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Frailty, Self-Directed Ageism, and Quality of Life in Community-Dwelling Older Adults: Evidence from the Belgian Ageing Studies

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Abstract

This study aimed to investigate the role of self-directed ageism in shaping the relationship between frailty and quality of life among community-dwelling older adults. A secondary analysis was conducted using data from the Belgian Ageing Studies. Between 2017 and 2019, a stratified sample of 1895 participants, based on age and gender according to census data, was selected. Frailty, quality of life, and self-directed ageism were measured using the Comprehensive Frailty Assessment Instrument, a numeric rating scale, and a newly developed self-directed ageism scale, respectively. The new scale's validity was evaluated through exploratory factor analysis, and mediation analysis assessed whether self-directed ageism mediated the association between frailty and quality of life.

The self-directed ageism scale demonstrated high reliability (Cronbach's $\alpha = 0.898$, Spearman-Brown = 0.906) and accounted for 58.86% of the variance in self-directed ageism. Participants had an average self-directed ageism score of 23.6/40, a mean frailty score of 26.94/100, and a median quality of life score of 8/10. Mediation analysis indicated that frailty was inversely related to quality of life and that this association was partially mediated by self-directed ageism. Most participants were mildly frail, experienced self-directed ageism, and those aged 80 or older reported a lower quality of life. The findings confirm that frailty negatively impacts quality of life, with self-directed ageism partially mediating this effect. Interventions targeting frailty, ageism, and self-directed ageism are essential to improve the quality of life for older adults living in the community.

Keywords: Frailty, Self-directed ageism, Quality of life, Community-dwelling, Older adults, Belgian Ageing Studies

Introduction

Improved living conditions and advancements in medical and technological fields have contributed to increased life expectancy. Globally, the population aged 60 and above is growing faster than younger age groups, resulting in an aging world population [1]. In 2022, around 10% of the global population was aged 65 or older, with projections suggesting an increase to 16% by 2050 [2]. This trend is also evident in Belgium, where 25% of the population was 60 or older in 2021 [3], with further growth anticipated [4]. Most older adults live at home and prefer to remain there as long as possible [5]. Despite greater longevity, evidence suggests that today's older adults do not necessarily experience better health than previous generations [6]. A lack of respect, pervasive stereotypes, and negative attitudes toward older people—collectively known as ageism—are contributing factors. Butler first defined "age-ism" in 1969 as prejudice by one age group against others, describing it as a form of bigotry [7]. The World Health Organization (WHO) characterizes ageism as a multifaceted social phenomenon encompassing age-based stereotypes, prejudice, and discrimination, which can be explicit or implicit and occur at institutional, interpersonal, or internalized (self-directed) levels [8]. While ageism can target any age group [9], this study focuses on ageism directed at older adults.

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Greenberg *et al*. [10] proposed that terror management theory explains ageism: individuals fear their vulnerability and mortality, employing defensive mechanisms to manage this fear. Martens *et al*. [11] extended this idea, suggesting that negative attitudes toward older adults reflect young people's fear of aging and death, expressed as stereotypes, prejudice, and discriminatory behaviors. Unlike other prejudices, such as sexism or racism, ageism targets a group that most people will eventually join [12].

Montepare and Zebrowitz [13] note that ageism emerges early, as children adopt societal age-related stereotypes, which accumulate over a lifetime. Cognitive decline in older age makes it harder to suppress these beliefs, resulting in self-directed ageism [14]. Allen *et al*. [15] found self-directed ageism to be the most prevalent form, affecting 81% of older adults in their study of 2035 participants.

Marques *et al*. [16] identified multiple determinants of both other- and self-directed ageism: age, fear of death, and fear of aging were linked to other-directed ageism, whereas poor mental and physical health were associated with self-directed ageism. Gekoski and Knox [17] found that prejudice targets frail or sick older adults, rather than age itself, with specific age-related traits (e.g., slowness, depression) driving negative perceptions. Similarly, James and Haley [18] concluded that older adults in poorer health face compounded risk for negative attitudes from mental health professionals.

The WHO [8] reports that ageism adversely affects health, well-being, and rights, contributing to reduced life expectancy, poorer physical and mental health, delayed recovery, cognitive decline, and increased risks of elder abuse. Allen *et al*. [15] further demonstrated that self-directed ageism is associated with the highest increases in risks for various health outcomes, including chronic conditions and depressive symptoms.

