Myths and Stereotypes About Aging

Introduction

What Does It Mean to Be “Old”? 
Not all of us understand aging very well, even after it begins to happen to us. Aging or aging well is not part of the curriculum in school, unless one has sought out that field of study. Still, we all have expectations and beliefs about aging, and there are many misconceptions about aging and what is “normal.” My effort here is to shed some light on the subject of aging and how individuals are affected by it. We may also learn here to change our expectations and beliefs to allow for greater acceptance of our aging clients—and whether your work is legal, business, finance, or other, you are going to encounter long-lived people as clients. As we increase our understanding of aging in general, we will better understand how to work with our aging clients and those in their lives.

Most of us have a mind-set about aging and what it means. It comes from our social conditioning, our families, and our own beliefs about how aging affects people. Some of these beliefs may be accurate, but some may be based on inaccurate stereotypes, myths, and ideas that can interfere with the professional services we want to offer. This chapter explores some of those common stereotypes and examines how they can interfere with giving each client truly individual treatment and the best possible service.
The Changes of Aging

It is clear that aging is a different experience for each person, just as the process of growing up is unique to each of us. We reach developmental milestones at different times, within a spectrum. A child may learn to walk at nine months, or a year, or even at two years. The range of what is considered “normal” is quite broad. Aging also covers a broad spectrum of change, but it tends to be along a spectrum of physical decline as the body shows the effects of wear and tear. The extent of decline varies a great deal from person to person. Some are vigorous at 95, whereas others are seriously disabled by the changes of aging at 70.

Aging brings with it numerous effects on the brain and nervous system. These changes are normal, but may predispose us to chronic diseases. For example, the brain transmits signals to the rest of the body by way of chemicals called neurotransmitters. With aging, the efficiency of neurotransmitters decreases, causing a slower reaction time to various stimuli.¹ We may see cognitive decline with aging, as discussed in more detail on the section of this chapter dealing with dementia. It is important to distinguish cognitive decline from decline in general intelligence, which is not a normal part of aging. In fact, studies indicate that our general intelligence does not diminish as we age unless something interferes with the normal functioning of the brain. Cognitive functioning remains normal and reasoning abilities and judgment are not altered in normal aging.²

This fact, in particular, is one that many of us may not expect. It contradicts the stereotypes of aging. We may expect all aging persons to be less capable cognitively, or we may misinterpret slightly slowed processing as diminished cognitive capacity. Though many aging persons do suffer from cognitive impairment, it is helpful for us to recognize that not all individuals experience cognitive decline.

Many of the elders we meet will be cognitively intact and fully capable of participation in decision making. Others will show signs of diminished cognitive function, and we must learn to accommodate this.

Society’s Attitudes About Aging

Our attitudes about aging form the basis of how we treat elders generally, and particularly how we treat them in our work. If we are to overcome dangerous stereotypes that can diminish our effectiveness, we need to understand what the stereotypes are and how they can affect us as well as others participating in work with aging clients.

American society has always valued productivity. The Puritan work ethic that makes up a fundamental part of our value system does not particularly value those who are no longer “productive” in the sense of working, making money, or raising families. This dismissive attitude often pervades how we treat elders from a financial, medical, social, and even governmental point of view, though this is changing.

We often associate the terms old or elder with infirmity, loss of competence, and other unfavorable images. This thinking, part of a general cultural outlook on aging, has given rise to the persistent urging to “turn back the clock,” “fight aging,” “reverse aging,” and other anti-aging messages throughout the media.

We do not hear or see a lot of press about celebrating longevity. While it is true that a few exceptional individuals may get media attention for living so long and still contributing to the world, we as a society are far less receptive to images of the old among us than we are to images of younger persons.

The United States is sometimes called a “youth-obsessed culture.” Youth pervades commercial messages, entertainment, sports, and print media except when companies are trying to sell to the middle-aged market. The messages all around us seem to tell us that even if you’re getting older, it’s better to look younger, feel younger, or be younger. Media tend to imprint ideas in our minds. Our stereotypes about aging are influenced by this in ways of which we may not be fully conscious.

