2007

Communication, Health and Aging: Promoting Empowerment

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part two
language and discourse in institutional talk

3
communication, health and ageing: promoting empowerment

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> Don't call me a young woman;
> it's not a compliment or courtesy
> but rather a grating discourtesy.
> Being old is a hard won achievement
> not something to be brushed aside
> treated as infirmity or ugliness
> or apologized away by 'young woman'.
>
> (Ruth Harriet Jacobs, 1997, p.8)

Negative stereotypes of old age remain salient in North American and other societies despite worldwide improvements in health and longevity and educational efforts regarding positive ageing (Harwood et al., 1996, 2001; Kite & Wagner, 2002; Levy & Banaji, 2002). Accordingly, the adverse impact of ageism on older adults continues to be productively studied (Nelson, 2002, 2005; Palmore, 1999). The communication predicament of ageing model (CPA) conceptualized by Ryan, Giles, Bartolucci, and Henwood in 1986 examined age stereotypes and ageism through the lens of language and social psychology, specifically communication accommodation theory (CAT; Giles, Coupland & Coupland, 1991). The CPA has had profound heuristic value in guiding research on how age stereotypes constrain intergenerational interactions, thereby reducing the degree to which older adults can demonstrate competent behaviours and experience a positive sense of personhood (Coupland, Coupland &

Giles, 1991; Hummert, Garstka, Ryan & Bonnesen, 2004; Williams & Nussbaum, 2001).

Age-biased communication tends to reduce opportunities to demonstrate competence and to contribute to satisfying conversations. Moreover, the predicament is deepened by the reinforcing of age-stereotyped behaviours such as painful self-disclosures, talk about the past, and age excuses (Coupland, Coupland & Giles, 1991; Ryan, Bieman-Copland, Kwong See, Ellis & Anas, 2002). Within this negative feedback model, repeated experiences of thwarted communication lead increasingly to feelings of reduced capability, withdrawal from activities, and loss of personal control (Baltes & Wahl, 1996; Rodin & Langer, 1980; Ryan, Anas & Gruneir, in press; Ryan, et al., 2002).

Such experiences can be especially harmful in health care interactions and for frail older persons. Within health care interactions, poor communication can lead to inadequate diagnosis, inappropriate treatment, and reduced compliance with life style, exercise, and medication prescriptions (Adelman, Greene & Ory, 2000; Street, 2001). The presence of age-related disabilities (e.g., sensory impairments, motor impairments, dementia) can have the effect of lowering the threshold at which age-stereotyped expectations are triggered. Hence, older persons with disabilities are more likely to experience stronger variants of the communication predicament due to the reactions of others to the cues associated with their disability than do older persons without disabilities (see Hummert et al., 2004; Pichora-Fuller & Carson, 2001; Ryan, Bajorek, Beaman & Anas, 2005).

purpose

As this discussion suggests, age biases and inappropriate communication can make it difficult for older persons to communicate effectively, to show their competence, and to maintain self-esteem and a sense of control. Yet communication also offers older persons a powerful means of countering age biases and inappropriate communication so that they can avoid, or at least reduce, these negative consequences (Hummert & Nussbaum, 2001). Our purpose in this chapter is to examine the role of communication in empowering older adults, especially those with physical, sensory or cognitive impairments. Specifically, we consider how assertiveness strategies can serve as a resource in coping with communication predicaments. From the perspective of communication accommodation theory (Giles et al., 1991), assertiveness strategies may be viewed as appropriate accommodations designed to interrupt (even

reverse) the negative feedback cycle conceptualized in the CPA model (Hummert et al., 2004). We focus especially on strategies that older adults can use to influence health care situations where power differences are inevitable, and where the consequences of poor communication can be so critical to their wellbeing and that of their caregivers.

empowerment and communication in later life

> I am an old woman, a long liver.
> I'm proud of it. I revel in it.
> I wear my grey hair and wrinkles
> as badges of triumphant survival
> and I intend to grow even older.
>
> (Ruth Harriet Jacobs, 1997, p.8)

empowerment of older adults

Empowerment has been defined as a process that helps people gain control over their lives (Solomon, 1976). Moreover, researchers have suggested that this process is not only limited to the personal/individual level (Zimmerman, 1995), but is strengthened by interaction with others and by supportive environments (Petterman, 2002; Zimmerman & Warschausky, 1998). From a health promotion perspective that goes beyond self-care, empowerment can involve the individual in mutual aid and in advocacy for healthy environments (Epp, 1986; Ryan, Meredith, MacLean & Orange, 1995). While group-level strategies involving advocacy by older adults themselves are an important part of empowerment, this chapter focuses primarily on individual and interpersonal strategies.

