Depression is one of the most prevalent diseases among older adults, and if it goes untreated, consequences such as higher suicide rates (Montesó et al., 2012), financial burdens, and lowered quality of life (Luppa et al., 2008) have been indicated as possible outcomes. Specific predictors of depression have been identified, some of which include loneliness, illness (Montesó et al., 2012), living alone (Aday, Kehoe, & Farney, 2006; Montesó et al., 2012), subjective age (Keyes & Westerhof, 2012), and lack of friendship (Aday et al., 2006). Seniors can utilize community senior centers in an attempt to prevent these aforementioned depressive risk factors.

**Senior Centers**

Extensive research has shown the influence that senior centers have on older adult populations (Aday et al., 2006; Chen et al., 2008; Fulbright, 2010; Turner, 2004). Fulbright (2010) found that a large number of older adults feel that their lives improved after taking part in activities at a senior center. Social support and developing friendships were among the most persuading reasons for seniors’ participation in senior center activities. The number of reported depressive symptoms decreased as a result of this participation and development of friendships (Fulbright, 2010). Similarly, Aday et al. (2006) identified senior center involvement as the key for older women living alone to develop and maintain friendships. Aday et al. (2006) used the awareness that there is a greater risk for depression in older women who live alone compared to women who do not live alone to identify the effects that senior centers may have. With data from senior centers all around the United States, Aday et al.

**ABSTRACT.** Depression is one of the most prevalent diseases among older adults (Montesó et al., 2012). Limited research has been conducted investigating relationships between subjective age, cognitive and physical activity, and depressive symptoms in older adults. We hypothesized negative relationships between youthful subjective age and depressive symptoms, activity level and depressive symptoms, and more hours a week of cognitive activity than physical activity. The sample consisted of 62 older adults (60 years of age and older; 15 men, 47 women) from a Northeastern senior center. We found that more cognitive activity took place than physical activity and we also found correlations of small to medium effect sizes between depressive symptoms and general subjective age and the subjective age Feel subscale. A positive relationship with a small effect size was found between total activity and the subjective age Interests subscale. Interactions of medium to large effect sizes between sex and mild depression occurred for general subjective age, $F(3) = 3.10$, $p = .03$, subjective age Interests subscale, $F(3) = 3.03$, $p = .04$, and cognitive activity, $F(3) = 2.78$, $p = .049$. Baby boomers entering older adulthood should be encouraged to take advantage of community senior centers and be aware of their desired subjective ages.
(2006) revealed a larger improvement in life satisfaction for women living alone than women who did not. These women attained a perceived support network that extended past emotional care, giving them the perception that the friendships could include outside activities such as going to church or grocery shopping. This perceived support network exhibited the benefits of senior center participation in the population of women, and showed an integral way to help reduce or prevent loneliness and depression (Aday et al., 2006).

Parallel to the emphasis on women’s depressive symptoms in Aday et al. (2006), Montesó et al. (2012) reported higher depression rates in women than in men largely due to the possession of multiple or chronic diseases putting women at higher risk for depression. Loneliness and physical difficulties like walking and driving have a greater predictive effect of depression in older men than women, which Montesó et al. (2012) argued was due to a loss of independence. Lee and Holm (2012) identified living arrangements and assimilated culture-specific stress as predictors of depression among older Korean immigrants. Increased depression was reported by the older adult immigrants who had lower income levels and stressors including lack of friendships, discrimination, family issues, and language difficulties (Lee & Holm, 2012).

Subjective Age
Age, both chronological and subjective, has become an increasingly popular variable of investigation in regard to depression (Wild et al., 2011), as well as other constructs such as life satisfaction (Stephan, Caudroit, & Chalabaev, 2011) or body consciousness (Montepare, 2006). Subjective age, compared to chronological age, refers to the personal belief and feeling of a person’s own age. This refers to a self-perceived age that reflects, and is widely measured by, factors such as how a person feels, acts, looks, and the age that properly indicates their interests (Stephan et al., 2011). Wild et al. (2011) investigated the association between clinically significant depressive symptoms and age with a representative sample of 7,878 older German adults. Interestingly, the youngest age category, 53 to 59 years of age, reported the highest amount of significant depressive symptoms. Wild et al. (2011) argued that the 53 to 59 years of age group might have had the most reported depressive symptoms because they encountered unique life changes such as the end of career-related relationships, children leaving home, and fluctuations in hormones. In addition to these findings, participants who were either women, single, widowed, divorced, smoking, or exhibiting little physical activity possessed characteristics that were significantly associated with depression (Wild et al., 2011).

