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An Investigation of the Perception of Elderspeak Among Community Dwelling Older Adults

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

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Abstract

This study aimed to expand the literature on the perception of elderspeak among community dwelling older adults with secondary purposes concerning how these perceptions vary across gender and region. Participants (n = 110) were presented a written vignette that depicted a nursing assistant in an assisted living facility waking a tenant from a nap and assisting the tenant to the bathroom before lunch. The nursing assistant uses elderspeak throughout the vignette. Following the vignette, participants' reactions to the use of elderspeak and perceptions of the nursing assistant in the vignette were assessed using a series of open-ended questions, the Positive and Negative Affect Schedule (PANAS; Watson et al., 1988), and the Emotional Tone Rating Scale (ETRS; Williams et al., 2012). Then, participants' personal experiences with elderspeak were examined using open-ended questions and the PANAS. Results indicated that elderspeak and the speaker were perceived negatively among community dwelling older adults, reagrdless of setting, gender, or region. Future research with a more racially diverse sample is warranted to determine how these findings generalize to the general population of older adults living in the community.

Keywords: elderspeak, affect, perceptions, older adults, community dwelling, gender, region

An Investigation of the Perception of Elderspeak among Community Dwelling Older Adults

The United States' population of older adults is growing rapidly. Starting in 2030, when all individuals in the Baby Boomer generation reach the age of 65, older Americans will make up 21% of the population, which is up from 15% in 2018 (Vespa, 2018). By 2060, almost one in four Americans will be 65 years of age and older (Vespa, 2018).

Many older adults remain at home and in the community as opposed to moving to an institutionalized setting such as a nursing home or assisted living facility. According to the 2016 American Community Survey (ACS) report, over 25% of older adults live alone and 67.9% live with family in a household. Only 3.1% live in group quarters such as a nursing home (Roberts et al., 2018).

Additionally, there has been widespread support for the Aging in Place (AIP) movement. The Center for Aging in Place defines AIP as "a national movement that enables people to stay in their own homes as they grow older by making available the social supports, wellness activities, and home maintenance services they require to live happy, productive lives in the community" (Center for Aging in Place, n.d., "What is AIP" section). The AARP's *2021 Home and Community Preferences Survey* reported that 79% of older adults in the U.S. own their own home and nearly two-thirds of older adults reported that they would like to remain in their community and in their home. Additionally, two-thirds of older adults indicated that they would prefer in-home assistance from family, friends, and professionals in the case of illness or disability to remain at home. Only 10% indicated they would prefer to move to a nursing home (AARP, 2021).

While aging is a biological process, it is largely the social construction of aging that contributes to successful outcomes in old age. Nussbaum et al. (2005) explain, "Successful, healthy ageing extends far beyond the physical/biological realm into the social nature of ageing" (p. 288). In Nussbaum et al.'s (2005) review of ageism and ageist language across the life span, they reported that ageism is pervasive in society with positive and negative age-related stereotypes appearing in the media, health care, education, the workplace, and everyday conversation. The term ageism was originally introduced by Butler (1969) and was described as a form of bigotry, similar to racism or sexism (Nussbaum et al., 2005). A more modern and well-rounded definition describes ageism as, ". . . negative or positive stereotypes, prejudice and/or discrimination against (or to the advantage of) elderly people on the basis of their chronological age or on the basis of a perception of them as being 'old' or 'elderly'" (Iverson er al., 2009, p. 15). Research has found that ageism has negative behavioral, psychological, and cognitive consequences for older adults (Levy, 2003; Swift et al., 2017; World Health Organization, 2021). It is estimated that over 6 million cases of depression worldwide are attributable to ageism (World Health Organization, 2021). A recent report by the World Health Organization (2021) revealed that every second person in the world is believed to hold ageist attitudes.

Due to this growing demographic, the push for aging in place, and the ubiquity of ageism in society, community dwelling older adults are a population that warrant research and discussion. Specifically, communication and interaction with community dwelling older adults is a critical area of study. It has been found that successful aging, in part, depends on social interaction. For example, Kiely et al. (2000) found that longevity was linked to social engagement. However, the content and delivery of communication with older adults is important. It has been found that patronizing communication can foster dependency and damage the older

individual's self-worth (La Tourette & Meeks, 2000). A hallmark of patronizing communication is elderspeak. Elderspeak has been a well-studied topic in the literature; however, community dwelling older adults have been a largely over-looked population in this research, with much of the literature focusing on institutionalized older adults.

Defining Elderspeak

The term "elderspeak" was first coined by Cohen and Faulkner in 1986 (Shaw & Gordon, 2021), although the phenomenon of patronizing speech directed toward older adults was being studied prior to this. In a literature review on patronizing speech to older individuals, Draper (2005) reported that some of the earliest researchers to explore this phenomenon were Ashburn and Gordon (1981) and Caporael (1981). Shaw and Gordon (2021) explained that the terms "secondary baby talk," "infantilizing speech," "communication overaccommodation," and "patronizing talk" have been used to describe this same phenomenon throughout the literature.

Elderspeak is a speech style that is often used with older adults. It is characterized by features such as a slow rate of speaking, simplified syntax, restricted vocabulary, increased volume, high pitch, greater repetitions, and exaggerated prosody (Caporael, 1981; Kemper & Harden, 1999). This style of speech often involves the use of inappropriate plural pronouns (i.e., "why don't we go to the bathroom") instead of individualized language (Cockrell, 2020; La Tourette & Meeks, 2000; Williams et al. 2005). It is also often includes the use of diminutives or infantile terms like "dearie" or "sweetie" while addressing older adults (Cockrell, 2020; O'Connor & St. Pierre, 2004; Williams et al., 2005). It also frequently involves the use of tag questions (i.e., "it is nice out today, isn't it?") and reflective statements (i.e., "take your medicine for me;" Cockrell, 2020). Elderspeak is most often observed in nursing homes and other health care settings, but it can occur in a wide range of settings

(O'Connor & Rigby, 1996; Ryan et al., 1995). It is often assumed to be an accommodation to the perceived communication needs and frailty of older adults (O'Connor & St. Pierre, 2004). Typically, these assumptions are based on stereotypes that older adults are less competent (O'Connor & St. Pierre, 2004; Williams et al., 2005). Younger people may believe that older adults are physically and cognitively weak, are lonely, or need cheering up. A frequent result of this belief is that the younger adult will use this "special" kind of speech typically reserved for infants and pets (O'Connor & St. Pierre, 2004). In fact, Caporael (1981) found that there is no evidence that baby talk used with children and baby talk used with older adults are paralinguistically distinguishable.

Adjusting one's speech style to the characteristics of those with which they interact is very common, natural, and often beneficial (Giles & Ogay, 2007). Nursing assistants report that they used this kind of speech with older adults because they believe it will make the resident feel comfortable, will make the nursing assistant seem friendlier, will improve communication, and will get the resident to cooperate (Grimme et al., 2015). However, these adjustments can become overaccommodations that have negative consequences on the recipient of the speech (Ryan et al., 1986). This style of speech is frequently judged as patronizing and disrespectful because it assumes that the older adult is cognitively impaired and treats them like a child (Kemper & Harden, 1999).

Theoretical Framework of Elderspeak

Communication Accommodation Theory (CAT)

Elderspeak involves accommodating one's communication style to fit the perceived needs of an older adult. This accommodation can be explained by the Communication Accommodation Theory (CAT; Giles & Ogay, 2007). This theory emphasizes the minimization

of social differences in people's communication. This can be done by matching one's vocabulary, accent, and cadence with the individual with whom they are communicating. This theory is based on two assumptions: (1) people make behavioral changes to adjust their communication to their communication partner and (2) the effectiveness of communication is directly related to the extent to which people perceive their communication partner is appropriately adapting to them (Momand & Dubrowski, 2020). The CAT argues that communication is perceived as effective and successful if the person communicating matches their style of communication to the individual they are speaking to (Momand & Dubrowski, 2020). In other words, ". . . communicators modify their speech and nonverbal behavior for different communication partners, with the goal of achieving satisfactory interactions" (Ryan et al., 1995, p. 146). It has been reported that this results in an overall increase in the efficiency of communication (Momand & Dubrowski, 2020).

Communication Predicament of Aging

The Communication Predicament of Aging (CPA) Model can help explain why elderspeak is used and why it may not be beneficial (Ryan et al., 1986). The CPA Model was introduced by Ryan et al. (1986) and was derived from the Communication Accommodation Theory. The CPA argues that the natural tendency to modify one's speech for different communication partners may result in communicators adapting their talk to older people based on erroneous assumptions and stereotyped expectations of dependence and incompetence. For instance, Caporael (1981) found that caregiver ratings of characteristics of their care recipients did not correlate with the percentage of baby talked used in communication with the care recipient. This suggests that the characteristics of older adults (i.e., perceived dependence level) did not elicit the use of elderspeak by the caregiver. Caporael (1981) and Kemper et al. (1996)

argued that this means that baby talk used with older adults is a sociolinguistic speech register as opposed to a continuous adaption of speech to the characteristics of the recipient. Therefore, the use of elderspeak may not be an effective adaptation like the Communication Accommodation Theory would suggest.

The CPA model then suggests that such modifications of communication based on stereotypes are seen as reinforcing age-stereotyped behaviors and constraining opportunities for satisfying conversation, with negative consequences for the self-esteem and psychological well-being of the older adults involved (Ryan et al., 1995). The model explains that young adults modify their style of speech toward older individuals due to negative stereotypes about older adults, resulting in patronization. A cooperative response from the older adult will reinforce the style of speech being used by the speaker and an assertive response from the older adult will either elicit another negative stereotype (i.e., that the older adult is curmudgeon) or a positive stereotype (i.e., that that older adult is a matriarch/patriarch; La Tourette & Meeks, 2000). The CPA model postulates that elderspeak contributes to social isolation and cognitive decline, which in turn triggers further speech simplifications (Ryan et al., 1986).