The process of becoming empowered has three components: participation, context awareness, and personal control (Cox & Parsons, 1994; Perkins & Zimmerman, 1995). One who is empowered is able to participate in decisions and activities that are important to both self and others. Therefore, participation is considered to be the ultimate indicator of empowerment, moving a person or group from awareness to action. Moreover, the three components of successful ageing outlined by Rowe and Kahn (1998) in their influential model all involve participation: minimizing disease and disability, maintaining physical and mental function, and continued engagement with life.

In order to take action, individuals must be aware of the context. Context awareness involves understanding the factors that enable or

hinder goal achievement. This process involves seeking knowledge, developing skills and networking with others in order to evaluate the factors that contribute to goal achievement. Context awareness informs the setting of realistic goals, including the reshaping of goals after age-related losses of social roles, physical and mental health, and family and friends (Baltes & Carstensen, 1999; Carstensen, Isaacowitz & Charles, 1999). In order to make choices and participate in important everyday activities, one needs timely access to high quality, relevant information that will enable oneself to decide which goal to pursue and make accurate judgements about how to achieve them (Miller, 2000).

Participation in decisions that affect one's life and in the desired activities associated with successful ageing also requires a sense of personal control. Empowerment for older adults often involves regaining personal control over situations, outcomes and self-care after age-related losses in status, roles, health and opportunities (Miller, 2000). Individuals feeling powerless need to find new motivations by determining what can and cannot be controlled. In most cases, this can be done by controlling interpretations of events instead of the events themselves and by choosing action goals that optimize existing abilities while compensating for age-related losses (Heckhausen & Schulz, 1995). As described in the quotations above, ageing brings with it the achievement of survival. Older adults have a wealth of resources, including the wisdom of life history and personal connections, which can help in regaining personal control over life events. Communication offers a primary means of using those resources to regain the personal control that will enable them to negotiate successfully the challenges of ageing (Hummert & Nussbaum, 2001).

assertive communication

As part of empowerment, assertive communication involves responding proactively in difficult situations rather than reacting passively or aggressively (Rakos, 1991). Assertiveness entails calm, direct, honest expression of feelings and needs. As seen in Table 3.1, assertive communication flows from responsible choices and is characterized by a poised, confident style conveyed verbally, vocally, and nonverbally (Doty, 1987; Paterson, 2000; Rakos, 1991; Ryan et al., 2005a; Wilson & Gallois, 1993). Assertive communication is particularly relevant to the following key aspects of older adults' control over their own lives: obtaining needed information, making decisions, making and declining requests, managing help, managing privacy, dealing with inappropriate talk to or about oneself, and caregiving (Gambrill, 1994; Northrop & Edelstein, 1998; Ryan et al., 2005b).

Table 3.1 Assertive communication*

	Passive	Assertive	Aggressive
Choices	follow others	choose responsibly for self	force choices upon others
Benefits	avoid risks, stay safe	engage in desired activities, self-respect, growth	control others
Outcome	fail to meet goals, frustration, helplessness	meet goals, finish tasks, self-confidence, respect	fail to meet goals, alienate others
Emotion	resignation, frustration, guilt	confidence, calm, in control, positive self-esteem	anger, frustration, feeling out of control, resentment, guilt
Style	timid, closed, inhibited, dishonest, self-denying, apologetic	poised, open, direct, honest, self-expressive, empowered	pushy, closed, explosive, self-righteous, over-expressive
Language	hidden meaning, filled with excuses, indirect, overly polite	clear message, express what is wanted, use 'I' language, direct, acknowledge positive behaviours	blunt message, demand what is wanted, use 'You' language, attacking, rude
Humour	self-deprecating, giggle	contextually sensitive	target others
Voice	weak, monotone, flat	firm, naturally expressive	loud, harsh, over-expressive
Posture	stooped, sagging, fidgety	upright, relaxed, fluid	stiff, towering, threatening
Hands	fluttering, clammy	open, smooth motions, gentle gestures	clenched, abrupt, pointing, arms crossed, over-gesture
Eyes	avoid eye contact, look down	Make frequent eye contact	stare, glare
Face	lack of expression, frowning, tense	open expression, smiling, relaxed	over-expressive, frowning, tense, high colour

* Adapted from Doty, 1987; Paterson, 2000; and others

Assertive behaviour can lead to greater likelihood of meeting personal needs and to more positive self concept. Originally designed for patients in clinical psychology, assertiveness training has been successfully extended to groups in the community traditionally accorded less status such as women, people with disabilities, and older adults (Doty, 1987; Engels, 1991; Franzke, 1987; Northrop & Edelstein, 1998; Rakos, 1991).

Since assertive behaviour can be interpreted as aggressive or selfish, it is associated with risks. Wilson and Gallois (1993) indicate that assertiveness is often associated with lower ratings of friendliness and appropriateness. They interpret this typical finding in terms of confusion between aggression and assertiveness and restrictive role expectations for members of particular social groups (e.g., women, medical patients). Assertiveness is less common among women and among older cohorts (Gallois, 2004; Rakos, 1991; Wilson & Gallois, 1993; Twenge, 2001). Older people are less assertive than younger peers because they never were as assertive and also because they may have lost the confidence to use assertiveness skills (Furnham & Pendleton, 1983). The 'me first' association with mislabelled assertiveness (actually aggressiveness) is a deterrent to groups socialized

to be other-oriented. In addition, assertive behaviour may be especially avoided in health care encounters, given that non-assertive behaviour is encouraged in such hierarchical contexts (Adler, McGraw & McKinlay, 1998).

