Psychosocial Perspectives on Discourse and Hearing Differences Among Older Adults

Le discours et les problèmes d'audition chez les personnes âgées : perspectives psychosociales

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Key words: Communication Predicament, aging, communication enhancement, communication accommodation

Abstract

This overview article provides psychosocial perspectives for understanding individual differences among older adults in communication skills, especially the discourse and hearing problems highlighted in the two special issues on *Discourse and Aging* (this issue), and *Hearing and Aging* (in press). Older adults often experience the Communication Predicament of aging (Ryan, Giles, Bartolucci, & Henwood, 1986), within which their opportunities to exhibit discourse and hearing competence are limited by their communication environments. Within a health promotion framework, communication enhancement strategies can work most effectively when care providers are enabled to empower their older clients to learn and use more productive communication skills. Clinical communication experts then become essential, not only for individual assessment and treatment, but also for expanding roles in staff, family, and volunteer education and training, and in negotiating more communicatively healthy environments.

Abrégé

Cet article offre un point de vue psychosocial qui nous permet de mieux saisir les variations des aptitudes à la communication chez les personnes âgées, plus précisément les problèmes de discours et d'audition mis en relief dans les deux numéros spéciaux rattachant ces aspects au vieillissement. Les aînés éprouvent souvent de la difficulté à communiquer lorsqu'ils vieillissent (Ryan, Giles, Bartolucci, & Henwood, 1986), leur aptitude à démontrer leurs compétences au niveau du discours et de l'audition étant limitée par le milieu dans lequel s'effectue la communication. Dans le contexte d'un programme de promotion de la santé, les stratégies visant à faciliter la communication donneront les meilleurs résultats quand ceux qui dispensent les soins sont en mesure d'aider leurs clients âgés à apprendre et à utiliser des moyens de communication plus efficaces. Les spécialistes de la communication clinique deviennent alors essentiels, non seulement pour l'évaluation et le traitement personnalisé, mais aussi pour l'élargissement des rôles au niveau de l'éducation et de la formation des employés, des parents et des bénévoles, et pour la négociation de conditions plus propices à la communication.

Current research on aging supports the claim that effective communication in later life is key for access to adequate health and social services, and to appropriate social support (i.e., family relationships, maintaining a confidant, caregiving, and care receiving) (Kreps, 1989). Communication skills are at risk in old age partly due to changes in the older person, and partly to inadequacies in the communication environment.

Scholarly interest in discourse and hearing in older adults has grown rapidly over the past decade. The traditional emphasis in cognitive psychology and psycholinguistics has been on receptive and expressive skills of healthy older adults - memory, speed, language, and hearing changes (Kemper, 1992; Light, 1990; Olsho, Harkins & Lenhardt, 1985). The traditional clinical emphasis has been on receptive and expressive problems in older adults with communication disorders (Hull, 1995; Lubinski, 1995; Ripich, 1991). Some particularly useful works have linked the cognitive/linguistic perspective on normal aging to a similar perspective on pathological aging and important clinical issues (Bayles & Kaszniak, 1987; Brownell & Joanette, 1993).

The non-clinical communication disciplines (e.g., communication, social psychology, sociolinguistics) offer complementary interdisciplinary viewpoints on aging (Coupland, Coupland, & Giles, 1991; Hummert, Wiemann, & Nussbaum, 1994; Ryan, 1994). For example, the recently published *Handbook of Communication and Aging* (Nussbaum & Coupland, 1995) includes sections on language and social aging, communicative construction of relationships in later life, organizational communication, political and mass communication, and health communication. The need to foster multidisciplinary cross-fertilization of ideas on communication and aging has never been greater. Speech-language pathologists and audiologists

benefit from taking into account the diverse theoretical perspectives held by colleagues in the social sciences. Opportunities to discuss communication, aging, and health issues with like-minded, non-clinically based colleagues have occurred over the past decade via international conferences (Giles, Coupland, & Wiemann, 1990; Hummert, 1996; Ryan, 1996). The themes addressed in these conferences include older adults in health care settings, functional assessment, coping with communication disorders, social support, social construction of health and aging, intergenerational communication, technology, ethnic differences, communication strategies for health professionals, physician-patient communication, among others. The establishment of national and international communication and aging interest groups, such as those in the Canadian Association of Speech-Language Pathologists and Audiologists and the Gerontological Society of America, reflect the growing interest in the area and the imperative for multidisciplinary research and educational collaborations.

