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Subjective Health: The Roles of Communication, Language, Aging, Stereotypes, and Culture

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Abstract

A consensually-agreed position among scholars of communication and aging is that while psychological and physical health mutually impact each other, the quality of *language* to and from older adult individuals shape each of these—and are shaped by them. Encounters with others inside and outside of one's age ingroup involve stereotyped expectations with regard to language and other speech behaviors, resulting in reinforcement of age-based stereotypes and changes in social interaction, personal control, and self-esteem. These outcomes interfere with the quality of care an older adult receives from medical practitioners as older patients simply enjoy more communication satisfaction with supportive physicians than those who utilize negative age stereotypes and language. Many studies have been language-oriented as evident in attention to patronizing talk, painful self-disclosures, and stereotypes. We overview some of the major findings arising from the study of language and aging, with a view to articulating a more cohesive, integrative model that can coalesce previous theoretical and empirical efforts.

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1. Introduction

The study of communication and aging is a flourishing, multi-method field that has theoretical and practical implications for health and health care (see Greene, Adelman, Friedmann, & Charon, 1994; Harwood, 2007; Nussbaum & Coupland, 2004). Indeed, a consensually-agreed position among scholars of this genre is that while psychological and physical health mutually impact each other, the quality of *language* to and from older adult individuals shape each of these—and are shaped by them (Giles, 2014). Indeed, encounters with others inside and outside of one's age ingroup typically involve stereotyped expectations with regard to language and other speech behaviors (see Harwood, Giles, & Ryan, 1995) and, as such, can result in reinforcement of age-based stereotypes and changes in lessened social interaction, loss of personal control, and self-esteem (Giles & Gasiorek, 2011). Moreover, these negative outcomes can interfere with the quality of care an older adult receives from a medical practitioner as older adult patients simply enjoy more communication satisfaction with compassionate and supportive physicians than those who utilize negative age stereotypes and language (Greene et al., 1994). Furthermore, many studies in the area of intergenerational communication and aging have been language-oriented as evident in attention to patronizing talk, painful self-disclosures (PSDs), and stereotypes.

In this article, we briefly overview some of the major findings arising from the study of language and aging, with a view to articulating a more cohesive, integrative model that can coalesce previous theoretical and empirical efforts. This enterprise is largely based on our own research program—one that is, arguably, among the most empirically and theoretically robust in this area. Before presenting our model, research and theory, including cross-cultural forays, foundational to this agenda will be overviewed.

2. Accommodative/Nonaccommodative Phenomena and Well-Being

In our own age-related courses over the years, students consistently estimate that, (only) 8% of their interactions involve unfamiliar older people (viz., those over 65-years of age), and the number increases to 12% if family members (or family-like elders) are included. Put another way, intergenerational contact for these two age groups is rather minimal. Furthermore, young adults report that, when they actually do communicate with older people they report it as dissatisfying, with Williams and Giles (1996) having found that the former will place the blame on older people for this outcome. Younger people also acknowledge that, they *avoid* interactions with older adults and if they find themselves in intergenerational situations, try to end them quickly (Ryan, See, Meneer, & Trovato, 1992). Such a disturbing communicative landscape (see Williams & Coupland, 1998) is not simply a feature of individualistic societies in the West, but also has been documented, with important caveats (see below) in culturally-diverse contexts, such as Eastern Europe, South and West Africa, and South and East Asia.

Communicative avoidance is not the only negative tactic that a younger communicator can take towards an older one. For instance, language choices by elder communicators that result in under-accommodative talk (Gasiorek, in press) are that which is topic-tangential and overly-effusive where older people can be seen to disclose too immediately, inappropriately, and excessively about difficult situations in their past (Coupland, Coupland, & Giles, 1991). Such under-accommodative language selections often takes place in the form of painful self-disclosures which, amongst older communicators, typically consist of unfortunate personal information on topics such as poor health, immobility, or bereavement and often perceived by others as disconnected, egocentric, or 'grumbling'. PSDs are typically perceived as abrupt and younger recipients of them may experience anxiety due to their uncertainty about how to respond (e.g., Fowler & Soliz, 2010). This process often leads to avoidant communicative tactics by younger people given they feel uncomfortable and dissatisfied with their interactions with older others. In effect, both age groups communication and language choices result in an inability to accommodate each other and, therefore, they both miss potentially valuable opportunities for further communication and

the sharing of potentially valuable information and views.