We have used the term s*elective assertiveness* to characterize the main strategy for recipients to interrupt the negative feedback cycle of the communication predicament model (Ryan et al., 2005a; see also Doty, 1987; Paterson, 2000; Taylor & Epstein, 1999). Assertive speakers communicate clearly while taking responsible control over meeting their goals. They neither defer passively to others nor impose on them aggressively. They are neither a pushover nor pushy. In line with socio-emotional selectivity theory, speakers make choices about important, realistic goals to fit the circumstances (Carstensen et al., 1999). Within a health promotion framework, assertiveness becomes part of managing one's health within a social environment. It is a matter of taking care of oneself, not a matter of being selfish.

Whether assertiveness is effective depends on its appropriateness in the specific situation. Lack of attention to contextual specificity is one reason for limited transfer to real life situations after assertiveness training (Rakos, 1991; Wilson & Gallois, 1993). The assertive speaker is tactful: aware of the social context and the other person's perspective; knows when to be direct or indirect; and acknowledges the communication partner's positive behaviours when appropriate (Ryan et al., 2005a; Wilson & Gallois, 1993). Older adults with age-related impairments can use these skills selectively for self advocacy and group advocacy (Gallois, 2004; Hickson & Worrall, 2003; Orr & Rogers, 2003).

The concept of selective assertiveness would encourage older adults to choose carefully when to voice their desires or concerns after assessing benefits and risks and to focus on fitting words and manner to the goals, speaker and situation (Ryan et al., 2005b). Teaching selective assertiveness would involve contingent communication strategies in terms of situational features, goals and behaviours (e.g., 'In a situation of . . . if you wish to . . . then try . . . .': Ohlsson, 1996, cited by Lizzio, Wilson, Gilchrist & Gallois, 2003).

Research by Birditt and Fingerman (2005) on choosing one's battles shows that older adults favour passive, accepting responses as compared to young adults, who are more likely to react aggressively in situations of interpersonal conflict. Training, including support groups, could assist older adults with disabilities to work out assertive strategies for use when the battle is especially important to reduce the frustrations associated with persistently avoiding such battles.

empowerment in health contexts: the challenge of disability

> The wounds, I suppose, teach – force to resolve, to surmount, to transcend. I will not be put down permanently like a dying animal. I can recover and go on creating. (Sarton, 1988, pp.230–231)

> My years with failing vision have prompted me to learn about the nature of the eye and the incredible gift of sight, which I had always taken for granted until it began to slip away. But I also learned about living within limits and overcoming disability. This, then, is not merely a story about seeing but also about living. It is a story not merely about losing sight but about gaining insight as well. (Grunwald, 2003, p.102)

> I would love to see some people with Alzheimer's not trying to stay in the shadows all the time but to say, damn it, we're people too. And we want to be talked to and respected as if we were honest to God real people. (Henderson & Andrews, 1998, p.7)

> I can be a care-partner with you, communicating my true feelings, my true needs, so that you can walk alongside me adjusting and compensating for these expressed needs as we face this struggle together. (Bryden, 2005, p.150)

Empowerment has been facilitated by the societal move toward interpreting disability as an interaction between a person and the demands of the environment rather than a deficiency solely within the person. Worrall and Hickson (2003) have elaborated on the World Health Organization International Classification of Functioning specifically in the context of age-related communication disabilities. We offer a slight adaptation here in terms of communication by people with varying disabilities. The WHO model emphasizes how the physical impairment and/or chronic health condition can limit activities and restrict participation in valued social domains. Key activities, for this chapter, are communication and interpersonal relationships. Limitations in these activities can restrict participation in domains such as personal maintenance, mobility, exchange of information, social relationships, occupation, economic life, and community life. Personal strengths and resources, as well as environmental threats and supports, can have a great influence on participation given any range of specific disabilities. Thus, stages of dementia or degrees of aphasia or levels of visual impairment

might not always predict participation restrictions. Communication predicaments, for example, might well reduce success of communication and interpersonal relationships, thereby exacerbating the disability in terms of participation restrictions. On the other hand, empowering environments might well compensate for much of the potential activity limitations usually associated with particular impairments. Relating back to our emphasis on goal setting, participation restrictions can be defined in terms of the individual's own goals.

empowered care receiving

The research programme of Greene and Adelman has identified a number of risks for older patients in health care situations that show the need for empowerment of older patients: being ignored in three-way conversations, little time to express concerns, and low responsiveness of physicians to their psychosocial concerns. Because they are often passive seekers of health information, older patients are less likely to use non-traditional sources of medical information (e.g., internet), instead relying heavily on their health care professionals for medical advice and decision-making (Bilodeau & Degner, 1996; Cassileth, Zupkis, Sutton-Smith & March, 1980). Older adults also ask fewer questions about their diagnoses and participate less actively in their health decisions than younger adults (Cameron & Horsburgh, 1998; Thompson, Robinson & Beisecker, 2004).

