Published in final edited form as:

J Aging Health. 2014 April ; 26(3): 458–473. doi:10.1177/0898264314523449.

Discrepancy Between Chronological Age and Felt Age: Age Group Difference in Objective and Subjective Health as Correlates

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Abstract

Objective—Guided by the social comparison theory, we examined correlates of the discrepancy between chronological and felt ages in three age groups of community-dwelling older adults: 65 to 69, 70 to 79, and 80 and older.

Method—Data from the National Health and Aging Trends Study and linear regression models were used to test the hypothesis that age discrepancy would be significantly associated with objective health indicators among those in the 65 to 69 and 70 to 79 age groups but not among the 80+ group.

Results—Objective health indicators were significantly associated with age discrepancy only in the 70 to 79 age group, while subjective health perceptions and psychological well-being were significantly associated with age discrepancy in all age groups.

Discussion—The correlates of the discrepancy in the 65 to 69 age group appear to resemble those in the 80+ group more than those in the 70 to 79 age group. Further research is needed to identify the determinants of age group differences.

Keywords

felt age; objective health; self-ratings of health

Introduction

Older adults across many disparate countries, both Western and Eastern, share a surprisingly universal view that they feel younger than their chronological age, and this tendency is more pronounced with increasing age (Barak, 2009; Barak & Stern, 1986; Cleaver & Muller, 2002; Hubley & Hultsch, 1994; Montepare & Lachman, 1989; Uotinen, Rantanen, Suutama,

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N. G. Choi and D. M. DiNitto planned the study, conducted data analysis using Stata, and wrote the article. J. Kim performed statistical analysis using Mplus and contributed to writing the analysis section of the article.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

& Ruoppila, 2006). Regardless of differences in social systems (e.g., retirement policies such as age requirements and programs such as Social Security) and cultural values (e.g., ageism, youth-oriented culture), individual conditions, especially physical and psychological health status, appear to be the primary determinants of subjective age (Barak, 2009).

Objective physical health conditions (e.g., medical conditions, bodily pain, and functional impairment in particular) and subjective health perceptions (e.g., self-rated health) explain the largest proportions of variance, with poorer health contributing to feeling older (Barrett, 2003; Demakakos, Gjonca, & Nazroo, 2007; Hubley & Russell, 2009; Knoll, Rieckmann, Scholz, & Schwarzer, 2004). A 13-year prospective study also found that older felt age predicted worsening health and higher mortality, even after adjusting for both objective and subjective health status as well as mental and cognitive health status, chronological age, and other demographic factors (Uotinen, Rantanen, & Suutama, 2005).

Previous research also shows that the following psychological health factors contribute to feeling younger, independent of health variables as opposed to moderating the relationship between health and subjective age: optimism and higher self-efficacy (Teuscher, 2009); internal locus of control and extraversion (Hubley & Hultsch, 1994); higher conscientiousness (i.e., meticulousness, reliability, tenacity, hard working, ambitiousness, and analytic qualities; Knoll et al., 2004); and higher levels of personal growth and generativity (Ward, 2010). In contrast to health and psychological variables, demographic variables such as gender, marital status, education, income, and race do not generally predict felt age (Barak & Rahtz, 1999; Baum & Boxley, 1983; Henderson, Goldsmith, & Flynn, 1995; Hubley & Russell, 2009; Kaufman & Elder, 2003; Uotinen et al., 2006). However, a few studies have found that people feel older when experiencing age-symbolic life events (e.g., retirement and widowhood) that serve as markers of transitions into social roles people are expected to enact at later life stages (Barak & Stern, 1986; Mathur & Moschis, 2005).

Although research has provided substantial knowledge regarding the correlates of subjective age, understanding why individuals perceive their age the way they do and why it changes or differs across the life span is limited (Montepare, 2009). With extended life expectancy, older adults are an increasingly diverse group of individuals with a wide range of chronological ages and physical, mental, and cognitive health conditions. As noted, discrepancies between chronological and felt ages are greater with increasing chronological age, despite the fact that advanced ages are associated with increased physical health problems. However, little research has been carried out to explicate possible differences in the correlates of discrepancies between chronological age and felt age in different age groups of older adults. Given subjective age's strong correlation with health and mortality, especially in late life, it is important to better understand older adults' subjective age experience in terms of individual as well as group differences. The purpose of the present study was to examine correlates of the discrepancy between chronological and felt ages among people in three age groups—65 to 69, 70 to 79, and 80 and older—focusing on the contributions of objective health indicators, subjective health perceptions, and psychological well-being indicators.

