Enhancing Communication With Older Adults
Overcoming Elderspeak

ABSTRACT

Gerontological nurses promote health and successful aging for a growing population of older adults. Young adult care providers unknowingly may communicate messages of dependence, incompetence, and control to older adults by using elderspeak, a speech style similar to baby talk, that fails to communicate appropriate respect. This article describes a communication training program that significantly reduced the use of elderspeak by nursing assistants and led to more respectful, less controlling, and equally as caring communication between nursing assistants and nursing home residents. Strategies to use in evaluating and enhancing interpersonal communication with older clients are provided. Therapeutic communication is a critical tool for nurses who provide health care to the growing population of older adults.

Social interaction or the ability to relate to others is a basic need of all humans that continues to be critical to the well-being of elderly individuals (Carstensen, 1991; Nussbaum, 1983). The importance of social relationships is described in Maslow's hierarchy of needs, which places the human need for affiliation second only to survival and safety (Maslow, 1954). "Successful aging" is defined as not only physical and functional health, but also high cognitive functioning and active involvement with society (Rowe & Kahn, 1997). The power of social interaction is demonstrated by the fact that older adults live longer and respond better to health-care interventions when they have social support and relate closely with care providers (Estes & Rundall, 1992; Kiely, Simon, Jones, & Morris, 2000).

Older adults who require supportive care in institutions or who are homebound may rely primarily on health-care providers for opportunities for social contact (Nussbaum, 1990). Nurses working with older adults strive to be sensitive to their unique needs and to reinforce the existing strengths of older adult clients in the process of promoting health. Unfortunately, many health-care providers working with older adults unknowingly use elderspeak, a style of speech that fails to support these goals and has potential negative impact (Caporael, 1981; Williams, Kemper, & Hummert, 2003). Elderspeak is based on stereotypes that older adults are less competent, so younger communication partners simplify their communication, attempt to clarify communication, and alter the emotional tone of messages when communicating with older adults (Ryan, Hummert, & Boich, 1995).

Research demonstrates young, middle-aged, and even older adults have negative stereotypes about older adults that are strongly grounded in society and influence intergenerational communication (Hummert, Garstka, Shaner, & Strahm, 1994). Research confirms that individuals with obvious physical or mental disabilities are more likely to receive patronizing talk (Hummert, 1994; Kemper, Finter-Urczyk, Ferrell, Harden, & Billington, 1998) and that older adults in environments suggesting dependency, such as institutions, trigger more speech modifications than those in community settings (Hummert, Shaner, Garstka, & Henry, 1998).

Research also has demonstrated these stereotypes impact provider-client interactions in health care. For instance, physicians have been found to provide more information, offer more support, and share more decision-making with clients who are younger compared to older adults (Adelman, Greene, & Charon, 1991).

KRISTINE WILLIAMS, PhD, RN, SUSAN KEMPER, PhD, AND MARY LEE HUMMERT, PhD

VARIATIONS IN THE EMOTIONAL TONE OF NURSING HOME INTERACTIONS

Mrs. W., a new resident in the nursing home, is walking toward another resident's room and is about to enter. Her caregiver observes her from the nursing station. The following scenarios illustrate three different communication styles the caregiver can adopt.

- **Overly Nurturing Talk (highly caring, not controlling, inappropriately intimate)**
  Caregiver: Where do you think you're going? That's not your room, you silly girl.
  [Mrs. W continues to enter the room.]
  Caregiver: Well goodness, honey, you really are lost, aren't you? We can't have that now, can we? Give me your hand and we'll find your room. Come on, sweetie.
- **Directive Talk (high degree of control, little recognition of autonomy of the listener, little caring)**
  Caregiver: That's not your room. You have no business being there. Residents can't go in the rooms of other residents.
  [Mrs. W looks worried and pauses.]
  Caregiver: Move along now and find your own room.
- **Affirming Talk (balanced care and control, indicates the partner is competent and independent)**
  Caregiver: Mrs. W., it looks like you're lost. Are you having trouble finding your room?
  Mrs. W: I do seem to have lost my way. I want to go to my room.
  Caregiver: Well, all of these doors look alike. Your room is just down the hall by the solarium. Let me show you back to your room.

This article describes a communication training program focused on educating nursing assistants about elderspeak and its underlying messages and providing practice of effective communication skills. Evaluation of the training program's effectiveness (Williams et al., 2003) revealed significant reductions in the use of elderspeak by nursing assistants and an increase in the use of communication that was rated as more respectful, less controlling, and equally as caring after training.

