Aging is a complex and ever-changing process from life’s birth until its close. In the year 2000, males in the United States living until the age of 65 had an average of 15.8 years of life ahead and females 19.3 years (Olshansky & Carnes, 2001). As life expectancy continues to grow, improving the quality of life in the later years has become a central research agenda in numerous disciplines. Applied communication research is no exception and has been instrumental in connecting three life facets—the physical, psychological, and social—identified as vital components of successful aging (Rowe & Kahn, 1998). Applied communication research is exceptionally well situated to examine the aging process of older adults in light of these complex facets. Not only is communication central in life at all ages but it also plays a fundamental role in maintaining the good health and quality social support needed to enhance the well-being of older individuals. An applied communication perspective allows theory and research to be linked with practice, which has the potential to improve the aging process at the later end of the life span.

Applied communication research in the context of aging has concentrated primarily on addressing environments in which older individuals manage problematic health matters associated with growing older (e.g., Beisecker, 1989; Charles, Goldsmith, Chambers, Haynes, & Gauld, 1996; Greene, Adelman, & Majerovitz, 1996; Ryan & Butler, 1996). Dominant avenues of research in the framework of aging have explored the communicative experience of living in long-term care facilities/communities (e.g., Carpiac-Claver & Levy-Storms, 2007; DiBerardinis, Barwind, & Wilmot, 1981; Hullett, McMillan, & Rogan, 2000; Sigman, 1986; Williams & Guendouzi, 2000) and the challenges of communicating with family members who have Alzheimer’s disease and related dementia (e.g., Baxter, Braithwaite, Golish, & Olson, 2002; Orange, 2001; Orange, VanGennep, Miller, & Johnson, 1998; Ory et al., 1985; Polk, 2005). Other related lines of inquiry have focused on managing the stigmas and stereotypes of older age (e.g., Harwood, Giles, Fox, Ryan, & Williams, 1993; Hummert, 1998; Sachweh, 1998; Williams, Kemper, & Hummert, 2003) and dealing with the complexities and obstacles associated with intergenerational exchanges (Anderson, Harwood, & Hummert, 2005; Giles, Dailey, Sarkar, & Makoni, 2007; Harwood, 1998; Lin, Harwood, & Hummert, 2008; Mesch, 2006; Ota, Giles, & Somera, 2007; Williams & Giles, 1996; Williams & Nussbaum, 2001).

These research areas address critical experiences that punctuate the course of aging for older persons. The focus on such problematic experiences, however, often overshadows work that aims to describe, explain, and enhance the normal or usual aging experience—the more mundane aspects of the aging process that make up day-by-day living for older adults. *Older adulthood*, as typically defined as the period of life after age 65, often is stereotyped as a single stage of life wrought with poor physical and mental health (Schaie & Willis, 2002). A more accurate view of aging stems from a life-span developmental...
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approach that emphasizes aging, even at the latter end of the life span, as a process. After all, “the physical and mental changes in the 30 years prior to the end of life are, in most respects, far greater than changes over a similar time span at other ages” (Schaie & Willis, 2002, p. 79). Age 65 can be viewed simply as a chronological number marking a natural part of life with unique concerns and rewards that can provide a very gratifying existence from that point through the entirety of a life span.

Thus, to challenge the notion that the pathological course of aging is typical, a central part of this chapter concentrates on the issues associated with the normal course of aging. In addition to reviewing what applied communication research has uncovered about understanding and improving communication competencies associated with the problems of aging, we also examine what scholarship has revealed about enhancing communication in the normal, everyday experience of aging. To link applied communication research on aging to practice, an understanding of the basic, biological considerations of aging should be part of any context of inquiry. As such, we first review normal changes in communication faculties that occur as being individuals age. We then consider two avenues of applied communication research identified as being of most concern for aging adults: health communication (see Kreps & Bonaguro, this volume) and interpersonal communication. We review not only research that has been conducted to solve pathological problems associated with aging but also research that focuses on pragmatic questions facing older adults in everyday life. We close by offering recommendations for future applied communication research on aging.

Changes in Communicative Faculties in Older Age

“Usual aging,” as described by Rowe and Kahn (1998), refers to well-functioning individuals at the later end of the life span who are at a substantial risk for disease or disability. Although aging persons do not necessarily fall prey to disease and disability, a gradual decline in functioning is “usual” for most individuals. “Optimal aging,” in contrast, occurs when old age is characterized by health, energy, and fitness that is better than that found in the average population of that age (O’Hanlon & Coleman, 2004). Although optimal aging may not be typical, a “normal” course of aging for older adults is not a “pathological” one in which there is clear evidence of physical or mental deterioration. Understanding the usual/normal changes for individuals as they age, thus, is important in applied communication research, as these changes can help to explain and then correct some of the communication dilemmas that individuals encounter as they age.

