

I'm Old

Milton Crum
2011

Contents

TIPPING POINT INTO OLD AGE	6
OLD FOLKS FROM A MIDDLE AGE PERSPECTIVE	9
Counsel to younger generation	
Age-defying illusions about old age	
OLD AGE FROM THE OLD PERSON'S PERSPECTIVE	15
Heroism of Old Age	
OLD AGE FROM A FACTUAL PERSPECTIVE	16
Negative views of us abound.	17
Radical changes occur in our bodies as we age.	22
We suffer many losses.	25
We suffer sleep deprivation.	26
We must resolve major psychological issues.	28
We live with aches and pains.	32
Our ears, our brains, and how people talk	
affect our speech comprehension.	33
Our digestive system changes.	44
We become more cautious: at least we should.	45
There are always two elephants in the room.	47
Old age changes and challenges us,	
but it doesn't always conquer us.	50
KNOWING OLD AGE	53
Aging Simulation	55
ENDNOTES	58

With appreciation for those who read and commented on various drafts, whom I won't name to protect them from any responsibility for the finished product,

and

with appreciation for family members and professionals who work with us to the extent that they make an effort to try to understand what it is to be old, especially 80+ "old old,"

and

with the hope that this paper might provide some help in their effort to understand.

Milton Crum
915 Saddle Drive
Helena, MT 59601
April 13, 2011

I'm Old

More precisely, I'm "old old."

A contemporary told me her frustration about not being able to explain to her son that she was not the person that she used to be before she got old. A little later, my wife Käthe and I received an invitation by a younger family member to attend a dinner followed by a lecture. We decided that the lateness of the event and the demands of comprehending a lecture were too much for us, so we declined. The response was a virtual chastisement: "you aren't too old to do things like that." When I asked contemporaries how they explained to their children that they were no longer the person they used to be, no one had an answer: they had either given up or not even tried.

The lack of understanding of the older generation by the younger generation (or by the older generation of ourselves) should not be surprising. A survey of the books "in the Aging sections of bookstores and libraries," found three kinds of books: (1) "the 'peppy papers' on how to stay perky in spite of aging, (2) the 'existential papers' on the grim life of loneliness, uselessness, and boredom that awaits the aged," and (3) how to "manage the unmanageable older adult." But there were no books that connected inter-generational "difficulties" with "developmental conflicts that senior adults must work through."¹

One of the problems of being old is that younger family members or friends seem to think that we should behave just like we did only a few years ago. They seem reluctant to accept that age has changed us, and many of us share their reluctance because "most people assume [or would like to believe] that getting old is just more of the same.

Aging is seen as being an adult, just older . . . older versions of the people they had always been.”²

Neither the younger people nor we old people anticipated nor were prepared for “the enormity of the psychological journey the elderly face.” How many of us knew in advance that “the aging process demands that older adults take a completely different tack in their lives that is totally foreign to anyone who is not yet old?” How many of us realized that “the elderly are on a mission that is not only far more complicated . . . but . . . the most significant of their lives”?³

So one purpose for writing this paper is to help younger people better understand what it is to be old and why we old folks are so different from the persons we used to be. (“Used to be” or “used to do” are frequently used phrases among us old folks.) But it will be impossible to accomplish this purpose because the experience of old age is unique. When younger people tell me, “I know how you feel,” the fact is, no matter how genuinely they try to be empathetic, they don’t know how it feels to be old because they *cannot* know. As Simone de Beauvoir wrote,

there is one form of experience that belongs only to those that are old – that of old age itself. The young have only vague and erroneous notions of it.⁴

The protagonist in Philip Roth’s *The Dying Animal* asks, “can you imagine old age?” and he answers, “of course you can’t. I didn’t. I couldn’t. I had no idea what it was like. Not even a false image—no image. And nobody wants anything else. Nobody wants to face any of this before he has to.”⁵ So the attempt by us old folks to explain old age to younger folks is probably largely futile. An attempt to explain old age to me just seven years ago at age eighty would have been futile, but perhaps it is always worth a try.

I am also writing this in an effort to help me (and, perhaps, contemporaries) better understand what it is to be old and why we old people are so different than we used to be. Such a study has been advised by two books about getting old. One book counsels that

“beginning in middle age, we must study how to be old” because “the later years require wisdom even more than do the decades that have preceded them.”⁶ The other book observes that “aging in contemporary America is so complex and multidimensional that studying it is worthwhile, even necessary, for those who wish to do it consciously and without fear.”⁷

Another reason is to help combat the shame we feel about old age: how we look, how we act, and our age-related limitations. “Old age” has been called “the prime occasion of shame” occasioned by “all the impediments to the enjoyment of life to which the aging body is vulnerable.”⁸ Therefore, “one of the crucial projects of a person’s life is to resign oneself to the process of aging.”⁹

An 1883 book, published in England, contains this exhortation.

Old age is honourable to those who are not ashamed of it; but, when men are ashamed of old age, then is old age ashamed of them . . . , it disgraces, humbles, and mortifies.¹⁰

Possibly the most important reason for writing (or reading) this paper is that unless we study old age, contemplating or living in it can easily weigh us down. Reading about old age gives us words and concepts that can enable us to think about it and talk about it: not just our immediate situation, but also the larger sphere of old age in general. The ability to *word* a situation (to think and talk about it) enables us, at least to a degree, to get on top of (transcend) a situation that was threatening to get on top of us and weigh us down. As the renowned psychiatrist Bruno Bettelheim wrote, “What cannot be talked about cannot be put to rest.” Dr. Bettelheim wrote these words in his *Surviving and Other Essays* from the perspective of the Nazi concentration camp survivor that he was. But his words were ineffective when Bettelheim became imprisoned in old age: widowed, in failing physical health, and suffering from the effects of a stroke which impaired his mental abilities and paralyzed part of his body. Bettelheim was unable to survive old age. He committed suicide by placing a plastic bag over his head.

I sometimes fantasize about a facetious use for this paper: I could give a copy to people who greet me with a “How’re you doing?” or “How are you?” I feel like a liar if I give the customary “Just fine” response and neither the greeter nor I have time for a factual response.

TIPPING POINT INTO OLD AGE

There is not a set chronological age for the tipping point from middle age to old age.

The Free Dictionary defines middle age as “the time in a person's life between youth and old age.” Some sociologists divide the years after middle age between “young old age” and “old old age.” “Young old age” refers roughly to our 60s and 70s when most of us were as hardy as we were in middle age. “Old old age” refers roughly to our 80s and 90s when most of us are radically different than we were, not only in middle age, but also in our “young old age.”

It is true for me, and I think for most of my contemporaries that when we were “young old age,” we were much more like we were in “middle age” than we were like the “old old” we are now. When I speak of “old age” in contrast to “middle age,” I am thinking of “old old.”

The tipping point into old age can happen at various chronological ages. Trauma or disease can bring a person to the tipping point earlier and more suddenly than the person who reaches the point later and more gradually. Whenever the tipping happens, what happens is that the changes characterized as “getting old” build up until the middle age perception of oneself tips over to perceiving oneself as old.¹¹

I have reached the tipping point: I own the fact that I am an old man. “Old” is defined both as “far

<p>Old Age</p> <p>Where once I had cheeks, I have only bone; when I sit down, I’m sitting on stone. Hair won’t grow where it used to grow: it grows on my ears, so all can know that I’m up in years. My steps once had spring, but now I hobble like an old starling. Yet I mustn’t complain about growing old: these are the years assayed as gold.</p>

advanced in years or life” and as “exhibiting the physical characteristics of age.” I meet both definitions. Euphemisms like an elderly man, a senior citizen, or an aging person do not make an old person any less old than does the euphemism “passed away” make the deceased any less dead. Anyone who tells me “you’re not old” must believe that I am too demented to know what I am. Anyone who says “you don’t look old” must be deficient in the eyesight department. Those who avoid using the word “old” treat it as if it were a bad word that should not be spoken.

We old folks have been categorized into three groups: (1) the “functionally fit survivors” who suffer “only moderate disabilities,” (2) the “chronically disabled” who manage to live “with a high level of disability,” and (3) the “increasingly disabled” who require rising levels of assistance.¹² At this time, I am blessed to be in the first group. What follows in this paper applies primarily to the first and second groups.

Being old is a mixed bag of good and bad for me and many other old people. We have lost much of what we once had and valued, but we have gained a freedom from daily work and time for other activities. But, whether for good or for bad, we are all different from what we were before we grew old. Physically, my body is different; psychologically, my perspectives are different. The radical nature of these changes has been described in this way.

Aging brings about such large changes in the individual that there may well come a point at which it is more illuminating to think of two or more persons “time-sharing” the same identity than of one person having different preferences.¹³

Old age is so different from middle age that Mary Pipher titles her book on the subject *Another Country*. In her 1970 classic *La Vieillesse* (Old Age), Simone de Beauvoir described this radical difference between middle age and old age. (When the book was translated into English in 1996, the American publishers changed the title to *The Coming of Age* because they were afraid that de Beauvoir’s title was too blunt and depressing and would not sell many books: a potent commentary on our culture’s attitude toward old age.)

Describing one's relationship with one's body in middle age, de Beauvoir wrote,

At forty, a healthy man is biologically free to do what he likes. He can push himself to the utmost limits of his strength – he knows he will soon regain it. The danger of sickness or accident does not frighten him overmuch – except in extremely serious cases he will get well and return to his former state. (304)

In contrast, describing one's relationship with one's body in old age, de Beauvoir wrote,

The aged man is obliged to take care of himself: excessive effort might cause heart-failure; an illness would leave him permanently weakened; he would never, or only very slowly, recover from an accident, since his wounds take a long time to heal. . . . Even if the elderly person bears his ailments with resignation, they come between him and the world: they are the price he pays for most of the things he does. So he can no longer yield to a sudden desire or follow his whims: he ponders on the consequences and he finds that he is forced to make a choice. If he goes for a walk to take advantage of a fine day, his feet will hurt him when he gets home; if he has a bath, his arthritis will torment him. . . . The level of inimicality in things rises: stairs are harder to climb, distances longer to travel, streets more dangerous to cross, parcels heavier to carry. The world is filled with traps; it bristles with threats. The old person may no longer stroll casually about in it. Every moment difficulties arise, and any mistake is severely punished. (304)

Describing a middle-aged person's relationship with the future, de Beauvoir wrote that

a man still has years enough before him to make up his mind to act, to decide upon undertakings and to take changes in the world or in his personal history for granted; he peoples the future with hopes – a future whose end he does not yet see. (377)

In contrast, de Beauvoir continued with this depiction of an old man's relation with time.

Age changes our relationship with time: as the years go by our future shortens, while our past grows heavier. The aged man may be defined as an individual with a long existence behind him, and before him a very limited expectation of life. The old person knows that his life is accomplished and that he will never re-fashion it. The very quality of the future changes between middle age and old age. One has exchanged an indefinite future – and one has a tendency to look at it as infinite – for a finite future. (361, 377-379)

OLD FOLKS FROM A MIDDLE AGE PERSPECTIVE

We old folks, just by being who we are, often present a problem to our middle-aged children. Consider the titles of books and articles on the subject.

- *Survive Your Aging Parents*
- *Are Your Parents Driving You Crazy?*
- *The Overwhelmed Woman's Guide to Caring for Aging Parents*
- "How to Talk to Your Elderly Parent Without Losing Your Mind"
- *Coping With Your Difficult Older Parent: A Guide for Stressed-Out Children*
- *Caring for Yourself While Caring for Your Aging Parents: How to Help, How to Survive*
- *The Caregiver's Survival Handbook: Caring for Your Aging Parents Without Losing Yourself*

Looking at members of the older generation, one middle-aged writer observes how they have changed.

Many of us look at members of our parents' generation and see a diminished version of the vibrant people we once knew. We observe that they move more slowly and aren't as physically strong as they used to be. In conversation they tend to repeat stories they've told us a dozen times or can't seem to stick to one subject. They fret over inconsequential details

or abruptly end important conversations before anything has been resolved. They didn't act or talk this way before they got old.¹⁴

Another middle-aged writer speaks of being bewildered by her parents.

Those of us who are caring for elderly parents are often bewildered by the decisions they make – and by their seemingly stubborn refusal to follow our advice. We shake our heads over their obsession with the past, their caution, and the glacial pace with which they make decisions and move through the world. As much as we love our parents, dealing with them can often be fraught with tension and frustration, as we try to bridge a communications gap as yawning as any we've experienced with rebellious toddlers or teenagers.¹⁵

This same writer observes that middle-aged children and their old parents often live by different agendas.