Older adults seeking health care, especially those who are frail or experiencing impairments, are in the position of asking for help. Research on communication and disability has identified helping situations as prime contexts for communication predicaments (Braithwaite & Eckstein, 2003; Braithwaite & Thompson, 2000). For instance, older persons are likely to find themselves in three-way conversations in which their health provider may speak mainly to an accompanying family member (Adelman et al., 2000). Older adults are even more likely to be excluded when their English (or main language of the culture) is not native, when they suffer from communication or cognitive impairments, or when they are seated in a wheelchair while others are standing (Frank, 1995; Hallberg, Norberg & Erikson, 1990; Ryan, Anas & Gruneir, 2006). Once providers and family members become comfortable speaking on behalf of older persons, it becomes all the more difficult for older individuals to regain their voice in future encounters (Braithwaite & Thompson, 2000). Another major source of communication difficulties is the pressure to disclose personal information – to fend off unwanted help, to account for help requests, or

simply to satisfy the curiosity of non-disabled communication partners (Braithwaite & Thompson, 2000; Ryan et al., 2005b). Helping behaviours incongruent with one's needs create excess disability, threaten personhood, and limit the potential for successful ageing through premature relinquishment of goals (Baltes & Carstensen, 1999).

Much of the literature on health provider–older adult relationships has focused on how the provider's communication should change to reduce these risks and to meet the individual needs of older adults (Clark, 1996; Ryan et al., 1995). This focus on the provider implicitly reflects a power differential in this relationship. However, consumers of health care, including older adults, are not powerless during the health encounter. In fact, the information provided by older adults about their health situation enables providers to make the best assessment (Brorsson & Rastam, 1993). Accessing relevant information for their health situation can improve the value of their questions to the providers, adherence to treatment, and health outcomes. Therefore, older adults have a responsibility to share their health concerns (Lambert, Street, Cegala, Smith, Kurtz & Schofield, 1997) and use that as an opportunity to empower themselves and their health provider. Below is a discussion of how older adults can actively participate when receiving care.

Previous research has shown that the more actively involved patients are in their health care, the better their health outcomes (Kaplan, Greenfield, Gandek, Rogers & Ware, 1996; Kreps & O'Hair, 1995). Street and Voigt (1997) found that participants who were more active in their health care believed they had more control over their situation and decision-making. Therefore, the natural next question is what communication strategies can empower older adults to take a more active role in their health care? Empowering communication strategies for older adults include asking questions to get clarification, expressing concerns, and being assertive (McGee & Cegala, 1998; Street, 2003). By expressing expectations for care and making suggestions for treatment, one can inform the health provider's choices of the best-fitting approach.

person-perception studies of communication strategies

The effectiveness of assertiveness as a strategy to communicate expectations of care while maintaining the face of health providers has been examined by person-perception studies. These studies have shown that assertive speakers are characterized as more competent compared to non-assertive speakers (Hummert & Mazloff, 2001) and less satisfied with patronizing communication (Ryan, Kennaley, Pratt & Shumovich, 2000). To further examine perceptions of assertiveness, Ryan, Anas and

Friedman (in press) compared assertive, aggressive and passive responses in problematic health care encounters (i.e., being ignored by a physician in favour of a companion, difficulty following a medication message delivered too quickly by a pharmacist, or misunderstanding a physiotherapist's exercise message because of noise). Older adults selecting assertive responses were rated as most competent and likely to be satisfied with future health encounters by both young and older participants. This finding suggests that assertiveness is a potentially useful response that is not bounded by contrasting ingroup or outgroup perceptions. The selective aspect, however, is critical. The assertive response was viewed as less polite than a passive response while being more polite than an aggressive one. The risk of crossing the line to aggressive and the social cost of standing up for oneself need to be weighed along with the benefits. Also, the health professional in the scenarios was rated more negatively when the older adult responded assertively or aggressively. This can be valuable in the sense that one avoids reinforcing the continuing negative feedback cycle.

Ryan, Anas, and Mays (2005a) took two steps in exploring the contextual variations on evaluations of older adult assertiveness within problematic health care encounters. This study examined the appropriateness of assertive responses by visually impaired older adults under different circumstances (serious or moderate) and in different contexts (community or institution). Both young and old participants rated conversational scenarios in which a visually impaired older adult responded either passively or assertively after requesting assistance with reading health-related information and not receiving it. Both older and young participants viewed the assertive older adult as more competent and responding more positively than the passive older adult. However, the appreciation for assertive responding was higher in the non-hierarchical community setting than in the hierarchical hospital setting (see Harwood et al., 1993; Harwood, Ryan, et al., 1997; Hummert et al., 1998 for similar findings). When the situation was of a serious nature, the assertive older adult was rated as even more competent and as having handled the situation better. Having the knowledge of when and where older adults will benefit most from an assertive style will work to alleviate the negative consequences of constantly being stereotyped and reinforcing those stereotypes with a passive style.