Conceptual Framework and Study Hypotheses

Older adults who feel younger than their chronological age have been described as engaging in self-motivation or self-enhancement, an approach reflecting positivity bias or positive illusions, since to feel, look, and act younger is generally considered beneficial and contributes to well-being and functioning (Barak & Stern, 1986; Hubley & Hultsch, 1994; Montepare, 2009; Teuscher, 2009). Research has shown that social comparisons may be the mechanism through which this self-enhancement is achieved (Heckhausen & Krueger, 1993; Wood, 1989). Social comparison theory was initially proposed in terms of accurately assessing/evaluating where one stands in comparison with similar others in terms of opinions and performance capabilities—what one can and cannot do (Festinger, 1954). Later revisions and extensions to social comparison theory in life-span developmental psychology highlighted three important points especially pertinent to later life. First, social comparisons in later life may function more as self-enhancement than an accurate rendering of abilities since older adults tend to make selective and strategic social comparisons to feel good and maintain a positive view of themselves. Second, social comparisons in later life involve much more than just one's physical/functional abilities as older adults have other goals, priorities, life tasks, and stakes that may differ from those of younger persons. Third, comparative judgments that older adults render about their attributes are likely to include affective/emotional domains and both similar and dissimilar others as targets of comparison (Heckhausen & Krueger, 1993; Kruglanski & Mayseless, 1990; Weiss & Freund, 2012; Wheeler, Martin, & Suls, 1997). Studies also show that people who felt happy and had high self-esteem engaged in downward comparisons (comparing themselves with those they perceive as less fortunate) to make themselves feel better (Suls, Martin, & Wheeler, 2002; Wheeler & Miyake, 1992). Conversely, people with negative affect elicit negative self-thoughts, leading to upward comparisons (comparing themselves with those they perceive as more fortunate), resulting in greater feelings of inferiority. These findings underscore the potentially significant role of psychological well-being variables in social comparison.

In the context of the self-enhancement function of social comparisons, the conceptual foundation of the present study was grounded in the following assumptions: (a) The oldest old (those aged 80+ years) are likely to have the greatest motivation for enhancing and protecting their subjective sense of well-being since they, on average, have the greatest challenges in health and functioning. (b) Faced with declining physical health, the oldest older adults are less likely to focus on objective health conditions and more on holistic and inclusive factors in ways that produce favorable self-evaluations. Previous research indeed found that the older the individuals were, the more favorably and holistically they assessed and perceived their health, for example, by focusing less on objective physical and functional health indicators and more on subjective indicators (Borawski, Kinney, & Kahana, 1996; Idler, 1993; Idler, Hudson, & Leventhal, 1999; Suls, Marco, & Tobin, 1991; van Doorn, 1999). (c) While older adults may tend to make downward social comparisons, positive or negative affect and their subjective sense of well-being are likely to determine the direction and outcome of their comparisons. Study hypotheses were as follows: Controlling for demographic and social support factors, (H1) the discrepancy between chronological and felt ages will be significantly associated with objective health conditions (number of chronic medical conditions, functional impairments, and delayed word recall

score) among those in the 65 to 69 and 70 to 79 age groups but not among the 80-and-older group; and (H2) the discrepancy will be significantly associated with subjective perceptions of health (self-ratings of health and memory), positive/negative affect, and psychological well-being in all three age groups.