Multiple Influences on Language Performance

The most important implication from psychological research on aging is the impressive heterogeneity of performance among older adults. Poor performance in a language assessment or in a broader functional assessment conducted through conversation can occur despite maintained competence. Multiple factors influence performance, including individual life history (e.g., noise induced hearing loss), current environment (especially lack of practice), changes in information processing (e.g., age-related difficulty hearing speech in noise), selection of social strategies, task demands, situational context, motivation, and interpersonal expectations (Ryan, Kwong See, Meneer, & Trovato, 1994).

In familiar everyday situations most older adults can compensate well for age-associated problems by utilizing their strengths, such as years of practice in speaking, listening, writing and reading, increased vocabulary, extensive world knowledge, and a history of successful adaptation. However, in unfamiliar contexts with time constraints and with little apparent meaningfulness or in anxiety-evoking assessment contexts, performance can be severely diminished. In addition, older adults may respond in ways that are expected, based on negative stereotyped expectations of competence held by clinicians and others.

Current research on verbosity (Gold, Arbuckle, & Andres, 1994) illustrates the interplay among life history, current environment, cognitive and psychosocial factors on poor language performance. Off-topic verbosity, defined as abundance of verbal output and lack of focus or coherence, is associated with age, with about 15% of older adults displaying this behaviour in a life history interview. Off-topic verbosity has been linked to a decrease in ability to inhibit task-irrelevant thoughts (current cognitive ability) but also to life-long extraversion (history), higher levels of stress (current environment), and less concern for social desirability (social strategy).

In the hearing domain, Hull (1995) has reported that 60-80% of the North American population over age 65 may have a degree of hearing impairment that can interfere with normal conversation. The effects of such hearing changes on social interactions may lead to withdrawal and/or an impression upon others of confusion and disorientation, that may reinforce negative expectations. Thus, the appearance of confusion, for example, may be misattributed to cognitive rather than receptive changes, further enhancing the negative stereotype. In a further example, one might speculate that one of the strategies used by hearing-impaired older adults finding it difficult to follow a conversation would be to monopolize the conversation, even becoming verbose.

The need for researchers and clinicians to explore alternate and multiple explanations for the varied communicative performance of older adults is critical. Interdisciplinary collaboration among the applied and basic health and social science researchers will advance our understanding of the multiple influences on older adults' discourse and hearing performance.

Communication Predicaments and Enhancement Strategies

> Why do you think the staff insists on talking baby talk when speaking to me? I understand English. I have a degree in music and am a certified teacher. Now I hear a lot of words that end in 'y'. Is this how my kids felt? My hearing aid works fine. There is little need for anyone to position their face directly in front of mine and raise their voice with those 'y' words. Sometimes it takes longer for a meaning to sink in; sometimes my mind wanders when I am bored. But there's no need to shout.
>
> I tried once or twice to make my feelings known. I even shouted once. That gained me a reputation of being 'crotchety'. Imagine me, crotchety. My children never heard me raise my voice. I surprised myself. After I've asked for help more than a dozen times and received nothing more than a dozen condescending smiles and a "Yes, deary, I'm working on it," something begins to break (Seaver, 1994, p. 11).

This nursing home resident eloquently expresses the Communication Predicament of aging (Coupland, et al.,

1991; Ryan, Giles, et al., 1986; Ryan, Hummert, & Boich, 1995) in which an older person's opportunity to communicate effectively is limited by their communication environment. Conversational partners frequently hold some negative stereotypes about old age (especially that older adults are less competent and more dependent) and modify their speech in line with these expectations (Hummert, 1994). They tend to make overgeneralized responses to the specific difficulties exhibited by some older adults (e.g., hearing problems, forgetting, lack of concentration, or slow, slurred speech).

