

WHEN MIDDLE AGE COMES INTO FOCUS

A bevy of cultural sacraments marks our passage into adulthood, but the yawning decades beyond it unspool without ceremony.

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Illustration by RavenJiang

About a year ago, I found it increasingly difficult to see things that were right in front of me. I'd been wearing contact lenses for myopia, or nearsightedness, for more than a decade, but never had trouble with closeups: reading food labels, clipping my nails. Suddenly, I did. The words in this and other magazines looked like vibrating ants. I thought that I might just be tired, or that the atmosphere around me was warped by an inexplicable haze. One day, while washing a wooden cutting board, a splinter lodged in my left index finger. I drew the finger to my face, then away, then close again, trying to get enough visibility to tweeze. I had contradictory thoughts: *Middle age is upon me*, followed by *This is how a newborn must see*.

I complained to a future me: a writer friend who's a bit older and has a penchant for big, dramatic glasses. We were standing at her kitchen island, where she likes to consult recipes and tap out e-mails. "I'm surprised you don't already have bifocals," she told me, rubbing the flesh under her nose pads. She meant no harm, but the comment stung like a poke in the eye.

Last summer, I made an appointment with my sometime optometrist, at a Costco in Washington State. Her practice was independent, but the glasses and contacts displayed outside the office were sold at Costco prices, to Costco members. Next door was the food court, where the chicken bake (\$3.99) and hot dog plus soda (\$1.50) were advertised in fonts so Costco-big, under such harsh overhead lighting, that they could not be missed, even by the most severe myopes. In this warehouse of giant things, my declining vision didn't seem to be as much of an issue.

The doctor was efficient and aloof. She wore glasses and a mix of denim and florals that reminded me of a nineties mom. (In the nineties, my mom was the age that I am now.) I told her that I'd come in for a regular checkup, but that I was also having difficulty with fine print. This was my way of inviting sympathy and reassurance, though I hoped to be diagnosed with something other than time-induced bodily deterioration. "Yup, you're at that age," the optometrist said, not making eye contact. "It happens."

Her small exam room was dim—an unfair handicap, I thought. She seated me in front of the eye-testing machine, a giant beige View-Master with a seemingly infinite store of retracting lenses. I looked through a pair, toward a digital version of the classic Snellen eye chart—E F P T O Z—projected on the opposite wall. "How's this?" *Clack*. "Can you read the third line up?" *Clack*. The lenses made a satisfying noise as they dropped into place. "Which is better—A?" *Clack*. "Or B?" *Clack*. I'd always found this aspect of the exam suspiciously unscientific, too trusting of the patient. Who was I to tell the difference between A and B?

She confirmed that I had graduated into a double prescription: myopia and “Yup, you’re at that age.” She didn’t name or explain the second condition before reviewing the most popular treatments. I could switch to full-time glasses, like the wiry metallic ones she was wearing—either bifocals, with that unsightly horizontal line, or progressives, which had blended bands of correction for distance, intermediate, and near vision. I could wear magnifying reading glasses on top of my myopia contacts. Or, mercifully, I could continue to wear contacts alone—multifocal ones, a newish technology that combined distance-treating bits with middle-aged-eye-treating bits. The two prescriptions would be arranged in concentric rings, alternating outward as though from a bull’s-eye.

Multifocal contacts would let me stay free of spectacles and the angry nose-pad marks that came with them, but there was a catch. The light entering my eyes would bend at two different angles, confusing my brain and making my vision a little blurry. “What do you mean?” I asked. Blurry at all distances? All the time? “It’s hard to explain,” the optometrist said. “You’ll see.”

The diagnosis she dared not speak was presbyopia—Greek, but not poetic, for “old eyes.” (*Presbys*: old man, elder, ambassador.) Presbyopia is technically an eye disorder, but one that everyone past the age of forty-five contracts. “We’ll all, if we’re lucky enough, experience it,” Houmam Araj, who directs lens research at the National Eye Institute, a part of the National Institutes of Health, told me. Before middle age, the two main vision disorders are myopia and hyperopia, or nearsightedness and farsightedness. Myopia is caused by an overlong eye; light carrying the image of an object comes through the cornea, and then the lens, but lands short of the retina—an exquisite layered tissue, composed of more than sixty types of neurons, which transform the light into electrical signals that are interpreted by the brain. Hyperopia, conversely, is a condition of smooshedness, of light going past the retina. About thirty per cent of all adults are myopes; the rate is similar for hyperopes.