Speech modifications based on stereotypes can threaten the self-esteem and social identity of the older adult and feed into a negative cycle that further limits opportunities for satisfying and meaningful conversations (Ryan et al., 1995). For example, an older adult may falsely believe that they are incompetent because of the patronizing messages behind elderspeak. Because the older adult believes they are incompetent, they are likely to seek assistance with tasks they can complete independently, which fosters a decline of abilities and increases dependence (Balsis & Carpenter, 2006; Williams et al., 2005). This cycle is depicted in Figure 1. This model helps explain the use of elderspeak while simultaneously highlighting

the negative implications of using such speech.

Implications of Elderspeak

The users of elderspeak often cite good intentions behind using elderspeak with older adults. For example, caregivers often report that they use elderspeak to improve communication and to convey messages of compassion and nurturance (Grimme et al., 2015; Lombardi et al; 2014). Many caregivers also believe that elderspeak makes the older adult more compliant, especially in dementia care (Herman & Williams, 2009). Naturally, the next question is whether these good intentions are supported by empirical findings. The literature has shown some positive implications of elderspeak; however, the literature has been heavily inundated with negative findings.

The literature on elderspeak has revealed some positive effects of this style of communication. For example, Caporael (1981) has found that the use of baby talk is perceived as more comforting and less irritating than non-baby talk. However, it is important to note that these judgments were made by college aged observers, and not by the older adults who were the recipients of elderspeak. Additionally, Kemper et al. (1996) found that older adults performed better on a referential communication task when elderspeak was used. However, despite the improved performance on the task, older adults self-reported more communication problems. The authors hypothesized that exaggerated pitch and repetitive speech were the components of elderspeak that led to negative self-attributions of the older adults and conversely that lower pitch and reduced pitch variability improved communication (Kemper et al., 1996).

While some potential positive effects of elderspeak have been found in the literature, most of the research demonstrates negative implications. In a literature review on patronizing speech, Draper (2005) found that the bulk of the literature indicated that patronizing speech

should be avoided. For example, it has been found that both people who use elderspeak and those who are recipients of elderspeak are regarded negatively. Those who use elderspeak are perceived as having a poor demeanor. Specifically, they are viewed as lacking in manners and respect and come across as insensitive (Balsis & Carpenter, 2006; Ryan et al., 1991). Additionally, they are perceived as less helpful and less trustworthy (Balsis & Carpenter, 2006). Ryan et al. (1991) found that nurses who used elderspeak were rated as less nurturant, less competent, and less benevolent. Furthermore, recipients of elderspeak were judged as having a poor mood and a decreased level of ability compared to older adults who did not receive elderspeak (Balsis & Carpenter, 2006). Elderspeak also makes the recipient appear less competent (La Tourette & Meeks, 2000). Ryan et al. (1991) reported that recipients of elderspeak were evaluated as more frustrated and helpless. Relatedly, Lombardi et al. (2014) found that ratings of appropriateness of elderspeak are relatively low.

Although research shows that elderspeak has low appropriateness ratings, it often deemed as more acceptable to use with individuals with cognitive impairments (Grimme et al., 2015; Kemper et al. 1998a; 1998b; Lombardi et al., 2014). While these accommodations may seem like a plausible strategy for enhancing communication with older adults, particularly for those with dementia, there has been no empirical support they are beneficial to the older adult (Kemper et al, 1998a). Furthermore, Herman and Williams (2009) found that older adults with dementia were more than twice as likely to be resistive to care when elderspeak was used by the caregiver. Zhang et al. (2020) reported similar findings that elderspeak increased resistiveness to care in dementia patients.

Ryan et al. (1995) reported that despite good intentions, elderspeak can be quite harmful with implications on emotional and physical well-being. Patronizing communication tends to

convey a sense of declining capability, loss of control, and helplessness (Ryan et al., 1995). For example, elderspeak results in increased communication problems, decreased performance on tasks, and negative self-assessment of communicative competence (Kemper et al., 1998b; Kemper & Harden, 1999). It has also been found that older adults' self-esteem may decline, older adults may withdraw from social interactions, and older adults may adopt more dependent behaviors because of elderspeak (Coupland et al., 1988; Kemper & Hardin, 1999). This likely will lead to negative social, physical, and psychological consequences (O'Connor & St. Pierre, 2004). For instance, in Draper's (2005) literature review it was stated that one consequence of this social withdrawal caused by elderspeak is that older adults will become less successful communicators over time.

On top of practical issues, elderspeak is not received well by older adults. In fact, several studies have found that older adults have negative perceptions of elderspeak. Many older adults find elderspeak to be infantilizing, patronizing, disrespectful, and condescending (La Tourette & Meeks, 2000; O'Connor & St. Pierre, 2004). These negative perceptions of the use of elderspeak can have very real consequences on older adults. For example, patronization leads to dependency which results in accelerated mental and physical decline and ultimately a decreased quality of life (La Tourette & Meeks, 2000). Additionally, Lagacé et al. (2012) found that patronizing communication in long term are facilities diminished older adults' evaluations of their living experience and quality of life. Similarly, Draper (2005) reported that the literature revealed that elderspeak causes isolation and depression. However, an interesting finding by O'Connor and Rigby (1996) showed that older adults, particularly those in nursing homes, adapt to situational demands by becoming more accepting of elderspeak. So, it is possible that the more an older adult is exposed to elderspeak, the more they will tolerate it.

Previous Elderspeak Research on Community Dwelling Older Adults

Much is known about the impact of elderspeak on older adults in institutionalized settings, but significantly less is known about the impact on community dwelling older adults. Within the few research studies that exist in the literature related to community dwelling older adults, there are mixed results. Some studies have found that there is no difference on perceptions of elderspeak between institutionalized older adults and community dwelling older adults, while others have reported differences. Furthermore, some studies suggest that community dwelling adults perceive elderspeak more negatively, while others suggest that they perceive it warmly.

In a special issue of the *Journal of Language & Communication*, Ryan et al. (1986) published an article on linguistic and social psychological components of communication with older adults. Within in this article, the authors included a section on speech accommodations used with non-institutionalized older adults. They discussed a previous article by Henwood & Giles (1985). The participants in this study consisted of 33 dyads of older women living alone at home and their home care aides. They found that elderspeak was used frequently, but that on many of those occasions, it was perceived favorably by the older adults. They reported that the use of elderspeak signaled affection, warmth, nurturance, and liking and conversely that the lack of elderspeak was often perceived as a lack of affection and empathy. However, they also reported that 40% of the participants claimed they had been the recipient of demeaning communication. In a sample that looked at community dwelling older adults who did not require a home care aide, they found that more than 50% claimed to have been the recipient of demeaning communication due to their age. Overall, this article illustrated that community dwelling older adults perceive elderspeak warmly, but that the utilization of home health

services may play a role in perceptions.

In Brown & Draper (2003), noninstitutionalized older adults' experiences with accommodative speech and terms of endearment were discussed. Specifically, they discussed the results of Giles et al. (1993), which examined community dwelling older adults' beliefs about the frequency of elderspeak. In this study, the authors found that 58% of noninstitutionalized older adults believed that elderspeak was used with older adults in general and 36% believed elderspeak happened often. Furthermore, 59% of noninstitutionalized older adults claimed that they had experienced elderspeak personally and 13% believed they had experienced elderspeak often. The study also found that over-accommodating speech made community dwelling older adults feel patronized, irritated, angry, and inferior.

A study by O'Connor & Rigby (1996) compared the perception and frequency of elderspeak among community dwelling older adults and older adults living in nursing homes. The study consisted of 113 older adults living in the community and 43 older adults living in nursing homes. The participants were presented with baby-talk and neutral-talk scenarios. Themes of warmth and superiority were found in the responses. Nursing home residents perceived less superiority in baby-talk than the older adults living in the community. However, when controlling for age and level of functional health, there was no difference in perception of baby-talk between nursing home residents and community dwelling older adults. This study also examined gender as a predictor of perceptions of elderspeak. They found that women in better functional health perceived more superiority in elderspeak than women in poorer functional health. However, they found no differences in perception or in how frequently elderspeak was used between men and women

Similarly, in La Tourette and Meeks' (2000) study, they compared community dwelling older adults and nursing home residents' evaluations of elderspeak. The authors also explored the influence of living environment and cognitive abilities on these perceptions of elderspeak. This study included 38 women living in nursing homes and 62 women living in the community. Each participant viewed two video vignettes that depicted an interaction occurring in a nurse's office in which an older woman is going receive a flu shot from a younger female nurse. In each of the two interactions, the older woman's script stayed the same, but the nurse's script was either patronizing or nonpatronizing. Each vignette occurred in either a nursing home or in the community. The order of the speech styles and the order of vignette setting were counterbalanced. After watching the vignette, the participants rated the nurse on dimensions of respectful, nurturing, benevolent, and competent using a scale of 1 (not at all) to 7 (very, very much). They also rated how satisfied they thought the older woman in the scenario was with the conversation (La Tourette & Meeks, 2000).

Overall, they found that both community dwelling older adults and nursing home residents preferred nonpatronizing speech over patronizing speech. The participants rated the nonpatronizing nurses as more respectful, nurturing, competent, and benevolent. They also rated the non-patronized older women as more satisfied with the conversation. Cognitive ability was a significant factor for both community dwelling older adults and nursing home residents. Specifically, higher cognitive ability was related to favorable ratings of competence and benevolence of the nonpatronizing nurse. However, the context in which the patronization took place (nursing home or community) did not have a significant influence on the participants' ratings (La Tourette & Meeks, 2000). Similar to the results of the O'Connor & Rigby (1996) study, no differences were found between nursing home residents and community dwelling older

adults. However, in contrast to the Henwood & Giles (1985) study that Ryan et al. (1986) discussed, these results seem to indicate that community dwelling older adults perceive elderspeak as disrespectful.