These outcomes become more salient when considering studies that have found an association between the above phenomena and the subjective health indices of self-esteem, life satisfaction, and depression (e.g., Cai, Giles, & Noels, 1998; Giles, Ryan, & Anas, 2008; Noels, Giles, Gallois, & Ng, 2001). More specifically, the more frequently older people report feeling that they have not been accommodated to by younger people, the lower their psychological well-being. In other words, older adults' quality of life is reduced if they feel put-down, left to deal with the negative encounters on their own, and avoided in conversations with younger people altogether. In short, older adults' subjective *health* can be compromised as a result of certain *language and communication usages* enacted by younger adults.

Arguably, the first attempt at theorizing about the interfaces between language, communication, aging, and health was the 'communication predicament of aging' (CPA) model (Ryan, Giles, Bartolucci, & Henwood, 1986). This framework, like the later stereotype activation model (e.g., Hummert, 2011) was inspired by communication accommodation theory (see, for example, Giles & Soliz, 2014) which proposed that there are important relationships between intergenerational accommodation and subjective well-being (Watson, Jones, & Hewett, in press) as ultimately documented above. The CPA attends to how younger people's negative stereotypes of older people (e.g., as frail, old-fashioned, communicatively incompetent, and despondent)—or rather certain older people (see Hummert, 2011)—may prompt them to adopt over-accommodative language choices that are very simple and exaggerated in intonation. Any continuation of these types of language usages can lead some older individuals to question if they are as truly as incompetent as messages to them from younger people suggest.

As a result, in a self-fulfilling prophecy, older people can accept the ageist characteristics (such as a slowed gait and voice perturbations) implied by younger persons' language choices towards them and even behaviorally re-enact them, despite the reality that a particular older adult may be completely competent and independent. These negative self-perceptions may cumulatively lead to social withdrawal, a lessened sense of self-worth, and even somatic changes accelerating physical deterioration. Furthermore, age stereotypes can lead to communicative failures between older adults and their younger health care providers as well as between various specialties and agencies that provide their care. Communication accommodation theory (CAT) is one framework that can help reduce miscommunication in these situations by alleviating disparagement of outgroups (e.g., doctors and nurses using overaccommodating language and tone with their older patients), thereby allowing more effective and accommodative language selection, and, hence, better patient care.

Moreover, reinforcement of negative age-based stereotypes has been found to be attenuated when older people become more assertive in response to patronizing language and the like (e.g., Harwood, Giles, Fox, Ryan, & Williams, 1993). This kind of communicative environment can be empowering to both sides, and can assist in dispelling negative age stereotypes instead of reinforcing them. That said, given that older adults can also negatively stereotype younger people by expressing disapproving opinions about life styles and values (Giles & Williams, 1994), short-term intervention strategies aimed at promoting healthier cross-age interactions should to be created for older people as well as younger (Williams, 2006; Williams, Kemper, & Hummert, 2003).

Complementarily, Giles, Davis, Gasiorek, and Giles (2013) proposed that, certain language choices among older folk promoted successful or unsuccessful aging. Testing an elaboration of this 'communicative ecology mode of aging', Fowler, Gasiorek, and Giles (in press) found that positive intergenerational communication experiences (e.g., not categorizing as old, not teasing others about their age, and expressing positive sentiments about the aging process) were associated with lower anxiety, lower uncertainty about the aging process, and higher efficacy in managing aging dilemmas, all of which lead to greater feelings of empowerment and successful aging. In a follow-up study using

latent class analysis on these (New Zealand) data as well as an additional American sample, Gasiorek, Fowler, and Giles (in press) found that, there were subtypes of older people who were more or less successful agers and had, correspondingly, different communicative practices and language implementation.

It is crucial to note that, while much of the literature has highlighted supportive and comforting language choices as being integral components of elder care (Farzadnia & Giles, 2015), communication accommodation practices are not always isomorphic with supportive tactics. For instance, high social support and accommodative language selections can lead to poor health outcomes in instances of co-dependency or enabling the furtherance of harmful communicative and personal habits. Sometimes high social support mixed with *non*-accommodation can enable positive health outcomes, by confronting older patients about their prevailing disabling behaviors and, sometimes, self-indulgences (see Williams, Giles, Coupland, Dalby, & Manasse, 1990). This communicative stance would require that elders' would cognitively re-assess their current condition in pursuit of more health-promoting behaviors. In addition, as noted above, Greene et al. (1994) have found that, older patients are more satisfied with their medical care when physicians use supportive language.

