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Paige T. Shoutz
Minnesota State University, Mankato

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**An Investigation into the Perceptions of Elderspeak and How It Effects Mood Among an
Assisted Living Population**

by

Paige T. Shoutz

A Thesis Submission in Partial Fulfillment of the Requirements for the Degree of Master of Arts

In

Clinical Psychology

Minnesota State University, Mankato

Mankato, Minnesota

May 8th, 2020

May 8th, 2020

An Investigation into the Perceptions of Elderspeak and How It Effects Mood Among an
Assisted Living Population

Paige T. Shoutz

This Master's Thesis has been examined and approved by the following members of the
student's committee.

Jeffrey Buchanan, Ph.D., Chairperson

Daniel Houlihan, Ph.D., Committee Member

Kristen Abbott-Anderson, Ph.D., Committee Member

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Abstract

This study aimed to examine perceptions of ES and its effect on mood among older adults residing in assisted living facilities (ALFs). Residents ($N=6$) were exposed to two videos comprised of an interaction of a nursing assistant aiding an older adult resident during activities of daily living. One of the videos demonstrated neutral communication, whereas the other video demonstrated communication with elderspeak. A mood rating was obtained prior to and immediately following exposure to each of the videos. Participants also provided ratings of the nursing assistant, and completed a qualitative interview that gathered their opinions, perceptions, and perceived differences between the videos. Results indicated that exposure to ES did not have a significant effect on negative or positive mood states. Differences in perceptions regarding the nursing assistant were present, as ES was found to be less caring and respectful and more controlling. Qualitative data suggest that differences in the communication styles were noticed. Future research with larger sample sizes is warranted to determine how communication using elements of ES affects the mood of older adults residing in ALFs.

Keywords: elderspeak, mood, perceptions, older adults, assisted living facility

An Investigation into the Perceptions of Elderspeak and How It Effects Mood Among an Assisted Living Population

For older adults living in long-term care (LTC) settings, the practice of quality communication by staff during cares and other interactions plays an imperative role in the health, well-being, and successful aging of residents. For example, effective communication between caregivers and residents is associated with a higher quality of life (Zimmerman et al., 2005), lower rates of depression, and fewer occurrences of verbal and physical aggression (Toseland et al., 1997). Furthermore, research has demonstrated that mortality rates decrease when older adults have the social support and close relationships with their caregivers (Williams et al., 2005).

For many caregivers in LTC settings, the use of a patronizing communication style, often known as elderspeak, is common. Elderspeak (ES) is a type of communication that encompasses a wide range of verbal and nonverbal features that is based on the stereotypes that older adults are less competent and more dependent compared to younger communication partners, which in turn leads to oversimplified speech (Ryan et al., 1995). Examples of the verbal features of ES include: the use of collective pronouns (e.g., “we”), terms of endearment (e.g., “honey”, “sweetie”), and restricted vocabulary, as well as frequent repetitions, recurrent interruptions, and exaggerated praise for minor accomplishments. Examples of the nonverbal features of ES include: elevated vocal pitch and volume, slowed rate of speech, exaggerated facial expressions, and inappropriate touches (e.g., pats on the head or hugs). Early reports of communication in LTC settings concluded that over 22 percent of speech as used with older adults was categorized as ES (Caporael, 1981). Furthermore, LTC resident reports have concluded that as much as 40 percent of speech as used by caregivers is perceived as patronizing (Williams et al., 2005).

When used by caregivers of older adults, ES is not only considered disrespectful, but also diminishes the competency and promotes the dependency of older adults (Caporale, 1981; Ryan et al., 1995). Although presented in a patronizing demeanor, the intent of using a communication style that comprises aspects of ES may often be a well-intended attempt by younger communication partners to effectively communicate with older adults in a caring manner (Grimme et al., 2015). For example, one study found that caregivers rated ES to be more appropriate when assisting with personal cares, which may have suggestions of nurturance during intimate tasks (Lombardi et al., 2014). However, even with the intent of benevolence, the Communication Predicament of Aging Model postulates a framework that describes how the use of ES fails to reach the goal of effective and caring communication with older adults (Williams et al., 2005).

Theoretical Framework of Elderspeak

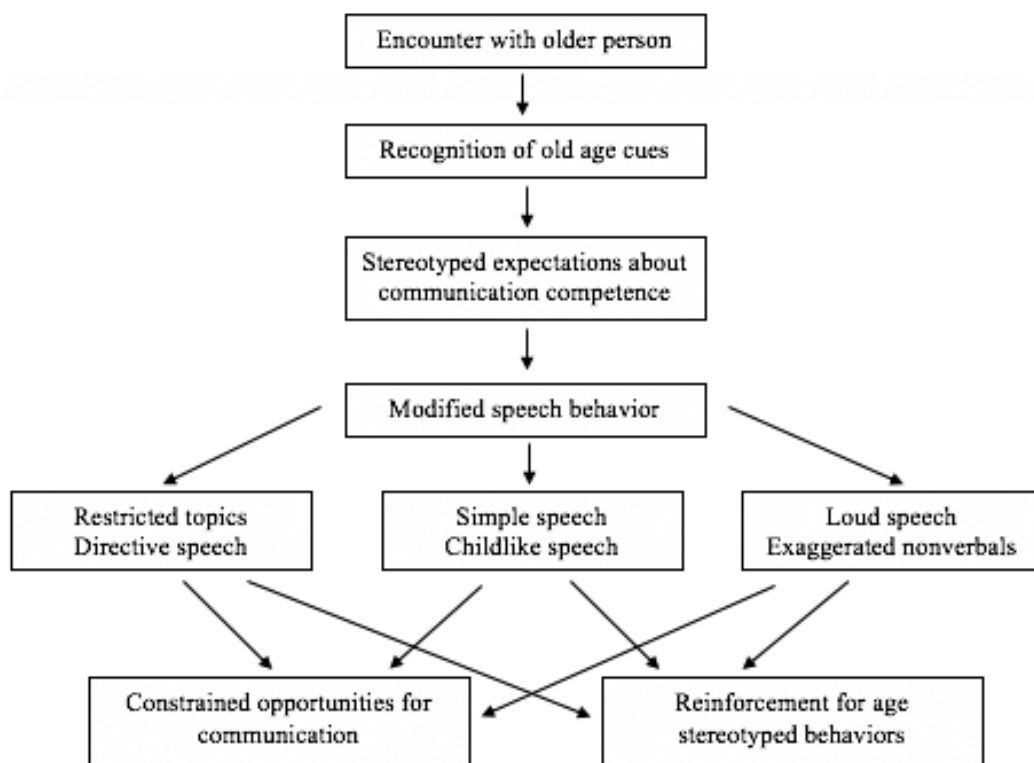
As proposed by Ryan and colleagues in 1986, the Communication Predicament of Aging Model (CPAM) intended to conceptualize the use and features of patronizing communication and identify the theory of speech modification used towards older adults. Based on the communication accommodation theory, this framework argued that speakers modify their speech and nonverbal behaviors towards older adults based on stereotypes and old age assumptions of dependence and incompetence. As a result of modifying speech towards older adults in response to old age cues, negative age stereotypes are reinforced, which in turn limits opportunity for fulfilling conversation, and leads to negative consequences for an older adult's quality of life and overall well-being.