In O'Conner and St. Pierre's (2004) study, 159 older adults were surveyed on their impressions of and experiences with elderspeak from five types of speakers: friends, same-age family members, younger family members, familiar service workers, and unfamiliar service workers. Two main themes came out of the analysis of the older adults' judgements of all five speaker types – "warmth" and "superiority."

Of the participants in this study, 131 were community-living and 28 were living in nursing homes. The participants were provided with two scenarios, one depicting elderspeak and one depicting a normal style of speech. The participants were asked to imagine that selected speakers (friends, same-age family members, younger family members, familiar service workers, and unfamiliar service worker) were the ones conversing with them in the scenarios – they went through each of the five speaker types, one by one. Participants were then asked to compare how frequent or common the elderspeak scenario was compared to the normal speech-style scenario in their real life. They were also asked how many times a week they received elderspeak from each of the five types of speakers (O'Conner & St. Pierre, 2004).

The findings of this study suggest that elderspeak is perceived more warmly when it comes from a familiar source and is perceived higher in superiority when it comes from an unfamiliar source. Additionally, they found that the nursing home residents perceived elderspeak more warmly than the community-living older adults. Furthermore, perceived superiority was lower for nursing home residents than community-living older adults. They also found that community-living older adults reported less frequency of elderspeak than nursing home residents

(O'Conner & St. Pierre, 2004). These results contrast the results from both the O'Connor and Rigby (1996) study and the LaTourette and Meeks (2000) study.

In Cockrell (2020), elderspeak in simulated preclinical chiropractic student encounters was explored. This study wanted to determine whether elderspeak was present in these simulated patient encounters, which type of elderspeak was used most frequently (if present), and whether gender was an influencing variable of elderspeak use (if present). This study included 42 older male patients and 18 older female patients. The results indicated that elderspeak was in fact present in student interactions with these patients. They found that the most common form of elderspeak used in these interactions was collective pronoun usage. Specifically, they reported that in any given encounter, up to nine occurrences of collective pronoun usage were recorded. They found that the only category of elderspeak influenced by patient gender was the use of tag questions, with students using more tag questions with male clients. However, there were no significant gender differences in the use of diminutives, collective pronoun use, or reflective statements.

Purpose of the Current Study

The existing literature on perceptions of elderspeak among community dwelling older adults presents mixed findings and is relatively dated. There is currently a whole new cohort of older adults than there was in the 1990s and early 2000s; it is highly plausible that there are generational differences in perceptions of elderspeak that need to be explored. Furthermore, there appears to be very little in the literature assessing gender differences in perceptions of elderspeak, with much of the existing research focusing on women. Finally, there is also very limited research examining differences in perception of elderspeak across regions of the U.S. Given these gaps in the current literature, the primary purpose of the present study is to expand

the literature on the perception of elderspeak among community dwelling older adults with secondary purposes concerning gender and regional differences in the perception of elderspeak.

Methods

Participants

Participants were 110 adults aged 65 or older who had no known diagnosis of a memory or cognitive disorder and who were living within the community as opposed to an institutionalized setting such as a nursing home or assisted living facility. Participants were recruited via a Qualtrics research panel and were compensated by their panel provider for participation. The majority of the respondents were white (n = 100) and female (female = 69, male = 41) with age ranging from 65 to 86 years old (M = 71.68, SD = 4.80). See Table 1 for a breakdown of participant ethnicity. The participants comprised a nationwide sample, with 48 living in the South, 21 in the Northeast, 17 in the Midwest, and 22 in the West. Regions were determined using the U.S. Census Bureau's (2010) region breakdown of the United States. Concerning education, the majority of participants reported their highest level of education attained being "some college" (n = 34), followed by a bachelor's degree (n = 25), high school (n = 21), a master's degree or beyond (n = 15), an associate degree (n = 14), and trade school (n =1), respectively. Participants reported that they primarily live in their own home (n = 85) with some living in an apartment or independent living facility (n = 20) or in a child or other family member's home (n =5). Three of the participants reported having previously lived in a nursing home or assisted living facility, including short term stays. None currently live in an institutionalized setting. Additionally, three participants reported that they receive in-home services such as a home health aide. Most of the participants reported having no concerns related

to their memory (n = 75). Of the participants who expressed concern pertaining to their memory (n =35), none had received a diagnosis related to their memory or cognition.

Procedure and Materials

A survey was constructed specifically for the purposes of this study to better understand the perspectives of participants on the use of elderspeak. The final version of this questionnaire can be seen in Appendix A. The survey was delivered and administered using *Qualtrics Survey Software*. Upon opening the anonymous survey link, participants were first presented with a consent form and were then required to answer the question, "do you consent to participate in this study?" (See Appendix B for consent form). If a participant responded "no," they were directed to the end of the survey. If consent was obtained, participants were brought to a series of demographic questions regarding the participant's age, gender, ethnicity, whether the participant has concerns or diagnoses related to memory, state of residence, level of education, current living situation, whether the participant has ever lived in an assisted living facility or nursing home, and whether the participant receives in-home services. Some demographic questions were used to screen out participants that did not meet inclusion criteria. For instance, individuals less than 65 years of age were directed to the end of the survey. In addition, participants indicating that they were diagnosed with a condition that caused memory impairment were unable to complete the study.

After completing the demographic questions, participants were presented with survey instructions. The instructions explained what elderspeak is and provided examples. To avoid participant bias, the word "elderspeak" was never used. Instead, after providing the definition and examples of the speech/language of interest, elderspeak was referred to only as "this type of speech." On the next page, participants were presented with a written vignette. The vignette depicted a nursing assistant using elderspeak in an interaction with an assisted living tenant. The

vignette was developed based on video vignettes created by certifiifed nursing assistants (CNAs). The participant was instructed to imagine themselves as the tenant as they read through the vignette. In the vignette, the nursing assistant has just woke the tenant from a nap and is assiting them to the bathroom before lunch.

Measures

After reading the vignette, the participant was asked questions about their reaction to the vignette. They were first asked to imagine how they would have felt if they were the tenant in the scenario. They were then asked to rank how comfortable (or uncomfortable) the vignette made them feel using a five-point Likert-scale ranging from "extremely uncomfortable" to "extremely comfortable."

Positive and Negative Affect Schedule

Next, the participant was presented with the Positive and Negative Affect Schedule (PANAS; Watson et al., 1988). The Positive and Negative Affect Schedule was developed by Watson et al. (1988) and measures two distinct dimensions: positive affect (PA) and negative affect (NA). PA refers to the extent to which an individual feels enthusiastic, active, and alert. Conversely, NA refers to subjective distress and unpleasurable engagement and includes moods such as anger, contempt, and fear. The PA scale includes the terms attentive, interested, alert, excited, enthusiastic, inspired, proud, determined, strong, and active. The NA scale includes the terms distressed, upset, hostile, irritable, scared, afraid, ashamed, guilty, nervous, and jittery. These items are rated on a five-point Likert-scale, ranging from "strongly disagree" to "strongly agree." The PANAS has been validated across various time frames. The current study asked participants to rate their current emotional state, so reliability and validity data related to this time frame will be reported. Watson et al. (1988) found that both the PA scale ($\alpha = .89$) and the

NA scale (α = .85) were highly reliable. This suggests that the items within each scale are highly related and measuring the same construct. The intercorrelation between the PA and NA scales was low (*r* = -.15), which indicates that the two constructs are independent from each other. The PANAS scales exhibited significant levels of test-retest reliability (PA: *r* = .54; NA: *r* = .45). Validity of the scale was established by correlating the PANAS scales with the two factors from a principal factor analysis of the 60 mood descriptors from Zevon and Tellegen (1982). The results of this analysis indicated both convergent and discriminant validity. Convergent correlations ranged from .91 to .95. Discriminant correlations ranged from -.02 to -.15. The current study adapted these scales to fit the context of the research. In the present study, both the NA (α = .86) and PA (α = .88) scales were highly reliable. This included six positive terms (i.e., comforted, calm, grateful, respected, trusting, and competent) and six negative terms (i.e., inadequate, discouraged, distressed, frustrated, embarassed, and offended). Participants were asked to rate the extent to which they felt each emotion while reading the vignette, using a five-point Likert-scale ranging from "strongly disagree" to "strongly agree."

Emotional Tone Ratng Scale

Participants were then asked to rate the nursing assistant from the vingnette using the Emotional Tone Rating Scale (ETRS; Williams et al., 2012). The ETRS was developed as a communication rating tool to measure the underlying affective qualities of communication with older adults. The scale measures person-centered communication. The scale includes a set of 12 adjectives that are rated using a 5-point Likert scale. A principal axis factor analysis revealed two factors: "person-centered" (PC) and "control-centered" (CC; Williams et al., 2012). The "person-centered" factor includes the following items: affirming, supportive, caring, nurturing, polite, respectful, and warm. The "control-centered" factor includes the adjectives dominating,

controlling, directive, bossy, and patronizing. The items on the PC subscale have high inter-item correlations ranging from .72 to .97. This suggests that the descriptors are closely related. The subscale had overall high reliability (α = .98). Similarly, the items on the CC subscale (excluding patronizing) were highly related with inter-item correlations ranging from .77 to .97. This subscale also had overall high reliability (α = .94). Concurrent validity was evaluated by correlating the two subscales with resident engagement in conversations (measured in number, length, and proportion of resident utterances; Williams et al., 2012). The PC subscale was positively correlated with the number of utterances (r = .31), the length of utterances (r = .21), and the proportion of utterances (r = .23). The CC subscale was negatively correlated with the number of utterances (r = -.26), length of utterances (r = -.23), and proportion of utterances (r = -.35). In the current study, the participants rated the nursing assistant on the the 12 dimensions from the ETRS. For each of these dimensions, the participant was asked to rate the nursing assistant from 1 (not at all) to 5 (very). The ETRS subscales had high overall reliability in the current study (PC: α = .94; CC: α = .72).

