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A Qualitative Analysis of Community-Dwelling Older Adults' Perspectives of Elderspeak

By

Katelynn R. Shimanski

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

Master of Arts

In

Clinical Psychology

Minnesota State University, Mankato

Mankato, Minnesota

May, 2024

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Abstract

Compared to other forms of discrimination, ageism, and specific forms of ageism such as elderspeak are understudied. Despite the fact that the majority of older adults are community-dwelling, much of the existing literature on elderspeak focuses on caregiver perceptions on elderspeak occurring in assisted living facilities and nursing homes. The present study analyzed community dwelling older adult's perceptions of elderspeak using their personal examples of experiences of elderspeak. Results indicated that the majority of participants had negative perceptions of elderspeak that would likely not be influenced by changes in contextual factors such as setting, relationship to the speaker, and gender of the speaker.

Introduction

Ageism

Ageism, a form of discrimination towards older adults, refers to the negative age-based stereotypes, prejudice, and discrimination related to old age, the aging process, and older adults. Ageism is prevalent in the United States, with experiences of ageism reported by more than 80% of older adults (Allen et al., 2020). Despite this, ageism and its implications are understudied in comparison to other forms of discrimination (Allen, 2016). As indicated by the World Health Organization (2022), the older adult population has, and will continue to increase world-wide. By 2030, 1 in 6 people will be aged 60 or older. Despite this, society's perceptions of older adults and aging remain mostly unchanged.

Beginning in childhood, many individuals develop negative stereotypes about older adults that are then reinforced through adulthood. By the time they reach older adulthood, individuals have spent decades internalizing negative ageist attitudes (Chasteen et al., 2002; Gilbert & Ricketts, 2008; Robinson & Howatson-Jones, 2014). Due to this, many older adults engage in self-stereotyping or hold negative implicit attitudes about aging, and will avoid identifying as old (Barber, 2017; Hurd, 1999; Ojala et al., 2016; Townsend et al., 2006). As noted by Angus and Reeve (2006), the omnipresence of ageist stereotypes has led to societal complacency towards ageism in many areas of life. Previous literature has identified age-based discrimination in the workplace, healthcare, and academia, with many older adults encountering routine, age-based discrimination, prejudice, and stereotyping in their everyday lives (Abecassis et al., 2012; Allen et al., 2020; Bender, 2012; Kydd & Fleming, 2015; Nelson, 2017).

Everyday Ageism

Routine, or everyday ageism, occurs often and affects many older adults. As described by Allen et al. (2022), everyday ageism consists of "brief verbal, nonverbal, and environmental indignities that convey hostility, a lack of value, or narrow stereotypes of older adults”. These incidents, also known as microaggressions, can include attributing forgetfulness to age or describing forgetting something as "having a senior moment", or telling an individual that they "look good for their age". Other examples of everyday ageism include anti-aging commercials, products, and services, or joke birthday cards and gifts that poke fun at aging. This type of ageism is often subtle and likely to be overlooked. Often times, perpetrators do not realize they are even being discriminatory. Despite this, everyday ageism takes away the individuality of older adults, forcing them to identify as part of a group that is separate from the rest of society, and thus, not entitled to the same respect, rights, and privileges as others. In comparison to other forms of ageism, everyday ageism is more common. Previous research by Allen et al. (2022) found that of older adults ages 50 to 80 years, 93.4% reported regularly experiencing ageism, which was found to be associated with an increased risk of negative mental and physical health outcomes.

Elderspeak

One of the ways everyday ageism can manifest is through the use of elderspeak. Elderspeak is a simplified speech register used with older adults, typically by a younger adult. This form of communication is derived from babytalk and shares characteristics with other speech registers, including those used with pets, non-native speakers, and inanimate objects. Like these registers, elderspeak is characterized by linguistic adjustments in areas including rhythm, sound, sentence structure, and meaning (Shaw & Gordon, 2021). Examples include simplifying

vocabulary and sentence structure, repetition, raised pitch and volume, slowed rate of speech, and the use of tag questions, collectives, and diminutives.

Negative Consequences of Elderspeak

While elderspeak occurs in a variety of settings, the existing research primarily focuses on its use in healthcare by a variety of providers including nurses, CNAs, physicians, occupational therapists, chiropractors, and social workers (Herman & Williams, 2009; Williams et al., 2009). In studies of assisted living facilities, elderspeak is most often used when assisting with activities of daily living such as eating, toileting, or bathing. The use of elderspeak results in communication breakdown, and increased problem behaviors in older adults (Herman & Williams, 2009). Observational studies of nursing care for individuals with dementia found that elderspeak staff communication triggered behaviors such as measurable aggression, withdrawal, vocal outbursts, and wandering. These behaviors resulted in disrupted care and contributed to staff stress, burnout, turnover, and increased costs (Herman & Williams, 2009; Williams et al., 2009).