Our middle age agendas are often in direct conflict with those of our parents. We're juggling a million work and family challenges and like to move quickly and efficiently through the world, accomplishing one task after another and checking it off our 'to do' lists. It's no wonder that our parents' reflections on the past and their reluctance to make decisions exasperate us. In addition, given our youth-oriented society, most of us are on a permanent quest to remain young (or at least young-looking). So it's no surprise that we have little tolerance or empathy for those who've already reached the place we have no desire to go.

Also from a late middle age perspective, Berman and Shulman find that “the distance between us and our aging parents seems insurmountable.”¹⁶

We're at two different places on our life journey. We've raised our kids. . . . We've paid our dues in the work place. Now we want to relax, have fun, do the things we've postponed. The vision of our mortality both depresses us and spray paints “Live now. It's my turn.” on our consciousness. . . . We decide to take

more vacations. Or to work less. We deserve it! Our thrust is to make the most of the life we have left.

But in Berman and Shulman's narrative, just when middle-aged children are anticipating new freedom and excitement, their "elderly parents are experiencing loss and failure on almost every front . . . sexual, occupational, and social" and begin to encroach on their children's time and attention. So they conclude their narrative with these words:

As our parents grow older and begin to lose the mental and physical capabilities we all took for granted, our relationship enters a new stage. . . . There is no happy ending.

Counsel to younger generation

The problems we create for our younger family members by getting old and increasingly debilitated has spawned a stack of books and articles offering counsel to the younger generation.

One book advises the children of elderly parents to

try to remember, 'this is *not* my mom (or dad) as I used to know her or him. They can't help it if they forget things or drive you crazy.' Remember that your elderly parent doesn't mean to make your life miserable or frustrate you with the same endless stories and questions. They're just as frustrated as you are.¹⁷

Another book tries to alleviate the responsibility children feel for their old parents.

Witnessing your parents' gradual decline or their struggles with major illness often creates a desire to do *something* to help. However, taking steps to make *yourself* feel better may not be in your parents' best interest. ***Sometimes you can do little or nothing to help your parents.***¹⁸

Age-defying illusions about old age

The baby boomer generation is roughly composed of people in the 45 -

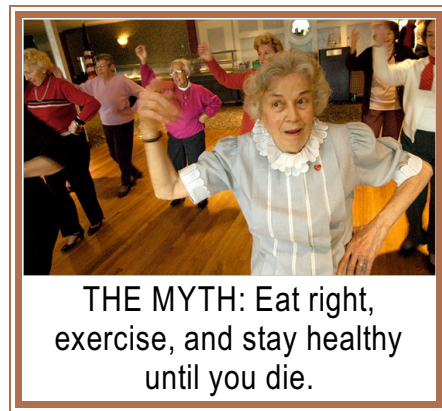
65 year old age range. In an earlier reference, Connie Matthiessen spoke of her baby boomer generation as being on “a permanent quest to remain young (or at least young-looking). So it's no surprise that we have little tolerance or empathy for those who've already reached the place [old age] we have no desire to go.”¹⁹

Harvard Medical School professor and baby-boomer, Dr. Muriel R. Gillick, elaborates on this quest by fellow baby boomers in her book *The Denial of Aging*.

We would like to think that if we eat nutritious meals and exercise faithfully, we will be able to fend off old age. When we believe we will stay young forever, and when we purchase special vitamins, herbs, and other youth-enhancing chemicals to promote longevity, we are engaging in massive denial. (3)

Dr. Gillick observes that Americans spend \$6 billion a year on "anti-aging" nostrums. Both the baby boomers and older people swallow pills and dietary supplements that purport to prevent illness, cure disease, and promote long life. However, the overwhelming evidence proves that the potions are ineffective at best, harmful at worst—and a phenomenal waste of money overall.²⁰

65 year olds can expect to live at least into their 80s. Yet, Dr. Gillick tells her fellow baby boomers, “we have chosen to engage in a collective denial of aging. We would prefer to believe that most people can skip old age altogether—proceeding directly from middle age (itself an extension of youth) to death, preferable dying in one’s sleep. We put our faith in exercise and diet as a means of assuring a healthy and vigorous old age, even though many of the principal scourges of old age cannot be prevented by diet or exercise.”²¹



Later in her book, Dr. Gillick repeats her assertion that her fellow baby boomers appear to “believe that abiding by the latest dietary

recommendations and adhering to a regular exercise regimen will suffice to keep us healthy and strong until, at age 100, we die in our sleep.” Gillick understands why people engage in *The Denial of Aging*.

Maybe the acknowledgment that before death comes a no-man’s-land in which many people merely exist—unproductive, unvalued, and often unwell, but alive—is just too mind-boggling to consider.²²

In her *Never Say Die: The Myth and Marketing of the New Old Age* (2011), Susan Jacoby, born in 1946 and just turning 65, also tells her fellow baby boomers the facts about old age.

Old age, before debility sets in, offers us many avenues for productivity and happiness: **if** we have enough money, **if** we are in reasonably good health, and **if** our brains are functioning well enough. A very few of us in our 80s and 90s, a few more in our 70s, continue in our middle age activities and serve as examples to whom the age-defying marketers point when they sell their products. But, without this relatively rare combination, for most of us, old age means putting on a happy face even when bones and muscles are aching, even when hearts are broken by the loss of people and things we loved, and even when our brains are too far gone to comprehend what is being said.²³

I confess that I engaged in the denial of aging until I reached my tipping point at age 86. I had all of my end-of-life papers in order (medical power of attorney, living will, agreement for my corpse to go to a medical school, and documents for transferring assets to beneficiaries), but I denied aging. For almost two decades, I lived by the illusion that if I kept on cutting wood in summer, shoveling snow in winter, and walking the trail I would die healthy. The fact that in my late 70s I stopped climbing up on the roof to clean our stove pipe and stopped taking long hikes was not enough to destroy the illusion. And I still tried to embrace a diluted version of the illusion even after I moved from the woods into the old folks home where I now live.

Using the term that one writer invented, my illusion was that, if I took

proper care of my body, as the years passed, I would become the still-vigorous “wellderly,” not the “illderly.” Susan Jacoby discredits this “fantasyland” with the fact that nearly every one of us who lives into our mid-80s will become “illderly.” We “can expect a period of extended frailty and disability” before we die. Jacoby debunks the often-cited “wellderly” statistics by pointing out that they are based “on the statistically disingenuous practice of lumping together all people over sixty-five.” Lumping together 65, 75, and 85 year olds for statistics regarding their physiological and psychological condition makes as much sense as lumping together 5, 15, and 25 year olds for statistics about the young. Based on the misleading statistical practice of lumping disparate age groups, only 5% of the over 65 age group are confined to nursing homes. But, the likelihood of spending time in a nursing home jumps to 50% in the 85 plus age group.²⁴

The more younger people believe the illusion that exercise and diet can assure a healthy and vigorous old age the less patience they have with us old people because they tend to see “the infirmities of old age as our fault rather than as inevitable.”²⁵ The unpleasant fact is that no matter how diligent we are in age-defying nutrition, exercise, and activities, as we grow older we lose capabilities we once took for granted: both mental and physical.²⁶ But the marketers of products with age-defying claims try to hide this fact. Advertisements for osteoporosis drugs show a young-looking active woman; they never show “a woman crippled by osteoporosis, hunched over her walker.” The ads try to hide “the fact that people are going to grow old, and visibly so, regardless of whatever drug they take, whatever they eat, and whatever ‘anti-aging’ potion they buy.”²⁷

It is not that a healthy life style never makes a difference in our capabilities. There are studies that find people in the 55-75 year old range can postpone morbidity by adopting healthy life styles. However, all people, regardless of life style, enter the same range of morbidity at about 80 years old.²⁸ The harsh reality is that no matter how healthy our life styles, “in real old age, as opposed to fantasyland, most people who live beyond their mid-eighties can expect a period of extended frailty and disability before they die.”²⁹

OLD AGE FROM THE OLD PERSON'S PERSPECTIVE

Most of us old people see old age, with all its changes and challenges, as neither all bad nor all good, but for many of us the bad outweighs the good. Lillian Rubin is an example of the latter. In her eighties she is active as an author, sociologist, and psychotherapist. At the age of eighty-two, she sold her first painting and published her book *60 on Up: The Truth about Aging in America*. The book opens with her opinion about old age.

Getting old sucks. It always has, it always will. Yes, I know about all those books and articles extolling the wonders of what the media call the 'new old age.' . . . They're either written by forty-year-olds who, like children afraid of the dark, draw rosy pictures as they try to convince themselves that no unknown monsters await them. Or they're lying. . . . Maybe it's not a lie but a wish, a hope, a need to believe there's something more to this business of getting old than we see around us.³⁰

Later Dr. Rubin comments

I sometimes think old age is two different countries. There's the real old age for those of us who live there [and] there's the old age of those who write about it, most of them middle-age women and men.³¹

Heroism of Old Age

Writing at the age of 87, Mary C. Morrison delineates the kinds of heroism required by old age.

Aging takes courage. To preside over the disintegration of one's own body, looking on as sight and hearing, strength, speed, and short-term memory deteriorate, calls for a heroism that is no less impressive for being quiet and patient.

To watch the same process taking place in someone whom one loves requires another kind of heroism, expressed in patience, devotion, and care.

And to endure or watch the kind of deterioration that leaves,

in the end, only the empty shell of a person, as with Alzheimer's, calls for a heroism in final defeat that is beyond words.³²

Therefore, Morrison concludes, "old age is not for the fainthearted, and anyone who watches it closely and with a sympathetic eye can be sometimes lost in admiration for the aging and their gallantry."³³

The book *Life Beyond 85 Years* contains heart-rending vignettes that describe how the 150 old folks who were interviewed over a period of six years found "the capacity to survive" old age and meet "the demands posed by their survival into late late life." They devised ways to cope (1) with their physical and social environments in spite of significant physical and mental debilitation, (2) with their losses of family members, often including their children, and (3) at the same time, they tried to maintain "a sense of control" over their lives in spite of their need for assistance.³⁴

OLD AGE FROM A FACTUAL PERSPECTIVE

Gaining a factual perspective is not easy because most of the gerontological studies have been based on the "younger old," roughly 65 to 75 or 80, age group. However, the "oldest age category are now the fastest growing group in America." There are now so many of us that more researchers are studying how we tick and what makes us tick, physiologically and psychologically. There are now so many of us that we have been given a new name: "the oldest old." Nevertheless, relatively little research has been done on us compared to what has been done on "younger old" people. The researchers who wrote *Life Beyond 85 Years* (2003) said that they were moving into "previously uncharted" territory. In so doing, they found, as I (we) know by experience, that "the oldest old are quite different from younger old people."³⁵ At 87, I feel that I changed more in the last 10 years than I did in the previous 30-40 years.

Because of the fact that we "oldest of the old" folk are so different from who and what we were even as "younger old" folk, we have developed new strategies to deal with the exigencies of being old old. Therefore, many of the "facts" about old age based on studies of younger old people do not apply to us. The study *Life Beyond 85 Years*, based on

interviews over a six-year period, found that “a long-term survivorship tends to stimulate changes in both cognitive and emotional processes, wherein conceptions of social relationships, the self concept, one’s orientation toward time, and even the meanings of life and death tend to be reconstituted.”³⁶

The specific changes that follow are based on studies of old people. I have only used material that seemed to me applicable to those of us who have passed our tipping points and become “the oldest of the old” at whatever chronological age, but are not totally disabled. What I have written is, of course, colored by my experience and that of friends. Not everything reported affects every old person to the same degree, but most of it affects most of us old people to some degree.

Negative views of us abound.