Method

Data and Sample

Data for this study were drawn from the first interview wave of the National Health and Aging Trends Study (NHATS; Kasper & Freedman, 2012) of a nationally representative sample of U.S. Medicare beneficiaries aged 65 years and older ($N = 8,077$) who resided in the community in their own or another's home or in residential care settings including nursing homes and other facilities. Face-to-face, individual interviews, lasting about 2 hr, were administered in 2011 by Westat with “sample persons” in all settings except nursing homes to collect detailed information on health conditions, psychological well-being, and other aspects of aging. The NHATS sample design was age-stratified so that persons were selected from 5-year age groups between the ages of 65 and 90, and from persons aged 90 and older. Persons in older age groups and persons whose race was listed as Black on the Center for Medicare and Medicaid Services enrollment file were oversampled (Montaquila, Freedman, Edwards, & Kasper, 2012). The present study included only those sample persons ($n = 6,680$; community-dwelling older adults) who resided in their own or another's home and excluded those in residential care settings (e.g., nursing homes [$n = 468$] or other such settings [$n = 412$]) and those represented by proxy respondents (e.g., their spouse or child [$n = 517$]) due to dementia, illness, hearing impairment, and/or speech impairment. These exclusions were based on both systematic and respondent-level missing data on many variables (e.g., psychological variables) included in this study.

Measures

Chronological age and age group—Chronological age, measured as a continuous variable (age in years), was used to group sample persons into 1 of 3 categories: younger older adults (aged 65–69); middle older adults (aged 70–79); and the oldest older adults (aged 80 and older).

Felt age—To measure felt age, each sample person was asked the following question: “Sometimes people feel older or younger than their age. During the last month, what age did you feel most of the time?” The age the sample person gave was recorded.

Discrepancy between chronological and felt ages—This was calculated by subtracting each respondent's chronological age from his/her felt age. Negative numbers indicate that respondents felt younger than their chronological age; zero indicates that felt age was the same as chronological age; and positive numbers indicate that respondents felt older than their chronological age.

Objective health conditions—These included the number of chronic medical conditions diagnosed by a doctor (including high blood pressure, heart attack/heart disease, arthritis,

osteoporosis, diabetes, lung disease, stroke, and cancer); the number of impairments in activities and instrumental activities of daily living and (ADLs/IADLs); whether or not bodily pain limited activities in the last month; and delayed word recall score (lower scores representing worse recall). ADLs included eating, bathing, toileting, dressing, getting in and out of bed, getting in and out of chair, and walking inside. IADLs included preparing meals, doing laundry, doing light housework, shopping for groceries, managing money, taking medication, and making telephone calls. The small number of missing values (did not know [DK] or refused to answer [RF]) in some of the medical conditions and ADL/IADL variables were treated as the absence of a diagnosis or impairment to arrive at conservative estimates.

Subjective perceptions of health—These included respondents' self-ratings of health and self-ratings of memory, measured on a 5-point Likert scale (1 = *excellent* to 5 = *poor*). Lower scores represent better subjective health.

Positive/negative affect—This was measured with the summed score from the following four questions: "During the last month, how often did you feel (a) cheerful, (b) full of life, (c) bored, and (d) upset?" The response categories were every day (7 days a week = 5), most days (5-6 days a week = 4), some days (2-4 days a week = 3), rarely (once a week or less = 2), and never (= 1). The responses to "bored" and "upset" were reverse-coded. Higher scores represent more positive affect. Cronbach' alpha for the study sample was .62.

Psychological well-being—To create a psychological well-being score, responses to the following seven questions were summed: *My life has meaning and purpose* (purpose in life); *I feel confident and good about myself* (self-acceptance); *I gave up trying to improve my life a long time ago* (personal growth; reverse-coded); *I like my living situation very much* (acceptance of living situation); *Other people determine most of what I can and cannot do* (perceived constraints; reverse-coded); *When I really want to do something, I usually find a way to do it* (personal mastery); and *I have an easy time adjusting to change* (self-efficacy). The response categories were as follows: agree not at all (= 1), agree a little (= 2), and agree a lot (= 3). According to the NHATS User Guide (Kasper & Freedman, 2012), these psychological variables are similar to those used to measure psychological well-being in Midlife in the United States: A Study of National Health and Wellbeing (MIDUS; Ryff et al., 2006), but with fewer response categories and with the reference period of "in the last month." Higher scores represent a higher perceived sense of well-being. Cronbach's alpha for the study sample was .74.