Research indicates that elderspeak can negatively impact the perceptions of both the speaker and the listener (Ryan et al., 1991; Balsis & Carpenter, 2006). Individuals who engage in elderspeak may be perceived as having lower intelligence, confidence, competence, friendliness, helpfulness, and trustworthiness (Ryan et al., 1991). Furthermore, they are also seen as disrespectful, patronizing, frustrated, unprofessional, angry, and unlikable (Balsis & Carpenter, 2006). Older adults, when the targets of elderspeak, are perceived by others as frustrated, incompetent, and having poor memory and communication skills (Balsis & Carpenter, 2006; Ryan et al., 1991).

In addition to the implications for care, elderspeak often elicits negative reactions from older adults. Research indicates that many in this demographic view elderspeak as belittling, patronizing, disrespectful, and condescending (La Tourette & Meeks, 2000; O'Connor & St. Pierre, 2004). Such negative attitudes towards elderspeak can lead to significant adverse effects on their well-being, such as reinforcing dependency and causing isolation and depression, which in turn may hasten cognitive and physical deterioration, consequently diminishing an older adult's quality of life (Draper, 2005; La Tourette & Meeks, 2000; Ryan et al., 1986; Ryan, et al., 1995). The use of elderspeak may also result in older adults feeling misunderstood or not respected. Consequently, they may avoid speaking to younger adults or may seek social interaction elsewhere, such as through watching television (Ryan et al., 1986; Ryan et al., 1995).

Intended Functions of Elderspeak

The prevalence of elderspeak in health care may be due to the varying views on what constitutes elderspeak, and whether components of elderspeak are beneficial or harmful to older adults. Grimme et al. (2015) found that the use of elderspeak in a long-term care setting was intended to increase comfort, verbal comprehension, and cooperation. There is some evidence to suggest that the use of simpler language and fewer complex clauses may be beneficial to communication task performance, characteristics like shortening sentence length, slowed rate of speech, and increased pitch resulted in more communication problems (Kemper & Harden, 1999). However, it is easy to overaccommodate when making adjustments in speech patterns, which can have the unintended negative consequences of disrespecting or infantilizing the older adult being spoken to (Kemper & Harden, 1999; Ryan et al., 1986).

Research has supported the critical need to prevent the use of elderspeak in dementia-care settings where it has been shown to increase the probability of resistiveness to care

(Williams et al., 2009). Others have also suggested contributing factors that the prevalence of elderspeak in healthcare settings may be due to a lack of training in communication skills and poor guidance by real-life and/or pseudo-mentors in popular media such as Grey's Anatomy (Rousseau, 2019).

Communication Predicament of Aging Model

Given the expansive research demonstrating that elderspeak has many downsides and is potentially harmful, the question becomes, "Why do people continue to use elderspeak?" Ryan et al. (1986) introduced the Communication Predicament of Aging Model as one explanation of why elderspeak is used. This model is derived from the Communication Accommodation Theory in which communicators modify their speech and nonverbal behavior for different communication partners with the goal of achieving successful interactions. As described by Ryan et al. (1986), the ability of older adults to communicate effectively relies on their cognitive and linguistic skills, as well as social opportunities and attitudinal expectations. Due to the often lower expectations of their abilities, older individuals frequently face what is known as the communication predicament of aging. This term describes the gap between the actual communicative skills of an older adult and the negative perceptions of their competence.

The problem with this tendency to modify communication behavior is that it may result in communicators adapting their speech with older adults based on stereotyped expectations of incompetence and dependence. According to this model, speakers may make these excessive speech accommodations based on incorrect assumptions about the listener such as mental or physical incompetence (Ryan et al., 1995). These assumptions may be based on the presence of certain old age cues, which may be features of the listener, such as using a cane, or features of the environment such as being in a nursing home. Elderspeak may then be expressed when a

speaker identifies these old age cues and interprets them as a need to accommodate communication to facilitate the comfort and comprehension of older adults (Grimme et al., 2015; Ryan et al., 1995; Shaw & Gordon, 2021).

Elderspeak in Community-Dwelling Older Adults

Much of the existing literature on elderspeak is focused on older adults in nursing homes, assisted living facilities, and hospitals. Given that residents or patients in these settings may have physical or cognitive impairments that require more dependence on a caregiver, the use of elderspeak in these settings can be viewed as more acceptable (Herman & Williams, 2009; Williams et al., 2009). However, there is very limited literature on perceptions of elderspeak in community-dwelling older adults.

Previous research has examined perceptions of baby-talk and neutral-talk scenarios in community-living seniors and nursing home residents (O'Connor & Rigby, 1996; O'Connor & St. Pierre, 2004). These studies were completed via questionnaire and involved participants looking at scenarios developed during the 1996 study (O'Connor & Rigby, 1996) where they pretended an individual used either neutral-talk or baby-talk with them. Participants rated the degree to which they agreed with statements pertaining to the communication style. Overall, significant interactions were found between perceptions and frequency of babytalk in the prediction of self-esteem. However, older adults with positive perceptions on babytalk reported higher self-esteem with frequent baby talk. Another study by La Tourette & Meeks (2000) included an all-female sample of nursing home residents and community-dwelling older adults. Participants in this study were polled on their perceptions after viewing two videotaped vignettes that depicted a nurse using either patronizing or nonpatronizing language. In both samples, participants reported preferring the non-elderspeak language.

