1 THE BODY

"Speak up! I can't hear you!"

Sometimes it does seem as if older people are all hard of hearing. When people can't hear, they may ask to have things repeated a lot or they may tune out and become uninvolved in conversation. Younger relatives end

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up shouting to try to make themselves heard, and they can lose patience when the older people won't try hearing aids. Younger people may overreact to the stereotype of the hard-of-hearing older person by "talking down" to all older people. In one survey of 84 people over age 60, 39% reported that they had been patronized or talked down to at least once (Palmore, 2001).

It is true that certain types of hearing loss are typically part of the "normal" aging process, but shouting is not usually the solution. It is also true that there are barriers for some people to getting hearing aids, but stubbornness is rarely one of them. Yet the myth persists. For example, a press release about a University of Florida study on the effects of hearing loss in older adults explicitly mentions the stereotype of older adults as being stubborn about admitting hearing loss. In this section we discuss the effects of the type of hearing loss that is typical of aging, and the best way to speak to someone who has this problem. We also evaluate the most likely reasons people might have for not purchasing hearing aids.

Myth #1 It is best to speak to an older person as you would to a small child – loudly, slowly, and with exaggerated emphasis

There is little doubt that changes in hearing trouble a large proportion of older adults. Hearing loss is among the most common conditions associated with aging. It affects approximately 18% of adults aged 45 to 64, 30% of adults aged 65 to 74, and 47% of adults 75 years and older (National Institute on Deafness and Other Communication Disorders, National Institutes of Health, 2010).

The type of age-related hearing loss characteristic of most individuals as they grow older is called *presbycusis*. It can come on so gradually that older adults do not necessarily notice any decline in their hearing. Perhaps for that reason, they are not always ready to admit they have a hearing loss, blaming any difficulty they experience on the acoustics of the room or the fact that the speaker is whispering.

When people, especially younger adults, assume that older adults cannot hear very well, they do what comes naturally: they speak louder, and when that doesn't work, they shout. Increasing the volume of speech may be helpful up to a point. Unfortunately, if the volume is too high, there is generally little gain. In fact, increasing the volume of speech beyond a reasonable level often backfires because it can actually distort the spoken

message. Older adults may say, "I hear it but I cannot understand it," which illustrates a phenomenon called *phonemic regression*.

With presbycusis, there is typically greater difficulty associated with high-frequency than with low-frequency tones. Women's voices usually have higher frequencies than men's voices. For this reason, older adults typically hear men better than they hear women. Also, within the range of human speech, consonants such as *f*, *t*, *th*, *s*, and *z* are characterized by high frequency, so it is not surprising that older adults have difficulty discriminating among words with high-frequency consonants (e.g., "fit" and "sit"). If frequency rather than volume is the problem, increasing the volume will not be as effective as lowering the frequency. One way to do that would be to reword the message, substituting key words that minimize high-frequency consonants. Also, women can make an effort to drop their voices to a lower pitch rather than increase the volume.

Here is another issue related to hearing loss in older adults: processing language takes time on a central (brain) level, and there is slowing with age in cognitive processing. To some extent, slowing down the pace of speech can be beneficial. But if the pace is so slow that it does not conform to the natural flow of language, slowing down is not usually helpful (Kemper, 1994; Wingfield & Stine-Morrow, 2000).

Prosody is an aspect of speech that refers to emphasis. People are known to use what has been termed *motherese* when speaking to small children. Motherese is characterized by exaggerated prosody, as well as by an unnaturally high-pitched tone often coupled with terms of endearment (e.g., *honey*, *sweetie*, *dear*). When directed toward older adults, this type of speech has been termed *elderspeak*. Elderspeak is characterized not only by shortened sentences, simplified grammar, and slower speech, but also by exaggerated pitch and intonation (exaggerated prosody).

Kemper and Harden (1999) set out to determine which characteristics of elderspeak are beneficial for older adult listeners and which may not be. They had older adults watch and listen to a videotape of a speaker who was describing a route while also tracing it on a map. The older adults reported that instructions were easier to follow when the speaker reduced the grammatical complexity of the instructions (that is, minimized the number of subordinated and embedded clauses) and when the speaker used semantic elaboration (that is, repeated and expanded upon what was said). (Note that the sentence you just read is pretty complex in that way.) If the speaker used simpler grammar and semantic elaboration, older adults improved their accuracy when they had to reproduce the same route on a map of their own. In contrast, cutting the length of the speaker's sentences did not improve their comprehension of the

instructions, nor did it improve their performance when they traced a map of their own. Also, older listeners did not find it helpful when the speaker spoke at an unnaturally slow rate with many pauses or with exaggerated prosody. In short, being spoken to at a slower than normal speed and in atypically short phrases, as well as with exaggerated pitch and intonation, does little to enhance older adults' ability to comprehend speech.

Furthermore, even though typically well-intentioned, using elderspeak may not be a nice thing to do. Ryan and her colleagues (Ryan, Anas, & Gruneir, 2006; Ryan, Hummert, & Boich, 1995) contend that exaggerated prosody and terms of endearment are patronizing and often lead to a "communication predicament" situation: older adults feel uncomfortable when speakers use this manner of speech, so they prefer to withdraw altogether from any communicative interaction.

In sum, communication with older adults who have typical age-related hearing loss is most satisfactory when the language used by the speaker has reasonable volume but is not too loud. Speech should not be overly fast, but it should be no slower than the natural flow of the language and should minimize the use of high-frequency key words. It is also helpful if the speakers' sentences are not too grammatically complex and if the speaker states the message in several different ways (elaborates). Finally, it is important for speakers to face older adult listeners, who can then take advantage of visual cues such as reading the speaker's lips and seeing the speaker's body language. If it becomes clear that an older listener does not understand a message, changing the wording will probably be more effective than increasing the volume, slowing down speech to a snail's pace, or using exaggerated prosody. And elderspeak is related to baby talk, so it can be offensive.

Myth #2 Hearing aids are beneficial for older adults in just about any situation, but many are just too stubborn to use them

There is little question that as people grow older, they experience changes in both vision and hearing. People do not seem to be ambivalent about wearing eyeglasses to correct their vision, nor do they hesitate to visit an eye-care specialist for a change in prescription that will improve their visual acuity. Yet as many as 22.9 million older Americans have a hearing loss but do not own or use a hearing aid (Chien & Lin, 2012). Lin, Thorpe, Gordon-Salant, and Ferrucci (2011) estimate that only approximately one-fifth of older adults with hearing loss use a hearing aid.

Popelka et al. (1998) conducted a study on 1,629 Wisconsin residents ranging in age from 48 to 92, all of whom had a hearing loss, to determine the extent to which they made use of hearing aids. Only 14.6% used hearing aids. Furthermore, among a subset of the study participants with severe hearing loss, the prevalence of hearing-aid use was only 55%. A number of participants reported that they owned a hearing aid but no longer used it. This problem is not confined to the U.S. A large-scale study was conducted in Australia on hearing-aid use among 3,000 individuals aged 49 to 99, with an average age of 67 (Hartley, Rochtchina, Newall, Golding, & Mitchell, 2010). Although 33% of the participants had a hearing loss, only 11% owned a hearing aid. Of those who did own a hearing aid, 24% reported that they never used it.

Given that hearing loss is a frequent occurrence among the older population, why are older adults not lining up to get hearing aids? The myth is that they are just too stubborn to do so. But according to Lin et al. (2011), older adults, and indeed people in general, tend to undervalue the negative impact of hearing loss not only on the ability to communicate but also potentially on health and general well-being. In fact, in a survey of 240 people who had no sight or hearing deficits, approximately three-quarters would prefer to lose hearing rather than sight (Kim, Goldman, & Biederman, 2008).

Age-related hearing difficulties usually come on gradually and insidiously, so many people do not realize that their hearing has declined until the loss is significant. Older adults may complain that other people are mumbling, that there is something wrong with the acoustics (sound system) in a movie theater or playhouse, and so on. They often deny that the problem lies with their own hearing capability, which could well be a reason for their low rate of hearing-aid use.