“Research on age attitudes have consistently found that negative attitudes toward older persons predominate over positive attitudes.” Factors in the negative attitudes include physical features such as “facial aging, vocal indicators of age, and slow gait” and behaviors such as “forgetting, rambling talk, and being inactive.”³⁷

In a similar vein, one gerontologist, observes that “as a culture, we tend to view our elderly parents as essentially obsolete – like old cars destined for the scrap heap.”³⁸ And, in his study *Aging and Old Age*, Posner asserts that “there is resentment and disdain of older people in our society, or widespread misunderstandings. . . . Elderly people may seem old-fashioned because they ‘cling’ to ‘outmoded’ methods.”³⁹

A list of colloquialisms used for old people includes “coot, crone, geezer, hag, old buzzard, old crock, old duffer, old fogey, old maid, old fangled, old fashioned, and over the hill.” Ironically, the word “old” was “originally associated with very positive meanings including skill and wisdom,” but “more recently it has taken on a very negative flavor.”⁴⁰

Posner agrees that “it is probably true that old people in the United States of the present day do not command the respect and affection they

once did.” Our accumulated experience and knowledge has lost much of the value it once held because “if society is changing rapidly, the rational young may not be much interested in what the old know”⁴¹

In a study of old people’s experience of ageism,⁴² Melissa Dittmann of the American Psychological Association found that “80 percent of respondents reported experiencing ageism—such as other people assuming they had memory or physical impairments due to their age.” Regarding the effects of ageism, Dittmann found that “not only are negative stereotypes hurtful to older people,” but they contribute “to worse memory and feelings of worthlessness,” and “they may even shorten their lives.” In contrast, it has been established that “older adults exposed to positive stereotypes have significantly better memory and balance.”

Dittmann also noted Doris Roberts’ (the Emmy-award winning actress in her seventies from the TV show "Everybody Loves Raymond") testimony at a Senate hearing on ageism. "My peers and I are portrayed as dependent, helpless, unproductive and demanding rather than deserving," Roberts testified.⁴³

Harvard University’s Project Implicit “measures *implicit* attitudes and beliefs that people are either unwilling or unable to report” about many contrasting subjects including Young - Old.⁴⁴ Since being placed online over 4½ million people have taken the tests. In the Young - Old test, 80% of the participants have an “automatic preference for Young people compared to Old people”: 35% strong, 29% moderate, 16% slight. Only 6% have a preference for Old people with 14% showing no automatic preference. Anyone can take this or the other tests and receive results at <https://implicit.harvard.edu/implicit/demo/takeatest.html>. The designers of the test found that some of their implicit attitudes were contrary to their explicit ones. I also found the test revealing, so I challenge you to take it for your own information about yourself.

We old people need to immunize ourselves against negative attitudes because “age prejudice is one of the most socially condoned, institutionalized forms of prejudice in the world—especially in the United States—today. For example, there is a whole industry in the greeting

card business built around the ‘over the hill’ theme.” The cards are portrayed as humorous, but “the essential message is that it is undesirable to get older.” This quotation comes from *Ageism: Stereotyping and Prejudice Against Older Persons*, a book which documents the editor’s verdict that “most Americans tend to have little tolerance for older persons and very few reservations about harboring negative attitudes toward older people.”⁴⁵

Whether we like it or not, “old age humor” is prevalent and seems here to stay. Old age humor can be harmful, but it can also be therapeutic. The book *Therapeutic Humor with the Elderly* delineates this distinction. Harmful humor laughs *at* someone; therapeutic humor laughs *with* someone. Harmful humor laughs *at* someone with contempt, abuse, or sarcasm. In contrast, laughing *with* someone is based on empathy and caring. Thus, humor about old age can be therapeutic if it complies with this dictum: “Humor is laughter made from pain—not pain inflicted by laughter.”⁴⁶

In studies of how people stereotype others, we old people fell into a “warm and incompetent” group, a perception that evoked “pity and sympathy” and into a “low status and relatively noncompetitive group.” When people view us as “warm and incompetent,” they relate to us accordingly. “Young people use baby talk—higher voices and simpler words.” People with the “warm and incompetent” view are less likely to engage us “in challenging conversations” or to ask us “difficult questions.” The general result of the “warm and incompetent” stereotype is that we “elderly people are subject to a paternalistic breed of prejudice; [we] are pitied but not respected.”⁴⁷

Negative attitudes by younger generations are understandable because we old people represent a drain on their time, a financial cost either directly or through taxes to pay for our Social Security and Medicare (we are expensive), and a preview of their future reality: a reality they do not want to face. But, if we old people accept the “negative beliefs and expectations about” us that others hold, we will also pay a price in lowered “self-esteem” and even in our “social, psychological, and physical health in important ways.”⁴⁸

Patronizing Speech

The “Patronizing Speech” section draws on sources listed in this end note.⁴⁹

“Is being called ‘dear’ in old age kindness or condescension? What about being told that you must have been beautiful when you were young? What do you make of the people who pat you on the head, as they might a small child or a dog? [What do you feel when] sing-alongs and bingo, unappealing pastimes even in middle age, are now assumed to be your idea of fun?” Although these questions are important enough to have been raised in a *New York Times* blog, they evoke different answers. For instance, the blog’s author seems to be unaware of *Play Therapy with Adults*. This book reports an experiment which found that playing Bingo enhances cognitive function.⁵⁰

Research shows that “age stereotype, especially negative stereotypes, are (a) quite widespread in our society” and (b) that they express themselves in various forms of intergenerational communication. Many of us old people have experienced being spoken to by younger people in what is variously called “patronizing speech,” “elderspeak,” “secondary baby talk,” “baby talk,” and “overaccommodation.”

What constitutes patronizing speech is partly in the mind of the receiver, but it is generally considered to include an overly caring but controlling tone of voice, exaggerated intonation, higher pitch, the use of the pronoun “we” rather than “you” (Are we having fun?), excess praise for a simple action as might be given to a child or a pet, and inappropriately intimate terms of endearment (“dear”). The words are sometimes accompanied by a gentle stroke or pat on the shoulder or head. One article describes patronizing speech as “a form of speech that is ‘particularly high pitched with exaggerated intonation contours’, or wide variations in the pitch of the voice.” In many respects, patronizing speech “resembles that which an adult would use when speaking with a language-learning child.”

A major study found much “empirical evidence that older people are often addressed in a childish way.” Some of us like being addressed in such a way, but “research has shown that more old people resent being spoken to in this way.” From the old person’s perspective, many of us feel patronized when younger people talk to us very differently than they would with their contemporaries: when they talk to us more like they talk to a child than in the way they talk to their contemporaries. Surveys have documented (and I concur) that many of us old people view patronizing speech and behavior “as communicating a lack of respect that undermines self-esteem and dignity.” More important than the way we feel about patronizing speech is the considerable evidence that it can have “negative effects on the psychological and physical health of older people” to whom it is addressed.



Research regarding the use of patronizing speech with old people has found prevalent use by professionals who care for them. For example, in a combined facility for old people and children that is part of a retirement community, Dr. Rosebrook, the director, admitted that in her facility “we have 300 elders who are ‘sweetie’d’ here. Our kids talk to elders with more respect than some of our professional care providers.” She said she considered “elderspeak” a form of bullying. “It’s talking down to them,” she said. “We do it to children so well. And it’s natural for the sandwich generation, since they address children that way.”

Patronizing may be done with good intentions when old people are thought of as in their “second childhood,” that is, in a state of mental infirmity as a consequence of old age. But, regardless of intentions, two facts about the consequences of patronizing speech on us old folks have been established: (1) it “can lead to more negative images of aging, and those [of us] who have more negative images of aging have worse functional health over time, including lower rates of survival” and (2) speaking to old people in a patronizing manner on the basis of their age and dependency leads to unfavorable perceptions of the caregiver by

the receivers.

Radical changes occur in our bodies as we age.

In his *The Art of Aging*, Dr. Nuland describes “aging” as a lifelong process “by which a healthy individual . . . gradually deteriorates into one that is frail . . . and one who is therefore becoming more and more vulnerable to disease and ultimate death.” Nuland lists four factors in the aging process: (1) “normative genetic aging changes,” (2) “disease,” (3) “environmental influences,” and (4) “decreased expectations resulting in inactivity of body and mind.” But the interaction of these factors is so “complex” that we cannot know what impact any combination will have on any one of us old people. So, in spite of much study, the “biology of aging” remains “a great mystery.”⁵¹

Although the biology of aging remains a mystery, the effects of even what is considered “healthy aging” make themselves harshly known: (1) “loss of physical vigor,” (2) “vision impairments, such as sensitivity to glare and impaired focus on moving objects,” (3) “hearing losses at high and low frequencies and associated loss of balance,” (4) “more fragile bones due to loss of calcium,” and (5) “some memory loss.”⁵² An online article on “Normal Aging Changes” lists 57 common ways that the body ages grouped in eight categories: all of them negative.⁵³

Furthermore, because “aging is a complex process, it is impossible to consider biological or physical aspects without a comparable concern for the psychological, emotional, and social factors involved.”⁵⁴

When I have symptoms and the doctor explains their causes, I feel some reassurance in that somebody knows what it going on in my body, even if I don’t understand everything the doctor says. Our old bodies produce many symptoms to let us know that they do not function as they used to. Even though I don’t understand much of the following quotation from a text book on neurophysiology, I found some reassurance that somebody seems to understand the inner workings of our bodies that affect their functioning when we get old. So I include the quotation in case it might offer a bit of reassurance to someone else. If it doesn’t,

skip it.

Aging leads to losses of muscle mass, strength, and α -motoneurons. Denervation, sprouting, and reinnervation result in a smaller number of motor units that are, on average, slower and larger than those found in younger persons. Sensory functions become impaired with age. Reactions to sensory stimuli, from monosynaptic reactions to voluntary actions, typically become slower and smaller in magnitude. The control of vertical posture and gait declines with age, leading to more frequent falls. This decline is reflected in larger postural sway, smaller and delayed APAs, and smaller pre-programmed reactions and perturbations. Movement patterns in elderly persons are characterized by slowness and excessive co-contraction of agonist-antagonist muscle pairs. Movements are less smooth and more variable. Prehensile tasks are associated with excessive grip forces and weaker multi-digit synergies stabilizing the hand action. Some of the features of movements in elderly persons reflect adaptive strategies of the central nervous system. Training can increase the strength and endurance of elderly persons as well as the accuracy achieved in force-producing tasks.⁵⁵

We look old.

Age causes many changes in our bodies that make us old people look old no matter how hard we try to look younger.

Our Skin

We experience many normal aging changes in our skin.⁵⁶

- Our old skin becomes thinner and less elastic and, therefore, more fragile and vulnerable to tear-type injuries and bruises that many of us display.
- Age spots can occur, and small growths called skin tags are more common.
- Our outer skin layer dries and loses subcutaneous fat. This can

cause us to feel coldness, even in warm temperatures.

- Our skin produces less natural oils. This makes our skin drier and more wrinkled and creates “turkey neck” skin on our elbows, necks, and elsewhere.
- Our skin begins to sag as muscle tone gradually decreases.



Our Posture and Gait

Many of us old folks look old when we stand and walk because we suffer what the experts call “Age-related Changes in Posture and Gait.” In ordinary language many of us stand or walk with a stoop (bent forward and down from the waist or the middle of the back) and/or with a sway (inclined or bent to one side). This happens because most of us suffer a reduced “ability to control vertical posture and gait.” Our old postural control muscles don’t work as well as they once did.⁵⁷ When I was hiking the mountains of West Virginia just a few years ago, I never expected that stepping down from a curb and staying upright would be a greater challenge and that walking down a gentle incline would incur more painful muscles.

A list of “Normal Aging Changes” includes the fact that for many of us a “spinal curvature develops and becomes visible with aging.”⁵⁸

Old age not only affects our posture and gait; it makes us shorter. In our 60s, 70s, and 80s we lose 1-3 inches in height.⁵⁹

Our Voice

We not only look old; many of us sound old. “Older speech” is often marked by a “slower speech rate, hoarse voice, lower volume, hypernasality, slower articulation, and imprecise consonants.”⁶⁰

We suffer many losses.