Although aging in place can enhance quality of life [19], functional decline can make it challenging. Older age is frequently associated with frailty, a condition that increases vulnerability to dependence, disability, falls, long-term care, and mortality [20]. Frailty has a well-established negative impact on quality of life [21–25], regardless of whether it is assessed from a biomedical or multidimensional perspective [23].

Given the emphasis on aging in place, a growing number of frail, community-dwelling older adults is expected. Considering the negative relationship between frailty and quality of life, as well as frailty's potential role in ageism, this study aims to examine how self-directed ageism influences the association between frailty and quality of life among older adults living in the community.

Materials and Methods

Objective

This research seeks to examine how self-directed ageism influences the connection between frailty and quality of life among older adults residing independently in the community. Prior investigations have investigated links between frailty and quality of life, as well as between ageism and quality of life, though self-directed ageism has received limited attention [26]. To our knowledge, this represents the initial effort to analyze the relationships involving self-directed ageism, frailty, and quality of life together.

Research design and data gathering

The present work constitutes a secondary analysis of information from the Belgian Ageing Studies (BAS), a long-term initiative that compiles data on community-based individuals aged 60 and over [27], implemented in the Flemish region of Belgium starting in 2004. Details on recruitment procedures are outlined in depth in the methods article by De Donder *et al*. [28]. Information for this rigorously designed cross-sectional survey was obtained via a participant-completed questionnaire covering diverse elements of later-life well-being and residential environments. Enhancements to the core questionnaire occurred in 2009 and 2015, incorporating items on quality of life and the Comprehensive Frailty Assessment Instrument [29]. From 2017 to 2019, stratified sampling—using population statistics for gender and age categories (60–69, 70–79, 80 +)—was applied in four municipalities. This yielded 1895 respondents in total, with at least 319 from each location. Questionnaire responses were recorded in Microsoft Access. The BAS protocol gained ethical clearance from the Vrije Universiteit review board (B.U.N. 143,201,111,521). Further BAS particulars appear in De Witte *et al*. [29].

Instruments

All instruments applied here are embedded within the questionnaire framework of the Belgian Ageing Studies initiative.

Demographic characteristics

The BAS captures multiple demographic details for independently living older persons, selecting age, gender, and marital status for use in this investigation.

Frailty evaluation

Frailty was measured comprehensively via the Comprehensive Frailty Assessment Instrument (CFAI), a participant-reported scale devised by De Witte *et al*. [29] to detect frailty in community-based seniors, exhibiting robust psychometric performance. Composed of 23 items across four areas—physical (general well-being), psychological (mood issues and emotional isolation), social (social isolation and network support), and environmental (dwelling and surroundings)—the CFAI follows specified scoring to derive domain totals, which are combined into an overall score of 0 to 100. Increased values signify heightened frailty severity. An in-depth CFAI overview is available in De Witte *et al*. [29].

Quality of life evaluation

Participants provided their personal ratings of quality of life by selecting a value on an 11-point scale (0 to 10), where 0 indicated extremely low quality of life, and 10 indicated excellent quality of life.

Self-directed ageism evaluation

Included in the BAS are 11 items targeting self-directed ageism in older community residents.

These items were employed earlier in ageism-related work by De Donder *et al*. [30] and Van Regenmortel *et al*. [31]. They appear in **Table 3**. Agreement levels were recorded on a 5-point Likert format, spanning fully disagree (1) to fully agree (5). Exploratory factor analysis was conducted to determine the latent construct framework.

Data analysis

Participants were first categorized into the three age groups defined by the BAS: 60–69 years, 70–79 years, and 80 years and above. The 11 items drawn from the Belgian Ageing Studies (BAS) then underwent exploratory factor analysis to identify their dimensional structure and to develop a scale capturing the construct of self-directed ageism. Prior to the analysis, an inter-item correlation matrix was computed to evaluate relationships among the items. Given their shared focus on self-directed ageism, moderate intercorrelations were anticipated. Following Field [32], correlations exceeding 0.8 would suggest item redundancy, while those below 0.3 would signal weak relevance to the target construct. Suitability for factor analysis was then verified using the Kaiser–Meyer–Olkin (KMO) sampling adequacy index and Bartlett's test of sphericity. The analysis itself applied varimax rotation to maximise variance in factor loadings and improve the interpretability of emergent components. Items showing loadings under 0.3 were considered inadequately related to their factor and were removed to ensure empirical fit with the conceptual framework.