Limitations in Elderspeak Research

Much of the existing elderspeak research is dated. While some studies have been done seeking to understand perceptions of elderspeak among older adults, participant samples come from a different generation of older adults. The lack of new research limits understanding of how the frequency of, and perceptions of, elderspeak have evolved between generations, especially with the growing understanding of ageism and age-related microaggressions such as elderspeak. In addition, most of the existing research focuses on the use of elderspeak by caregivers, particularly those working with older adults experiencing Alzheimer's disease or other forms of dementia, in assisted living facilities, nursing homes, and hospitals. While this research is beneficial, the majority of older adults do not live in these settings. Additionally, elderspeak literature often focuses on caregiver perceptions of elderspeak and whether they view it as helpful or acceptable. To better understand elderspeak, more research is needed that studies how community-dwelling older adults perceive instances of elderspeak. As with ageism research in general, the common occurrence of female-heavy samples extends to elderspeak-focused studies, resulting in a lack of familiarity on male perceptions of elderspeak. While research suggests that there are no differences in the frequency of elderspeak use with men and women (O'Connor & Rigby, 1996), many studies lack male participants.

Purpose of Study

Despite research suggesting that ageism has been and continues to be a common experience among various generations of older adults, ageism and its consequences are relatively understudied compared to other forms of discrimination (Allen, 2016). Of the existing literature, there is evidence to support the relationship between experiences of ageism and negative health, particularly between health and self-perceptions of aging (Hu et al., 2021). However, a lack of

established, high-quality ageism measures and the limited ability to capture the many dimensions of ageism that older adults can experience prevents a full understanding of the implications of ageism (Allen et al. 2022; Hu et al., 2021).

As mentioned previously, much of the existing literature on ageism, including its frequency, is based upon female-dominated samples. Research focused on the experiences of males related to ageism is less documented, with results being more obscure. Clarke & Korotchenko (2015), have argued that, unlike women, men are offered a natural immunity to ageism because of their privileged social position. Despite the majority of participants acknowledging the presence of ageism, many participants felt they had not directly experienced ageism, instead identifying women and nursing home/assisted living facility dwelling older adults as more vulnerable to this type of discrimination (Clarke & Korotchenko, 2015). Conversely, other research has suggested that men are not immune to ageism, but instead that their perceptions about ageism are heavily depended on the specific contexts in which the interactions occur. While occurrences of ageism in informal or personal settings, such as with family, were often perceived as acceptable, ageism in more formal settings was easily recognized as discrimination.

The purpose of this thesis is to expand upon the current literature pertaining to the perceptions of elderspeak among older adults. Specifically, this study sought to investigate how context may change perspectives on elderspeak in community-dwelling individuals over the age of 65. By exploring community-dwelling older adults' perspectives on the use of elderspeak, the findings of this research can help to educate both the public and assisted living personnel on the implications of elderspeak and hopefully create a more dignified and respectful environment within the community for older adults.

Methods

Participants

Participants included a sample of 18 adults aged 65 or older. The demographic breakdown indicated an average age of 72.83 (*SD* = 4.9) with an age range of 66 to 81. Participants were 100% white, and all originally from the Midwestern United States. The gender composition of the sample was 61.11% female, and 38.88% male. Most participants had either a 4-year degree (44.44%) or beyond a 4-year degree (38.88); however, the highest level of education was "some college" for three individuals (16.66%). Regarding marital status, 55.55% of participants were married, 27.77% were widows, and 16.66% were single.

Procedure/Materials

Participants were recruited via a member newsletter (see Appendix A) and email list (see Appendix B) at a local community center for older adults. They were then notified that participation would involve an interview where they would be asked a variety of questions about their "perceptions and experience with this type of language".

Upon arriving for the interview either in person or via Zoom, participants were presented with an informed consent sheet (see Appendix C) and asked for verbal consent as to whether the interview could be recorded. Once informed consent was obtained, participants were instructed to complete a questionnaire (see Appendix D) that included a series of demographic questions regarding the participant’s age, gender, ethnicity, marital status, highest level of education, what region of the country they were from, and whether they had a diagnosis of a disease that causes memory loss. Some demographic questions were used to screen out participants that did not meet inclusion criteria. For instance, individuals less than 65 years of age or participants who

indicated that they were diagnosed with a condition that caused memory impairment were ineligible to complete the study. However, no participants were excluded based on these criteria.

After completing the demographic questions, participants were read interview instructions. The instructions reiterated that, "the purpose of this interview is to get your opinions about a certain type of speech/language that is present in a variety of caregiving and social settings". Next, common characteristics of elderspeak such as "the use of simplified vocabulary/sentence structure" and "collective pronoun usage" were shared with the participant. When further explanation was needed on these characteristics, participants were provided examples including "using the word potty instead of bathroom" and "using 'we', 'us', and 'our' instead of 'you'". To avoid participant bias, the word “elderspeak” was never used during the course of the interview. Instead, after providing the characteristics and examples of the speech/language, elderspeak was referred to only as “this type of speech or language.” For the purposes of this study, the interview was split into two parts.