At some point, however, hearing loss can become sufficiently severe that older adults are no longer able to deny it and are forced to recognize that their hearing difficulties are not solely attributable to other people's mumbling or poor environmental acoustics. Also, other people (often family members) start to broach the subject of hearing impairment with the older adults. Then why do many older adults who could benefit from a hearing aid not get one?

Before assuming it is just stubbornness that prevents older adults from obtaining and/or using a hearing aid, it is important to recognize that there are a number of other reasons. First, getting and/or wearing a hearing aid is likely to signify to people that they are growing older, certainly more so than is the case with eyeglasses, which are worn by people of all ages. This means that failure to get a hearing aid could stem from denial

about aging. In addition, some older adults may feel that wearing a hearing aid would make them look "stupid," and would signify that they are incompetent. In short, wearing a hearing aid is a threat to their self-image (Ryan, Hummert, & Anas, 1997, November). This fear is not completely unfounded, given the existence of ageism in the U.S. as well as other countries (e.g., Belgium, Costa Rica, Hong Kong, Japan, Israel, and South Korea), wherein older adults are considered to be sweet and warm, but feeble (Cuddy, Norton, & Fiske, 2005).

Failure to get or use a hearing aid for fear of being considered incompetent could well be a reason for the low rate of hearing-aid use among older adults. But nowadays, many people wear an earpiece to talk on the phone or listen to music. Also, many modern hearing aids are very small and can be reasonably well hidden. Even so, small hearing aids can be extremely costly for older adults living on limited budgets and may also be difficult to manipulate. Larger, less expensive ones may not look so "hip."

Another reason for older adults' low rate of hearing-aid use could be that it takes careful evaluation by ear, nose, and throat specialists and/or audiologists to determine whether a person with a specific type of hearing loss will benefit from a hearing aid. And when a hearing aid could help, it must be carefully tailored to a person's hearing loss. A hearing aid that amplifies all frequencies (even ones for which the wearer has relatively normal hearing) will be uncomfortable and probably not very useful. Many people try several hearing aids before they find one that works well for them (National Institute on Deafness and Other Communication Disorders, National Institutes of Health, 2001). Once again, there is the expense – hearing aids custom-made for an individual's specific hearing loss are costly and not covered by health insurance. Furthermore, hearing-aid owners do not just walk out the door after purchasing a hearing aid. Rather, they must be counseled on how to operate a hearing aid to achieve the maximum benefit. Popelka et al. (1998) suggest that to best deal with barriers to hearing-aid use, it may be necessary for hearing-aid professionals to offer users a long-term program of ongoing support and counseling.

Unlike eyeglasses, which can be prescribed to correct vision across a variety of situations, hearing aids may not be beneficial in every situation. Older hearing aids had limited usefulness in environments with background noise, such as restaurants with clattering dishes and multiple conversations going on (Schneider & Pichora-Fuller, 2000). Some older adults may have tried those in the past and become too frustrated to try the newer generation of hearing aids, which are better at reducing background noise. Also, expense is an issue: modern digital hearing aids

with circuitry that selectively reduces the amplification of noise are costly, though still not perfect (Hamilton, 2013). Even so, many older adults could benefit from a hearing aid even if their difficulties are not completely resolved. But successful hearing aid users need training in how to adjust the hearing aid, and professionals who fit older adults with hearing aids should be ready to provide support until older adults are confident that their use is worthwhile. One further consideration is that even though modern hearing aids may modify the intensity of sound, they do not address difficulties with auditory processing at the central (brain) level (Wingfield, Tun, & McCoy, 2005). The impact of hearing loss on cognitive functioning remains to be more fully determined (Chien & Lin, 2012).

In sum, hearing loss remains largely untreated in the older adult population. Hearing aids can assist with communication if they are properly fitted and if older adults learn how to make the best use of them. But based on the statistics mentioned earlier, older adults do not seem eager to purchase them, and even when they do, they do not always use them. Even so, to assume that older adults are just stubborn is shortsighted and overly simplistic. The reasons older adults do not use hearing aids include denial of aging, the desire not to seem old and stupid, the expense, the difficulty of getting the devices to work just right, and negative experiences with older and less precise models. It is important to fully understand the reason(s) many older adults elect to miss out on the conversation rather than wear a hearing aid if we want to be effective educators regarding the potential value of these devices.

You can't be too careful (or … falling down and crashing cars)

No one likes to fall down or crash a car. But older people, in their presumed frailty, seem most at risk. Is this because they actually fall and crash more than anyone else? Should we worry about our own older relatives whenever they go out on their own? What about making sure they get out from behind the driver's seat when they reach a certain age? The facts we examine in this section lead to the conclusion that the answer to each of these questions is a resounding *yes and no*. Older people do fall down. But maybe they don't worry about it as much as their younger relatives worry about it for them. As for problems behind the wheel, getting a driver for every Miss Daisy is not practical. Furthermore, it is not especially useful because older drivers don't crash cars all that much – it is safer to be on the road with them than it is to be on the road with

certain other age groups. Maybe we should consider getting a driver for every Ferris Bueller instead.

Myth #3

Older people worry too much about falling

Falls are a more serious concern for older adults than most people (including older adults themselves) actually realize. According to the Centers for Disease Control and Prevention (CDC, 2012), one out of every three adults over age 65 experiences a fall every year. Furthermore, plenty of folks fall more than once in a given year. In fact, falls are the leading cause of injury-related death in this age group. What about lasting consequences for those who do recover? Twenty to thirty percent of those who fall suffer moderate to severe injuries (e.g., hip fractures and head trauma), which can increase the risk of loss of independence and even early death. Although most otherwise healthy people who sustain these injuries are able to pick up their routines after treatment, those who had physical or cognitive problems before the injury may not be capable of returning to their former lifestyle.

Falls can happen anywhere, but well over half of them happen at home – during everyday activities (National Institute on Aging, National Institutes of Health, 2013). So staying home is not a good way to avoid falling. The floor might be wet, the rug might be loose, the nightlight might be out, and your shoes may be in the way. What if the bathroom does not have grab bars? If you lose your balance in the shower, you are going down!

The National Council on Aging (2013) sponsors a National Falls Prevention Awareness Day to convince older people not to think of falling as a normal part of aging. Some of the risk factors for falling include muscle weakness, balance or gait problems, blood pressure dropping when standing up, slow reflexes, foot problems, vision problems, confusion (even if it is brief), and medication side effects that lead to dizziness or confusion (and the more medications the greater the risk of that). When you think about it, most of these risks can be managed. People don't have to have weak muscles. They can exercise. They can use a cane or a walker if they have balance problems that can't be handled with medication. Many vision problems can be treated to some extent. Medication side effects can be monitored by a physician so that the person taking the medication does not have to fall down while taking it. Also, all of the things around the house that pose a danger can be improved.

Paradoxically, it turns out that fear of falling is itself a risk factor for falling. The fear can result in gait abnormalities and changes in postural control, both of which can increase the risk of falling (Delbaere, Crombez, Van Den Noortgate, Willems, & Cambier, 2006). Also, people who are afraid of falling down might limit their activities in order to avoid falls. This is a bad idea. Restricting activities can lead to physical decline (such as deconditioning, muscle atrophy, and poor balance) and could ultimately increase the risk of falls. Limiting activities might also result in limiting social contacts – this can lead to loneliness or depression (Scheffer, Schuurmans, van Dijk, van der Hooft, & de Rooij, 2008).