In a sample of 250 older adults, Stephan et al. (2011) found that a youthful subjective age was associated with a higher life satisfaction in older adults. In addition, subjective age has been utilized as a possible predictor to constructs such as body consciousness in older adult populations (Montepare, 2006). Specifically, the seniors’ subjective age was assessed as a possible predictor to their perception of physical appearance, internalized sensations in the body, and overall body evaluations. Results indicated a significant association between older adults exhibiting positive reports of body consciousness and having youthful subjective ages (Montepare, 2006). Associations between subjective age and life satisfaction (Stephen et al., 2011) and body consciousness (Montepare, 2006) have been reported, but little research has linked subjective age to depression in older adults.

Senior Center Activities
Similar to a senior’s youthful subjective age being associated with higher life satisfaction, participation in leisure activities significantly contributes to subjective well-being (Brajša-Zganec, Merkaš, & Šverko, 2011). Across all adult age groups in a Croatian citizen sample, Brajša-Zganec et al. (2011) found that leisure activities helped people with social relationships, emotional positivity, as well as gaining skill sets and knowledge that could be instrumental to subjective well-being. Senior center activities are related to higher life satisfaction (Aday et al., 2006) and decreased depressive symptoms (Fulbright, 2010) in older populations. Chen et al. (2008) investigated, via a pretest and posttest design, the efficacy of a 24-week silver yoga exercise program, with either a complete 70-min routine or a condensed 55-min routine. Both programs significantly improved physical fitness of the senior center participants, but a strong preference for the condensed program was suggested. Chen et al. (2008) recommended such programs be implemented in senior centers, especially because the results exhibited significant improvements in the older adult sample.

Turner (2004) conducted an extensive exploration into the influence of senior center activity participation. The sample included 856
older adults from 27 senior centers reporting information regarding their participation in various cognitive and physical activities offered at their centers. Results indicated the most participation in cognitive activities involving card and table games (66% of the sample) along with the most participation in physical activities such as fitness exercises (52%), trips (61%), dance/aerobics (36%), and chair exercise (47%; Turner, 2004). In addition, Turner (2004) identified participation in senior centers’ nutrition programs as being a significant outlet for seniors to benefit from socialization and eating nutritious meals.

**Purpose**

With this literature as a foundation, we investigated the relationships between subjective age, senior center activity, and depressive symptoms in male and female older adults. We intended to fill a gap in the literature on predictors of older adult depressive symptoms by tying together subjective age and cognitive and physical activity. Limited research has explored these variables’ relationship to depressive symptoms. Wild et al. (2011) controlled for physical activity as a risk factor in the association between depression and age category, but did not feature specifically subjective age and cognitive and physical activity as primary predictors of depressive symptoms. The role of activity and how old a person feels should be better understood in order to further understand depression in older adults. By using a senior center sample, we explored these relationships in a setting where ample resources for cognitive and physical activity are provided. We hypothesized that seniors’ youthful subjective age would be negatively correlated with depressive symptoms. Additionally, we predicted a negative relationship between seniors’ activity level and depressive symptoms. Based on Turner’s (2004) finding of 66% of senior center members participating in cognitive activities featuring card and table games, we expected a larger amount of hours a week of cognitive activity than physical activity to occur.

**Method**

**Participants**

A sample of 62 older adults (60 years of age and older) at a senior center in the northeast was recruited to participate in the present study using convenience sampling. Of the 62 participants, 15 were men and 47 were women (M = 76.42 years of age, SD = 8.01 years of age). Ethnic demographics included 81% European American, 11% identifying as other, 3% African American, 3% American Indian, and 2% Asian. Hispanics or Latino/Latinas comprised 7% of the sample. With regard to marital status of participants, demographics included 45% married, 40% percent widowed, 11% divorced, and 3% single. Data collection took place each day of the Monday to Friday hours of operation at the center to ensure that each member doing an activity or class during the two weeks of collection had an opportunity to take part in the study.