As demonstrated by Figure 1, the model begins with an individual having an encounter with an older adult. This interaction then leads to the recognition of old age cues, such as

physical characteristics (e.g., gray hair, slumped posture), mobility aids (e.g., cane, walker), or social roles (e.g., role of a grandparent). The recognition of old age cues then leads to stereotyped expectations about communication competence and the requirement of speech adaptations. Although prior research has identified positive and negative stereotypes associated with older adulthood, the communication predicament predicts accommodations to occur following the recognition of negative stereotypes (Ryan et al, 1995). For example, stereotypes that shed a negative light on older adults recognize them as depressed, hopeless, dependent, slow-thinking, incompetent, incapable, bitter, or being hearing or cognitively impaired. If one of these negative stereotypes is identified by the speaker, speech modification is likely to occur compared to if a positive stereotype was identified (e.g., active, lively, nostalgic).

Figure 1

The Communication Predicament of Aging Model (Ryan et al., 1995)



Even if the negative stereotypes are inaccurate, the individual advances with a modification of their speech, which includes the use of restricted topics, using simple or childlike wording, and demonstrating loud and exaggerated speech and nonverbals. The result of such modifications limits the opportunity for communication and reinforces age stereotype behaviors, such as incompetence, while conveying a sense of declining capability, loss of control, and helplessness. Constant exposure to ES then reinforces dependency, social isolation, and depression, all of which can contribute to the decline of physical, cognitive, and functional status of older adults. Because the patronizing communication reinforces negative stereotypes associated with being an older adult, elders often adapt to such stereotypes, which is when decline accelerates. For example, if an older adult who receives ES falsely believes they are incapable, as inherited through the patronizing messages of ES, they may actively seek help for tasks that they are able to complete independently (Balsis & Carpenter, 2005), and therefore diminish their existing abilities.

Previous Research of Elderspeak

Primary investigations into the communication styles used with older adults in institutionalized settings revealed ES, or “baby talk” as it was first described as, to be commonly used (up to 22% of speech) by caregivers and indistinguishable from baby talk speech as used with children (Caporael, 1981). In fact, Caporael’s study (1981) found that 75 percent of speech used by nursing home caregivers that was directed towards residents was misidentified as speech towards children.

Views of patronizing speech may be either positive or negative among public perception. Those who view ES positively deemed it to be more comforting and less irritating and arousing compared to neutral, normal speech (Caporael, 1981), whereas those who view ES to be negative

deemed it to come across in a less respectful, nurturing, competent, and benevolent manner that fostered dependency and helplessness in the targeted residents compared to neutral, normal speech (Ryan et al., 1991). Research into the public perceptions provide insight into the paradoxical use of ES, as caregivers may assume ES to convey messages of care and nurturance, but ultimately it reinforces negative views of dependence, vulnerability, and incompetence (Williams et al., 2005).

Previous research regarding older adult perceptions of ES have targeted both community-dwelling and nursing home residents. In a study conducted by O'Connor and Rigby (1996), older adults who lived in the community or in a nursing home were asked to imagine themselves in a scenario that portrayed either ES or normal communication as an attempt to identify the relationship among ES and self-esteem. The results indicated that for those older adults who perceived ES as undesirable and who had frequently been recipients of ES often ranked the lowest in self-esteem. Although significant differences were not found regarding community or nursing home status, differences in appropriateness regarding age and gender were found. In other words, older participants and females perceived ES to be more appropriate.

La Tourette and Meeks (2000) also examined a population of community-dwelling older adults and nursing home residents. After watching two videotaped vignettes of an interaction between an elderly woman and a nurse portraying either patronizing or non-patronizing communication, both the community-dwelling and nursing home residents rated the nurse more favorably and the elderly actress more satisfied in the nonpatronizing video. Moreover, for those participants who were community-dwelling, they ranked the woman in the video receiving care by the patronizing nurse as less competent.

Similarly, Balsis and Carpenter (2005) concluded that among an older adult sample, negative perceptions exist for both the one using ES and the target of ES. After reading scripts that depicted different communication styles, it was found that speakers using ES were rated as having a worse demeanor compared to the speaker who used normal communication. The targets of ES were not only seen as possessing decreased abilities and competencies, but were also viewed to exhibit negative affect states, including frustration, anger, unhappiness, and displeasure.

Other research investigating perceptions among long-term care residents have found patronizing communication to diminish resident's view of their living experience and quality of life within the facility (Lagacé et al., 2015). Additionally, it was found that although residents had negative perceptions of ES among caregivers, residents would rather accommodate caregivers rather than challenge them when patronizing communication is used. These passive responses, in turn, reinforce negative stereotypes associated with aging, including dependency and incompetency, as described by the CPAM (Ryan et al., 1995).

Perceptions of ES among caregivers in LTC settings to assess contextual variables that may increase the occurrence of ES have also been examined. As reported by Lombardi and colleagues (2014), ES was considered to be more acceptable to use with older residents (i.e., >70), for those who are cognitively impaired, for those who present as sad or happy, in situations where no one else is present, and when providing hands on tasks, such as personal cares. Grimme et al. (2015) provided support for similar findings, as ES was considered to be more appropriate when staff needed residents to complete a task and when residents demonstrated cognitive impairments.

Among studies that examined staff perceptions, reports have concluded that the use of ES derives from a genuine nature to provide comfort and care to the residents when providing assistance (Grimme et al., 2015). One study supports the usefulness of ES, as Kemper et al. (1996) discovered that older adults who drew routes on a city map performed better when they were instructed with elderspeak. The findings of this study support the notion ES may be presented sincerely to assist an older adult in completing tasks, such as in the case of personal cares.

