

Evaluative Perceptions of Patronizing Speech Addressed to Elders

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Within a speech accommodation framework, speech modifications based on stereotyped expectations of elderly persons (such as patronizing speech) are hypothesized to convey less respect. Adult volunteers ($N = 186$) read scripts of a conversation between a nurse caregiver, using either patronizing speech or a more neutral variant, and a 76-year-old nursing home resident, depicted either as alert or forgetful. Respondents viewed the nurse in the patronizing condition as significantly less respectful and less nurturant and the recipient as more frustrated. The patronizing nurse was also rated as significantly less competent and benevolent than her counterpart in the neutral condition. The ecological validity of the contrasts between scripts was confirmed by inferences that patronizing speech was more shrill, louder, and produced with more exaggerated intonation.

The communicative strategies that characterize encounters between younger and older people are attracting increasing interest in the research literature. For instance, slower speech, exaggerated intonation, higher pitch, increased loudness, repetitions, tag questions and close-ended questions, and simplification of vocabulary and grammar are all adaptations that have been identified in speech addressed to frail older residents in institutional settings (Ashburn & Gordon, 1981; Caporael, 1981; Coupland, Coupland, Giles, & Henwood, 1988; Lanceley, 1985). In addition, speech adaptations toward elders residing in the community have also been noted (Coupland et al., 1988; Henwood & Giles, cited in Ryan, Giles, Bartolucci, & Henwood, 1986).

A particular form of speech sometimes addressed to elderly persons is known as "secondary baby talk" (Caporael, Lukaszewski, & Culbertson, 1983). Secondary baby talk is exemplified by exaggerated intonation and high pitch. Such speech is associated with low respect, but with a positive value for nurturance (Caporael et al., 1983). In their studies of baby talk, Caporael et al. (1983) showed that caregivers varied in their use of baby talk and care recipients varied in their preferences for baby talk, but the variations in usage did not correspond to variations in preference. Whereas preferences for baby talk were largely related to low functional status of the elderly residents, use of baby talk was related to the caregivers' expectations that baby talk was good for elders in general. In a study by

Ryan and Cole (1990), elderly respondents expressed a preference for speech from young people to be more respectful as well as more nurturant. However, the respondents in this study who resided in an institution showed a greater preference for simple, slow, and clear speech than did the less frail group residing in the community.

Speech accommodation theory provides a useful framework for exploring the social psychological antecedents and consequences of modifying speech addressed to elderly persons (Coupland et al., 1988; Ryan et al., 1986). This theory attempts to explain and predict sociolinguistic behavior within interpersonal situations in terms of convergent or divergent orientations toward interlocutors and particular goals of the interaction (see also Giles, Mulac, Bradac, & Johnson, 1987; Giles & Powesland, 1975). On the basis of accommodation theory and the emerging evidence that attests to the distinctive features of talk addressed to elders, Ryan et al. (1986) proposed four types of accommodation strategies in young-old talk that could interfere with effective intergenerational communication.

The first strategy, overaccommodation due to physical-sensory handicap, is observed when speakers modify their speech beyond an optimal level for addressees who are correctly or incorrectly perceived to have a specific handicap (e.g., hearing impairment or physical disability). Simplification and exaggerated carefulness of speech as well as the prosodic features associated with baby talk are some of the modifications that characterize overaccommodation due to physical-sensory handicaps (see Caporael, 1981; Coupland et al., 1988).

The second strategy is dependency-related overaccommodation, which is triggered by the role relationship between caregiver and dependent care recipients, typically within institutional settings. This discourse strategy is likely to involve overbearing, patronizing speech with overly directive and regulatory features (Coupland et al., 1988; Lanceley, 1985).

