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The Role of Subjective Age and Ageism in Shaping Quality of Life in Israeli Older Adults

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Abstract

Purpose

This study examined how subjective age and ageism relate to quality of life (QoL) among older adults in Israel. Drawing on stereotype embodiment theory, we conceptualized subjective age (feeling younger or older than one's chronological age) as a psychological resource and ageism as a psychosocial risk factor that may mediate the link between internal perceptions of aging and well-being.

Method

Data were drawn from Wave 8 of the Survey of Health, Ageing and Retirement in Europe (SHARE-Israel). The analytic sample included 528 community-dwelling adults aged 50 and older who completed the Israeli drop-off questionnaire. QoL was assessed with the CASP-12 scale, subjective age was operationalized as a proportional discrepancy between felt and chronological age, and ageism was measured with 10 items adapted from the Ageism Survey. Mediation was tested using PROCESS Model 4, controlling for sociodemographic and health covariates.

Results

Feeling younger than one's chronological age was associated with higher QoL (total effect: $b = 5.70$, $p < .001$), and this association remained significant after accounting for ageism (direct effect: $b = 4.51$, $p < .001$). Ageism partially mediated the association between subjective age and QoL (indirect effect: $b = 1.18$, 95% CI [0.22, 2.18]). Additionally, Jewish and Arab Israelis reported higher QoL than immigrants from the Former Soviet Union.

Conclusions

Findings highlight subjective age as a key psychological resource, and ageism as an important social mechanism, shaping QoL in later life within a multicultural context.

INTRODUCTION

The global rise in population aging creates numerous challenges that can reduce people's quality of life (QoL). Older individuals often experience difficulties performing daily activities, suffer from chronic illnesses, and have feelings of lower self-worth [1]. These adversities, together with biological and psychological changes, influence how older adults perceive their own age and how others perceive them. Society often describes older people as "boring, forgetful, grumpy, incompetent, sickly, and unattractive" [2, p.4], which strengthens ageism—stereotypes, prejudice, and discrimination based on age [3, 4].

Quality of life (QoL) is a multidimensional concept. Early studies focused mainly on physical health and disability [5, 6]. In recent years, research has broadened to include psychological and social well-being as well as general life satisfaction. This perspective builds on Rowe and Kahn's [7] model of successful ageing which identifies three central elements: a low risk of disease, strong physical and mental functioning, and active engagement in daily life [8–11].

Subjective age, i.e. how older adults feel versus their chronological age, is an important factor for well-being [12]. Feeling younger has been linked to better mood, sharper thinking, and fewer depressive symptoms [13]. Longitudinal data show that those with a younger subjective age have lower mortality rates and maintain daily functioning better over time [14]. One recent review found that positive attitudes toward aging are associated with a higher quality of life [15]. Most adults feel about 11 years younger than they actually are, and this gap correlates with better health outcomes, more optimism, and greater resilience [12].

Research suggests that subjective age and ageism influence each other bidirectionally. Internalizing negative age stereotypes can affect how old an individual feels; as these stereotypes become personally relevant in midlife, identifying with them makes people feel older and more negative [4]. Data from the U.S. Health and Retirement Study (N = 4,776) showed that experiencing age discrimination led people to feel older than their peers [16]. The reverse may also be true: a negative sense of subjective age might affect one's sensitivity to discrimination. Those who feel younger may psychologically separate themselves from being "old," while those who feel older might be more likely to perceive their behavior as age-related [3]. A study of 568 Israeli adults aged 50–95 found that feeling younger was connected to less workplace age discrimination, whereas feeling older was linked to experiencing more discrimination - particularly among people with lower levels of mental health [17].

Subjective age influences how individuals perceive and respond to societal views on aging. The stereotype embodiment theory posits that age-related stereotypes shape self-perception, behavior, and health [4]. Those who feel older often identify with negative stereotypes and experience age prejudice, while those who feel younger are less affected by such ageism [3, 14]. Thus, feeling younger may enhance self-esteem and well-being, while feeling older may increase vulnerability to discrimination and lower quality of life [16–19]. Ultimately, ageism acts as a pathway linking internal perceptions of aging with external social experiences, leading to disparities in well-being among older adults.

