abstract

Today's health care provider works to promote health and successful aging of the growing population of older adults. Unknowingly, younger care providers may communicate messages of dependence, incompetence and control to older adults through the use of elderspeak, a common intergenerational speech style. This article describes elderspeak, its underlying negative messages and strategies for clinicians to use in evaluating and enhancing their own interpersonal communication with older patients. Issues critical to communication with older adults are examined and the importance of communication as a therapeutic tool for health care providers is explored.

Key words: *communication, provider-client relationship, elderspeak.*

Elderspeak: Impact on Geriatric Care

Kristine N. Williams, RN, CS, FNP, PhD, University of Kansas School of Nursing, Kansas City, KS, USA.

Introduction

Communication is a critical but frequently overlooked element in providing quality health care to older patients. Communication is central to the provider-patient relationship and is particularly important for older patients since their ability to understand and adhere to treatment regimens and their satisfaction with the health care provider are greatly influenced by interpersonal communication. Health care providers may fail to recognize the importance of communication to therapeutic relationships with older clients, and how stereotypes and other factors may impact their relationships with patients in geriatric care. For instance, physicians have been found to provide more information and support and share more decision making with younger patients than with older adults.[1] Providers working with older adults may avoid sensitive topics and fail to focus on psychosocial issues that are critical for this patient group.[2] Communication with older adults also may be complicated by inclusion of family members, as well as by altered communication due to intergenerational stereotypes—a phenomenon called elderspeak that is the primary focus of this article.

Elderspeak

Elderspeak is commonly heard in communications between younger and older adults and frequently occurs in settings where health care is provided to older adults. This style of speech may be indistinguishable from baby talk, and features a slower rate of speech, exaggerated intonation, elevated pitch and volume, greater repetition and simpler vocabulary and grammar than normal adult speech.[3,4]

Although elderspeak may be an attempt on the part of younger communicators to promote clear and effective communication and to show caring, the Communication Predicament of Aging Model provides a framework to explore how this speech style fails to accomplish these goals.[5] Stereotypes that older adults are less competent trigger younger persons to modify their speech in intergenerational communication, such as implementing strategies to simplify speech, add clarification and alter the emotional tone of messages. Providers may assume that frail older adults prefer the nurturance of elderspeak. However, older adults in a variety of settings report that up to 40% of interactions with caregivers are demeaning.[6,7]

Because older recipients of elderspeak perceive it as patronizing and implying incompetence, they may respond with lowered self-esteem, depression, withdrawal from social interactions and even assumption of dependent behaviour consistent with their own stereotypes of frail older adults.[8,9] Not only does elderspeak fail to improve communication effectiveness for older adults,[8,9] but the messages inherent in elderspeak may unknowingly reinforce dependency and engender isolation and depression, contributing to the spiral of decline in physical, cognitive and functional status common among frail older adults.[10] These outcomes are incongruent with a goal of promoting independence and successful aging.

Communications between the health care provider and older patient

Table 1: Examples of Variations in the Emotional Tone of Provider-Older Client Interactions

Overly Nurturing Talk (highly caring, not controlling, inappropriately intimate)

Geriatrician: "Have you been doing your exercises? Let's show me how."

Mrs. W. fails to demonstrate the exercise.

Geriatrician: "Well goodness, honey, you've forgotten how to do them. We can't have that now can we? Let's go back and sit down and I will show you again. Come on sweetie."

Directive Talk (high degree of control, little recognition of autonomy of the listener, little caring)

Geriatrician: "Show me how you do your exercises. You have been doing them twice a day haven't you?"

Mrs. W looks worried and pauses.

Geriatrician: "You haven't been doing them have you? Well you certainly won't get better without them. Some people are just lazy. Didn't you understand how important they are to your recovery?"

Affirming Talk (balanced care and control, indicates the partner is competent and independent)

Geriatrician: "Mrs. W., can you show me how you are doing with your exercise program?

Mrs. W grimaces.

Geriatrician: "Are you having trouble remembering? Or are you having too much pain?"

Mrs. W: "I do seem to have forgotten the first part and my arm seems so sore today."

Geriatrician: "Tell me about the pain and then let me show you how to do them again. I might ask the physical therapist to visit you at home for a few days to get you started."

frequently feature elderspeak, revealing an imbalance of care and control.[11] Overly directive or bossy talk, which reflects a high degree of control but fails to recognize the autonomy of the listener, may occur when a care provider is under pressure to complete multiple work tasks.[9] Overly nurturing or baby talk reflects an inappropriate intimacy, high levels of caring and little emphasis on control.[12] This excessive caring may be an attempt of the caregiver to soften the directiveness in his or her communication.[11] In contrast, most adults prefer an affirming emotional tone that appropriately balances care and control, communicating that they are competent to comprehend the message and act independently.[5] Table 1 provides examples of how a health care provider might communicate differently with an older adult in the same communication scenario, contrasting imbalances of care and control with that of affirming messages.