REVIEW OF THE LITERATURE

Elderspeak is commonly heard in communication between young and older adults and frequently occurs in settings in which health care is provided to older adults. Early social scientists first identified elderspeak and estimated 20% of the communication occurring in nursing homes is actually elderspeak (Caporael, 1981). This style of speech may be indistinguishable from baby talk and features a slower rate of speech, exaggerated intonation, elevated pitch and volume, greater repetitions, and simpler vocabulary and grammar than normal adult speech (Caporael, 1981; Kemper, 1994).

Although elderspeak may be an attempt on the part of young communicators to promote clear and effective communication and to show caring, the Communication Predicament of Aging Model provides a framework to understand how this speech style fails to accomplish these goals (Ryan et al., 1995). The model describes how stereotypes that older adults are less competent trigger young individuals to modify their speech in intergenerational communication, implementing strategies to simplify speech, add clarification, and alter the emotional tone of messages.

Caregivers may assume older adults prefer the nurturance of elderspeak. However, older adults in both institutional settings and those receiving home care services report as many as 40% of their caregivers use speech they perceive as demeaning (Caporael & Culbertston, 1986; Henwood & Giles, 1985).

Because older adult recipients of elderspeak perceive it as patronizing and implying incompetence, these individuals may respond with lowered self-esteem, depression, withdrawal from social interactions, and even assumption of dependent behavior consistent with their own stereotypes of elderly individuals (Kemper & Harden, 1999; Ryan, Bourhis, & Knops, 1991). Not only does elderspeak fail to improve communication effectiveness for older adults (Kemper & Harden, 1999), 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 for elderly individuals (Ryan, Giles, Bartolucci, & Henwood, 1986). These outcomes are incongruent with nursing's goal of promoting independence in aging clients (Ryan et al., 1995).

The following excerpt from a caregiving interaction in a nursing home illustrates some features of elderspeak that are common in settings serving older adults. This type of communication could easily be mistaken for that between a caregiver and an infant or child (Williams,

2001):

> Good morning, Jenny. [Pause] Jenny. [Pause] My goodness. Where's your leg? Ooh, hanging off the bed, girl, hanging off the bed. Hey Jenny, how are you? You're zonked this morning, aren't you girlie? Sound asleep.

Health-care provider-client communications, such as this example, frequently include elderspeak, revealing an imbalance of care and control (Hummert & Ryan, 1996). This imbalance may be caused by the demands of work assignments. Overly directive or bossy talk that reflects a high degree of control but fails to recognize the autonomy of the listener may occur when care providers are under pressure to complete multiple work tasks (Ryan et al., 1991). Overly nurturing or baby talk reflects an inappropriate intimacy, high levels of caring, and little emphasis on control (Hummert et al., 1998). This excessive caring may be an attempt of caregivers to soften the directiveness in their communication (Hummert & Ryan, 1996).

In contrast, most adults prefer an affirming emotional tone that appropriately balances care and control, communicating the listener is competent to comprehend the message and act independently (Ryan, Meredith, Maclean, & Orange, 1995). The Sidebar provides examples of how a caregiver 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 well prepared to communicate with elderly individuals and may, in fact, be socialized to using elderspeak. Licensed practical nurses, registered nurses, and other health-care team professionals seldom have specific training and expertise in communication and aging (Grant, Pothoff, Ryden, & Kane, 1998) and can benefit from evaluating their own communication practices.

Most health-care workers do not realize they use elderspeak or the negative messages it provides. However, caregivers who become aware of elderspeak and realize its potential negative messages can consciously reduce their use of elderspeak, enhancing their communication effectiveness and improving their working relationships with clients. Even though longstanding behaviors are difficult to change, research supports the ability of providers to modify their caregiving behaviors as a result of education (Baltes, Neumann, & Zank, 1994; Campbell, Knight, Benson, & Colling, 1991; Kihlgren et al., 1993). In fact, communication skill training has resulted in significant improvements in interactions in long-term care settings (Baltes et al., 1994; Kihlgren et al., 1993; Roth, Stevens, Burgio, & Burgio, 2002) as well as in other health-care provider-client interactions (Roter et al., 1995).

PROGRAM DESCRIPTION

A recent study was designed to assess whether health-care workers who were made aware of elderspeak and its potential negative effects on older adults would reduce their use of elderspeak in interactions with care recipients (Williams et al., 2003). A brief intervention based on the Communication Enhancement Model (Ryan et al., 1995) focused on alerting nursing home caregivers to elderspeak, its messages, and potential negative effects.