Despite the prevalence of falling, there is evidence that plenty of older people are not as worried as they should be. For example, Yardley, Donovan-Hall, Francis, and Todd (2006) held focus groups with 66 community-dwelling adults aged 61 to 94 in the U.K. to explore their perceptions of fall-prevention advice. These individuals tended to react positively to advice about the benefits of exercise for balance and mobility. However, their attitude was mixed when it came to lifestyle-related fall prevention suggestions. They explained that they had good reasons for the type of eyewear or footwear they used or for the furnishings in their homes, all of which carried some risk. For example, women who were 74, 78, and 88 years old and who had recently fallen rejected the idea of wearing padded hip protectors for reasons of vanity. A common response to the necessity for prevention advice was that it was important only for *other* people, typically people older than themselves. Some who had themselves recently fallen attributed the fall to a one-time lapse (e.g., inattention or illness). Some of the participants indicated that it was an issue of pride – getting a leaflet on fall prevention would imply that they are senile, ancient, or devoid of common sense.

In sum, if one in three of your peers fell down this year, why *shouldn't* you be worried? And not only that, but among some of your friends who have experienced a fall, life will not be the same ever again. Clearly, some older adults may worry about falling, but it is hard to say that they worry too much – the threat is real and should be taken more seriously by everyone. Of course, if fear limits older adults' enjoyment of life outside the home, it is too much fear – especially because the real threat is right there in the home! People do have to see to it that their homes are made as safe as possible. If a worry is based in reality, as is the fear of falling, then interventions (even at the family level) that aim to reduce the worry without reducing the risk are not ameliorating a problem that really can be helped. And let's not forget that only *some* older adults worry about falling. A significant number think that falling is someone else's problem.

Myth #4 Older people get into more car accidents than younger people

In a study of older driver stereotypes, young adult participants described typical older drivers as unsafe and dangerous (Joanisse, Gagnon, & Voloaca, 2012). News reports about accidents caused by older drivers are certainly sensational. There was the incident in an open-air market in Santa Monica in 2003 in which an 86-year-old man stepped on the gas pedal instead of the brake pedal. Ten people were killed and 63 were injured. We also read about incidents in which older drivers crash through walls, like the 89-year-old woman on her way to a hair salon in Marlboro, Massachusetts, in 2012. She was aiming for a handicap parking space in front of a storefront office but instead went flying though the hedges and into the building. No one was hurt that time, but she missed a group of people by only a few inches. Reports like these contribute to the myth that older people are more prone than any other age group to get into accidents and that we need to get older folks off the road.

However, the drivers we should really be most afraid of are the 16- to 19-year-olds. They actually have the highest number of moving violations and crashes. According to the U.S. Census Bureau (2012), in 2009, people 19 years and younger made up 4.9% of the drivers but accounted for 12.2% of the accidents. By contrast, people 75 and older made up 6.5% of the drivers but accounted for only 3.3% of the accidents. It is true that older people drive fewer miles overall than do people in other age groups, but even by those calculations they are not as dangerous as teenagers.

According to the Centers for Disease Control and Prevention (CDC, 2013b), older adults are doing some things right. More than three-quarters of older drivers and passengers who were in fatal car crashes in 2009 were wearing seat belts – a higher proportion than in any other age group. Older drivers are also more likely to take to the road when conditions are the safest, avoiding nighttime and bad weather. Furthermore, they are less likely to be driving while impaired. For example, only 5% of older drivers involved in fatal crashes had a blood alcohol concentration higher than .08, compared with 25% of drivers between the ages of 21 and 64.

According to the Insurance Institute for Highway Safety (IIHS, 2014), between 1997 and 2012, fatal crash involvement for drivers aged 70 and older declined at a faster rate than did fatal crash involvement for drivers aged 35 to 54. Furthermore, these reductions were the greatest among the oldest drivers (80+). Also, based on insurance claims, the IIHS found that

property damage claims start increasing after about age 65, but they never reach as high a level as the claims for the youngest drivers.

In a study of U.S. data on both fatal and non-fatal crashes, including data supplied by nine insurers, Braver and Trempel (2004) found that drivers aged 75 and older had actually killed fewer people outside of their own cars than did drivers aged 30 to 59. However, people inside their cars, including older drivers themselves, were not so lucky, perhaps because both they and their passengers tend to be frail. Non-fatal injury and property losses are a different story, however. Bodily injury liability claims nearly doubled for drivers aged 85 and older compared with those aged 30 to 59. Property damage liability claims were at their lowest for drivers aged 60 to 69 but increased dramatically after that, doubling for drivers 85 and older.

Let's get back to crashing into crowds at open-air markets and storefronts when drivers confuse the gas pedal with the brakes. What situations are really the most risky for older drivers? Intersections. Older drivers are much more likely than younger drivers to crash at intersections (Mayhew, Simpson, & Ferguson, 2006). Therefore, Braitman, Kirley, Chaudhary, and Ferguson (2007) studied the causes of intersection crashes among two groups of older drivers, those aged 70 to 79 and those aged 80 and older. Failure to yield the right of way was a problem that increased with age among older drivers, and it occurred mostly at stop signs, especially when drivers were trying to turn left. Admittedly, this is a complex situation, and it is particularly fraught for many of us. The researchers found that the drivers aged 70 to 79 made more evaluation errors such as seeing another car approaching but being wrong about how much time there was available to make the turn. Those 80 and over who crashed were more likely to have failed to notice the other car at all. Yikes! Thank goodness older drivers are not likely to be texting while driving.

As of June 2014, 29 states and the District of Columbia had implemented special requirements for people aged 65 or 70 and older who want to renew their drivers' licenses. These requirements vary, but include accelerated renewal cycles with shorter periods between renewals, requirements to renew in person rather than by mail or electronically, and testing that is over and above what is routinely required for younger drivers (e.g., road tests). If there is an issue about continued fitness for driving (e.g., a history of crashes, a report by a physician, or something noticed in the person's demeanor at renewal), states may require physical exams or a full retake of the standard licensing test – again, something not required for a typical renewal. Rather than refusing to renew a license

altogether, a state might impose restrictions based on the outcome of the tests. Restrictions might include prohibition of nighttime driving, requiring additional mirrors on the vehicle, or limiting the distance from home that a person may drive (IIHS, 2014).

Unfortunately, the effectiveness of such special regulations for license renewal has not yet been established. The Insurance Institute for Highway Safety cites studies showing that vision testing for older adults is associated with lower fatal crash rates. According to the IIHS (2014), one study found that states with laws requiring in-person driver's license renewals had a 17% lower fatality rate per licensed driver among the oldest drivers (85+) compared with states without such laws. However, the IIHS notes that another study found that for drivers aged 65 and older, fatality rates per licensed driver did not differ between states with laws and states without laws for vision testing, road testing, or shortened renewal periods.

There is some self-limiting going on, however. An IIHS study (2014) of over 2,500 drivers aged 65 and older in three states showed that as people get older, they drive fewer miles. They avoid night driving, make fewer trips, travel shorter distances, and avoid driving on interstate highways and roads that are icy or snowy. Even people who know they have been diagnosed with mild Alzheimer's disease have been shown (through real-life in-car video recording) to confine their driving to daytime hours, sunny weather, light traffic, residential environments, and situations that involve no passengers. In this case, it is likely that although they had passed their state road test in order to be eligible to participate in the study, they regulated their driving behavior based on the knowledge of their diagnosis (Festa, Ott, Manning, Davis, & Heindel, 2012).

With regard to the effectiveness of driver education for older adults, Marottoli (2007) conducted a study for the AAA Foundation for Traffic Safety to assess the effectiveness of an education program that included classroom and road training. Participants were 126 drivers aged 70 and older. The experimental group had two four-hour classes and two one-hour on-road sessions that were focused on common problem areas for older drivers. The control group had a different course in vehicle, home, and environment safety that was presented to them individually. They had no on-road sessions. After the intervention, the experimental group did better than the control group on both written tests and road tests. The IIHS (2014) notes, however, that we should be cautious about taking findings like this at face value because drivers who take these courses tend to have lower crash rates even before taking the course than do those who opt not to take these courses. That makes the effectiveness of these courses difficult to evaluate.