The Pervasiveness of Ageism

Advertising pitched to those aged 65 and older is heavily laden with urgings to buy medications, supplements, and assistive devices; it assumes that you must need to function better in your sex life, which you can surely do if you buy their pill.
The unspoken message, repeated endlessly, is that there is something wrong with aging itself. The aging person is portrayed or perceived as less capable, less important, less interesting, or less deserving than a younger, more “productive” person. We characterize these attitudes in our language, as well, with slang that often has negative connotations: “geezer,” “old fart,” “doddering old fool,” “old biddy,” “the shuffleboard set,” “useless old man,” “old codger,” “the blue-hair crowd,” and even “little old lady” communicate less than a dignified or reverent attitude toward older members of society. The concept that “an old dog can’t learn new tricks” is illustrative. It is also untrue.

No one is totally immune from ageist imprinting. To work at developing the deepest respect for the aged among us, we have to expose ourselves to older persons, their achievements, their struggles, their wisdom, and their value. We do this in our daily lives both outside our work and in our direct work with elders in practice or mediation. Developing a respectful attitude and overcoming all the negative messages about aging takes effort. As with other biases and prejudices, we overcome stereotypes regarding aging through intention, self-education, and exposure to the subject of our bias and prejudice. We seek to understand what it must be like to be negatively characterized so pervasively.


> As we age, we believe what we’re trained to believe about how old people think and live. The Ego gets us to view ourselves as something less than when we were when young, rather than something more. And yet we have the power to age as we choose, and to use our changing circumstances to benefit the world and ourselves, if we take the time to know the mind and how it determines the quality of life.\(^3\)

**Fear of Aging**

It is worthwhile examining our own attitudes about aging to raise awareness of our fears about the aging process. We will be less than effective if we

---

\(^3\) Ram Dass, *Still Here* (Berkeley Publishing Group, 2002), 33.
carry a fear of our own aging into our practice as we meet elders. Negative stereotypes can quietly but significantly affect us.

If we have a fear of the loss of control that we think comes with aging, we may project that fear onto anyone we represent. If an elder is being asked to give up an important freedom, we may see ourselves in her shoes and overidentify with her. Acquiring an attitude that is comfortable with aging, even with all the messiness and the duties surrounding it, will allow us to be most effective.

For example, if a conflict breaks out about how a cognitively impaired elder spends his money, and he is perceived by the parties as being vulnerable to manipulation, the issue in the case could be how much control over money the elder should be allowed to retain. If we imagine ourselves in the elder’s place and project our own fears about control over money, we might not be able to see the need for those involved to find a way to restrict this particular elder’s access to his bank account. We simply need to be aware of how our attitudes affect what we perceive. We can become advocates for something unsafe if we are not aware of our own attitudes.

Our own beliefs require a close, objective look, especially if a client is involved in a case that has elements reflecting experiences we have had in our own lives with persons close to the age of our own parents or grandparents. We do not want our vision of the client before us to be obscured or distorted by our personal negative experiences or fears about growing older.

**Stereotypes and the Effect on Elders**

**The Risk of Not Being Heard**

Conflicts, cases, and planning involving elders will be colored by the biases and prejudices of those involved in the matter. Opponents, other players, and parties may be influenced by peers, upbringing, cultural values and beliefs, and society’s messages in general about aging, just as we ourselves can be so influenced. Attorneys, family members, caregivers, and associated others can manifest ageist stereotypes in their communications. Positioning as to what is “right” for a particular elder is the effect of these beliefs.
If we are self-aware enough to see past the ageist beliefs that we ourselves may have held, we can see the aging client for who she is, not who we think she might be or should be. We are responsible for observing and limiting the effect of stereotyping and ageism on the elder. The elder may or may not see the negative attitudes toward aging—and may even harbor some of them herself. If the elder is impaired, he may have insufficient mental capacity to recognize the effect of such attitudes. If the elder is unable to hear all that is said or to track and process the multiple expressions that fly back and forth as family members or others describe him, he may not have the opportunity to fully voice his ideas and preferences. If the elder is represented, his attorney needs to be that voice and to ensure that it is heard. If the elder is before you alone, your consciousness needs to be tuned in to anything you may be inclined to do that is driven by assumptions about aging people in general. This client may not fit such preconceived ideas.