Presbyopia isn't a problem of eyeball shape but of the lens: a convex disk, the size of a mini M&M, that sits behind the cornea and helps the eye adjust its focus. In the young eye, the lens is flexible. Stringy ciliary muscles, like the springs of a trampoline, surround the lens and pull on its edges, making it rounder or flatter as needed. A youthful viewer can thus flit between near (a Lego piece) and far (the playground down the street) without any noticeable transition. The lens of a camera mimics this automatic activity. But, in what doctors refer to as the "mature eye," the lens becomes rigid, and the ciliary muscles malfunction. Feeling both nearsighted and farsighted at once is the result of a "lack of accommodation," the failure to toggle between focal lengths. By middle age, everyone loses around a third of their amplitude of accommodation.

I was surprised to learn that, were it not for my myopia, I might have noticed the presbyopia sooner. "A low amount of myopia is actually very, very convenient," Xiaoying Zhu, a professor who specializes in myopia management, explained. "For myopic patients, if you don't wear your distance correction, it's like you have a pair of built-in reading glasses."

Globally, people are living, and therefore aging, longer. There are more presbyopes than ever before—around 1.8 billion of us. A disproportionate number are concentrated in East and South Asia, where the population is very big, and very old. By 2030, some 2.1 billion people will be afflicted by middle-aged eyeballs. Then, by 2050, this figure is predicted to drop, owing to an uptick in myopia. Many researchers believe that smartphone use and a lack of outdoor activity (see: iPad kid) are making more of us nearsighted at an earlier age. Perhaps, in a thousand years, the average visual field won't extend beyond a phone held at arm's length, and our lenses will barely need to flex at all.

There's no cure for presbyopia, just a lot of treatments. Besides glasses and ready-made soft contacts, there are customizable hard contacts, Lasik-type surgeries, and prescription eye drops (with punny brand names such as Qlōsi

—“close-y”—and Vuity—“view-ity”) that temporarily relieve symptoms by simulating the light-reducing “pinhole effect,” the kind of sharpness you get from squinting. But the drops can come with unpleasant side effects, such as tachycardia and retinal detachment. Araj’s institute is funding research on how to make old lenses young. “There’s a grantee looking into hyaluronic acid,” he told me. “Can we add more of it and get less of the stiffness?” I recognized the name of this substance—which naturally occurs in the eyes, joints, and skin—as the active ingredient in anti-aging serums. Araj was pleased by the study’s early indications. Somewhere, I imagined, the lenses of middle-aged monkeys were getting more supple. “I would *love* to get more and more applications related to presbyopia,” Araj told me. “It’s difficult to think of another disease that has that prevalence.”

Araj’s own presbyopic moment arrived when he was fifty years old, browsing his favorite used bookshop in Montgomery County, Maryland. “I’d been there hundreds of times,” he told me. He was scanning a shelf to his right, on histories of the Second World War, then looked left and encountered a blur. “It was weird,” he said. “I’m not seeing the titles anymore. Of course, I know about presbyopia, but it’s different when it happens to you.”

As with many aspects of middle age—wrinkles, gray hair, crackly joints, fatigue—I was aware of presbyopia, but unprepared to actually experience it. A repertoire of cultural sacraments marks our passage into biological adulthood, but the yawning decades beyond it unspool without ceremony. Dennis Cheng, an optometrist in my Brooklyn neighborhood, told me that many of his newly presbyopic patients come in “genuinely panicked,” convinced that something has gone terribly wrong. Much of his job, he said, “is reassuring them that everything is going to be fine”—to the extent that approaching death is fine. The lens, like the rest of the body, simply becomes less flexible. “When you’re younger, you could sit crisscrossed on the floor,” he said. “Now your hips are screaming at you.” The mature lens can no longer do the splits.