Demographic and social support controls—Demographic variables were gender (female vs. male); race/ethnicity (non-Hispanic White [reference group], non-Hispanic Black, Hispanic, all others); level of education (less than high school/DK/RF [reference group], high school diploma or GED (General Education Development), some college or associate's degree, and bachelor's degree or higher). Missing values in education level due to DK or RF responses were grouped with the "less than high school" category based on multiple bivariate analyses of other sample characteristics (e.g., sociodemo-graphics, health conditions, psychological/social capital) that showed similarities between the DK/RF group

(unweighted $n = 67$) and the “less than high school” group. Social support variables were living arrangement (living with spouse vs. not living with spouse) and the number of members in the participant's social network, which was derived from a series of questions that began with, “Looking back over the last year, who are the people you talked with most often about important things?”

Analysis

Bivariate analyses, using χ^2 and one-way ANOVA, were used to examine age group differences in demographic and social support variables, objective and subjective health, psychological variables, felt age, and discrepancy between chronological and felt ages. Examination of pairwise correlation coefficients indicated no multicollinearity among predictor variables that would bias hypothesis testing. Hypotheses were tested using linear regression analyses for each age group, with discrepancy between chronological and felt ages as the dependent variable. Because 5% of persons in the study sample (3.2%, 4%, and 7.0% of the 65-69 group, 70-79 group, and 80-and-older group, respectively) did not provide their felt age, the dependent variable for these sample persons had missing data. We ran two linear regression analyses for each age group to examine any potential bias due to the substantial proportion of missing data in the dependent variable: One included only those who reported their felt age ($n = 1,311$ for the 65-69 group; $n = 2,700$ for the 70-79 group; and $n = 2,237$ for the 80-and-older group) using the `svy` command of Stata13; the other included the complete study sample ($n = 1,342$ for the 65-69 group; $n = 2,782$ for the 70-79 group; and $n = 2,375$ for the 80-and-older group) using the *Mplus* 7.0 full information maximum likelihood method (Muthén & Muthén, 1998-2013). In the latter case, *Mplus* procedures for missing data recommended by Acock (2005) were followed, in which additional variables that may explain missingness in the dependent variable were entered as “mechanism” variables in the regression model. Household income (in units of \$5,000) and the clock drawing test scores (range = 0-5) were used as mechanisms given that they were significantly different between those who reported felt age and those who did not, even though they were not significant predictors of felt age for any age group in the regression models. Since a comparison of the results from the models with and without the cases that had the missing dependent variable were almost identical, we report findings from the Stata regression model that excluded the missing dependent variable cases.

Results

Sample Characteristics and Bivariate Correlations

Table 1 shows that the three age groups did not differ in racial/ethnic composition. As expected, the oldest group had a higher proportion of women, lower level of education, lower income, and lower proportion of those living with their spouse than the two younger groups. The oldest group also had a smaller social network, more chronic medical conditions and ADL/IADL impairment, lower word recall scores, lower self-ratings of health and memory, and lower scores on positive/negative affect and psychological well-being indicators. The three age groups did not differ in the proportions of those who reported that bodily pain limited their daily activities.

As in previous studies, a majority of older adults, regardless of their age, reported feeling younger than their chronological age. Of the 65 to 69 age group, 72.0% felt younger and 16.0% felt older than their chronological age; 8.8% felt the same as their chronological age. Of the 70 to 79 age group, 71.5% felt younger, 6.0% felt older, and 18.5% felt the same as their chronological age. Of the 80-and-older group, 67.8% felt younger, 5.9% felt older, and 19.3% felt the same. Though the proportion of those aged 80-and-older who felt younger was slightly smaller than that in the two younger age groups, these oldest adults felt younger than their chronological age by a wider margin (19 years vs. 17 years for the younger groups), $F(df) = 13.30(2)$, $p < .001$. Those aged 65 to 69 and 70 to 79 who felt older did so by 8.8 and 8.4 years, respectively, compared with 6.7 years for those 80 years and older, but the difference between the two younger groups and the oldest group was not significant, $F(df) = 1.76(2)$, $p = .173$. The average discrepancy between chronological age and felt age for all members of each group was -11.9 years for those aged 65 to 69, -12.4 years for those aged 70 to 79, and -13.6 years for those aged 80-and-older, with a significant difference between the two younger groups and the oldest group, $F(df) = 7.07(2)$, $p = .001$. No significant difference was found between two younger groups.