Now let's consider the reasons older people may have reduced competency behind the wheel. One we have hinted at already: visual acuity. The type of vision required for driving is quite complex. Researchers have focused on *useful field of view* (UFOV) to identify vision requirements for driving that may capture the type of vision needed for driving more realistically than the typical acuity test. As reported in the *Monitor on Psychology* (DeAngelis, 2009, November), psychologist Karlene Ball developed the concept of UFOV while still a graduate student. As its name implies, UFOV is the spatial area that you can pay attention to in a glance – without head or eye movement. It varies depending on the task and it also varies across individuals. Obviously, acuity is part of it, but so is the ability to ignore distraction, to divide your attention, and to process what is going on in that visual space both quickly and effectively. Thus, in addition to pure visual acuity, UFOV includes some cognitive abilities. There is ample evidence that UFOV declines with age (e.g., Sekuler, Bennett, & Mamelak, 2000) and that it is associated with driving performance in older adults (Ball et al., 2005).

Ball initiated the development of a computerized UFOV test (Visual Awareness Research Group, Inc., 2009) that consists of three parts designed to assess visual processing under increasingly complex task demands. In the first part (processing speed), the examinee identifies a target that is presented briefly (an icon of either a car or a truck) in a box in the center of a screen. In the second part (divided attention), the examinee does the same thing, but this time must also indicate where on the periphery another target (always a car) appears simultaneously. In the third part (selective attention), the task is the same as in the second part, but the car on the periphery is embedded in a field of 47 triangles. "'We do all kinds of things to mess them up!'" quipped Ball (DeAngelis, 2009, November).

UFOV seems to be amenable to improvement with training. In one study (Roenker, Cissell, Ball, Wadley, & Edwards, 2003), older adults who received speed-of-processing training were tested 18 months later. They improved on their UFOV test and undertook fewer dangerous maneuvers in an open-road driving evaluation. Unfortunately, it is not yet standard practice for states to test UFOV as a requirement for obtaining a driver's license.

In addition to UFOV problems, older adults experience more difficulties with divided attention than do younger adults. In one study (McKnight & McKnight, 1993), young, middle-aged, and older adults viewed videos of traffic situations and responded to them using simulated vehicle controls. At the same time, some of them engaged in distracting activities such as talking on a cell phone. The oldest group (aged 50 to 80) was

more likely than the other groups to make inappropriate responses on the simulated controls when distracted.

Additional factors may impair the ability of older drivers. For example, cataracts reduce contrast sensitivity by increasing glare. Reaction time slowing is a consequence of normal aging (Kausler, Kausler, & Krupshaw, 2007), and it is easy to see how reaction time could be a problem when drivers have to make a split-second decision about whether to step on the gas or the brake.

We've provided a few reasons why older adults might be at a disadvantage when driving. At the same time, we should recognize the wide variability among older adults with regard to reaction time and attentional capabilities. Also, many older adults recognize their limitations. As we have noted, they self-limit and drive only when they consider it likely that they will not have difficulties. Also, some older adults know that it can be risky to carry on conversations while driving – they recognize they must focus all their attention on the road when traveling to their destination. We know of one older driver who refuses to drive with a passenger because she realizes that she is safest if she is not distracted with conversation.

Giving up a driver's license is fraught with issues of independence for older adults. This is not surprising, given that (with a few exceptions in urban areas such as New York City) public transportation is not an adequate substitute for being able to drive one's own car. It would be reasonable, however, to initiate changes in the driving environment. More left-turn lanes and traffic light arrows would mitigate the dangers at intersections. So would replacing stop signs with traffic lights. Obviously, there is room for improvement by making signs more visible and by posting warning signs well in advance of danger areas. Making improvements in automobiles themselves is more problematic. If we add extra information to the dashboard that might help younger drivers, older drivers may be overloaded with too many things to pay attention to. However, devices could be installed to enhance environmental warnings. An extra sound coming from the car would be useful for someone who cannot hear the ambulance siren soon enough to pull over.

In conclusion, where do we stand on the myth that older people get into more accidents than younger people? They are emphatically safer than the youngest drivers. They are cautious about when and where they drive, they wear seatbelts, and they don't drink and drive as much as do younger people. True, age-related perceptual and cognitive difficulties can impair driving. Older people tend to be aware of these problems, but we can do better as a society to make the roads safer for them and thus for all of us. There is a lot of room for creativity in this endeavor, and understanding the needs of older people in this regard is the place to start.

Now that you don't have sex anymore…

Do older people lose interest in sex or do younger people resist the idea that they don't? Talking about older people's sexuality is a sure-fire way to find out where ageism is lurking in our society. According to the Pew Research Center (2009), for many people, losing interest in sex is literally a defining feature of old age: 46% of the 18- to 29-year-olds surveyed agreed with the notion that a person is old when he or she is no longer sexually active. In the sections that follow we will try to convince you that most grandparents and many great-grandparents are still feeling sexy and want to be attractive to potential partners. It is not really nice for people to assume otherwise; in fact, it is demeaning. Advertisers have learned that it pays to treat the situation with more respect. Grownups with bladder problems are not likely to buy products called *diapers*, so it seems only reasonable for everyone else to treat the medical problem of incontinence with more dignity. Nevertheless, 51% of adults aged 18 to 29 surveyed by the Pew Research Center (2009) endorsed the opinion that bladder-control problems are a marker for old age. Finally, let's accept the fact that some people are doing just fine by themselves. Not every older person needs to be married to be happy or to be safe.

Myth #5

Older people lose interest in sex

There is a great deal of research on the importance that people place on their sexuality across the lifespan. In general, there is no evidence that older people lose interest in sex. According to the National Social Life, Health and Aging Project (Waite, Laumann, Das, & Schumm, 2009), 73.6% of women and 71.7% of men aged 75 to 85 said that satisfactory sex is essential to maintaining a relationship. Even more telling is an AARP/*Modern Maturity* survey (AARP, 1999) of 1,384 adults aged 45 and older (average age was 60 for men and 61 for women), which found that only 1.9% of the men and 4.9% of the women agreed that sex is only for younger people.

Here's how 93-year-old Roger Angell, long-time editor at the *New Yorker*, speaks of the need for intimacy after the death of his wife:

> Getting old is the second-biggest surprise of my life, but the first, by a mile, is our increasing need for deep attachment and intimate love. We oldies yearn daily and hourly for conversation and a renewed domesticity … for someone close by in the car when coming home at night … This is why we

throng Match.com and OkCupid in such numbers – but not just for this … everyone in the world wants to be with someone else tonight, together in the dark, with the sweet warmth of a hip or a foot or a bare expanse of shoulder within reach. (2014, February 17 & 24, p. 65)

Apparently, sex is important to the majority of older adults, but how is this fact reflected in their behavior? In a study of 2,783 Australian men aged 70 to 95 (Hyde et al., 2010), one-third reported that they were sexually active. In a U.S. study using data from a nationally representative sample of 3,005 adults who participated in the National Social Life, Health, and Aging Project, 72% of the men and 45.5% of the women aged 57 to 72 reported that they were sexually active (Karraker, DeLamater, & Schwartz, 2011). Waite et al. (2009) found that for those heterosexual men and women aged 75 to 84 (in the same National Social Life, Health, and Aging Project sample) who did report being sexually active, the rates of sexual activity remained constant from age 65 to 75 with only a small decline after that. As for the type of sexual activity in which they engaged, 87% of women and 91% of men between the ages of 57 and 84 said that vaginal sex was always or usually part of their sexual activity. Individuals between the ages of 75 and 85 reported somewhat less frequent vaginal intercourse, but no decrease at all in hugging, kissing, or other sexual touching.

Despite the desire for a full sexual life, there can be barriers to sexual activity in the older age group. For heterosexual women, the lack of an available partner is a serious problem. Starting at age 40, there are more women than men in the population, and by age 85 the ratio is about 2 to 1 (Karraker et al., 2011). Add to that the fact that older men tend to choose younger women when they become widowed or divorced, and the pool of available men for older women is even more diminished. Susan Sontag (1972, September 23) put this dilemma in emotional terms: "Thus, for most women, aging means a humiliating process of gradual sexual disqualification" (p. 32).

