Toner, Shadden, and Gluth begin by challenging clinicians to examine their own perceptions of and biases about aging and the elderly. After asking readers to examine their personal perspectives, the authors introduce basic text concepts and provide demographics in the form of questions about common aspects of aging and the elderly. Chapter 1 next highlights the diversity of research approaches used to study aging and the complexity of aging phenomena. The central text concepts of primary, secondary, and tertiary aging are defined. Professionals working with the elderly and in diverse healthcare settings are identified, and the potential impact of stereotypical ways of communication (e.g., elderspeak) is noted. Chapter 1 ends with an overview of the content of the book chapters.

Most people know that the elderly population is growing and the burden on the healthcare system is increasing. In the next 20 years, the older population will grow to become approximately 20% of the American population. Statistics describing the elderly population are available at www.agingstats.gov. Effective service delivery for this rapidly growing portion of our population will require a larger body of professionals who have a thorough understanding of the characteristics of aging and the healthcare issues involved. Quality care is not determined by the clinician’s technical skills alone. The clinician’s ability to interact and communicate appropriately with older clients is an essential factor for optimal care. In this first
chapter, therefore, we attempt to personalize your reading experience by asking you to reflect on your own views of aging and the elderly.

**What Is Your Perspective on Aging?**

How do you really feel about aging and elderly people? What are the first words that come to your mind when you hear the words *old people*? Do the words tend to be negative: *sick, weak, death,* or *Alzheimer’s*? Do you picture nursing homes and canes? Are you ever tempted to say things like “They’re too old to care,” “All old people do that,” “That’s wasted on somebody that old”? Alternatively, are you more prone to words like *stability, grandchildren, relaxation, vacationing,* and *wisdom*? Do you find yourself asking older people for advice and input, or do you become annoyed when they relate stories about things that happened to them? Do you discount the value of knowing anything that happened before you were born, or do you find it interesting to learn about past events and people? Your responses to these questions may tell you something about how you feel about aging and how you will approach elderly patients.

Recognizing your personal biases is particularly important in working with older adults. Many clinicians have biases about aging, age-related disorders, and what the elderly should or should not be doing. Some of these biases are negative, in terms of the diminished value attributed to the older adult or certain stereotypes of limited capacity that are associated with aging. Negative biases may influence decisions about the length or nature of intervention and determinations of prognosis. Positive biases also exist. The “Isn’t she a sweet little old lady?” perspective does not further the therapeutic process, and denial of very real aspects of aging and decline may prevent development of a reasonable and practical treatment program. All biases affect the way clinicians talk and interact with older clients.

Some healthcare professionals may fear what is happening to the older person, perhaps due to personal experiences with older family members. Overpersonalizing can be positive (“You remind me of my grandmother”) but still inappropriate. Professionals may feel that they need to control the client and caregiver, or they may have preconceived ideas about what the elderly client and caregiver should want, do, and feel. The clinician must be careful not to assume anything simply because a client or caregiver is old.

Stereotypes, biases, and fears are exacerbated when the practitioner has little or no understanding of normal aging and the complex variability associated with the aging process and with older adults. Healthcare pro-
fessionals working with the elderly should acknowledge their biases and stereotypes, as well as their strengths and weaknesses concerning their knowledge of normal aging. They need to be aware of the factors in their personal background and training that may influence the way they treat their elderly clients.

The culture itself is biased. It isn’t a good thing to be old, and aging certainly isn’t easy. Numerous physical, emotional, and financial challenges confront the elderly person. The challenge of dealing with healthcare professionals who are governed by bias instead of knowledge should not be added to the elderly person’s burden.

What Do You Know About Aging?

Even if you have a positive, realistic attitude toward aging, you may be biased by common myths. Answer the following questions to see if you know some of the basic “truths” about aging.