**Materials**

**Subjective age.** Subjective age was measured using a scale and particular questions that have been used in existing research (Montepare, 1996, 2006; Stephan et al., 2011). General subjective age was measured by a single item taken from Montepare’s (1996) psychological age subscale of the Subjective Age and Gender Scale (SAGS), asking, “In general, I feel . . . .” Answered on a 7-point Likert-type scale, this subscale ranges from 1 (a lot younger than my age) to 7 (a lot older than my age). Four additional inquiries were used to measure subjective age based on past research (Stephen et al., 2011). Participants were questioned on how old they felt (i.e., “Right now, I feel about . . . years”), acted (i.e., “I act as if I am . . . years”), looked (i.e., “I look as if I am . . . years”), and the age that properly indicated their interests (i.e., “My interests are those of someone who is . . . years”). Participants answered each question by inputting an integer that reflected how old the participant felt, acted, looked, and the age that best indicated their interests. For example, if a participant believed they acted as if they were 40 years of age, the participant would input a “40” in the question, “I act as if I am . . . years.” A total subjective age score was determined by subtracting the age inputted for the subscale for how old participants felt from their chronological age. If the value was positive, a youthful subjective age was indicated, and if the value was negative, an older subjective age was indicated. Analyses were conducted using individual subscales, as well as the total subjective age values. Good internal consistency was demonstrated by Montepare (2006) for the psychological age subscale of the SAGS (α = .88). Good internal consistency was demonstrated by Stephan et al. (2011) for the four subjective age inquiries of Feel, Act, Look, and Interests (α = .87). In the present study, good internal consistency was demonstrated among the subjective age Feel, Act, Look, and Interests.
Depressive symptoms. Depressive symptoms were assessed using the Geriatric Depression Scale (GDS) created by Yesavage et al. (1983). It is a 30-item questionnaire designed to identify an older person’s depressive symptoms and utilized by many as a popular screening tool to detect depression in older populations (Lopez, Quan, & Carvajal, 2010). It has continued its widespread popularity due to the simple yes or no answering format required from participants. This format allows for minimal cognitive load necessary while answering the questionnaire, allowing participants with various cognitive abilities to complete it. It is scored by assigning one point to answers that correspond with a depressive symptom; certain questions would require a yes, and other questions would require a no. For example, a participant showing a depressive symptom toward a question would answer yes to the item, “Life is empty,” and answer no to the item, “Wonderful to be alive.” A total score is computed by adding up all of the points acquired throughout the questionnaire. Scores ranged from 0 to 9 to indicate participants without depressive symptoms, from 10 to 19 to indicate mild depressive symptoms, and from 20 to 30 to indicate severe depressive symptoms. Lopez et al. (2010) conducted extensive psychometric research providing internal consistency calculations on the GDS. With a sample of 417 medical patient older adults, Lopez et al. (2010) demonstrated good internal consistency reliability (α = .88). Nonsignificant results and similar alphas between older adult patients scoring greater or less than 17 on a mental exam (αs = .89, .88) made clear that there was no influence from the older adult patients’ differing cognitive abilities (Lopez et al., 2010). In the present study, internal consistency was adequate (α = .70).

Cognitive and physical activity. The level of cognitive and physical activity was measured by a questionnaire designed to determine which types of activities participants took part in at the senior center, and for how many hr per week. The measure has three columns: Activity for the type of senior center activity; Yes/No to determine whether the participant takes part in the activity; and Approximate Hr a Week to determine the estimated amount of time spent in each activity. Because this was designed to reflect the activities at the sample’s senior center, the activities included every class offered at the location. Although the activities were randomized in the questionnaire, they were divided into cognitive and physical activities for analyses. The 14 cognitive activities included poker, drawing, oil painting, water colors, mah jong, duplicate bridge, dominoes, pinochle, canasta, knit and crochet, nutrition program, bingo, computer classes, and reading in the library. The 15 physical activities included yoga, bands/pilates, chair exercise, Jazzercise, other exercise classes, bocce, singing group, line dance, ballroom dance, Zumba, Tai Chi, drama club, and senior center trips. Totals for cognitive activity and physical activity were computed by adding the corresponding hr per week for each of the respective activities. Total activity was calculated by adding the total hr per week for all classes in which the older adult participated in at the senior center.

Procedure
After institutional review board approval (IRB Protocol #1316), participants were given an informed consent form providing a general overview of the study and their rights, followed by a demographic form and each measure in this order: subjective age items, cognitive and physical activity questionnaire, and the GDS. After completing the packet, they read a debriefing form.