The first part of the interview focused on the topography of elderspeak, with participants answering open-ended questions aimed at gauging what elderspeak looks like, how often it occurs, and any potential impact. This portion of the interview (see Appendix E) involved first asking participants, "have you ever been in a conversation where someone used this type of speech/language?" If they responded "yes", the interview proceeded with no changes. If a participant responded "no", they were then asked, "have you ever witnessed a conversation where someone used this type of speech/language". All participants who were asked this second question answered "yes" resulting in the interview continuing; however, only with the interviewer asking questions 4, 5, 8, 9, 12, and 13. After answering question one, the next five questions involved clarifying the participant’s relationship with the speaker, when and where it

had occurred, what was said, and what tone was used by the speaker. When needed, specific examples were provided such as "speaking in a sing-song tone of voice" for question six. Participants were then asked, "how did you feel when this event occurred" and "what was the impact of this experience on you".

The second part of the interview was related to context, with questions aimed at gauging how contextual factors may change perspectives of elderspeak. Using their provided example, participants were asked a variety of questions (see Appendix E) on whether the appropriateness of this type of language would change based on setting, gender of the speaker, and their familiarity with the individual. Finally, participants were asked "would your opinion on using this type of speech be different if it was used with individuals with cognitive impairment/visible physical disability?". After the completion of the interview, interviewees were compensated with a $15 gift card.

Data Analysis and Coding

For each of the 11 questions a coding system was developed, and an independent coder was trained on the coding system. Inter-rater reliability training involved providing a definition for each question's themes along with response examples and nonexamples for each theme. For example, five themes, including "angry/annoyed" arose within the responses to "how did you feel when this even occurred?". An example response fitting this theme would be "I was so shocked and angry when he said that", whereas a nonexample was "It really doesn't bother me". For each question, both coders sorted responses into the themes. Exact interobserver agreement was calculated and revealed 100% agreement.

Results

Qualitative Analysis

The interview included 13 questions, 11 of which were open-ended. The first four open-ended questions (2, 4, 5, and 6) allowed participants to describe examples of elderspeak that they have experienced in their personal life. The remaining seven questions were aimed at exploring the individuals' feelings about the use of elderspeak in their provided example, any potential long-term impacts, and their perception on the incident should factors such as setting or gender of the speaker had changed.

Of the 18 participants, 21 instances of elderspeak were evaluated, with three participants speaking about two instances each. Many participants provided examples where elderspeak was used by a healthcare provider (33.33%). Example responses included, "He kept calling me hon as he was examining me". This use of elderspeak by caregivers was distressing for participants. Consequently, a common theme arose of participants expressing that the use of elderspeak by a caregiver was more inappropriate. Other themes included participants expressing that they would be more uncomfortable with a male using elderspeak. Example responses that fit this theme included, “It would be much worse if it was a man”.

Most participants' experiences occurred "about one month ago" (33.33%), with 28.57% occurring "less than six months ago", 14.29% occurring "less than 1 year ago" and 23.81% occurring "more than one year ago". Of these instances, the majority of individuals who used elderspeak were either a family member (33.33%) or a medical professional (33.33%), which included doctors, nurses, or other medical staff. Use of elderspeak by a family member was almost as common (28.57%) and one individual reported use by a friend (4.76%). Consistent with the existing research, elderspeak occurred in a variety of different settings including

healthcare settings (33.33%), their homes (28.57%), restaurants and retail shops (28.57%), and other settings including a library and a golf course (9.52%).

Elderspeak is characterized by several different changes in speech. According to these results, the use of overly endearing nicknames was the most common (47.62%). Many participants noted that this was very common, with one noting an instance where, at a doctor's appointment, a nurse stated, "Oh honey, you look great". The use of an elevated pitch or volume was also common among speakers (38.1%). Many participants' examples also included the use of collectives (33.33%) such as a participant's experience of being asked "How are we doing today?" and the repetition of words/phrases by the speaker (19.05%). One participant noted that they had experienced the use of simplified vocabulary or sentence structure. None of the participants noted experiencing slowed rate or a speaker answering questions for them. Most participants did not notice any change in tone when the individual was speaking to them, but 19.05% stated that the speaker's tone was higher pitched, like how they would speak to a child or a baby.

Question 7

Question 7 of the interview asked, "How did you feel when this event occurred?" In a thematic analysis of the responses five themes arose, including “angry/annoyed”, “embarrassed”, “disrespected/infantilized”, “indifferent”, and “reassured” (see Table 1). The most common theme among responses to this question was "angry/annoyed" with 35% of participants providing responses related to this theme (n=7). This was followed by 25% feeling "indifferent" (n = 5), 20% "disrespected/infantilized" (n = 4), 15% feeling "embarrassed" (n = 3), and 5% "reassured" (n = 1).