Systematic speech accommodation to stereotyped expectations of older adults, especially those with communication impairments and those living in institutions, has been described in field studies (e.g., Caporael, 1981; Kemper, 1994; Kemper, Vandeputte, Rice, Cheung, & Gubarchuk, 1995; Ryan, Wood, Sachweh, & Kroger, 1995). Key features of such accommodation are simpler grammar, simpler vocabulary, repetitions, brief imperatives, restricted topic selection, exaggerated praise, and overly familiar forms of address. Parallel nonverbal accommodations include both vocal features (high pitch, exaggerated intonation, slower speech rate, and loudness) and nonvocal features (rolling eyes, abrupt or dismissive movements, less eye contact, raising eyebrows, and dominant stance) (McGee & Barker, 1982).

Older adults are especially vulnerable in health care situations, where important interactions tend to be time-constrained and controlled by the health professional, and frequently occur with unfamiliar professionals in unfamiliar surroundings. Furthermore, in the medical context, psychosocial issues raised by older adults are more likely to be ignored. The greater likelihood of a third person in a doctor-patient visit also threatens the older person's ability to be heard (Adelman, Greene, & Charon, 1987; Greene, Hoffman, Charon, & Adelman, 1987; McCormick, Inui, & Roter, in press). Such conditions create an environment that undermines the unique identity of older adults, masks true needs, and leads to even greater clinician reliance on stereotyped expectations of performance.

The Communication Predicament for older adults is characterized by a negative feedback loop (Ryan et al., 1986; Ryan, Hummert, et al., 1995). Inappropriate accommodations not only reinforce age stereotypes but also constrain opportunities for communication. This pattern in turn can lead to significant consequences in terms of withdrawal from psychological and social activity, lowered self-esteem, and eventual declines in health.

Changes in discourse production reinforce old age behaviours (e.g., relying on others for help, speaking about the past). Research in North America and in Germany (Baltes & Wahl, 1996) has demonstrated the prevalence of a dependency-inducing script whereby long term care staff provide systematic social reinforcement for dependent behaviours in elderly residents. The intervention research by Baltes and Wahl highlights the causal link between such staff behaviour and resident dependency.

Applying the Predicament framework to verbosity and age-related hearing impairments suggests some research questions for health care encounters. Do care providers, expecting verbosity, repetition of personal stories from older adults, and hearing difficulties, give fewer cues to keep the conversation on track and show more signs of impatience than they would for younger adults? Are verbose older adults more vulnerable because of care providers' overgeneralizations of their previous behaviours? Do some older adults learn to become verbose because they expect not to be listened to? We would speculate that older patients might become verbose during health visits because of previous experiences with very quick interruptions by clinicians and their patterns of non-listening to the older adults' agenda.

Health providers also face a communication predicament, that of seeking the balance between conveying respect for older individuals and accommodating to their real needs (Ryan, Hummert, et al., 1995). This is a particular challenge when roles emphasize task completion and efficiency rather than effective communication. Only now are researchers and clinicians exploring effective communication options and testing their effects on myriad performance measures of older adults and their caregivers (e.g., levels of depression, degrees of challenging behaviours, stress and burden levels).

Disuse is an important component of preventable loss of discourse and hearing performance in both normal and pathological aging. To counteract this consequence of the Communication Predicament, Ryan, Meredith, MacLean and Orange (1995) presented a Communication Enhancement model derived from health promotion principles: self-care, mutual aid, and healthy environment (see also Lubinski, 1988; McWilliam, Brown, Carmichael, & Lehman, 1994; Pichora-Fuller, 1994). The model stresses recognition of individualized cues, modification of communication to suit individual needs and situations, and appropriate assessment of the health/social problems. The model also emphasizes that all of these dyadic activities are influenced by multiple environmental factors, some of which are modifiable. Communication enhancement strategies can work most effectively when care providers are enabled to empower their older clients to learn and use more productive discourse and hearing strategies. This goal can only be achieved in a communication enhancing environment where hearing, vision, and comfort needs of the older person are accommodated, where speech- language pathologists and audiologists adopt new roles as co-advocate or partner in decision making, and where such new roles are supported organizationally.