Scale reliability was examined through Cronbach's alpha, a standard indicator of internal consistency where values near 0.8 reflect good reliability [32]. Split-half reliability was also computed via the Spearman-Brown formula using an odd-even split of items; high agreement between the two halves supports stronger overall consistency.

Variable distributions were evaluated for normality using skewness and kurtosis statistics. Results were reported as means with standard deviations for normally distributed data or as medians for non-normal distributions. A total score for the newly derived ageism scale was generated, with higher values reflecting greater self-directed ageism. Frailty scores were similarly derived following the CFAI protocol [29], where elevated scores denote increased frailty. Group comparisons of ageism, frailty, and quality-of-life scores by gender and age category employed either independent t-tests/Mann–Whitney U tests (gender) or one-way ANOVA/Kruskal–Wallis tests (age groups), selected according to normality and homogeneity of variance (assessed via Levene's test). Associations among variables were explored across the full sample and within subgroups using Pearson's r for normal data or Spearman's rho for non-normal data. Mediation testing to determine whether self-directed ageism mediated the frailty–quality-of-life relationship was performed with the Hayes PROCESS macro (version 3.5) in SPSS, controlling for gender, age, and marital status. Statistical significance was defined as $p < 0.05$; all procedures used IBM SPSS Statistics version 25.

For variables with skewed distributions and in group comparisons, means, standard deviations, and medians were all reported to maximise transparency regarding data spread.

Results and Discussion

Participant profile

Descriptive data for the 1895 individuals surveyed in the BAS from 2016 to 2021 are shown in **Table 1**. Ages ranged from 60 to 101 years, with a mean of 72.15 (SD = 8.80). Precisely 46% fell in the 60–69 bracket, 30.5% in the 70–79 bracket, and 23.5% were 80 years or older. Females comprised 52.8% of the sample, 64.5% were married, 17.7% widowed, and 9.3% divorced.

Table 1. Participant characteristics

Characteristics respondents	
Gender (n = 1895)	
Woman, n (%)	999 (52.8)
Marital status (n = 1852)	
Married, n (%)	1206 (64.5)
Never married, n (%)	92 (4.9)
Divorced, n (%)	174 (9.3)
Cohabiting, n (%)	67 (3.6)
Widowed, n (%)	331 (17.7)
Age (n = 1874)	
60–69, n (%)	862 (46)
70–79, n (%)	571 (30.5)
80 + , n (%)	441 (23.5)
Mean, ± SD	72.2, 8.80
Range	60–101

Construction of the self-directed ageism measure

The inter-item correlation table, prepared before exploratory factor analysis, appears in **Table 2**. Several items (8, 10, and 11) displayed correlations under 0.30. No pairings exceeded 0.80, ruling out multicollinearity, so the full set of 11 items proceeded to factor analysis to uncover latent dimensions and improve scale robustness. Factor analysis outcomes are shown in **Table 3**. Sampling adequacy was strong (KMO = 0.923), and Bartlett's test of sphericity was highly significant ($p < 0.001$), confirming suitability for factor extraction.

Table 2. Inter-item correlations for the 11 self-directed ageism items

Statements	**Stmt 1**	**Stmt 2**	**Stmt 3**	**Stmt 4**	**Stmt 5**	**Stmt 6**	**Stmt 7**	**Stmt 8**	**Stmt 9**	**Stmt 10**	**Stmt 11**
Statement 1. In difficult times, older adults tend to suffer the most	1										
Statement 2. Older adults form a distinct group in society with their own specific interests	0.495 **	1									
Statement 3. Society places a strong emphasis on young people, while the needs of older adults are often overlooked	0.549 **	0.512 **	1								
Statement 4. Certain individuals behave as if I no longer have anything valuable to offer society now that I am older	0.485 **	0.464 **	0.631 **	1							
Statement 5. I feel that older people are no longer valued in today's world	0.514 **	0.421 **	0.676 **	0.728 **	1						

Statement 6. Older adults should have a much greater influence on decisions about what is arranged for them	0.412**	0.481**	0.520**	0.469**	0.496**	1					
Statement 7. Since becoming older, I have often noticed that others no longer take me seriously	0.384**	0.359**	0.507**	0.623**	0.615**	0.406**	1				
Statement 8. In comparison to other older adults, I consider myself very fortunate	0.111**	0.223**	0.131**	0.105**	0.083**	0.266**	0.093**	1			
Statement 9. I feel that older people are frequently viewed as less important or treated unjustly relative to other groups in society	0.520**	0.470**	0.641**	0.598**	0.651**	0.523**	0.590**	0.143**	1		
Statement 10. I find it difficult to accept being an older person	0.190**	0.179**	0.215**	0.260**	0.256**	0.222**	0.284**	0.143**	0.295**	1	
Statement 11. Older people today face greater challenges than they did in previous generations	0.321**	0.252**	0.404**	0.393**	0.427**	0.335**	0.406**	0.019	0.487**	0.291**	1