Question 8

Question 8 asked, "What was the impact of this experience on you?" In a thematic analysis of the responses two themes arose, including "no impact" and "long-term impact". Examples of both themes can be seen in Table 2. The most common theme among responses to this question was "no impact" with 80.95% of participants providing responses related to this theme (n=17). This was followed by 14.29% providing responses indicating a "long-term impact" such as switching healthcare providers/facilities and/or residual emotions around the event (n = 3).

Question 9

Question 9 of the interview asked, "Would this type of speech be more appropriate in a different setting?" In a thematic analysis of the responses two themes arose, including "not more appropriate" and "healthcare impact". Examples of both themes can be seen in Table 3. The most common theme among responses to this question was "not more appropriate" with 90.48% of participants providing responses related to this theme that indicated this type of speech would not be more appropriate in a different setting (n=19). This was followed by 9.52% (n = 3) providing responses indicating a "healthcare impact". Specifically, respondents indicated that this type of language is more appropriate when used by healthcare providers or staff a nursing homes/assisted living facilities, with one stating "I can understand the use of it (elderspeak) there by a nurse who is trying to be supportive".

Question 10

Question 10 asked, "Would the experience have been different if that individual was a different gender?" In a thematic analysis of the responses two themes arose, including "no difference" and "male effect" (see Table 4). The most common theme among responses to this

question was "no difference" with 60% of participants providing responses indicated that their experience would not have been impacted by a change in the speaker's gender (n=12). On the other hand, 40% of responses indicated a "male effect" (n = 8), with participants noting that they would perceive the experience as more inappropriate if a male used elderspeak. See Table 4 for examples of this response.

Question 11

Question 11 of the interview asked, "Would the experience have been different if this person was a stranger?" or "Would the experience have been different if this person was an acquaintance?" depending on their relationship to the speaker in their example. In a thematic analysis of the responses three themes arose, including "family/friend effect", "relationship effect", and "no difference" (see Table 5 for examples of themes). The most common theme among responses to this question was "no difference" with 65% of participants providing responses indicating that their closeness with the speaker would not impact their perception of the event (n=13). Furthermore, 30% of responses indicated a "family/friend effect" (n = 6), with participants noting that they would perceive the use of elderspeak in a more positive light were it used by a family member or a friend. One participant's response (5%) fit with an opposing theme, "relationship effect", and they noted that the use of this type of speech/language would be more negatively perceived if used by someone whom they have a close relationship with.

Question 12

Question 12 asked, "Do you think this kind of speech would be less appropriate in a different setting?" In a thematic analysis of the responses two themes arose, including "caregiver impact" and "no difference" (see Table 6). Sixteen participants (76.19%) provided responses fitting with the "no difference" theme that indicated they would not find this kind of speech less

appropriate in a different setting. The remaining 23.81% of responses (n = 5) fit with the "caregiver impact" theme in which use of elderspeak in a healthcare setting was perceived as less appropriate. Responses fitting in this theme (see Table 6) were similar in that participants reported the use of elderspeak by a caregiver, such as a doctor or a nurse, as more inappropriate because of the sensitive nature of interactions with these persons. Additionally, two participants who identified themselves as retired nurses both noted that they had experience extensive training on not using this type of language, and thus, felt healthcare providers should know better than persons working in other fields.

Question 13

Question 13 of the interview asked, "Would your opinion on using this type of speech be different if it was used with an individual with a cognitive impairment/visible physical disability?" In a thematic analysis of the responses three themes arose, including "more appropriate", "more inappropriate", and "equally appropriate" (see Table 7). Of the responses, 33.33% fit within the theme of "more appropriate" (n = 6), and 33.33% fit within the theme of "equally appropriate" with respondents indicating that elderspeak is no-more or no-less appropriate when used with individuals with a cognitive impairment/disability (n = 6). In addition, 27.77% of responses fit within the theme of "less appropriate", with participants' responses indicating that the use of elderspeak is less appropriate with these individuals (n = 5).

Discussion

The purpose of the current study was to determine what elderspeak looks like from the perspective of community-dwelling older adults, and how contextual factors may change these perspectives on elderspeak. One of the main findings of this study was that the use of elderspeak is widespread and common among older adults, with some literature suggesting that community-

dwelling older adults experience elderspeak about one to five times per week (Allen et al., 2020; O'Connor & St. Pierre, 2004). Of the 18 participants in this study, the majority (n = 17) were able to provide a personal experience where elderspeak was used when speaking to them. The remaining participant was unable to provide a personal instance, but was able to speak about a conversation they witness where elderspeak was used. In the current study, many participants had negative perceptions of elderspeak (70%), expressing emotional responses that fit themes ranging from "angry/annoyed" (n = 7), to "disrespected/infantilized" (n = 4), and "embarrassed" (n = 3). These themes are in line with existing research which has found that elderspeak makes older adults feel incompetent, helpless, frustrated, and degraded (Brown & Draper, 2003; Caporael et al., 1983; Hermann & Williams, 2009; Kemper et al., 1998a; Kemper & Harden, 1999; LaTourette & Meeks, 2000; Ryan et al., 1991; Ryan et al., 1995).