The disproportionate sex ratio also means that older men are more likely than older women to be married – 72% of men aged 65 and older are married but only 45% of women aged 65 and older are married (U.S. Department of Health and Human Services, Administration on Aging, Administration for Community Living, 2012). According to Karraker et al. (2011), a change in marital status is unrelated to any decline in sexual activity for men aged 57 to 85. Among women in that age range, however, the change from married to widowed explains a good part of any decline in sexual activity. In a survey of a nationally representative

sample of people aged 57 to 85, Lindau et al. (2007) found that of those who were not in a marital or other intimate relationship, 22% of men and 4% of women reported they had been sexually active in the previous year. Clearly, the lack of an available partner interferes with sexual frequency for women more than it does for men.

When people answer surveys about their interest in sex, they may be influenced by their own life situation. That is, it's possible to imagine people saying they are not interested in having sex if there is nobody available for them to have sex with. Even so, they may still feel sexy, so perhaps they masturbate. DeLamater (2012) looked at data on masturbation from the National Survey of Sexual Health and Behavior conducted in 2009. It turns out that adults aged 70 and older engage in a fair amount of masturbation: 46% of men and 33% of women reported engaging in solo masturbation. However, there does seem to be a decline with age: 72% of men and 54% of women in their 50s reported that they masturbated alone.

Does decline in physical health explain some of the decline in sexual activity? Yes, it does, and some studies (e.g., Karraker et al., 2011) indicate that this is especially true for men. Lindau et al. (2007) found that in a sample of over 3,000 men and women aged 57 to 85 who were in an intimate relationship but had been sexually inactive for three months or more, the most common reason for sexual inactivity was the male partner's physical health. Any decline in a husband's health is bound to affect the frequency of partnered sexual activity for the wife as well. A study conducted by the AARP in 2010 shows a strong relationship between a positive rating of one's health and reported frequency of sexual intercourse. In another AARP survey (1999), among the oldest respondents (aged 75 and older), only 45% of men and 13% of women said they had any condition that restricted sexual activity. Once again, note that men's physical health status is probably more responsible for any decline in sexual activity for older couples. Finally, what about those sexual problems we hear so much about – erectile dysfunction, menopausal issues, and so on? Of respondents to the 2010 AARP survey, 29% of men and 13% of women responded "yes" when asked if they had ever had problems with sexual functioning. The percentage reporting problems increased with age for men (23% for those aged 45 to 49 and 38% for those aged 70 and older), but there was no increase for women.

Let's look at erectile dysfunction (ED) first. Shabsigh (2006) reminds us that back in 1948, Kinsey found that the prevalence of ED increased with age from 0.1% at age 20 to 75% at age 80. These percentages of ED by age still seem to apply today. A study conducted by the Harvard School

of Public Health (Bacon et al., 2003) on more than 31,000 men aged 53 to 90 also indicates that, sure enough, not much has changed: fewer than 2% of the men in the study who reported that they had erection problems experienced them before age 40. The increase in the percentage who experienced problems was steady thereafter: 4% between ages 40 and 49, 26% between 50 and 59, 40% between 60 and 69, and 71% for men aged 70 and over. The good news is that the men in that study who were physically active, didn't smoke, drank alcohol only moderately, and generally kept their cardiovascular system healthy (an erection is a vascular phenomenon, after all) had a 30% lower risk than the rest. And don't forget, there is treatment today for ED that wasn't around in Kinsey's era: Viagra®, Cialis®, Levitra®, and others. As of 1999, about 10% of men reported that they had used medications or hormones to improve sexual function (AARP, 1999).

Television commercials for Viagra and Cialis have made ED easier to discuss among the general population. However, changes in women's physiology with age haven't gotten as much (positive) screen time. For older women, postmenopausal vaginal changes are a concern. With menopause, levels of estrogen decline, and this causes the tissue lining the inside of the vagina to become thin. In turn, this causes other cell and tissue changes that result in decreased vaginal blood flow and vaginal lubrication. In addition, pH changes cause certain bacteria to proliferate, which in turn can cause infection and inflammation that can make intercourse painful. MacBride, Rhodes, and Shuster's (2010) review of studies on this topic indicated that the prevalence of these symptoms is about 4% in early premenopausal women, but it increases to 47% in late postmenopausal women. They also note that breast cancer survivors – over 2.8 million women in the U.S. as of September, 2013 (American Cancer Society, 2013) – have a higher rate of vaginal symptoms because treatments for breast cancer can affect hormone levels.

Thus, it is possible that nearly half of older women suffer pain during intercourse due to lack of lubrication, frequent urinary tract infections, small tears in the vaginal tissue, and so on. Low-dose vaginal estrogen cream may be a good solution for many of them. Over-the-counter long-acting moisturizers like Replens® can be effective. And of course there are lots of lubricants for use during sex – and we do see those products beginning to appear in TV ads. Unfortunately, current cohorts of older women are a bit shy about reporting pain during intercourse to their physicians. Furthermore, they may have bought into the very myth that we are discussing: sex is for the young. Therefore, they do not seek treatment and we do not have accurate statistics about prevalence. But

perhaps the cohort of women who are in their 50s and early 60s today came of age at a time when it was less difficult to discuss sex, and they may report problems to their physicians with greater alacrity.

One thing for sure is that the "ick" factor, which is part of the current culture on issues of older adult sexuality, is one of the more blatant forms of ageism in today's society. Young adults do not want to think about their grandparents having sex with each other or masturbating when they are thought to be reading alone in their beds. Advertisements for ED drugs play into this stereotype by featuring men who appear to be middle-aged – men who look fit and are just beginning to gray but are feeling sexy about their stylish, 40ish female companions. There is no 75-year-old in the picture. The same goes for ads for vaginal lubricants (oops, the products are called *personal lubricants*, perhaps because people don't want to ask a salesperson for help finding a product with *vagina* in its name).

But get ready for some edgy new advertising. Late in 2012, Canadian ads for Mae by Damiva® (think dame, diva, and Mae West – remembered for her raunchy sexuality in films of the 1930s and 1940s) look like this: "Get ready to feel like a teenager again, but with better judgment. Hi, I'm Mae and I naturally restore vaginal moisture. Your vagina, and your honey, will thank you" (Cullers, 2012, November 28).

Another way that ageism about sexuality can play out is in the infantilizing of the romantic side of older adult relationships. "Aren't they cute?" is a way of desexualizing an affectionate older couple. When people think this way, they are able to look at an older couple (who are, for example, holding hands in public) and not have to think about what they do in bed – it's as if a pair of 4-year-olds were holding hands.

The fact that our culture desexualizes older adults can ultimately present problems for them. They may be less informed about how to protect themselves from and monitor themselves for STDs. However, STDs can be a problem even in late adulthood. It's also easy to imagine that when older adults go through a course of rehabilitation (e.g., after a broken hip), there are sex positions that would be safe and comfortable for them, but it is unlikely that this issue is covered in every rehabilitation environment. Also, as DeLamater (2012) suggests, some older people are under the mistaken impression that they should not have sex if they or their partners have had major health problems, such as heart attacks. If they don't obtain adequate sex education from medical personnel, they may buy into the stereotype that they should not be interested in sex anymore.

Many people find it disturbing that even people with dementia who reside in nursing homes may seek sexual intimacy. Bryan Gruley at

Bloomberg.com (2013, July 22) recently reported on a case from an Iowa nursing home. A 78-year-old man was found having intercourse with an 87-year-old woman. Both had dementia. The question for the nursing home administrators was whether these residents had the capacity to consent. Federal and state laws require that nursing homes respect residents' right to privacy but also guarantee their safety. This requirement is enforced very differently in different locations. In the Iowa case, the authorities decided that both residents were calmer and happier together than apart. However, the woman's family filed a lawsuit against the nursing home, claiming that she had been raped. Yet Gruley cites experts who argue that even when people are too cognitively impaired to make financial decisions, they are able to decide whether they want to have sex at any given moment.

