Research Summary: Patronizing Names and Forms of Address Used with Older Adults

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The use of personal names, related forms of address and references directed toward older adults, especially in health care settings such as hospitals and nursing homes, is ageist and infantilizes older adults. We provide a number of examples of this practice from the available literature.

Introduction

This report concerns the names and related forms of address used either in direct interaction with older adults, or in consulting with others in their presence in health care environments such as physicians' offices, nursing homes, hospitals or rehabilitation centers. These expressions tend to be disparaging and demeaning, and reflect the lack of power and vulnerability of older adults. Wood and Ryan (1991) comment upon the significance of forms of address in establishing social relationships:

> First, the exchange of address forms is the clearest instance of language that encodes social relationships.... Second, address forms are particularly important for defining relationships because of their usual positioning at the beginning of interactions. Further, although they may seem innocuous, they may have powerful effects. Finally, in contrast to some other features of discourse, forms of address are readily identifiable and data on their usage are relatively easy to obtain through either observation or participants' reports. (173)

A large body of research shows that many references to older adults are ageist. Ageism is a form of prejudice and may be expressed by a negative or demeaning attitude toward older adults. It may also refer to

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illegal acts of discrimination such as the dismissal of an employee on the basis of chronological age alone (Levin and Levin 1980, 72-73). Previous research on the lexicon used to refer to older adults shows that this vocabulary is frequently derogatory (Nuessel 1982; 1984; 1992a; 1992b). When older adults are in dependent roles such as when they are confined to a nursing home or rehabilitation center or in guardianship relations, direct communication with them is often ageist. Ageist language is a sociolinguistic symbol of oppression of geriatric patients because it marks their social dependence and their frequently subordinate socioeconomic status. Furthermore, such verbal derogation may indicate possible elder abuse since this type of language conveys a negative attitude and a lack of consideration toward older adults.

The substantial extant research on intergenerational communication, including that between health-care providers and geriatric patients, has been concerned with the following:

1. Medical encounters, with or without a third person present (Adelman, Greene, and Charon 1987; Beisecker 1989; Beisecker and Beisecker 1996; Greene and Adelman 1996; Haug 1996; McCormack, Inui, and Roter 1996; Rost and Frankel 1993; Ryan, Meredith, MacLean, and Orange 1995).

2. Institutionalized geriatric patients (Caporael 1981; Caporael, Lukaszewski, and Culbertson 1983; Caporael and Culbertson 1986; Edwards and Noller 1993; Grainger 1993; Remper 1994; Lanceley 1985; Mader and Ford 1995; O'Connor and Rigby 1996; Ryan, Bourhis, and Knops 1991; Ryan, Meredith, MacLean, and Orange 1995; Ryan, Hummert, and Boich 1995; Sachwech 1998; Thimm, Rademacher, and Kruse 1998).

3. Infantilizing or patronizing communication (Arluke and Levin 1984; Ashburn and Gordon 1981; Benjamins 1986; Gresham 1976; Remper 1994; O'Connor and Rigby 1996; Ryan, Bourhis, and Knops 1991; Thimm, Rademacher, and Kruse 1998; Whitbourne, Culgin and Cassidy 1995; Williams and Coupland 1995; Wood and Ryan 1991).

4. Intergenerational communication (Coupland, Coupland, and Giles 1991; Edwards and Giles 1998; Giles, Coupland, Coupland, Williams, and Nussbaum 1992; Harwood 1998; Ryan, Anas, Hummert, and Laver-Ingram 1998).

Here we show that naming patterns and forms of address represent a system of inappropriate verbal behavior with older adults, especially when found in a clinical context, constituting in microcosm a pattern of contemporary societal ageism (Levin and Levin 1980; Nuessel 1992b; Palmore 1990). In particular, the points noted here correspond to that part of speech accommodation theory known as "dependency-related overaccommodation" (Coupland, Coupland, Giles, and Henwood 1988; Coupland, Coupland, and Giles 1991; Lanceley 1985), which "is triggered by the role relationship between caregiver and dependent care recipients, typically within institutional settings. This discourse strategy is likely to involve overbearing, patronizing speech with overly directive and regulatory features" (Ryan, Bourhis, and Knops 1991, 442).

Communication with Older Adults

Arluke and Levin (1984, 7-10) and Gresham (1976, 196-97) point out one particularly harmful stereotype of older adults, namely their "infantilization" and they discuss the ways in which old age is portrayed as a kind of "second childhood," leading to treating the elderly as if they were children. This inappropriate treatment, the authors warn, demeans and deprecates older adults and may have such negative results as the diminution of social status, loss of political power, and possibly even inappropriate medical treatment or legal actions. Conceptualizing older adults in this way may also lead to patronizing verbal behavior (Ryan, Hummert, and Boich 1995). Brown and Levinson (1987), in their discussion of politeness, noted that the use of names and forms of address in face-to-face situations contribute to the roles played by the participants in interactive or dyadic speech situations, particularly those of solidarity, distance, subordination, and domination.