Even sophisticated professionals working in the field of some aspect of aging or elder-care can possess ageist attitudes. These could directly affect a conflict in a negative way. As an example, I was doing some research for a presentation on the rights of elders to sexual expression in long-term care facilities. I found a number of articles on the subject written by social workers, nurses, and others in the elder-care field. I found various references to elder sexuality in such terms as “the yuck factor” and other negatively characterized terminology. This was from elder-care professionals!

Note that sexuality in a younger person would not likely ever be characterized in this way. The negative implication is that if you are older, sexuality and sexual expression are “yucky,” but not if you are younger. These words, in professional journal articles, vetted and published for all, reflect exactly what we see all around us. If we are counting on anyone to be free of all negative stereotypes about aging, we are missing the truly ubiquitous nature of ageism.

If we miss the stereotypes, if we let ageism slip by us, the risk to the elder is loss of rights, loss of dignity, and loss of a sense of equality. Even if the elder himself or herself cannot attend every legal proceeding or make every financial or business decision due to physical or cognitive impairment, the elder has a right to a position uncompromised by ageism. The elder’s representative, whether family, attorney, or other, needs to have a fair opportunity
to advocate for long-standing beliefs or values of the elder. Simply put, we do not want any elder we represent to be thought of as less valuable, less important, or less worth hearing than anyone else.

The Risk of Social and Emotional Needs Being Overlooked
The risk of the elder’s voice being lost or of assumptions about aging taking over the conversation may be very apparent—and quite high—when it comes to the elder’s social and emotional needs. In this particular aspect, we as a society seem to deny that our emotions are ageless. As lawyers, I believe we have a particular role in and responsibility for drawing out and upholding the preferences, feelings, values, and beliefs of those we represent. This may well apply to financial planners, business advisors, and others working with elderly clients as well. It is so easy for others to dismiss these things, based on the faulty assumption that they are unimportant or that somehow, with aging, they no longer exist.

For example, the hot-button issue of widowed aging parents’ social lives and romantic interests may be an issue in any legal matter involving an elder and her family members. An aging person’s need for companionship or love may easily be lost in a dispute about who has the right to decide how Dad is going to spend his money or where he is going to live. Even an incapacitated person who cannot make reasonable money decisions still has emotional needs. The elder’s need for enjoyment, company, and other social/emotional aspects of life can often be ignored or drowned out in a fight over other issues concerning safety and care. It is up to the lawyer representing the elder to elicit the elder’s preferences and to ensure the elder’s right to self-determine, within safe limits, what he or she does about these emotional needs.

If we wish to reduce the risk that elders’ social and emotional needs will be overlooked, we need to draw out the elder, or those who care for him or her, to directly address these questions. In my own experience, many elders seem to experience discomfort in talking about feelings, although perhaps not everyone will find this true. I speculate that I have encountered this because the generation we now consider “elders” lived through world wars and the Great Depression, and for much of their lives focused primarily on survival. Talking about their own feelings was just not done. Other serious
matters were discussed, but feelings were not emphasized. Perhaps many elders simply never developed a vocabulary for expressing or describing their own emotions. Nevertheless, the social and emotional aspects of an elder’s quality of daily life must be a part of any discussion about what should happen to him or her. The issue of where an elder is going to live and be cared for, and by whom, are often the context in which these issues arise.

**Raising Our Own Awareness**

One can imagine that if the elder’s own lawyer has the attitude that any aspect of an elder’s rights or any part of an elder’s wishes is “yucky,” a dispute about these issues might not go so well for the elder. If we find ourselves uncomfortable about any aspect of representing an aging client, we need to ask ourselves the question: “Why does this subject make me feel uncomfortable?” This is an essential part of self-reflection that can enable us to most effectively represent this age cohort without imposing ageist beliefs on them. Should any part of an elder’s life or situation bring up uneasy feelings in us that would not be there but for the age of the person before us, it is time to look within for the answer.

We may each have our own blind spots about what it means to age well in our society, with or without the impairments of aging. Do we personally think the elder in question should or should not be placed under a conservatorship/guardianship? Live independently? Give money to some potential heirs and not others? Have the right to be included in discussion about finances when his capacity is impaired? These are issues that require our own understanding while respecting the elder’s right to participate in decision making.