Directly assertive responses tend to threaten the face of health care professionals, who could retaliate intentionally or unconsciously. Some indirectly assertive approaches (e.g., humorous and appreciative) have

elicited favourable reactions and can be especially useful for older adults dependent upon others for care (Hummert & Mazloff, 2001; Hummert & Ryan, 2001; Hummert et al., 2004; Ryan et al., 2000). Hence, future research is needed to determine the suitability of different forms of older adult assertiveness in specific contexts.

communication interventions and training programmes

Being able to communicate competently does not always come naturally, especially when it can be an uphill battle due to communication predicaments in hierarchical health care settings. Some researchers also suggest that older adults find it more difficult to seek useful health information during a health encounter (Greene, Adelman, Charon & Hoffman, 1986; Rost & Frankel, 1993). Therefore, it is important to prepare and practise appropriate communication (Street, 2003). Preparation and practice enables one to develop a repertoire of communication behaviours/skills that can be easily accessed depending on the situation (Parks, 1994). In an empowerment intervention for cancer patients, participants in the experimental group thought about the information needed from their doctor, generated questions, and searched for information in a packet they received (Davison & Degner, 1997). The control group only received the information packet. Compared to the control group, participants in the experimental group were more active in treatment decisions and less anxious about their health in a six-week follow-up. Community workshops on communicating with health providers have been helpful in teaching older adults about the need to prepare and present information effectively, and to express concerns and ask questions (Towle, Godolphin, Manklow & Wiesinger, 2003).

Cegala and colleagues' PACE programme (2001) trained older adults how to ask questions, provide information and verify information in medical interviews using a 30-minute one-on-one session prior to a medical visit. The older adults learned to organize and present medical information and questions using the PACE acronym as a guide: Present, Ask, Check, Express. Specifically, older persons were taught to Present their feelings in detail, Ask questions when the information they required was not provided, Check their understanding of information that was communicated to them, and Express concerns regarding suggested treatments. Results showed that in comparison to a control group, those who experienced the PACE training were more active participants in a subsequent medical interview, asking more questions about medically related topics and providing more detailed responses to the

doctor's questions. In short, the PACE group, after only the briefest of training experiences, exhibited the participation that is the hallmark of empowerment and which positioned them as shared decision makers in their health care planning.

Tennstedt's (2000) intensive two-hour group community-based intervention also stressed active participation by older adults. The programme involved modelling desirable and ineffective patient behaviours, and taught older adults to record medical information and prioritize their health concerns. The negative consequences of passive interactions during a health visit were discussed and participants received cue cards with a list of active behaviours to try before, during and after the visit. Examples include preparing a list of prioritized concerns, discussing medications, expressing preferences for treatment, and following up with the physician regarding side-effects of treatments. Programme outcomes included active participation and patient satisfaction with the medical visit. Compared with an untrained control group, older adults in the programme reported a greater number of active behaviours and were more likely to be satisfied with their health encounter.

Training for older individuals with disability can be empowering in facilitating growth and use of skills of self-advocacy as well as mutual support. Such training is often conducted in small groups for the advantages of sharing ideas and emotions, role play, and feedback on possible strategies. Worrall and Hickson (2003) review several studies with the Keep on Talking approach of assisting older individuals in small groups to identify their own communication skills learning priorities and to learn and practise relevant strategies. This community approach has been successful in reaching older adults with hearing impairments who would not otherwise access help. Many seniors are interested in this proactive approach to prepare for possible future communication difficulties for themselves or for family members.

Orr and Rogers (2003) have produced a programme tested across the USA for facilitating learning groups of older individuals with visual impairment to gain self-advocacy skills. These individuals can learn to ensure their needs are met as they continue to age with visual difficulties through knowledge, practice, and feedback concerning various strategies to find targeted information in a timely manner, manage health care, interact with family caregivers, retain and share decision making, and handle the crises of life. The training package is sufficiently detailed and available in alternative formats so that the groups can be led by peer trainers, an especially empowering approach.

computer-mediated communication

Supporting existing strengths is vital to engendering personal control. Seeing oneself as separate from the disease process (i.e., a person is more than the disease itself) and viewing disability as a difference instead of as dependence or disadvantage is key to maintaining personal control (Orr & Rogers, 2003; Ryan et al., 2005b; Schulz, 2000). Acquiring skills that enable better communication (e.g., lip reading, using adaptive technologies such as computers) can help older adults regain confidence and control over their changing environments. For instance, if older adults with sensory difficulties associated with vision or hearing are equipped with assistive devices and communication skills that help them to navigate their social environments, they are more likely to resume former roles or gain new ones (Orr & Rogers, 2003).