The present study suggests that while elderspeak can occur in a variety of settings, it is prevalent among medical professionals. Multiple participants cited interactions with healthcare professionals where elderspeak was used, such as being called "hon" or "sweetheart" during an examination. While the present research was not specific to the use of elderspeak in healthcare settings, this is consistent with existing research on the use of elderspeak by nurses, CNAs, physicians, occupational therapists, and chiropractors (Herman & Williams, 2009; Williams et al., 2009). In addition to negative perceptions about the use of elderspeak, some participants (n = 2) noted that their interaction had such a significant impact on them that both participants switched providers, and one filed a complaint. This further supports the need for additional training for healthcare workers to prevent the use of elderspeak when treating older adults.

This study suggests that while overall, community-dwelling older adults have negative perceptions about the use of elderspeak, they also expressed that elderspeak was more

appropriate to use with individuals with visible physical disabilities or cognitive impairments. These findings are consistent with the existing literature which suggests that the presence of cognitive impairments positively correlates with healthcare provider perceptions on the appropriateness of using elderspeak (Grimme et al., 2015; Kemper et al. 1998a; 1998b; Lombardi et al., 2014).

While there is significant lack of research looking at male older adult's perceptions on elderspeak, the findings of the current study are consistent with the existing ageism literature which concludes that like women, male older adults experience ageism (Clarke & Korotchenko, 2015; O'Connor & Rigby, 1996). When asked about how they felt when elderspeak was used, men's examples included responses that fit with a number of themes including "angry/annoyed" (n = 1), "disrespected/infantilized" (n = 1), "indifferent" (n = 4), and "reassured (n = 1)". No males provided responses that fit with the theme of "embarrassed". Conversely, women reported feeling "angry/annoyed" (n = 6), "disrespected/infantilized" (n = 3), "embarrassed" (n = 3), and "indifferent" (n = 1). No female participants provided a response that fit the theme of "reassured". Therefore, it appears as if women were more likely to report negative emotional responses to elderspeak compared to males.

Previous work by Clarke & Korochenko (2015) suggests that ageism in informal or personal settings, such as with family, are more often perceived by men as acceptable. However, the current study did not support these results. When asked question 11 , "Would the experience have been different if this person was a stranger/acquaintance?", most men (71.43%, n = 5) indicated that the closeness of their relationship with the speaker would have no impact on their perceptions on elderspeak.

Limitations and Future Directions

Several limitations should be considered when evaluating the results of the present study. First, the study consisted of a small sample size. Due to the qualitative nature of the study, only 18 participants were interviewed. This, in addition to the homogeneity of the sample, reduces the generalizability of the current study. Additionally, all participants in the present study originated from the Midwest region of the United States. Future research should evaluate a larger sample of older adults, with greater ethnic and racial diversity. Future research should also evaluate a nationwide sample of older adults to determine whether there are any regional differences in perspectives of elderspeak. For instance, this type of speech may be more common and familiar to those living in the Southeastern United States, which may alter perceptions of elderspeak compared to those living in other areas of the county where elderspeak is less likely to be part of the regional dialect.

Another limitation was the participant's understanding of elderspeak. The present study involved prompting participants to share their experiences with elderspeak by describing common characteristics of "this type of speech/language". Some participants had further clarifying questions about this, such as whether the examples they provided needed to included every characteristic that was provided in the prompt. Additionally, when given the opportunity to provide an additional example, one participant provided examples of non-elderspeak interactions, such as a spouse using collectives such as "we" and "our" . Future research may benefit from the use of a vignette or video example in order to clarify what elderspeak looks and sounds like, especially as some characteristics, such as the use of collectives or overly endearing nicknames, occur outside of elderspeak.

Based on the current findings, it is unclear which specific components of elderspeak are more or less acceptable to older adults. Many older adults provided examples that included multiple components of elderspeak such as collective pronoun use, increased pitch/volume, and the use of overly endearing nicknames. Therefore, future research could ask more detailed questions to better understand which aspects of elderspeak are more or less appropriate or acceptable.

Conclusion

Overall, the present study suggested that elderspeak was prevalent among this sample of community-dwelling older adults. All participants in the present study were able to provide at least one experience of elderspeak, with most indicating they have negative perceptions of elderspeak that are unlikely to be influenced by changes in contextual factors such as setting, relationship to the speaker, and gender of the speaker. The individual using elderspeak was most commonly a family member or healthcare provider, with experiences occurring most often in a healthcare setting. Despite most participants expressing negative perceptions about their personal experiences with elderspeak, some participants felt as though elderspeak was more acceptable when used with individuals with a visible physical disability or a cognitive impairment. Despite the limitations of this study, the results provide a much needed insight into the perceptions of elderspeak in community-dwelling older adults.

