

# Communication in the Clinical Environment

Considerations for Hearing-Impaired  
Elders

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# Overview

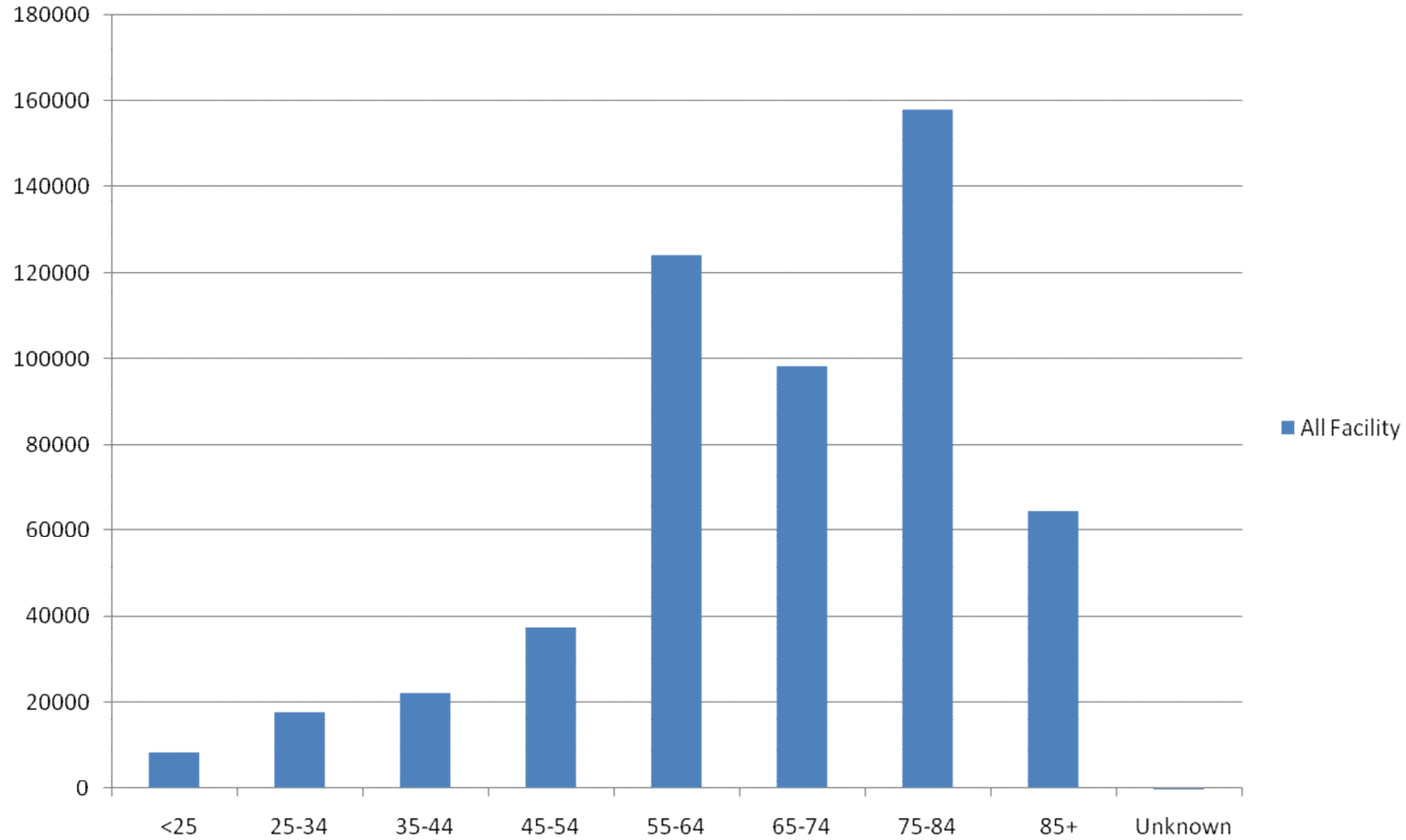
- Gerontology Basics
- Psychological and Social Aspects of Aging
  - How do we see the aged?
  - How do elders see themselves?
- Issues in Clinical Communication:
  - Elderspeak
  - Third-party dynamics
  - Verbosity

# Demographics

- Defining “old”
- Increasing number and proportion of older persons
- VA audiology patient demographics
- Relevance to audiology practice

# VA Audiology Patients by Age

All Facilities, FY 2008 (source: DSS)



# Biological Aspects of Aging

- Aging changes vs. disease
- Trajectory of increasing vulnerability to disease
- Aging vs. disuse atrophy, lifestyle issues
- Heterogeneity

# Challenges in Gerontology Research

- Cohorts/Period effects
- Sampling
- Heterogeneity

How do we see older people?