1. **Does cultural background affect aging and the response to it?** Cultural influences do affect attitudes about aging, but those effects interact with socioeconomic influences and life experiences. Expectations of old age are strongly influenced by life experiences, and life experiences are obviously influenced by both culture and socioeconomic status. One study reported that various cultural groups had similar concerns about their future but ranked them differently (Condor, 2003). White, Black, and Hispanic elderly people ranked “loss of independence due to physical deterioration” and “being a victim of crime other than fraud” as their number one and two concerns. The Black and Hispanic elderly respondents rated “becoming a financial burden” as their third concern, whereas White elderly people ranked it fifth. Black elderly respondents did not rank “going to a nursing home” in their top five concerns, but it was ranked fourth by Whites and fifth by Hispanics.

2. **Is becoming senile a natural part of aging?** The elderly do experience changes in cognitive functioning, but those changes are generally mild and do not interfere significantly with daily functioning. A significant cognitive problem is a sign of a disorder, but people should not assume that every change is a sign of Alzheimer’s disease. Many factors are
associated with a decline in cognitive functioning, and often the declines are reversible with appropriate identification and intervention.

3. **Is it safe for older people to exercise?** The *Older Americans 2008: Key Indicators of Well-Being* report indicates that in the period from 2004 to 2006, 74% of people over the age of 65 rated their health as good or excellent, with the percentage being higher for Whites than Blacks or Hispanics (Federal Interagency Forum on Aging-Related Statistics, 2008). People who exercise as young and middle-age adults are likely to continue to exercise into their later years. Exercise in the elderly helps maintain both physical health and cognitive abilities. Motivation to exercise may actually increase in later years, when people have greater awareness of its benefits for bone health, cardiac functioning, and respiratory health. It is never too late to begin an appropriate exercise program to slow or reverse some effects of aging.

4. **Do people experience fewer negative emotions as they get older?** Personality does not change significantly, but there is evidence that negative emotions decline as one ages. The decline is strongest up to age 65, and then it decreases more slowly up to the age of 80 (Charles, Reynolds, & Gatz, 2001). It appears that older people develop coping skills that allow them to respond less emotionally to negative experiences.

5. **Does aging affect everyone in the same way?** The expression of aging in any individual reflects a combination of influences including genetic, health, and socioeconomic ones. Basic physiological changes are expected in all people as they become older, but the age at which those changes appear varies widely. People born into families with healthy, active elderly members are more likely to show effects of aging at later ages than are those born into families with members that became frail or died at relatively early ages. Activities and experiences in early life, however, can counteract some genetic influences. For example, people from a family filled with healthy elders are more likely to show early signs of aging if they smoked from an early age, never exercised, and had a poor diet.

6. **Are older people motivated to learn new things?** The older generation is more educated than ever and is capable
of learning new information and new skills. Awareness that active learning helps maintain cognitive ability adds to the motivation of many elderly people. Older individuals are more self-directed in their learning than are their younger counterparts. Although they are more likely to disregard information that does not appear relevant to them, they are skilled at acquiring information that answers questions of interest. Their experience also allows them to associate and apply information they learn.

7. **Are older people a financial burden on society?** The majority of people over age 65 do receive income from Social Security; however, it accounts for less than half of the income reported by over 60% of that group. Data reported in *Older Americans 2008: Key Indicators of Well-Being* (Federal Interagency Forum on Aging-Related Statistics, 2008) indicate that one third of the elderly receive income from continued employment. They also report income from pensions and assets. Less than 10% of the elderly live at or below the poverty level, with more than 78% reporting incomes at or above 150% of the poverty level. The nation’s economy definitely affects income for the elderly, so times of economic hardship for the country are also times of increased hardship for the elderly. Income statistics vary significantly for different races and educational levels, but most elderly people “pay their own way.”

8. **Do most elderly individuals end up in nursing homes or under the care of professional caregivers?** Most elderly people who require long-term care receive that care at home, not in an institutional setting. Spector, Fleishman, Pezzin, and Spillman (2000) reported that only 5% of the elderly live in nursing homes. Most individuals over 65 are able to care for themselves and live independently. The majority of elderly individuals live with a spouse, although elderly women are more likely to live alone than are elderly men. When care is needed, it is usually provided by a family member or friend. Often, the caregiver is an elderly spouse who also has health problems.