Although the program was targeted for communication with cognitively intact older adults, residents with varying levels of cognitive decline were included in the sample because there are diverse opinions regarding optimal communication strategies for individuals suffering from dementia. Some researchers believe features of elderspeak such as accentuated speech modulation may improve comprehension for those with dementia (Bayles, Boone, Tomoeda, Slauson, & Kaszniak, 1989), while other researchers believe elderspeak may be perceived negatively by those suffering from cognitive deficits (Ryan et al., 1995).

Realizing the current crisis in nursing home staffing and the goal to develop an intervention that would be feasible in today's health-care environment, the program was limited to three 60-minute sessions (Banazak, Mickus, Averill, & Colenda, 2000). Because older adults residing in nursing homes are particularly dependent on staff contact for social interaction and because nursing assistants are estimated to provide 80% of social contacts (Feldt & Ryden, 1992; Nussbaum, 1990), these participants were selected as study participants. The program was presented to small groups of three to five nursing assistants (N = 20) in five different licensed nursing homes in Kansas.

The program focused on alerting participants to the socialization needs of older adults, the communication barriers within nursing homes, understanding elderspeak and its potential negative effects on residents, and practicing effective communication skills. Teaching strategies were selected for their appropriateness for adult learners and included limited lecture, group discussion, and role-play to practice new skills (Cervantes, Heid-Grubman, & Schuerman, 1995).

A central feature of the program was the inclusion of videotaped staff-resident interactions from an actual nursing home as well as simulated vignettes between two role-playing actresses. These vignettes were used to illustrate elderspeak features presented in the lectures. Participants critiqued these vignettes and then reenacted them substituting effective communication strategies for those of elderspeak.

Participants also were given the opportunity to listen to excerpts of their own conversations with residents recorded before the training.

TABLE 1

CONTENT AREAS AND OBJECTIVES FOR COMMUNICATION TRAINING EDUCATIONAL PROGRAM

Day One: Importance of Communication in Nursing Homes

Objectives

- Identify communication barriers for nursing home residents.
- Identify effective and ineffective communication behaviors in a series of videotaped staff-resident interactions.
- Practice strategies at work.
- Contrast personal interactions that were effective or problematic.

Content

- Review why we communicate and research that demonstrates how communication affects resident independence and quality of life as well as staff job satisfaction.
- Review characteristics of effective versus ineffective communication.

Day Two: Common Communication Problems in the Nursing Home

Objectives

- Identify the features of elderspeak and how patronizing communication can negatively affect older adults.
- Identify features of elderspeak in videotaped interactions.
- Identify elderspeak in recordings of one's own talk.

Content

- Discuss problems related to a lack of opportunities, ignoring talk, and task talk.

Day Three: Affirming Communication

Objectives

- Identify affirming messages in videotaped examples of staff-resident interactions and the importance of non-verbal messages.
- Critique videotapes of staff-resident interactions, rewriting the script and role-playing without elderspeak.

Content

- Characteristics of affirming communication.

This was a non-threatening way to make them aware of their personal use of elderspeak. The communication training program content and objectives are listed in Table 1.

PROGRAM EVALUATION AND FINDINGS

To evaluate the specific aim of increasing participant knowledge about effective communication with older adults, a program evaluation was used. Each participant anonymously rated the program using a Likert scale to indicate whether they disagreed (1) or agreed (5) that the program met the objectives. Ratings ranged from 4.1 to 4.8 for the eight items and included ratings of the content and teaching methods, as well as the applicability of learned skills to their job.

A second mechanism was used to determine whether participant learning occurred as a result of education. Each participant watched a videotaped nursing home interaction and evaluated the staff communication behaviors reflecting elderspeak. The same videotape was evaluated before and after training. The following is an excerpt of the transcript from the nursing home interaction that was used for the pre- and post-training evaluation. Brackets indicate features of elderspeak used by the nursing assistant; in addition, accentuated and high-pitched intonation, pauses, and slowed rate of speech also were used.

Nursing assistant: No, this is for you.

Resident: But I want it. I want it there.

Nursing assistant: Well, we'll [collective pronoun substitution] get some glue down there, okay? You ready to go to your room or out to

TABLE 2

PAIRED COMPARISON OF PRE- AND POST-TRAINING DIFFERENCES IN RATING ON SCALED ITEMS (N = 20)

Evaluation Item	Pre-training Mean (SD)	Post-training Mean (SD)	Paired t Test Statistic	p Value
The nursing assistant's speech was: Effective (1 = ineffective to 5 = effective)	2.75 (1.41)	2.25 (1.37)	1.14	.27
Appropriate (1 = inappropriate to 5 = appropriate)	3.50 (1.43)	2.65 (1.14)	2.99	.01*
The nursing assistant acted like she: (1 = disagree to 5 = agree)				
Doesn't really care what happens to residents	2.05 (1.18)	2.74 (1.15)	-1.99	.06
Seemed emotionally drained from her work	2.10 (.91)	2.30 (1.13)	-.75	.46
Probably feels she positively influences the lives of residents	3.05 (1.09)	3.10 (.79)	-.21	.83

*$p < .05$

see some TV or something?