In sum, although many studies have reported negative outcomes related to ES, some studies have found potential benefits. The differences in outcomes appear to be related to variables such as gender, age, place of residence, and severity of dependency on others. Therefore, additional research is needed to determine situations under which ES is more or less appropriate and/or acceptable.

Purpose of the Study

Among the literature that exists on elderspeak and its perceptions, much has focused on either community dwelling older adults or older adults requiring extensive care residing in a nursing home, and little research has focused on older adults residing in assisted living facilities (ALFs). Older adults who live in an assisted living setting are a unique population because functionally they fall between the population of older adults who are community dwelling and independent, and those living in skilled care facilities who are institutionalized and need a greater degree of assistance with activities of daily living. Typically, residents of ALFs possess some independent living skills, yet require some assistance with care tasks to make sure their personal needs are achieved. As a result, those living on ALFs have somewhat less contact with caregiving staff but are still immersed within a healthcare facility where elderspeak is quite

common. Previous literature on elderspeak has failed to expand upon the circumstances of this unique group of older adults. Previous research has also provided limited insight into the effects on mood of targets of ES.

Therefore, the purpose of this study is to expand the literature on elderspeak by examining perceptions among older adults residing in ALFs, and to assess its effect on mood. Moreover, this study will specifically aim to ascertain: 1) how communication using elements of elderspeak affects the mood of older adults residing in ALFs compared to communication that does not use elements of elements of elderspeak, 2) if residents of ALFs perceive communication with elderspeak or without elderspeak differently, and 3) if the length of time spent living in an ALF contributes to resident communication preferences.

In this study, it is hypothesized that greater negative mood states will be reported after exposure to elderspeak (ES) communication compared to non-elderspeak (N-ES) communication. Furthermore, it is predicted that the communication style comprising of elements of ES will be perceived as more controlling, whereas the N-ES communication will be perceived as more caring and respectful. Lastly, it is predicted that the greater amount of time spent living in an ALF, the more appropriate ES communication will be perceived.

Method

Participants

Participants included six older adults residing in ALFs. Participants were recruited from two assisted living facilities located in the Midwest. Inclusion criteria to enter the study included: being age of 65 or older, having no documented cognitive impairment as reported by direct caregivers who has access to medical records, and the presence of adequate verbal abilities to

respond to assessment instruments. Participants meeting these criteria were identified by facility staff and were then referred to the researchers to be screened for study eligibility.

In order to verify the lack of cognitive impairment, participants were required to score at least a 13 on the Brief Interview for Mental Status (BIMS; Chodosh et al., 2008). The BIMS is a cognitive functioning screening tool that measures attention, temporal orientation, and memory. Scoring for the BIMS ranges from 0-15, with a score of 13 or higher indicating “cognitively intact.” Of the eight participants identified for the study, five scored 13 or higher on the BIMS. One participant scored below the minimum requirement, but an absence of cognitive impairment was verified through a medical records review completed by a staff member, which granted inclusion. The mean BIMS score for all six participants was 14.00 ($SD = 1.26$), with scores ranging from 12 to 15. See Appendix A for a copy of the BIMS.

In addition, all participants were white females whose ages ranged from 83 to 102 years ($M = 90.33$, $SD = 6.74$), had an average of 14.50 years of education ($SD = 2.51$), and had been residing in their current assisted living facility between .50 to 8.50 years ($M = 3.58$, $SD = 3.44$).

Materials

Videos. The videos used in the experimental conditions were written by students and faculty who had experience in clinical psychology and nursing. The caregiver-resident interactions depicted in the videos were based on the experience of nursing students who had professional experience working in long-term care settings with older adults. Both of the videos were similar in content and length (approx. 6-minutes) but differed in terms of the type of communication style portrayed. Each of the videos depicted a scene of a nursing assistant in a long-term care facility aiding an older adult woman with physical impairments. Specifically, the nursing assistant is depicted waking the resident from a nap, helping the resident out of her bed,

assisting the resident with putting on her socks, shoes, and a sweater, aiding the resident to the bathroom to groom, and helping the resident out the door.

One of the videos demonstrated neutral “normal” communication. For example, the nursing assistant addressed the older woman by using her title and last name, talked to the woman in a neutral tone, pace, and volume, and used singular pronouns. Furthermore, the older adult in the video was given the opportunity to make her own decision, such as if she was ready to get out of bed and what clothes she wanted to wear.

The second video that portrayed patronizing communication included specific behaviors of ES, such as addressing the woman with terms of endearment, demonstrating elevated pitch, and using collective pronouns. Additionally, the older adult woman was provided with little opportunity for choice in decision making. Refer to Appendix B for the transcripts of the videos.

Both videos were validated by a sample of caregivers who had experience in working in long-term care settings. Caregivers were asked to view the videos and answer several questions regarding the relevance and accuracy of the videos in terms of setting, the tasks completed by the nursing assistant, and the communication styles used. All caregivers interviewed reported that they have observed both of the communication styles demonstrated in the videos. All but one caregiver reported using ES, and all caregivers reported also using N-ES. The caregivers reported that the setting, interactions, and behaviors demonstrated by the older adult in both of the videos were realistic.

Mood measure. In order to assess current mood state, the Positive and Negative Affect Schedule (PANAS; Watson et al., 1988) was administered prior to and immediately following each of the two videos. The PANAS is a 20-item, self-report questionnaire that aims to measure to what extent the participant is experiencing a variety of positive or negative mood states. Items

comprising the positive affect subscale include descriptors such as interested, enthusiastic, and inspired. High positive affect scores indicate full concentration and pleasurable engagement. Items comprising the negative affect subscale include descriptors such as disinterested, irritable, and ashamed. High negative affect scores indicate distress and unpleasurable engagement. Participants were required to rate how they “feel right now at the present moment” by ranking 20 emotions. The items on the PANAS are scored on a 5-point Likert scale, ranging from “very slightly or not at all” (1) to “extremely” (5) (Watson et al., 1988). Refer to Appendix C for a copy of the PANAS.

Communication perception. To measure the affective qualities of the communication style used by the nursing assistant in the video, participants completed the Emotional Tone Rating Scale (ETRS; Williams et al., 2012) after watching each video. This 12-item self-report scale consists of three dimensions of messages that are commonly portrayed during communication with older adults: 1) care (i.e., nurturing, caring, warm, supportive), 2) respect (i.e., polite, affirming, respectful, patronizing), and 3) control (i.e., dominating, controlling, bossy, directive). Participants were asked to rate the communication style of the nursing assistant in the video, which were scored on a 5-point Likert scale, ranging from “not at all” (1) to “very” (5). See Appendix D for the qualities of communication measure.