Health care providers who interact with older adults are seldom prepared to communicate with them and may in fact be socialized to use elderspeak. Many health care workers do not realize that they use elderspeak or the negative messages that it projects. However, caregivers who become aware of elderspeak and realize its potential negative messages can monitor personal communication, limit its use and improve their working relationships with patients. Even though longstanding behaviours are difficult to change, research supports the ability of providers to modify their caregiving behaviours as a result of education,[13,14] resulting in significant improvements in interactions in provider-patient interactions.[15]

Research Findings

Recent research determined that health care workers who were made aware of elderspeak and its potential negative effects on older adults reduced its use in interactions with care recipients. A brief intervention was designed to alert nursing home caregivers to elderspeak, its messages and its potential negative effects.[16] The program featured videotaped staff-resident interactions from an actual nursing home as well as simulated vignettes that participants critiqued and re-enacted, substituting effective communication strategies for those of elderspeak. Participants had the opportunity to listen to excerpts of their own recorded conversations with older adults.

Participants rated the program as valuable, increases in knowledge about effective communication were documented, and recorded conversations with older adults following the intervention included significantly fewer psycholinguistic features of elderspeak. This analysis, reported elsewhere,[17] also demonstrated that communication was more respectful and less controlling after training compared to pre-training conversations.

Implications for Practice

How can health care providers reduce their use of elderspeak to communicate more effectively with older adults? The Communication Enhancement Model, the basis of the communication-training program in the Williams, *et al.* study,[17] provides a framework for effective communication with older adults,[18] charging professionals to perform an individual assessment of each older patient's communication needs, employing simplification and clarification strategies only when indicated. In this way, older adults with intact cognitive and communicative abilities will receive messages from caregivers that affirm their abilities and reinforce their strengths and functional abilities, creating a partnership to meet health and daily care needs.

Specific markers of elderspeak are relatively easy to identify and self-monitor. Characteristic features of elderspeak include diminutives, inappropriate collective pronoun substitutions, tag questions and slow, loud speech. Table 2 provides descriptions and examples of these features and suggests improved strategies for com-

munication. By limiting these features of elderspeak, caregivers may significantly improve the messages they provide to older patients.

Diminutives include inappropriately intimate and childish names and may imply a parent-child nature to the relationship. Collective pronouns inappropriately substitute a collective noun when the singular form is grammatically correct. Such substitutions imply that the older adult cannot act alone or make independent decisions. Tag questions appear to offer a choice to the recipient; however, the implication is that the speaker has to guide the recipient to select the appropriate response. Together, these features of elderspeak contribute to the overall message that the recipient is incompetent and dependent.

Increasing voice volume is a frequent strategy for communicating with older adults and for some elders with hearing loss, yet this strategy may be inappropriate. For most older adults with normal hearing loss, greatly increased volume only further distorts their hearing. Use of high-pitched intonation, common in elderspeak, provides additional challenges for older adults who typically lose the ability to comprehend these higher pitched frequencies.[19]

Slowing the rate of speech and limiting talk to short sentences is another common feature of elderspeak. For older adults experiencing normal changes in aging, including reductions in working memory, and for older adults with pathological memory loss, research shows that simply shortening speech into smaller segments does not result in increased speech comprehension.[8] Use of childish vocabulary and grammar also are frequently employed. However, older adults are not simply regressing in terms of communication, and research has shown these simplification and clarification attempts are perceived as patronizing by older adults.[8]

Provider-patient interactions also may be complicated by a third party, such as a family member, who may accompany the patient and provide much of their health care support. Including an additional person in communication may disrupt the traditional dyadic nature of the provider-patient relationship and may result in focusing the communication on the family caregiver rather than on the patient.[2]

Today's busy health care provider often overlooks the critical importance of nonverbal communication, even though it has been demonstrated to provide a stronger message than spoken words. Keeping in mind that eye contact and body language signals provide an ultimate message of engagement in interaction with older adults, and remembering to provide nonverbal messages that compliment spoken language, are essential to effective communication.

Conclusions

The Communication Enhancement Model describes potential benefits of eliminating elderspeak in speech to older adults. Minimizing the use of elderspeak is hypothesized to reduce stereotype-based messages that older adults are incompetent and dependent. Improved communication should, in turn, promote cognitive and functional abilities for older adults, thereby contributing to their quality of life.

