Language, Communication, and Expectations in Aging: Insights for Interactions with Patients

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Overview of presentation

- My perspective: A linguist among clinicians
- Building blocks
  - Focus on language and communication
  - Focus on aging
  - Focus on health context
- Challenges at the intersection: Language and communication in health care visits with aging patients
- Brief workshop with recording and transcript of physician-patient visit
- Recommendations
- Closing comments
- Questions/Responses
A linguist’s perspective on language: one of many

What is a linguist? Analyst of language structure, history, acquisition/learning, and how language works in the world

Analysis connected to *Professional Vision* (Goodwin 1994)
“All vision is perspectival and lodged within endogenous communities of practice. An archaeologist and a farmer see quite different phenomena in the same patch of dirt.”
Life as a linguist among clinicians

- Alzheimer’s disease and conversation
- Defense Head Injury Project (Walter Reed Army Medical Center)
- “Hospitalk” project
- Genetic counseling as discourse
- BMT-Talk: Online health support groups
- Managing the Dialogue between MDs and patients
- Health literacy in interaction
- Alzheimer’s and the arts: Museums and performance
Applied linguistics: “the theoretical and empirical investigation of real-world problems in which language is a central issue” Brumfit (1995)
Objectives

At the end of the presentation, the attendee should be able to:

1. Recognize ways in which cultural notions about aging and related changes may affect interactions between health care providers and their patients;
2. Describe general characteristics of health care provider-patient interactions that may present challenges to effective and satisfying communication;
3. Consider how age-related changes in an individual’s communication may affect his or her interactions with health care providers.
The power of language/communication in health care

Video recording of a 70 year old woman with Type 2 Diabetes, Francine C., talking about language/communication in its relation to her perception of her physician (DVD clip)

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Language/Communication, Aging, and Health Visits

Language and communication in health visits with aging patients
Building Blocks: Focus on Language/Communication

Aging

Language and communication in health visits with aging patients

Language & comm.

Health care visits
Focus on Language and Communication

Public discourse

Contexts of communication
activities & physical environments

Communicative analyses
speakers’ words and actions
“When people talk they communicate not only information but also images of themselves....

Ways of showing that you’re interested, glad, or angry; how and when to tell a joke or a story; when to start talking and when to stop; when (or whether) it’s appropriate to talk at the same time that someone else is speaking; how loudly to talk; what intonation to use --- these and many other features of language are not typically questioned by speakers, but they vary widely....

Conversational style is not something extra or fancy, as if some people speak with style and others speak plainly. Rather, conversational style refers to the basic tools with which people communicate. Anything that is said must be said in some way, and that way is style.”

Tannen (2005: 3-4) Conversational Style
More on the importance of language variation (or why we all don’t say things in the same way)

No one-to-one correspondence between language and actions, thoughts, perceptions, emotions

Language can be one window into differences in the ways individuals see the world

Resulting differences in language use can lead to ‘cross-talk’ / when we think we are understanding each other but actually are not
Sample methodology to identify underpinnings of ‘crosstalk’ in health care provider-patient interaction

Audio-video recordings of provider-patient visits

What was said?

Separate post-visit interviews with providers and patients

What was understood?

Where were providers and patients “aligned” on understandings?
Where was there misunderstanding?

Was there a communicative pattern to provider-patient alignment?
How language varies

- **Word choice** (referring terms for people, objects, actions)
  - *your sugars, your blood glucose*

- **Use of negation** (window into expectations – of self and others)
  - *I had sugar because I didn’t have any Sweet n’ Low left*

- **How ‘reality’ is carved up into ‘events’ – what is mentioned**
  - *I got a man to take me home because I was too dizzy.*

- **What is not mentioned; what is presupposed**
  - **DR:** *The best thing is to check your blood glucose with your meter right away.*
  - **PAT:** *I’m not using that.*
  - **DR:** *Oh, you don’t have a meter?*
  - **PAT:** *I have it, but I’m not using it... I don’t know how.*
How language varies (continued)

- **Expression of agency**
  - *I don’t know how.* (low agency)
  - *I don’t want to see her no more.* (high agency)

- **Expression of affect**
  - *I was scared, I was scared.*

- **Expression of ways of knowing (sources of knowledge)**
  - *She said my sugar was a little high this morning.*

- **Expression of levels of certainty**
  - *I can’t eat when I’m not hungry.*
Illuminating discourse coherence

“The production of coherent discourse is an interactive process that requires speakers to draw upon several different types of communicative knowledge that complement more code-based grammatical knowledge of sound, form, and meaning *per se*.”

Specifically located in how words are used to:
- Express ideas
- Exchange and manage information
- Carry out actions
- Display and construct social relations and identities
- Exchange turns-at-talk

Schiffrin (2003)
Unexpected twists and turns in conversation

“Talking with another person is....like climbing a tree that climbs back.”