Additional information was gathered about perceptions of communication styles via a qualitative interview. The interview consisted of closed and opened-ended questions regarding opinions and experiences of the participant related to the communication styles observed in the videos. Sample interview questions included: “Have you directly experienced this type of communication style with a staff member?”, “How do you think the patient in the video felt?”, and “Would you want this nurse to take care of you?”.

After viewing both videos, participants also answered qualitative questions that assessed their opinions and perceptions about the differences among the two videos. Sample interview questions included: “Do you believe there are any important differences between the two videos you just watched?”, “In your experience, of the two videos you watched, which one is most similar of typical staff-resident interactions that occur in care facilities?”, and “Of the two videos you watched, which one was a better example of how nursing staff should interact with residents?”. Refer to Appendix E for the full interview.

Procedure

After obtaining consent from the participants, a trained researcher administered the BIMS. Those participants who were identified as cognitively intact (i.e., scored ≤ 13) were included in the study, and were scheduled to complete the experimental procedure on another day. Prior to watching the first video, the PANAS was administered. Then, using a within-subjects design, participants were randomly assigned to watch either the N-ES video or the ES video. The presentation order of the videos was counterbalanced across all participants. After viewing the first video, participants were asked to complete the mood measure again, followed by the ETRS and qualitative interview. Following a five-minute break, the procedure was repeated with the remaining video, with the addition of administering the interview regarding the similarities, differences, and preferences amongst the two videos.

All data collection occurred in participants’ individual room, and both of the videos were displayed on the researcher’s laptop. With the exclusion of the administering the BIMS, the experimental procedure took approximately 45-minutes to complete.

Results

Mood. To assess the effect of the different types of communication on participant mood, a “positive affect” and “negative affect” score was calculated by establishing an average score for all the positive and negative items on the PANAS, respectively. This was done for all pre- and post- video ratings. Additionally, change scores were calculated for both the positive and negative affect scales by subtracting the average post-scores with the average pre-scores. The change scores were then compared between each video. Changes in mood were examined through a series of paired-samples t-tests. Although changes in negative affect were of primary interest in this study, exploratory analyses regarding differences in positive affect were also examined.

When examining the negative affect change scores between pre- and post-video measurements, the results of the paired-samples t-test revealed that there was no significant differences between the ES ($M = .44, SD = .52$) and N-ES ($M = -.02, SD = .04$) videos, $t(5) = 2.11, p = .09, d = -.56$. When examining the positive affect change scores between pre- and post-video measurements, the results of the paired-samples t-test resulted in no significant differences between the ES ($M = -.47, SD = .52$) and the N-ES ($M = -.31, SD = .55$) videos, $t(5) = .50, p = .64, d = .22$. See Table 1 for a summary of change scores for both conditions.

Table 1

Positive and Negative Affect Averages and Change Scores

Variable	ES				N-ES			
Positive Mood Mean (SD)	Positive Mood Δ	Negative Mood Mean (SD)	Negative Mood Δ	Positive Mood Mean (SD)	Positive Mood Δ	Negative Mood Mean (SD)	Negative Mood Δ	

Pre	2.89 (.64)	-.47	1.02 (.04)	.44	2.58 (1.18)	-.31	1.02 (.04)	-.02
Post	2.40 (.91)		1.46 (.50)		2.27 (.74)		1.00 (.00)	

To test whether there was a difference in post-video mood measures between the two conditions, a paired-samples t-test was conducted. When examining the results of post-negative affect scores, the analysis found no significant differences, $t(5) = -2.24, p = .08$, between the ES ($M = 1.46, SD = .50$) and N-ES ($M = 1.00, SD = .00$) videos. No significant differences were found among the post-positive affect measures between the ES ($M = 2.40, SD = .91$) and N-ES ($M = 2.27, SD = .74$) videos as well, $t(5) = -.53, p = .62, d = -.20$,

Lastly, a paired-samples t-test was conducted to examine if pre- and post-video affect scores differed for only the ES video. The results indicated that there were no significant differences regarding negative affect on pre- ($M = 1.02, SD = .04$) and post-measures ($M = 1.46, SD = .50$) following the ES video, $t(5) = 2.07, p = .09, d = 6.46$. No significant differences were found among the pre- ($M = 2.87, SD = .64$) and post-measures ($M = 2.40, SD = .91$) for positive affect following the ES video, $t(5) = -2.20, p = .08, d = -1.26$.

Communication perception. A series of paired-samples t-tests were conducted to examine how participants rated the nursing assistant on the three ETRS subscales (i.e., care, respect, and control) in the ES video compared to the N-ES video. Results are summarized in Table 2. Significant differences and large effect sizes between post ratings on the ES and N-ES videos were found on all three subscales: care, $t(5) = 2.65, p < .05, d = 1.25$; respect, $t(5) = 3.88, p = .01, d = 1.57$; and control, $t(5) = -3.56, p = .02, d = -1.24$.

Table 2*ETRS Subscale Paired-Samples T-Test Results Summary*

ETRS Subscale	Video Condition		t-statistic	Significance
	ES Mean (SD)	N-ES Mean (SD)		
Care	$M = 2.42$ (1.29)	$M = 3.79$ (1.44)	2.65	.046
Respect	$M = 2.42$ (1.39)	$M = 4.13$ (1.07)	3.88	.012
Control	$M = 3.75$ (1.39)	$M = 2.00$ (.74)	-3.56	.016

Perceptions of ES and length of stay in ALF. In order to examine how perceptions of ES were related to the amount of time participants had spent living in the ALF, participants were divided into three categories of length of time spent living in their current assisted living facility. The length of time spent living in the facility was categorized as “relatively new” (those living in AL for less than one year), “moderate” (those living in AL for 1-3 years), and “experienced” (those living in AL for more than three years). Then, a series of one-way ANOVAs were conducted to assess if length of time spent living in assisted living would affect participant perception of how appropriate they find ES communication to be. Appropriateness was measured by scores on the positive affect subscale of the PANAS and the care and respect subscale of the ETRS. The results revealed that there were no significant differences found related to time spent living in AL and post-video positive affect subscale scores, $F(2, 3) = .98, p = .92$, care subscale scores, $F(2, 3) = 1.89, p = .29$, or respect subscale scores, $F(2, 3) = .93, p = .48$. The means and standard deviations of the positive affect subscale and the ETRS subscale scores for each category of length of time spent living in the assisted living facility are provided in Table 3. A summary of the ANOVAs is provided in Table 4.