Additional Questions

Next, participants were asked an open ended question about why they believe care providers in assisted living facilities use this kind of speech and two open ended questions about situations where this type of speech is appropriate/useful and situations where it is not. Then, participants were asked an open ended question about what feedback they would give to the nursing assistant based on the interaction they read.

The final three questions were about the participants' personal experiences with elderspeak. First, participants were asked to provide up to three examples of personal experience with elderspeak. Then, the participant was presented with the same adapted version of the

PANAS from earlier in the survey and asked to rate the extent to which they felt each postive and negative emotion in their personal experience with elderspeak. Finally, participants were asked how frequently they experience elderspeak. This was a multiple choice question with the following options: multiple times a day, once a day, multiple times a week, once a week, a few times a month, once a month, less than once a month, and never.

Results

Four sets of analyses were conducted: 1) a descriptive analysis of individual survey items; 2) an examination of the relationship between participant gender and emotional reactions to the vignette and ratings of the nursing assistant; 3) an examination of the relationship between participant region of residence and emotional reactions to the vignette and ratings of the nursing assistant; 4) and lastly, a thematic evaluation of the open-ended questions. Pertaining to the first set of analyses, descriptive statistics were calculated to examine the average ratings of each item on both the PANAS and the ETRS. For the second set of analyses, a series of independent-samples t-tests were conducted to compare gender differences on responses to both the PANAS and ETRS. Similarly, for the third set of analyses, a series of one-way ANOVAs were conducted to compare regional differences on both the PANAS and ETRS. Throughout this study, a total of 14 statistical analyses were conducted. To account for the increased probability of type I error, a Bonferroni adjusted alpha of .003 was used for each test. For the final set of analyses, qualitative analyses of responses to each open-ended question were completed.

Descriptive Analysis

Several descriptive statistics were calculated to provide a broad view of trends in the data. For example, one survey item asked participants to rate how comfortable or uncomfortable the vignette made them feel on 5-point Likert scale with one meaning 'extremely uncomfortable'

and five meaning 'extremely comfortable.' The data showed that participants, on average, felt uncomfortable after reading the vignette (M = 1.88, SD = 1.29).

PANAS*: *Vignette Reactions

Focusing next on the 12 items from the PANAS used to evaluate the vignette, there was an evident pattern of high ratings of negative affect descriptors and low ratings of positive affect descriptors. Participants were asked to rate each descriptor on a scale of one to five, with one indicating “strongly disagree” and five indicating “strongly agree.” Thus, each item could have a score between one and five and each subscale could have a score between six and 30. Low scores indicated strong disagreement and high scores indicated strong agreement. The negative affect scale, on average, had a score of 23.05 (SD = 5.39) out of a possible 30 among participants. Within this subscale, participants, on average, most strongly agreed with the item “offended” (M = 4.15, SD = 1.12).

The positive affect scale, on average, had an agreement score of 14.58 (SD = 4.77) out of a possible 30. Within this subscale, participants, on average, disagreed most with the item “comforted” (M = 1.91, SD = 1.32). See Table 2 for a complete list of descriptive statistics for each item from the PANAS.

ETRS

Regarding the 12 items from the ETRS, the descriptive analysis illustrated a clear pattern of high ratings of control-centered traits and low ratings of person-centered traits. The ETRS asked the participants to rate the nursing assistant from the vignette on 12 items, comprised of two subscales, using a 5-point Likert scale, with one meaning “not at all” and five meaning “very.” Therefore, possible scores range from one to five for each item. The subscale scores are means of all items within the subscale, so possible scores also range from one to five. The

control-centered subscale, on average, had a score of 3.70 out of a possible five (M = 3.70, SD = .96). Within the control-centered subscale, participants, on average, rated the item "dominating" highest (M = 3.84, SD = 1.35), which is higher than normative data for this item (M = 1.8, SD = .5; Williams et al., 2012). See Table 3 for the normative data of each item on the ETRS. However, it should be noted that comparisons to the normative data are rough comparisons due to differences in age between the current sample and the normative sample.

Conversely, the person-centered subscale, on average, had a score of 2.32 out of a possible five (M = 2.32, SD = 1.33). Within the person-centered subscale, participants, on average, rated the item "respectful" lowest (M = 1.99, SD = 1.26), which is low compared to normative data for this item (M = 3.5, SD = .5; Williams et al., 2012). See Table 3 for a complete list of descriptive statistics for each item from the ETRS.

PANAS: Personal Experience Reactions

Concerning the 12 items from the PANAS used to evaluate personal experiences with elderspeak, participants agreed more strongly with the negative affect items when describing their personal experience with elderspeak. The descriptive analysis revealed that participants, on average, scored 22.07 out of a possible 30 on the negative affect subscale (M = 22.07, SD = 5.81), while the average score on the positive affect scale was 16.50 out of a possible 30 (M = 16.50, SD = 3.68). Within the negative affect subscale, participants rated "distressed" the highest (M = 3.97, SD = 1.15), while on the positive affect subscale, participants rated "respected" the lowest (M = 2.31, SD = .71). See Table 4 for a complete list of descriptive statistics for each item from the PANAS.

Frequency of Elderspeak

One final item asked participants to rate the frequency of elderspeak as it occurs in their personal life. Over 68% of participants reported that they never experience the type of speech used in the vignette in their personal lives. See Table 5 for the breakdown of reported frequency of elderspeak in the participants' personal lives.

Comparative Analysis of Gender

An independent samples t-test was conducted to examine gender differences on ratings of the item from the questionnaire asking participants to rate how comfortable or uncomfortable the vignette made them feel. No significant differences were found between male and female ratings on this item, $t(65.50) = 2.29$, $p = .03$.

Two independent samples t-tests were conducted to compare gender differences on the subscales of the PANAS used to rate emotional reactions to the vignette. There was no significant gender difference on the positive affect subscale, $t(67.20) = 2.29$, $p = .03$, nor the negative affect subscale, $t(108) = -1.59$, $p = .11$.

Additionally, two independent samples t-tests were conducted to compare gender differences on the subscales of the ETRS. There was no significant gender difference on the person-centered subscale, $t(108) = 1.92$, $p = .06$, nor the control-centered subscale, $t(106) = .92$, $p = .94$.

Furthermore, two independent samples t-tests were conducted to compare gender differences on the subscales of the PANAS used to rate emotional reactions to personal experiences with elderspeak. There was no significant gender difference on the positive affect subscale, $t(26) = 1.51$, $p = .14$, nor the negative affect subscale $t(27) = -2.17$, $p = .04$.

Comparative Analysis of Region

A one-way ANOVA was conducted to compare ratings of "comfortableness" with the vignette for the four regions of the United States. The results indicated no significant difference between region, $F(3, 104) = .81$, $p = .49$.

Two, one-way ANOVAs were conducted to compare regional differences on the subscales of the PANAS used to rate emotional reactions to the vignette. There was no significant regional difference on the positive affect subscale, $F(3, 104) = .96$, $p = .42$. Levene's test of homogeneity of variance showed that the variances for ratings on the negative affect subscale were not equal between regions, $F(3, 104) = 3.71$, $p = .01$. Because the assumption of homogeneity of variance was not met for this data, a Welch's adjusted F ratio was used. This result was not significant, Welch's $F(3, 52.12) = 4.37$, $p = .01$.

Additionally, two one-way ANOVAs were conducted to compare regional differences on the subscales of the ETRS. There was no significant regional difference on the person-centered subscale, $F(3, 104) = 1.44$, $p = .06$, nor the control-centered subscale, $F(3, 102) = 1.31$, $p = .28$.

Furthermore, two one-way ANOVAs were conducted to compare regional differences on the subscales of the PANAS used to rate emotional reactions to personal experiences with elderspeak. Levene's test of homogeneity of variance showed that the variances for ratings on the positive affect subscale were not equal between regions, $F(3, 23) = 6.89$, $p = .002$. Because the assumption of homogeneity of variance was not met for this data, a Welch's adjusted F ratio was used. This result was not significant, Welch's $F(3, 8.88) = 1.74$, $p = .23$. Additionally, there was no significant regional difference on the negative affect subscale $F(3, 24) = .68$, $p = .58$.

Qualitative Evaluation

The questionnaire included six open-ended questions. Five of these questions allowed participants to elaborate and expand upon their reactions to the vignette. The final open-ended

question allowed participants to provide examples of elderspeak they have experienced in their personal lives. A coding system was developed for each of the five questions about reactions to the vignette. An independent coder was trained on this coding system for each question. Training involved a definition for each theme along with examples of responses that fit the theme and nonexamples that did not fit theme.

Question 19

Question 19 on the survey asked, "How would you have felt if this were you in this scenario?" In a thematic analysis of the responses, ten themes were found. These themes included patronized, mad, bad, uncertain, embarrassed, disrespected, cared for, incompetent, intimidated, and indifferent. Out of the 110 responses, ten responses were either undecipherable or did not answer the question. See Table 6 for example responses for each theme. Independent coding was conducted for 31% of responses (n =34). Block-by-block interobserver agreement was calculated and revealed 84.62% agreement.

The most common theme found in response to this question was "patronized," with 45.5% of participants providing answers related to this theme (n = 50). The next most common theme indicated in the responses was "mad" (n = 35), followed by "incompetent" (n = 20), "embarrassed" (n = 16), and "disrespected" (n = 14), respectively. Less than 6% of participants indicated themes of "cared for" (n = 5) or "indifferent" (n = 1). See Table 6 for the frequency of each theme.

Question 23

Question 23 on the survey asked, "Why do you think care providers in assisted living facilities use this kind of speech?" In a thematic analysis of the responses, nine themes were found. These themes included impaired/child-like, difficult, lack of training, helpful/necessary,

task-oriented, power dynamic, disrespectful, uncertain, and normal. Of the 110 responses, six responses were undecipherable or did not answer the question. See Table 7 for an example response for each theme. Independent coding was conducted for 31% of responses (n =34). Block-by-block interobserver agreement was calculated and revealed 81.62% agreement.