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Table 1

Frequency and Example Response for Each Theme on Question 7

Theme	Example Response	Frequency
Angry/Annoyed	“"He talks to me like I can't understand him. It pisses me off”	7
Indifferent	“It (elderspeak) happens, you get used to it.”	5
Disrespected/Infantilized	“She treated me like a child and wasn’t able to understand (medication) instructions.”	4
Embarrassed	“It happens a lot with young people but I was so embarrassed.”	3
Reassured	“I think it's appropriate to use. It's reassuring as a patient.”	1

Table 2

Frequency and Example Response for Each Theme on Question 8

Theme	Example Response	Frequency
No Impact	“It was put down-ish, like, you're old. But it didn’t have any impact on me after it happened.”	7
Long-Term Impact	“It felt personal, but I think it was a habit. I didn’t go back to him (doctor) again though.”	3

Table 3

Frequency and Example Response for Each Theme on Question 9

Theme	Example Response	Frequency
Not more appropriate	"No, it's (elderspeak) bad in all settings"	19
Healthcare Impact	"I can understand the use of it (elderspeak) there by a nurse who is trying to be supportive."	3

Table 4

Frequency and Example Response for Each Theme on Question 10

Theme	Example Response	Frequency
No Difference	“No difference, but males tend to do it less I'd say.”	12
Male Effect	“Yes, I would really get upset if a male does this. I would really be uncomfortable.”	8

Table 5

Frequency and Example Response for Each Theme on Question 11

Theme	Example Response	Frequency
No Difference	"Treat the patient as an adult"	13
Family/Friend Effect	"It is more offensive when it's someone you don't know. If it was someone I knew, it wouldn't matter as much."	6
Relationship Effect	"Worse, family should know you don't need them to help you in that way."	1

Table 6

Frequency and Example Response for Each Theme on Question 12

Theme	Example Response	Frequency
No Difference	“It would be the same level of inappropriateness assuming I still don’t know the person.”	16
Caregiver Impact	“It would be much worse at a doctor’s office”	5

Table 7

Frequency and Example Response for Each Theme on Question 13

Theme	Example Response	Frequency
More Appropriate	“Yes, I think maybe it might be helpful if they need it.”	6
Equally Appropriate	“I think it shouldn't happen no matter what.”	6
More Inappropriate	“I have a sister with a cognitive impairment. I think in this situation it’s even more important not to do this.”	5

Appendix A

Recruitment Newsletter

Research Opportunity:

A student at Minnesota State University, Mankato is conducting research on how older adults perceive a common type of speech/language that is present in a variety of caregiving and social settings. The study consists of an interview where you will be asked a variety of questions about your perceptions and experience with this type of speech/language. The study will be completed in person and will take approximately 60 minutes to complete. If you would like to participate, but are unable to meet in person, please contact the researcher to inquire about completing the study online.

If you are willing to participate or have questions, please contact Dr. Jeffrey Buchanan, Ph.D. at 507-389-5824 or jeffrey.buchanan@mnsu.edu. Thank you for your consideration!

MSU IRBNet LOG # 2007805

Appendix B

Recruitment Email

Greetings,

My name is Katelynn Shimanski, and I am a clinical psychology graduate student at Minnesota State University, Mankato. I am currently working with Dr. Buchanan on a research study examining how older adults perceive a common type of speech/language that is present in a variety of caregiving and social settings. I am asking that you consider participating in our study. Participation in this study will consist of:

- Meeting with the researcher in person
- Answering demographic questions about yourself
- Providing an example of a time that you experienced this type of speech/language
- Discussing your perceptions on this type of speech/language
- The study will take approximately 60 minutes

For this study, risks are considered to be 'less than minimal.' There is no direct benefit associated with study participation, however, it is hoped that this research will help us educate the public and assisted livings personnel on the implications of elderspeak and hopefully create a more dignified and respectful environment within the community for older adults.

Records of this study will be kept private. An alphanumeric code will be placed on all data collection forms collected during this study to further protect participant confidentiality.

If you would like to participate, but are unable to meet in person, please contact the researcher to inquire about completing the study online.

If you have any questions, I have included my advisor, Dr. Jeffrey Buchanan (jeffrey.buchanan@mnsu.edu), in the email. His phone number is (507) 389-5824.

Thank you for your time and consideration.

Best regards,

Katelynn Shimanski

Appendix C

Informed Consent

CONSENT FORM

Title: The title for this research study is: "A Qualitative Analysis of Community-Dwelling Older Adults' Perspectives of Elderspeak."

Investigators: This study is being conducted by Katelynn Shimanski, a graduate student in clinical psychology, under the direct supervision of Jeffery Buchanan, PhD, of Minnesota State University Mankato's Department of Psychology.

Purpose: The current project is intended to analyze how older adults perceive a common type of speech/language that is present in a variety of caregiving and social settings.

Procedures: You will first be asked to complete a demographics form, which gathers information such as age, gender, and ethnicity. Next, you will be given a set of instructions for the interview. After you have read the instructions, the interview will begin. You will be asked a series of questions on an experience you had where someone used this type of language with you. It is anticipated that participation will take approximately 60 minutes.