We suffer losses all through our lives, but the older we get, the more these losses multiply, and the losses are of many varieties:⁶¹

- the loss of loved ones
- the loss of companionship
- the loss of independence
- in old folks homes, the loss of privacy and familiar surroundings
- the loss of physical capacity: vision, hearing, stamina
- for many of us, loss of general health
- the loss of good looks as generally judged
- the loss of the ability to drive a car
- the loss of mental capacity: especially memory
- the loss of one's life work
- the impending loss of life

Slowness

Most of us lose the ability to move fast. In both men and women, muscle mass declines steadily. By age 70, we've lost 30% of the muscle mass we had at age 20: by age 80 or 90 much more. This drop in muscle mass decreases our strength and increases our fatigue.⁶² The "decreases in muscle mass" and "weakness" (*sarcopenia*) constitute "a major risk factor for falling."⁶³

Not only do we lose muscle mass, the ligaments that connect our joints waste away and our joints degenerate. These changes cause us to experience stiffness, pain, and a limited range of motion, so we move more slowly.⁶⁴ For a time, we may be able compensate for these changes to some extent by regular exercising and stretching, but only to some extent and only for some time. Age deterioration cannot be stopped.⁶⁵ Furthermore, we have less stamina, that is, we have less "enduring energy, strength, and resilience." This makes it more difficult to keep our bodies fit.⁶⁶

Another reason for our slowness has to do with our brains. "With aging, decreased blood flow and reduced oxygenation to the brain causes

slower transmission of nerve impulses. This change causes the elderly to need additional time for motor and sensory tasks involving speed, balance, coordination, and fine motor activities (buttoning buttons, opening bottles, etc.).”⁶⁷

Given the decline in our bodies, it is not surprising that gerontologist find that “slowness of behavior with advancing age” is “one of the most reliable features of human life.”⁶⁸

Keeping Busy with Survival

When I was still middle-aged, I asked an older retired friend how he passed the time. His reply was that everything he did took longer. Now that I am old, I can understand what he was talking about. The general age-related slowing down is one factor in filling up our days. It takes longer to stand up, longer to walk across a room, longer to get dressed, longer to do personal care. Just turning around is a slow process: quick turns cause falls, a careful turn requires a dozen small steps. And, besides taking longer to do what we do, with our diminished stamina, it takes a lot less doing for it to feel like a day’s work.

Life Beyond 85 Years describes how many of us “ritualize everyday life” and follow our routines with deliberate care. Ritualizing our days gives us a degree of predictability in our uncertain worlds. It also helps our fleeting memories remember to do what needs to be done. Most of us have to count out and take medications at least twice a day. Many of us have to deal with degrees of incontinence. So it is that the basics of old age survival keep us busy.

We suffer sleep deprivation.

The “sleep deprivation” section draws on the sources listed in this end note.⁶⁹

Studies of “Sleep Disorders in the Elderly” find that about half of us old folks suffer “chronic trouble with sleep.” Our sleep is more fragmented, as evidenced by an increase in the number of sleep stage shifts, arousals, and awakenings. This fragmented sleep results in an increase

in daytime sleepiness.

It is virtually impossible for us old folks to spend enough time in bed to get the deep sleep we need to prevent daytime sleepiness. In middle age, about 10% of our sleeping time was the deep sleep needed to be adequately rested. By 65, the deep sleep portion was down to about 5%, and now in old age it is even less. If we needed 7-9 hours of sleep in middle age to get enough deep sleep to be rested, we old folks could not get enough deep sleep even if we slept virtually all the time.

The daytime sleepiness resulting from inadequate deep sleep plays a significant role in making us different from the way we were before we got old. Obesity and high blood pressure have been connected with inadequate deep sleep. Daytime sleepiness gives rise to an increased risk of falls because it engenders difficulty with ambulation, balance, and vision—even after controlling for medication use. Daytime sleepiness hinders our ability for social interaction because it leads to deficits in attention; it slows response times; it interferes with short-term memory and, therefore, with verbal comprehension; it can spawn a negative mood and behavior; and it lowers performance level in everything we do.

One of the reasons for our lack of deep sleep is that many of us suffer chronic pain. (See the section “We suffer aches and pains.”) This means that some of us cannot lie down to sleep and others must take pain killers.

Muscle cramping and the restless legs that are prevalent among us old folks contribute to sleep deprivation. In muscle cramping, the muscle feels tight and painful, and the pain can last from a few seconds to hours. Restless legs is characterized by a strong urge to move the legs repeatedly which interferes with falling asleep and interrupts sleep.

Another impediment to deep sleep is that we have to get up and go to the bathroom at night more often because of such “Normal Aging Changes” as these.⁷⁰

- The kidney function of us old people increases when we are lying down, so we have to get up more often.

- Age has weakened our bladder and perineal muscles and this causes inadequate bladder emptying. Thus, more trips to the bathroom at night.
- For many of us old men an enlarged prostate gland causes an increase in the frequency of urination.

We must resolve major psychological issues.

One writer about old age alludes to “the enormity of the psychological journey the elderly face.”⁷¹ Another writer maintains that “quite a number of complex tasks have to be dealt with at the outset and continuing through old age.”⁷² Robert Peck gives specifics to what these two writers assert in his article “Psychological Development in the Second Half of Life.” He outlines three “psychological problems that must be universally met and mastered” in old age.⁷³ These three problems with quotations from Peck and others follow.

1. Rethink the Basis for Our Self-esteem. When we retire from our primary occupations, Peck says that “the chief issue” is the question whether I am a “worthwhile person only insofar as” I can perform my occupation or whether I am worthwhile on the basis of various roles that I can still play and of “the kind of person I am.”⁷⁴ One 85+ person put it this way: to adapt to being old, I have had to “reconstitute a self-concept that is consistent with the realities” of old age.⁷⁵

2. Revise Our Relationship with Our Bodies. Our old bodies are more vulnerable to sickness, they have less recuperative powers, and they suffer more aches and pains. “People to whom pleasure and comfort mean predominantly physical well-being” spend their elder years in a “preoccupation with the state of their bodies.” But others find “social and mental sources of pleasure and self-respect” that get the better of preoccupation with their bodies.⁷⁶

3. Facing Death. In earlier years, we knew that we were mortal, but imminent death was unexpected and unlikely. In old age, relatively imminent personal death is both expected and likely. Peck suggests that this fact can be transcended by a belief in the “enduring significance” of

what we have done and whatever we can do until the end “to make life more secure, more meaningful, or happier” for others.⁷⁷

We must also adjust to a new situation that is described by the title of a book aimed at our adult children: *When Roles Reverse: A Guide to Parenting Your Parents*. The new situation arises when we become more debilitated and our “adult children want to shelter and protect their aging parents.” One intergenerational counselor points to the “baby boomer children who feel the overwhelming need to parent their parents.”⁷⁸ The book *Life Beyond 85 Years* found adult children making decisions about their parents “even against their parents’ will, most likely because it alleviated their own filial anxiety about caring for a parent.”⁷⁹

The adjustment problem occurs when the adult children’s desire to parent their parents “conflicts with their parents’ emphasis on the need for independence, autonomy, retaining control, and minimizing change and loss.”⁸⁰ According to a survey by Home Instead Senior Care, even when the need of assistance is obvious, our desire to remain independent is so strong that only 25% of us will ask for help, so the other 75% of us will resist assistance by our children.⁸¹ Many of us have said, “I never want to be a burden on my children,” so we have “few expectations of [our] children’s help.” Most of us “prefer to be independent from [our] children.”⁸²

We can remind our adult children that we felt anxiety when we let them take risks on their way to gaining independence. And, if something bad had happened to them, our guilt would have been excruciating. Now, it is their turn to bear anxiety and chance guilt in order to let us take risks required for maintaining our independence. We can also remind them that, even as we become physically dependent, we need to maintain our psychological independence. To the extent that we become psychologically dependent on anyone, we will expect that person to solve all our problems and will, therefore, be angry at them if they don’t.⁸³ Perhaps our children will be less offended by our contrariness if they understand that we are desperately trying to maintain our psychological independence even as old age makes us more physiologically dependent.

The article “Parenting Your Parents” alerts adult children that their parents “may not want to accept help from loved ones for fear of losing their independence” and advises them to handle us old folks with “kid gloves” and “gentle talk.”⁸⁴ But fortunately for both generations, the article “Why the Phrase ‘Parenting Your Parents’ is Demeaning” opposes the concept of adult children parenting their parents. It admonishes adult children that if “you begin to care for your parents with the mindset that your parents are like children, you and they will suffer. For your parents are the people who, whether they did it well or not, brought you up in this world and provided for you. They have lived a life. They are not infants with new hope ahead of them.”⁸⁵

Rather than treating one’s old parents as children, filial maturity “implies relating to and supporting aging parents in an adult way.” At the same time, “parental maturity means parents also accept their adult children as adults, forego condescending attitudes and willingly accept help from the younger generation.”⁸⁶

Such maturity is needed for the reversal of roles that often happens by the time we old folks reach our 80s. Over the years our children, even in their adulthood, turned to us in times of stress for guidance and support, both emotional and financial. Now we are part of an increasing number of “two-generation geriatric families.” We 85+ survivors are often in need of guidance and support by our 65+ children. Such a radical reversal of roles, requires maturity and difficult adjustments by both generations to maintain a positive intergenerational relationship. And maintaining a positive relationship is urgent because “to the extent that these intergenerational relationships are negative, decades of conflict, guilt, disappointment, and stress may result.”⁸⁷

To round out the picture of adult children caring for their parents, *Life Beyond 85 Years* found that even those who “feel some norms of responsibility” for their parents “do not feel obligated to make sacrifices for them.” It has also been determined “that only 25 percent of the older population nationally have a child as a caregiver” and that “almost one third have no children.” Not only that, “24 percent no longer maintain ongoing family relations.”⁸⁸

Worry and Fear

Worry has been described as a kind of fear: one that is persistent and does not let go.⁸⁹ It has been noticed that “many children think that elderly parents don’t have anything to worry about.” But the fact is that we have much to worry about: things such as our financial security, our medical needs, and our future health.⁹⁰

A home care service lists “The Top Ten Fears of Elderly Adults” on its web site.⁹¹ At least some of these fears apply to all of us old people.

1. Loss of independence.
2. Declining health.
3. Running out of money.
4. Not being able to live at home.
5. Death of a spouse or other family member.
6. Inability to manage their own activities of daily living.
7. Not being able to drive.
8. Isolation or loneliness.
9. Strangers caring for them.
10. Fear of falling or hurting themselves.

We are engaged in major psychological issues and beset by worries and fears, but most of us do not show it. In a study comparing older and younger people, it was found that we old people are more likely than younger people to endorse these statements:

- "I seldom cry."
- "Whether I'm happy or sad inside, I look pretty much the same."
- "I try hard to stay in a neutral state and to avoid emotional situations."
- "I try to avoid reacting emotionally, whether the emotion is positive or negative."

The study concluded that “age is associated with diminished intensity of emotional impulses, a concomitant lessening of outward signs of both positive and negative emotional expressions, and increased emotional control.” The researchers interpreted our greater control of emotion as

our way of dampening our experience of aversive negative emotions such as sadness, anger, and fear.⁹² This study resonates with me.

We live with aches and pains.

I am like the person who said that “‘ignore old age’ is my motto. Then some of the aches and pains of arthritis catch up to me and old age cannot be ignored.”⁹³

Although the experts say that “persistent pain is not an inevitable part of aging,” the reality is that “between 25% and 50% [it increases with longevity] of the general geriatric population and 45% to 80% of those in nursing homes have this problem.”⁹⁴ Our “joints get swollen, stiff, and painful.”⁹⁵ Walking, that once was a joy, becomes a painful challenge, if we can still walk at all.

71% of us take prescription analgesics and 72% of us take OTC analgesics. This may help make aches and pains bearable, but it also causes side effects in at least 26% of us, some serious.⁹⁶

The UCLA Multicampus Program of Geriatrics and Gerontology lists “Common Causes of Pain in the Elderly” as

- Osteoarthritis: back, knee, hip
- Night-time leg cramps
- Claudication [“pain, tension, and weakness in the legs”]
- Neuropathies [“diseases of the nervous system”]:
 - idiopathic [“a disease having no known cause”]
 - traumatic [“pertaining to an injury”]
 - diabetic [“resulting from diabetes”]
 - herpetic [“relating to any of several viral diseases causing the eruption of small blisterlike vesicles”]
- Cancer

Our ears, our brains, and how people talk affect our speech comprehension.

Many of the resources used in this sections are listed in this end note.⁹⁷

Psycholinguists (who study the ability to comprehend speech) speak of “the incredible complexity of human speech.” The process is described this way: “successful comprehension requires that the words of a sentence be perceptually encoded, their linguistical relationships be determined, and a coherence (meaning) structure of the message be constructed, all with the speech arriving at a rate of 2.3 to 3.0 words per second.”

I will try to illustrate how I understand this jargon and apply it to me. Suppose a speaker, in order to help listeners comprehend her presentation, begins by stating her topic: “My topic is why many old people find it difficult to comprehend what people say.”

I can hear the speaker’s words if she projects them with sufficient energy and proper diction. But they will be just words unless my brain can do its work of connecting the words with their referents, for example, as follows:

- “old people”: Is the speaker referring to me or old people I know or to whom?
- “what people say”: Is the speaker referring to conversations or group presentations like hers?
- “difficult to comprehend”: Is the speaker referring to difficulty in hearing the words, difficulty in understanding the meanings of words, difficulty in grasping a speaker’s concepts, or all of these things?