Ryan, Hummert, and Boich (1995) define "patronizing communication" as "overaccommodation in communication with older adults based on stereotyped expectations of incompetence and dependence" (145). Included in this broad definition are communication styles described as secondary baby talk (Caporael 1981), controlling talk (Lanceley 1985), and elderspeak (Kemper 1994). Ryan, Hummert and Boich (1995, 154) list a number of the linguistic features of patronizing communication, including the use of a simplified lexicon, simplification of grammatical structures, the use of child-like forms of address, topic management (control of conversational subject matter), voice modulation (slowness

of speech, loudness), and exaggeration of such nonverbal communication features as proxemics and touch.

The use of patronizing names and forms of address with older adults in general and with geriatric patients in particular usually occurs at the outset of a conversation and thus establishes the sociolinguistic context for the rest of the communication as well as defining the dominant and the subordinate speakers in a conversational dyad or triad.

The following is a list of the ageist use of names (1-5) and forms of address (6-7) commonly found in communication with older adults in medical settings:

1. Given Name. The inappropriate (and unjustified) use of a person's given name is one way of establishing a relationship of power and dominance (Gresham 1976, 205-06; Haug 1996, 33-34; Ryan, Hummert, and Boich 1995, 150-51; Wood and Ryan 1991, 175-78). Using an older adult's given name without first asking permission, especially by younger adults, or by people who have had only limited contact with the older adult, is one example of what Arluke and Levin (1984, 7) call the "infantilization" of older adults. This uninvited familiarity underscores the powerlessness of older adults, many of whom no longer are employed and may have little social status. A better alternative would be to address the older adult with a suitable title (if known) or by Mr., Mrs., or Ms.

2. Diminutive Name Forms. First name forms such as *Annie* or *Freddie* are those that we use with young children and using them with older adults constitutes another, possibly even more degrading form of "infantilization" (Ryan, Hummert, and Boich 1995, 151; Sachwech 1998, 54).

3. Terms of Affection and Endearment. The use of terms commonly used with children, such as *dear*, *honey*, *poor dear* and *good girl*, constitutes another instance of communicative infantilization (Arluke and Levin 1984; Gresham 1976, 207; Ryan, Hummert, and Boich 1995, 155). The use of these expressions with diminutive endings, e.g., *dearie* and *sweetie*, particularly emphasize the process of infantilization.

4. Generic Names. The use of generic names, especially those based upon kinship, such as *gramps* or *granny* is often patronizing since these are expressions used by small children for their older relatives (Ryan, Hummert, and Boich 1995, 150).

5. Anonymity. The lack of identification of older adults which results from failing to use their names at all is part of a general pattern of disregard of older adults and occurs in many third-party situations where an older adult requires the assistance of another person. The most common occurrence is during a medical interview when a physician or nurse discusses the patient's situation with a third party (Wood and Ryan 1991, 181-82). In this context the failure to include the older adults in the conversation marks them as non-entities.

6. Third-Person References. The use of third-person references, such as "*She's having a problem today*," when talking about older adults as if they were uninvolved third parties while in their presence, is perhaps the ultimate objectification (Ryan, Hummert, and Boich 1995, 151-59; Wood and Ryan 1991, 178-89).

7. First Person Plural. *We* is a form of reference rather than a form of address (Ashburn and Gordon 1981; Ryan, Hummert, and Boich 1995; Sachwech 1998; Wood and Ryan 1991). When it refers only to the subordinate party in an act of communication, *we* "may signal the treatment of the person as a member of a category and [be] interpreted as condescending or insulting" (Wood and Ryan 1991, 180). (This is, of course, distinct from the use of inclusive *we*, which indicates solidarity and the participation of both parties in a conversational dyad.) A classic example of the condescending use of *we* is when a doctor or nurse asks "*How are we doing today?*" when it is quite clear that *we* refers only to the patient.

The use of an appropriate title (*Mr.*, *Mrs.* or other) plus the surname of an older adult is perhaps the most appropriate way to initiate a conversation in a medical setting (Wood and Ryan 1991, 173-78). Nevertheless, even this putatively desirable form of naming may be inappropriate if, as Ryan, Hummert, and Boich (1995) point out, "the speaker places great stress on the title and uses rising intonation, the utterance (Mrs. Smith) conveys feigned deference or disrespect" (153).

Conclusion

Our purpose in this review was to discuss the use and meaning of names and forms of address in geriatric medical settings. These naming practices are but one manifestation of the infantilization of older adults and they reflect prevailing social attitudes towards older adults. We have

documented the most common forms of these naming practices. The use and meaning of these names and forms of address in a conversation with an older adult constitute a reasonable linguistic indication that the person addressing the older adults harbors, consciously or unconsciously, stereotypical beliefs about older adults. When these names and forms of address are used in clinical settings, the older adults themselves, their relatives, their caregivers, or their guardians should consider a change of health care provider or institution. We believe that awareness of such verbal behavior is one way of communicating its significance and such awareness may reduce certain undesirable behaviors (ageism, discrimination, elder abuse) associated with it. This information also has important curricular implications (sensitivity training) for colleges and universities involved in training personnel who work in nursing homes, hospitals, doctors' offices and rehabilitation centers. For a discussion of these implications, see Arluke and Levin (1984, 10-11; Graham 1976, 208; Ryan, Hummert, and Boich 1995, 162-63; Sachwech 1998, 62-63).

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