Further analysis showed that the correlation between chronological age and age discrepancy (difference between chronological age and felt age, in years) was not statistically significant for either of the two younger age groups, while the correlation was very weak but significant (-0.08 , $p < .01$) for the oldest group. Of all the predictors, self-rated health had the strongest correlation with the age discrepancy variable ($r = .31$ for the 65 to 69 age group, $r = 0.26$ for the 70 to 79 age group, and $r = .27$ for the 80-and-older group, all at $p < .001$), with poorer self-ratings of health associated with feeling not as young (and feeling older). The psychological well-being variable had the second strongest correlation with the age discrepancy variable ($r = .26$ for the 65 to 69 age group, $r = .21$ for the 70 to 79 age group, and $r = .22$ for the 80-and-older group, all at $p < .001$). Other significant correlates of the age discrepancy variable for all three age groups were number of medical conditions, number of ADL/IADL impairments, bodily pain limiting daily activities, positive/negative affect, and self-rated memory. All these relationships were weak ($r = .21$ or lower). In addition, there was a very weak negative but significant correlation between age discrepancy and word recall for the 65 to 69 age group only ($r = -.07$, $p < .01$).

Multivariate Findings

Table 2 shows findings from the linear regression models. Neither the number of medical conditions nor delayed word recall scores were significantly associated with age discrepancy for any age group. The number of ADL/IADL impairments and pain were significant (those with more impairments and pain were more likely to feel older and less likely to feel younger) only for the 70 to 79 age group. Self-ratings of health and memory were significant correlates of age discrepancy for all three age groups, showing that those with poorer self-rated health and poorer self-rated memory were more likely to feel older and less likely to feel younger than their chronological age. The negative (inverse) relationships between age discrepancy and both positive affect and psychological well-being in all three age groups indicate that those who have higher levels of psychological well-being are more likely to feel younger and less likely to feel older than their chronological age.

In summary, the findings only partially support H1 regarding the relationships between age discrepancy and objective health conditions as age discrepancy was not related to number of diagnosed chronic medical conditions in any group. For both the 65 to 69 age group and the 80-and-older group, age discrepancy was not significantly associated with ADL/IADL impairments or pain that limits activities, whereas in the 70 to 79 age group, both these variables were significant correlates of age discrepancy, with more impairment related to feeling less young/older. The findings support H2, since regardless of chronological age, among all three age groups, those who rated their health and memory as poorer were more likely to feel older and those with higher self-reported positive affect and psychological well-being tended to feel younger. In all three age groups, the amount of variance explained by the variables in the model (R^2) was relatively small, ranging from 13% to 16%.

Discussion

This study expands prior research by examining age group differences in factors associated with discrepancy between chronological age and felt age among community-dwelling older adults. According to prior research, younger subjective age reflects a complex array of motivational factors and expectations about aging. Compared with younger adults, older adults, who face declining physical/functional health, have more reasons and greater motivation for feeling younger than their chronological age as a self-enhancement or self-protection strategy. The present study shows that as hypothesized, positive/negative affect and psychological well-being are associated with discrepancy between chronological and felt ages among older adults in all age groups, but physical/functional health is not associated with age discrepancy among those aged 80-and-older, providing empirical evidence for the relative lack of importance of functional abilities in their self-concept and self-evaluation. Physical/functional health problems and dependency needs are expected in the eighth and ninth decades of life. The findings of this study suggest that people in this age group accept or downplay these disabling conditions and do not let them significantly affect their positive sense of self. Doing so may also allow them to maintain a positive view of themselves and faith in the future and feel younger despite age-related losses. The selective and strategic social comparisons this oldest age group makes appear to focus on aspects of life that transcend their physical/functional abilities. According to previous research, people tend to engage, both intentionally and unintentionally, in downward comparison in situations that cannot be remedied with instrumental actions (e.g., changing certain health problems) or when individuals feel threatened (e.g., when faced with a potentially serious health problem; Wills, 1981; Wood, 1989). Downward comparison serves to enhance or protect individuals' own subjective well-being by comparing themselves with less fortunate others. Collins (2000) also found that people also compare themselves, both intentionally and unintentionally, with better-off others to make perceptions of themselves more positive or to create a more positive perception of their personal reality—"that they are among the better ones" (p. 170). For some older adults, self-enhancement and protection strategies may also involve conscious or subconscious processes in which they conjure up and distance themselves from stereotypical images of the frail older adult (Teuscher, 2009; Weiss & Freund, 2012; Weiss & Lang, 2012).