A number of physiological and psychological changes that influence communication occur as adults age. The most widely recognized and researched physiological issue influencing communication in older age is prescubysis—the aging of the auditory system (e.g., Nerbonne, 1988). Prescubysis affects elderly persons’ relationships due to its effects on the ability to process the content of speech (e.g., Carmichael, 1988; T. L. Thompson & Nussbaum, 1988). A typical feature of prescubysis is that listeners have trouble discriminating, listening, and comprehending words, phrases, and sentences, yet can detect that talk is occurring (e.g., Harford & Dodds, 1982; Pichora-Fuller & Carson, 2001; Villaume, Brown, & Darling, 1994; Villaume & Reid, 1990). Prescubysic listeners usually find that their difficulties with listening are amplified when environmental factors, such as background noise, disrupt the situation (Villaume et al., 1994). To compensate for their hearing and listening difficulties, prescubysic listeners often adjust their verbal interaction styles in conversations. For example, Ragan (1983) noted that prescubysis listeners use a variety of aligning actions or explicit verbal forms of metacommunication (e.g., “I didn’t hear what you just said”) to adapt to problematic conversation. Villaume
(1987) found that certain aligning actions, such as metatalk, mediators, clarifiers, confirmations, modifiers of utterance force, and backchannels, increase in middle age and decrease around ages 60 to 71. The use of aligning actions, however, decreases considerably when people are in their late 70s and 80s. Villaume concluded that as middle-aged adults begin to experience the onset of presbycusis, they may deal with the associated problems strategically, thus using aligning actions, in hopes of not appearing to be less powerful in speech. Specifically, Villaume et al. (1994) found that as older adults experience presbycusis, they have a tendency to rely more on people’s nonverbal cues, particularly paralanguage (e.g., pitch, rhythm, volume, and intonation) to comprehend missed speech. Research also has shown that in response to age-related declines in hearing and working memory, elderly persons increase reliance on paralinguistic, prosodic (Cutler, Dahan, & van Donselaar, 1997), and other nonverbal types of cues offered by conversation partners to comprehend and recall speech (e.g., G. Cohen & Faulkner, 1986; Fredrickson & Cartensen, 1990; Stine & Wingfield, 1987; Wingfield, Lahar, & Stine, 1989; Wingfield, Wayland, & Stine, 1992).

Ironically, as older adults rely more on nonverbal than verbal communication, they also exhibit a decreased ability to process these nonverbal behaviors in others (e.g., Hooyman & Kiyak, 1988; Lieberman, Rigo, & Campain, 1988; Neils, Newman, Hill, & Weiler, 1991). For example, older adults, in comparison to younger adults, who serve as the comparison group in research, tend to make more errors in judging facial expressions (McDowell, Harrison, & Demaree, 1994), are less skilled at perceiving and identifying body cues (Montepare, Koff, Zaichik, & Albert, 1999), and have a decreased ability to differentiate levels of emotional intensity (T. L. Thompson et al., 2001). The reasons for such declining abilities in nonverbal interpretation are unclear. More research needs to address changes in the perception of nonverbal and emotional messages as individuals age, because it could have important implications for providing older adults with social support (T. L. Thompson, Aidinjad, & Ponte, 2001) and delivering emotionally laden messages to them, such as negative news in health-care settings.

Research on other physiological changes that accompany aging may provide insight to the causes of decline in nonverbal perceptions in older age. For example, Rousseau, Lamson, and Rogers (1998) synthesized a host of age-related changes in perceptual abilities that affect older adults’ discernment of warnings. Relevant abilities that are affected as one ages include color vision, contrast sensitivity, glare sensitivity, temporal resolution, visual acuity, and visual search. Just as a decline in ability to perceive small details or to track stimulus changes affect people’s capability to process warnings; such changes in perceptual abilities also may be relevant in other communication situations. Perceptual changes also may account for a myriad of environmental distractions that affect communication for older adults.

Various aspects of cognitive change also can affect the communication performance of older adults (Nussbaum, Hummert, Williams, & Harwood, 1996). Working memory, language comprehension, prospective memory, and symbol comprehension (Rousseau et al., 1998) tend to decline as one ages, as well as processing speed and name retrieval (Kemper, Kynette, Rash, O’Brien, & Sprott, 1989). These declines in cognitive functioning can have significant effects for older communicators (which we address in subsequent sections).

Another area of cognitive change associated with aging is Alzheimer’s disease and related dementia (ADRD). Although sometimes stereotyped as part of the normal aging process, ADRD is not part of the usual aging process. The incidence of Alzheimer’s disease is about 5% of individuals over 65, 20% above the age of 85, and 40% after the age of 90 (Lavretsky & Jarvik, 1994). Nonetheless, the number of elderly persons with ADRD
is estimated to double or triple in the next 25 years, making it a public health concern (Kawas, 1999). ADRD has numerous effects of varying severity on communication and language (Kemper & Lyons, 1994). It impairs the semantic memory network (Kempler, 1991) and, as a result, communication is affected due to memory deficits, leading to a gradual curtailment of conversation and perhaps even a withdrawal to mutism (Kemper & Lyons, 1994). The impairments of language and communication can result in empty speech, discourse incoherence, and uninformative content in communication (Kemper & Lyons, 1994), leading to the failure to sustain everyday conversations (Rau, 1991) and to social isolation (Orange, 1991). ADRD poses serious concerns for older adults afflicted by the disease and their family members. However, although a significant portion of the population suffers from a pathological course of cognitive change, as in the case of ADRD, the vast majority of older adults will not be afflicted. Normal cognitive change as a result of aging does not result in ADRD or even a decline in intellect (O’Hanlon & Coleman, 2004). Thus, stereotypes associated with such dementia are not appropriate foundations for interactions with older adults.

The changes, whether normal or pathological, that individuals experience due to physical or psychological declines in later life have important consequences for their communication. These communicative challenges manifest in various important contexts in older adults’ everyday lives. Of specific concern in applied communication research are health-care settings and interpersonal interactions. Therefore, in the following sections, we review literature examining how the challenges of aging manifest in these particular settings.

Health Communication and Aging

Changes in physiological and psychological functioning as a result of the normal aging process are at the forefront of health-care interactions with older patients. As a result, medical professionals must demonstrate sensitivity to the individual needs of each older person without falling prey to stereotypes associated with older age that may taint a medical diagnosis. The communication predicament of aging model (e.g., Nussbaum, Pecchioni, Grant, & Folwell, 2000; Ryan, Giles, Bartolucci, & Henwood, 1986; Ryan & Norris, 2001) provides a framework for understanding how health providers’ expectations for interactions with older patients can affect the medical encounter. The model contends that younger individuals, such as younger physicians, notice physical cues of aging when approaching an interaction with an older individual, triggering negative stereotypical expectations of aging and, thereby, causing physicians to modify their speech behavior in their interactions and provide reinforcement for stereotyped behaviors. For example, physicians not familiar with the medical history of an older patient may apply old-age stereotypes to make the visit more time efficient (e.g., “We expect people in your age group to be lonely and depressed.”). Applying old-age stereotypes may be inaccurate and can result in negative consequences for an elderly person, such as reduced self-esteem, reduced activity, less social interaction, and loss of a sense of personal control.