Some examples can be cited. The Baltes and Wahl (1996) intervention study fits within this framework by creating an environment where staff are enabled to reinforce resident independence. This can be accomplished by clinicians who take on new roles beside the traditional one as diagnostician. Moving beyond the mere identification of discourse and hearing-based problems in staff-resident interactions, clinicians function as facilitator of communication within the broader context of health promotion. Kagan (1995), Lyon (1992), and Hinckley, Packard, and Bardach's (1995) intervention programmes focus on teaching conversation partners (including health professionals and family members) about ways to enable aphasic adults to reveal their communication competence normally masked by their language difficulties. The same principle holds true for Erber's (1988) functional communication aural rehabilitation programme which emphasizes the use of retained hearing skills and discourse-based interaction strategies (verbal and nonverbal) to overcome hearing (acuity and discrimination) problems.

Let us consider these intervention models with respect to verbosity in older adults. Are health providers sometimes too quick to expect verbosity, to cut off meaningful conversation prematurely, and to give up redirecting the conversation back on track? Do they display nonverbal signals of impatience and boredom before the speaker goes off-track? Do they ignore environmental distractors that might decrease the person's ability to follow the conversation or keep track of his or her own thoughts? To overcome some of the automatic behaviours of both the verbose older person and the conversational partner, an intervention strategy could include the following: to show real interest and attention in what the person is saying for a specified period of time, to indicate the amount of time available, to establish agreement on the purpose of the visit, to assess ability to hear the conversation, to test out different environmental options (e.g., select locations where face-to-face attentive conversation is easier and where there are fewer distractions), and to redirect the speaker's attention to the topic of conversation consistently.

Implications for Expanding Roles of Speech-Language Pathologists and Audiologists

The major conclusion of the formal interdisciplinary discussion during the Second International Conference on Communication, Aging, and Health (Ryan & Butler, 1996) was:

> the resolve to focus research on ways to enhance communication between older adults and health providers in order to improve patient outcomes and satisfaction with care, increased job satisfaction among providers, and improve the efficiency and appropriateness of services for older people.

Speech-language pathologists and audiologists have pivotal roles to play in achieving this objective (Lubinski, 1988; Pichora-Fuller, 1994; Shadden, 1995). With knowledge about the age-associated changes and disorders which threaten discourse and hearing skills in old age as well as a conceptual understanding of the multiple non-competence factors influencing performance, communication specialists can provide appropriate assessment and treatment services directly to older adults experiencing difficulties. Beyond this traditional role, they are also increasingly involved in serving as educational resources for other health providers in terms of dyadic interaction strategies and recommended environmental modifications. They can foster the development, implementation, and evaluation of intervention strategies to enhance older adults' communication skills, their effectiveness with conversational partners trained to accommodate to their individual impairments, and their opportunities for meaningful social interactions. They can also collaborate with policy makers, administration, staff, family, and older adults to change the communication environments in health care settings, long term care institutions, community settings, and individual homes.

It would be advisable that speech-language pathologists and audiologists continue to develop collaborative links with their communication research colleagues from various disciplines, so that theory-based, empirically motivated, and clinically oriented communication intervention programmes for older adults can be developed and tested. Such collaborations also promise to enrich the scope of fundamental research and theory-building necessary for long-term gains regarding older adults' communication. In the various communication disciplines, graduate education should emphasize the training of gerontological clinical investigators with a health promotion perspective on the antecedents, contextual factors, and consequences of improved communication by and with older adults.

Author's note
Preparation of this article was supported by a grant from the Social Sciences and Humanities Research Council of Canada. Helpful comments on the draft article from J. B. Orange and M. Cheesman are gratefully acknowledged.

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