Results
Descriptive statistics were reported for the subscales of subjective age, level of activity, and depressive symptoms (see Table 1). The average of the four subjective age subscales, Feel, Act, Look, and Interests (Mage = 60.99, SD = 14.31) was lower than the average of the sample’s chronological age (Mage = 76.42, SD = 8.01). With regard to level of activity, more cognitive activity (Mage = 8.61 hr/week, SD = 9.02) took place at the senior center than physical activity (Mage = 5.46 hr/week, SD = 4.75). Of the cognitive activities, the most prevalent activities taken part in were pinochle (Mage = 1.74 hr/week, SD = 4.05), poker (Mage = 1.69 hr/week, SD = 4.23), nutrition program (Mage = 1.67 hr/week, SD = 5.12), and reading in the library (Mage = 1.17 hr/week, SD = 3.33). Of these physical activities, the most prevalent activities taken part in were trips (Mage = 1.78 hr/week, SD = 2.60), other exercise classes (Mage = 0.73 hr/week, SD = 1.71), singing group (Mage = 0.66 hr/week, SD = 2.10), and Jazzercise (Mage = 0.55 hr/week, SD = 1.02). Of the participants, 14.52% (n = 9) were categorized in the mild depressive symptoms category of the GDS, with 85.48%, the rest of the sample, categorized as without depressive symptoms.
Subjective Age, Activity, and Depression

et al., 1983). Standard deviations are reported based on scores on the Geriatric Depression Scale (Yesavage

In the Total Depressive Symptoms entry, means and standard deviations are reported in years of age. In the Level of Activity scales, means are reported for the number of hours in which older adults participated in each activity. In the Subjective Age subscales, means and standard deviations are reported in years of age. In the Level of Activity scales, means are reported for the number of hours in which older adults participated in each activity. In the Total Depressive Symptoms entry, means and standard deviations are reported based on scores on the Geriatric Depression Scale (Yesavage et al., 1983).

Note. In the Subjective Age subscales, means and standard deviations are reported in years of age. In the Level of Activity scales, means are reported for the number of hours in which older adults participated in each activity. In the Total Depressive Symptoms entry, means and standard deviations are reported based on scores on the Geriatric Depression Scale (Yesavage et al., 1983).

Bivariate correlations were conducted in an attempt to identify significant relationships between subjective age, level of activity, and depressive symptoms. Per Cohen (1992), an r of .10 to .30 indicates a small effect size, .30 to .50 indicates a medium effect size, and .50 and larger indicates a large effect size. Pearson’s r correlations revealed significant positive relationships between the older adults’ total depressive symptoms and the General Subjective Age subscale (r = .30, p = .02), and the subjective age subscale Feel (r = .26, p = .04). With regard to the seniors’ total cognitive and physical activity, a significant positive relationship was revealed between the older adults’ total activity and the subjective age Interest subscale (r = .26, p = .04). Nonsignificant relationships were found between depressive symptoms and subjective age subscale’s Act (r = .19, p = .14), Look (r = .23, p = .07), and Interest (r = .21, p = .10), as well as cognitive activity (r = .18, p = .15) and physical activity (r = -0.03, p = .83).

A 2 x 2 multivariate Analysis of Variance was conducted to investigate possible interactions among the sample and the variables involved (see Table 2). This included two independent variables, with two levels each: sex (men and women) and depressive symptoms (mild or without depressive symptoms), and the dependent variables included subjective age subscales, cognitive activity, and physical activity. A significant interaction between sex and depressive symptoms was found for general subjective age, Interests, and the number of hours spent in each activity (Table 2).
in which older adults participated in cognitive activities. Per Cohen (1988), a $\eta^2$ of .01 to .039 indicates a small effect size, .06 to .14 indicates a medium effect size, and .14 to .20 indicates a large effect size.

Specifically, the interaction between sex and mild depression occurring for the General Subjective Age subscale, $F(3) = 3.10, p = .03$ (see Figure 1), had a large effect size ($\eta^2 = .14$) and consisted of men without depressive symptoms scoring higher on the General Subjective Age subscale ($M = 3.27, SEM = .41$) than men with mild depressive symptoms ($M = 3.00, SEM = .68$), and women without depressive symptoms scoring lower on the General Subjective Age subscale ($M = 2.23, SEM = .21$) than women with mild depressive symptoms ($M = 3.80, SEM = .60$). The model’s interaction with subjective age Interests subscale, $F(3) = 3.03, p = .04$ (see Figure 2), had a large effect size ($\eta^2 = .14$) and consisted of men without depressive symptoms having an older subjective age ($M = 61.18, SEM = 4.67$) than men with mild depressive symptoms ($M = 43.75, SEM = 7.73$), and women without depressive symptoms having a more youthful subjective age ($M = 56.52, SEM = 2.39$) than women with mild depressive symptoms ($M = 73.20, SEM = 6.92$).