Computers are useful assistive devices that help older adults with mobility restrictions. Such restrictions can physically and socially isolate individuals, leaving them homebound and experiencing a loss of control in their day-to-day activities. Wright (2000) found that computer-mediated communication can be an important source of social support in coping with such challenges. McMellon and Schiffman (2002) assert that the internet can empower older adults on personal and social levels. Specifically, the internet can personally empower older adults by allowing them to engage with others, reconnect with past pleasures, be a source of information gathering, and increase personal control. The internet also empowers older adults on a community level because it allows them to interact with other individuals, institutions or interest groups. This type of interaction allows older adults to discuss current events, share experiences, be more informed, and find support. McMellon and Schiffman (2002) also contend that internet empowerment contributes to successful ageing because learning computer skills keeps older adults mentally active. Moreover, older adults are more actively engaged with life when they connect with family/friends, develop social networks and explore interests on the internet (Rowe & Kahn, 1998). The potential is great for personal computer usage by older adults, especially with improvements in ease of software usage, teaching approaches, and valuable accessibility options for those with physical and visual impairments (see Charness, Park & Sabel, 2001).

writing for oneself and for publication

Most of the empowerment strategies we have discussed come from within and build on existing abilities of older adults. One of the most

empowering communication strategies has been the publication of life stories by older authors, some with disabilities. These provide engaging narratives of age-related losses and specific journeys of coping as well as heartfelt acknowledgement of age-related gains that surprise even the authors themselves. Writing a journal or a memoir or an illness narrative has great power in helping an individual to transform their sense of their life story – to take a broader perspective, to grow from 'why me' to 'why not me', to accept their life as their own, to recreate the beauty that they have experienced and to reap the lessons from their lives (Kenyon, Clark & de Vries, 2001; Smyth & Pennebaker, 1999). Berman (1994) has analysed five personal journals (including the well-known journals of May Sarton and Florida Scott-Maxwell), giving a year-to-year sense of how ageing voices talk about their changing/continuing sense of self across age. Autobiographies or memoirs can teach us about life span development, family history, local and world history, and spiritual growth. In publishing their stories, older adults can reach a wider audience, reporting back from the frontier about what their life is like after many decades. These reports can open hearts and transform the readers' views of ageing and of loss and of illness.

For older adults with an acquired disability or progressive chronic illness, writing in a journal can be an important part of finding a new sense of identity. Such individuals can find the inner voice that underlies key elements of assertiveness (i.e., calm, confidence, what to say). When they choose to convey their messages in writing (in a letter or email message or for publication), writing can facilitate selective assertiveness through greater control, away from the shaping power of the communication predicaments experienced in conversation (Ryan, 2006, in press).

empowered caregiving by older adults

Caregiving involves advocating on behalf of the care receiver, especially when he/she cannot self-advocate due to communication difficulties. Kahana and Kahana (2003) suggest that family members can help care receivers be proactive by gathering information on health conditions. Family members can influence health beliefs of care receivers by being for or against certain treatments or practices. They influence care receivers' participation in their own self-care by helping them adhere to treatment plans, providing emotional support, allowing time to learn and practise new techniques (support without pressure), and taking part in instruction of rehabilitation techniques. This description represents the empowered caregiver. However, caregiving is effortful. The enormity of juggling

multiple care-tasks while dealing with possible changes in relationships and lifestyles can easily engender a sense of powerlessness.

Older adults, especially spouses, assume new roles as caregivers to other older adults with complex and often multiple chronic conditions that affect communication. These conditions include losses in hearing and vision, and dementia. Over the past few decades, there has been considerable research on the deleterious psychosocial and physical impact of caregiving (Schulz, O'Brien, Bookwala & Fleissner, 1995; Schulz, 2000).

Caregiving often becomes an all-consuming role, especially with complex conditions such as Alzheimer's disease that affect cognitive-communicative, physical and behavioural health. As a result, caregivers who do not receive necessary and timely support are at risk of disempowerment. Specifically, unsupported caregivers are likely to feel overwhelmed by the numerous day-to-day tasks associated with cognitive-communicative and physical declines. Moreover, the unpredictability of disruptive behaviours, such as agitation and aggression, only adds to the diminished sense of personal control caregivers experience (McCarty et al., 2000). This lack of caregiving mastery has been identified as an important factor in a caregiver's physical and psychological decline, and in strained relationships with their family member with dementia (Narayan, Lewis, Tornatore, Hepburn & Corcoran-Perry, 2001; Pearlin & Schooler, 1978).