Ageism itself has well-documented effects on QoL. Stereotype embodiment theory posits that internalized stereotypes shape health through psychological, behavioral, and physiological pathways [4]. Systematic reviews found consistent negative effects of ageism on older adults' psychological well-being and health [18, 20]. Similarly, in a study of dependent older adults, age discrimination predicted lower baseline QoL and greater decline over time [19]. Experimental evidence has shown that exposure to negative ageing stereotypes can reduce older adults' perceived future opportunities, further illustrating the broad impact of ageism on well-being [21].

Socio-demographic variables such as gender, education, cohort, and health status also influence QoL [22–26]. By situating subjective age and ageism within this broader context, we can clarify individual differences in QoL and identify intervention points for promoting healthy and successful ageing.

In sum, feeling younger than one's chronological age appears to buffer against negative stereotypes, whereas feeling older heightens sensitivity to ageism. This suggests that ageism may mediate the relationship between subjective age and QoL [2, 4]. The present study therefore aims to examine these interrelationships among older adults in Israel by investigating how subjective age is associated with QoL, how it relates to experiences of ageism, and whether ageism functions as a mediating mechanism linking subjective age to QoL within a multicultural context (Fig. 1). Understanding these psychosocial pathways is crucial for explaining how internal perceptions of ageing and external stereotypes jointly shape well-being in later life.

HYPOTHESES

1. Higher subjective age (feeling younger relative to chronological age) will positively associate with QOL both directly and indirectly via perceived ageism, controlling for covariates.
2. Higher subjective age (feeling younger than one's chronological age) will be associated with higher QOL.
3. Higher subjective age (feeling younger than one's chronological age) will be associated with lower perceived ageism, which in turn will be associated with higher QOL.

METHODS

DESIGN AND METHODS

Participants were drawn from wave 8 of the Survey of Health, Ageing, and Retirement in Europe (SHARE) which surveys community-dwelling adults aged 50 and older in Europe and Israel [27]. Data for this wave were collected during 2019/2020 through face-to-face, computer-assisted personal interviews conducted by trained interviewers. All respondents provided informed consent prior to participation. In addition to the main interview, participants were asked to complete a country-specific paper drop-off questionnaire, which in Israel also included items on subjective age and experiences of ageism. These data formed the basis of the present analysis, which focused exclusively on the Israeli sub-sample of SHARE. SHARE-Israel was approved by the Institutional Review Board of the Hebrew University of Jerusalem [28].

Our analytic sample was restricted to respondents who completed the Israeli drop-off questionnaire. Of the 744 Israeli individuals participating in the Wave 8 SHARE sample, 528 participants aged 50 and older completed both the SHARE questionnaire and the sub-sample submitted only to the Israeli participants. Thus, responses could be had across all study variables and those 528 participants were included in the analyses. Attrition analyses indicated that excluded participants (i.e. those under the age of 50 and with incomplete data) reported significantly lower experiences of ageism, lower education levels, and poorer health perceptions compared with those retained ($p < .05$). In contrast, no significant differences were observed for sex, ethnicity, chronological age, subjective age, functional limitations (IADL), or QoL.

MEASURES

Dependent variable

Quality of life **–**Quality of life was measured using the CASP-12 scale, a shortened version of the original CASP-19 [29]. The scale assesses four dimensions—control, autonomy, self-realization, and pleasure—through 12 items rated on a four-point Likert scale ("often," "sometimes," "rarely," "never"). Total scores range from 12 to 48, with higher scores reflecting better quality of life.

Independent variable

Subjective age **-** Participants were asked: *"Most of the time, how old do you feel?"* and were instructed to indicate an age between 1 and 120 years. A discrepancy score was then calculated by subtracting the reported felt age from the participant's chronological age and dividing by chronological age [30]. Negative values represent feeling older than one's actual age, while positive values represent feeling younger.