A host of applied health communication research supports the communication predicament of aging model (Hummert, Garstka, Ryan, & Bonnesen, 2004). Our review focuses on provider–older patient interactions, with specific emphasis on third-party companions during medical encounters and socialization in long-term care settings (for a review of applied health communication with patients who are aging, see Fowler & Nussbaum, 2008).
Provider–Older Patient Interactions

The first point to consider about physician–older patient interactions is the undeniable importance of this relationship. Physician–older patient relationships are more common than physician–younger patient relationships (U.S. Census Bureau, 1999), in part, because older adults are more likely than younger individuals to have more multiple, chronic, and acute medical problems (e.g., Greene & Adelman, 2001). Older adults’ interactions with physicians have critical outcomes for their health and quality of life (T. L. Thompson, Robinson, & Beisecker, 2004). The onset of managed care in the United States precipitated the emergence of a primary care physician who serves as a “gatekeeper” for other medical services (Nussbaum, Pecchioni, & Crowell, 2001), making a primary care physician even more of a focal point in medical care for older persons. Thus, the relational component of physician–older patient interaction is particularly important (e.g., Coupland & Coupland, 2001).

Having an effective, mutually satisfying, and meaningful physician–patient relationship can have consequences for patient adherence to therapeutic regimens, health status, and reduced anxiety (Greene & Adelman, 2001). Applied communication research on the content and interactional processes of physician–older patient medical encounters reveals behaviors that create a high-quality physician–older patient relationship. From their synthesis of research on this issue, Greene and Adelman (2001) concluded that physicians need to actively develop the relationship by acknowledging the personhood and uniqueness of an older patient and supporting that person’s presentation of self or view of his or her health. Research has found, however, that physicians frequently do not give older patients a chance to initiate discussion of concerns (Marvel, Epstein, Flowers, & Beckman, 1999). In light of such findings, Greene and Adelman recommended that physicians take a more “patient-centered” approach that encourages older patients to direct the flow of the interaction. Greene and Adelman also encouraged physicians to create an environment in which older patients feel free to discuss difficult-to-talk-about issues, such as depression, fear of death, advanced directives, memory loss, incontinence, and sexual dysfunction. Older patients often are hesitant to discuss such intimate issues with their physicians, which, obviously, can have severe, negative consequences for effective health care (Greene, Adelman, Rizzo, & Friedman, 1994). Physicians may encourage discussion of more delicate topics by asking questions about the physical, psychological, and social aspects of life that may be relevant factors in the health and well-being of older patients.

Greene and Adelman (2001) also noted the importance of coordinating the various facets of geriatric care. As mentioned previously, older patients frequently have multiple health-care concerns that need to be addressed by various health-care providers. To best provide health care to and develop an effective and satisfying relationship with an older patient, a primary care physician may need to collaborate with other professionals caring for that patient. Nussbaum et al. (2001) suggested that health-care teams are gaining credibility as a necessary unit for geriatric care to manage the multifaceted health problems experienced by older adults. Although research on health-care teams has demonstrated both positive and negative effects (Poole & Real, 2003), such teams potentially can result in high-quality care decisions, particularly for older individuals with diverse medical needs, as well as improve the physician–older patient relationship by helping physicians to treat more effectively the “whole” older person. The current state of medical care, however, may not be conducive to improving communication within the physician–patient visit in these ways, as the managed care culture tends to place limits on the time allotted to each visit and may not support “extra” services, such as the coordination of professionals in the form of health-care teams.
Dependency and control are additional concerns for older adults in health-care settings. Especially in comparison to younger counterparts, older patients often encounter issues of dependency and loss of perceived control from the transmittal of information to assistance in making medical decisions. As a general rule, the more physicians try to dominate the conversation, the less patients are satisfied with the interaction (Bertakis, Roter, & Putnam, 1991). In fact, Adelman, Greene, Chor, and Friedman (1992) concluded that older patients may experience difficulty getting their concerns addressed because physicians dominate conversation by not responding with as much information as such patients desire. Agee and Blanton (2000) reported that health-care providers are more likely to assume “educator” roles than to function as listeners in caregiving decision making by frail elders and their families. Research has shown that, overall, there is less concordance on major health-care goals and topics of conversation between physicians and older patients (Greene, Adelman, Charon, & Friedman, 1989), and that there is less joint decision making in interactions between physicians and older patients. Physicians also are less egalitarian, patient, engaged, respectful, and optimistic with older patients than with younger ones, which further exacerbates the problem that older patients are less assertive than younger patients (Greene, cited in Greene & Adelman, 2001).

A caveat to much of the applied communication research regarding control and decision making in medical encounters is that although older patients desire medical information, they do not always want as much involvement in medical decision making as do younger patients (Adelman, Greene, & Charon, 1991; Beisecker, 1989; Haug & Ory, 1987), perhaps due to life experiences in health care before patient-centered care was a norm. Although no clear-cut directives exist for how to deal with some older patients wanting more control than others, the personhood of older patients is an essential component of overall geriatric care, as suggested previously by Greene and Adelman (2001). Greene and Adelman consequently recommended that physicians take a “values history” or “life review” to understand an older person’s life expectations and to develop an intimate understanding about the patient and his or her preferences. After all, as Greene et al. (1994) concluded, “The better physicians know geriatric patients, the less likely they are to use ageist or other stereotypes to guide communication, diagnosis, treatment, and care” (pp. 248–249). In taking a value history, the physician is likely to detect whether the older patient, in fact, wants more involvement during the medical encounter. The presence of a third party during the medical encounter also can affect the dependence and control that older adults perceive over their health and health-care decisions. Coupland and Coupland (2001) found that a third-party presence in medical consultations between physicians and older patients is relatively common. When third parties are present, they also tend to be active in the consultation proceedings, which, as Coupland and Coupland explained, complicates the medical encounter:

When older patients are accompanied to clinics by a friend or another family member, and when the consultation then becomes, at least in a literal sense, triadic, many relational configurations become possible. For example, the accompanying person and the doctor can enter into various sorts of confederation, perhaps with persuasive intentions, trying to gain the elderly patient’s compliance with a course of treatment or an advised lifestyle change. (p. 122)

Feeling a lack of control easily can arise in an older adult when a third party is involved in a medical encounter. Coupland and Coupland (2001) noted that when third parties
form confederations with physicians to persuade older patients to engage in a particular medical regimen or course of action, older persons feel and become more dependent on those companions. Dependency-inducing communication during the medical consultation also may affect dependency beyond the consultation. For example, if a physician and a third party exclude an older patient from conversation during the medical encounter, the helplessness felt by the patient may transfer to interactions between the older person and the third party at home.

Although third-party companions can complicate a medical encounter, their presence should not be viewed as wholly negative. In fact, Coupland and Coupland (2001) suggested that providing health care for older persons often needs to be a collaborative and multiparty process:

Alternatively, family members may share in voicing the experiences of their co-present elderly relatives, validating their accounts of symptoms or troubles. Third parties may collaborate with patients in telling troubles of describing health and social changes, or they may act as, in a sense, surrogate patients. (p. 122)

Although physicians cannot entirely control the appropriateness and effectiveness of third-party participants, physicians can work with older persons’ companions during a medical encounter to make third-party contributions more positive. Greene and Adelman (2001), therefore, encouraged geriatricians to discuss medical concerns with family members and other caregivers who accompany older individuals, as working with those caregivers can help to provide optimal care for such patients.

Socialization of Elderly Residents in Long-Term Care Settings

Interactions with physicians comprise many of the encounters that older individuals have in medical settings. For older individuals residing in a long-term care (LTC) facility, however, a substantial amount of their daily interactions are health-related encounters that do not occur with physicians. About 20% of those over the age of 85 are likely to need LTC in some form (M. Henwood, 1990), although the quality of care in LTC institutions, which depends largely on the caregiver–resident relationship (e.g., Caris-Verhallen, Kerkstra, & Bensing, 1997), increasingly is a concern (Grainger, 2004). Nussbaum (1990) suggested that studying message exchange in nursing homes could improve their quality of care. Although the value of applied communication research in gerontological settings through discourse analysis (DA) has been advocated (e.g., Bryan & Maxim, 1998; Erber, 1994), most studies do not provide more than a cursory description of communication in nursing homes (Grainger, 2004; for an exception, see Dijkstra, Bougeois, Petrie, Burgio, & Allen-Burge, 2002; for a review of DA in applied communication scholarship, including health communication, see Tracy & Mirivel, this volume).

What applied research has found thus far is that communication in LTC settings is far from ideal. Institutionalized adults tend to have a communicatively impoverished life if only because of the absence of talk (Grainger, 2004). Moreover, the talk that does occur between caregivers and residents in LTC institutions leaves much to be desired. For example, Sigman (1986) conducted observations in nursing homes and found that staff–patient interactions often negatively affected patients’ adjustment. In sum, Sigman found that patient adjustment to a nursing home is a social interaction accomplishment rather than an objective fact or trait. The staff in the nursing home studied contributed to the socialization process by selecting a ward for residents and imposing labels on them (e.g., typical veterans). Staff members also expected residents’ adjustment to be a traumatic experience and, therefore, offered residents medication to ease their transition. As a result, residents’
gradual adjustment to the home was “controlled by the explanatory labels and expectation frameworks held by institutional members” (Sigman, p. 47). When residents rejected a certain label assigned to them, it resulted in more negative labels being applied by the staff to those “recalcitrant” residents. The results of such socialization can have consequences on residents’ psychological and medical conditions.

Grainger’s (1993) study found that communication between institutionalized older people and their caregivers was disjointed due to conflicting institutional and personal goals. Nurses, for example, had many task-oriented goals, whereas residents expressed more relational needs, and, at times, nurses stayed on task-oriented communication and ignored or deflected other issues that residents communicated. Grainger (2004) attributed this tendency to nurse training, which, until recently, typically has lacked grounding in communication and counseling. Although responding to the troubles of older patients can be frustrating, evading or deflecting difficult talk can result in many negative consequences for residents. If their troubles consistently are avoided or dismissed, residents’ physical and mental health likely will be compromised (Grainger, 2004).

Furthermore, as in physician–older people interactions, dependency-inducing talk also occurs in LTC settings. Although mission statements and institutional policies may indicate that a residence or facility is meant to enable residents to become independently functioning members of society, many of the practices and characteristics of institutionalized living actually induce dependency (Goffman, 1961). Research by Grainger (2004) showed that caregivers’ expectations of dependency in institutionalized older adults is apparent in their speech to older adults, just as the communication predicament of aging model suggests. Studies have found that caregivers often speak to older adults in the same manner that people talk to younger children (e.g., using shorter utterances, more redundancy, and more interrogatives) or they use baby talk, both of which create dependency (e.g., Ashburn & Gordon, 1981; Caporael, Lukaszewski, & Culbertson, 1983). Caporael (1981) also discovered that caregivers promoted dependency in those for whom they were caring by using a form of nonbaby talk that tends to have the same content as baby talk but does not exhibit the same prosody, making it less affectionate.

Patronizing communication and negative stereotypes are rampant in interactions not only with the institutionalized elderly but also with older populations as a whole (Hummert et al., 2004) and can have negative consequences for elders. In fact, elderly individuals point to stereotypes as the reason for patronizing speech being used with them (Giles, Fox, & Smith, 1993) and, as a result, they often come to believe that the stereotypes are true (Hummert et al., 2004).