**p < 0.01

Table 3. Exploratory factor analysis outcomes and reliability indicators

Statements	Model 1 Factor loadings	Model 1 CITC	Model 2 Factor loadings	Model 2 CITC	Model 3 Factor loadings	Model 3 CITC	Model 4 Factor loadings	Model 4 CITC
1. In difficult times, older adults tend to suffer the most	0.630	0.286	0.596	0.691	0.602	0.696	0.612	0.704
2. Older adults form a distinct group in society with their own specific interests	0.504	0.529	0.574	0.651	0.561	0.656	0.570	0.670
3. Society places a strong emphasis on young people, while the needs of older adults are often overlooked	0.77	0.256	0.729	0.816	0.738	0.823	0.754	0.828
4. Certain individuals behave as if I no longer have anything valuable to offer society now that I am older	0.809	0.152	0.724	0.815	0.737	0.817	0.744	0.824
5. I feel that older people are no longer valued in today's world	0.843	0.118	0.724	0.836	0.760	0.840	0.769	0.843
6. Older adults should have a much greater influence on decisions about what is arranged for them	0.55	0.515	0.619	0.686	0.601	0.688	0.604	0.693
7. Since becoming older, I have often noticed that others no longer take me seriously	0.758	0.065	0.642	0.737	0.653	0.735	0.649	0.733
8. In comparison to other older adults, I consider myself very fortunate	−0.090	0.881	0.185					
9. I feel that older people are frequently viewed as less important or treated unjustly relative to other groups in society	0.799	0.219	0.752	0.827	0.760	0.827	0.761	0.821
10. I find it difficult to accept being an older person	0.356	0.176	0.335	0.392	0.327			
11. Older people today face greater challenges than they did in previous generations	0.648	−0.072	0.491	0.588	0.508	0.581	0.491	
% Variance	46.95	10.10		51.25		55.53		58.68
Cronbach's alpha	0.849			0.886		0.897		0.898
Spearman-Brown coefficient								0.906

CITC Corrected Item Total Correlation

A preliminary model incorporating every item (model 1) yielded two factors accounting for 57.05% of variance. However, cross-loadings were evident on certain items (e.g., items 2 and 6). Item 8 showed a weak contribution in reliability testing (CITC = 0.185) and was dropped, producing model 2. This shifted to a single-factor

structure explaining 51.25% of variance, with every loading exceeding 0.3. Cronbach's alpha reached 0.886, though item 10 had the weakest CITC (0.327); its exclusion promised alpha improvement and was implemented, creating model 3. The single factor in model 3 captured 55.53% of variance, with alpha rising to 0.897. Item 11 then displayed the lowest CITC; removing it further boosted alpha and formed model 4—the retained version—explaining 58.86% of variance with alpha = 0.898, reflecting solid consistency. Additional item removals reduced alpha, validating model 4 as optimal. Odd-even split-half reliability produced a Spearman-Brown coefficient of 0.906.

The final self-directed ageism measure comprises eight items, scored from 8 to 40, where elevated values denote greater internalised ageism.

Levels of frailty, self-directed ageism, and quality of life

Descriptive statistics for frailty, self-directed ageism, and quality of life appear in **Table 4**. The sample recorded a frailty mean of 26.94, ranging from 0 to 73.96. Using cut-points established by De Witte and colleagues [33], categories yielded 36.9% with no/low frailty, 42.9% mildly frail, and 20.2% highly frail.

Table 4. Levels of frailty, self-directed ageism, and quality of life, plus gender and age-group contrasts