The most common theme found in response to this question was "impaired/child-like," with 42.7% of participants including a statement suggesting that care providers use this type of speech because older adults are cognitively impaired or child-like (n = 47). The next most common theme was "helpful/necessary" (n = 24), followed by "lack of training" (n = 15) and "power dynamic" (n = 15). See Table 7 for the frequency of each theme.

Question 24

Question 24 asked, "What are situations or circumstances you think this type of speech might be appropriate or useful?" In a thematic analysis of the responses, 11 themes were found. These themes included: uncertain; never appropriate; appropriate with children; appropriate with someone with emotional needs/mental health concerns; appropriate with older adults who are cognitively impaired; appropriate when the aide is trying to be helpful and effective; appropriate when the older adult is child-like; appropriate when the older adult is being difficult; always appropriate; appropriate when the older adult is physically impaired; and in close relationships. Of the 110 responses, four responses were undecipherable or did not answer the question. See Table 8 for an example of each theme. Independent coding was conducted for 31% of responses (n =34). Block-by-block interobserver agreement was calculated and revealed 91.18% agreement.

The most common theme found in response to this question was "never appropriate," with 33.6% of participants reporting that they do not believe elderspeak is ever appropriate (n =

37). The next most common theme was “appropriate when older adult is incompetent/cognitively impaired” (n = 31), followed by “appropriate with children” (n = 16). See Table 8 for the frequency of each theme.

Question 25

Question 25 asked, “What are situation or circumstances you think this type of speech might be inappropriate or less useful?” In a thematic analysis of the responses, nine themes were recognized. These themes included: competent/capable, always inappropriate, policy violation, emergency, public situations, preferences, child-like, cooperative, and uncertain. Out of the 110 responses, ten responses were either undecipherable or did not answer the question. See Table 9 for an example of each theme. Independent coding was conducted for 31% of responses (n =34). Block-by-block interobserver agreement was calculated and revealed 89.71% agreement.

The most common theme found in response to this question was “always inappropriate,” with 31.4% of participants indicating that they think elderspeak is inappropriate in all contexts (n = 43). The next most common theme was “competent/capable” (n = 40) followed by “preferences” (n = 6) and “childlike” (n = 4), respectively. See Table 9 for the frequency of each theme.

Question 26

Question 26 asked, “If you could give feedback or advice to the nursing assistant based on the way they interacted with the tenant in the scenario, what would you tell them?” In a thematic analysis of the responses, eight themes were recognized. These themes included: no advice, respect, training, patience, independence, compassion, listen/pay attention, and quit. Of the 110 responses, eight responses were either undecipherable or did not answer the question. See Table 10 for an example of each theme. Independent coding was conducted for 31% of

responses (n =34). Block-by-block interobserver agreement was calculated and revealed 88.24% agreement.

The most frequent theme mentioned in the responses to this question was “respect,” with 50% of participants indicating that their advice for the nursing assistant from the vignette would be to treat older adults with respect and like other adults, (n = 55). The next most common theme indicated in the responses was “compassion” (n = 28), followed by “independence” (n = 16), “listen/pay attention” (n = 11), and “patience” (n = 10), respectively. See Table 10 for the frequency of each theme.

Question 29

Question 29 asked participants to provide up to three examples of personal experience with elderspeak. Of the 110 participants, 22 different participants provided 40 personal examples. These examples were divided into two main categories: primary experiences and secondary experiences. Primary experiences (n = 14) were examples that happened to the participant. For example, one participant recounted being told, “I think you should retire instead of going out on unemployment. You are old enough.” Secondary experiences (n = 24) were examples that the participant witnessed. For example, one participant wrote, “I was the primary caretaker for my 95-year-old father. When he was under palliative care several of the staff would talk to him like he was a toddler. . . "

The examples were then further categorized by the setting in which they occurred. Most examples occurred in a health care setting (i.e., nursing home, hospital, dentist, etc.; n = 30). For example, one participant wrote, “I've worked in long term care for years and heard my CNAs talk like this.” Additionally, four examples occurred in the workplace. For example, one participant wrote, “Girls it’s time for our team meeting. (We are all older than you).”

Furthermore, three of the examples occurred among friends or family. For instance, one participant wrote, "(This is) How my sisters-in-law spoke to my dad before he had to be put in a nursing home."

Discussion

The purpose of the current study was to examine the perspective community dwelling older adults have on both elderspeak used in institutionalized settings and in their personal lives. This study also set out to explore how these perspectives vary across gender and region.

Perceptions of Elderspeak in Institutionalized Settings

The findings of the current study indicated that community dwelling older adults are uncomfortable with the use of elderspeak. This aligns with previous findings that have demonstrated that older adults living in institutionalized settings neither like nor prefer elderspeak and often deem is as unwelcome (Brown & Draper, 2003; Caporael et al., 1983; Draper, 2005).

The descriptive analysis of the individual items from the PANAS used to evaluate reactions to the vignette suggest that community dwelling older adults have negative reactions to elderspeak, with frequent and potent themes of offense and embarrassment. This parallels previous research that have found that elderspeak makes older adults feel degraded, frustrated, helpless, and incompetent (Brown & Draper, 2003; Hermann & Williams, 2009; Kemper et al., 1998b; Kemper & Harden, 1999; LaTourette & Meeks, 2000; Ryan et al., 1991; Ryan et al., 1995).

The findings from descriptive analysis of the ETRS in the current study suggest that the nursing assistant who used elderspeak was perceived as controlling and dominating and, conversely, did not appear to be respectful or nurturing. The participants rated the nursing

assistant from the vignette has highly control-centered and much less person-centered. These results are consistent with the bulk of the previous literature which has found that those who use elderspeak are perceived as insensitive, disrespectful, less nurturant, and less benevolent (Balsis & Carpenter, 2006; Brown & Draper, 2003; O'Connor & St. Pierre, 2004; Ryan et al., 1991).

However, these findings are inconsistent with the findings from the Henwood and Giles (1985) study which found that community dwelling older adults perceived users of elderspeak favorably (Ryan et al., 1986). Specifically, these authors found that elderspeak signaled affection, warmth, and nurturance. It is possible that the discrepancy between the findings of this study and the current study are due to familiarity. As St. Pierre and O'Connor (2004) found, elderspeak is perceived as higher in warmth and lower in superiority when it comes from a familiar source. The Henwood and Giles (1985) study examined caregiver dyads. This is likely to create a higher sense of familiarity than the fictional nursing assistant from the current study. Additionally, it is possible that the functional level of the older adult resulted in different perceptions. In the Henwood and Giles (1985) study, the older adults utilized home care services. In the present study, only three of the 110 participants reported utilizing home care services. Therefore, it is possible that there was a difference in the functional ability of participants between the two studies and perhaps those who require more care perceive elderspeak as more nurturing. This aligns with O'Connor and Rigby's (1996) hypothesis that older adults adapt to situational demands by becoming more accepting of elderspeak.

Perceptions of Elderspeak in Personal Examples

The findings from the descriptive analysis of the PANAS used to evaluate reactions to personal experiences with elderspeak indicate that participants had negative reactions with strong themes of distress and offense to the use of elderspeak as it occurred in their personal lives.

These results are consistent with previous findings that indicate elderspeak makes older adults feel demeaned, frustrated, discouraged, and incompetent (Brown & Draper, 2003; Kemper et al., 1998b; Kemper & Harden, 1999; LaTourette & Meeks, 2000; Ryan et al., 1991; Ryan et al., 1995). This pattern of responses was also consistent with the pattern of responding on the PANAS used to evaluate emotional reactions to the vignette from the present study. This suggests that participants perceive elderspeak negatively in both institutionalized settings and community settings.

Frequency of Elderspeak

In the current study, 70% of participants reported they have never experienced elderspeak. This is inconsistent with much of the previous literature on elderspeak which has found that community dwelling older adults experience elderspeak roughly one to five times a week (O'Connor & St. Pierre, 2004). Additionally, Giles et al. (1993), as discussed by Brown and Draper (2003), found that 36% of noninstitutionalized older adults believed that elderspeak happened often to older adults and 59% believed they had personally experienced elderspeak.

The current findings may be inconsistent with the literature for several reasons. First, O'Connor and St. Pierre (2004) asked about frequency in terms of instances of elderspeak per week. The current study asked about frequency using a range of "multiple times a day" to "less than once a month" and included a "never" option. It is possible that the participants in the O'Connor and St. Pierre (2004) study were primed to think of higher frequency and participants in the current study were primed to think of lower frequency merely based on the response options they were provided.

Furthermore, Giles et al. (1993) found that 36% of noninstitutionalized older adults believed that elderspeak happened often to older adults in general, but only 13% of

noninstitutionalized older adults believed that elderspeak personally happened to them often (Brown & Draper, 2003). This perhaps suggests that older adults are not able to recognize the use of elderspeak when it is directed to themselves, but they are able to recognize it when it is directed toward others. This may help explain why the reported frequency of elderspeak was low in the current study.

Additionally, in the current study, participants may have been primed to think of elderspeak in terms of institutionalized settings. The vignette in the present study took place in an assisted living facility and the subsequent questions asked participants to put themselves in the shoes of the tenant from the vignette. This may have led participants to think of examples in a similar context (i.e., in an assisted living facility). Considering that all participants were community dwelling, they would have experienced few personal examples that fit this context. In fact, 37.5% of the examples provided in response to question 29, which asked for personal examples of elderspeak, took place in either a nursing home, assisted living, or home care setting. Therefore, the low frequency of elderspeak reported in the current study may be due to a priming effect.

However, the results of the present study are somewhat more consistent with the results of the Giles et al. (1993) study that was discussed in Brown and Draper (2003). Giles et al. (1993) reported that only 13% of noninstitutionalized older adults personally experienced elderspeak often. Similarly, in the present study, roughly 13% of community dwelling older adults reported personally experiencing elderspeak once a month or more. Therefore, it appears as if further research may be warranted to better understand how often community dwelling older adults experience elderspeak in their daily lives.