Stereotypes often are activated and acted on as a response to the physical cues of aging, as mentioned previously. Health-care settings, however, are not the only context in which patronizing communication and ageist stereotypes produce significant repercussions; older adults also encounter stereotypes in everyday social settings that can significantly complicate their communicative encounters.

**Interpersonal Interactions**

Maintaining physical and psychological health is a common goal for the great majority of older adults (Rowe & Kahn, 1998) and having an appropriately broad social support network is key in maintaining health in older age (O’Hanlon & Coleman, 2004). Research has established that social support has positive effects on physical and mental health throughout the entirety of the life span. In particular, studies have found a posi-
tive relationship between social support and physical well-being in elderly populations (e.g., Dickson-Markman & Shern, 1990; Ryff, 1991), as well as between that population’s social relationships and psychological well-being (e.g., Nussbaum, 1985; Rook, 1990). Social support also significantly enhances general well-being and provides buffering effects for various stressors, such as serious illness (Albrecht, Burleson, & Goldsmith, 1994; Burleson & Goldsmith, 1998; S. Cohen & Wills, 1985; Coyne & Smith, 1994). Other studies have found that the lack of competent social support is a risk factor for physical and mental health problems (e.g., Bertera, 2005; Kiecolt-Glaser, 1999; Segrin, 2001). As people age, however, they often become more socially isolated due to the death of friends and family members, decreased mobility, illness, and disability (Ade-Ridder & Kaplan, 1993). Decreases in social contacts as individuals age are not necessarily detrimental to the well-being of older individuals, as proposed in earlier gerontological research. Instead, socioemotional selectivity theory (e.g., Baltes & Carstensen, 2003; Carstensen, Isaacowitz, & Charles, 1999; Keyes, 2002) proposes that the importance of the practical aspects of available social interactions, such as information acquisition, identity maintenance, and emotion regulation, change as a function of perceived time. Accordingly, as people age and perceive their time to be more limited, they pay greater attention to the emotional quality of relationships. Hence, although the number of social network members may decline as people grow older, those relationships, depending how well they meet emotional needs, may be more satisfying (Keyes, 2002). Indeed, research repeatedly has demonstrated that older persons’ psychological well-being and morale are significantly associated with the quality of interaction characterizing their stable relationships, but not with the overall quantity of their social encounters (e.g., Conner, Powers, & Bultena, 1979; Lowenthal & Haven, 1968; Strain & Chappell, 1982). Below, we explore research related to the importance of two types of interpersonal relationships—friends and family members—for older persons.

**Friendships**

Although not plentiful, research has shown that friendships in older age are valuable to successful aging and can have a tremendous positive impact on older adults (Nussbaum, 1994). Engaging in a relationship with even one close friend may be enough to inhibit older persons’ demoralization and maintain good mental health (Blau, 1973; Lowenthal & Haven, 1968). Talking with close friends helps older individuals to see each other as valued persons despite changes in physical appearance or capabilities. Friends acknowledge each other as whole persons by recognizing and admiring one another across time and in a variety of social roles and predicaments (Lemon, Bengston, & Peterson, 1972). Friends call on each other for help and support in later life, but they usually do so sporadically or only in emergencies (Cantor, 1979), which can prolong individuals’ sense of autonomy (Rawlins, 2004). Carefully managed requests and aid for help between friends in older age enhances people’s self-esteem; cultivates the voluntary, equal, mutual, and affective qualities of friendships; and helps friends to show caring, competence, and the ability to assist (Bamford et al., 1998). Friendships are voluntary, of equivalent status, and fairly mutual. For these reasons, friends are more closely related to psychological well-being (e.g., Phillipson, 1997) and life satisfaction for older adults (e.g., Chappell, 1983) than are family interactions. Friends relieve loneliness, meet incidental needs, connect individuals to larger communities, and foster ongoing enjoyment of life (Rawlins, 2004). Friendships, thus, play a vital role in sustaining older persons’ well-being and satisfaction.
Family Relationships

Whereas friendships in older age are valued for companionship, familial relationships tend to be valued more for instrumental help (e.g., Bowling & Browne, 1991; Felton & Berry, 1992; Rook & Ituarte, 1999; Stoller & Earl, 1983; Walen & Lachman, 2000). Interactions with kin, as compared to those with friends, have been found to be more preferable for older adults (e.g., Adams & Blieszner, 1995; Reinhardt, 2001). The older one becomes, the greater the tendency to rely on family to accomplish the daily activities of life (e.g., Connidis & Davies, 1992). Unavailability or absence of family members, especially adult children, to assume caregiving responsibilities likely is the strongest predictor of nursing home placement (High, 1990).

Specific family interactions and relationships produce various outcomes for the health and well-being of older individuals. An important, if not the most important, form of social support for older adults is a spouse. The study of communication in marital relationships at the end of the life span, however, has been neglected (e.g., Braithwaite & Baxter, 1995). What research does exist has found that older marital couples are characterized by commitment, mutual dependence, sharing, stability, and high satisfaction (e.g., Huyck, 1996; Nussbaum, Pecchioni, Robinson, & Thompson, 2000; Sillars & Wilmot, 1989). Older marital partners also demonstrate lower rates of institutionalized care than those who are single (e.g., Huyck, 1996). However, very little research has investigated marital relationships that experience critical threats due to serious illness of a marital partner in older age (Braithwaite, 2002). Marital relationships increasingly become important for older adults as couples depend on each other for companionship and physical assistance (Braithwaite, 2002). In fact, when older adults become seriously ill, spouses often serve as the primary caregiver (Huyck, 1996); indeed, Stone, Cafferata, and Sangl (1987) found that close to 36% of primary informal caregivers of adults over the age of 65 were spouses. Husbands and wives, thus, provide a considerable amount of care for their ailing spouse and, over time, adjust very well to their roles (Mares & Fitzpatrick, 2004). Nonetheless, social support for spousal caregivers, especially caregivers of those with ADRD, is critical to the health of the caregiver and can alleviate strains on the marital relationship that are associated with long-term spousal caregiving (Long & Mancini, 1990).