The third and most pervasive strategy, intergroup overaccommodation, involves modification of speech based on sim-

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ply the addressee's perceived membership in a social category—being elderly. Although attitudes toward the elderly are not uniformly negative, stereotypes about the elderly as less competent, more forgetful, slower, more dependent, and less active can influence conversational strategies (Kite & Johnson, 1988; Kogan, 1979; Levin & Levin, 1980; Rubin & Brown, 1975; Ryan, in press; Ryan & Heaven, 1988; Ryan & Laurie, 1990). Speech to elders based on stereotypes of older people will usually incorporate modifications that do not match their individual communication needs (Atkinson & Coupland, 1988; Caporeal et al., 1983; Nussbaum, Thompson, & Robinson, 1988; Shadden, 1988). As Dowd (1981) and Rodin and Langer (1980) have argued, the elderly in Western culture suffer within intergenerational relationships because as a group the elderly lack status and power in society. Characteristics of speech to elders underestimating their competence, autonomy, and influence include slow speech rate, simplification of vocabulary and grammar, restricted topic selection, impatience, inattention, and patronizing speech style.

The fourth strategy identified by Ryan et al. (1986), presumably rare and not relevant to this article, is age-related divergence in which young speakers convey subtly or explicitly the desire to dissociate themselves from the elderly by talking "young" (e.g., using fast speech or slang, discussing youth-oriented topics, and showing lack of interest in elders' comments).

According to this model of conversational strategies to elders, overaccommodation in terms of stereotypes and role expectations is hypothesized to convey a lack of respect to the older listener and to contribute thereby to feelings of lowered self-esteem and communication satisfaction. The lack of respect should be particularly felt by those elders who have maintained their cognitive and sensory abilities at a high level.

We designed this study in order to gather empirical evidence about perceived meanings of speech overaccommodation. Current research has identified various characteristics of overaccommodating speech addressed to elders with varying capabilities, but no investigations of evaluations of such speech have yet been conducted. Continued elaboration of speech accommodation theory requires the testing of predictions concerning evaluations of contrasting speech styles as well as the factors that influence those evaluations.

This study examined evaluative reactions toward one type of age-biased overaccommodation—patronizing speech. The patronizing speech featured characteristics associated with controlling language and parentlike styles identified in the literature on talk to institutional residents (Kahana & Kiyak, 1984; Lanceley, 1985). Whereas the defining features of secondary baby talk are paralinguistic (pitch and intonation), patronizing speech was characterized here in terms of wording. Moreover, wording that might connote the nurturant quality associated with baby talk was deliberately omitted from this operationalization of patronizing speech.

A person-perception paradigm was used in which respondents reacted to a dialogue sequence involving a nurse and an institutionalized elderly resident (see Genesee & Bourhis, 1982, 1988). Participants read one of a series of written scenarios, in which the nurse caregiver addressed the resident by using either an institutional task-oriented style or a patronizing variant of

that style. The situation portrayed was one in which we might expect to find overaccommodation based on intergroup expectations and on the role-related dependency of the elder. The patronizing speech was predicted to convey a lack of respect for the resident and to be associated with perceived frustration by the resident. Moreover, the patronizing speech was predicted to reflect negatively on the competence of the speaker.

The scenarios also varied in their depiction of the resident as either alert and active or as forgetful and confused. Speech accommodation theory predicts that the patronizing style would be viewed as less suitable for the alert resident than for the forgetful resident, whose need for speech modifications was more explicit. A final prediction based on the feedback models of Rodin and Langer (1980) and Ryan et al. (1986) was that the recipient of patronizing speech would be viewed as less capable than the recipient of neutral institutional speech.

A psycholinguistic innovation in this study was the elicitation of inferred paralinguistic speech traits from written dialogue sequences. Instead of presenting the actual voices of stimulus speakers portraying the roles, only a written script of the dialogue was presented to the raters. This manipulation allowed respondents to judge the desirability of the neutral and patronizing discourse without being influenced by the actual voice quality and prosodic features of potential actors. The presentation of a written text rather than a spoken text also had the advantage of permitting examination of raters' stereotypes of what they perceived to be the paralinguistic features of speech of the dialogue speakers (neutral vs. patronizing conditions) and elderly residents (alert vs. forgetful conditions).