Comparative Analysis of Gender

Overall, in the current study, both men and women seemed to be offended and embarrassed by elderspeak and viewed the nursing assistant who used elderspeak as controlling, dominating, and lacking nurturance. This suggests that men and women perceive elderspeak similarly. These findings are relatively consistent with the existing literature. However, the existing literature only has looked at gender differences in the frequency of elderspeak and gender differences in the delivery of elderspeak. On the contrary, the present study looked at gender differences in the perception of elderspeak. O'Connor and Rigby (1996) found no differences in how frequently elderspeak was used with men and women. In a study on differences in the delivery of elderspeak, Cockrell (2020) found that male patients in a chiropractic clinic experienced more tag questions than female patients. However, there were no differences between men and women with the use of diminutives, collective pronoun use, or reflective questions. The current study in combination with the previous literature suggests that men and women experience elderspeak similarly in terms of frequency, delivery, and perception.

Comparative Analysis of Region

The present study is the first to explore differences in the perception of elderspeak across regions in the U.S. The participant's region did not seem to play an important role in the perception of elderspeak. Regardless of where participants lived, elderspeak and the speaker were perceived negatively.

The current study hypothesized that there may be differences in the perception of elderspeak across regions in the U.S. due to dialectical and cultural differences. In a study about the use of terms of endearment in nursing, Comerford (2015) wrote, "Cultural sensitivities and local idiom would also influence what was considered appropriate," (p. 13) referring to the appropriateness of terms of endearment. In the United States, there are a variety of cultural

stereotypes based on region. For instance, there is the idea of "Midwest nice" and "Southern hospitality." People in the Midwest are known for being polite and kind. People in the South are often considered gracious and friendly. While these are stereotypes, there is some substance behind these claims. In Shah's (2019) study on patterns of accent bias, the Southern accent was rated as the friendliest, followed by the Midwest. Similarly, the Southern and Midwest accents were rated highly on the attributes "honesty" and "pleasantness." Given this information, it may be reasonable to assume that terms of endearment, a common component of elderspeak (Cockrell, 2020), may be perceived differently by people from different regions due to dialectical patterns. Therefore, in the current study it was hypothesized that people in the South and Midwest may perceive elderspeak more warmly due to its similarity to the typical dialect used in these areas. However, this hypothesis was not substantiated by the present findings.

It is possible that this hypothesis was not corroborated by the findings of the current study for a number of reasons. First, it is possible that there is no difference in the perception of elderspeak across regions in the U.S. However, it is also possible that certain components of elderspeak (i.e., terms of endearment) may be desirable to some regions, while other components (i.e., reflective statements) may be seen as more patronizing and unwelcome. The use of the undesirable components of elderspeak may lead to the older adult rating elderspeak negatively. Future research is necessary to disentangle which components of elderspeak are rated as desirable versus undesirable across the regions within the U.S. Additionally, it is possible that the region where participants spent the majority of their life or childhood may play a larger role in perceptions of elderspeak than their current region.

Qualitative Evaluation

The present study overwhelmingly found that participants felt patronized by elderspeak in the vignette, which is consistent with the previous literature (Brown & Draper, 2003; Hermann & Williams, 2009; Kemper et al., 1998b; Kemper & Harden, 1999; LaTourette & Meeks, 2000; Ryan et al., 1991; Ryan et al., 1995). Only 8% of participants expressed a positive or neutral reaction to the use of elderspeak. These responses, in conjunction with the results of the descriptive analysis, suggest that community dwelling older adults experience negative emotional reactions to elderspeak.

These results also extend the findings from Grimme et al. (2015), which suggested that nursing assistants use elderspeak because they believe it comes across as friendlier and more respectful. The current study extends this by showing older adults, despite good intentions of the nursing assistant, do not perceive elderspeak as warm or nurturing. Instead, older adults find the users of elderspeak to be patronizing and upsetting.

In the present study, it was evident that participants believed nursing assistants use elderspeak because they view that the older adult as cognitively impaired. The existing literature has examined nursing assistants' reasons for using elderspeak, but not older adults' beliefs as to why it is used. However, the beliefs as to why elderspeak is used reported by participants in the current study align relatively well with the reasons nursing assistants have provided in previous research. For example, CNAs reported using elderspeak more if the resident had severe memory problems (Grimme et al., 2015; Lombardi et al., 2014). In the current study, participants also hypothesized that nursing assistants use elderspeak because they believe it is either helpful or necessary for effective communication, which is consistent with CNA rationale for using elderspeak (Grimme et al., 2015).

However, some of the participants' hypotheses as to why nursing assistants use elderspeak diverge from the rationale provided by CNAs (Grimme at al., 2015). For instance, many participants reported that they believe nursing assistants use elderspeak because they lack training. Furthermore, some of the findings from the current study suggest that participants believe nursing assistants use elderspeak out of ill intent, or at the very least not out of good intentions. For example, many participants believed that CNAs use this kind of speech because they feel superior to the residents that they care for. Relatedly, participants described nursing assistants who use elderspeak as task-oriented. Participants also felt that nursing assistants use this type of speech because they are disrespectful. Therefore, even though nursing assistants purport good intentions, those good intentions do not always translate to the older adult they are speaking to.

Predominantly, participants in the current study felt that elderspeak was never appropriate and should be never used. This aligns with nursing assistants' ratings of appropriateness (Grimme et al., 2015). In the present study, many participants also felt that elderspeak was more appropriate to use with individuals with cognitive impairments. This is also consistent with the existing literature (Grimme et al., 2015; Kemper et al. 1998a; 1998b; Lombardi et al., 2014). Overall, the community dwelling older adults in the present study felt that elderspeak was inappropriate in most situations.

In the present study, participants suggested that the nursing assistant from the vignette be more respectful and compassionate. They also suggested that the nursing assistant allow the tenant to be independent and to listen to their preferences. Corroborating the findings from the descriptive analysis of the ETRS, which found that participants viewed the nursing assistant from the vignette as control-centered, this qualitative evaluation suggests that participants believe the

nursing assistant should be more person-centered; Maintaining independence of residents is a primary goal of person-centered care. This is the first study to ask older adults what advice they have for care providers that use elderspeak. However, the advice that participants in the current study provided are highly consistent with previous recommendations for enhancing communication and overcoming elderspeak (Williams et al., 2005). It is also important to note that in the current study, some participants indicated that the nursing assistant should quit or be fired. This emphasizes how severe of an offense elderspeak can be. These results once again suggest that the good intentions behind elderspeak are not always apparent to the older adult.

When asked for personal examples of elderspeak, participants primarily provided secondary examples. In other words, they provided examples that they have witnessed rather than examples where they were the target of elderspeak. Furthermore, most examples occurred in a health care setting (i.e., nursing home, hospital, clinic, dentist office, etc.). This might suggest that elderspeak is most prevalent in this kind of setting. However, as postulated previously, it is possible that a priming effect occurred. Most of the questionnaire asked participants to put themselves in the shoes of an assisted living tenant. It is possible that this led participants to think about elderspeak only in terms of health care, which would also explain why many of the examples were secondary.

Limitations and Future Directions

Several limitations should be considered when evaluating the results of the present study. First, the scope of the statistical analyses in this study was very broad, which increases the chance for type I error. This was accounted for by using a Bonferroni corrected alpha. However, the Bonferroni correction has been criticized for being overly conservative (VanderWeele & Mathur, 2018). In future studies, it may be beneficial to examine these variables through a

narrower scope. For instance, it may be advantageous to focus on either gender or region within a single study rather than examining both, as in the current study. This could help decrease the chances of type I error and possibly reveal significant effects that were hidden by the conservative effects of the Bonferroni correction.

Second, the present study used a very homogenous sample, with participants being predominantly Caucasian. This reduces the generalizability of the current study. Future research should aim to achieve more ethnic and racial diversity.

Additionally, the current study did not utilize a non-elderspeak vignette. Including a non-elderspeak vignette would have helped reduce the chance of confounding variables. Without a non-elderspeak vignette as a control, it is difficult to say with certainty that the reactions and perceptions found in the current study were truly from the use of elderspeak. Furthermore, it is possible that the topic of the vignette (incontinence) could have contributed to negative reactions, particularly themes of embarrassment. It is pertinent for future studies to include a non-elderspeak vignette as a control.

Furthermore, although the vignette in the current study was developed from video vignettes created by nursing assistants, these vignettes have not been validated. These videos (and the written vignette based on these videos) need to be further validated by gathering a sample of CNAs to view the videos to confirm that they represent interactions that occur in assisted living facilities.

Another limitation of the current study is that participants may have been primed to think of health care settings. The first half of the questionnaire focused on elderspeak in an assisted living facility. This may have carried over into the second half of the questionnaire that was meant to focus on personal experiences with elderspeak. Future studies should consider

providing participants with non-health care examples of elderspeak to determine if perceptions differ depending on the context in which elderspeak is used.

An additional limitation of this study was the ambiguity of the gender of the nursing assistant from the vignette. No gender was provided when referring to the nursing assistant. It is possible that how the participant perceived the nursing assistant (male versus female) played a role in how they perceived the use of elderspeak. A future study should examine how men and women perceive elderspeak when it is coming from a male versus a female speaker. Relatedly, future studies should examine how the race of the speaker and the race of the recipient of elderspeak impact the perceptions of elderspeak.

Furthermore, the functional level of the older adult may play a crucial role in the perceptions of elderspeak (O'Connor & Rigby, 1996; Ryan et al., 1986). The current study failed to examine the participants' functional abilities. In future studies, measures of dependence and frailty should be examined as moderators of perceptions of elderspeak.

Another future direction would be to examine older adults' abilities to recognize the use of elderspeak. Specifically, the older adult's ability to recognize elderspeak as a target versus a witness should be studied. Doing so would help inform researchers on methods of assessing elderspeak.