At times, a spousal caregiver, usually the wife, as a woman’s life expectancy is longer than that of a man (Olshansky & Carnes, 2001), no longer is able to care for a partner at home. When a woman’s husband moves into a nursing home, she may experience significant stress, a diminished emotional state, depression, social isolation, and physical illness (Ade-Ridder & Kaplan, 1993). Braithwaite (2002) investigated this state of “married widowhood,” where a wife lives at home and the husband dwells in a long-term care community. Many of the women who experience married widowhood are hesitant to seek out and use formal services available to help them cope with adjustments and transitions that accompany having a spouse enter an LTC facility (Ade-Ridder & Kaplan, 1993; Long & Mancini, 1990). The nursing staff, however, does not usually have the time, training, or motivation to effectively manage the resident’s interactions with the spouse successfully (Nussbaum, Pecchioni, Robinson, & Thompson, 2000). Braithwaite (2002) suggested that more research is needed on helping marital partners to better maintain and enact their marital relationships after a partner moves into a nursing home.

For older adults with children, the adult–child relationship becomes increasingly important as individuals age. Golish (2000) noted that the parent–child relationship is one of the most enduring and dynamic relationships that individuals have over the course of their life span. Mutual helping between parents and their children is charac-
teristic across the life span (Cicirelli, 1981, 1983; Troll, 1986). Parents often provide support to their children well into their adult years (Bankoff, 1983; Ward, 1996), but after a parent reaches the age of 75, children begin to provide caregiving services for parents (Nussbaum, Pecchioni, Robinson, & Thompson, 2000; Ward, 1996). Despite the fact that adult children typically are called on to provide care for their parents at some point (Miller, Shoemaker, Willyard, & Addison, 2008), parents and their adult children rarely discuss parents’ caregiving preferences, especially before the onset of dependency (Pecchioni & Nussbaum, 2000). This lack of discussion may be due to elderly parents remaining independent from their adult children to maintain autonomy and personhood (Nussbaum, Pecchioni, Robinson, & Thompson, 2000). If caregiving decisions fail to maintain the autonomy of a parent, the parent is at risk for potentially negative health consequences (Pecchioni & Nussbaum, 2000).

Research has identified several important considerations for mother–daughter relationships when a mother enters older age. The mother–daughter dyad is the closest parent–adult child relationship (Cicirelli, 1983; Troll, 1986), but is particularly complex, consisting of a mixture of strong positive and negative feelings (Fingerman, 2001). For example, mothers and daughters are very invested in their relationship but sometimes feel tension in balancing their simultaneous needs for intimacy and autonomy.

Understanding such tensions can have significant implications for applied communication research. Research has demonstrated that the struggle for autonomy and independence is a significant consideration in parent–adult child relationships. For example, K. L. Henwood (2004) noted that older women sometimes see very close mother–daughter relationships as a face threat due to the power associated with the daughter as the mother ages. Although research has found that older mother–daughter relationships usually are characterized by love (Fingerman, 2001), the complexities associated with control, dominance, and dependence often can taint the positive affect associated with these relationships. Mothers and daughters are invested in their relationship, but when a mother communicates a need to maintain a position as matriarch in a family, a daughter’s ambivalent or resentful communication in response can certainly complicate that relationship (Fingerman, 2001).

Many questions remain regarding the older mother–daughter relationship, and the consequences of the control-related tensions characterizing that relationship still are unclear (Fingerman, 2001; Morgan & Hummert, 2000). In terms of applied consequences, research findings about parent shifts from independence to dependence on an adult child may be amplified in mother–daughter relationships, where power complexities are rampant. Given that females typically assume the caregiver role for both the young and the aged (Moen, Harris-Abbott, Lee, & Roehling, 1999), more research needs to investigate positive adjustment strategies for mothers and daughters.

Sibling relationships also can have important consequences social support in older individuals. About 80% of older people have siblings and remain in contact with them throughout their life (McKay & Caverly, 2004). Siblings provide each other with one of the longest, if not the longest, relationship experienced. As a result, sibling relationships can have some of the most meaningful effects on older adult life. Cicirelli (1985) found that brother–sister and sister–sister relationships usually are very close, provide a sense of security in the life of older people, and that older people feel comfortable asking their sibling(s) for assistance. Scott (1983) found that siblings were helpful for older persons making major decisions and meeting their transportation needs. Borland (1987) found that cohabitation among older adult siblings is considered to be a reasonable and comfortable alternative to institutionalization. Siblings depend on each other for companionship activities, such as recreation, regular visits, organizing family reunions, and,
sometimes, even business ventures (Scott). Sibling commitment also remains stable across the life span (Rittenour, Myers, & Brann, 2007). The sibling relationship certainly can have a large and significant effect on the provision of social support in older age. Sibling relationships, like friendships, are one of the only forms of social support for an elderly individual that occurs on a relatively egalitarian level. Moreover, siblings’ use of verbally aggressive messages decreases across the life span (Myers & Goodboy, 2006). Because sibling relationships can be much longer term and more solidly bonded than friendships, their implications on the health and well-being of older adults is a particularly fruitful area of inquiry for applied communication scholarship.