Table 3*Means and Standard Deviations of Length of Stay in ALF and Perception of ES Appropriateness*

Length of Time in Current AL	N	Positive Affect Mean (SD)	ETRS Subscale	
			Care Mean	Respect (SD)
< 1 year “Relatively new”	2	M = 2.40 (1.41)	M = 1.25 (.00)	M = 1.38 (.53)
1-3 years “Moderate”	1	M = 2.00 (*)	M = 2.00 (*)	M = 2.25 (*)
>3 years “Experienced”	3	M = 2.53 (.98)	M = 2.42 (1.39)	M = 2.75 (1.30)

* = no standard deviation, only one participant

Table 4*Summary of ANOVAs on Length of Stay in ALFs and Perception of ES Appropriateness*

Subscale	F-statistic	Significance
Positive Affect	.98	.92
Care	1.89	.29
Respect	.93	.48

Qualitative Interviews. After watching each of the videos, participants were asked a series of closed and open-ended questions. First, participants were asked if they had directly experienced the type of communication style demonstrated in each the video. Two participants reported they had directly experienced ES with a staff member, and four said they had not. Of the two participants who experienced ES, they reported experiencing ES daily ($N=1$) to several times a week ($N=1$). ES had been reported to be experienced with every interaction with a staff member, from morning to night, and specifically during meals.

The majority of participants ($N=5$) reported directly experiencing non-ES communication with a staff member. These participants reported experiencing this communication style daily ($N=2$) to several times a week ($N=3$) in several specific places in their living facility, including their apartment/room and the dining room. When asked during what times of the day and during

what activities participants experienced N-ES communication style, participants reported a variety of responses, including a time frame of morning and evenings, and during activities such as exercise, mealtimes, when getting dressed, and when alone with a staff member.

Participants were also asked if they had observed the different communication styles during staff interactions with other residents. From the ES condition, half ($N=3$) of the participants had reported observing ES. Observations of ES occurred during activities, mealtimes, and overall, in “most places” daily ($N=3$). For the N-ES condition, five participants identified observing the communication style. Participants reported observing the N-ES communication in the dining room, hallways, and in other people’s living areas as often as daily ($N=2$) to several times a week ($N=3$). Some of the specific times of day N-ES was observed included during dining hours, facility programs, activity hours, and in the mornings.

Each participant was also asked how they thought the resident in each video felt. The responses towards the ES video were mostly negative (e.g., hurried, not relaxed, upset, disrespected, irritated) compared to overall positive responses towards the N-ES video (e.g., positive, accommodated, cared for, respected, not embarrassed). Moreover, all of the participants indicated that they would want the nursing assistant in the N-ES video to take care of them for reasons such as the aid was observant, qualified, respectful, caring, interested in what the woman wanted, and took her time with the resident. Only two participants reported wanting the nursing assistant in the ES video to take care of them (e.g., friendly, knowledgeable, caring). Of those ($N=4$) who did not want the ES nursing assistant to take care of them, participants found her to be too much in a rush, having little patience, and being too rigid and bossy.

Lastly, participants were asked if the interaction that they watched in each of the videos was realistic of typical interactions between residents and staff during personal care tasks. Five

participants reported that the ES portrayal was realistic, with one participant reporting that the video was not realistic because the nursing assistant did not allow the woman a choice on what type of sweater she wanted to wear. Four participants reported that the N-ES video was realistic, with one participant reported that it was not realistic, and one participant could not answer concretely whether the video was or was not realistic. For the participant who reported that the portrayal was not realistic, the participant stated that staff never have as much time as the video demonstrated to spend one-to-one with all of the residents, and therefore was not realistic.

Participants were also asked about perceived differences between the videos. Foremost, all participants indicated that they noticed important differences between the two videos. Among the identified differences were: the pace of the nursing assistant (e.g., if she was in a rush or not), the nursing assistant's attitude (e.g., differences in level of kindness, respect, and desire to help), the autonomy given to the resident (e.g., if the resident was given options to make her own decisions or not, if the resident was being listened to), and the attitude of the resident (e.g., if she was being combative or accommodating).

When asked which of the two videos was most similar to typical staff-resident interactions, results indicated that half ($N=3$) found the ES video to be most similar, and the other half indicated the N-ES video to be most similar. Finally, all participants reported that the N-ES video represented a better example of how nursing staff should interact with residents.

Discussion

This current study attempted to examine perceptions of a type of patronizing communication style and neutral communication style among older adults residing in ALFs, and to assess its effect on mood. Inconsistent with previous research findings, the results of this study did not demonstrate notable differences in negative or positive mood states after exposure to a

communication style that demonstrated aspects ES. As determined by Balsis and Carpenter (2005), recipients of ES are viewed to possess more negative mood states compared to recipients of neutral communication, including frustration, anger, unhappiness, and displeasure. Other conclusions have also determined that targets of ES ranked lower in self-esteem (O'Connor & Rigby, 1996), which could have implications for increased negative affect due to damaged self-esteem. The findings of this study do not support the hypothesis that exposure to ES would result in greater negative mood states compared to neutral communication. In fact, there were no significant differences found between pre- and post-ES negative mood scores, nor differences in ES and N-ES post-negative affect scores. Although negative affect was of primary interest, the exploratory analysis of positive affect also did not result in noteworthy differences between the two conditions. These findings imply that exposure to the different communication styles did not affect participants' mood in a negative or positive way. Although the PANAS is a reliable instrument for measuring current mood states, perhaps total positive and negative scale scores are not sensitive enough to detect momentary changes in mood compared to instruments with fewer items. Because each PANAS subscale is comprised of many individual mood states, this could have dampened the sensitivity to detect changes in specific moods where subtle changes were observed, but not large enough to contribute to a significant change. For example, through observation, noticeable differences were found between measures on distress, upset, and irritable. However, because these items were grouped with other negative affect measures that did not demonstrate noticeable differences, the overall effect dampened the individual results that could have revealed significance.

The second hypothesis of this study proposed that the communication style comprising of elements of ES will be perceived as more controlling, whereas the N-ES communication will be

perceived as more caring and respectful. This hypothesis was supported, and significant differences were demonstrated between the two communication styles and ratings on the care, respect, and control subscales. These findings are consistent with the conclusions of several previous research studies (La Tourette & Meeks, 2000; Ryan et al., 1991).