My brain must make these connections or I will not really be on board with the presentation in a way that the words connect with my life. If the speaker speaks rapidly, she will state her topic in about 5 seconds. If she speaks deliberately with pauses (as she should), she will state her topic in about 12 seconds. The 12-second speaker gives me a better

chance of making the connections before she starts giving me more words to process. If she repeats her topic with a brief pause, she gives me a much better chance of making connections between her words and my world.

What I have described regarding the speaker's first sentence applies to her whole presentation. If her words are to be more than just words, I must connect her words with my world while she is talking. I must either do a simultaneous translation from her words to my world or try to hold her words in my age-impaired short term memory for later translation. Unlike a book, I cannot pause to think about what the speaker *has said* without missing what she *is saying*. I cannot reread a sentence I missed, and I cannot glance at the chapter heading to get the speaker's topic if she does not make it clear.

Because of this complexity, processing and comprehending speech requires both (1) considerable acoustical acuity and (2) considerable cognitive ability. So it is that "spoken language comprehension represents a complex process that may strain cognitive resources even for the young adults whose memory capabilities and processing speed are presumably at their peak." But we "older listeners" are no longer at the peak of "hearing acuity" or at the peak "capacity of working memory." Therefore, we are not at the peak speed for processing and comprehending speech.

So it is that most of us old folks have suffered some age-related loss in our ability to comprehend spoken language. This loss of speech comprehension can be the result of (1) diminished acoustical acuity (hearing loss) or (2) diminished cognitive ability (age-related cognitive slowing) or (3) the quality of the speech or, more likely, (4) a combination of all three.

Acoustical acuity: changes in our hearing

Over half of us old people suffer some age-related peripheral hearing loss caused by disorders of the structures of the ear. For many of us, age causes a stiffening of the tiny bones of the inner ear that transmit sound; our eardrums may lose elasticity; and a decline in the number of

sensory cells in our inner ear often causes an inability to hear high-frequency sounds.

If our hearing loss is below 30 decibels, we will not have much trouble with ordinary day-to-day conversation, but we may have some difficulty in larger settings unless the speech is adequately projected and articulated.

With losses between 30 and 40 decibels, we will often miss the quieter speech sounds, chiefly the consonants and unstressed syllables, especially if the speaker fails to clearly articulate and project what he says.

Those of us with losses between 40 and 50 decibels cannot follow conversational voice beyond 5 feet and will usually need a hearing aid for everyday use. If our loss becomes greater than 50 decibels, we will definitely require a hearing aid.

The Mayo Clinic describes the work of hearing aids in this way: “all hearing aids amplify sounds, making them louder so that you can hear them better.” Digital hearing aids can also analyze and adjust the sound based on the user’s hearing loss, listening needs, and the level of surrounding sounds. However, the Mayo Clinic warns that even with digital technology, “hearing aids can’t restore normal hearing or eliminate all background noise.” So it is that only 55% of hearing aid purchasers say they are “satisfied” or “very satisfied.” Furthermore, 23% report being only “somewhat satisfied” and 22% say they are “totally dissatisfied” with their hearing aids or have simply stopped using them.

Cognitive ability: changes in our brains

Besides the likelihood of peripheral hearing loss, we old folks suffer declines in our brain’s short term (working) memory and in its speech processing speed. These faculties are needed for the simultaneously storing and processing information that are essential for speech comprehension.

Even with the age-related declines in our brain’s speech processing

ability, many of us can hear normally in quiet settings. In contrast, we may have difficulty making sense of what we hear in complex listening situations, such as trying to understand a conversation amid distracting background noises. The reason we experience this difference is that comprehending speech when there is competing noise requires more of our brain's speech processing ability than is required in a quiet setting.

These age-related declines in cognitive abilities are even more critical when we are hearing-impaired. With impaired hearing, our brain is assigned the additional task of making out the words being spoken before it can begin the complex task of processing and comprehending what is being said.

How it is said affects our comprehension.

The factors that cause us old people problems with speech comprehension can be an impaired hearing acuity or cognitive limitations or a combination of the two. But there is a third factor: the way the speaker speaks. A study of spoken language comprehension found that "prosodic phrasing is central to language comprehension." Prosody includes speech elements such as patterns of stress, intonation, pitch, rate, loudness, rhythm, timing, etc. So it is that how a sentence is spoken affects our ability to comprehend what the speaker is trying to communicate.

Comprehension inhibiting speech

There are many speakers and many types of speech that are difficult to comprehend. The array of names for them suggests their prevalence.

- Mumblemouth. The *Urban Dictionary* defines a mumblemouth as "someone who you have no idea what they are saying because they are either far too quiet, or they are mumbling (or a combination of both)."
- Mushmouth: *American Slang* defines a mushmouth as "a person who speaks indistinctly and slurringly."

- Motor-mouth: *Slang-Dictionary* defines a motor-mouth as a person who talks so fast that people lose part of the message.
- Lazy tongue, lazy mouth, sloppy speech: *Broadcast Voice Handbook* uses these terms to denote poor articulation of the sounds in words.

Many aspects of difficult-to-understand speech have been identified by speech experts. Some of them are as follows:

- “Speech is **often underarticulated** to the degree that many words in fluent discourse would be completely unintelligible were it not for listeners’ ability to **rapidly factor in the surrounding linguistic context.**” [Articulate: to pronounce distinctly and carefully; to express in coherent verbal form.]
- “Talking too quickly is one of the most common impediments to clear speaking because such a speaker is more likely to mispronounce words or delete specific sounds and syllables that compromise crisp articulation and diction.” Also, “when speech is too fast and loud the listener's brain tunes it out.”

The countless college and self-improvement courses designed to teach people to speak clearly suggest that what I am calling “comprehension inhibiting speech” is commonplace for all ages. A college text book, *Speaking Clearly*, describes the kinds of unclear speaking the students had probably done before taking the course:

- “mumbled or ran words together”
- “kept your mouth nearly closed while speaking, hardly moving your lips”
- “your speech came out in a rush”
- “you interrupted yourself in the middle of one thought and jumped to another”
- “your voice sounded too high, too low, too loud or too soft”
- “errors in pronunciation and word choice.”

The upshot is that our problem with speech comprehension may well be

partially caused by our old ears and brains, but a big factor in our problem can often be the speaker whose speech is difficult to comprehend. On the other hand, there are speakers who practice comprehension enhancing speech. Many TV interviews provide examples of this contrast. The professional broadcaster conducting the interview can be easily understood, but the interviewee often speaks in ways that are difficult to understand.

Comprehension enhancing speech

The book *Marketing to Older Consumers* teaches merchants the most effective way to speak to old people. The author explains that because of changes in our auditory systems and cognitive speed, we can comprehend spoken language better

- (a) if the speaker speaks with a lower pitch,
- (b) if the rate of speech is consistent and deliberate (not too fast or too slow),
- (c) if the speaker's points are stressed and repeated, and
- (d) if background noise and other distractions are avoided.

Many of us know from experience that the above factors help us comprehend what is said. In addition, numerous studies have identified these ingredients as essential to "clear speech" for everyone, and especially for our old ears and brains.

A Projected Voice, Not a Loud Voice

Resources used in the subsection on "A Projected Voice, Not a Loud Voice" are listed in this end note.⁹⁸

Many of us have experienced people talking to us in a very loud voice, virtually a shout. The setting might be a large room to a group or one-on-one conversation. The reason for the very loud voice is probably twofold. (1) The speaker knows we are hearing-impaired or assumes hearing-impaired because we are old. (2) The speaker believes that speaking in a very loud voice makes speech more comprehensible for hearing-impaired people. But, in fact, the Audiology Centre finds that "loud speech or yelling increases audibility, but it may decrease intelligibility,"

so we might hear more sound, “but understand fewer words.” Another article on “Speech Intelligibility” concurs: “it has been shown that loud or shouted speech is more difficult to understand.” This fact is “due mainly to changes in phonetics and intonation” by the speaker.

Although loud speech may not enable us to comprehend what is being said, if speakers *project* what they say, everyone, including us old folks, will be better able to comprehend it. Projection does not mean “to speak louder, because loud usually means ugly or unpleasant.” To the contrary, “projection is natural, relaxed conversational speech, but with more energy and focus.” The importance of speech projection for speech comprehension is that when speakers project, their “speaking becomes clearer,” and they can “be heard from far away without shouting.”⁹⁹

It is likely that all of us have enjoyed being spoken to, especially in group settings, by people who project their words with adequate “energy and focus” to be easily understood. They seem to have followed the advice of the article on “How to Project One's Speaking Voice.” They breathe and speak from their diaphragm (not merely from their chest or throat) in order to project their words with sufficient energy to be understood. They project their voices to the person farthest away. One speech instructor suggests that speakers, who try to connect with each individual audience member and who exert the necessary energy to do so, will naturally project their voices so that we can hear them.

Microphones

I reckon that we have all been in meetings where the speakers seemed to think that a microphone was like a magic wand to effect clear communication. They seemed not to know that “a microphone is a tool to amplify your voice, not a substitute for good vocal expression.”¹⁰⁰ They seemed not to know that the pros say, “use vocal energy as you would when speaking without a microphone. Project – make your voice as resonant as possible.”¹⁰¹

We have probably also seen speakers who seemed to have made the mistake that “How to Use Microphones” warns against: “the mistake of

assuming that using a microphone is easy.” To the contrary, the article continues, good “microphone technique is a learned skill - plugging it in and pointing it isn't always enough.” A speaker who blows into or taps the head of the microphone has not learned enough to know that these practices can damage microphones and/or speakers.

So, to speakers who think that if they speak loudly or use a speaker system and we don't comprehend what they are saying, it's because we are old, we can say two things.

- (1) We can agree that our ears and brains may well be part of the problem, but only a part.
- (2) We can tell the speaker that loud speech can decrease intelligibility and that volume is only one ingredient in clear and comprehensible speech.

Syntax

A speaker's syntax, his pattern of sentence structure, exerts a major influence on the clarity and comprehensibility of his speech.

Research reported in *Cognition, Aging, and Self-reports* found that short sentences with simple straightforward syntax contribute to successful oral communication, especially for old people. “Longer sentences and more complex syntax (that might be reasonable for comprehending written prose) could place a greater memory and processing burden on a listener.” This problem is more acute with us old people because of our “slower processing rates and greater susceptibility to working memory overload.” Therefore, persons who speak to old folks are advised to

avoid the use of language structures that place a heavy burden on memory capacity. This would include very long sentences, sentences whose structure requires memory for referents that occurred far previously in the passage, and sentences with especially high propositional density or complex syntax.¹⁰²

Even short sentences can embody a syntax that makes them difficult to

comprehend. A study of the “Effects of Adult Aging and Hearing Loss on Comprehension of Rapid Speech Varying in Syntactic Complexity” refers to such a sentence: “Boys that help girls are caring.” In this sentence the basic subject-predicate thought (“Boys are caring”) is interrupted by the relative clause (“that help girls”). This syntax would cause no problem in a written document. But when spoken, we listeners have the added burden of retaining the relative clause in our memory, while at the same time processing the main clause and integrating the two clauses in order to comprehend the full thought. The author’s point out that “this syntactic operation” must be conducted by our fading short term memory—a task that may be too much for old brains.

So it is that the role that many speakers play in our recurrent difficulty in comprehending what they are saying is that their syntax may include complex sentences, sentence fragments, run-on sentences, and incomplete sentences. On the other hand, one experiment found when the speaker used “simple statements,” the older participants held their own with college students in recalling what was said. But the “college students had a better recall than did older adults for syntactically complex statements.” This experiment provides another example of the reduction in working (short term, immediate) memory capacity that accompanies old age. Such memory is required for processing and comprehending sentences with complex syntax.

Prosody

Syntax refers to sentence structure. Prosody refers to speech elements such as patterns of stress, intonation, pitch, rate, loudness, rhythm, timing, etc.

A speaker’s “prosody” affects “the understanding of sentences” so much that psycholinguists have found that “prosodic phrasing is central to language comprehension.”¹⁰³ Thus, the way speakers speak to us plays a key role in how well we comprehend what they say.