It was predicted that respondents would associate the typical paralinguistic characteristics of secondary baby talk with patronizing speech (e.g., high pitch and exaggerated intonation). Furthermore, because the study of age perceptions of voices has led to suggestions that beliefs about vocal changes play a role in older persons' adjustment to aging, this method can provide relevant data regarding expected age and health differences in the vocal attributes of alert and forgetful elderly speakers (see Benjamin, 1988).

Method

Subjects

Adult visitors to a science center were recruited to participate in a psychology study by means of a sign posted in a busy area. Those interested received a brief description of the questionnaire in which they were asked to form impressions of two people in a conversational script. The 186 volunteers (60% female and 40% male) ranged in age from 18 to 82 years ($M = 31.2$ years, $SD = 12.2$). All were residents of either Canada or the United States. They either were native speakers of English or rated themselves as proficient speakers of English. In this highly educated sample, 56% were university graduates, whereas only 3% had not completed secondary school.

Materials and Procedure

The basic scenario consisted of a brief description of the two interlocutors, a middle-aged nurse and an elderly nursing home resident, and a conversational script about taking medication. To emphasize the mental capabilities of the resident in the alert condition, she

was described as a 76-year-old woman with physical difficulties who served as a member of the Residents' Council of the institution. In the forgetful condition, the 76-year-old resident was described as having had difficulties managing her affairs prior to admission, as not involved in activities in the home, and as confused and forgetful. These two descriptions constituted the manipulation of status of the elderly resident as alert versus forgetful.

The neutral institutional text contained five conversational turns for the nurse caregiver and four turns for the resident. The neutral dialogue contained content features depicting an ordinary task-oriented encounter between a caregiver and an institutionalized elderly resident. The patronizing version was similar except that the caregiver's conversational turns incorporated several cues associated with condescending or simplified speech (i.e., presumption about inability to understand and enjoy a television program, use of brief imperatives, and use of the expressions "poor dear" and "good girl"). These two dialogues constitute the manipulation of the nurse caregiver's speech style as neutral versus patronizing (see the Appendix for the contrasting conversational turns). The term *neutral* is used here only in comparison to the more patronizing version. It should be noted that the responses of the elder were held constant under all conditions of caregiver style and elder alertness. The scenario was developed jointly for this study and for a follow-up study (Shantz, Ryan, & Bourhis, 1989).

The response booklet contained six sets of ratings to address each of six questions: (a) the feelings of the nurse toward the resident and feelings of the resident toward the nurse; (b) the personal characteristics of the nurse and then the personal characteristics of the resident; and (c) what the voice of the nurse sounded like and then what the voice of the resident sounded like. The same sets of 7-point Likert scales were used for the nurse caregiver and the resident, although some items were more pertinent to one or the other. Ratings for how the nurse (resident) felt toward the other conversational partner were made along three a priori dimensions: (a) respect (dominant, respectful, and patronizing); (b) nurturance (considerate, warm, supportive, and nurturing); and (c) frustration (frustrated and helpless). Items for the first two dimensions are similar to those used by Ryan and Cole (1990), whereas the frustration items were included primarily to assess this reaction in the resident. As in Stewart and Ryan (1982), personal characteristics were assessed in terms of competence (intelligent, incompetent, and confident) and benevolence (unfriendly, helpful, and trustworthy). Also, three activity-potency items (alert, active, and weak) were included to assess the alertness manipulation regarding the resident. Speech ratings included seven characteristics associated with the older voice (i.e., [less] fast, wavering, hesitant, thin, [less] loud, [less] understandable, and [less] expressive) in addition to three items (shrill, high pitch, and exaggerated intonation) potentially associated with patronizing speech (Benjamin, 1988; Caporalet, 1981; Helfrich, 1979; Lanceley, 1985; Stewart & Ryan, 1982).