For example, you might hear a party or family member say something like “people her age should be in a nursing home.” That kind of comment is not unusual, and it is a stereotypical attitude about persons of a certain age. If we ourselves think the same thing, and are not aware of the ageist nature of this belief, we can’t possibly be proper legal representatives. It may or may not be true that a particular client has physical and care needs that require a nursing home, but those needs should be determined by examination of the facts and evidence available, rather than on the basis of a predetermined notion of what “should” be.
Overcoming Assumptions About Elders

The Basis of Assumptions About Aging Persons
We are best prepared to work with elders if we are aware of common problems affecting elders, while at the same time making no assumptions that every elder will have these problems. We can’t presuppose that a 90-year-old is deaf any more than we can assume that a 70-year-old is mentally sharp. We know that many older persons develop cognitive difficulties as they age, but we cannot assume that every older person does, just because it is common. Nor can we assume that the particular elder we are meeting is like any other elder we have known.

Your own experiences with aging persons can lead to assumptions, even if you do not consider yourself an ageist. One’s own negative and positive past contacts with aging persons may give rise to somewhat automatic assumptions about elders in general. We learn from the first older persons we are exposed to in our lives what it means to age or to “be old.” Whether we are aware of it later in life or not, we may carry those perceptions and attitudes with us.

Family Experiences with Aging Relatives
If you had a grouchy grandparent, you may unconsciously assume that older people are frequently grouchy. If you had an older relative who was kind and gracious, you may believe that all elders are going to be kind and gracious. If all the older persons you knew in your life had physical difficulties, such as trouble walking or seeing, you may expect that to be true of all the elders you meet going forward in your work. If you had a relative with dementia, you may believe that you know all about the journey of some other person with dementia, though this may be quite untrue. Each person’s experience of aging and whatever problems come with it is different. The limited experience of one’s own family or neighborhood can narrow our views and keep us stuck in stereotypical thinking.

Because we are products of our own experiences with aging based on others in our lives, we are likely to have incorporated the way others in our lives view aging itself. If your aging relatives had negative experiences of aging, you may have absorbed those attitudes. If you grew up hearing a lot
of complaints about aging from someone who was your own elder, it will likely have affected your beliefs. The important thing is to recognize how your experience can influence your work with elders and your effectiveness in problem solving as a lawyer or other professional. It is possible to develop a very empathetic and effective way of working with elders, even if the elders in your own life made you feel that you never wanted to get old.

The Effect of Broadening Our Experience of Older Persons

The only effective way to overcome our own assumptions, whether they are deeply imbedded or not, is to expose ourselves to the world of aging persons in a variety of ways. This can include reading about the aging process, attending events in which the featured speaker is elderly, becoming involved in community activities focused on elders, volunteering with elders, and doing our own research on any part of aging with which we have no experience. As our society ages, and the Baby Boomer generation in particular ages, the opportunities to learn more about elders and aging increase. Exposure to different kinds of aging persons enables us to work more effectively with this population because we can recognize and discard our assumptions as we find people who contradict them.

Examining Our Feelings About Our Own Aging

In addition to broadening our view of elders in general, it is useful to examine how we feel about our own aging. We can take the time to reflect upon what relationships with aging persons have been like in our families and social groups. We can check in with our own attitudes by first raising our awareness of them. If anything about aging, from the way it changes your bodies to the way it can cause your health to decline, is something that makes you cringe or turn away, it’s time to examine why and to learn within yourself how this reaction can be changed. We need to value the process and personal impact of aging if we are to be effective in working with aging individuals. We need to be very cautious about reacting to aging with fear, as so many people in our society do.

The broadening of our experience with elders in general has the positive effect of helping us overcome stereotypes, as well as helping us to accept and understand our own aging process. With an accepting attitude about
our own aging, we are freer to encourage and suggest positive ways for our clients and their families to work out age-related issues and conflicts. We can see our aging clients in the same way we would see anyone else, but with a unique set of issues. Financial issues might focus more on making money last for years longer than expected or paying for long-term care. This kind of problem may not arise until a client is of advanced age. For example, legally, a client may lose her ability to be the trustee of the family trust; we need to appreciate that special circumstance connected to disabilities that often—but not always—accompany aging. Generally, we must be “tuned in” to what is likely to happen with our aging clients but not assume that anything we anticipate will always affect every aging client.