Fine-tuning interpersonal communication by overcoming elderspeak is one strategy care providers can use to promote successful aging for older patients. Communication is a powerful tool for health care providers who work with older adults to promote health and well-being. Although providers frequently focus on the content and technology inherent in interventions, the process or art of giving care remains a critical determinate of the quality of care provided. ◆

Table 2: Features of Elderspeak and Alternative Strategies

Diminutives (inappropriately intimate terms of endearment)	
Example	*Alternative Strategy*
"Honey", "sweetie", "dearie", "grandma", "good girl"	Refer to older adult by their full name (i.e., Mrs. Robinson) or by their preferred name
Collective Pronouns (substituting a collective or "we" pronoun when referring to an independent older adult)	
Example	*Alternative Strategy*
"Are we ready for our medicine? Our bath?"	"Are *you* ready for *your* medicine? Your bath?"
"*Let's* take *our* blood pressure now"	"Let *me* take *your* blood pressure now."
Tag Questions (prompts the answer to the question)	
Example	*Alternative Strategy*
"You would have the earliest test, wouldn't you?"	"When would you like to schedule your colonoscopy?"
Isolation due to Third Person	
Example	*Alternative Strategy*
"She's doing much better today"	"Mrs. Smith, you are doing much better today."
Shortened sentences, slow speech rate and simple vocabulary (sounds like baby talk)	
These strategies do not improve comprehension of speech for most older adults and are perceived as patronizing or demeaning.	

This work was supported by the John A. Hartford Association Building Academic Geriatric Nursing Capacity Scholar Program, administered by the American Academy of Nursing.

References

1. Adelman RD, Greene MG, Charon R. Issues in physician-elderly patient interaction. Ageing Soc 1991;2:127-48.
2. Greene MG, Adelman RD. Building the physician-older patient relationship. In: Nussbaum MLHJF, editor. Aging, communication, and health: Linking research and practice for successful aging. Mahwah, NJ: Lawrence Erlbaum, 2001:101-20.
3. Kemper S. Elderspeak: Speech accommodations to older adults. Aging and Cognition 1994;1:17-28.
4. Caporael L. The paralanguage of caregiving: Baby talk to the institutionalized aged. J Pers Soc Psychol 1981;40:876-84.
5. Ryan EB, Hummert ML, Boich LH. Communication predicaments of aging; Patronizing behavior toward older adults. Journal of Language and Social Psychology 1995;14:144-66.
6. Caporael L, Culbertson G. Verbal response modes of baby talk and other speech at institutions for the aged. Lang Commun 1986;6:99-112.
7. Henwood K, Giles H. An investgation of the relationship between stereotypes of the elderly and interpersonal communication between young and old. London: Final Report to the Nuffield Foundation, 1985.
8. Kemper S, Harden T. Experimentally disentagling what's beneficial about elderspeak from what's not. Psychol Aging 1999;14: 656-70.
9. Ryan EB, Bourhis RY, Knops U. Evaluative perceptions of patronizing speech addressed to elders. Psychol Aging 1991;6:442-50.
10. Ryan EB, Giles H, Bartolucci RY, et al. Psycholinguistic and social psychological components of communication by and with the elderly. Lang Commun 1986;6:1-24.
11. Hummert ML, Ryan EB. Toward understanding variations in patronizing talk addressed to older adults: Psycholinguistic features of care and control. International Journal of Psycholinguistics 1996;12:149-69.
12. Hummert ML, Shaner J, Garstka T, et al. Communication with older adults: The influence of age stereotypes, context, and communicator age. Hum Commun Res 1998; 25:124-51.
13. Baltes MM, Neumann E-M, Zank S. Maintenance and rehabilitation of independence in old age: An intervention program for staff. Psychol Aging 1994;9:179-88.
14. Kihlgren M, Kuremyr D, Norberg A, et al. Nurse-patient interaction after training in integrity promoting care at a long-term ward: Analysis of video recorded morning care sessions. Int J Nurs Stud 1993;30:1-13.
15. Roter DL, Hall JA, Kern D, et al. Improving physicians' interviewing skills and reducing patients' emotional distress. Arch Intern Med 1995;155:1877-84.
16. Williams K, Kemper S, Hummert ML. Enhancing communication with older adults: Overcoming elderspeak. The Journal of Gerontological Nursing. In press.
17. Williams K, Kemper S, Hummert ML. Improving communication in the nursing home: An intervention to reduce elderspeak. Gerontologist 2003;43:242-7.
18. Ryan EB, Meredith SD, Maclean MJ, et al. Changing the way we talk with elders: Promoting health using the communication enhancement model. Int J Aging Hum Dev 1995;41: 89-107.
19. Abrams W, Beers M, Berkow R. The Merck Manual of Geriatrics. Whitehouse Station, New Jersey: Merck Research Laboratories, 1995.