Unlike those in their '80s and '90s, those currently in their 70's generally enjoy better health and are likely to feel they have a number of good years ahead, owing to reduced morbidity and increased life expectancy. As older adults withdraw from the labor force and are freed of many family-related responsibilities, they tend to view this "third age" as a time of liberation, self-realization, fulfillment, and greater personal enjoyment (Laslett, 1991). But the present study shows that those in the 70 to 79 age group with disabling conditions are likely to feel older than their chronological age, suggesting that functional impairment and bodily pain severe enough to limit daily activities collide with their once high expectations about living a healthy and active life in this third age period. As hypothesized, they appear to compare themselves with their age-group peers without disabling conditions, resulting in upward comparisons that negatively affect their perceived age.

Perhaps the most interesting and unexpected finding pertains to the 65 to 69 age group, because the correlates of discrepancy between chronological and felt ages in this young-old group resemble those in the 80-and-older group more than those in the 70 to 79 age group. The assumption was that disabling conditions (ADL/IADL impairments and pain) would be a more significant correlate of chronological and felt age discrepancy among the two younger groups than among the oldest group. While this was true for the 70 to 79 age group, it was not for the 65 to 69 age group, perhaps because the young olds have fewer disabling conditions or their disabling conditions are not as severe yet. The youngest older adults with disabling conditions may also have intentionally chosen to focus on other aspects of life than their disabilities to maintain a better sense of subjective well-being. A previous study of Canadians between 55 and 97 years also found that physical functioning accounted for a smaller amount of variability in felt age in the 55 to 69 group than in the 70+ group (Hubley & Russell, 2009). In addition, a Finnish study's finding that youthful felt age became more pronounced as older adults aged (Uotinen et al., 2006) also suggests that our findings may be generalizable to older adults in other countries.

Limitations of this study include the use of cross-sectional data since only correlational, not causal, relationships can be suggested, and possible temporal comparisons across life stages could not be examined. The data set did not include sufficient measures of personality traits and other psychological variables such as internal locus of control and generativity that may potentially mediate or moderate the effects of felt age. In addition, the data set included only one question about felt age, which limited more in-depth analysis.

Given the significant relationship between felt age and psychological well-being and mortality in late life, future research on older adults' felt age is needed in at least four areas: (a) Older adults should be asked to elaborate on the reasons they felt younger, the same, or older than their chronological age to provide the empirical data needed to develop and test theoretical assumptions; (b) a more in-depth consideration of individual psychological variables and cultural/other contextual variables is needed to understand the predictors of felt age; (c) longitudinal data on felt age are needed to better examine age group differences, not only in the context of social comparisons but also across individuals' life spans and developmental stages; (d) more research is needed to identify the determinants of felt age in the young-old group. With the baby boomers advancing into this age cohort, research on

how their felt age is constructed and what its relationship may be to self-efficacy and subjective well-being will provide valuable insights into their aging process.

Acknowledgments

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This study was supported by faculty research resources at the University of Texas at Austin.

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Table 1

Sample Characteristics by Age Group.