Resident: I don't want to go to my room. I just started this painting.

Nursing assistant: Okay.

Resident: But it never will be finished.

Nursing assistant: Well, it's finished, honey [diminutive], look.

Resident: But it will never be finished.

Nursing assistant: See, it's all finished [repetition]. All painted [shortened, simplified statements]. Got your ribbon put on.

Paired comparisons of pre- and post-training ratings of this interaction revealed significant changes in participants' identification of the use of baby talk and failure to acknowledge what the resident said, and increased ratings of inappropriateness. Two-tailed paired t tests were used to evaluate pre- and post-training differences in rating on the scaled items (Table 2) and the McNemar binomial test was used to evaluate the differences in proportions for the dichotomous items (Table 3). The findings showed nursing assistants gained knowledge about communication and became more sensitive to staff-resident communication following the communication training program.

Nursing assistants who participated in communication training also were able to identify their own use of elderspeak. Participants who listened to recordings of their own interactions with residents during routine care expressed alarm at their own personal use of elderspeak, confirming a lack of conscious awareness of elderspeak by health-care workers.

In addition to the knowledge assessment, participants' conversations with residents were recorded before and after training. Analysis of those conversations, which is described in detail elsewhere (Williams et al., 2003), focused on both psycholinguistic features and evaluations of the affective qualities of care, respect, and control. Those analyses revealed conversations with residents included fewer psycholinguistic features of elderspeak after training than before training; in addition, post-training speech was perceived as more respectful and less controlling than pre-training conversations. However, the caring dimension did not vary between the pre- and post-training recordings, demonstrating that the intervention altered the emotional tone of nursing assistants' speech to the residents by reducing controlling messages and increasing respect, while still maintaining caring aspects.

DISCUSSION AND NURSING IMPLICATIONS

The success of this brief educational intervention in reducing the use of elderspeak suggests it is a feasible mechanism to improve nursing home communication. Although nursing assistants who worked in long-term care settings participated in the study, other members of the health-care team in nursing homes as well as those who interact with older adults in residential or community settings also could benefit from enhancing their communication with older adults.

Listening to conversations between young and older adults is an

TABLE 3

EVALUATION OF DIFFERENCES IN PROPORTIONS FOR COMPARISON OF DICHOTOMOUS ITEMS PRE- AND POST-TRAINING (N = 20)

	% Responded Yes		McNemar Binomial
	Pre-training	Post-training	p Value
The nursing assistant:			
Used a kind of baby talk	10.0	52.4	.016*
Used short sentences	66.7	71.4	1.000
Used inappropriate terms of endearment	38.1	57.1	.375
Used "we" and "us" when referring to things only the resident can do	33.3	61.90	.227
Stayed on the resident's topic	71.4	38.1	.092
Acknowledged what the resident said	71.4	33.3	.039*

*$p < .05$

effective way to identify and sensitize oneself to the use of elderspeak. Elderspeak is apparent in intergenerational conversations in everyday settings such as grocery stores, banks, and fast food lines. As revealed in the study, participants were unaware of their personal use of elderspeak with nursing home residents. Recognizing one's own use of elderspeak with older adults is a first step to modifying communication practices to enhance interpersonal communication skills.

Nurses and other health-care providers can reduce their use of elderspeak and communicate more effectively in working with older adults to meet their health-care needs by using the Communication Enhancement Model. This model, which served as the basis of the communication training program in this study, provides a framework for effective communication with older adults that reflects the nursing process (Ryan et al., 1995). The Communication Enhancement Model charges professionals to perform individual assessments of older adult clients' communication needs, using simplification and clarification strategies only when indicated by communication needs of clients.

By using this model, 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 work to meet health and daily care needs. The increasing prevalence of nursing home residents with dementia points to a need to investigate the effect of elderspeak in communication with this growing population of elders.

Specific markers of elderspeak are relatively easy to identify and self-monitor in one's own communication. These characteristic features of elderspeak include diminutives, inappropriate plural pronoun use, tag questions, and slow, loud speech. The Sidebar provides descriptions and examples of these features and suggests alternative strategies for improved communication. The communication training program succeeded in not only reducing these features in nursing assistant-resident communication, but the resulting communication was judged to be more respectful and less controlling, yet equally as caring as elderspeak. By limiting the use of a few select features of elderspeak, caregivers may significantly improve the messages they provide to older adults.