Medical Stereotyping of Elders

Stereotyping of elders is not limited to laypersons, those with less education, or those who do not work with elders. As a part of our society, medical professionals may fall victim to the same biased mind-set about aging as anyone else. Outside the specialized area of geriatric medicine, doctors may dismiss complaints from elders with “you’re just getting old.” Adult children may not perceive the dangers of their aging parents’ social isolation, depression, loss of a sense of purpose, and need for many kinds of assistance because physicians are not helpful or even knowledgeable about these issues. If the doctor isn’t concerned about an elder’s complaints, the family or others in the elder’s life may not be either.

My mother-in-law, age 92 at the time I write this, became very upset with a doctor she saw for a particular complaint. Rather than listening respectfully and working with her on the problem, he said, “What do you expect? You’re 92.” She was more than a little annoyed by his response and never went back. Unfortunately, this doctor’s attitude is not unusual.

The concerns of elders can be affected by dismissive attitudes toward them from health-care professionals. These attitudes may be reflected by various caregivers and family who are involved in the daily lives of elders. Conflicts can arise over an elder’s condition, care, independence, and needs. Elders themselves may feel less valued because they do not receive the same
attention from a physician or other health-care provider that a younger person might. What is best for an elder and what is wrong or not wrong with the elder is a frequent source of conflict. Medical stereotyping can both create and exacerbate conflicts with and about elders.

**Illustration: Richard’s Case**

Richard, an 85-year-old, saw his doctor because he had been losing weight. He wanted to continue to live in his own home and was willing to let others help him, but he was struggling. His family was complaining that he shouldn’t live by himself anymore. His doctor saw Richard for about 20 minutes, did some superficial testing, and concluded that Richard should go to a senior living community, which he pushed Richard to do. No time was taken to explore what Richard wanted, which was to remain in his own home. No effort was made to explore the options available other than giving up his home. The family agreed with what the doctor told them and Richard’s preferences were ignored.

“The doctor said” became a very aggravating source of conflict in the family, despite the fact that the doctor in a busy clinic was not likely to have taken the time to consider Richard’s need to make up his own mind about possibly giving up his home. We concluded that Richard’s wishes had been disregarded and dismissed because of his age and the assumption that he could not manage at home, even if a good support system were put in place. No opportunity to try out what the elder wanted was going to be allowed. Lawyers for the family and for Richard were hired. The ugly battle that ensued could have been avoided.

This illustration typifies how quickly some medical professionals dismiss the voice of the elder in favor of their own, preconceived notions of what it means to be old. Typically, the physician’s opinion, whether or not truly informed or respectful of the elder, carries a lot of weight with those in the elder’s life. Unfortunately, many physicians are not specifically educated to work with elders, and stereotypes about aging can affect their recommendations and interactions with aging persons in ways that are far from ideal—and may even be unwittingly harmful.

In the preceding example, the family had repeatedly argued with Richard that he needed to go to a care facility. He had considered doing
so, but wasn’t quite ready to take that step yet. The family pitted themselves against him, basing their arguments in part on the doctor’s rather superficial examination, which did not go far enough to explore the reasons why Richard had been losing weight. Richard’s attorney had a more comprehensive examination of his mental status done by a mental health professional in order to obtain a better picture of Richard’s ability to care for himself. The examining psychologist found Richard competent to make his own decisions. He needed some help at home with meal preparation, but was competent to decide when it was time to give up his home and move to a care facility. When he got the help at home that he needed, he gained weight and managed for a time until he made his own decision to move.

This example also illustrates how the “too old to live by himself anymore” stereotype was adopted, first by the treating medical doctor and next by the family members, who ignored their father’s wishes and took steps to force him to move. They failed, but this bitter family struggle and the legal expenses incurred in Richard’s stand for his right to independence could have been avoided.