# Aging Stereotypes

## Hummert (1994)

### **Negative:**

- Shrew, curmudgeon
- Despondent
- Recluse
- Self-Centered
- Vulnerable
- Impaired

# Aging Stereotypes

## Hummert (1994)

### **Positive**

- Golden Ager
- Perfect Grandparent
- Small Town Neighbor

# Modernization

- Elders are afforded differing degrees of respect/position across cultures
- Modernization theory: Status of elders decreases with increasing societal modernization
- However, negative or ambiguous attitudes toward older persons exist in all cultures

# Ageism

- “A systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this with skin color and gender” (Butler 1969)

“Our expectations of others can be powerful determinants of how we behave toward them, and how they, in turn, respond to us”  
(Harris et al, 1994)

# Psychological and Social Aging

- What is it like to grow old?
- Many older persons maintain stability in self-esteem, and relatively high levels of subjective well-being
- Helping others can increase self-esteem, AND receiving help may reduce self-esteem
- Adaptation
  - To changing health, social roles, relationships
- Successful aging = Resiliency?

# Social/Psychological Theories of Aging

# Disengagement Theory

Cumming & Henry 1961

- Normal aging involves a natural, inevitable, mutual disengagement of aging persons and others in the social system
- Loss of roles, increasing detachment from society
- “Mutual contract” prepares the individual and society for death, i.e. deaths of elders do not thus “disrupt” social order; mutually satisfying
- Theory sharply criticized

# Activity Theory

- Disengagement is NOT normal, but related to unfortunate circumstances, such as poor health, lack of social support, or lifelong patterns of isolation
- Optimal aging=staying active, engaged with society, replacing lost roles/activities with new ones
- Life satisfaction associated with social network friends, family

# Continuity Theory

- Older adults make adaptive choices in an effort to maintain sense of self, maintain patterns established during the life course, preserve coherent sense of identity
- “The Ageless Self”

# Gerotranscendence

- Focus on inner vs. outer life
- Continued personal growth need not imply high levels of external social activity
- Could be seen as a modern re-interpretation of Disengagement Theory

# Life-Span Control Theory (Schulz et al)

Psychological factors characterizing disablement process in elders

- Primary control: Targets the external world, take action
- Secondary control: Targets internal self, perspective
  - Increases with age

# Presbycusis: Basic Clinical Profile

- High frequency SNHL
- Speech understanding decrements
- Older people consistently show poorer performance in speech understanding tasks involving background noise, or greater complexity

# Cognitive Aging

- Dementia is not a normal part of aging
- Slower processing speeds
- Fluid vs. Crystallized intelligence
- Declines in primary working memory
- Long-term memory often well-preserved

# Cognitive Aging

- Ability to learn is maintained, but becomes more effortful:
  - Need more time
  - Need more reinforcement/repetition
  - More vulnerable to distractions
  - Visual reinforcements helpful

# Clinical Communication

- Dynamics
- Power imbalance
- How do we develop our specific patient interaction style?
- Communication affects outcomes
- Patient-centered care
- Medical Sociologists vs. Clinicians

# Elder patient cohort issues

In general, the current cohort of older patients:

- want less active decision making
- have less general health knowledge, lower health literacy

---vs. Baby Boom cohort?

# Elderspeak

- Patronizing speech
- Over-accommodating speech
- Secondary baby talk
- Elderese
- Similar in structure and prosody to Motherese

Often observed in interactions between younger and older adults

# Elements of Elderspeak

- Slower rate
- Exaggerated prosody, higher pitch, sing-song
- Simplified content, semantic elaboration
- Repetition
- Vocabulary restrictions
- Overly directive
- Over-familiarity

# Elderspeak

Reflects negative stereotypes that the elder is:

- Cognitively impaired
- Has sensory limitations (HL, vision loss)
- Incompetent
- Helpless
- Can reflect good intention to convey nurturance and caring

# Elderspeak

Most commonly observed:

- In health care settings, nursing homes
- By family members in disputes with older relatives (establish social control)
- In public places when elders are perceived to be moving too slowly