The ratings were arranged in a fixed random order on six separate pages, with ratings of the caregiver and then ratings of the resident on each of the three sets of evaluations.

Participants were given a booklet consisting of instructions, the written scenario, the rating scales, and a background questionnaire. They usually completed the task in approximately 15 min.

Results

Separate multivariate analyses of variance were conducted for the ratings of the caregiver and the resident for each of the three sets of evaluations using a between-subjects design (Speech Style \times Resident Alertness). As noted in Tables 1-5, small amounts of missing data resulted in slight variations in the sample size for the various analyses. The relational feelings

and personal variables are grouped in the tables according to the a priori dimensions, but the multivariate analyses were performed on all of the individual items within each evaluation set.

As is seen later in the results, the manipulations of speech style and alertness were effective. The nurse caregiver in the patronizing speech condition was viewed as more patronizing, more dominant, and less respectful than in the neutral speech condition. The resident depicted as forgetful was rated as less active and less alert than the resident depicted as alert. The differentiation by the respondents between the two elderly resident descriptions was, nonetheless, not as strong as anticipated.

Ratings of Feelings Toward Conversational Partner

The multivariate effect for speech style was significant for the ratings of the nurse's feelings toward the resident, $F(9, 170) = 10.6, p < .001$. There was no multivariate effect on these ratings for resident alertness or for the interaction between speech style and resident alertness. Therefore, means are presented in Table 1 for the two speech styles, but not in terms of alertness. Respondents perceived the patronizing speech style as conveying reliably less respect on all three items and less concern on all four items than the neutral institutional style. Moreover, the patronizing caregiver gave the impression of being less helpless (more controlling) and more frustrated with the resident. In line with speech accommodation theory predictions, the use of a patronizing style was viewed as reflecting a more dominant and less respectful relationship with the elderly addressee. Diminished nurturance and the appearance of frustration in the caregiver are empirical findings that fit anecdotal discussions about the controlling and poor listening features associated with the patronizing style (see Lanceley, 1985; McGee & Barker, 1982). Such an evaluative pattern is also consistent with the characterization of dependency-related overaccommodation given by Coupland et al. (1988). Because the predicted multivariate interaction between speech style and resident alertness did not achieve significance, no evidence was obtained for different evaluative impact of the speech contrasts on the perceived relationship with the alert resident in comparison with the forgetful resident.

For judgments of how the resident felt toward the nurse, only the multivariate effect for speech style was significant, $F(9, 170) = 3.42, p < .001$. This was reflected in the two ratings predicted to be sensitive to this manipulation: helpless and frustrated (see Table 2). In addition, the resident was seen as reliably less dominant and patronizing as well as more warm, supportive, and nurturing in the patronizing speech condition. The perception that recipients of the patronizing style were more helpless and frustrated confirms the notion that overaccommodation is seen as a frustrating and inappropriate strategy, even by our nonelderly observers (Ryan et al., 1986). The inferences of greater warmth, supportiveness, and nurturance appear to be based on sympathy for the underdog and consequent enhancement of positive qualities (Scheier, Carver, Schulz, Glass, & Katz, 1978). No multivariate effect for resident status or for the interaction was observed.

Ratings of Personal Attributes

With regard to personal attributes of the nurse, the only multivariate effect was for speech style, $F(9, 174) = 6.78, p < .001$.