Contrary to the third proposed hypothesis, the length of time spent in an ALF did not have any effect on how appropriate participants perceived ES to be. Regardless if participants were classified as “relatively new” or “experienced”, the results of this study did not demonstrate any significant differences among how appropriate they found ES to be. This finding is inconsistent with previous research that suggests older adults living in an institutionalized setting may become habituated with the constant demonstration of patronizing communication overtime, and therefore are more tolerable to the communication style (Caporeal, 1981). Perhaps with a larger sample size and an equal number of participants in each category distinctions among appropriateness ratings may present, and therefore reveal conclusions as to whether or not length of time spent living in an ALF changes perception of appropriateness.

Although the distinctions in the videos did not evoke different emotional responses, the results of the analyses regarding communication perception and qualitative data support the notion that all participants were able to notice differences among the two communication styles. The qualitative data provided in this study offered valuable insight into the occurrences of ES, whether directly experienced or observed. Interestingly, the reported occurrences of ES and N-ES did not directly align with the reports of how similar each communication style reflected typical staff-resident interactions. In other words, although five of the six participants reported both directly experiencing and observing N-ES, overall, only half reported the N-ES

communication to be most similar to typical staff-resident interactions and the other half reported ES to be most similar.

Limitations and Future Directions

This study was subject to several limitations that deserve mention. First, it should be noted that this study was suspended prematurely due to extenuating global circumstances at the time of data collection. As a result, a small sample size was analyzed, which limits statistical power. Results of the analyses should be interpreted with caution. Future research should continue to collect data to establish a larger sample size as proposed. As discovered in the results, mood changes in both the negative and positive affect scores indicated $p < .10$. If a larger sample size was obtained these trends may have reached statistical significance.

Another limitation regarding the sample obtained is concerned with the homogeneity of the participant characteristics. All participants were white females, which limits the generalizability of the results. Future research should aim to diversify the sample to examine how different ethnic groups perceive ES. Furthermore, perceptions of ES among different genders should also be examined. Previous research has identified that females view ES more positively compared to males (O'Connor & Rigby, 1996), but women are also subject to sex-based discrimination that may reinforce the use of ES more frequently than men (Draper, 2005). Further exploration is warranted to examine how perceptions of ES and its effect on mood differ between males and females.

The limited sample size also may also have been a contributing factor as to why no significant differences were found between time spent living in an ALF and the perceived appropriateness of ES. By conducting a qualitative study, future research could further examine

what influences older adult's perceptions of ES, which could include time spent living in an ALF.

Future research should also aim to examine perceptions of ES in different regions of the United States. For example, in the southern United States certain aspects of ES, such as terms of endearment, are common characteristics of the language used and may be perceived as signs of caring and respect as opposed to demeaning and disrespectful. Research could examine potential differences among ES perceptions and effects on mood within different regions of the country.

One limitation related to the results of this study was revealed in the lack of differences found on the mood measure between the two conditions. Considering that the videos were relatively short in length, it may have not been enough time or was not realistic enough to induce differentiated mood states. Although videos are commonly used to elicit emotional reactions, the use of an analogue scenario or naturalistic observation may reveal more accurate and differentiated perceptions and affect ratings among the two communication styles. Future research should explore different possibilities of emotional provocation.

An additional limitation related to the videos should be noted. The videos created for this study were intended to depict a scenario of a younger nursing assistant aiding an older adult during activities of daily living (ADLs). Considering the professional setting of the scenarios, there may have been a natural sense of control that was to be expected of the nursing assistant. In other words, residents may expect that behaving in a controlling manner is a part of the job of nursing assistants because their job involves assisting residents with specific ADLs. This interpretation is supported by the qualitative results of the study where some participants reported that they would want the nursing assistant who used ES to take care of them because of her sense of control and direction initiating cares. Furthermore, it was reported by one participant

that in the ES video the resident was combative to the demands of the nursing assistant. This result could suggest support of the expected compliance during ADLs within LTC settings. Previous research supports the idea of innate control, as findings from Lombardi and colleagues (2014) found that use of ES is deemed more appropriate in the institutionalized settings.

Another limitation of the videos was that they included aspects of patronizing communication that are not categorized under the verbal or nonverbal features of ES. For example, within the ES video, the resident was not offered a choice regarding decisions about how she wanted to get ready, and she was also rushed through the tasks. These types of behaviors demonstrated by the nursing assistant better fit under the broader construct of patronizing behavior rather than the communication style of ES. Therefore, it is unclear as to whether the responses from the video were specifically related to the aspects of ES or examples of patronizing communication. Future research should attempt to distinguish the type of communication and actions that participants are reacting to, which would help to identify what specific features of the communication styles provoke the greatest negative effects.

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Appendices

Appendix A

Brief Interview for Mental Status (BIMS)

Resident Name _____ Identification # _____ Date _____

Brief Interview for Mental Status (BIMS)Repetition of Three Words

Ask resident: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: **sock, blue and bed**. Now tell me the three words."

Number of words repeated after first attempt:

0. None 1. One 2. Two 3. Three

After the resident's first attempt, repeat the words using cues ("sock, something to wear; blue, a color; bed, a piece of furniture"). You may repeat the words up to two more times.

Temporal Orientation (orientation to month, year and day)

Ask resident: "Please tell me what year it is right now."

Able to report correct year

0. Missed by > 5 years, or no answer
 1. Missed by 2-5 years
 2. Missed by 1 year
 3. Correct

Ask resident: "What month are we in right now?"

Able to report correct month

0. Missed by > 1 month, or no answer
 1. Missed by 6 days to one month
 2. Accurate within 5 days

Ask resident: "What day of the week is today?"

Able to report correct day of the week

0. Incorrect, or no answer
 1. Correct

Recall

Ask resident: "Let's go back to the earlier question. What were the three words that I asked you to repeat?"
 If unable to remember a word, give cue ("something to wear," "a color," "a piece of furniture") for that word.

Able to recall "sock"	<input type="checkbox"/> 0. No - could not recall	<input type="checkbox"/> 1. Yes, after cueing ("something to wear")	<input type="checkbox"/> 2. Yes, no cue required
Able to recall "blue"	<input type="checkbox"/> 0. No - could not recall	<input type="checkbox"/> 1. Yes, after cueing ("a color")	<input type="checkbox"/> 2. Yes, no cue required
Able to recall "bed"	<input type="checkbox"/> 0. No - could not recall	<input type="checkbox"/> 1. Yes, after cueing ("a piece of furniture")	<input type="checkbox"/> 2. Yes, no cue required

Summary Score

Add scores for each question and fill in total score (00-15).

Enter 99 if the resident was unable to complete the interview. _____

Appendix B
Video Scripts

Elderspeak Script

In this scenario, the aid is talking to Mrs. Smith in a loud, high voice and continually cuts her off, almost like she is speaking for her and assuming she knows exactly what Mrs. Smith wants

Aid: Good afternoon honey, it's time to get up from your nap, here we go!