Bottom line: It is a myth that all older people lose interest in sex, though some may. There are health problems, both general and sexual, that do increase with age, but the majority of people can be treated for them. Nevertheless, one thing is certain: Young people do not like to think that older people (especially their parents and grandparents!) are having sex or even thinking about it, as dramatized by this interchange between Homer Simpson and Grampa Simpson:

GRAMPA: "Welcome home, Son. I broke two lamps and lost all your mail. What's wrong with your wife?"
HOMER: "Never mind, you wouldn't understand."
GRAMPA: "Flu?"
HOMER: "No."
GRAMPA: "Protein deficiency?"
HOMER: "No."
GRAMPA: "Pneumonoultramicroscopicsilicovolcanoconiosis?"
HOMER: "No."
GRAMPA: "Unsatisfying sex life?"
HOMER: "N– yes! But please, don't you say that word!"
GRAMPA: "What, seeeex? What's so unappealing about hearing your elderly father talk about sex? I had sex."

Myth #6

Older women do not care about their looks

Look at the birthday cards in the "humor" section of your local card shop. Such cards exemplify the cultural stereotype that older women tend to be saggy, baggy, and dowdy. Greeting cards certainly do their share to perpetuate a myth that older women are unattractive and have no interest whatsoever in looking physically appealing and chic.

In her classic essay, Sontag (1972, September 23) observed that in American culture, there is a *double standard of aging* – we view signs of aging more negatively in women than in men.

> Only one standard of female beauty is sanctioned: the *girl*. The great advantage men have is that our culture allows two standards of male beauty: the *boy* and the *man* … A man does not grieve when he loses the smooth, unlined, hairless skin of a boy. For he has only exchanged one form of attractiveness for another … There is no equivalent of this second standard for women … Every wrinkle, every line, every grey hair is a defeat … the standard of beauty in a woman of any age is how far she retains, or how she manages to simulate, the appearance of youth.(p. 36)

Of 3,200 women aged 18 to 64 who participated in a global study by Etcoff, Orbach, Scott, and D'Agostino (2004), only 2% considered themselves to be beautiful. A larger proportion of these women were more comfortable calling themselves *natural* (31%) or *average* (29%). Many of the women, especially those who were more satisfied with their own appearance, thought that non-physical factors (e.g., happiness, confidence, dignity, humor, and intelligence) contribute to making a woman beautiful. Those who were less satisfied with their appearance were more likely to think that cosmetics make a woman beautiful. Nevertheless, 89% of the respondents strongly agreed that "A woman can be beautiful at any age" (p. 40). At the same time, 75% of the women strongly agreed that they wished "the media did a better job of portraying women of diverse physical attractiveness – age, shape and size" (p. 43). The older women in this study (aged 45 to 64) expressed a clear interest in seeing attractive women of different ages depicted in the media.

Some women are bound to respond to ageism by minimizing visible signs of their own aging as much as possible (including everything from hair dye to cosmetic surgery). This behavior is sometimes referred to as *beauty work*. Hurd Clarke and Griffin (2008) interviewed 44 women aged 50 to 70 about beauty work. More than half of the women admitted to using hair dyes, and 37 out of the 44 said they used make-up. A small number (6 or fewer) reported that they had had surgical procedures (e.g., liposuction) or non-surgical cosmetic procedures (e.g., chemical peels, Botox®).

Cosmetic procedures have become more popular every year. The American Society for Aesthetic Plastic Surgery (2012) reported that in the years 1997 to 2012 there was an 80% increase in the number of cosmetic surgical procedures performed and a nearly 500% increase in the number

of minimally invasive procedures (e.g., skin resurfacing). If older women do not care about their looks, how can we explain the fact that, in 2012, 30% of surgical procedures and 38% of nonsurgical procedures performed were on people over the age of 50? Eyelid surgery (85% were women), facelifts (90% were women), and liposuction (87% were women) were the most popular surgeries in that age group, whereas breast augmentation and nose jobs were more popular with younger adults. Some of the women in the Hurd Clarke and Griffin (2008) study who had had beauty work done gave reasons related to their attempts to feel less invisible to potential sexual partners. Another reason for beauty work was to avoid feeling discriminated against in the workplace. In general, these women acknowledged that the societal emphasis on youthful appearance affected their self-esteem.

How do we feel about others who do beauty work? Harvard Medical School researcher Nancy Etcoff, quoted in the *New York Times* (Ellin, 2011, August 8), is supportive of women who want to have procedures that make them look younger: "'If an older woman wants to regain eyelids or wants a breast that she doesn't have to tuck into a waistband, then why not?'" Etcoff contends that our culture offers mixed messages about older people who actively look for romance. "'Here we are in the age of Viagra, which is very well accepted, but suddenly the idea of older people, mostly women, wanting to be sexually attractive at that age makes us uncomfortable.'"

Harris (1994) investigated how people judge others who use cosmetic procedures such as hair dye, facelifts, and wrinkle cream. Participants (men and women aged 18 to 80) read a scenario about a man or a woman who was described as having gray hair, sagging skin, and wrinkles. Half of the participants were told that the man or woman in the scenario used age-concealment techniques. As we might expect, respondents thought that most of those physical signs of aging were unattractive. Even so, they did not have a favorable view of those who used age-concealment techniques, although they found it somewhat more acceptable for women than they did for men. Ironically, however, respondents (both male and female) found it perfectly acceptable to use these techniques on themselves. Go figure.

In the years since Sontag wrote her 1972 essay on the double standard of aging, evolutionary psychologists have weighed in on why the double standard might exist. In a classic study, Buss (1989) argued that men value physical attractiveness and youth in women because they see it as a cue of health and thus high reproductive capacity. By contrast, in all 37 of the cultures that Buss studied, women preferred somewhat older men.

He contends that older men are desirable because their mature age provides cues for longevity, maturity, prowess, and experience – all cues that they will be good providers. Buss reminds us that this preference seems to exist even among nonhuman species. This theory has not been without controversy, but there has not been much disagreement about the fact that older men seem to make acceptable mates for younger women, but most often not the other way around.

What about gay men and lesbians? This gets complicated, and the prediction here is not as straightforward. Silverthorne and Quinsey (2000) asked 18- to 52-year-olds to look at facial pictures of people of different ages and rate how sexually attractive they found each face to be. Regardless of their sexual orientation, men showed a preference for the younger faces of their preferred sex. For both straight women and lesbians it was the reverse – regardless of their sexual orientation they preferred the older faces of their preferred sex. Thus, regardless of sexual orientation, the double standard holds up: men want younger partners and women want older partners.

However, in a study that included both straight and gay men and women aged 16 to 83 (Teuscher & Teuscher, 2007), everyone rated the younger-looking faces they were shown as more attractive than the older-looking faces – and this was the case for both male and female raters regardless of their sexual orientation. Nevertheless, if they were told that the face was a potential sexual partner (i.e., a man's face for a straight woman or a gay man and a woman's face for a straight man or a lesbian), the men's preference for youth was more pronounced than the women's preference.

Given the stigma of physical aging, the recent trend to emphasize stylish aging is especially interesting. Take a look at Ari Seth Cohen's blog (http://advancedstyle.blogspot.com/) or book (*Advanced Style*) for some images of fabulous women over 60. The over-50 crowd now includes celebrities such as Holly Hunter, Michelle Pfeiffer, Sharon Stone, Melanie Griffith, and Madonna. Www.askmen.com names the top 10 sexiest ladies over 60: Meryl Streep (b. 1949), Helen Mirren (b. 1945), Susan Sarandon (b. 1946), Lauren Hutton (b. 1943), and Tina Turner (b. 1939) are on the list.