Measures	Total	Gender Women	Gender Men	Age groups 60–69	Age groups 70–79	Age groups 80+
Frailty (0–100) (n = 1542)						
Mean	26.94	28.57	25.26	24.08	26.13	34.44
SD	14.10	14.50	13.49	13.22	13.42	14.10
Median	24.37	28.57	25.26	21.66	23.85	34.89
Range	73.96	73.75	71.46	73.96	72.50	70
Significance		t(1537.49) = −4.63, p < 0.001		H(2) = 126.39, p < 0.001		
SELF-directed ageism (8–40) (n = 1746)						
Mean	23.62	23.63	23.63	23.31	23.87	23.87
SD	7.35	7.36	7.34	6.93	7.41	8
Median	24	24	24	24	24	24
Range	32	32	32	32	32	32
Significance		t(1740) = 0.010, p = 0.992		H(2) = 5.095, p = 0.078		
Quality of life (0–10) (n = 1895)						
Mean	7.51	7.45	7.58	7.62	7.65	7.17
SD	1.52	1.57	1.46	1.38	1.47	1.73
Median	8	8	8	8	8	7
Range	10	10	10	8	10	10
Significance		U = 429,509.50, p = 0.162		H(2) = 25.28, p < 0.001		

Females exhibited markedly higher frailty than males (t(1537.49) = −4.63, p < 0.001). Frailty also varied substantially by age category (H(2) = 126.39, p < 0.001), with post-hoc tests revealing lower levels in the 60–69 and 70–79 groups compared to those aged 80+.

Self-directed ageism averaged 23.62 across participants. Gender showed no meaningful difference (t(1740) = 0.010, p = 0.992), and age categories similarly lacked significance (H(2) = 5.095, p = 0.078).

Quality of life registered a median of 8 (range 0–10). Gender differences were absent (U = 429,509.50, p = 0.162), but age groups differed significantly (H(2) = 25.28, p < 0.001). Follow-up comparisons confirmed lower ratings among those 80+ relative to the 60–69 and 70–79 cohorts.

Links connecting frailty, internalised ageism, and well-being

Internalised ageism demonstrated a direct positive link with frailty levels. Well-being exhibited inverse links with both frailty and internalised ageism. Comparable patterns emerged across different age cohorts and sexes, showing somewhat stronger links among females and individuals aged 60–69. Details of these links are provided in **Table 5**.

Table 5. Summary displaying links among internalised ageism, frailty, and well-being

Correlations	Total	Gender Women	Gender Men	Age groups 60–69	Age groups 70–79	Age groups 80+
Self-directed ageism and frailty (r)	0.302**	0.309**	0.295**	0.338**	0.256**	0.256**
Quality of life and frailty (rs)	−0.483**	−0.503**	−0.451**	−0.497**	−0.417**	−0.437**
Quality of life and self-directed ageism (rs)	−0.213**	−0.214**	−0.212**	−0.240**	−0.223**	−0.139*

*p < 0.01
**p < 0.001

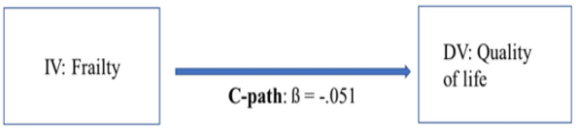
Results from mediation testing

The main mediation testing outputs are detailed in **Table 6**. In the absence of the mediator (C-path), frailty directly lowered predictions for well-being (ß = −0.051), capturing 24.54% of variation.

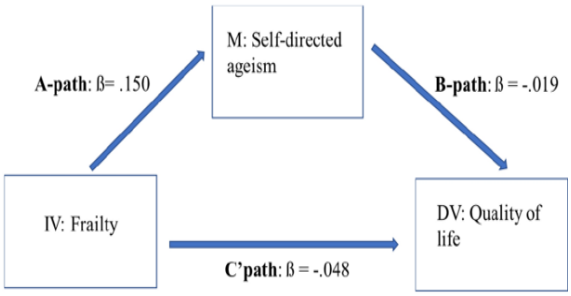
Table 6. Outcomes from testing mediation in the frailty–well-being connection through internalised (S-D) ageism

Results from PROCESS Macro: Mediation Model Testing Self-Directed Ageism							
Effect / Variable	R^2	F	p	ß	t	p	95% CI
C-path: Total effect of frailty on quality of life	0.245	119.501	< 0.001	−0.051	−20.736	< 0.001	[−0.056, −0.046]
A-path: Effect of frailty on self-directed ageism	0.095	38.376	< 0.001	0.150	11.571	< 0.001	[0.124, 0.175]
B-path: Effect of self-directed ageism on quality of life	0.253	99.692	< 0.001	−0.019	−3.960	< 0.001	[−0.029, −0.009]
C'-path: Direct effect of frailty on quality of life (controlling for self-directed ageism)	0.253	99.692	< 0.001	−0.048	−18.807	< 0.001	[−0.053, −0.043]
(AB) Indirect effect of frailty on quality of life through self-directed ageism				−0.003			[−0.005, −0.001]

