. Findings also suggest a prevailing assumption that all older adults are susceptible to risks such as falls (negative, cognitive, other-directed) which might lead to another belief, that older adults must be constantly supervised. These ideas seem to be manifested in stringent monitoring of older adult's movements and, in some cases, the imposition of restrictive measures (negative, behavioral, other-directed).

As a result of the findings of this study, it is strongly suggested that other-directed negative stereotypes might fuel affective and behavioral negative manifestations. However, we also found positive manifestations of ageism that seem to be rooted in negative beliefs. For example, the assumption of incompetence (negative, cognitive, other-directed) appears to be linked to practices such as acting on the behalf of older adults, e.g., managing their finances, which was framed as measures intended to protect older adults (positive, behavioral, other-directed). The same negative belief of incompetence, associated with others, such as the idea that older adults are resistant to change or that they are difficult, might be associated with institutional practices such as bypassing consent for administering medication – measures that are seen as protective (positive, behavioral, other-directed, meso level). Positive cognitive ageism directed by professionals does not seem to be related to any behavioral manifestations, e.g., the belief that older adults are reliable and honest does not seem to be associated with any discriminatory practices, either in favor or disfavor of older adults. Positive self-directed cognitive ageism, on the other hand, such as older adults acknowledging their wisdom and life experience, is related to positive self-directed behavioral manifestations (e.g., challenging demeaning labels such as being called 'oldies'). However, these positive behavioral manifestations seem directed at their peers and not professionals; therefore, they are kept as self-directed.

Discussion

This research suggests that manifestations of ageism in LTC settings are related to the central core of the social representation of older people held by professionals, which, in turn, may be strongly influenced by stereotypes, as Moliner & Vidal (2003) suggest. However, while positive attributes such as 'Wisdom,' 'Experience,' and 'Respect' are part of the representational structure, the study

suggests that both positive and negative manifestations of ageism by professionals are related to negative representations such as 'Dependence' and 'Frailty.' Even though some discriminatory practices are seen as protective and well-intentioned, they are rooted in negative beliefs and are often paternalistic and controlling. These two representations related to decline seem to justify the need for 'Care' – another word in the central core. However, we also find 'Loneliness' and 'Affection' among the verbal outputs that confer stability to the social representation of older people. The salience of 'Loneliness' aligns with previous literature, which often identifies it as a key element in representations of ageing (Dafinoiu & Crumpei, 2013; Daniel et al., 2015). This seems to sustain the understanding that older adults are emotionally, cognitively and physically vulnerable. Since social representations do not exist in a vacuum, it is important to reflect on the learning dimensions in these institutions that support the stability of this shared 'knowledge' among professionals.

According to Malcolm et al. (2003) framework, the *content* is one of the attributes of learning and, in this context, entails 'knowledge' that informs everyday care practice. This emerges from power dynamics that shape how individuals engage with and interpret each other in social interactions. Just as power is embedded in the relationship between teacher and student in a structured and intentional pedagogical setting, in LTC settings, power is inherent in the care relationship. Our study suggests that the power imbalance between actors involved in the care practices in these settings results from mainly negative social representations of older people. This shared 'knowledge' supports practices that reinforce the exercise of power by caregivers, expressed as manifestations of ageism. We cannot, of course, dissociate between the fact that these are care professionals and the idea that providing care involves some level of dependency and frailty for the recipient. However, looking at how practices in these settings are based on the accentuation of vulnerability instead of empowerment provides insight into the learnt curriculum of these contexts.

The learning *process*, i.e., the human activity in which learning occurs in these settings, is, therefore, care practice. So, *content* and *process* are two dimensions which must be discussed interdependently in light of the study's findings. Caring for older adults in LTC seems to be organized around the premise of incompetence and decline of older adults (*content*), which leads to care practices (*process*) that, explicitly or implicitly, promote loss of autonomy and increased dependence. As mentioned before, stereotypes, emotions, and behaviours are deeply intertwined. Stereotypes generate emotions and drive actions, which, in turn, reinforce those very stereotypes, a dynamic also noted by Palmore (1999). So, for example, since there is a shared belief that older adults are 'difficult' and 'need authoritative behaviour like children,' we will find the prevalent use of commanding tones. Harmful behavior toward older adults is, however, condemned socially. Therefore, there is an implicit belief that all practices are intentionally designed to protect older adults (positive ageism). Paradoxically, even the social and recreational activities designed for older adults – arguably the closest to a didactically structured learning situation in these contexts – are shaped by negative stereotypes. Activities that are encouraged tend to focus on cognitive stimulation (e.g., time orientation exercises) or physical exercise (e.g., to increase mobility) supported by the premise of decline. Other occupational activities such as games, coloring or music are not so explicitly relatable to decline. Still, participant observation allowed us to understand that, for example, the music sessions aimed to stimulate memory with music, which implicitly relies on the same belief. Moreover, positive ageism was not only shaped as protection but also as affection, and infantilization was also seen implicitly in affectionate interactions, suggesting a protective yet diminishing attitude.