A final family relationship that scholars increasingly have studied is the grandparent–grandchild relationship (Nussbaum, Pecchioni, Robinson, & Thompson, 2000). Grandparents provide grandchildren with a source of learning and emotional support (Hartshorne & Manaster, 1982), and grandchildren who interact with grandparents have better attitudes toward aging and older adults (Becker & Taylor, 1996). Grandparents glean valuable benefits from their relationship with their grandchildren as well, getting satisfaction from contributing to their grandchildren’s lives (McKay & Caverly, 2004; L. Thompson, Clark, & Gunn, 1985) and experiencing a sense of continuity with their own lives by sharing personal and family history (Atchley, 1991).

Although grandparent–grandchild relationships are characterized mainly by positive affect, those relationships exhibit complexities and disparaging aspects as well. For example, Harwood and Lin (2000) reported that grandparents describe not only affiliation, pride, and exchange as typifying the grandparent–grandchild relationship but also distance. In some cases, that distance is physical, with grandparents and grandchildren geographically separated, which makes the relationship harder to maintain (Holladay & Seipke, 2007). Pecchioni and Croghan (2002) found that although young adults are less likely to apply stereotypes to their closest grandparents than to other older adults, they still may not overcome negative stereotypes of older adults when interacting with their grandparents (see also Anderson et al., 2005). As a result, interactions with their grandparents still may utilize ageist stereotypes that could diminish the quality of those interactions and lower the self-esteem of grandparents (Pecchioni & Croghan, 2002). Ageist stereotypes also might explain why there are only moderate levels of agreement in the topics discussed between grandparents and college-age grandchildren (Lin, Harwood, & Bonnesen, 2002).

Stereotyping and ageism, thus, have consequences not only in health-care settings but also even in close relationships. Relationships with spouse, friends, and siblings tend to be very satisfying overall, perhaps because these relationships are less likely than other relationships to be fraught with the negative effects of ageism. However, parents’ relationships with children and grandchildren seem to be constrained by factors associated with ageist expectations. Future applied communication research can help to manage people’s expectations of usual aging and minimize the use of stereotypic and ageist behaviors. As such, we offer the following recommendations for future directions in applied communication research on aging.

Future Directions for Applied Communication Research on Aging

Before considering specific recommendations for future applied communication research on aging, an important point to make is that just as aging is a diverse and complex process, research seeking to understand and enrich the aging process must necessarily be a multifaceted endeavor. Applied communication scholars, therefore, have a daunting task of bridging the various aspects of aging in specific, age-relevant contexts to improve
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the aging experience. To simplify directions for future research, we begin by offering an overarching theoretical framework for applied communication research on aging, a framework that could benefit all aspects of the discipline. We conclude this chapter with more specific courses of action for applied communication and aging research.

The communication enhancement model (e.g., Baltes, Neumann, & Zank, 1994; Ryan, Meredith, MacLean, & Orange, 1995; Ryan & Norris, 2001) provides an excellent theoretical framework for communication research on interventions to transpose the cycle of negative communication during the aging process that often results from old-age stereotypes. The model suggests that interactions with older adults are influenced by multiple environmental factors, such as background noise that can interfere with hearing a message. Consequently, changing or modifying environmental factors upfront can improve the communication environment for older individuals. Recognizing older adults’ communicative needs and cues on an individual basis can influence people to modify their behavior to accommodate an older person’s personal needs and can aid in the contextual assessment and planning for an older person. Such modifications can lead to feelings of empowerment on the part of an older adult rather than dependency, as well as increased communication effectiveness and satisfaction rather than feeling stereotyped and patronized. Recognizing older adults on an individualized level as communicators and making accommodations based on older adults’ personal needs (as opposed to applying blanket accommodations on the basis of stereotypes) also optimizes older adults’ competence, health, and well-being, and maximizes their communication effectiveness (Ryan et al., 1995; Ryan & Norris, 2001).

Using the communication enhancement model to guide research has been thoroughly discussed elsewhere (Hummert et al., 2004); here, we emphasize the importance of applying it in applied communication contexts to develop interventions (see Frey & SunWolf, this volume) that manage specific communication situations faced by the elderly. Using this model specifically to direct applied scholarship on communication and aging facilitates a research agenda that is not chiefly concerned with the adversities of old age. Focusing primarily on the problems associated with communication and aging can reemphasize the notion that old age is a negative phase of life and reinforce the stereotypes associated with older age. Applying the communication enhancement model emphasizes the recognition of cues on a more individualized basis as a first step to optimal compensation for normal aging and to maximize effective communication with and by older adults. As a result, interventions developed from the model will encourage attention to the usual or normal process of aging as opposed to the stereotypical or pathological course of aging. For example, in health communication, instead of developing interventions that assume physical cues of aging, such as wrinkled skin or graying hair, accompany a natural psychological decline and lowered communicative competence, interventions should focus on individual communication cues, such as modifying utterance force to signal difficulties hearing, that often indicate only slight modification in interactive behavior, such as speaking with more clarity and volume so that an older conversational partner can hear one better. Although applied research has been conducted from this perspective (particularly the work by Greene, Adelman, and their colleagues), continuing this line of inquiry is critical to address the ever-changing and ever-problematic health-care delivery system (see Kreps & Bonaguro, this volume) experienced by older adults in the United States.

With the communication enhancement model as a foundation for future work, we turn to more specific applied research agendas on communication and aging that can add much knowledge to the field and enhance the experience of aging. Although there are a multitude of important research agendas that are possible, we focus on specific directions in the areas of health, group, family, and communication technology.
As discussed previously, much of the extant research on communication and aging concentrates on health communication concerns. We need to apply what we have learned from the contexts of nursing homes and physician–patient interactions to other healthcare settings. Health-care provision for older adults occurs as much outside as it does inside the physician–patient interactional context. Issues of concern revolve around understanding and delivery of health insurance/Medicare/Medicaid, distribution of medication and information about medications, various therapies, and family decision-making encounters. Another important consideration is the numerous options of independent and assisted living now available for older adults. What holds true for a nursing home may not hold true for assisted-living facilities or other types of retirement communities, as the populations of individuals residing in the diverse types of available living arrangements are not homogeneous. Different forms of living could offer varied communication processes and consequences for older adults. For instance, friendship formation possibilities and intergenerational communication opportunities may be enhanced in certain living situations. Researchers, thus, should seek to understand the communicative consequences and benefits of residing in these different settings.