In studying us “older listeners,” it has been found that our “speech comprehension” is “especially disturbed when speech is delivered with an anomalous [irregular, abnormal, or incongruous] or unusual prosodic

pattern.” In contrast, on the positive side, “the presence of normal prosody (intonation, timing, stress) has been shown to help older listeners by aiding in the rapid detection of the linguistic structure and the semantic focus of a question or statement.” However, the authors add a warning to people who speak to us old folks: “it is important, however, to avoid an exaggerated prosody that crosses over the line into patronizing ‘elderspeak.’”¹⁰⁴

Speed

A speech instructor enjoins people in business who speak to all ages that if you want “to increase credibility, confidence, and clarity,” you must “slow down your speed talking!”¹⁰⁵ Similarly, an article on public speaking recommends that speakers, “speak slowly, enunciate clearly.”¹⁰⁶ A training program for businesses warns that speaking in a “fast pace usually leads to indistinct speech sounds, dropped endings of words, and missing information.”¹⁰⁷

So the problem of comprehending fast talk is not limited to us old people, but the problem is more pressing with us. The book *Cognition, Aging, and Self-reports* asks, “Does Slowing Speech Help?” Its answer is “yes,” it does. Many of the “older subjects said that they preferred the speech with slower rates.” Also, slowing speech increased comprehension, but only if it was done without “slowing the speech too much.” In other words, slowing speech has been found to increase comprehension if “slowing” means speaking more deliberately and thoughtfully and does not mean speaking each word at an artificially fixed slow rate.

Our experience of a speaker’s speed comprises both (1) the rate at which words arrive and (2) the rate at which sentences arrive.

(1) *the rate at which words arrive.* Most of us old folks can comprehend thoughtful conversation in which people speak about 90 words per minute (wpm). Many of us can keep up with more animated conversations in which the speech rate may be between 140 and 180 wpm. But a speaker, especially a nervous one, can easily exceed 210 wpm. Given the “older adults’ well-known difficulty with especially rapid

speech,” we cannot keep up with such a speaker.¹⁰⁸

(2) *the rate at which sentences arrive*. One speech instructor maintains that the speed problem for us listeners is often not that the speaker says “the words too fast.” Rather, this instructor argues that the problem stems from speaker’s stringing sentences together without coming to a stop with a brief pause between them. “People,” the instructor observes, “need a few seconds to process what was just said.”¹⁰⁹ This observation was borne out by a study of speech comprehension by older adults: they had much better recall when the speakers used “pause and inflection” to emphasize their points.

Offering older adults additional time to process rapid speech input by pausing at periodic intervals is helpful. . . . Pausing for a beat or two at the ends of sentences, clauses . . . will facilitate understanding and retention for what has been heard.¹¹⁰

In its handout on “Speeches,” The Writing Center of the University of North Carolina at Chapel Hill stresses practices that benefit all listeners, but would especially benefit us older listeners.¹¹¹

- **Limit pronoun use**

Listeners may have a hard time remembering or figuring out what “it,” “they,” or “this” refers to. Be specific by using a key noun instead of unclear pronouns.

- **Rely on shorter, simpler sentence structures**

Don't get too complicated.
Avoid using too many subordinate clauses.
Place subjects and verbs close together.

- **Repeat crucial points**

Keep reminding your audience of the main points you've made.

Summary

If people who speak to us old folks get a bit frustrated when we don’t understand what they are saying, there are several things we can say to

them.

- Yes, we probably suffer an age-related reduction in hearing acuity, even if we have a hearing aid. But we can also tell them that they can help us (and themselves) by practicing good diction and exerting the energy to project their voices (with an explanation that this is not the same as loud talk).
- Yes, we probably suffer an age-related reduction in our brain's capacity to process speech. But we can also tell them that they can help us (and themselves) by speaking in straightforward sentences in which the point is clear, by speaking deliberately with full stops at the end of sentences, and by making the subject about which they are talking explicit.

In these ways speakers to whom we are listening can help us with both our “bottom-up” speech processing and our “top-down” speech processing. In “bottom-up” processing we listen for the 40 sounds (phonemes) that make up the English language and, from that input, we discern words, sentences, and thoughts. In “top-down” processing, we use what we already know about the topic to help comprehend what is being said. So if a speaker makes her topic known, sticks to it, and repeats it, we have a better chance of understanding what she says.

Our digestive system changes.

Our digestive system changes so much that Johns Hopkins *Health Alerts* included an article on “Your Aging Digestive System.”¹¹² Nearly 40% of us older adults have one or more digestive disorder symptoms each year, largely due to the changes that occur in the digestive tract with age.

- Swallowing can become difficult as a result of dry mouth or tooth decay.
- With age, the stomach takes longer to empty into the small intestine, making us more vulnerable to ulcers and bleeding from medications.

- The stomach becomes less elastic and can hold less food, meaning that we adults feel full more quickly.
- Our small intestines becomes less able to absorb certain vitamins and minerals such as vitamin D, vitamin B12, and calcium. Bacterial overgrowth can occur as well, which can cause diarrhea and unintentional weight loss.
- Our large intestines lose muscle strength. This can result in diverticulosis or constipation.
- Our livers becomes less able to metabolize medications, so they are more susceptible to damage.
- Our gallbladders produce less bile, which may lead to gallstones.
- Our increased “gaseousness” is such a frequent complaint that a Canadian doctor has published an article called “An Approach to Management of Gas in the Elderly.”¹¹³ (As early as 400 BC, the importance of relieving gaseousness was treated in a whole book, *The Flatuosities*, by Hippocrates, the father of western medicine.)

We become more cautious: at least we should.

Old people are more “cautious.” As the value of “sex, travel, rich food and drink, and strenuous exercise” decline for us, we old people “reallocate resources to life-extending investments in medical care and safety.” What old people give up by being cautious and what they might “gain from taking risks” are worth less to them than they are to younger people who are less cautious.¹¹⁴

“Age-related decline” helps explain the “hesitation and tentativeness” that many of us old people exhibit. These traits often constitute a rationally chosen adaptation to our diminished capability. We have a greater risk of falling than a young person does. We have poorer balance and eyesight, our reflexes are slower, and we are more likely to be injured if we fall.¹¹⁵

“Age-related decline” in our “fluid intelligence” helps explain why many of us are “less receptive to new ideas than the young” people are. Another explanation is that we are less likely to “earn a return” from new ideas. A third explanation is that our “practices, attitudes, and responses” are “more deeply entrenched and costly to change.” Whatever the reason, Posner speaks of the “aversion of the old to risk-taking activity,” of the prevalence of our “conservative, rote style,” and of the “characteristic resistance of the elderly to novelty.”¹¹⁶

An examination of the lives of 400-500 distinguished men and women from at least seven different fields found that “aging brought about a decline in enthusiasm and a preference for the routine.”¹¹⁷ So, if we “get more set in our ways” and “more focused on our personal worlds,” we are normal for our age group.¹¹⁸

Life Beyond 85 Years takes issue with the widespread view that “self-direction, activity, and social involvement” are always “positive forces” and that “passivity and disengagement” are always “signs of unsuccessful aging.” Interviews of 85+ people over a six-year period found that “when social involvement becomes too complicated to sustain, and physical problems make the social environment too difficult to manage, the oldest old usually welcome increased detachment and aloofness from potentially bothersome, demanding, or stressful roles and relationships.” Furthermore, it was found that making these changes “do not generally undermine their well-being.”¹¹⁹

Falls

A gerontologist observed that “older people worry that they'll fall on ice, fall down steps, trip on broken sidewalks.” Furthermore, “it's not unusual for older folks to restrict their physical activity because of this fear.”¹²⁰

We are being rational if we are cautious about falling because over half of 80 year olds fall annually.¹²¹ Falls are the leading cause of injury and death for old people. They are also our most common cause of nonfatal injuries and hospital admissions for trauma such as lacerations, brain injuries, or broken hips.¹²² Mortality rates in the first year following a broken hip are over 25% for us old folks. Furthermore, only about 25%

of us who sustain a broken hip return to our pre-injury level of activity. Recovery from a broken hip requires prolonged specialized care, such as a long-term nursing or rehabilitation facility. And, if we break a hip, we are at a higher risk of breaking our hip again.¹²³

The need for caution is often in conflict with psychological issues. Mobility enhances “self-esteem, self-image, and morale,” but immobility can induce a negative self-image. We are often urged to use canes, walkers, or scooters for mobility and safety, but a conflict resides here. A study of old folks called “Use of Assistive Devices – a Reality Full of Contradictions in Elderly Persons' Everyday Life” found that the reactions to such use varied widely. On the one hand, the devices were “enablers,” but on the other, they evoked negative personal and social reactions. The hard fact is that, no matter how we feel about it, many of us, including regular exercisers, will experience a progression from canes, to walkers, to scooters.

There are always two elephants in the room.

Most of us don't like to talk about them, but we always have two elephants of the room with us: age-related diseases and death.

Diseases

We are vulnerable to many age-related diseases, often more than one at the same time. Most fearful are diseases that do not kill us, but leave us debilitated or in pain. “Pain is the most feared complication of illness.”¹²⁴

Researchers say that the age-related diseases we face may include one or more of the following:

Arthritis, Cancer, Cardiovascular (Blood Pressure and Heart Disease), Cerebrovascular (Strokes), Dementia (including Alzheimer's), Depression, Diabetes, Destructive Eye Diseases, Falls and Injuries, Gastrointestinal Disorders, Hearing impairment, Osteoporosis, Parkinson's Disease, Respiratory Disease, Pressure ulcers, Sleep problems, Stroke, Thyroid Disease, Type 2 Diabetes, Urinary Disorders and Visual

impairment.¹²⁵

Writing about us old people, Dr. Mary Pipher describes “illness” as “the battle ground of old age. It’s where we make our last stand. It’s the World War, the Great Depression, the Hurricane Hugo.” So, if we do talk about our ailments, medications, and doctor’s appointments, it’s our way of working through trauma. Health issues make up a “fast-breaking disaster story” for many old people.¹²⁶

One of the more dreaded disaster stories for old people (and for their families) is that of dementia, usually caused by Alzheimer’s disease. It’s a disease I fear because my mother was ten years younger than I am when her dementia made her so paranoid and belligerent that the state hospital was the only place that would care for her. The “new old age” proponents tell us that only 10% of people over sixty-five suffer dementia. This is a true but misleading statement because it fails to tell us that about half of us 85+ folk suffer dementia.¹²⁷

Death

We seem to think mostly about dying from one of the above named age-related diseases. This may stem from the fact that as Dr. Nuland observes in his book *How We Die*, every diseased condition is given the name of a treatable disease, probably to encourage hope that we will be cured. Then at death, Dr. Nuland continues, the law requires that “everyone must die of a named entity”: it is illegal for a doctor to write “old age” as the cause of death on a death certificate. Nevertheless, Dr. Nuland asserts, “I’m convinced that plenty of people do die of old age.” To illustrate his assertion, Nuland recounts how, as a child, he watched his grandmother “gradually die of old age.” “Old age,” Dr. Nuland states, “is as insoluble as it is inevitable”; and, probably for these reasons, “it is not politically correct to admit that some people die of old age.”¹²⁸

In residential communities for old folks, “death and dying tend to be ignored as taboo topics by both the elderly and by staff.”¹²⁹ I sometimes picture us here in the old folks home in which I live as being like the sparrows who eat at the feeder on our first-floor apartment’s balcony. A large evergreen bush on one side of the balcony serves as their

apartments. At meal time, they fly en masse to their dining room. Occasionally, a sparrow hawk takes a sparrow away, but that does not seem to faze the other sparrows; they go right on eating at the same feeder.

Attitudes toward death

At age 64, Sheldon Tobin describes the difference between his attitude toward death (of loved ones and of oneself) and that of the over 85 years old people interviewed in the poignant book *Life Beyond 85 Years*. Tobin expresses admiration for their ability to “disengage from formerly significant others who are now departed, to accept a quiescent, withdrawn equanimity.” Sheldon confesses that he could not manage such losses as well: they “would be premature, too early in life.” Turning toward his own death. Sheldon writes, “if death was approaching, I would not find it acceptable. It too would be premature . . . there is business yet to be done.” But, with the “oldest of the old,” the time “when there is no unfinished business” is accompanied with “accepting death.”¹³⁰ I think that I will probably not only *accept* death, but *welcome* it, if I no longer have significant (in my evaluation) “unfinished business” that I am able to do, such as this paper. Without a significant pending file, I would lose much of my reason to get up in the morning.