The dynamics of the care relationship in these settings are learnt not only by staff but also by older adults. The study suggests that older people, seen as passive care recipients, follow instructions unquestioningly, often deferring entirely to caregivers or staff. Manifestations of ageism such as the self-directed comments 'You're the ones in charge' and 'The director is now my mother' accentuate older adults' perceived lack of autonomy. Moreover, compliance is regarded as a virtue, with the belief that 'what they tell us to do is for our own good,' reinforcing passive acceptance of older adults' reduced authority. Power differentials in the care experiences of older people have been explored by Doyle (2014), whose study points to

similar findings to ours, namely poor-quality care, unnecessary controls and restrictions, helplessness felt by older adults who perceive a lack of viable choices, and experiences of abuse. Indeed, examining the manifestations of self-directed ageism, we observed expressions of fear, dependency, and reduced self-worth. These are outcomes of the intersubjective relationships formed between individuals in social situations, which, as we found, are shaped by unequal relationships with caregivers and a persistent diminished sense of agency among older adults in institutional settings. As a result, we suggest that ageism is prevalent in LTC settings because of how older people are presented (to themselves and others) – which is not dissociated from the social construction of old age – and the type of relationships promoted in those settings.

Regarding the *location* attribute, we argue that all contexts are formative, and even within institutions, the architecture of the space is formative as it reflects and exacerbates the nature of the pedagogic relationship, either emancipatory or oppressive. The fact that spaces are designed more for efficiency than for comfort or social interactions – due, for example, to the way chairs are placed – perpetuates the dependency of older adults. Therefore, the physical layout of care homes reinforces feelings of depersonalization and control. Regardless of the diverse needs of older adults requiring care, the residents or service users have no choice in how spaces are utilized. Often, residents with less autonomy were left in separate rooms during activities, for example. Control was exercised in many forms and took precedence over privacy, as caregivers entered so-called private spaces without authorization. Moreover, privacy was not safeguarded during hygiene-related tasks since these spaces were perceived as public, with priority given to task completion rather than to the individual's dignity and autonomy. Other studies support the importance of the architecture of spaces in LTC, by exploring how the lobby of two distinct types of institutions can serve as a key space for residents to develop different coping mechanisms related to their aging identity (Gamliel, 2000).

Finally, we suggest that the *purpose* of learning is often unconscious and unintentional. The manifestations of implicit ageism reveal how deeply ingrained it is in these contexts. Combined with the fact that seemingly positive, benevolent practices can conceal the negative effects of ageism, this creates further challenges in disrupting the cycle of tacit ageism learning.

Conclusion

Our study attempts to shed light on the informal learning processes within these settings and it does so by exploring the manifestations of ageism and their underlying social representations. The learning dimensions, particularly *process* and *content* are very much embedded in the nature of the caring relationship, i.e., the symbolic meaning of the action 'to care' and the state of 'being cared for.' Even at the linguistic level, this framing reinforces the implicit idea of passivity in the role of the care recipient.

The paradigm of care for older adults must be changed, treating social situations such as interacting with older people in LTC centers as opportunities for challenging ageism instead of reinforcing dependency relationships between care providers and care recipients. Educational interventions to combat ageism must consider structured learning settings and everyday informal learning since, as our study suggests, standardized and implicit ageist practices within care settings can overcome professionals' training.

To conclude, we argue that a critical mechanism for combating ageism is breaking away from an assistentialist paradigm and moving toward critical educational gerontology principles such as the idea of a *revolutionary praxis* (Formosa, 2011). We strongly believe that, in essence, the idea of a 'critical engagement with historically accumulated concepts and practices' (Formosa, 2011, p. 327) calls for the recognition of older adults as key educators of society, particularly by fostering their conscious understanding of their role in perpetuating ageism and enabling them to actively co-construct emancipatory social interactions.

Limitations

One limitation of this study is that observations were conducted exclusively in institutional premises, excluding in-home services. As a result, and even though 18% of survey participants work in all three services, the observational data does not capture potential manifestations of ageism in the context of in-home care.

Additionally, instruments identified by Levy and Banaji (2002), such as the Stereotype Priming and Implicit Association Test, could have been useful for measuring implicit ageism. These tools would help mitigate the influence of social desirability bias in participants' responses, particularly given the self-selection process used, thereby enhancing the reliability of the data collected.

Note

1. We do not use the terms education and learning interchangeably as they are categorically distinct (Billett, 2018). Learning is an ongoing and inherent process that occurs through engagement with experiences, activities, and social interactions while education refers to structured, intentional processes designed to promote specific changes in people, i.e., learning.

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