Risks and Benefits: Risks in terms of emotional stress/discomfort and undesirable social, economic, and financial status are considered to be 'less than minimal', although you may choose not to answer any questions. There are no direct benefits associated with participation in this study; however, it is hoped that this research will help us educate the public and assisted livings personnel on the implications of elderspeak and hopefully create a more dignified and respectful environment within the community for older adults. If you choose to be interviewed in person, to minimize risks of COVID-19 transmission, the researchers have been vaccinated, will wear masks, will keep 6 feet away while interviewing, and agree to adhere to CDC and facility guidelines.

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 from your interview. 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, and supervised members of Dr. Buchanan's research team in the Psychology Department at Minnesota State University, Mankato.

Voluntary nature of study

Your decision whether or not to participate in this research will not affect your current or future relations with Minnesota State University, Mankato. Even if you sign the consent form, you are free to withdrawal from the study at any time by contacting Dr. Jeffrey Buchanan at 507-389-5824.

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, Jeffery Buchanan, Ph.D. at (507) 389-5824 or jeffrey.buchanan@mnsu.edu. If you have questions about participants' rights and research-related injuries, please contact the Director of the Institutional Review Board at (507) 389-1242.

Closing Statement: My signed below indicates that I have decided to participate in a research study, I am above the age of 18, and that I have read this form, and understand it. We may provide an additional copy of this consent form for your records if you wish.

Please sign your name here: ____

MSU IRBNet LOG # 2007805

Appendix D

Demographics Questionnaire

Demographic Information:

1.) Age: ___________

2.) Gender:

Male

Female

Transgender

Non-binary/third gender

Prefer not to say

Other: Please Specify __________________

3.) Highest level of education completed:

Less than high school

High school graduate

Some college

2-year degree

4-year degree

Beyond 4-year degree

4.) Marital Status

Married

Single

Widow/widower

5.) Ethnicity:

American Indian or Alaska Native

Asian

Black or African American

Hispanic or Latino

Native Hawaiian or Pacific Islander

White

Other: Please Specify _________________

6.) Are you originally from the Midwest?

Yes

No

- If no, please specify region? __________________

7.) Do you have a diagnosis of a disease that causes memory loss?

Yes

No

Appendix E

Interview

Administration Instructions:

1.) Participant will be presented with consent form to view and sign before beginning the study.
2.) Remind participant about how long the study should take and give time for allowing them to ask any questions.
3.) The interviewer will hand participant a demographics survey and give them time to complete the sheet.
4.) The interviewer will go through "Interview Part 1" with the participant, allowing them time to answer each question.
5.) The interviewer will go through "Interview Part 2" with the participant, allowing them time to answer each question.
6.) If time allows, ask the participant if they have another instance of this type of speech/language that they would like to discuss. If yes, repeat interview.

Interview 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 caregiving and social settings.

The speech/language of interest has several characteristics:

- The use of simplified vocabulary/sentence structure *(e.g., using the word potty instead of bathroom)*
- Repetition of words/phrases *(e.g., repeatedly asking someone if they are hungry)*
- Elevated pitch/volume *(e.g., talking louder than usual)*
- Slowed rate of delivery *(e.g., speaking slower than usual)*
- Answering questions for someone *(e.g., "you would like to eat now, wouldn't you?")*
- Collective pronoun usage *(e.g., using "we", "us", and "our" instead of "you")*
- The use of overly-endearing nicknames *(e.g., calling someone "honey" or "sweetheart")*

We now want to ask you questions about your experience with this type of speech/language.

Interview Part 1:

1.) Have you ever been in a conversation where someone used this type of speech/language?

If participant answers "no" to this question, ask "have you ever witnessed a conversation where someone used this type of speech/language? If no, interview ends. If yes, ask the following questions: 4, 5, 8, 9, 12, 13.

Yes

No

2.) What is/was your relationship with the individual who used this type of speech/language? *(e.g., family member, acquaintance, stranger, etc.)*

3.) Roughly how long ago did you experience this instance of this type of speech/language?

Within the last week

Within the last 2 weeks

About 1 month ago

Less than 6 months ago

Less than 1 year ago

More than 1 year ago

4.) Where did this experience occur?

5.) In as much detail as possible, please describe what was said by this individual?

6.) What tone did they use when speaking to you?

(e.g., speaking in a sing-song tone of voice)

7.) How did you feel when this event occurred?

If participant is unable to answer this question ask, "what were you thinking during this conversation?"

8.) What was the impact of this experience on you?

If participant is unable to answer this question ask, "looking back, how do you feel about this experience?"

<u>Interview Part 2:</u>

9.) Would this type of speech have been more appropriate in a different setting?

If participant is unable to answer this question ask, "would this type of speech have been less appropriate in a different setting?

10.) Would the experience have been different if that individual was a different gender?

11.) w

If participant's story was about a stranger use <u>acquaintance</u>. If participant's story was about an acquaintance use <u>stranger</u>.

12.) Do you think this kind of speech would be less appropriate in a different setting?

13.) Would your opinion on using this type of speech be different if it was used with individuals with a cognitive impairment/visible physical disability?