Preparing for death

Many of us have heeded the advice to make end-of-life arrangements: given medical power of attorney to someone, signed living wills, made plans for our corpses, and executed documents for transferring our assets to beneficiaries. In addition, many of us make our personal preparations. As we approach death, many of us prepare by narrowing and simplifying our lives. Some of us give away possessions; some of us stop sending holiday cards and do less communicating with distant friends; other feel less concern about the news and politics. The everyday effort required for survival begins to consume more of our attention and energy. Non-essentials that once seemed critically important fade from our concern. It is a preparatory letting go before death takes us away from everything. Most of us do not fear death—some of us would welcome it, but nearly all of us fear a long

process of dying. We would like to die in our sleep.¹³¹

The fear of “a long process of dying” has a real basis in fact because few of us will die in our sleep and, in spite of the fact that 90% of us say we would prefer to die at home, only 20% of us will. More than 50% of us will die in hospitals, many “in intensive care units, hooked up to machines that do nothing but prolong the inevitable and isolate [us] from family and friends.” Besides the personal price paid by the old person, younger generations pay a financial price in their taxes because “one-third of the entire Medicare budget is spent on care in the final year of life” and one-third of that in the final month of life. Unless we prevent it by executing living wills and medical powers of attorney, medical professionals are obligated to “do everything” to keep us alive a little longer.¹³²

The platitude that is often inflicted on us old folks — “it’s better than the alternative” — is not only trite; it might well be false. We have no facts about the alternative, only beliefs. But we have many facts about the age-related decline that becomes steeper the longer we live. If we don’t die beforehand, the downhill path often leads from our homes to old folks homes, to assisted living, to nursing homes.

Old age changes and challenges us, but it doesn’t always conquer us.

In many ways I (and other people I know) agree with Dr. Rubin, who at age 82, wrote, “getting old sucks. It always has, it always will.”¹³³ We cannot do many of the things we “used to do” (a phrase often used by us old people) and would like to “still do” (a phrase used less often). But there are some things we can do, some of which we could not do before. For example, my having the time to write this paper and being able to write it from the perspective of an old man.

The book *Life Beyond 85 Years* provides many examples of very old people who, for all the changes and challenges visited upon them by old age were not conquered by it. The authors interviewed 150 people who were 85+ years old over a period of years. These 85+ years old folks had to “deal with persistent pain, problems with mobility, loss of vision

and hearing, the recurrent death of contemporaries, and even the onset of old age among their children.” In spite of these challenges, the authors found that “most were handling their lives competently and with good spirits.”

In sum, the interviewers found that their 85+ interviewees “were adapting well to seemingly impossible odds.” Furthermore, the “respondents discussed their lives and their experiences with a profound grasp of the practical and philosophical aspects of long-term survivorship.”¹³⁴ I wonder if there are any old folks homes in which such substantive discussions are part of their programs.

One of the people who conducted interviews for the 85+ project wrote an “Afterward” to the book in which she gave her impressions of the people she interviewed.

Some of them felt despair. The majority, however, managed to feel consistency and integrity. Their morale stayed impressively consistent over the years [of the interviews], even though their physical condition and consequently their quality of life deteriorated tragically. . . . I am less than a generation younger than these oldest-old. I could call myself “young-old.” And they seem truly “old” to me. But I wonder whether I, too, will feel integrity and consistency as the same inevitable changes occur to me and I move into the world of the “oldest-old.”¹³⁵

Although I am already 85+, I also wonder how I will manage if I live long enough to experience such a tragic deterioration of my physical condition, a deterioration that often includes our brains as well as the rest of our bodies. Already, I (along with my contemporaries) are engaged in an age-related “downsizing.”

Downsizing

A stack of calendars marking the years of our lives;
the stack is downsized until none remain.

We cannot look at them before their time;
we cannot know how many are left,
but we know there are fewer than before.

When the stack was high,
it seemed there would always be more calendars to live.

Our lives were filled up with activities and possessions,
with people and desires and future plans.

As the stack becomes downsized,
living space is downsized; we are downsized:

- downsized literally, made shorter
by gravity as we grow older,
- downsized energy for activities we once enjoyed,
so we downsize our activities to fit our energy;
- downsized craving and downsized room
for possessions once deemed essential,
so we downsize our possessions:
find people who want them, saving our heirs the task;
- downsized need for as many casual friends,
so we downsize to the close ones;
- downsized desire for anything, less get-up-and-go,
so we downsize our wants and what we do;
- downsized future and, knowing it will be more
what happens to us than what we plan and do,
we do less planning, and as a centenarian admonished,
we learn to “take it as it comes.”

But we are thankful for the good years we have had,
and try to find joy in the life we still have.



KNOWING OLD AGE

There are two ways of knowing about old age. One is by knowledge about old age gained through words, such as this paper. This kind of knowledge is variously called before-experience (a priori) knowledge or derivative (derived from words) knowledge or intellectual knowledge. The other kind of knowledge is gained through experience. This kind of knowledge is variously called after-experience (a posteriori) knowledge or firsthand knowledge or experiential knowledge.

Words about old age can give someone a derivative, before-experience knowledge *about* old age. Knowledge *about* old age can serve valuable purposes, but it is not the same as a firsthand, experiential knowledge of old age. Experiential knowledge can only be gained through experiencing old age first-hand. As Simone de Beauvoir wrote, “there is one form of experience that belongs only to those that are old – that of old age itself. The young have only vague and erroneous notions of it.”

Those of you readers of this paper who are not yet old cannot experience old age firsthand. However, there follow two things that you can do to gain a bit of simulated experiential knowledge about old age. I challenge you to do them. They will not only help you understand the old people with whom you relate, they will give you some preparation for your own old age. The simulations require some effort, but simulating old age is much easier than being old, and unlike being old, you can stop simulating whenever you like.

(1) The Macklin Intergenerational Institute offers a program in which participants simulate some aspects of being old. A taste of the program was presented on NBC’s Today Show. It can be viewed at <http://today.msnbc.msn.com/id/26184891/vp/18424824#27336610>. At the least, look at the program. Better still, do the exercises, especially the personal loss one that was alluded to. Lay out 3 sets of 5 pieces of note paper on a table. On set #1, write your 5 most enjoyed activities; on set #2, write your 5 most valued possessions; on set #3, write your 5 most loved people. Then “lose” them one by one, trying to feel each loss, until you have lost them all.

(2) Texas A&M University offers a plan for a do-it-yourself “Aging Simulation” workshop. The full plan is available online.¹³⁶ What follows on the next three pages contains the essence of the plan. The plan is designed for groups, perhaps professional colleagues or families, but some simulations can be done alone.



Aging Simulation

Sensitizing People to the Process of Aging

(condensed)

The following activities were developed to help people experience some of the sensory changes that older adults may experience. These may be used with small or large groups. With a large group, divide into small groups and provide each group with a different simulation. Each group can then share their feelings with the total group. To set this program up as “learning stations,” use the “table tents” that identify the different activities at each station.

Becoming Sensitive to Changes in Sight

1. Obtain a set of swimmer’s goggles:
 - a. Paste yellow transparent plastic paper on the lenses to represent the yellowing of the lens of the eye.
 - b. Paste strips of black paper in a circle around each eye to depict tunnel vision.

Have participants copy a list of words from a chart.

Chronic Care Challenges Simulation Glasses may be obtained from eNasco Online Catalog (<http://www.enasco.com/product/SB24999G>). These glasses help the wearer experience cataracts, glaucoma, macular degeneration, retinopathy, hemianopsia and detached retina.

Changes in Vision Related to Medical Conditions –
<http://fcs.tamu.edu/families/aging/vision/index.php>

2. Vary the light intensity of the room slowly and dramatically to illustrate the circumstances of light and dark adaptation. Ask participants to read the first word on the chart.
3. Use totally blackened goggles to represent blindness.

Becoming Sensitive to Changes in Hearing

1. Use a set of swimmer’s ear plugs, ear muffs or stocking hat to dull the sound of people talking. Give the person directions on how to accomplish a simple task

such as separating an egg. Time the people to illustrate how hearing loss may affect how fast a person accomplishes a given assignment.

2. Use speech itself as a training tool.
 - a. Have two or three people give instructions to a person at the same time. Ask the person to repeat the instructions given.
 - b. Have different people with different voice levels read aloud the same passage from behind a screen.
 - c. Have people speak at differing speeds.
3. Do not forget the interrelation of vision and hearing. Have a blindfolded person listen to instructions which are given at a fast pace. This will illustrate how often we depend upon seeing someone talk to hear what they are saying.

Becoming Sensitive to Changes in Touch

1. Plastic Gloves: Through the use of plastic gloves, the person can simulate difficulties in distinguishing water temperatures and in grasping small objects. Ask participants to pick up a small square of paper from the table.
2. Numz-It: This liquid material used on babies' teeth desensitizes the fingers for a short period of time.
3. Have the person wear a pair of thick gloves and then have him tie his shoe or do any other similar intricate task—button a shirt or buckle a belt.

Becoming Sensitive to Changes in Dexterity

1. One-handed exercises will demonstrate the difficulty encountered by a person who is missing a limb or who has lost the use of a limb. Have participants try to write their names using their left hand.
2. Take masking tape and place it around several fingers and/or joints to represent a missing finger or stiffened joint. Have participants unscrew a jar lid, or open a can.
3. Use elastic bandages to totally or partially disrupt the functioning of one limb, such as a leg or a knee joint.

Becoming Sensitive to Changes in Taste

1. Block out the visual and smelling capacities of the person by use of a blindfold and cotton in the nose and have him identify:
 - a. An apple versus a potato (food with similar textures)
 - b. A potato chip versus a corn chip

2. Blindfold participants and get them to identify substances such as lemons, beef, or pudding that has been pureed in a blender. Texture no longer aids in identification.
3. Use mouthwash to clean the mouth and eliminate taste of foods.

Becoming Sensitive to Changes in Smell

1. Use nose plugs or pieces of cotton to block the nostrils. Have subjects describe what it is they smell or taste. Use a range of foods—apples, oranges, peanut butter and chocolate.
2. Blindfold participants and present them with a variety of odors which they have to identify. Be certain to use a range of odors.
3. Use on strong odor, such as musk oil, to mask other odors. Then have the participants try to tell you what the other odors are.

Becoming Sensitive to Changes in Mobility and Balance

1. Have people attempt to carry a set of packages in their hand while trying to use a walker or a cane. Note how few women have pockets in which to carry possessions when they have to use a walker.
2. Set a person in a desk chair and spin him around a few times. Then ask him to walk in a straight line. A person who is having a mobility problem will have a similar kind of dizziness.
3. Paste heavy sponge rubber on the bottom of a pair of shoes or put the right shoe on the left foot, etc. and have the person walk in them. Be certain to use ill-fitting shoes since many people, particularly older people, do not have adequate foot wear.

Adapted from *Sensitizing People to the Processes of Aging: The In-Service Educator's Guide* by Marvin Ernst and Herbert Shore, Dallas Geriatric Research Institute, 1977. Distributed by: Judith L. Warren, Ph.D., Associate Director for Human Sciences, Texas AgriLife Extension Service, The Texas A&M System, College Station, Texas. 2007

ENDNOTES

1. David Solie, *How to Say It to Seniors: Closing the Communication Gap with Our Elders* (2004), 5.
2. Solie, *How to Say It to Seniors*, 12.
3. Solie, *How to Say It to Seniors*, 2, 12.
4. Simone de Beauvoir, *The Coming of Age*, trans by Patrick O'Brian (1996), 381.
5. Philip Roth, *The Dying Animal* (2001), 35.
6. Sherwin B. Nuland, *The Art of Aging* (2008), 283.
7. Margaret Cruikshank, *Learning to Be Old: Gender, Culture, and Aging* (2003), ix.
8. Virginia Burrus, *Saving Shame* (2008), 46.
9. Ernest Becker, *The Denial of Death* (1973), 215.
10. M. A. Scargill, ed, *The Puritan's Grave*, Vol 1, (1883), 204.
11. **Tipping point:** "Small changes may have little effect until they build up to critical mass, then the next small change may suddenly change everything. This is the tipping point."
(UsingEnglish.com)
12. Colleen Johnson and Barbara M. Barer, *Life Beyond 85 Years* (2003), 75.
13. Richard A. Posner, *Aging and Old Age*, 86-87.
14. Solie, *How to Say It to Seniors*, 2.
15. Connie Matthiessen, Caring.com Senior Editor, "Demystifying Your Aging Parents' New Stage of Life," Caring.com.
16. Raeann Berman and Bernard H. Shulman, M.D., *How To Survive Your Aging Parents* (2001), 2-3, 17.
17. Venice Kichura, "How To Talk to Your Elderly Parent Without Losing Your Mind," AssociatedContent.com.
18. Joseph A. Ilardo, Carole R. Rothman, *Are Your Parents Driving You Crazy?* (2006), 6-7.
19. Connie Matthiessen, "Demystifying Your Aging Parents' New Stage of Life," Caring.com.
20. Muriel R. Gillick, *The Denial of Aging* (2007), 3.
21. Gillick, *The Denial of Aging*, 5-6.
22. Gillick, *The Denial of Aging*, 255-256.
23. paraphrased from Susan Jacoby, *Never Say Die: The Myth and Marketing of the New Old Age* (2011), xii. Jacoby's *Newsweek* article "The Myth of Aging Gracefully" is online at Newsweek.com/2011/01/30/the-myth-of-aging-gracefully.html.
24. Jacoby, *Never Say Die*, 11-12.
25. Posner, *Aging and Old Age*, 223.
26. Sue V. Saxon and others, *Physical Change & Aging* (2002), 7.
27. Susan Jacoby, *Never Say Die*, 14.