Table 1
*Mean Ratings of Nurse Caregiver's Feelings Toward Resident
 in Neutral and Patronizing Speech Conditions*

Caregiver's feeling	Speech style				<i>F</i> (1, 178)	Proportion of variance
	Neutral		Patronizing			
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Respect						
Dominant	4.34	1.7	5.57	1.6	24.4***	.12
Respectful	5.07	1.5	2.99	1.7	78.1***	.30
Patronizing	4.06	2.0	5.38	1.9	20.5***	.10
Nurturance						
Considerate	5.22	1.5	3.60	1.6	49.2***	.21
Warm	4.67	1.5	3.60	1.7	21.1***	.10
Supportive	4.68	1.5	3.50	1.6	25.3***	.12
Nurturing	4.11	1.8	3.34	1.8	8.7**	.04
Frustration						
Helpless	1.82	1.5	2.33	1.9	3.9*	.02
Frustrated	1.90	1.3	2.54	1.6	8.4**	.04

Note. In the neutral speech condition, $n = 88$; in the patronizing speech condition, $n = 94$.
 * $p < .05$. ** $p < .01$. *** $p < .001$.

As seen in Table 3, the patronizing caregiver was judged to be reliably less intelligent, competent, confident, friendly, helpful, trustworthy, alert, and strong than her counterpart using the institutional style. Hence, patronizing speech reflects badly on the speaker in terms of inferred stable characteristics related to competence, benevolence, and potency.

For personal characteristics of residents, there was no multivariate effect for speech style or for the interaction. The values are, therefore, not shown in tabular form. However, the manipulation of resident description did yield a multivariate effect for resident status, $F(9, 171) = 2.74$, $p < .001$. The negative impact of forgetfulness was seen in two univariate analyses of these

ratings: active ($M = 3.12$ vs. 2.18 , $F(1, 179) = 18.6$, $p < .001$, $\omega^2 = .09$); and alert ($M = 4.67$ vs. 4.11 , $F(1, 179) = 6.1$, $p < .05$, $\omega^2 = .03$). The lack of significant univariate effects for the three competence-related attributes indicates the limited differentiation made by these respondents between the alert and forgetful residents.

Ratings of Inferred Speech Traits

Ratings of inferred speech traits of the caregiver yielded a multivariate effect for speech style, $F(10, 172) = 1.87$, $p < .053$. Univariate analyses (see Table 4) revealed that patronizing

Table 2
*Mean Ratings of Resident's Feelings Toward Nurse Caregiver
 in Neutral and Patronizing Speech Conditions*

Resident's feeling	Speech style				<i>F</i> (1, 178)	Proportion of variance
	Neutral		Patronizing			
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Respect						
Dominant	2.69	1.8	2.14	1.6	4.6*	.02
Respectful	4.02	1.5	4.27	1.6	<i>ns</i>	
Patronizing	3.48	2.0	2.87	1.9	4.5*	.02
Nurturance						
Considerate	3.97	1.5	4.13	1.7	<i>ns</i>	
Warm	3.08	1.4	3.59	1.7	4.9*	.03
Supportive	2.99	1.5	3.53	1.9	4.6*	.02
Nurturing	2.37	1.5	2.88	1.7	4.7*	.03
Frustration						
Helpless	3.96	1.9	4.92	2.2	9.9**	.05
Frustrated	4.28	1.8	4.96	1.9	5.7*	.03

Note. In the neutral speech conditions, $n = 89$; in the patronizing speech condition, $n = 93$.
 * $p < .05$. ** $p < .01$.

Table 3
*Mean Ratings of Nurse Caregiver's Personal Attributes
 in Neutral and Patronizing Speech Conditions*

Attribute	Speech style				<i>F</i> (1, 182)	Proportion of variance
	Neutral		Patronizing			
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Competence						
Intelligent	5.08	1.2	3.88	1.5	35.9***	.17
Incompetent	2.12	1.5	3.03	1.8	13.8***	.07
Confident	5.81	1.2	5.23	1.6	7.9**	.04
Benevolence						
Helpful	5.04	1.4	4.06	1.7	18.3***	.09
Unfriendly	2.66	1.6	3.52	1.8	11.7***	.06
Trustworthy	5.07	1.4	4.05	1.7	19.3***	.10
Activity-Potency						
Active	4.23	1.5	4.52	1.5	<i>ns</i>	
Alert	5.01	1.6	4.23	1.7	10.7**	.05
Weak	1.94	1.3	2.45	1.6	5.7*	.03