9. **Do older people have trouble understanding what you say and find it easier if you speak louder, exaggerate your speech, and use simple words?** The senses, including hearing, do decline somewhat, but a significant
impaired is not attributable to normal aging. Speaking loudly is not an appropriate communication strategy; it may actually decrease understanding. It is also not appropriate to make language oversimplistic. Healthy older people have no problem understanding language if they can hear the speaker. Oversimplification of language and use of an exaggerated speaking style may suggest more about the speaker than the listener.

10. **Do older people know what to expect as they age?** The elderly are as uninformed as the rest of the population about the actual effects of normal aging. When they do experience a problem, the elderly often attribute signs of disease to the unavoidable effects of aging. As a result, they may assume nothing can be done and choose not to seek medical help. It is also easier to recognize when others are “getting old” than to recognize the same signs in oneself. Although people are aware they are getting older, they may not feel they are “old” as long as they are relatively healthy and independent.

**When Is Someone Old?**

It is almost impossible to define what we mean when we talk about aging or the elderly. In a college class on communication and aging, students were asked how they would define getting old. There were almost as many answers as there were students. We often call someone old when they reach a certain age, but that age is a moving target. For example, the American Association of Retired Persons begins membership at age 50. Senior citizen discounts may not take effect until 55 or 60. One becomes eligible for Social Security at age 62, but full retirement age varies from 65 to 67 years of age, depending on the year of birth. The highest benefits are currently not paid until age 70. Even if we could agree on one chronological age as the starting point for becoming “old,” people are living longer and there is more than one generation of elderly individuals. Although some references use descriptions such as young-old, middle-old, and old-old, there is no standard agreement on the chronological ages assigned to each category.

One’s physical condition cannot be predicted based solely on chronological age; therefore, some people suggest that aging should be defined in terms of biological or health status. Some people show very few signs of aging into their 80s, while others the same age have multiple impairments.
Attempts have been made to quantify biological aging in terms of measures such as strength, respiratory capacity, cardiac function, or even cellular changes. Although all of these physical markers are useful, they fail to capture the full sense of aging.

Sometimes, being seen as old is a by-product of the roles played by each individual. For example, retirement means loss of the role of productive worker and can signal old age to some people. Not surprisingly, it may be difficult for some aging adults to adjust well to retirement. Becoming a grandparent may also be a marker of old age. How often do you hear someone say, “I can’t believe you’re a grandmother; you seem so young”? Some of these old-age roles are signs of moving forward through somewhat predictable life stages, which can become another sign of aging.

In recent years, aging has often been characterized in terms of daily functioning, independence, and well-being. Terms such as aging well, aging productively, and successful aging are used to indicate that an elderly person is making appropriate adaptations to remain healthy, active, and well-adjusted. Some individuals continue to show only minor effects of aging well into their eighth and ninth decades. These people are sometimes referred to as “geriatric supermen.”

How Do We Learn About Aging and the Elderly?

Older adults and the aging process have been studied in a variety of ways. Some researchers compare groups of young and old people on a particular task in order to understand differences between age groups. These are called cross-sectional studies. Other researchers use longitudinal designs, which track a group of adults across the lifespan. These longitudinal studies provide important information about how a cohort of individuals from a specific generation develop and change over time. The term cohort is used to refer to a group of people who have lived through similar historical, social, and economic experiences because they were born around the same time.

One challenge in studying normal aging is the fact that the elderly are such a heterogeneous group, making it difficult to draw conclusions about what is “normal” aging. Another challenge stems from the fact that researchers like to control characteristics of the subjects in their studies. If people who have health problems, demonstrate a sensory impairment,
or take prescription medications are excluded from participation as subjects, it is difficult to feel comfortable calling the remaining subjects typical of the elderly population. Sometimes, researchers end up using subjects who resemble geriatric supermen more closely than the majority of older persons.