The Mediator

Ageism – Ageism was assessed in SHARE-Israel Wave 8 using 10 items adapted from the Ageism Survey [31]. Respondents reported experiences of age-based discrimination in domains such as employment ("I was denied employment or promotion because of my age"), health care ("I was denied medical treatment because of my age"), financial services ("I had difficulty getting a loan/mortgage because of my age"), and everyday interactions ("I was patronized or 'talked down to' because of my age"). Responses were given on a 3-point scale (0 = never, 1 = once, 2 = more than once). Items were summed to produce a total score ranging from 0 to 20, with higher scores reflecting greater exposure to ageism. The scale demonstrated good internal reliability in this sample (α = .86).

Covariates

Analyses adjusted for the following background covariates: chronological age, sex (male = 1, female = 0), IADL limitations, number of chronic diseases, self-rated health (1 = poor to 5 = excellent), education, and ethnicity. Education followed the ISCED-97 scale (0 = no formal education to 5 = tertiary education/college or university degree). Ethnicity was coded with two dummy variables—Arab (1 = Arab, 0 = otherwise) and Jewish (1 = Jewish, 0 = otherwise)—with immigrants from the Former Soviet Union (FSU) serving as the reference category.

Data analyses

Descriptive statistics were conducted to summarize the study variables, including means, medians, ranges, and standard deviations for continuous variables, and frequencies and percentages for categorical variables. Associations between baseline variables—independent variable (subjective age), mediator (ageism), and dependent variable (quality of life)—were assessed using correlation analyses. To test the mediation hypotheses, we applied the analytic approach described by Preacher and Hayes (33) using PROCESS Model 4. In this model, ageism served as a mediator between subjective age and QOL. The significance of the indirect effect was examined by estimating the pathway from subjective age to ageism (path a), from ageism to QOL (path b), the direct effect of subjective age on QOL controlling for the mediator (path c'), and the total effect without the mediator (path c), adjusting for background covariates. Indirect effects (a × b) were evaluated using bootstrapping with 5,000 samples, generating bias-corrected 95% confidence intervals based on the empirical distribution of resampled estimates. All analyses were performed in SPSS version 28.0 using the PROCESS macro (32).

RESULTS

Table 1 summarizes sample characteristics. The analytic sample comprised 744 adults aged 50–109 years (M = 78.1, SD = 8.4); 60.1% were women. Most identified as Jews (82.7%), with 10.2% immigrants from the Former Soviet Union (FSU) and 7.1% Arab Israelis. Information on education was available for 87% of respondents and ranged from no formal schooling (3.6%) to higher education (36.2%); 25.7% completed secondary education. Participants reported on average 3.2 chronic conditions (SD = 1.6) and modest IADL limitations (M = 1.9, SD = 1.7). Mean self-rated health was 2.8 (SD = 1.1; 1–5 scale). On average, participants felt younger than their chronological age (subjective-age discrepancy M = 0.21, SD = 0.18). QOL averaged 36.2 (SD = 5.6; range = 19–48). Perceived ageism averaged 2.6 (SD = 3.9) (see Table 1 and Supplementary Table).

Table 1
Descriptive Statistics of the Study Variables (N = 744)

Variable	Category	n	%	M	SD	Range
Sex	Female	447	60.1			
	Male	297	39.9			
Ethnicity	Jews	615	82.7			
	Arabs	53	7.1			
	FSU	76	10.2			
Education	None	23	3.6			
	Primary	126	19.5			
	Lower secondary	60	9.3			
	Upper secondary	166	25.7			
	Post-secondary non-tertiary	38	5.9			
	First stage tertiary	234	36.2			
	Second stage tertiary	0	0			
Age				78.11	8.36	50–109
Number of chronic diseases				3.19	1.63	0–5
IADL limitations				1.85	1.71	0–10
Self-rated health				2.84	1.12	1–5
Quality of life				36.15	5.58	19–48
Ageism				2.62	3.94	0 – 17
Subjective age				0.21	0.18	−0.47–1.00

Note. Percentages are valid percentages. IADL: Instrumental Activities of Daily Living

Table 2 reports Pearson correlations among the study variables. QOL correlated positively with subjective age (feeling younger relative to chronological age), education, male sex, Jewish ethnicity (vs. FSU), and better self-rated health. QOL correlated negatively with ageism, chronological age, number of chronic conditions, and IADL limitations. Higher subjective age (feeling younger) correlated positively with better self-rated health and negatively with ageism and Arab ethnicity (vs. FSU).