Note. In the neutral speech condition, $n = 90$; in the patronizing speech condition, $n = 96$.
 * $p < .05$. ** $p < .01$. *** $p < .001$.

speech was reliably rated as having the shrillness and exaggerated intonation taken as prime characteristics of baby talk to elders (Caporaël, 1981). In addition, the voice was rated as louder and less understandable. It is clear from these inferred speech traits that the listeners recognized the patronizing style as distinctive from neutral institutional discourse.

Analyses of speech inferences for the resident yielded no multivariate effects. The respondents did not display sensitivity to the alertness of the resident in rating her speech characteristics.

A final comparison of speech ratings was made to provide further information regarding age expectations about voice differences (see Table 5). A multivariate analysis of the speech ratings, with speech style and resident status again as between-

subjects variables and with speaker (42-year-old caregiver vs. 76-year-old resident) as a within-subject variable, was conducted. The multivariate effect for speaker, $F(10, 169) = 43.4$, $p < .001$, was supported by significant univariate effects on all voice traits except shrill. Hence, the voice of the institutionalized elderly woman was inferred to be slower, softer, more wavering, more hesitant, thinner, lower pitched, less exaggerated (intonation), less expressive, and less understandable than that of the middle-aged caregiver. Moreover, the multivariate interaction with speech style, $F(10, 169) = 2.53$, $p < .01$, was supported by three univariate analyses. Ratings of the caregiver's voice on loud, exaggerated intonation, and understandable were predictably more influenced by speech style differences than were corresponding ratings of the resident ($p < .05$).

Table 4
Inferred Speech Traits of Nurse Caregiver in Neutral and Patronizing Speech Conditions

Trait	Speech style				<i>F</i> (1, 181)	Proportion of variance
	Neutral		Patronizing			
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Fast	3.57	1.7	3.66	2.0	<i>ns</i>	
Shrill	2.28	1.4	2.94	1.7	8.2**	.04
Wavering	2.07	1.5	2.39	1.7	<i>ns</i>	
Hesitant	1.61	0.9	1.92	1.4	<i>ns</i>	
Thin	2.10	1.5	2.41	1.8	<i>ns</i>	
Loud	3.51	2.0	4.55	2.1	12.0***	.06
Exaggerated intonation	4.18	2.0	5.33	2.0	15.1***	.08
High pitch	2.82	1.7	3.21	1.9	<i>ns</i>	
Understandable	5.42	1.7	4.82	2.0	4.7*	.02
Expressive	5.31	1.6	4.81	2.0	<i>ns</i>	

Note. In the neutral speech condition, $n = 90$; in the patronizing speech condition, $n = 95$.
 * $p < .05$. ** $p < .01$. *** $p < .001$.

Table 5
Inferred Speech Traits of Nurse Caregiver and Resident

Trait	Caregiver		Older resident		<i>F</i> (1, 178)	Proportion of variance
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Fast	3.63	1.8	2.03	1.2	88.8*	.33
Shrill	2.62	1.6	2.60	1.6	<i>ns</i>	
Wavering	2.23	1.6	4.60	1.8	149.7*	.46
Hesitant	1.77	1.2	4.48	1.9	271.4*	.60
Thin	2.27	1.7	4.41	1.9	142.6*	.44
Loud	4.04	2.1	2.33	1.5	86.5*	.31
Exaggerated intonation	4.78	2.1	2.71	1.8	99.8*	.35
High pitch	3.03	1.9	2.33	1.5	17.5*	.07
Understandable	5.10	1.9	4.12	1.7	28.6*	.12
Expressive	5.06	1.9	3.69	1.8	54.3*	.15

Note. For both caregiver and older resident, *n* = 182.

* *p* < .001.