Fred Erickson (1985: 316)
Climbing a tree that climbs back (example)

Dr: You need to every morning at about the same time eat a little bit of breakfast, [okay?]

Pat: [oh okay]

Dr: And then maybe a little snack between breakfast and lunch. Have a nice small, you know, lunch.

Pat: Okay.

Dr: Maybe a little snack in the afternoon. I’m just meaning like a fruit or some carrots, okay?

Pat: Okay.

Dr: And then your dinner. You need to keep about the same amount of sugar in your blood at all times, okay?

(continued on next slide)
Climbing a tree that climbs back (example cont’d)

Pat: [uh huh]
Dr: [You don’t want to eat a [big breakfast]
P at: [Okay well can I- can I say something?]
Dr: Of course.
Pat: If I eat like ten or eleven o’clock
Dr: Okay.
Pat: Now I won’t eat any more until about eight o’clock at night. I just.. lunch is something I don’t have.
Dr: Okay.
Pat: I’m not hungry. I can’t eat when I’m not hungry.
Dr: Right.
Pat: So what do I do about that?
Dr: Well (three second pause)
Building Blocks: Focus on Aging

Language and communication in health visits with aging patients
One individual’s perspective on age and aging

“The dislocation created out of the contradictions between how I feel and look – and what I know – and how society perceives me – physically, socially, economically, emotionally – is a very real element in every day.”

Randall (1986:127)
Phenomenon of ‘disjunctive’ aging for individuals

Refers to the phenomenon of individuals feeling older or younger than their actual chronological age

Coupland, Coupland, and Giles (1989)
Conceptualizations of age

- **Chronological age**
  calendar time

- **Functional age**
  refers to changes in person’s sight or hearing, appearance, physical and mental health, activity level

- **Historical age**
  refers to one’s age as related to a specific historical event which is significant to the society in which the individual lives (e.g., the Great Depression)

- **Social age**
  refers to the ‘rites of passage’ in a given society (e.g., becoming a grandparent regardless of chronological age)

- **Societal aging**
  ‘ageism’: where a generalized other is projected onto individuals which does not correspond to their own self-image

Based on Counts and Counts (1985) and Copper (1986)
Ageism (Scrutton 1990: 13)

“Where the assumptions made about old age are negative they lead to ageism, which treats older people not as individuals but as a homogeneous group which can be discriminated against.

Ageism creates and fosters prejudices about the nature and experience of old age.

These usually project unpleasant images of older people which subtly undermine their personal value and worth.

Commonly held ideas restrict the social role and status of older people, structure their expectations of themselves, prevent them achieving their potential and deny them equal opportunities.”
Aging, Change, and Perceptions of Change
How are health care visits shaped by these changes?

- Physiologic
- Cultural Products and Practices
- Cognitive
- Professional
- Social
Focusing in on cognitive changes

- Physiologic
- Cultural Products and Practices
- Professional
- Social
- Cognitive
Example of cognitive changes: Alzheimer’s disease & language

Lexical and discourse levels are relatively more affected than phonology, morphology, and syntax.

Although individuals’ language use varies, there is an overall progression to the changes:

- content (topic and sentence construction)
- management of social relations
- more formal, procedural dimensions (e.g., turn-taking, greetings, etc.)

Relatively more automatic processes are generally preserved longer than more conscious processes.

INFLUENCE OF THESE CHANGES ON HEALTH CARE VISITS?
Public discourses regarding dementia: INFLUENCE OF THESE EXPECTATIONS ON HEALTH CARE VISITS?

Neuropsychiatric model with focus on intellect and reasoning (Downs et al)

Hypercognitive culture (Post)

Malignant positioning (Sabat)
‘Loss of self’
‘Empty shell’
‘A long goodbye’

‘As if’ (Vaihinger) self is diminished

Individualized memory

Psychosocial model with focus on relational and aesthetic aspects (Downs et al)

‘Personhood’ movement (Kitwood)

Identification of active coping strategies and lifting self-esteem
Beyond cognition
Beyond memories

‘As if’ (Vaihinger) there is a self trying to be recognized

Interactive memory
L: Once you have that label [Alzheimer’s], it changes the way people communicate with you. Everyone treats you with..uh..you know, they don’t want to=

K: =upset you.

L: Yeah, upset you or anything like that. You’re just treated differently.

Snyder (2006:267)
Building Blocks: Focus on Health Context

Language and communication in health visits with aging patients

Aging

Language & comm.