In a *New York Times* feature, Mireille Silcoff (2013, April 26) speculates on a phenomenon she calls *Eldertopia*, which is a "pro-aged paradise lovingly promoted by people who are themselves not even close to middle-aged." She claims that the interest in "cool old people" is a way of saying, "'This is how I want to be when I get old.'" This view may explain how a 2010 Facebook petition got actress Betty White (b. 1922)

to host *Saturday Night Live*. Silcoff thinks the driving force for the trend toward Eldertopia is related to the stress the younger generation feels about having to live up to cultural norms. They would like to think that they can age into a feeling of being immune to that pressure – they can stop worrying about looking hot or being cool, and instead, achieve this "chosen aesthetic – this doddering chic … the imagined authenticity of old age."

In addition to the possibility of a stylish older age, there seems to be a gradual cultural shift, which values a look that implies vital middle age. Dr. Macrena Alexiades-Armenakas is a dermatologist with a Park Avenue practice who was profiled in a *New York Times* feature (Schwartz, 2013, July 31). She has developed a highly successful practice that includes New York professional women concerned about being perceived as too old. However, they are not looking for a youthful image. Rather, they are "aiming for a cosmetic sweet spot: old enough to command respect, yet fresh enough to remain vital … eternal early middle age."

In summary, it seems that older women do indeed care about their looks. They are fully aware of the double standard of aging and they know that reducing signs of physical aging is in their best interest. It should not be surprising that women have most of the cosmetic procedures. Fortunately, we are entering a period that may be getting friendlier to older women, as evidenced by the recent hype about chic older women who maintain their style without disguising their age.

Myth #7 Older people need to wear diapers, and how sexy is that?

There is a myth that as people grow older, they are bound to have serious issues with bladder control and, inevitably, they will experience sufficient leakage to necessitate the need for diapers. Let's start with an explanation of the medical issues that could result in leakage. Urinary incontinence (UI) is the loss of bladder control (the National Institutes of Health website is a good source for information about this topic: http://www.nlm.nih.gov/medlineplus/urinaryincontinence.html#cat1).

UI actually includes everything from a little leak to a complete wetting. If it occurs because bladder muscles are weak, then it is the sort of leaking that occurs with sneezing or having a giggle fit. That is called *stress incontinence*, which is the most common type of UI and is usually a problem for women more than for men. Stress incontinence can affect even young and middle-aged women. In fact, childbirth can weaken those muscles.

If bladder muscles are too active, the reverse can happen – you feel you have to go but you really only have a bit of urine in your bladder. That is called *urge incontinence*. This sort of UI can increase with age. Urge incontinence is a problem because even though you don't have much urine to pass, you may not make it in time to the bathroom. Urge incontinence can occur with diabetes, Alzheimer's disease, Parkinson's disease, multiple sclerosis, and stroke.

Another type of UI, *overflow incontinence*, can happen when a little bit of urine leaks from a bladder that always seems full. This is often a male problem and can be caused by an enlarged prostate. Finally, *functional incontinence* occurs when you can't make it to the bathroom because of some unrelated problem such as arthritis, which makes it hard to move quickly.

How prevalent is UI? In a large study that sampled people with AARP Medicare supplement insurance (Hawkins et al., 2011), 37.5% of the respondents reported having some type of urinary incontinence. In addition to advancing age, the strongest predictors were being female and being obese. For the people in this study, the negative effect of UI on quality of life (both physical and social well-being) was even greater than that experienced with problems such as diabetes, cancer, and arthritis. Yet, only 59.4% of the respondents said they had spoken to their doctor about it. This fact is surprising, especially in light of a study by Sims, Browning, Lundgren-Lindquist, and Kendig (2011), which found that mood was negatively affected even when individuals had only low levels of urge incontinence.

Fortunately, there is help for many older adults who do have UI. Pelvic muscle exercises (*Kegel exercises*) are prescribed to strengthen the muscle that helps you hold it in. Holding it in is an important skill that is taken for granted by those who can do it. Another treatment sometimes recommended is called *timed voiding*, which involves urinating on a schedule.

In some cases, lifestyle changes are called for: losing weight, giving up smoking, cutting down on alcohol and caffeine. In some cases medications can be prescribed, depending on the cause of the problem. For example, estrogen cream is sometimes helpful for older women with mild stress incontinence. Surgery may be an option if UI is due to the position of the bladder or to an enlarged prostate.

Not only can UI be treated, but in many cases it can be prevented (Sievert et al., 2012). By middle age, women can begin to work on strengthening their pelvic floor muscles as part of an exercise routine. With lifestyle changes in at-risk populations such as those with obesity and diabetes (which can affect bladder functioning), UI can often be

prevented. Providing information about the risk of incontinence to such people can be a motivator. What about the risk factor of childbirth? Pelvic floor muscle training may help those women too.

Now that we've gone over some facts on incontinence, let's move on to hygiene products that are designed for those who experience UI but have not been able to treat the problem with other means. Used effectively, such products can have a positive impact on the quality of life and can reduce any feelings of self-consciousness in those with UI. Unfortunately, such products are sometimes referred to as *adult diapers*. We noted in the myth "Older people lose interest in sex" our objection to infantilizing older adult sexuality ("Aren't they cute") as a way of desexualizing older adults for the comfort of younger adults. So what does it mean when we refer to urinary incontinence products as diapers? We don't refer to hygiene products related to menstruation as diapers. Interestingly, manufacturers are beginning to realize that they will be more effective in marketing such products to the large baby boomer generation if they respect these individuals and take care not to patronize them. To wit, these products are rarely referred to as diapers anymore. For example, Depend® (one of the major suppliers) advertises hygiene products as underwear and briefs, not diapers. And this company is beginning to court men in a specific advertising campaign (Neff, 2013, April 22):

> Former National Football League defensive tackle Tony Siragusa is telling men to put on pads – and it has nothing to do with football … It's the first time the Kimberly-Clark Corp. brand has used media advertising to highlight light bladder leakage for men, something the company says afflicts 23 million – including one in five men over 60 – a phenomenon far less discussed publicly than the same problem for women … Only 20% of men who suffer light bladder leakage use any products for it at all, and many who do so use women's products, [the Deputy Brand Director] said. The rest rely on makeshift solutions such as wadded up paper towels and toilet paper – or simply nothing and change their clothes as needed. Depend has had the Guards product on the market for years, but without specific media support, and is launching the smaller Shields as part of the new campaign. Both products have been designed or redesigned "to be more masculine."

In summary, UI is not inevitable in older adulthood. It can be a problem for about one-third of older adults at some time, but in many cases there are ways to treat it effectively. However, if people are shy about reporting it to their physician they are unlikely to get the help they need. Yet it is extremely important that they do so, because UI can have a negative impact on quality of life. It seems obvious that it would be

beneficial for people to view UI as just another medical problem that needs diagnosis, treatment, and management. If the problem had less stigma associated with it, we would undoubtedly see a reduction in the negative psychological impact UI has on the people who experience it, and we would also see more people being proactive in managing the symptoms.

Myth #8 It's always best for older adults to be married rather than single

As of 2012, 72% of men and 45% of women aged 65 and older were married (U.S. Department of Health and Human Services, Administration on Aging, Administration for Community Living, 2012). Are those married folks better off than the rest? The rest add up to an awful lot of people, after all. Are all of those married folks healthier, happier, less lonely, less depressed, and more satisfied with their lives than their unmarried counterparts?

Before we attempt to answer this question, we should note that *married* is not the only way to think of *not single*. We are fully aware that lots of people who are living in long-term committed relationships are not officially married. However, the research we rely on when we discuss this myth has been undertaken with married people as participants. Even so, we can certainly think more inclusively about this group. So when we use the term *married* in the discussion that follows, it is likely that what we say applies to couples who live as if married but who, for one reason or another, do not have a marriage license.

Clearly, being married has its advantages, so claiming that it's always best for older adults to be married does not seem like much of a myth. It goes without saying that combined households are more efficient economically than single ones. Also, as couples segue into their later years, it sometimes happens that one partner develops health issues that limit what he or she can do. Usually the other partner does not have the identical difficulties or limitations. This means that one member of an older couple may need help with something that the other member is capable of providing. In one instance we know of, the wife has such severe arthritis that she cannot drive herself to her frequent medical appointments or to the grocery store. In fact, there are very few days when she is well enough to navigate a grocery store even if someone drives her there. Fortunately, her husband is a capable driver, and he is certainly able to purchase whatever groceries the couple needs. Despite her disabilities, the

wife is still capable of cooking and enjoys it, which is a good thing because the husband has no skills in the kitchen.