Discussion

Our main hypothesis regarding the negative evaluation of patronizing speech was supported by the results obtained in this study. The lower ratings for both respect and nurturance confirm the anticipated inappropriateness of the patronizing speech, even for a forgetful resident. It should be noted that relatively minor modifications in the script were successful in eliciting an impression of a patronizing caregiver. Clearly, speaking to elders in a patronizing manner on the basis of their age and dependency leads to unfavorable perceptions of the caregiver. Further research with additional scenarios is needed in order to establish the generality of the evaluative distinctions between patronizing and neutral institutional discourse. Future work should address the specific features of patronizing talk that elicit the differential perceptions.

As anticipated by speech accommodation theory (Ryan et al., 1986), the recipients of the patronizing style were considered to be more helpless and frustrated than were recipients of the more neutral institutional style. This finding supports an essential component of the theory, namely that overaccommodation has negative consequences for the recipient. Further research is needed to explore the range of negative feelings that respondents attribute to recipients of overaccommodating speech and the anticipated implications for their future behavior. As argued by Rodin and Langer (1980), elders in such situations can be expected to become less successful communicators over time (see also Ryan & Cole, 1990). For example, possible behavioral consequences for regular recipients of speech overaccommodation in an institutional setting include avoidance of speech situations, engagement in more dependent behaviors, displacement of anger toward family members, and gradual acceptance of impolite speech (see Coupland et al., 1988).

The fact that this patronizing discourse was perceived as less nurturant than the more neutral comparison, as anticipated, contrasts with observations of the nurturant meaning of secondary baby talk (Caporael, 1981; Caporael et al., 1983). Future work with written texts and with audiotapes can examine the

roles of situation (i.e., task-oriented as in the present scenarios vs. ones in which an individual needs comforting), wording, and paralinguistic features in eliciting a sense of nurturance.

In this study, adults reacted to the conversation as quite uninvolved observers. The perspectives of members of the two relevant constituent groups would be interesting to compare, namely caregivers and elderly residents themselves. On the basis of the findings of Caporael et al. (1983), one might expect considerable variability among both of these groups. Caregivers will differ in the extent to which they believe major speech modifications are appropriate for the elderly and whether respect or nurturance is the more important dimension to emphasize with elders. Elderly residents will vary in terms of whether they resent, accept, or desire overaccommodating modifications (see Caporael et al., 1983). However, given the adjustments required in the institutionalization process, we would anticipate that acceptance of overaccommodation is the dominant perspective (see Shantz et al., 1989).

The strategy of eliciting inferred speech traits provided important, supportive data. The distinctive profiles of speech evaluations elicited for the patronizing discourse and for the older speaker confirm the ecological validity of the stimulus dialogues in that respondents could "hear" anticipated paralinguistic features in the written dialogues. The specific inferences made about patronizing speech in comparison to neutral institutional speech offer an intriguing picture of speech that is predictably inferred to be shrill and involving exaggerated intonation, as in secondary baby talk, and loud, as in a domineering speech style (Caporael, 1981; Scherer, 1979). Future research with this paradigm can provide greater insight into the paralinguistic patterns associated with contrasting styles of discourse. The paradigm could be extended by requesting respondents to infer also the nonverbal characteristics (kinesics and proxemics) of the patronizing versus neutral discourse (see Lanceley, 1985; McGee & Barker, 1982). This would allow for the exploration of more effective verbal and nonverbal communication strategies between younger and older individuals. In addition, as in Genesee and Bourhis (1982, 1988), the evaluative task

could be made more realistic by using theoretically interesting permutations of recorded conversations between caregivers and elderly persons.

The speech trait inferences for the older person fit well with data on perceptions of actual voices representing different ages (Benjamin, 1988; Huntley, Hollien, & Shipp, 1987; Stewart & Ryan, 1982). This correspondence supports the notion presented by both Benjamin (1988) and Ramig (1986) that stereotypes influence the perceptions of voices. The apparent exaggeration of vocal differences between middle-aged and elder speakers in this case may be related to the presumed frailty of the resident or to the situational roles. Future studies can determine whether beliefs about voices of different age groups are affected specifically by health and roles.