Aid does not give the resident time to wake up, get adjusted to the time, or ensure she is not too dizzy/weak before starting to get dressed and up for lunch Mrs. Smith: Oh hi okay already?

Aid: Yep, let's get going we have a lot to do this afternoon and I have other residents to wake up. Let's see it's gotten pretty chilly out there since you laid down, what sweater should I put you in?

Mrs. Smith: Well I...

Aid interrupts and does not let resident finish sentence

Aid: Oh I love this pink one it is so cute you are going to look so pretty in it, I can't wait for everyone to see how beautiful you are!

Mrs. Smith: Oh I'm not that pretty.

Aid: Oh my goodness yes you are, you are the prettiest resident in the building they won't be able to stop staring.

Mrs. Smith: Well whatever you say.

Aid: Here you go sweet pea let's put your left arm in and then we'll sneak around and get your other arm in here, perfect it looks so good on you, you are the cutest little thing! Let's put this necklace on you too because I think the jewel will really bring out your sparkly blue eyes.

Mrs. Smith: No, no that's oh...

Aid interrupts

Aid: Oh alright I just assumed that'd be something you would like. Okay anyways now shoes, let's see what shoes do you have here. Oh okay I like these ones, these will make you look even more spiffed up.

Mrs. Smith: I like comfy slippers.

Aid: Here you go we will wear these boots to match the sweater you have on. Alright let's go use the potty and get your pearly whites brushed up so you have fresh breath before lunch.

Mrs. Smith: Okay, yeah.

Aid: Alright let's stand up and get moving here, we're gonna pivot right into your wheelchair in 1...2....3...

Aid puts gait belt onto resident and does not ask the resident if she is ready to stand

Mrs. Smith: Whoa, okay...

Aid: Alright let's get wheeling over to bathroom here and we'll use the potty and check your diaper to make sure you did not wet yourself.

Mrs. Smith: I did not wet...

Aid interrupts again

Aid: Well sometimes you do wet your diaper so I just want to make sure I don't need to change you and get your bottom wiped up.

Mrs. Smith: Okay. I'd like to brush my teeth first.

Aid: Alright let me get your toothbrush and toothpaste ready here for ya then, okay open on up and I'll start scrubbin for ya.

Mrs. Smith: ...I can do it myself.

Aid: Oh alright are you sure you can do it? You spill a lot and make a mess when you do it by yourself.

Mrs. Smith: Yes I want to.

Aid: Okay I will let you do it then little lady

Aid starts combing hair while resident brushes teeth without asking, assuming she wants her hair combed

Mrs. Smith: Okay I am done.

Aid: Alright let's get you to the bathroom to use the potty.

Mrs. Smith: I do not have to go to the bathroom.

Aid: Okay sweetie, but we need to check your diaper to make sure it is not wet, I need to clean your bottom up.

Mrs. Smith: My pad is not wet.

Aid: Well alright then if you say so. Wash up your little fingers for lunch before we head down to eat.

Mrs. Smith: Okay good idea.

Aid: Alright here we go on down now.

Does not ask resident if she is ready

Mrs. Smith: Oh okay.

Aid: Okay beautiful, enjoy your yummy meal and have a good rest of your day, I love you!

Gives big hug and kiss on the cheek

Non-Elderspeak Script

Aid knocks and enters room, and speaks to resident in a calm, clear voice Aid: Good morning,

Mrs. Smith! How was your nap?

Mrs. Smith: It was nice, still a little tired, how are you feeling?

Aid: I'm feeling good today, thank you for asking. Do you want a little more time to rest or are you ready to get up? It will be time for dinner soon.

Mrs. Smith: Oh is it that time already? I suppose I better get up now.

Aid: It's a little chilly in here. Would you like to put on a sweater?

Mrs. Smith: Yes, a sweater would be nice. Thank you.

Aid: Okay, I will grab a few sweaters for you to pick from while you make your way out of bed.

grabs 3 sweaters from closet and holds them up to Smith Which one would you like to wear?

Mrs. Smith: I like the pink zip-up one. It's always nice and warm.

Aid: I like that one too, it looks perfect for spring and you look very nice in it. Would you like me to help you put it on?

Mrs. Smith: I can do most of it, but if you could reach behind me and hand me the other sleeve that would be helpful. My arms don't stretch as far as they used to!

Aid: Of course. *Helps put on sweater*. I see your blue necklace on your nightstand, would you like to put that on as well? It looks so nice on you and I notice that it matches the color of your eyes.

Mrs. Smith: No, I'd prefer not to wear that today.

Aid: No problem. Would you like me to grab you for shoes?

Mrs. Smith: I'll wear my slippers please.

Aid: *sets the slippers on the floor for the resident to slip into* Do you feel like you are ready to get up?

Mrs. Smith: Oh I'm feeling just fine, I'm ready to get up.

Aid: Would you like to use your walker to walk down to the cafeteria?

Smith: Oh yes, thank you. I was hoping to get a walk in this afternoon.

Aid: I think that's a good idea to get some exercise. Although, we will still have to use the gait belt for safety.

Puts on gait belt and helps resident stand

Let me know if the belt is too tight. Do you feel steady?

Mrs. Smith: Yes, I feel steady. Thank you.

Aid: You're welcome. Do you feel like you need to use the restroom before we leave or would you like me to grab you a new brief?

Mrs. Smith: I went to the bathroom before I laid down so I am fine.

Aid: Okay, let me know if you change your mind. Would you like to brush your teeth or brush your hair before going down to lunch?

Mrs. Smith: Oh, that would be great. Would you mind grabbing my toothbrush, toothpaste, and hairbrush as well?

Aid: Yes I can. *grabs hairbrush and toothbrush/toothpaste to lay out for Mrs. Smith* Would you like any help? I know your arthritis gives you trouble sometimes. Otherwise, I can make your bed as you get ready.

Mrs. Smith: I can do it myself, that would be nice if you made my bed up for me while you wait.

Mrs. Smith finishes getting ready as aid makes bed

Aid: Your hair looks great! Mrs. Smith make sure you wash your hands before we head down to lunch.

Mrs. Smith: Oh thank you for reminding me. Alright, I'm all ready to go! Thank you for your help. Aid: *Aid touches Mrs. Smith's hand or shoulder*

Of course Mrs. Smith, you are always so kind. Enjoy your dinner and have a good rest of your day. *Exit room as aid helps ambulate*

Appendix C

PANAS

Positive and Negative Affect Schedule

This scale consists of a number of words that describe different feelings and emotions. Read each item and then mark the appropriate answer in the space next to that word. Indicate to what extent you feel this way right now, that is, at the present moment. Use the following scale to record your answers.