The model’s interaction with cognitive activity (see Figure 3), $F(3) = 2.79, p = .049$, had a medium effect size ($\eta^2 = .13$) and consisted of men without depressive symptoms participating in more cognitive activity ($M = 14.55$ hr/week, $SEM = 2.61$) than men with mild depressive symptoms ($M = 10.50$ hr/week, $SEM = 4.33$), and women without depressive symptoms participating in less cognitive activity ($M = 6.53$ hr/week, $SEM = 1.34$) than women with mild depressive symptoms ($M = 11.50$ hr/week, $SEM = 3.87$). Nonsignificant interactions of small to medium effect sizes occurred for subjective age Feel, $F(3) = 2.55, p = .07$, Act, $F(3) = 1.86, p = .15$, Look, $F(3) = 0.97, p = .41$, and physical activity, $F(3) = 0.96, p = .42$.

**Discussion**

The present study investigated the relationships between subjective age, cognitive and physical activity, and depressive symptoms in a senior center sample of older adults. We hypothesized that a senior’s youthful subjective age would be negatively correlated with depressive symptoms. Additionally, a negative relationship between the amount of cognitive and physical activity and depressive symptoms was predicted. Also, a larger amount of hr a week of cognitive activity than physical activity was expected. In line with the first hypothesis, significant positive relationships between the older adults’ total depressive symptoms and the General Subjective Age subscale and a subjective age Feel subscale was found, indicating the associations between more depressive symptoms and older reported subjective ages. Although the additional hypothesis regarding total activity and depressive symptoms was not supported, a significant positive relationship was revealed between the older adults’ total cognitive and physical activity and the subjective age Interests subscale, indicating the association between more activities taken part in at the senior center and an older subjective age. Additional analyses found a significant interaction between sex and depressive symptoms for the General Subjective Age subscale, subjective age Interests subscale, and the number of hours in which older adults participated in cognitive activities. The expected larger amount of hours a week of cognitive activity participation over physical activity was supported.

The relationship found between the subjective age variables and depressive symptoms was expected due to the literature tying seniors’ youthful subjective ages with higher life satisfaction (Stephan et al., 2011) and lower depressive symptoms (Wild et al., 2011). The positive relationship between total activity and the subjective age Interests subscale, was an unexpected finding. This
Subjective Age, Activity, and Depression

Although the men with mild depressive symptoms feel as if their chronological age and being satisfied with it, depressive symptoms could have been coming to terms with depressive symptoms. The men without depressive symptoms reported having older subjective ages than men who had mild depressive symptoms. For both of the subjective age measures, men indicated a more youthful subjective age and those who had mild depressive symptoms reported older subjective ages. This was consistent with Stephan et al.'s (2011) findings that youthful subjective ages are associated with higher life satisfaction in older adults. However, the male participants in the present study reported the opposite association. For both of the subjective age measures, men without depressive symptoms reported having older subjective ages than men who had mild depressive symptoms. The men without depressive symptoms could have been coming to terms with their chronological age and being satisfied with it, although the men with mild depressive symptoms might have a bit more confusion in their lives with discrepancies between their subjective age and actual age. This could possibly influence them to experience more depressive symptoms. With all this considered, it is important to know that the mentioned averages ($M_{age} = 60.99, SD = 14.31$) all indicate youthful subjective ages (younger than the sample’s chronological age; $M_{age} = 76.42, SD = 8.01$). Therefore, explanations include the existing awareness of the sample feeling younger than their age.

Men without depressive symptoms took part in more cognitive activity than those who had mild depressive symptoms. This was consistent with Fulbright’s (2010) finding of an increase of activity related to decreased depressive symptoms, as well as Brajša-Žganec et al.’s (2011) finding that participation in leisure activities significantly contributed to subjective well-being. In contrast, women without depressive symptoms actually took part in less cognitive activity than those with mild depressive symptoms. The women with mild depressive symptoms might not have had as strong a support system outside the senior center as the women without depressive symptoms, which could have made them eager to engage in more cognitive activity because they felt it could help them.

Aday et al. (2006) identified the importance of senior center involvement for women who live alone due to the greater risk for these women to develop depression. The present study may support the importance of senior center involvement for women because women who reported mild depressive symptoms took part in more cognitive activity than women without depressive symptoms. Also, the sample consisted primarily of women, which may suggest a preference for more senior center participation in women than men.