According to the U.S. Department of Health and Human Services, Administration on Aging, Administration for Community Living (2012), women make up more than two-thirds of the nursing home population. Why do we see nursing homes and assisted living facilities more populated by older women than by older men? A likely reason is that women tend to marry men of the same age or older. This, combined with women's longer life expectancy, means that women are more likely than men to be widowed and left living on their own and unable to manage in their later years. Living with a partner might have been a way to age more comfortably at home.

Given all we have reviewed, how can the statement, "It's always best for older adults to be married rather than single" be a myth? Well, simply because it is becoming more apparent in recent years that marriage may not be for everyone. This was illustrated pointedly in a classic study by Tucker, Wingard, Friedman, and Schwartz (1996), who examined data from 1,077 men and women who participated in the Terman Life-Cycle Longitudinal Study that was initiated in 1921. Terman's study participants were a select group of intelligent, educated, middle-class, primarily European American children born in 1910. Tucker et al. categorized the Terman study participants according to their marital status as of midlife (in 1950) as follows: (1) consistently married (married with no prior marital breakups); (2) inconsistently married (married, but with a prior marital breakup); (3) separated or divorced; (4) single. When the mortality of these individuals was checked in 1991, those who were married as of 1950 had lived longer than those separated or divorced as of 1950. So at first blush, it does appear that being married is preferable. However, several additional findings remind us that we should not jump to conclusions. First, in this select sample of educationally and economically privileged individuals, those who were single as of midlife (1950) had no greater mortality risk than those married as of 1950. Second, particularly for men, those who were married at midlife but had already experienced a marital breakup (inconsistently married) had a higher mortality risk than those who were consistently married. Tucker et al. speculated that marital breakup may have long-term negative effects that are not completely reduced by remarriage. Or perhaps marital inconsistency is associated with lower conscientiousness about health. In any case, Tucker el al.'s findings indicate that we should exercise caution before assuming marriage is a uniformly protective factor when it comes to longevity.

People often assume that couples married for decades are happy, satisfied, and in agreement on most issues. Carstensen, Gottman, and Levenson (1995) and Levenson, Carstensen, and Gottman (1993) studied middle-aged couples (aged 40–50 and married at least 15 years) and older couples (aged 60–70 and married at least 35 years). These couples, most in first marriages, lived in Berkeley, California, and were predominantly European American, upper-middle-class, and well-educated. The good news is that, overall, older couples reported fewer disagreements than middle-aged couples. Even so, there was considerable variation in study participants' responses to a self-report questionnaire on marital satisfaction. Those lower in satisfaction reported more disagreements than those higher in satisfaction. And among couples who were less satisfied, wives reported more physical and psychological symptoms than husbands did. It seems that as a group, men may be better off when married, but women are better off only when *happily* married. When the relationship is not fulfilling, women suffer more (physically and emotionally), whereas men tend to buffer themselves against health problems by withdrawing from conflict (Levenson et al., 1993).

In addition to collecting self-report data on marital satisfaction, Carstensen et al. (1995) made video recordings as each couple interacted during the course of a 15-minute conversation about a problem that they claimed was causing continuing disagreement in their marriage. Objective observers rated the emotional affect shown by members of the pair with regard to verbal content, voice tone, facial expression, gestures, and body movement. Compared with the middle-aged couples, the older couples displayed less emotion, both positive (interest, humor, joy) and negative (anger, disgust, belligerence, defensiveness, whining). However, in both middle-aged and older couples there were gender differences: the wives' facial expressions and verbal interactions showed more emotion, both positive and negative. In contrast, the husbands' facial expressions were more neutral and their verbal expression of emotion was more restrained. Husbands in the dissatisfied couples were especially avoidant of conflict.

Overall, these findings illustrate that even after many years of marriage, some couples are happy and satisfied, but others are not. Even in long-term marriages there can be dissatisfaction and negative emotions, though older couples may show more restraint in expressing them. In general, however, women seem to be more negatively affected by disharmony. Men may be better able to weather difficulties in a marital relationship.

When we refer to older adults who are not married, we must remember that they can be single for several reasons. Some older adults have always been single (never married), a category that is likely to become more

common than it was in earlier decades. According to the CDC (2013a) the marriage rate in the U.S. has declined from 8.2 per 1,000 to 6.8 per 1,000 just in the first decade of the 21st century. DePaulo and Morris (2006) contend that despite the negative stereotypes associated with being single – the term they use is *singlism* – their review of research findings indicates that those who have always been single do not differ much in health and happiness compared with those who have been continuously married.

Some older adults are single because, once married, they are now divorced. Divorce can wreak economic havoc, especially if a marriage was long-term and particularly if one member of the pair (usually the woman) did not have a steady work career. Divorce can also be traumatic if one member of the pair was somehow in the dark that the marriage was not going so well. Even so, divorce can be preferable to an unhappy and unsatisfying marriage. In fact, movies have themes along these lines (e.g., *Eat Pray Love*).

Overall, the divorce rate in the U.S. is steady or declining. However, the divorce rate among middle-aged and older adults has doubled in the last two decades. So assuming that single older people are widowed is no longer accurate. In fact, one in four of the people who divorced in 2010 was 50 or older. Brown and Lin (2012) have studied what they call "the gray divorce revolution." In reporting on this phenomenon for the *New York Times*, Rachel Swarns (2012, March 1) noted that in 2010 about one-third of adults aged 46 to 64 were divorced, separated, or never married. This figure compares with only 13% in 1970. Many older single people have financial independence and prefer to keep it that way. But even if divorce results in financial instability, it can make some individuals feel liberated – especially after a period of living alone and coming to a point of feeling empowered by the independence. Swarns discussed the case of a divorced 55-year-old woman who has no health insurance or pension. She knows that the years ahead may hold economic hardship. Yet, she "still savors her freedom."

Finally, older adults can be single because their spouses have died. We tend to assume that older adults who are widowed want to remarry (we discuss a variation of this idea in Myth #34, "If older widows date, it's to find a new husband"). For our present purposes, let's discuss not just dating, but rather actual remarriage.

It is commonly believed that men who are widowed are better off if they remarry. Many people think men need a spouse to take charge of nutritional habits and to organize the couple's social life. If this is indeed the case, then men who are married or remarried are better off compared

with men who are single. Also, as we noted earlier, married men seem less likely than married women to react to conflict.

But what about women? Are they always better off married? In a recent article in the *AARP Magazine*, Marion Winik (2013, August–September) describes her own experience with marriage and singlehood. She had two marriages, both of which she claimed had some positive and some negative qualities. Her first husband died young after a long illness. The second marriage started out well but deteriorated, so the reader assumes it ended in divorce. Subsequently, Winik describes how she spent a great deal of time and effort following the end of her second marriage seeking out a third marital partner. However, she suddenly realized she was happier single than she had ever been when married. After publishing a book on single living, she began seeing a man who lived an hour away. She reports that she cares for him and enjoys his company, but she likes the one-hour distance between them and has no intention of becoming a wife again. Rather, she is enjoying a rich life in singlehood with work and her relationships with adult children and friends. In her article, Winik mentions several researchers who have reported that people, especially older adults, are often content with singlehood.

In sum, there is no clear answer to the question of whether it is better for older people to be married. It depends. Financially, it's probably better to be married. Certainly in terms of caregiving, it is better for the needier member of the pair to be married, and sometimes both members benefit if the needs of one can be met by the other. However, some people are definitely better off single. Because individual differences are so important with regard to the benefits of marriage, perhaps we should not give in to our matchmaking impulses unless we are sure they are welcomed. Some of our older friends and relatives might enjoy dating the people we introduce them to, but that may not mean that they would be better off married to those people.