On the opposite side of the picture is the physician who may have known the elder for many years and is unwilling to state that he or she is no longer competent to make certain decisions, such as financial decisions. It is my experience that most medical doctors do not take the time—nor can they take the time in a routine office visit—to assess an elder’s competence regarding decision making. As discussed in later chapters, mental health professionals are best suited to do testing that provides reliable, objective data with which to measure competence for specific tasks. It is risky for anyone, including the elder, to rely exclusively on the long-time primary care doctor, internist, or cardiologist to make such a decision about competence. Some physicians will decline to say anything one way or the other. Others may opine that the elder “seems fine” after a short visit, adding nothing to the effort by others to determine the elder’s true capacity for making decisions. Some may have their own stereotypical beliefs about their patients, such as that unless they complain of being impaired, they should be allowed to remain independent in all things. Either way, whether dismissing the elder’s right to be independent too quickly or glossing over concerns raised by
others regarding the elder, the physician may or may not help with ageist perspectives that lead to disputes.

**Addressing Medical Stereotyping**

When we are faced with a conflict such as described in these examples, in which the medical assessment of an elder is an issue, it may be helpful to suggest getting a second opinion from a physician who specializes in working with elders. When a dispute exists, it is possible that medical stereotyping can worsen the conflict or be inadequate to answer the questions that lie at the heart of the conflict. The elder’s right to self-determination may necessitate obtaining additional information so that you have better information to help keep your client safe.

You are likely to be in the position of trusted professional with your older clients and their families. If you sense, from what your client tells you about something that affects your work, that a physician has a dismissive attitude, take the initiative to suggest getting a second opinion from a physician who specializes in working with elders. Although geriatricians are sometimes hard to find, that would be a first choice for getting another opinion. The geriatrician’s special training in the medical issues of aging patients will give the client a better chance at solving whatever medical problem is at hand, or at least addressing it fairly. Your suggestions and recommendations matter to your clients.

Here is another example of how a physician, though well-meaning, can harm an elder.

**Illustration: Jeanine’s Case**

Jeanine, age 85, has been in conflict with her daughters for some time. She refuses to sign any legal documents, such as a power of attorney allowing them to help her manage her finances or any other aspect of her life. She has fallen repeatedly, has memory loss problems, and forgets to turn off the stove and the faucet. She fails to take prescribed medications. Her daughter, Janet, has been urging her to go to the doctor, and in fact finally got Jeanine to go by personally driving her to the doctor’s office. Jeanine hadn’t seen the doctor for nearly a year, despite Janet’s urgings.
Prior to the visit, Janet wrote a letter to the doctor, spelling out the specifics of why she was worried about her mother, describing the dangers at home, and asking for his help in talking to Jeanine about signing a release of information so Janet could talk directly to the doctor about her mother. Instead, the doctor advised Jeanine not to sign anything! Now Janet must seek a new doctor who takes Jeanine’s Medicare plan and set up an appointment, all with resistance from Jeanine. Seeing that unhelpful doctor made a bad situation worse and made Janine even less safe. The doctor had a careless attitude toward Jeanine and may not have recognized the obvious signs of dementia pointed out in Janet’s letter.

A fair-minded doctor would have taken the family member’s report seriously and would have spent some time with the elder going over the problems raised in the letter. In addition, the doctor could have ordered some neuropsychological testing to determine whether there was indeed cognitive impairment. Unfortunately, this doctor’s action exacerbated the dispute between the elder and her daughters. The situation was headed toward guardianship, as there was physical danger to Jeanine from the stove and water left on.

Conclusion

Stereotypes about aging are everywhere. It is very likely that we will encounter unfair attitudes and beliefs about aging in our work. We can overcome the negative effects of our society’s ageist attitudes by first becoming conscious of our own attitudes, reflecting on them, and raising our personal awareness of how these beliefs can interfere with a fair process for elders. Our unique responsibility is to aim for fairness, first from ourselves, as the legal representatives or other professionals, and then from all others involved in the conflicts we encounter concerning elders. If there is an issue in which you are not directly involved, but you know what might make a difference for the client, speak up. Serving our clients as best we can is always our business. Whether others listen to our suggestions is up to them, but we serve best if we offer what guidance we can.