Another health communication issue related to aging of which we have little understanding is communication involving sexual issues. As a result of the rise in HIV and AIDS in older populations (National Commission on AIDS, 1993) and increased negative discourse surrounding sexuality and sexual dysfunction as individuals age (Kleinplatz, 2004), communicating about sexual health issues with older adults deserves increased attention in medical settings. These issues also have become more of a concern for older couples in romantic relationships, as well as throughout the entirety of the life span, yet few studies have examined how couples negotiate them (Mares & Fitzpatrick, 2004). Discourse surrounding sexual issues in health-care settings and in romantic relationships is especially important and timely, given that a continuation in sexual relationships is part of the normal/usual course of aging.

Health-care contexts also may offer valuable opportunities to study groups in older age. In 1987, Klinger-Vartabedian called for studying formal group communication of older adults as a research imperative; however, very little research regarding groups and older adults has been conducted since that time. Like individuals of all age groups, older individuals frequently find that interaction in formal groups, such as support groups or activity groups fulfills important needs (Garstka, McCallion, & Toseland, 2001). Groups of older individuals often form to enhance a healthy lifestyle, remain socially active, entertain, stay informed, take care of those who need help, or just to reminisce. The study of the formal and informal groups in which older adults participate has been neglected and should be considered a research imperative for applied communication scholars interested in aging.

Another important area of consideration for older adults is the family. As discussed previously, different familial relationships hold different meanings for older adults, but each relationship potentially plays a meaningful role in the life of older individuals. Much still needs to be understood about the mother–daughter relationship to decrease the toxic emotional stress often experienced in that relationship. The son’s role in parent–adult child relationships also may be particularly important in making decisions in later life, given that the type of help that sons offer often involves financial advice (Moen et al., 1999). In addition, of course, the spouse of an adult child may be particularly significant. Moreover, as a result of finding that marital satisfaction decreased when an older adult parent lived with a couple, Bethea (2002) encouraged further examination of caregiver and care-recipient roles in family caregiving situations. Given that the trend of family caregiving likely will increase as the Baby Boom cohort moves beyond middle age, under-
standing how family members manage their new roles has important implications for the health and well-being of the family (Bethea, 2002).

An additional consideration within family communication concerns the role of older adults in the life of their grandchildren. An increasing number of grandparents have assumed the role of a primary caregiver to a grandchild (Bryson & Casper, 1999). When grandparents raise their grandchildren, grandparents are more likely to have stress-related illnesses and social isolation than when children are raised by a parent (Minkler & Roe, 1996). Many factors likely contribute to this stress, but few studies have addressed family communication where grandparents are the primary caregivers. Given the implications for both grandparents and grandchildren, this family structure certainly deserves consideration from applied communication researchers. An applicable line of research could utilize Harwood’s (1998) work regarding intergenerational communication schemas (ICSs). Harwood suggested that younger individuals tend to apply particular cognitive schemas or maps to guide their conversations with older adults. ICSs constitute a formalized repertoire for intergenerational communication that may be useful not only in developing interventions for grandparent-grandchild interactions, for example, but also for other important intergenerational conversations that may occur in medical or educational settings, for instance (Harwood, McKee, & Lin, 2000).

A final area for applied communication research with older adults involves communication technology. Older adults who use the Internet, as opposed to those who do not, have more positive attitudes toward aging, higher levels of perceived social support, and higher levels of connectivity (Cody, Dunn, Hoppin, & Wendt, 1999). The Internet has provided older adults with new ways to express their identities (see Harwood’s, 2004, study of grandparents’ personal Web sites), a means to stay in touch with grandchildren who are located far away (Holladay & Seipke, 2007), and a large network for social support that helps to lower their perceived life stress (Wright, 2000), as well as a way for older adults to participate more in society (Furlong, 1989).

However, a large digital divide between the young and old is well documented (Loges & Jung, 2001). Furthermore, older adults who use the Internet may find it lacking in resources for mature issues, as seen in the lack of online resources for older adults with sexual concerns (Harris, Dersch, Kimball, Marshall, & Negretti, 1999). Given the constantly changing form of the Internet, further understanding of its role in the life of older adults, especially with regard to its implications for support, is a valuable line of applied communication research.

The potential for communication technology to enhance life for older adults certainly is not limited to Internet use. Other communication technology aimed at improving the life of older individuals include telemedicine (e.g., Greenberger & Puffer, 1989) and the use of “smart” homes equipped with blood-pressure monitors and teleconferencing equipment for residents to communicate with their health-care providers (Walters, 2002; see also Lievrouw, this volume).

**Conclusion**

Valuable applied research on aging with respect to health communication and interpersonal interactions has been accomplished, as demonstrated throughout this chapter. Nonetheless, applied communication and aging research can be advanced by using what is known about the normal changes in communicative faculties to augment and link current research to practice. Such work is aided by using the communication enhancement model to guide the study of communication and aging in applied contexts. There are many potential lines of applied communication research on aging that can utilize this
model; they certainly are not limited to the recommendations noted here. Researchers should keep in mind that some of the most significant studies concerning aging in communication do not need to address the trendy issues in aging but simply aid in understanding everyday issues that are relevant to older adults and developing interventions to manage the day-to-day experiences of growing older. Given that later age potentially is an active and rewarding time of life, applied communication and aging scholarship should seek to describe, explain, and enhance the normal/usual living experience of older adults, in addition to improving the more problematic and pathological courses of aging. Such efforts undoubtedly will aid in understanding how physical, psychological, and social factors intertwine to affect the aging experience, providing knowledge that can be used to improve the quality of life for those at the later end of the life span.

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