Diminutives include inappropriately intimate and childish names such as "honey" and "good girl." These references may imply a parent-child nature to the relationship. Collective pronouns inappropriately substitute a collective form when the singular form in grammatically correct (e.g., "Are we ready for our bath?"). Such substitutions imply the older individual cannot act alone or make independent decisions. Tag questions (e.g., "You want to take your medicine now, don't you?") appear to offer a choice to the recipient. However, the implication is the speaker has to guide the recipient to select the appropriate response. Together, these features of elderspeak contribute to messages that the recipient is incompetent and dependent.

Increasing voice volume is a frequent strategy for communicating with older adults; for some elders with hearing loss, this strategy may be appropriate. However, for most elders with normal hearing loss, greatly increased volume only further distorts their hearing while the use of high-pitched intonation, simi-

lar to talk used with infants, provides additional challenges for older adults who typically lose the ability to comprehend these higher pitched frequencies (Abrams, Beers, & Berkow, 1995).

Slowing of speech and limiting talk to short sentences is another common pitfall. For older adults experiencing normal changes in aging including reductions in working memory and for older adults with pathological memory loss, research shows simply shortening speech into smaller segments does not result in increased speech comprehension (Kemper & Harden, 1999). Use of childish vocabulary and grammar also are frequently used. 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 cognitively intact older adults (Kemper & Harden, 1999).

Today's busy health-care providers often overlook the critical importance of non-verbal communication even though it has been demonstrated to provide a stronger message than spoken words. Eye contact and body language signals provide an ultimate message of engagement in interaction with older adults, and providing non-verbal messages that complement spoken language is essential to effective communication.

Because communication behaviors are difficult to change, practicing speech without elderspeak is helpful in preparing for actual clinical situations. 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. An improved communication environment in turn promotes cognitive and functional abilities for older adults. Achieving optimal communication environments may contribute to higher levels of well-being for older adults and to increased quality of life. Young adult care providers also may benefit from increased job satisfaction if they relate closely with care recipients.

FEATURES OF ELDERSPEAK AND ALTERNATIVE STRATEGIES

- Diminutives (inappropriately intimate terms of endearment, imply parent-child relationship)
  Examples: honey, sweetie, dearie, grandma

Alternative strategy: refer to residents by their full name (i.e., Mrs. Robinson) or by their preferred name

- Inappropriate plural pronouns (substituting a collective pronoun, e.g., we, when referring to an independent older adult)
  Example: "Are *we* ready for *our* medicine?"

Alternative strategy: "Are *you* ready for *your* medicine?"

- Tag questions (prompts the answer to the question and implies the older adult can't act alone)
  Example: "You would rather wear the blue socks, *wouldn't you*?"

Alternative strategy: "Would you like to wear the blue socks?"

- Shortened sentences, slow speech rate, and simple vocabulary (sounds like baby talk)

These communication patterns do not improve comprehension of speech for most older adults and are perceived as patronizing or demeaning.

CONCLUSION

Working to overcome elderspeak through awareness and self-monitoring as well as through formal educational programs are strategies nurses and other care providers can use to promote successful aging for older clients. Despite the challenge of understaffing and work conditions, individuals working with older adults can periodically reassess and fine-tune their communication and the messages they provide to older adults. Communication is a powerful tool for nurses and health-care workers to capitalize on when working with clients to promote health and well-being.

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KEYPOINTS

Enhancing Communication With Older Adults

Williams, K., Kemper, S., & Hummert, M.L. **Enhancing Communication With Older Adults: Overcoming Elderspeak**. *Journal of Gerontological Nursing*, 2004, 30(10): xx-xx.

1. Elderspeak is a common way of speaking to older adults that has potential negative effects.
2. Health-care workers who became aware of elderspeak were able to identify more effective communication strategies in working with older adults.
3. Awareness and monitoring of communication skills are important aspects of providing quality health care to older adults.

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ABOUT THE AUTHORS

Dr. Williams is Assistant Professor, University of Kansas School of Nursing, Kansas City, Kansas. Dr. Kemper is Roberts Distinguished Professor of Psychology and Gerontology, University of Kansas Gerontology Center, Lawrence, Kansas. Dr. Hummert is Professor of Communication Studies and Graduate Advisor, Gerontology, Communication Studies Department,

University of Kansas, Lawrence, Kansas.

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Address correspondence to Kristine Williams, RN, PhD, Assistant Professor, University of Kansas School of Nursing, 3901 Rainbow Boulevard, Kansas City, KS 66160.