3. Cross-Cultural Intergenerational Communication Research

Many of the abovementioned studies have characteristically been conducted in 'Western' settings, mostly in the UK, Canada, Australasia, and the USA. However, there is a significant body of cross-cultural research and complex patterns have emerged between nations regarding intergenerational communication that space precludes a detailed analysis (for a summary of findings, however, see Appendix 1, Table 1). One consistent finding across very different cultures, including South Africa, Ghana, Mongolia, Iran, India, and Bulgaria (e.g., Giles, Hajek, Stoitsova, & Choi, 2010; Giles, Khajavy, & Choi, 2012), is a 'communicative respect-plus-avoidance pattern'. As participants move from assessing younger adults to middle-aged to elderly people, the more positively these age targets are perceived in terms of certain age norms (e.g., politeness and deference) and positive age stereotypes (e.g., kindness and wisdom) but, at the same time and linearly, they reported to being avoided more. Interestingly, the less young Indians felt a need to use more polite language when communicating with older people and the more they perceived them as benevolent and active, the more communication satisfaction they reported with elders (Giles, Dailey, Sarkar, & Makoni, 2007).

When cross-cultural *differences* emerge, intergenerational communication climates are perceived, perhaps surprisingly given traditional philosophies, more *un*favorably in Asian contexts such as the Vietnams, the Philippines, China, and Japan than in 'Western' settings (Giles, McCann, Ota, & Noels, 2002). For instance, and compared to an American sample, younger adults in the Philippines and Japan were more likely to perceive their communication with older others as negative, felt more obligated to show deference, and more likely to avoid communicating with older others than their American counterparts (Ota, Giles, & Somera, 2007); these perceptions, in turn, were associated with negative subjective health outcomes for older adults. Similarly, Mongolian youths were not as polite to their older counterparts as those in the USA, yet were more deferent and less likely to avoid communicating with them (Choi, Khajavy, Giles, & Hajek, 2013).

These more negative perceptions are also manifest in Thailand and in the organizational sphere (McCann & Giles, 2007). Here, younger Thai workers possessed more negative stereotypes, such as older workers (i.e., those over 40 years of age) make more mental mistakes, are slower to adapt to new technology, are more fearful of technology, and are less flexible at work than younger American workers. On the other hand, they also embraced more positive stereotypes, such as older workers are absent less, have a better attitude toward work, and have a higher level of commitment to the organization than younger workers. The younger Thai workers also perceive members of their own age ingroup as communicating in a more nonaccommodating manner with older

workers than do younger American workers (McCann & Keaton, 2013). In both studies, there were main effects for nationality, suggesting that, there was a consistent overall difference in the manners in which younger Thais and Americans perceive their older and younger counterparts in terms of stereotyped and accommodative language.

Finally, elder psychological health has also been predicted by how much elder people report their *same-aged peers* accommodate them or not. For instance, in the People's Republic of China and Thailand, older adults' communication perceptions have been found to be related to feelings of depression, self-esteem, and a sense of coherence (e.g., Cai et al., 1998; for Thailand, see Keaton, McCann, & Giles, in press; Noels et al., 2001). Consequently, ingroup *and* outgroup communication perceptions are important to any model informed by CAT (see Barker, Giles, & Harwood, 2004).

4. Towards an Integrative Framework

In the above sections, and without recourse to their visual representations, a number of different, albeit allied, models have been highlighted (Fowler et al., in press; Harwood, Giles, Fox, Ryan, & Williams, 1993; Hummert, 2011). Clearly, we are blessed with an abundance of separate models, yet they can work cumulatively against overall coherence and parsimony. In response to this state of affairs, we propose (an admittedly schematically complex) model that synthesizes and does justice to the many processes and phenomena outlined above. This framework begins by targeting a prototypical (and problematic) intergenerational encounter where conversational participants are confronted with negative age stereotypes that can lead to a variety of positive and negative behavioral options (see Appendix 2, Figure 1). Focusing thence on the older adult's behavioral options, there are a variety of language selections an communicative tactics they can enact. When the older adult chooses to use under-accommodating or non-accommodating language (perhaps by offering unwanted or unsolicited painful self-disclosures), these selections often lead to a negative cognitive assessment by the younger other. When younger others consequently veer toward negative perceptions of older folk, this inclination can result in the reinforcement of negative age stereotypes which, in turn, leads to avoidance by the younger individual. This trajectory can then lead to a variety of outcomes for the older adult, including higher anxiety, lower subjective well-being, lower communication satisfaction, and increased uncertainty about the aging process ahead of them. The cumulative outcome for the older other would be an inclination towards unsuccessful aging. On the other hand, if the older adult chooses to be assertive, it can lead to a positive assessment by the younger others, dispelling negative age stereotypes, leading to more frequent, quality communication, less avoidance, and more respect. In this instance, the older adult often feels more positive subjective well-being and empowerment that can promote successful aging. Nonetheless, it can also lead to younger adults feeling threatened and find it difficult to manage (Harwood et al., 1993).