Research tools continue to evolve over time. One exciting development in our efforts to understand aging involves the use of sophisticated research tools such as functional magnetic imaging and evoked cortical potentials. Functional magnetic resonance imaging (fMRI) is a minimally invasive imaging technique that allows measurement of changes in blood flow in the brain during brain activation. It allows investigators to determine which cortical regions are engaged during specific cognitive activities. Evoked cortical potential measures how the nervous system responds to an incoming stimulus. It provides information about where and when responses occur and the amplitude of the responses. These tools allow us to combine measures of behavior with analyses of underlying brain activity. The resulting data help us understand what is and is not normal in the aging brain, as well as how the brain compensates for age-related changes.

What Makes Aging So Complex?

It should already be clear that defining aging and understanding the elderly is not a simple task. One part of the challenge for professionals is to understand the difference between normal aging and disordered processes. If we expect the elderly to have difficulty in speaking, understanding, thinking, and swallowing, we are likely to overlook the early signs of disorders that should be identified and treated. On the other hand, if we assume that all signs of aging indicate disorder, we may inappropriately recommend intervention for a “normal” person.

Various models or theories describe the aging process and the variables that influence that process. Some of these models are discussed in Chapters 7 and 9. To facilitate understanding of the important distinctions between normal and abnormal aging, the chapters of this book use a model that describes primary, secondary, and tertiary aging factors (Granieri, 1990).

Primary aging factors are the result of the normal aging process and are expected to appear in many older adults. Primary changes may be relatively neutral (e.g., gray hair), or they may alter functions. However, they do not pose a significant threat or interfere in any major way with daily activities. As we age, we draw upon our “reserve capacity” to allow us to adapt to the
effects of aging. As the degree of primary aging increases, reserve capacity is reduced and the risk of disease, injury, or disorder is increased.

The prefix *presby-* denotes old age. It should not be confused with the prefixes that suggest abnormality or illness (e.g., *dys-, dis-*). Technically, *presby-* does not indicate a disorder but instead the natural changes that take place. There is no general agreement on the use of this prefix in areas affecting communication disorders. Some sources use the prefix to denote changes related to the normal aging process that are not clinically significant. Others use the prefix to describe a clinically significant problem that is related to the aging process. For example, in the current text, *presbycusis* (hearing) is described as an age-related decline that may benefit from some clinical intervention, whereas *presbyphagia* (swallowing) is used to describe changes that the elderly adapt to without significant impairment of daily functioning.

*Secondary aging factors* represent pathologies. Elderly people are more prone to diseases and disorders such as stroke, heart disease, arthritis, and sensory impairments; they are also likely to suffer from more than one condition. Additionally, medications, surgeries, and treatments that address the elderly person’s medical problems may add to the impairments experienced.

*Tertiary aging factors* are those that result from social, psychological, and environmental changes. The social and support network of the elderly client is often reduced due to retirement, death of peers, children moving away, and loss of mobility. Elderly couples may be on a fixed income, with illness further reducing their financial resources. When these factors combine, it is not unusual for the older person to experience depression. If both the client and the spouse are elderly, the aging factors affecting each can contribute to further declines.

Who Cares for the Elderly?

When an elderly person’s health declines, someone must provide assistance to meet his or her daily needs. Most elderly persons are cared for in the home, with spouses or adult children providing much of the necessary assistance. Some of these children are themselves senior citizens. The care provided by family members is often called “informal caregiving” because caregivers are not trained for this role and do not receive reimbursement. Most of the caregiving in the United States is informal. It is not unusual for these older caregivers to assume responsibility for more than one aging family member (e.g., a parent and a spouse). The impact of caregiving on
the physical and emotional health of any family member should not be
underestimated, but serving as a caregiver is especially risky for the elderly,
who are likely to suffer from chronic health problems themselves.