Table 2
Pearson correlations between independent variable, mediator, covariates and quality of life (N = 744)

Variable	1	2	3	4	5	6	7	8	9	10
1. Quality of life	1.00									
2. Subjective age	.24**	1.00								
3. Ageism	− .25**	− .15**	1.00							
4. Age	− .15**	.01	− .12**	1.00						
5. Sex	.08*	− .03	− .00	.08*	1.00					
6. Education	.17**	.03	− .10*	− .14**	− .01	1.00				
7. Jews	.21**	.18**	.04	− .23**	.00	.01	1.00			
8. Arabs	− .10**	− .17**	.12**	.13**	.02	− .35**	− .61**	1.00		
9. SHR	.35**	.11**	.08*	− .34**	− .02	.24**	.31**	− .17**	1.00	
10. Chronic diseases	− .27**	− .02	− .10**	.28**	− .04	− .10*	− .28**	.03	− .54**	1.00
11. IADL limitations	− .40**	− .07	− .01	.38**	− .14**	− .18**	− .32**	.20**	− .45**	.44**

Note. SHR = self-rated health; IADL = instrumental activities of daily living; Sex: (1 = male, 0 = female); (Arabs = 0; FSU immigrants = 0); Arabs (Jews = 0; FSU immigrants = 0)

* p < .05, ** p < .01 (2-tailed).

Using PROCESS Model 4 [32, 33], we tested whether ageism mediates the longitudinal link between subjective age and QOL while adjusting for covariates (Table 3). The model predicting QOL was significant, $F(10, 517) = 22.63$, $p < .001$, $R^2 = .304$. The total effect of subjective age on QOL was positive and significant ($b = 5.70$, $SE = 1.28$, $p < .001$). After including the mediator, the direct effect remained significant but was attenuated ($b = 4.51$, $SE = 1.23$, $p < .001$). The indirect effect via ageism was significant ($b = 1.18$, 95% CI [0.22, 2.18]). Higher subjective age (feeling younger) predicted lower ageism ($b = − 3.01$, $SE = 1.02$, $p = .003$), and this, in turn, predicted higher QOL ($b = − 0.39$, $SE = 0.05$, $p < .001$). Thus, ageism partially mediated the association between subjective age and QOL. In addition, relative to FSU immigrants, both Arab Israelis ($b = 2.65$, $p = .026$) and Jews ($b = 1.82$, $p = .017$) reported higher QOL after controlling for subjective age, ageism, and health covariates, suggesting persistent QOL disadvantage among FSU immigrants.

Table 3
Direct and indirect effect of subjective age on QOL through the mediator (ageism) controlling for covariates (N = 528)

	Total effect (c) without mediator controlling covariates				
Path / Effect	b	SE	t	P	95% CI
Path c: Subjective age → QOL	5.70	1.28	4.44	< .001	[3.18, 8.22]
	Effect of subjective age on the mediator (ageism)				
Path a: Subjective age → Ageism	-3.01	1.02	-2.94	.003	[-5.01, -1.00]
	Direct effect with the mediator controlling covariates				
Path c': Subjective age → QOL	4.51	1.23	3.67	< .001	[2.10, 6.93]
Path b: Ageism → QOL	-0.39	0.05	-7.50	< .001	[-0.50, -0.29]
Sex	0.68	0.43	1.61	.106	[-0.14, 1.54]
Age	0.02	0.02	0.69	.486	[-0.03, 0.07]
Education	0.29	0.14	2.03	.042	[0.01, 0.58]
Chronic diseases	-0.09	0.16	-0.57	.568	[-0.40, 0.22]
IADL	-0.81	0.15	-5.32	< .001	[-1.11, -0.51]
SHR	0.98	0.24	3.93	< .001	[0.49, 1.47]
Ethnicity – Jews	1.82	0.76	2.38	0.017	[0.32, 3.32]
Ethnicity – Arabs	2.65	1.18	2.22	0.026	[0.31, 4.98]
	Indirect effect (axb)				
	b	BootSE			95% CI
Subjective age → Ageism → QOL	1.18	0.50*	—	—	[0.22, 2.18]

Notes. *Unstandardized coefficients and confidence intervals (95% CI) are reported*. SHR = self-rated health; IADL = instrumental activities of daily living; sex (1 = male, 0 = female); Jews (1) (Arabs = 0; FSU immigrants = 0); Arabs (Jews = 0; FSU immigrants = 0).