The younger individual is also faced with language choices concerning over-accommodation, accommodation, politeness, and/or deference. As noted in many studies above, over-accommodative language is perceived as patronizing by socially- and cognitively-active older adults. Hence, this tactic can lead to negative cognitive assessments the reinforcement of negative age stereotypes and avoidance, with older people thereby fewer positive feelings about their subjective well-being, lowered empowerment, and lessened feelings of successful aging. Accommodative and polite language selections, on the other hand, lead to precisely the opposite outcomes.

5. Concluding Remarks

This model centers on the importance of language choices and communicative tactics in intergenerational encounters that invite negative age stereotypes. Several important implications emerge, and although as we mentioned the complexity of the model above as a potential limitation, the crux is the moment when intergenerational participants are faced with language choices (or dilemmas) with regard to negative age stereotypes. One suggestion is that, for older adults to experience greater subjective and physical

health and more positive feelings of successful aging regardless of culture, they should avoid under- or non-accommodating language when communicating with younger caretakers. Indeed, it has been suggested that, under certain circumstances, such communicative patterns can processually lead to elderly people ultimately being the recipients of certain kinds of elder abuse (see Lin & Giles, 2013). Instead, older adult patients might choose to use more assertive language in the face of communicative ageism yet also take into account the values and communicative needs of their younger counterparts. Reciprocally, it can be helpful for younger communicators in these situations to use polite, compassionate, supportive, and accommodating language. With all good nurturing intents aside, younger adults should avoid over-accommodative and patronizing language to achieve intergenerational harmony.

In parallel, this approach can have important ramifications for the medical and health care arenas. For instance, the manner in which clinicians communicate to their patients can have adverse effects on their careers. Whether the clinician is older or younger, the intergenerational language selections outlined above can help establish better relationships and better care of older patients. Older patients have more satisfaction and experience better feelings when they are confronted with accommodating language, and this tactic is just as easily assumed by physicians and health workers. Clinicians should avoid over-accommodative language with cognitively-alert elder patients, especially in the form of elderspeak that can lead to resistant behaviors by the latter, as well as be cautious about invoking such tactics with those who have illnesses such as dementias and whose cognitive and emotional capacities might be under-appreciated. Under-accommodative and non-accommodative language—and particularly any disposition towards negative age stereotypes—should also be avoided by health care providers when dealing with older patients. These tactics should lead to better communication between clinicians and patients, better subjective self-esteem for older patients, and overall better patient care.

Hopefully, our integrative model of intergenerational communication and subjective health (and the attending research) can have utility not only for interacting with, and caring for, older people but also can have value for medical education. Obviously, our model needs to be subjected to empirical scrutiny by examining ongoing intergenerational discourse, focusing also on the critical roles of different age groups, gender, sexual orientation, and health status to name but a few. The manners in which we perceive and react to others—whether of similar or differing ages—have important implications for our relationships, personally and professionally. These choices and dilemmas can have an effect on the way we feel about ourselves mentally and physically as well as whether we are aging and managing our lives successfully. Finally, it is our contention that it is not so much age being in the mind and how old you feel, as much as: you are as old as you communicate, are communicated to, and are communicated about that leads to efficacy in managing the process of our successful and healthy aging.

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Appendices

Appendix 1

Table 1

The Relationship between Intergenerational Language Choices and Subjective Health Outcomes

		Communication Factors						Subjective Health Outcomes					
	P	IG	PS	NS	NA	OA	A	D	SE	CSE	S	LOC	WB
Revenson (1989)													
USA	O	+	+	-			+				+		
Harwood et al. (1993)													
USA	O	+				+					-		-
Greene et al. (1994)													
USA	O	+	+				+				+		
Cai et al. (1998)													
People's Republic of China	O	+						+	+	+			
Giles et al. (2005)													
USA	Y	+									-		
Republic of South Africa	Y	+									-		
Ghana	Y	+									+		
McCann & Giles (2007)													
Thailand	Y	+			+								
USA	Y	+			+								
Giles et al. (2007)													
India	Y	+									-		
Giles et al. (2008)													
UK	Y	+									+		
Giles et al. (2010)													
Bulgaria	Y	+									-		
USA	Y	+									-		
Giles & Gasiorek (2011)													
multiple studies	O	+		+					-			-	
Giles et al. (2012)													
Iran	Y	+									-		
McCann & Keaton (2013)													
Thailand	Y	+	+	+									