It is essential that healthcare professionals understand the needs of
primary caregivers, the burdens placed on them by the older care recipient,
and their response to the stress of changes in roles and added responsibili-
ties. Caregiver stress is influenced by many variables; stress is particularly
increased by change in the caregiver’s life. Areas of change are multiple: role
reversal, social network reduction, altered living environment, and strained
financial status. Financial strains can be particularly difficult to manage
when a caregiver must leave a job because of caregiving responsibilities or
when a caregiver tries to juggle work and caregiving simultaneously.

Relationship to the client can also be a factor in stress. Spouses suffer
the most stress, and “favored” children report more stress but less burden
than do “problem” children (Cantor, 1983; Henderson, 1994). Caregivers
with limited family ties and those who are not “raised” to be caregivers ex-
perience higher stress levels. Female caregivers feel more emotional stress
than do male caregivers, which may be due in part to females being less
likely to seek help from other family members and more likely to quit their
jobs instead of hiring outside help.

Degree of caregiver stress has also been found to vary with the type of
disorder demonstrated by the client. Although we often think of the great-
est burden being experienced by those who provide physical care, the level
of caregiver stress is actually greater when the disorder is characterized
by cognitive changes and declines in communication ability. Caregivers of
clients with dementia often feel that their social network is reduced and
experience feelings of isolation.

The issues confronting the caregiver are obviously multiple and com-
plex. Consequences of resulting stress can be devastating, with numerous
possible physical effects (Pruchno & Resch, 1989). The autoimmune sys-

...
ing available financial help because they do not know it is available, do not know how to apply for it, or feel that it carries a social stigma.

### Who Works with Older Adults?

The complexity of aging requires the involvement of a number of healthcare professionals to help maintain optimal functioning of the elderly person. Because the elderly are more likely to experience multiple health problems, they are also more likely to be under the care of more than one medical specialist.

Most elderly patients have a primary healthcare provider. Primary care providers serve elderly clients with a wide range of needs. Their clients include the geriatric supermen as well as those in the poorest health. In addition to the primary healthcare provider, older adults and their families may see social workers, counseling and psychiatric professionals, physical therapists or occupational therapists, and other care providers. Most healthcare professions have developed specialized fields of study in geriatrics or gerontology, but much more training is needed to ensure a workforce knowledgeable enough to work with the elderly.

When an elderly person experiences a communication or swallowing problem, it is likely that his or her first contact in the healthcare system will be with a primary care provider. It is the responsibility of the primary care provider to refer elderly patients to appropriate medical specialists or rehabilitation professionals. It is not uncommon, however, for a speech–language pathologist or audiologist to be the first contact an elderly client makes for a potentially serious health problem. For that reason, communication disorders professionals must have a clear understanding of both normal and pathological aging factors and be prepared to provide information regarding previously unidentified medical issues.

The elderly are seen in a variety of healthcare settings. The characteristics of each setting and the needs of individual clients influence which healthcare professionals are available and the types of services that can be provided. In some settings, healthy elderly people may be seen only for services that maintain their health, such as hearing screenings at health fairs. In contrast, those individuals whose health is compromised may be served in settings such as acute care, outpatient clinics, short- and long-term rehabilitation settings, or home healthcare. In recent years, more facilities have been providing healthcare specifically targeting the unique needs and characteristics of the elderly.
Regardless of setting or profession, healthcare providers need to communicate effectively and appropriately with aging clients. Unfortunately, given common biases about aging and the elderly, professionals often fall into a pattern of communication called *elderspeak*. Elderspeak essentially involves talking down to an older person just because he or she appears to be old. This behavior will be discussed further in the final chapter of this text, but it is important to note here that use of elderspeak can interfere with effective clinical interaction and service delivery.

**What Is This Book About?**

The expanding elderly population is expected to require the services of an increasing number of healthcare professionals with more specialized knowledge. Communication is critical to quality of life and to accessing services; therefore, speech–language pathologists and audiologists are among the professionals who will be serving more elderly clients. The intent of this book is to provide clinicians and students in communication disorders with an overview of normal and pathological aging and the services commonly provided to the elderly. This text is not designed to be a comprehensive discussion of the assessment and treatment of disorders, nor does it provide an exhaustive review of the research literature. It highlights those factors that are most pertinent to the care of the elderly population.