# Triggers for Elderspeak

- Visible signs of age (wrinkles? hearing aids?)
- Signs of poor health
- Poor grooming/dress
- Younger individuals, or those who hold a less complex view of aging, may be more likely to use elderspeak

# Elderspeak vs. Motherese

- Similar in structure and prosody (but not content)
- Motherese is thought to be beneficial in language acquisition, attracts the infant's attention
- Similar patterns in the way we speak to pets, inanimate objects, foreigners

# Elderspeak: Negative outcomes

- Interpreted as demeaning, patronizing, lacking respect
- Can reinforce internalized ageist stereotypes, and lead to less communicative competence
- Many of the elements of elderspeak do not enhance speech understanding

# Elderspeak: Negative outcomes

- Exaggerated prosody distorts normal paralinguistic cues
- Reducing MLU (mean length of utterance) not effective
- Overall slowing of speech rate not helpful.

# Positive aspects of Elderspeak

- Syntactic simplification
- Reducing MCU (mean clauses per utterance)
- Semantic elaboration
- Pausing at the end of sentences
- Repetition
- The most frail elders may perceive the tone as nurturing

# Strategies

- Assume competence of the older patient
- Interact with the individual, not the stereotype
- Employ “clear speech”
- Employ simplification techniques only as needed
- Avoid condescending tone
- Always strive to convey respect

# Medical Companions: Dynamics

- Older patient often accompanied by another
- How does this affect how you relate to the patient?
- Alliances
- Older study (Greene): patients raised fewer topics, less assertive, less joint-decision making, less shared laughter in triadic visits

# Medical Visit Companions: Characteristics (Wolff & Roter, 2008)

~40% of older patients are typically accompanied to their medical visits

More likely to bring a companion if:

- Older
- Less educated
- Poorer health/greater disability

# Medical Visit Companions: Characteristics (Wolff & Roter, 2008)

- Spouse (53%)
- Adult Children (32%)
- Other relatives (7%)
- Non-relatives (3%)
- Patients in poorer health more likely to be accompanied by an adult child or non-relative

# Medical Visit Companions:

## Functions (Wolff & Roter, 2008)

- Record /explain physician instructions
- Provide information re: the pt. to the physician
- Ask questions
- Logistics/transportation
- Provide moral support

Companions perform more of these functions  
for patients in poorer health

# Medical Visit Companions:

## Outcomes (Wolff & Roter, 2008)

- Accompanied patients more satisfied with their physicians':
  - Technical skills
  - Information giving
  - Interpersonal skills

Especially true for the most vulnerable patients.

Companions bridge Pt./Dr. communication barriers

# Implications

- What is your communication style in medical triads?
- Do you ever have a companion obstructing or undermining the patient?
- How does it affect how you view the patient's competence?

# Problems in Physician-Patient Communication

- Pt. /Dr. communication becomes more problematic the sicker the patient
- Less comprehensive solicitation of pt. info
- Dr.'s engage in less social dialogue w/these pt.
- Dr.'s like sick patients less
- In turn, these patients like their Dr.'s less and are less satisfied with their care

# Verbosity

- Off-Target Verbosity: abundant speech with lack of focus
- At extreme, becomes a monologue without regard for the context of the conversation

# OTV

- Are older people more prone to OTV?
  - Yes, but still only a small minority. In general, social skills are preserved in aging

## Why? Theories:

- Poorer cognitive inhibitory function?
- Reduced social networks?
- Extraversion?
- Need to reinforce self?

# Secondary Presbycusis

(Villaume et al. 1994)

- Impaired ability to use paralinguistic cues
- Affects discourse patterns of older (old old) persons
- Less sensitive to nuances of emotion, meaning in tone, prosody
- Less fluid conversations, more like individual monologues when two older persons are talking, compared to young old

# Patient Presentation of Self

- The most socially isolated, lonely, or depressed elders may want to disclose more information to the clinician
- Older patient may recall era of family dr. house calls, more personal intimacy
- We may be afraid that follow-up questions lead to Pandora's box, too much elaboration
- “Painful self-disclosure”

# Clinicians' responses

- Time constraints
- Change the subject, dismiss
- “mm-hmm”, “O my”
- Fear that signaling interest may lead to escalation?
- What information/recommendations do we provide or withhold?

# Summary

- The ageless self
- Respect
- Complexity
  
- “Look at Me” video on CDN

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