Note: P=age perspective; O=older; Y=younger; IG=intergenerational communication; PS=positive stereotypes; NS=negative stereotypes; NA=nonaccommodation; OA=overaccommodation; A=accommodation; D=depression; SE=self-esteem; CSE=collective self-esteem; S=satisfaction; LOC=locus of control; WB=well-being

Appendix 2

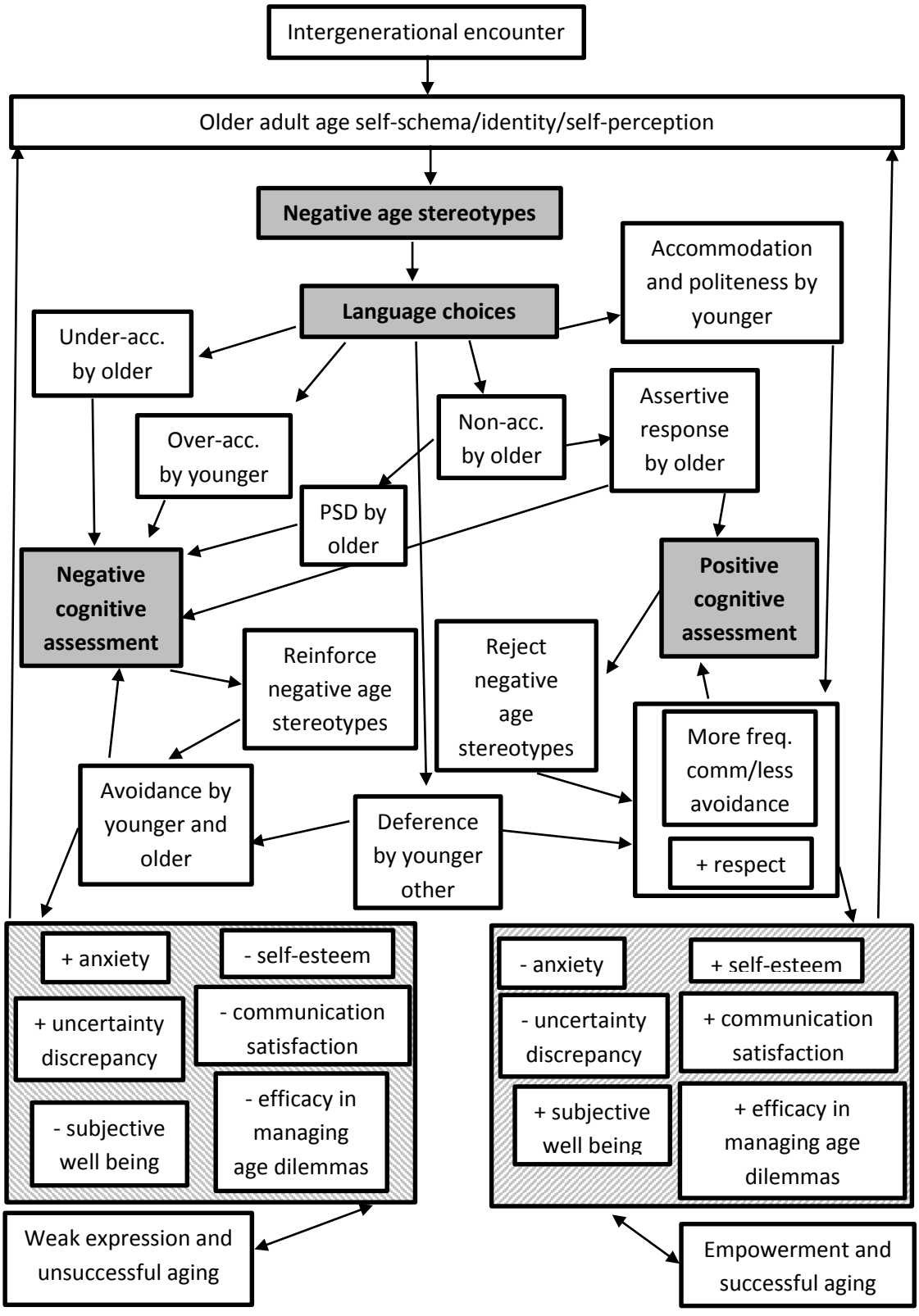

Figure 1
The Integrative Intergenerational Communication and Subjective Health Model