1 =	2 =	3 =	4 =	5 =
Very slightly	A little	Moderately	Quite a bit	Extremely
or not at all				

_____	Interested	_____	Irritable
_____	Distressed	_____	Alert
_____	Excited	_____	Ashamed
_____	Upset	_____	Inspired
_____	Strong	_____	Nervous
_____	Guilty	_____	Determined
_____	Scared	_____	Attentive
_____	Hostile	_____	Jittery
_____	Enthusiastic	_____	Active
_____	Proud	_____	Afraid

Appendix D

ETRS

Emotional Tone Rating Scale

Rate the nursing assistant for the following. The nursing assistant was:

	Not at All				Very
Nurturing	1	2	3	4	5
Directive	1	2	3	4	5
Affirming	1	2	3	4	5
Respectful	1	2	3	4	5
Patronizing	1	2	3	4	5
Supportive	1	2	3	4	5
Polite	1	2	3	4	5
Bossy	1	2	3	4	5
Caring	1	2	3	4	5
Dominating	1	2	3	4	5
Warm	1	2	3	4	5
Controlling	1	2	3	4	5

Appendix E

Qualitative Interview

The following questions will ask you about your opinions of the video that you just watched. Answer each question as honestly and completely as you can.

1. Have you directly experienced this type of communication style with a staff member?

Yes

No

- a. If you answered “yes”, please identify in which locations you have experienced it (e.g., apartment, dining room, community rooms).

- b. Also if you answered “yes”, please circle the number that best identifies the amount you experience this type of communication style.

1	2	3	4	5
Very Frequently: Daily	Frequently: Several Times a Week	Sometimes: 2-4 Times per Month	Rarely: 2-4 Times per Year	Never

- c. Also if you answered “yes”, during what times of the day and during what activities/tasks do you experience this type of communication style?

2. Have you observed this type of communication style among a resident and staff member?

Yes

No

- a. If you answered “yes”, please identify in which locations you have observed it (e.g., apartment, dining room, community rooms).

- b. Also if you answered “yes”, please circle the number that best identifies the amount you have observed this type of communication style.

1	2	3	4	5
Very Frequently: Daily	Frequently: Several Times a Week	Sometimes: 2-4 Times per Month	Rarely: 2-4 Times per Year	Never

- c. Also if you answered “yes”, during what times of the day and during what activities/tasks do you experience this type of communication style?

3. How do you think the resident in the video felt?

4. Would you want this nursing assistant to take care of you?

Yes

No

- a. If you answered “yes”, why would you want this nurse to take care of you?

- a. If you answered “no”, why would you not want this nurse to take care of you?

5. In your experience, do you think the interaction you just watched is realistic or typical of interactions that occur between residents and staff members during personal care tasks (circle your answer below)?

Yes

No

- a. If you answered “no”, please describe the one thing you found most unrealistic about the video.

The following questions will ask you about differences among the two videos that you just watched. Answer each question as honestly and completely as you can.

1. Do you believe there are any important differences between the two videos you just watched (circle your answer below)?

Yes

No

- a. If so, please list 2-3 of differences that you believe were most important or noticeable.

2. In your experience, of the two videos you watched, which one is most similar to typical staff-resident interactions that occur in care facilities?

 Video 1 Video 2 Both videos were equal

3. Of the two videos you watched, which one was a better example of how nursing staff *should* interact with residents?

 Video 1 Video 2 Both videos were equal

- a. If you chose Video 1 or 2, please provide one reason why you think it was a better example of how nursing staff should interact with residents.

Appendix F

Consent Form

Informed Consent for Participation in the Research

Title of the Research Study: “An Investigation of the Perception of Elderspeak and Its Effect on Mood among an Assisted Living Population”

Researchers

The experimenter of this study will be a student researcher working under the supervision of Dr. Jeffrey Buchanan.

Purpose

The purpose of the research is to examine your perceptions about caregiver communication and how different types of communication styles affect your mood.

Participants

You have been asked to participate because you live in a senior living community.

Procedure

The student researcher will ask you questions to assess your memory and language skills. These questions will take about 5 minutes.

The student researcher will ask you to watch two different videos of simulated interactions between a nurse and an older adult. Before and after each video, the student researcher will ask you several questions to assess your mood. After watching each video, the student researcher will ask for your opinions about the video. This procedure will take approximately 50 minutes.

The videos will be viewed on the student researcher’s laptop computer in a private location at your place of residence (e.g., in a conference room). Meetings will be scheduled at a time that is convenient for you. The study will be completed and end when both of the videos and sets of questions have been presented.

Risks

The risks associated with the study are no greater than those risks encountered in general activities or normal daily life. It is possible that you may not like videos or the questions we will be asking. If this occurs, we will immediately stop the video and/or stop asking you questions.

Benefits

For the participant, a benefit could include enjoyment of the videos. The results of the study may also have utility for caregivers and older adults residing in assisted living facilities.

Confidentiality

The findings of the study will be kept completely confidential. Confidentiality will be protected in that your name will not be included on any records. All of the information collected during the time of the study will be used for research purposes only. The records will only be accessible to the principal investigator, Dr. Jeffrey Buchanan, and supervised members of Dr. Buchanan's research team in the Psychology Department at Minnesota State University, Mankato. The information and records will be kept in a locked cabinet in the principal investigator's office and destroyed after three years.

Right to Refuse or Withdraw

Participation in the study is completely voluntary. You may refuse to participate or end your participation at any time throughout the study without repercussions. Refusal or withdrawal can be completed by contacting the principal investigator at the phone number below, or by telling a staff member at your place of residence. Your decision whether or not to participate will not affect your relationship with Minnesota State University, Mankato, and refusal to participate will involve no penalty or loss of benefits.

Questions

If any questions shall arise, you are free to ask them. If you have additional questions, you may contact the office of the principal investigator, Dr. Jeffrey Buchanan, at (507) 389-5824 or the student investigator, Paige Shoutz at (507) 469-3886. If you have questions about participants' rights or for research-related injuries, please contact the Administrator of the Institutional Review Board at (507) 389-1242.

Closing Statement

Your signature below indicates that you have decided to participate in a research study, and that you have read this form, understand it, and have received a copy of this consent form.

Your signature

Date

Signature of investigator

Date

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