DISCUSSION

This study investigated how subjective age and ageism relate to quality of life among older adults in Israel. The findings supported our hypotheses: feeling younger than one's actual age was linked to better quality of life, both directly and indirectly through experiencing less ageism. These results match earlier research showing that younger subjective age predicts better physical and psychological outcomes [12–14], and supports stereotype embodiment theory [4] which maintains that internalized attitudes about aging influence a person's well-being.

The mediation results show that ageism works as a psychosocial pathway connecting how people view their own aging to their life satisfaction. Those who felt younger reported experiencing less discrimination, which was linked

to a better quality of life. These findings align with research showing that positive views of aging can buffer against negative stereotypes [2, 16, 18], and with evidence that internalized ageism damages both mental and physical health [20, 34].

A notable finding concerns ethnic differences in quality of life. Arab and Jewish Israelis reported higher quality of life than immigrants from former Soviet Union (FSU) countries, even after accounting for subjective age, ageism, and health factors. This finding aligns with previous SHARE survey studies showing persistent gaps between veteran groups and immigrants [35]. FSU immigrants, many of whom arrived in mid-life or as older adults, may continually face language barriers, limited social integration, and restricted access to services. In contrast, Jews and Arabs in Israel may benefit from stronger community and family ties, though economic and geographic inequality remains a challenge, particularly among Israeli Arabs.

Israel's multicultural setting offers an important model for understanding how cultural context shapes the links between subjective age, ageism, and well-being. The observed ethnic differences highlight that experiences of aging and discrimination reflect broader social structures, migration histories, and cultural norms. These insights have implications for other diverse societies such as the United States, Canada and European countries, where aging populations and ethnic diversity similarly influence perceptions of aging. Culturally informed interventions addressing both ageism and minority integration may be essential for promoting equitable aging worldwide.

LIMITATIONS

Several limitations should be noted. First, the cross-sectional design prevents us from drawing causal conclusions about how subjective age, ageism, and quality of life influence each other. Longitudinal analyses using multiple SHARE waves would offer stronger evidence. Second, the data came from self-reports, which can be affected by recall bias or social desirability. Finally, while the Israeli sample provides useful multicultural insights, the findings may not apply to institutionalized older adults or those who did not participate in the survey.

CONCLUSIONS AND IMPLICATIONS

The findings support the study’s hypotheses and enhance understanding of how subjective age and ageism together influence well-being. Feeling younger than one’s actual age appears to be a psychological resource that improves quality of life both directly and by lowering sensitivity to discrimination. Ageism thus serves as an important psychosocial mechanism connecting internal perceptions of aging with external experiences of bias. The Israeli context provides cross-cultural insights relevant to other societies experiencing demographic aging and growing ethnic diversity.

In practical terms, the results highlight the need to promote positive attitudes toward aging and to confront ageism. Educational and intergenerational programs that challenge age stereotypes can strengthen autonomy and life satisfaction [2, 21], while contact-based interventions have been shown to reduce ageist views and encourage inclusion [36]. Future studies should employ longitudinal and cross-cultural designs to explore whether changing subjective age or reducing ageism can lead to better quality of life across diverse aging populations.

Declarations

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Authors Contributions

Both authors (R.K and A.V.S) contributed equally to the study conception, design, data analysis, and to the writing of the manuscript. Both authors review and approved the final manuscript.