The present study provided valuable information regarding particular classes and activities in which seniors like to participate. It is clear that the sample participated in more cognitive activities ($M = 8.61$ hr/week, $SD = 9.02$) than physical activities ($M = 5.46$ hr/week, $SD = 4.75$). The 3.15 averaged $hr/week$ difference indicated participation data that can be utilized by the senior center staff and director to maximize involvement among members. In addition, the most prevalent cognitive activities were pinochle, poker, nutrition program, and reading in the library; the most prevalent physical activities were trips, other exercise classes, singing group, and Jazzercise. These findings were consistent with the programs that had the largest amount of involvement by the 27 different senior..
centers sampled by Turner (2004). Just as Turner (2004) identified the seniors’ higher participation in cognitive activities involving card and table games, the present study’s sample reported the majority of its cognitive activity for pinochle and poker. Similarly, Turner (2004) found the largest involvement in physical activity including fitness exercises, trips, and dance classes. Trips, exercise classes like Jazzercise and yoga, and singing classes were the most prevalent physical activity programs reported in the present study. Moreover, the nutrition programs taken part in for both the present study and Turner (2004) were found to be strongly utilized by members.

Several limitations should be considered in interpreting the present study. For example, the sample consisted of primarily White American female senior center members, making the sample limited in size and diversity. Only nine participants were categorized in the mild depressive symptoms category, compared to 53 participants categorized as without depressive symptoms. There was inadequate power to detect differences due to this limited sample size. The older adults’ self-reported measuring of their subjective age, total activity, and depressive symptoms should be taken into consideration because they could have misinterpreted questions and answered with uncertainty. In addition, the correlational design created a lack of control that limits the conclusions drawn regarding direction and nature of the aforementioned relationships. It should be noted that a single item from the SAGS psychological age subscale (Montepare, 1996) was used with four additional subjective age inquiries used in past research (Stephan et al., 2011) when interpreting the reliability and validity of the current study’s findings. It should also be noted that the level of activity variables were defined as hours a week of participation at the senior center. Therefore, we did not take into account other forms of activity throughout participants’ days that could allow for different activity levels (e.g., neighborhood walks, family excursions, household activities).

In spite of these limitations, this work may have implications for older adults, caregivers, and employees of senior centers. Older adults can utilize these findings in their lives as senior center members. With the knowledge of the significant association between having a youthful subjective age and lower depressive symptoms, older adults can try to perceive themselves in a more youthful light. One of the best ways to do so is to make use of their community senior centers, whose influence on older adult’s life satisfaction (Aday et al., 2006), physical fitness (Chen et al., 2008), and social interaction (Fulbright, 2010) have been shown in previous literature. The work of Chen et al. (2008) resulted in the recommendation of an efficacious physical fitness yoga program to be implemented in senior centers. Similarly, senior center directors and program developers can take note of the amount of participation displayed by the current study’s sample for cognitive and physical activities in hopes to create the most appealing and preferred center for their community’s older adult population.

Further research should be conducted to increase the understanding of subjective age’s role in depression in older adults, possibly isolating more subjective age subscales of importance. Utilizing scales with more subjective age items will increase psychometrical soundness and provide more insight into other subscales of subjective age. For example, the SAGS (Montepare, 1996) includes various items that identify psychological, physical, and social subjective ages. Also, future research should utilize methodology with more control than the present study to further investigate a possible greater influence on depressive symptoms from cognitive and physical activity. The finding regarding the positive relationship between total activity and subjective age interests subscale brought up an interesting research question that would be a valuable contribution to literature in this field. Future studies should investigate, beyond number of hours...
participated, the way senior center members feel toward the classes offered to them to further the understanding of the influence of senior centers on older adults. A comparative study of senior center members and nonsenior center members should be conducted to explore differences in subjective age, activity levels, and depression between the two older adult groups. This could help to further investigate the impact senior center participation has on well-being in older adults.

We argue from these findings that there is an association between seniors possessing a youthful subjective age and reporting fewer depressive symptoms (among a limited sample of older adults). The current study suggested that cognitive and physical senior center activities may relate to depression and subjective age. Although more research is needed to understand if there is a causal relationship, baby boomers entering older adulthood should be encouraged to take advantage of their community senior centers and be aware of their desired subjective ages.

References


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