Health care visits
Four challenges in physician-patient talk (Hamilton 2004)

*Attunement* issues between MD and patient: knowledge, perspective, priorities, and experiences

‘4-walls’ dilemma: how to bring the patient’s ‘lifeworld’ experiences into the office

*General to particular*: how to move between large-scale scientific studies to the particularities of the patient in the office

*Talking the preferred relationship into being*: especially challenging with cognitive changes and with companions (spouse, adult child, friend) who accompany the patient
Four interactional asymmetries in physician-patient talk (Heritage 1997)

Asymmetries of participation (e.g., topic selection, distribution of questions posed)

Asymmetries of interactional and institutional ‘knowhow’ (e.g., ‘routine case’ vs. ‘personal and unique case’)

Epistemological caution and asymmetries of knowledge (e.g., sources of knowledge, kinds of expertise, caution regarding firm positions)

Rights of access to knowledge (e.g., Is one entitled to knowledge? Can one come to it in an appropriate way?)
Narrative medicine (Rita Charon, MD, PhD)

Narrative Medicine fortifies clinical practice with the narrative competence to recognize, absorb, metabolize, interpret, and be moved by the stories of illness. Through narrative training, the Program in Narrative Medicine helps doctors, nurses, social workers, and therapists to improve the effectiveness of care by developing the capacity for attention, reflection, representation, and affiliation with patients and colleagues. Our research and outreach missions are conceptualizing, evaluating, and spear-heading these ideas and practices nationally and internationally.

Mission statement of Program in Narrative Medicine, College of Physicians and Surgeons, Columbia University
All illness, care, and healing processes occur in relationship—relationships of an individual with self and with others.

Relationship-centered care (RCC) is an important framework for conceptualizing health care, recognizing that the nature and the quality of relationships are central to health care and the broader health care delivery system.

Relationship-centered care (Beach et al 2006)

RCC is founded upon 4 principles:

1) that relationships in health care ought to include the personhood of the participants,
2) that affect and emotion are important components of these relationships,
3) that all health care relationships occur in the context of reciprocal influence, and
4) that the formation and maintenance of genuine relationships in health care is morally valuable.

In RCC, relationships between patients and clinicians remain central, although the relationships of clinicians with themselves, with each other and with community are also emphasized.
Challenges at the Intersection: Language, Aging, and Health

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Health care visits
Challenges at the intersection

Focus on language/communication
- Triadic interaction (patient and adult child, spouse, companion)
- Changes that are associated with early memory loss, mild cognitive impairment/dementias

From aging
- Management of comorbidities, multiple medications
- Patient’s social networks/ support system may be changing
- Monitoring mental health and emotion

From health context
- Health literacy issues, changing landscape re health information and where to obtain it
- Different socialization into interactions with healthcare providers
Getting the most out of the clinical encounter:
The Four Habits Model (Frankel & Stein 1999)

Consider how these recommendations may be shaped by aging patients:

**Invest in the beginning**
- Create rapport quickly
- Elicit patient’s concerns
- Plan the visit with the patient

**Elicit the patient’s perspective**
- Ask for patient’s ideas
- Elicit specific requests
- Explore the impact on the patient’s life
Getting the most out of the clinical encounter: The Four Habits Model (Frankel & Stein 1999)

Demonstrate empathy
- Be open to patient’s emotions
- Make at least one empathic statement
- Convey empathy nonverbally
- Be aware of your own reactions

Invest in the end
- Deliver diagnostic information
- Provide education
- Involve patient in making decisions
- Complete the visit
Mini workshop

Watch 7-minute video clip of a physician-patient interaction

Work with the video transcript in small groups

Debrief the small group workshops as a large group

Watch the clip again (if time allows)
Video workshop with transcript

Video recording of Francine C. talking with her physician (first 7 minutes of a 15 minute visit)

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Recommendations

- Recognize simple but profound importance of ‘conversation as care’ (E. Ryan)
- Encourage increased offerings of/participation in activities that are socially engaging and/or cognitively stimulating, including intergenerational ones (arts, sports, discussion groups, professionals networks, mentoring, etc.)
- Provide workshops on aging-in-place for family members and community volunteers
- Offer outreach opportunities for support group members to broader community (ex: ‘To Whom I May Concern’ project of Maureen Matthews for early memory loss groups)
- Educate nurses’ aides and other team members in assisted living centers regarding the vital importance of engaging communication opportunities (‘conversation as care’, memory boxes, letter writing initiatives)
- Play close attention to the public image of aging individuals (both language and visual images) in health campaigns, advertising of community resources for seniors, etc.
Your power as health care providers to be uplifting

Video recording of Francine C. talking about her physician (DVD clip)

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In closing

I hope these thoughts have illuminated the mutual influence of aging and communication within health care interactions.

Be ever mindful of the tree that climbs back!
Questions, Comments, Discussion

THANK YOU FOR YOUR ENGAGEMENT!
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Selected relevant works (1 of 3)


Selected relevant works (3 of 3)