Ethics and consent to participate:

The SHARE project has received comprehensive ethical approval from the Ethics Council of the Max Planck Society, as detailed in the document dated June 8th, 2021. The Ethics Council reviewed the project's design and implementation across multiple waves (Waves 4-9) and confirmed that there were no research-ethical concerns. Additionally, the project complies with the ethical principles outlined in the Declaration of Helsinki, as confirmed by ethics committees across participating countries. **Informed consent was obtained from all individual participants included in the study.**

Data availability statement: The data that support the findings of this study are available from the Survey of Health, Ageing and Retirement in Europe (SHARE). Restrictions apply to the availability of these data, which were used under license for this study. Data are available free of charge for scientific use to registered researchers via the SHARE Research Data Center (www.share-project.org) with the permission of SHARE

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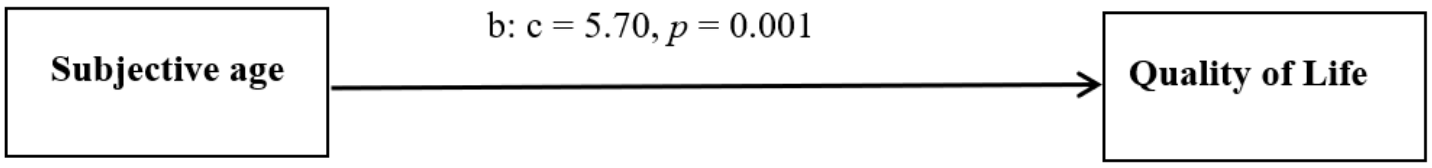
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Figures

Graphic A.



Graphic B.

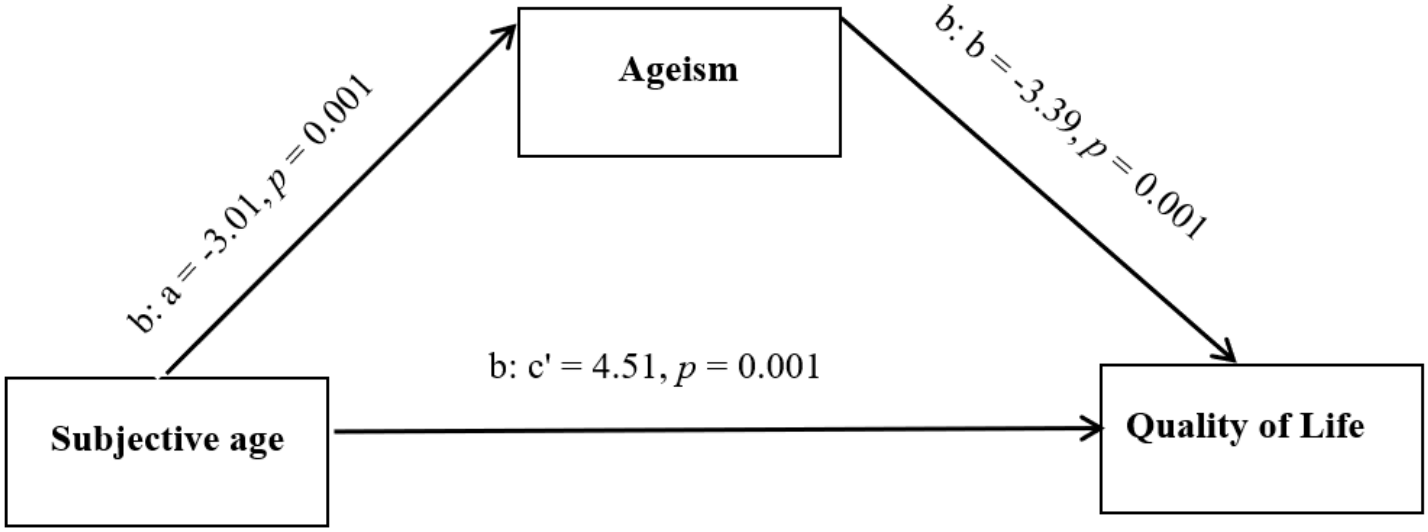


Figure 1

PROCESS Model 4 depicting direct and indirect effects of the association between subjective age on quality of life (QOL) through ageism, controlling for covariates. Graphic A depicts the total effect of subjective age on QoL (weight C). Graphic B depicts the direct effect of subjective age on QoL with mediator (weight C'), and the indirect effects through the mediator (ageism) controlling for all covariates. Values represent unstandardized regression coefficients *p<.001

Supplementary Files

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- SupplementaryTable.docx