Consequently, interventions have focused on empowering caregivers with instrumental issues such as increasing knowledge and problem-solving skills about disease processes affecting their loved ones, knowing how to advocate for them, effective communication, and accessing health care and community services (Burns, Nichols, Martindale-Adams, Graney & Lummus, 2003; Brodaty, Green & Koschera, 2003; Kahana & Kahana, 2003; Ostwald, Hepburn, Caron, Burns & Mantell, 1999; Ripich, Ziol, Fritsch & Durand, 1999; Schulz et al., 2002). Additionally, many interventions also targeted relational issues such as caregiver burden, depression, and improved caregiver–care receiver relationships (McCallion, Toseland & Freeman, 1999; Mittleman, Ferris, Shulman, Steinberg & Levin, 1996). Burns and colleagues (2003) found that interventions including both educational and relational components are more effective than those that only consider one aspect.

The outcomes of such interventions are not only limited to empowering the older caregiver but extend to simultaneously increasing participation of the older care receiver. Bourgeois and colleagues' communication interventions trained family caregivers to use external memory aids (e.g., memory wallets) to increase the use of on-topic statements about personal

information and decrease repetitive verbalizations by individuals with dementia (Bourgeois, 1992; Bourgeois, Burgio, Schulz, Beach & Palmer, 1997; Bourgeois, Schulz, Burgio & Beach, 2002). Similarly, another communication intervention by Ripich and others (1999) showed that changing the way caregivers asked questions when communicating with their family members with dementia led to improved conversation exchange. These interventions show that by teaching caregivers to communicate effectively with their family members with dementia, they not only empower themselves but also enable their family members to participate on a level that suits their abilities.

Empowered caregiving is also not limited to the individual family caregiver or care receiver. Some interventions target feelings of powerlessness by connecting individuals with others who are in similar life situations. Caregiver support groups are excellent examples of mutual aid, where individuals experiencing similar challenges share their concerns and problem solve together. Czaja and Mark (2002) developed a telecommunications system that enhanced caregivers' access to formal and informal support services. The system also facilitated linkages among caregivers and between caregivers and other family members. Online discussion groups and resource guides helped caregivers connect with others sharing similar experiences and also helped them remain up-to-date on opportunities and technologies that might assist them. Again, it is likely that caregivers benefited from the *combination* of instrumental coping skills with shared personal experiences. Although information is powerful, the vast amount of health information available can overload caregivers. Therefore, being able to discuss the practicality and relevance of the available information with other caregivers is an invaluable resource.

enabling environments: role of health/social provider

Empowering older clients to cope with age biases and inappropriate communication is one avenue for avoiding the negative feedback cycle of the communication predicament of ageing model. Another equally important avenue, however, is developing the communication competencies of physicians and other health professionals because they play influential roles in creating health care interactions that facilitate empowerment. Prior research shows that through their communication practices, physicians and other health professionals may contribute to the negative feedback cycle of the communication predicament model. These practices may reflect stereotyped-based stylistic modifications such as exaggerated intonation, high pitch, increased loudness, simpler

vocabulary, increased redundancy, and reduced grammatical complexity (Caporael, 1981; Coupland et al., 1991; Kemper, 2001; Sachweh, 1998), as well as content modifications such as restricted topic selection (e.g., avoidance of explicit reference to long-term prognosis), reduced time allotment, and frequent interruptions (Adelman, Greene, Charon & Friedmann, 1992; Greene, Adelman & Rizzo, 1996; Meyer, Russo & Talbot, 1995). For example, physicians and oncologists often do not communicate in as much detail with older patients as they do with younger patients (Greene et al., 1996). Such speech modifications can be driven by a dismissive or impatient task orientation, but they often arise from a nurturing, overprotective concern (Hummert & Ryan, 1996, 2001; Kemper, 2001). Regardless of the motivation, a patronizing manner of communication implicitly primes negative self-stereotypes held by the older recipients. Levy's innovative research on implicit priming of either negative or positive old age stereotypes has documented corresponding behavioural changes in memory, gait, cardiovascular indicators, and handwriting (Levy, 2003).

The communication enhancement model (Ryan et al., 1995) outlines how social partners, especially health care professionals, can modify their communication to meet the actual needs of older adults. The model suggests that interventions focus on appropriate speech accommodations, supportive physical environments, and creating positive social environments. This process, involving individualized assessment and repeated cycles of adjusting manner and content of communication, empowers both the care provider and older adult. Empowerment in this model is linked to health provider facilitation of the three intervention domains of health promotion: self-care, mutual aid, and healthy environments (Epp, 1986).

Kahana and Kahana's (2003) health care partnership (HCP) model also acknowledges the important role of providers in affecting patient outcomes. Content and relational aspects of physicians' communication are expected to affect especially patients' satisfaction with their health care encounter and participation in health promotion and prevention. Content of communication includes information about prevention, diagnosis, health maintenance, and corrective action. Relational aspects of the physician's communication include support, reassurance, hope, respectfulness and shared decision making. Older patients gain more control when the content of physician's communication is presented using jargon-free information that accounts for their health beliefs and concerns. In turn, older adults are more likely to participate in decision making (Mills & Sullivan, 1999). Research also suggests that the quality

of physician communication is associated with patient adherence to physician's treatment plans, instructions and advice (Kahana & Kahana, 2003). Although the content of physician communication is often highlighted in discussions of the quality of interactions with patients, relational aspects of the communication are equally important but often overlooked (Cegala, McGee & McNellis, 1996; Greene, Adelman, Rizzo & Friedmann, 1994).