28. Waneen Wyrick Spirduso, Karen L. Francis, Priscilla G. MacRae, *Physical Dimensions of Aging* (2004), 26.
29. Jacoby, *Never Say Die*, 12.
30. Lillian B. Rubin, *60 on Up: The Truth About Aging in America* (2007), 1.
31. Rubin, *60 on Up*, 7-8.
32. Mary C. Morrison, *Let Evening Come* (1998), 2-3.
33. Morrison, *Let Evening Come*, 3.
34. Colleen Johnson and Barbara M. Barer, *Life Beyond 85 Years* (2003), 7-8.
35. Colleen Johnson and Barbara M. Barer, *Life Beyond 85 Years* (2003), 3-6.
36. Johnson and Barer, *Life Beyond 85 Years*, 6.
37. *Handbook of the Psychology of Aging* (2011), 253.
38. Matthiessen, "How to Talk to the Elderly," Caring.com.
39. Posner, *Aging and Old Age*, 320.
40. Angie Williams and Jon F. Nussbaum, *Intergenerational Communication Across the Life Span* (2001), 44.
41. Posner, *Aging and Old Age*, 219, 360.
42. ageism: discrimination based on age, especially prejudice against the elderly. TheFreeDictionary.com.
43. Melissa Dittmann, "Fighting Ageism," APA.org/monitor.
44. Implicit. Harvard.edu/implicit/demo/background.
45. Todd D. Nelson, ed, *Ageism: Stereotyping and Prejudice Against Older Persons* (2004), ix.
46. Francis A. McGuire and others, *Therapeutic Humor with the Elderly* (1992), 60-61.
47. Nelson, ed, *Ageism*, 10-12, 17-18.
48. Williams and Nussbaum, *Intergenerational Communication Across the Life Span*, 62.
49. The "Patronizing Speech" section draws on these sources. Williams and Nussbaum, *Intergenerational Communication Across the Life Span*; "Patronizing Behavior: Where it Stems from, What to Do if You Dole it Out or Receive," sedonamethodcommunity.com; Angie Brown and Peter Draper, "Accommodative Speech and Terms of Endearment: Elements Of a Language Mode Often Experienced by Older Adults," *Journal of Advanced Nursing* 41(1).
50. Charles E. Schaefer, ed, *Play Therapy with Adults* (2003), 279.
51. Sherwin B. Nuland, *The Art of Aging: A Doctor's Prescription for Well-Being* (2008), 27-28, 59.
52. Lawrence A. Frolik, ed, *Aging And The Law: An Interdisciplinary Reader* (1999), 15.
53. "Normal Aging Changes," TexasInjuryAttorney.com.
54. Sue V. Saxon and others, *Physical Change & Aging* (2002), 7.
55. Mark L. Latash, *Neurophysiological Basis of Movement* (2008), 287.
56. "Normal Aging Changes," TexasInjuryAttorney.com; "Aging: What to expect as You Get Older," MayoClinic.com.

57. Latash, *Neurophysiological Basis of Movement*, 284.
58. TexasInjuryAttorney.com.
59. Saxon and others, *Physical Change & Aging*, 56.
60. Williams and Nussbaum, *Intergenerational Communication Across the Life Span*, 72.
61. Grace Lebow and Barbara Kane, *Coping With Your Difficult Older Parent: A Guide for Stressed-Out Children* (1999), 160.
62. Julie K. Silver, M.D., "Aging and Energy: Why Energy Levels Go down as We Get Older," Health.gather.com.
63. Saxon and others, *Physical Change & Aging*, 73.
64. "Normal Aging Changes," TexasInjuryAttorney.com.
65. Silver, "Aging and Energy," Health.gather.com.
66. fitnessihub.com/easing-aches-and-pains-of-old-age.
67. "Normal Aging Changes," TexasInjuryAttorney.com.
68. *Annual Review of Psychology* 46:1995.
69. The "sleep deprivation" section draws on these sources: "Sleep Disorders in the Elderly" *Psychiatric Times* 25.4; Julie K. Silver, M.D., "Aging and Energy: Why Energy Levels Go down as We Get Older;" and Sue V. Saxon and others, *Physical Change & Aging* (2002) 73, 99.
70. "Normal Aging Changes," TexasInjuryAttorney.com.
71. David Solie, *How to Say It to Seniors*, 2.
72. Robert Bounds Burns, *Essential Psychology: for Students and Professionals in the Health and Social Services* (1991), 79.
73. Robert C. Peck, "Psychological Development in the Second Half of Life" in *Middle Age and Aging*, ed. B. L. Neugarten (1968).
74.
Peck, "Psychological Development in the Second Half of Life."
75. Colleen Johnson and Barbara M. Barer, *Life Beyond 85 Years* (2003), 220.
76. Peck, "Psychological Development in the Second Half of Life."
77. Peck, "Psychological Development in the Second Half of Life."
78. HealthZone.ca/health/yourhealth/agingwell/article/856361--seniors-resist-help-at-home.
79. Colleen Johnson and Barbara M. Barer, *Life Beyond 85 Years* (2003), 55.
80. John W. Gibson. *The Dynamics of Aging Families: A Handbook for Adult Children* (2006), 24.
81. SeniorCareCentralpa.wordpress.com/2010/08/19/what-to-do-when-seniors-resist-help.
82.
Colleen Johnson and Barbara M. Barer, *Life Beyond 85 Years* (2003), 86.
83.
Wilfred Bion described this phenomenon in his *Experiences in Groups* (1980), but it can also apply to individual.
84. MerckSource.com >Resource Library.

85. "Why the Phrase 'Parenting Your Parents' is Demeaning," ElderCareLink.com.
86. Texas A&M University, "Adult Children and Aging Parents Series: Building Positive Relationships."
87. Karl A. Pillemer and Kathleen McCartney, eds., *Parent-child Relations Throughout Life* (1991) 29, 255.
88. *Life Beyond 85 Years*, 86, 99, 220.
89. Paul A. Hauck, *Overcoming Worry and Fear* (1975), 25.
90. Boomers-with-Elderly-Parents.com/elderly-parents-senior-concerns.
91. SeniorsBayArea.com/senior-care-blog/the-top-ten-fears-of-elderly-adults.
92. "Emotion and Aging: Experience, Expression, and Control," *Psychology and Aging*, 1997, 12:4.
93. Seniors-Site.com/coping/old_age.
94. *Psychiatric Times* 26.7 (July 2009).
95. CanadianImmigrant.ca/health/carefitness/article/1921.
96. UCLA Multicampus Program of Geriatrics and Gerontology.
97. The section "Our ears, our brains, and how you talk affect our speech comprehension" draws on these resources. "Age-related Hearing Loss," ncbi.nlm.nih.gov/pubmedhealth; G. Alexander Fee, "Use and Limitations of Hearing Aids," *Canadian Medical Association Journal*. 1947 April; 56(4); Mathias Hällgren, "Hearing and Cognition in Speech Comprehension," Linköping University Electronic Press; Lyn Frazier and others, "Prosodic Phrasing is Central to Language Comprehension," *TRENDS in Cognitive Sciences*, 10:6; *Mind, Mood & Memory*, 2009; Liz Peterson, "Learning How to Control Your Fast Rate of Speech," EzineArticles.com; Arthur Wingfield and others, "Effects of Adult Aging and Hearing Loss on Comprehension of Rapid Speech Varying in Syntactic Complexity," *Journal of the American Academy of Audiology*, 17; Modisett & Luter, *Speaking Clearly* (2006); George P. Moschis, *Marketing to Older Consumers* (1992); Norbert Schwarz, editor, *Cognition, Aging, and Self-reports* (1998); W. Stephen Smith, Michael Chipman, *The Naked Voice* (2007); Ann S. Utterback with Michael G. Freedman, *Broadcast Voice Handbook* (2005); Angie Williams and Jon F. Nussbaum, *Intergenerational Communication Across the Life Span* (2001).
98. Resources used in the subsection on "A Projected Voice, Not a Loud Voice" include "How to Project One's Speaking Voice," eHow.com; Olivia Mitchell, "How to Project Your Voice," SpeakingAboutPresenting.com; Carol Flexer, AudiologyCentre.com; Andrew Marsh, "Speech Intelligibility"; Williams and Nussbaum, *Intergenerational Communication Across the Life Span*; "When You're Using A Microphone," TotalCommunicator.com; "How to Use Microphones," MediaCollege.com; "8 Tips for Using a Microphone When Speaking," ismckenzie.com.
99. Smith & Chipman, *The Naked Voice*, 52.
100. "When You're Using A Microphone," TotalCommunicator.com.
101. "8 Tips for Using a Microphone When Speaking," ismckenzie.com.
102. Norbert Schwarz, ed, *Cognition, Aging, and Self-reports* (1998).
103. Lyn Frazier and others, "Prosodic Phrasing is Central to Language Comprehension," Docs.Google.com.
104. *Cognition, Aging, and Self-reports*, 217-218.
105. Diane DiResta, "Slow Down Speed Talking," Diresta.com.

106. "Presentation Tips for Public Speaking," aresearchguide.com.
107. Brenda C. Smith, "Why do Small Businesses Need Customer Service Voice Techniques?" BizyMoms.com.
108. Wingfield and others, "Speech Comprehension."
109. DiResta, "Slow Down Speed Talking," Diresta.com.
110. Schwarz, *Cognition, Aging, and Self-reports*, 224.
111. UNC.edu/depts/wcweb >Students Resources >Handouts >Speeches.
112. "Your Aging Digestive System," JohnsHopkinsHealthAlerts.com.
113. David B. Hogan, MD, "An Approach to Management of Gas in the Elderly," en.scientificcommons.org.
114. Richard A. Posner, *Aging and Old Age*, 112.
115. Posner, *Aging and Old Age*, 115-116.
116. Posner, *Aging and Old Age*, 116, 230.
117. Martin S. Lindauer, *Aging, Creativity, and Art*, 55-56.
118. George P. Moschis, *Marketing to Older Consumers*, 102.
119. *Life Beyond 85 Years*, 5-6.
120. "Your Aging Parents' Fears," Life.FamilyEducation.com.
121. LearnNotToFall.com/content/fall-facts/how-often.jsp.
122. CDC.gov/HomeandRecreationalSafety/Falls/adultfalls.
123. Orthopedics.about.com.
124. UCLA Multicampus Program of Geriatrics and Gerontology.
125. LiveStrong.com; HealthyLivingover40.blogspot.com.
126. Mary Pipher, *Another Country: Navigating the Emotional Terrain of Our Elders* (2000), 185.
127. Susan Jacoby, *Never Say Die*, 12.
128. Sherwin B. Nuland, *How We Die* (1995), 43-44, 72.
129. Robert Bounds Burns, *Essential Psychology* (1991), 84.
130. Johnson and Barer, *Life Beyond 85 Years*, viii-ix.
131. Colleen Johnson and Barbara M. Barer, *Life Beyond 85 Years* (2003), 202-206.
132. Susan Jacoby, *Never Say Die: The Myth and Marketing of the New Old Age* (2011), 210-211, 219.
133. Lillian B. Rubin, *60 on Up*, 1.
134. Johnson and Barer, *Life Beyond 85 Years*, 4.
135. Johnson and Barer, *Life Beyond 85 Years*, 233.
136. http://fcs.tamu.edu/families/aging/aging_simulation/index.php