Future research is also necessary to disentangle which components of elderspeak are preferred or tolerated and which are not in the various region in the U.S. For instance, the use of tag questions, diminutives, collective pronoun use, collective statements, high pitch, exaggerated prosody, etc. should be evaluated. This would provide a better sense of how older adults in these regions perceive elderspeak as well as it would inform professionals working with older adults on which accommodations are appropriate and which are not.

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Figure 1

Interactive Model for the Communicative Predicament of Aging (Ryan et al., 1986)

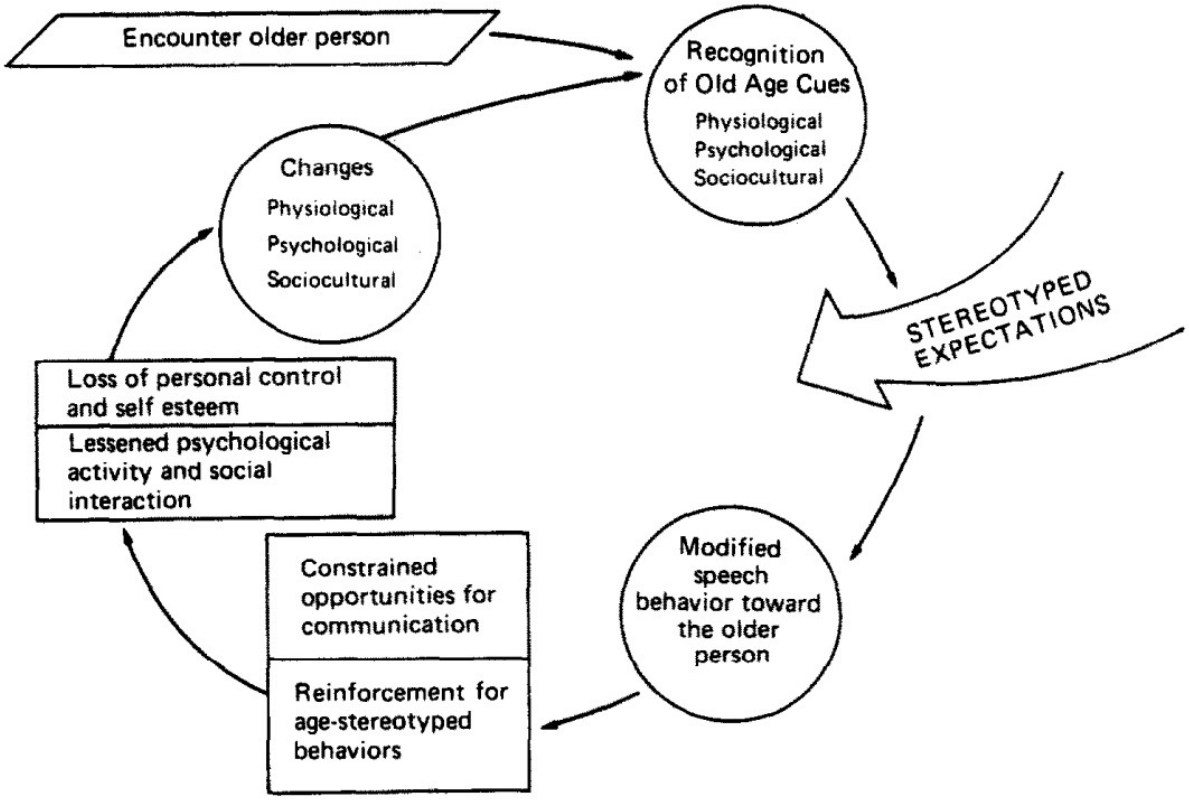

Table 1

Frequency of Participant Ethnicity

Ethnicity	Frequency	Percent
White	100	90.91%
Black or African American	4	3.64%
Hispanic or Latino	2	1.82%
Asian	1	0.91%
American Indian or Alaska Native	1	0.91%
Native Hawaiian or Pacific Islander	1	0.91%
Not Identified	1	0.91%

Table 2

Descriptive Statistics of PANAS Items and Subscales (Vignette)

Scale Items	*M*	*SD*
Offended	4.15	1.12
Embarrassed	4.02	1.17
Discouraged	3.88	1.07
Frustrated	3.82	1.21
Distressed	3.61	1.17
Inadequate	3.57	1.19
Competent	2.71	1.07
Calm	2.57	.96
Grateful	2.55	.93
Trusting	2.51	.90
Respected	2.34	.82
Comforted	1.91	1.32
Positive Affect Subscale	14.58	4.77
Negative Affect Subscale	23.05	5.39

Table 3

Descriptive Statistics of ETRS Items and Subscales

	Current Sample		*Normative Sample*	
Scale Items	*M*	*SD*	*M*	*SD*
Controlling	4.08	1.24	1.8	.5
Dominating	3.84	1.35	1.8	.5
Patronizing	3.81	1.48	2.0	.4
Bossy	3.61	1.38	1.7	.5
Directive	3.18	1.29	2.5	.4
Affirming	2.54	1.32	2.9	.3
Polite	2.52	1.33	3.6	.5
Caring	2.46	1.21	3.6	.5
Supportive	2.32	1.29	3.4	.5
Warm	2.28	1.23	3.5	.5
Nurturing	2.14	1.20	3.4	.6
Respectful	1.99	1.26	3.5	.5
Person-Centered Subscale	2.32	1.33	-	-
Control-Centered Subscale	3.70	.96	-	-

Table 4

Descriptive Statistics of PANAS Items and Subscales (Personal)

Scale Items	*M*	*SD*
Distressed	3.97	1.15
Offended	3.83	1.31
Frustrated	3.76	1.24
Embarrassed	3.76	1.30
Discouraged	3.52	1.24
Inadequate	3.25	1.24
Competent	3.14	1.27
Calm	2.62	1.08
Grateful	2.59	.98
Comforted	2.55	1.06
Trusting	2.55	.95
Respected	2.31	.71
Positive Affect Subscale	16.5	3.68
Negative Affect Subscale	22.07	5.81

Table 5

Reported Frequency of Elderspeak in Participants' Personal Lives

	Frequency	Percent	Cumulative Percent
Multiple Times a Day	5	4.5	4.5
Once a Day	1	.9	5.5
Multiple Times a Week	2	1.8	7.3
Once a Week	0	0	7.3
A Few Times a Month	3	2.7	10.0
Once a Month	3	2.7	12.7
Less than Once a Month	21	19.1	31.8
Never	75	68.2	100.0

Table 6

Frequency and Example Response for Each Theme on Question 19

Theme	Example Response	Frequency
Patronized	"I would certainly feel like a little child because of the way she's talking to me."	50
Mad	"Angry and ready to slap the person. I'm a grown woman and you don't need to treat me like this"	35
Incompetent	"I would feel that I was losing my independence. The aid was talking down to me. She was not looking at me as an independent person"	20
Embarrassed	"Embarrassed! Like a child. God-awful! I think I'd rather be dead than have to endure this."	16
Disrespected	"I would have felt inferior and disrespected by this kind of talk."	14
Bad	"Not good at all"	6
Cared For	"Feeling well cared of the nursing aides, she is concerned of my well-being"	5
Uncertain	"Don't know how I would react"	3
Intimidated	"Intimidated but if you need help you just have to get used to it"	1
Indifferent	"I think I would be fine with this person. To me there weren't any derogatory comments toward the tenant."	1

Table 7

Frequency and Example Response for Each Theme on Question 23

Theme	Example Response	Frequency
Impaired/Child-Like	"I guess they feel everybody that lives there has the mind of a child and so they treat them as a child"	47
Helpful/Necessary	"They think they are being helpful and kind, but are really not."	24
Lack of Training	"Evidently they have not had the proper training."	15
Power Dynamic	"They think they are superior to others "	15
Task-Oriented	"I guess that deal with all types of mental status patients and it is just easier to treat them all the same instead of getting to know each individual and their needs as most patients are in for some length of time. Individualizing their care would be a good priority"	14
Disrespectful	"Because they don't care and they have no respect for the elderly"	11
Uncertain	"I don't know why anyone would ever talk to anybody like this"	3
Difficult	"Because the ones they are helping can be hard to get along with"	2
Normal	"It is rather a normal way of treating the elderly it seems."	1

Table 8

Frequency and Example Response for Each Theme on Question 24

Theme	Example Response	Frequency
Never Appropriate	"None, this is not how a caregiver should interact"	37
Appropriate when Older Adult is Incompetent/Cognitively Impaired	"I think it's appropriate when the tenant's capacity is limited, like unable to speak or communicate effectively."	31
Appropriate with Children	"This speech pattern is appropriate only for a small child."	16
Uncertain	"I am not sure"	6
Appropriate when Aide is Trying to be Helpful/Effective	"Effective, there is an understanding to both parties on what to do first and another attending job to be done to the tenants or patient"	6
Appropriate when Older Adult is Child-like	"Only if the patient is actually childlike and doesn't respond to normal conversation."	5
Always Appropriate	"All the time"	5
Appropriate when Older Adult is Physically Impaired/Sensory Impairment	"Only if someone was senile or physically unable to function"	4
Appropriate when Older Adult is Difficult/Resistant	"When the client is combative"	3
Appropriate with Someone with Emotional Needs/Mental Health Concerns	"When speaking to someone with emotional needs."	2
Close Relationships	"Maybe when you are dealing with a close family member u have had a relationship with for years"	1

Table 9

Frequency and Example Response for Each Theme on Question 25

Theme	Example Response	Frequency
Always Inappropriate	"Always it demeans the speaker and the patient"	43
Competent/Capable	"When the adult knows what is going on and can still function"	40
Preferences	"Well, if the nurse didn't respect what the tenant said and grabbed the toothbrush, etc. and not let her do it."	6
Childlike	"When the staff begin to treat the patient like they are in kindergarten"	4
Policy Violation	"In my opinion the caregiver was acting in a normal way, but if the policy is to let the tenant decide when they want to brush their teeth who change their diaper then it could seem inappropriate."	3
Uncertain	"Don't know"	2
Emergency	"In an emergency."	1
Public Situations	"If it was in a common area"	1
Cooperative	"When patient is cooperating"	1

Table 10

Frequency and Example Response for Each Theme on Question 26

Theme	Example Response	Frequency
Respect	"Treat the patient as an adult"	55
Compassion	"I would tell them to please talk to me like you would like to be talked to."	28
Independence	"I would tell the assistant to ask more questions of the tenant instead of reminding he or she of their past mistakes. They should try not to take away what little independence they still feel they have."	16
Listen/Pay Attention	"To listen and pay attention to what is being said by the resident and how they are responding to the way you are treating them."	11
Patience	"Don't rush, no baby talk, let the tenant perform the care for herself and help when needed"	10
No Advice	"I think overall they did a good job"	6
Training	"Take another course in the basics of communication."	5
Quit	"You need to get out of this kind of job because you are not qualified for it."	4
Uncertain	"Don't know"	1

Appendix A

Questionnaire

Do you consent to participate in this study?