The manipulation of the cognitive status of the resident did not yield the expected differences in speech style evaluations. Although reliable differences in personal evaluations of the forgetful, confused resident as compared to the alert resident were observed, respondents did not discriminate clearly between the two types of resident on speech variables or on the evaluative impact of the contrasting speech styles. The limited influence of cognitive status differences may well be due to the respondents' focus on the common age, physical illness, and dependence of the two residents portrayed.

Our intention, with this first study, was to provide a minimal cue about the resident's forgetfulness, but it may be necessary to indicate greater confusion in the initial description and to reinforce the manipulation by contrasting the coherence of the residents' discourse (see Rodin & Langer, 1980). This generally young sample of adults may have paid less attention to resident status characteristics because of lack of familiarity with older people living in nursing homes. Older adults, or those providing services to elderly individuals, would be expected to be more sensitive to the differences between the two types of resident (see Crockett & Hummert, 1987). It may also be that the discourse of the resident was a much more powerful cue to the cognitive status, and that reflecting cognitive confusion in the discourse itself would be sufficient to trigger evaluative differences (see Potter & Wetherell, 1987). Future studies with a greater differentiation between types of older residents should afford a stronger test of the direction of interaction effects as well as the expected impact of patronizing speech on perceptions of the resident's competence and other traits.

The discourse-evaluation procedure developed in this study can serve as a valuable tool for testing a variety of implications of speech accommodation theory. For the first time, predictions were tested about evaluative perceptions of two discourse styles differing in the degree to which speech reflected intergroup and dependency-based stereotyped expectations (Coupland et al., 1988). The impact of recipient age and institutional residency could be readily assessed in subsequent studies by manipulating this information across scenarios. In the future, the social meanings of alternative caregiver conversational strategies (e.g., use of title and last name vs. use of first name in addressing elders) can be productively explored with this paradigm (Wood & Ryan, in press). Theoretically interesting or empirically derived novel speech strategies for caregivers can be assessed for their potential positive or negative evaluative im-

act on different audiences. In line with the theoretical importance of environment on the display of communicative competence, the impact on evaluative perceptions can also be investigated for contrasting features of setting, participants, and specific situation (see Lubinski, 1988; Shadden, 1988).

In conclusion, a sample of well-educated adults reacted to brief descriptions of two interactants and a short conversational script. Interpretation of the findings of differentiation between patronizing and neutral institutional speech must be made cautiously in light of limitations associated with the use of a single scenario with a single operationalization of patronizing speech.

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(Appendix follows on next page)

Appendix

Contrasting Conversation Styles

Neutral Institutional Style

Mrs. Johnson
Did you have a nice day, today?

Oh, I'm sure you saw some of your favorite morning programs. It's time for you to take your pills.

Yes, I must stay until you've taken your pills. Here's your glass of water, but take your time.

That is a good habit that will make sure your pills are all the way down.

You're welcome.

Patronizing Style

Mrs. Johnson
Did you have a nice day, today?

Poor dear! You probably slept there all morning. I'm here to give you your pills.

Of course I do! Now, just stay there while I get some more water for you. Be a good girl and take them right now.

That's fine, just get those pills all the way down.

Good girl.

Mrs. Smith

Well, it was all right. . . . I tried to watch some television in the lounge.

I suppose you would prefer me to take them while you're here, right?

I like to drink a lot of water with my pills.

There . . . I've swallowed them. Thank you.

Mrs. Smith

Well, it was all right. . . . I tried to watch some television in the lounge.

I suppose you would prefer me to take them all while you're here, right?

I like to drink a lot of water with my pills.

There . . . I've swallowed them. Thank you.

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