A temple to eye science sits, unassumingly, in midtown Manhattan, next to a Joe & the Juice and across from Bryant Park. The SUNY College of Optometry, where Zhu leads a myopia program, is a combination eye clinic and research lab. On a recent Thursday afternoon, an optometrist named Marina Su was peering into the eyes of Martha Infante, a forty-one-year-old mother and kitchen designer. Early last year, Infante had woken up, grabbed her phone, and found that she was unable to read a text message from a friend. She'd been wearing glasses to treat an astigmatism—a warping of the cornea or lens—but they were no help. “I got worried, because I am diabetic,” she recalled. (High glucose levels can damage the blood vessels in the retina, causing blindness.) “I waited a little bit. I tried to make the light more bright. I had to move my phone in different directions—closer, farther. I was trying to close my eyes a little. I finally read it, but it was really, really hard.” An optometrist eventually diagnosed her with presbyopia and added magnification to her prescription. That helped for reading up close, but Infante felt dizzy when she walked, and if she tried to walk or drive *without* glasses she could barely see.

She showed her Gucci-striped progressives to Su, who was puzzled by the level of magnification: 2.25. “When you put these on initially, when you first got them, did they feel good?” Su asked. “No,” Infante said. She had gone back to the other optometrist three times. “Where do you normally hold things, or read?” Su asked. “What’s your everyday usage? Where’s your computer?” Infante held out her arms to indicate several distances. Su opened a drawer full of lenses, snapped two into a pair of industrial-looking metal frames, and rested them on Infante’s face, trying to fine-tune the level of magnification. She asked Infante to walk down the hall and back. “I’d rather give you the minimum,” Su explained. “That way you have room to increase as things get worse.”

All this fuss made me wonder about my own prescription. I read an academic paper recommending that providers who treat presbyopes “should cover not only medical aspects, but also private, occupational, and non-

medical factors,” including a patient’s “daily routine” and “expectations, views, and wishes.” A nearsighted and presbyopic truck driver, needing to prioritize distance viewing, might be better served by progressive glasses or myopia-only contacts than fuzzy multifocal contacts. An accountant with a similar prescription might prefer multifocals, or reading glasses, to enable the full range of closeup work. But optometry isn’t therapy. How many eye doctors had the time to take such an inventory of their patients’ lives?

Su’s next patient, a seventy-three-year-old woman, had long ago dealt with her presbyopia. She was now on the cusp of geriatric vision, meaning cataracts. She’d been experiencing a nighttime glare so significant that she’d given up driving in the dark. Her vision also blurred when she went from indoors to out. An exam showed indications of a posterior subcapsular cataract in her left eye. “A very fancy term,” Su told the patient. “All it means is that it’s affecting the back side of your lens inside your eye, and it’s making it cloudy.” The lens already lacked accommodation; now it was starting to discolor. In a typical life cycle, cataracts follow presbyopia by a decade or two, at which point glasses and contacts are of little use. Luckily, the treatment for cataracts involves a simple surgery to replace the yellowed natural lens with an artificial version customized to the patient. A hyperopic presbyope, for example, can choose to have multifocal lenses permanently installed in their eyeballs. (Cataract surgery is generally covered by Medicare; without insurance, it costs around three thousand dollars.) “If I get cataract surgery now—I am seventy-three—is this gonna last me till I’m a hundred and three, which is my plan?” the patient asked. “Yeah,” Su said. “It’ll last you two hundred years.”

Upstairs, in the research labs, Su’s colleagues were exploring how to better diagnose, stop, and possibly reverse various eye disorders. Children were fitted with multifocal contacts (much like mine) and trained in eye-muscle exercises meant to slow down the progression of nearsightedness. Gene therapies and virtual-reality programs—which staged daily tasks, such as placing a fork on a plate, in high-contrast black-and-white—were helping

adults with low vision hang on to what remained of their sight. Mice predisposed to retinal disease were being guarded and watched, around the clock, like tiny celebrities.