- ○ Yes
- ○ No

Age

_____

Gender

- ○ Male
- ○ Female
- ○ Non-binary / third gender
- ○ Prefer not to say

What is your ethnicity?

- ○ American Indian or Alaska Native
- ○ Asian
- ○ Black or African American
- ○ Hispanic or Latino
- ○ Native Hawaiian or Pacific Islander
- ○ White
- ○ Other: Please Specify _____

Do you have any concerns related to your memory?

- ○ Yes
- ○ No

Have you received any diagnoses related to your cognition or memory?

- ○ Yes
- ○ No

What state did you spend the majority of your childhood in? (Select state from drop down tab)

▼ Alabama ... Other

What state have you spent the majority of your life in? (Select state from drop down tab)

▼ Alabama ... Other

What state do you currently reside in? (Select state from drop down tab)

▼ Alabama ... Other

Level of Education (Select One):

- ○ High School
- ○ Some College
- ○ Associate's Degree
- ○ Bachelor's Degree
- ○ Master's Degree or Beyond
- ○ Other (Please Specify) _____

Current Living Situation (Select One):

- ○ Own Home
- ○ Apartment/Independent Living Facility
- ○ Child/Other Family Member's Home
- ○ Other (please specify): _____

Have you ever resided in an assisted living facility or nursing home setting (including short-term stays)?

- ○ Yes
- ○ No

Do you utilize any in home care services (i.e., an aide to help with activities of daily living such as bathing, dressing and meal prep or a home health nurse who administers medications)?

- ○ Yes
- ○ No

Survey Instructions:

The purpose of this interview is to get your opinions about a certain type of speech/language that is present in a variety of care giving and social settings.

The speech/language of interest is noted as incorporating shorter sentences with a simplified vocabulary (*e.g., using the word potty instead of bathroom*), personal terms of endearment (*e.g., calling someone sweetie or good girl*), and collective pronoun usage (*e.g., asking if we are ready for our bath instead of asking if you are ready for your bath*).

This speech/language is also noted for several key characteristics:

- exaggerated intonation (*e.g., talking with an excited tone as if talking to a child*)
- elevated pitch/volume (*e.g., talking more loudly than is usual for a typical conversation*)
- repetition of words/phrases (*e.g., repeatedly asking if someone is hungry*)
- a slowed rate of delivery (*e.g., talking more slowly than usual*)

On the following screen you will be presented with a scenario using this type of speech. The scenario involves an interaction between a nursing assistant and a tenant in an assisted living. You will be asked to put yourself in the shoes of the tenant while reading the scenario. Additional instruction will be provided before the scenario.

Following the scenario, you will be asked several questions regarding your reactions to this scenario.

<u>Below is an example of an interaction using this type of speech/language</u>. As you read through this scenario, please imagine that you are the "tenant." Put yourself in their shoes in this story. Later, we will be asking you questions about how you would feel if you were the tenant in this story.

In this scenario, the nursing aid is talking to a tenant (you), who lives in the assisted living facility, in a loud, high voice. The aid just woke the tenant from a nap and is assisting the tenant to the bathroom before lunch*

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.

Tenant: I did not wet…

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.

Tenant: 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.

Tenant: …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.

Tenant: Yes I want to.

Aid: Okay I will let you do it then, sweetie pie.

Tenant: Okay, I am done.

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

Tenant: 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.

Tenant: My pad is not wet.

Aid: Well alright then if you say so. Washy facey before we head down to eat.

We now want to ask you several questions about this type of speech.

Answer the following questions based on how you would feel if you were the tenant in the story you just read:

How would you have felt if this were you in this scenario?

_____

_____

_____

_____

_____

On a scale from 1-5, with 1 being 'extremely uncomfortable' and 5 being 'extremely comfortable', please rate how comfortable or uncomfortable did this scenario make you feel.

	1 (Extremely Uncomfortable)	2	3	4	5 (Extremely Comfortable)
How comfortable or uncomfortable did this scenario make you feel?	○	○	○	○	○

Below are a number of statements that describe different feelings and emotions. Rate each statement from "strongly disagree" to "strongly agree."

While reading this scenario. . .

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
I felt comforted	○	○	○	○	○
I felt inadequate	○	○	○	○	○
I felt calm	○	○	○	○	○
I felt discouraged	○	○	○	○	○
I felt grateful	○	○	○	○	○
I felt distressed	○	○	○	○	○
I felt respected	○	○	○	○	○
I felt frustrated	○	○	○	○	○
I felt trusting	○	○	○	○	○
I felt competent	○	○	○	○	○
I felt embarrassed	○	○	○	○	○
I felt offended	○	○	○	○	○

Rate the nursing assistant for the following.

The nursing assistant was . . .

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

Why do you think care providers in assisted living facilities use this kind of speech?

_____

_____

_____

_____

What are situations or circumstances you think this type of speech might be appropriate or useful?

_____

_____

_____

_____

What are situations or circumstances you think this type of speech might be inappropriate or less useful?

_____

_____

_____

_____

If you could give feedback or advice to the nursing assistant based on the way they interacted with the tenant in the scenario, what would you tell them?

_____

_____

_____

_____

Answer the following questions based on your own personal experience in your real life:

Do you have any personal experience with this type of speech?

- ○ Yes
- ○ No

Please provide up to three (3) examples of personal experience with this type of speech. (Please put each example in a separate text box)

- ○ Example 1 _____
- ○ Example 2 _____
- ○ Example 3 _____

Below are a number of statements that describe different feelings and emotions. Rate each statement from "strongly disagree" to "strongly agree." When this type of speech was used (in reference to the example(s) you provided) . . .

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
I felt comforted	○	○	○	○	○
I felt inadequate	○	○	○	○	○
I felt calm	○	○	○	○	○
I felt discouraged	○	○	○	○	○
I felt grateful	○	○	○	○	○
I felt distressed	○	○	○	○	○
I felt respected	○	○	○	○	○
I felt frustrated	○	○	○	○	○
I felt trusting	○	○	○	○	○
I felt competent	○	○	○	○	○
I felt embarrassed	○	○	○	○	○
I felt offended	○	○	○	○	○

How often would you say you experience this type of speech? (Select One)

- ○ Multiple times a day
- ○ Once a day
- ○ Multiple times a week
- ○ Once a week
- ○ A few times a month
- ○ Once a month
- ○ Less than once a month
- ○ Never

Appendix B

Informed Consent

Informed Consent for Participation in the Research

Title: The title of this research study is, "An Investigation of the Perception of Elderspeak among Community Dwelling Older Adults"

Investigators
This study is conducted by Abby Teply under the guidance of Dr. Jeffrey Buchanan of Minnesota State University, Mankato's Psychology Department.

Purpose
The purpose of this research study is to see how older adults perceive the usage of a specific form of speech (called elderspeak) that is often used by healthcare providers when speaking with older adults.

Participants
You have been asked to participate because you are 65 years of age or older.

Procedure
A story will be provided via an online survey that depicts a nursing assistant interacting with a tenant living in an assisted living facility. You will first be asked some demographic questions. You will then read the story and answer some questions about your response to the story as well as some questions about your own personal experiences. It is estimated that your participation will take about 30 minutes. The study will end when all the questions are answered, and you may close your browser.

Risks
The risks associated with this study are no more than experienced in normal daily life. It is possible that some of the questions asked could cause emotional discomfort. Should this occur, you may choose not to answer any of the survey questions and you have the option to end your participation at any time by exiting out of the survey. The experimenters encourage you to use a secure internet connection, and to participate in the study where you would have privacy where only you can view your computer screen. You may choose not to answer any of the survey questions or end your participation at any time by exiting the survey.

Benefits
Results of the study will provide information about how community dwelling older adults perceive the use of elderspeak which could have utility for caregivers and the general public.

Compensation
Your panel provider will compensate you for your participation.

Confidentiality

The findings of this study will be completely confidential. Confidentiality will be protected in that your name will not be included on any records. All information collected during this study will be used for research purposes only and will only be accessible to the principal investigator, Dr. Jeffrey Buchanan, the student investigator, Abby Teply. If you would like more information about the specific privacy and anonymity risks posed by online surveys, please contact the Minnesota State University, Mankato IT Solutions Center (507-389-6654) and ask to speak to the Information Security Manager.

Right to Refuse or Withdraw
Participation in this study is voluntary. You may choose not to answer any of the survey questions or you may end your participation at any time by closing the web browser. 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 you have any questions, you are free to ask them. If you have any additional questions, you may contact the office of the principal investigator, Jeffrey Buchanan, Ph.D. at (507) 389-5824. If you have questions about participants' rights and for research-related injuries, please contact the Administrator of the Institutional Review Board at (507) 389-1242.

Closing Statement
Submitting the completed survey will indicate your informed consent to participate and indicate your assurance that you are at least 18 years of age.

Please print a copy of this consent form for your records.

Minnesota State University, Mankato IRBNet LOG # 1733386