Frailty boosted internalised ageism positively (ß = 0.150; A-path), whereas internalised ageism lowered well-being (ß = −0.019; B-path). Testing of indirect pathways confirmed meaningful mediation by internalised ageism in the frailty–well-being association (ab = −0.003). The 95% confidence bounds excluded zero, indicating a small yet authentic mediated pathway. Additionally, frailty maintained an independent lowering effect on well-being even with the mediator included (ß = −0.048; C'-path). The complete mediated framework captured 25.34% of well-being variation. Negative values highlight reductions in well-being accompanying rises in frailty or internalised ageism. The mediated framework is depicted in **Figure 1**.



a)



b)

Figure 1. Framework illustrating frailty's influence on well-being via internalised ageism

Current work analysed connections involving frailty, internalised ageism, and well-being within 1895 home-based older Flemish individuals. Dimensional patterns for the initial 11 internalised ageism items were probed via exploratory factor extraction. The refined measure reflects the central dimension noted earlier by Van Regenmortel *et al.* [31]. The benefits of this updated internalised ageism instrument encompass superior

consistency metrics (Cronbach's alpha = 0.898; Spearman-Brown = 0.906), unified dimensionality, and lower response demands from limiting to 8 items. Short tools offer benefits in wide-ranging evaluations, as noted by Burton *et al*. [34]. This instrument accounted for 58.86% of internalised ageism variation while proving highly consistent (α = 0.898), rated as elevated by Field [32].

Internalised ageism proved common, appearing at least mildly in most cases, with rare complete absence. Levels remained comparable regardless of sex or age cohort. Such patterns match Palmore [35] yet diverge somewhat from Rippon *et al*. [36], where internalised ageism rose progressively and maximised in advanced age. Frailty impacted most participants from moderate to severe, particularly females and those 80+, mirroring Collard *et al*. [37] plus Gobbens and van der Ploeg [38]. Well-being reached its lowest marks in the 80+ cohort, paralleling Bowling [39], Gobbens and van der Ploeg [38], and Henchoz [40].

Link patterns aligned with existing research: internalised ageism rose alongside frailty per Zora *et al*. [41]; well-being declined with greater frailty, consistent with Papathanasiou *et al*. [42], Vanleerberghe *et al*. [22], Veronese *et al*. [43]; and with ageism per Chang *et al*. [44].

Mediation outcomes positioned frailty plus internalised ageism as influences on well-being for home-living seniors. Elevated frailty promoted higher internalised ageism, subsequently lowering well-being. Frailty's independent pathway to well-being persisted significantly beside the mediator, supporting partial mediation via internalised ageism here.

According to Levy and Banaji [45] and Montepare and Zebrowitz [13], age-related stereotypes begin to form in childhood. By the time individuals reach older adulthood, they have been exposed to these stereotypes for many years. Because this exposure occurs largely unconsciously, older adults develop little resistance to their negative effects, making them particularly vulnerable to self-directed ageism. Our findings indicate that frailty increases susceptibility to self-directed ageism, thereby further reducing quality of life among frail older adults. Frailty negatively affects quality of life both directly and indirectly through self-directed ageism, highlighting the importance of interventions targeting both frailty and ageism. Early identification of frailty enables targeted interventions to mitigate its effects, while measures to reduce ageism can decrease both external and self-directed ageism, ultimately improving the quality of life for older adults living at home.

This study has several limitations. First, its cross-sectional design prevents establishing causality or observing temporal changes [46]. Therefore, longitudinal or lifespan studies are recommended for future research. Second, data were collected using self-administered questionnaires, which may be prone to social desirability bias. Nonetheless, given the subjective nature of frailty, self-directed ageism, and quality of life, we expect this limitation to have minimal impact. Third, our findings reflect only the Flemish population, so international studies would be beneficial. Strengths of this study include the large sample of community-dwelling older adults and the proportional stratified sampling employed in the BAS. Additionally, to our knowledge, this is the first study examining the combined relationship between frailty, quality of life, and self-directed ageism.

Conclusion

This study aimed to investigate the role of self-directed ageism in the association between frailty and quality of life in older adults living in the community. Most participants were classified as mildly frail and reported experiencing self-directed ageism, with those aged 80 and above reporting a lower quality of life. The findings indicate that frailty is negatively associated with quality of life, and that self-directed ageism partially mediates this relationship. Consequently, strategies to reduce frailty, ageism, and self-directed ageism are strongly advised, given their impact on the well-being of older adults living at home.

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