Listening to the researchers, I became convinced of the eye's singular beauty. Even in the nineteenth century, before the neuron machinery of the retina was fully understood, biologists approached the eye with wonderment. Darwin called it an organ "of extreme perfection and complication," and acknowledged that its "inimitable contrivances for adjusting the focus to different distances, for admitting different amounts of light, and for the correction of spherical and chromatic aberration" were so unfathomably elegant as to cast doubt on the theory of natural selection. The retina, with its delicate photosensitive cells, is like an enchanted darkroom. It's also an extension of the brain and a part of the central nervous system. More than one SUNY professor quoted the apocryphal (Shakespearean? Biblical? Chinese? Roman?) adage "The eyes are the window to the soul." By scanning the back of the eye, optometrists can, and do, detect all kinds of trouble: diabetes, hypertension, even cancer. In 2024, Shaoheng Chen, then a student at the optometry college, had assisted a professor with a seventy-four-year-old female patient who had bleeding and leopard-spot lesions on her retina. The pattern reminded Chen of retinal images he'd seen in an academic paper—of a woman with metastatic breast cancer, which can travel through the body and show up in the eye. "I talked to my supervisor," Chen said. "This is not a benign lesion. It may even be malignant." His professor called the patient to ask about her last mammogram and urged her to see her primary physician. The patient was soon diagnosed with Stage IV breast cancer, and, with treatment, survived.

I first visited an optometrist when I was in my twenties, during law school. I'd been squinting a lot during class and at parties—a reflexive attempt to decipher faces and whiteboard scrawl. At first, glasses were merely helpful. Because I only needed them occasionally, I wasn't bothered by their weight on my nose and ears. I liked the aesthetic possibilities of frames, and hoped

that the pairs I chose—translucent red ovals; purplish squares—made me look older and wiser in the heat of Socratic debate. Later, when I didn't want to look older and couldn't function without corrective lenses, I switched to disposable contacts.

My nearsightedness worsened gradually but consistently. Every annual exam pushed my prescription further into negative territory, from just below zero into the ones, then twos, then threes. By my fortieth birthday, I was hovering around negative 4, which meant that even household distances were a watercolor wash. My contacts prescription is now negative 4.5, with the addition of low magnification for presbyopia. The multifocals work well at close and intermediate distances, but I've had to give up on street signs and the departures display at J.F.K. While reporting in court a few months ago, I struggled to follow the virtual testimony on a screen at the front of the room. The captions were minuscule. Another journalist seemed to be in the same situation. She leaned over a wooden divider to try to decipher a name.

To solve my distance problem, and get "that crispness that you love," Su recommended that I try a variation on monovision, an old-fashioned approach that corrects one eye for distance and the other for presbyopia. I could wear a contact for distance vision in my left eye, and a multifocal contact in my right. My brain would blend the difference, but my depth perception would take a hit. It sounded terrifying.

Forty- and fiftysomething friends are all adapting, each in their own way. Andy carried multiple pairs of glasses, for reading, computer distance, and outdoor distance. Paula wore reading glasses at her desk, Coke-bottle glasses for distance on Zoom, and multifocal contacts out to dinner. Josh bought stylish progressive glasses that cost more than a thousand dollars, but he still needed contacts to jog. Another friend decided to undertreat her myopia, so that the faraway world was mostly clear and the intimate world mistily adequate. Myopia prescriptions generally plateau by the onset of presbyopia. Derek Louie, an ophthalmology professor in Oregon, told me that the level

of magnification for presbyopia eventually “caps at about 2.5, because most people don’t need to bring anything closer than eleven or twelve inches from their face.”

Around the time of my diagnosis, a host of other middle-age concerns rushed in. I developed a sore left hip and sporadic insomnia. My uncle in Korea, who’d been complaining about his vision, was hospitalized after an aneurysm and a series of strokes. My parents, contemplating their mortality, decided to relocate from the Pacific Northwest to an apartment near me. My dad was fitted for a hearing aid and had surgery to remove his cataracts. Over the years, I’d noticed him reading less and watching or listening to YouTube a lot more, and now I understood why. I, too, was consuming an increasing share of media through my ears, “read by an A.I. voice.” My eyes were exhausted. I had no choice but to accommodate my lack of accommodation.

Before my uncle got sick, he’d joked that we were all living way too long, forced into a game of chicken with our own bodies. Our medically extended life spans, he said, gave us too much time to think—about ourselves, mostly. He puffed on a cigarette. We looked at each other and laughed in narcissistic recognition. ♦



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