	Age 65-69 <i>n</i> = 1,360	Age 70-79 <i>n</i> = 2,864	Age 80+ <i>n</i> = 2,456
Gender (%) ***			
Male	46.5	45.3	39.3
Female	53.5	55.7	60.7
Race/ethnicity (%)			
Non-Hispanic White	81.1	80.5	83.7
Black	8.0	8.4	7.0
Hispanic	6.7	6.9	6.1
Other	4.2	4.2	3.3
Education (%) ***			
<High school/DK/refused	15.6	22.0	27.6
High school/GED	24.7	27.8	28.7
Some college	29.4	26.4	23.5
BA/BS or higher	30.3	23.8	20.2
Median income (\$)	43,200	32,000	24,000
Living with spouse (%) ***	70.2	60.3	41.3
No. in social network (<i>SE</i>) ***	2.08 (0.04) ^a	1.94 (0.02) ^b	1.86 (0.03) ^b
No. of chronic medical conditions (<i>SE</i>) ***	2.05 (0.04) ^a	2.41 (0.03) ^b	2.57 (0.03) ^c
No. of ADL/IADL impairment (<i>SE</i>) ***	0.77 (0.07) ^a	0.86 (0.05) ^a	1.68 (0.07) ^b
Pain limits activities (%)	30.1	28.4	28.5
Delayed word recall score (<i>SE</i>) ***	4.32 (0.05) ^a	3.64 (0.04) ^b	2.61 (0.04) ^c
Self-rated health (<i>SE</i>) ^I ***	2.50 (0.03) ^a	2.69 (0.02) ^b	2.86 (0.02) ^c
Self-rated memory (<i>SE</i>) ^I ***	2.43 (0.03) ^a	2.55 (0.02) ^b	2.78 (0.02) ^c
Positive affect (<i>SE</i>) ***	12.29 (0.04) ^a	12.19 (0.03) ^a	12.01 (0.04) ^b
Positive attitude/efficacy (<i>SE</i>) ***	19.21 (0.06) ^a	19.12 (0.04) ^a	18.59 (0.05) ^b
Mean age (<i>SE</i>) ***	67.33 (0.03) ^a	74.02 (0.05) ^b	84.42 (0.08) ^c
Felt age (<i>SE</i>) ***	55.42 (0.36) ^a	61.62 (0.25) ^b	70.81 (0.31) ^c
Felt age category (%) ***			
Felt younger	72.0	71.5	67.8
Felt the same age	16.0	18.5	19.3
Felt older	8.8	6.0	5.9
DK/refused	3.2	4.0	7.0
Years felt younger (<i>SE</i>) ***	-17.01 (0.27) ^a	-17.28 (0.24) ^a	-19.20 (0.40) ^b
Years felt older (<i>SE</i>)	8.83 (0.66)	8.43 (0.62)	6.69 (0.68)

	<u>Age 65-69</u>	<u>Age 70-79</u>	<u>Age 80+</u>
	<i>n</i> = 1,360	<i>n</i> = 2,864	<i>n</i> = 2,456
Average age discrepancy (felt age–chronological age; <i>SE</i>) ^{***}	–11.91 (0.36) ^a	–12.41 (0.25) ^a	–13.61 (0.31) ^b

Note. All estimates are based on weighted data. DK = did not know; ADL = activities of daily living; IADL = instrumental activities of daily living; *SE* = standard error.

^{**}*p* < .01.

^l Higher scores represent lower perceived health.

^a Denote significantly different pairs.

^b Denote significantly different pairs.

^c Denote significantly different pairs.

^{***}
p < .001.

Table 2

Correlates of Chronological and Felt Age Discrepancy Within Three Age Groups: Results From Linear Regression.

	<u>Age 65-69 (n = 1,311)</u>	<u>Age 70-79 (n = 2,700)</u>	<u>Age 80+ (n = 2,237)</u>
	<i>B (SE)</i>	<i>B (SE)</i>	<i>B (SE)</i>
Chronological age	−0.63 (0.28) *	−0.21 (0.10) *	−0.37 (0.09) ***
No. of chronic medical conditions	0.39 (0.32)	0.24 (0.21)	−0.14 (0.26)
No. of ADL/IADL impairment	−0.27 (0.23)	0.26 (0.11) *	−0.09 (0.14)
Pain limits activities	1.01 (0.85)	2.11 (0.75) **	1.12 (0.76)
Delayed word recall score	0.00 (0.22)	0.07 (0.14)	−0.08 (0.14)
Self-rated health	2.18 (0.47) ***	1.76 (0.35) ***	3.02 (0.37) ***
Self-rated memory	0.94 (0.42) *	1.53 (0.32) ***	1.19 (0.39) **
Positive affect	−1.00 (0.26) ***	−0.50 (0.17) **	−0.64 (0.18) ***
Psychological well-being	−0.92 (0.24) ***	−0.79 (0.11) ***	−0.93 (0.17) ***
<i>R</i> ²	.16	.13	.13
<i>p</i>	<.001	<.001	<.001

Note. Gender, race/ethnicity, education, living with spouse, and number in social network were controlled in each regression model. *SE* = standard error; ADL = activities of daily living; IADL = instrumental activities of daily living

*
p < .05.

**
p < .01.

p < .001.