Research by Watson and Gallois (2004) illustrates that managing relational needs of patients deserves as much attention as providing accurate information. Using written retrospective accounts of satisfactory and unsatisfactory medical encounters, the authors examined health professionals' use of communication strategies, including emotional expression. In satisfactory health care encounters, patients described health professionals as treating them as individuals, listening to their concerns, allowing them to negotiate topic selection and expressing emotions. Conversely, in unsatisfactory encounters, health professionals did not express any positive emotions, were not responsive, did not show concern and even showed displeasure towards patients. As a result, patients in unsatisfactory encounters were perceived as having less control.

Thus far, we have discussed the need for facilitative environments to counter stereotypes of incompetence and dependence associated with normal ageing. The communication predicament becomes more pronounced for individuals with cognitive-communicative impairments (e.g., dementia), especially those in social contexts that invoke negative age stereotypes (e.g., long-term care facilities). Health providers, especially long-term care staff, tend to maintain misperceptions of poor interactions by using patronizing speech, by neglecting remaining abilities, and by promoting dependent behaviours (Baltes & Wahl, 1996; Richter, Bottenberg & Roberto, 1993; Orange, Ryan, Meredith & MacLean, 1995).

Researchers continue to develop the groundwork for interventions that can prevent or reduce patronizing communication. Baltes and Wahl (1996) demonstrated that training nursing home staff to change the usual independence-ignore script by rewarding independent behaviours led to more independent self-care behaviours by the residents. Other researchers have proposed incorporating personhood (Kitwood, 1997) and simplifying language (Kemper & Harden, 1999) to communicate clearly with people with dementia while minimizing the patronizing tone. Using a vignette evaluation method, Savundranayagam, Ryan, Anas and Orange (2005) investigated whether long-term care staff depicted using personhood strategies would be perceived more positively than those using directive language. They also investigated whether perceptions of the resident

depicted identically in the scenarios would differ in personhood versus directive conversations. Finally, they examined whether simplifying complex language and adding repetitions would influence the positive effect of personhood on perceptions of LTC staff and residents. Results showed that personhood-based language had positive effects on both perceptions of staff and residents. Simplified language strengthened those effects by showing staff as less patronizing, and residents as more competent. Therefore, in support of the CEM, changing staff communication alone empowers both staff and residents.

conclusions

In this chapter we have focused on older adults as care receivers and caregivers, noting that empowerment has a function in both roles. Moreover, we have highlighted the importance of facilitative social environments that provide opportunities for older adults to be active participants in important decisions, especially within health care encounters. Acknowledging that power differentials exist in everyday encounters for older adults, we have argued that communication can be a useful resource in narrowing gaps in power. Older adults can use the strategies we have outlined, notably assertiveness, to participate in activities that matter to them. Learning such strategies engenders confidence, which can help older adults resume former roles or gain new ones, as well as select appropriate goals. Although we have focused on empowering older individuals, many of the strategies considered in this chapter can also be extended to other vulnerable groups, including women in male-dominated settings, ethnic minorities, and individuals with chronic diseases and disabilities (Hummert & Ryan, 2001).

Future research should consider the impact of different communication strategies on personal control, and also investigate the extent to which increasing personal control affects older adults' participation in activities that are important to them. Additionally, future research should consider the longer-term impact of communication skills training. Currently, it appears that communication skills training is effective before a health encounter; more research is needed on whether such training programmes affect older adults' decisions to follow-up with a health provider and use the learned skills. Certainly, systematic, longitudinal studies are needed to evaluate the role of communication on context awareness, personal control and participation, and to consider the interplay between those aspects of empowerment.

Our goal in this chapter was to promote opportunities for vulnerable older adults to age successfully through their own enhanced communication skills and through the improved communication skills of those interacting with them. We hope that readers agree that older adults and health providers alike need to examine whether expectations go beyond age and/or disability stereotypes to consider older adults in individualized interactions. The quotations throughout this chapter illustrate that the accomplishment of ageing must be embraced and that empowerment comes from within the individual and from healthy interactions with others.

> We who are old know that age is more than a disability. It is an intense and varied experience, almost beyond our capacity at times, but something to be carried high. If it is a long defeat it is also a victory, meaningful for the initiates of time, if not for those who have come less far. (Scott-Maxwell, 1979, p.5)

acknowledgements

We would like to thank Ann Anas, Jake Harwood and the editors for comments on this chapter. We also acknowledge financial support from a grant to E. Ryan from the Social Sciences and Humanities Research Council of Canada.

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