Professions vary in their approach to aging issues and use language that is distinctive when discussing those issues. Differences in perspective also exist between the various specialties within the field of communication disorders. Additionally, emphasis may differ based on work setting. For example, academically oriented and clinically based professionals are likely to relate differently to the details of reimbursement. To facilitate multidisciplinary interactions, it is helpful for healthcare professionals to become familiar with these differing viewpoints. In this text, contributions from authors representing a variety of professions, specialties, and work settings make these differences clear.

**How Is the Book Organized?**

This is the second edition of *Aging and Communication: For Clinicians by Clinicians*. A number of changes have been made to make the book more clinician-friendly and inclusive of other disciplines. To begin, a nurse practitioner provides an overview of physical aging in Chapter 2. It
is sometimes difficult for professionals to understand where normal aging ends and pathological aging begins. For that reason, aspects of communication and swallowing are approached from the perspective of primary, secondary, and tertiary aging, as defined earlier in this chapter. Chapter 3 combines otolaryngology and audiology viewpoints on aging of the hearing mechanism. Speech and voice are presented from a medical perspective in Chapter 4 and from a speech–language pathology perspective in Chapter 5. The differing approaches to diagnosis and treatment of speech disorders in the elderly are provided, with the physicians emphasizing diagnosis of organic pathologies that determine medical and surgical interventions and the speech–language pathologists emphasizing functional, perceptual, and acoustic characteristics that influence speech interventions. Chapter 6 provides a comprehensive view of aging and swallowing, with an emphasis on the role of the speech–language pathologist.

In considering aging of the cognitive and linguistic systems, primary and tertiary aspects are addressed separately from secondary aspects. Chapter 7 discusses primary and tertiary aspects of cognitive aging. Chapter 8 discusses secondary aspects of cognitive aging, including Alzheimer’s disease. Chapter 9 describes aging of the linguistic system. Chapter 10 describes language assessment and intervention. This organization facilitates discussion of primary and tertiary aging issues of interest to practitioners from many fields separately from the detailed discussion of assessment and intervention strategies relevant to the practice of speech–language pathology.

The text concludes with chapters that introduce broader considerations in working with older adults. Chapter 11 takes on the challenge of end-of-life decision making and care. Chapter 12 examines clinical interactions with aging adults and makes recommendations for more effective counseling and communication.

At the end of each relevant chapter, information regarding reimbursement for speech–language pathology and audiology services is provided. The coding systems used to obtain reimbursement are discussed. These systems include the following:

- **Current Procedural Terminology (CPT; American Medical Association [AMA], 2009a):** These codes indicate procedures conducted during a contact with a client.
- **Healthcare Common Procedure Coding System (HCPCS; AMA, 2009b):** Services not included in the CPT system are specified by the HCPCS codes. These codes may be used when devices or equipment are required.
• International Classification of Diseases–Clinical Modification, 9th Revision (ICD-9-CM; National Center for Health Statistics [NCHS], 2009): The disorder or diagnosis is identified using ICD-9-CM codes. The 10th revision of the codes (ICD-10-CM) is scheduled to go into effect in 2013 (NCHS, 2010).

These are not static coding systems. They are updated to reflect advances in diagnostic and treatment procedures. Professionals should not assume that all of their services will be covered by Medicare or by many private insurance policies. Reimbursement issues may dictate which services are provided; therefore, it is essential for speech–language pathologists and audiologists to understand how to obtain funding for needed services and be able to provide that information to their elderly clients. The American Speech-Language-Hearing Association provides extensive reimbursement information for speech–language pathologists and audiologists, including current diagnostic and procedural codes.

Finally, each chapter concludes with Key Points that capture the most important “take-home” messages. Collectively, these chapters provide students and clinicians with an overview of aspects of aging, common communication and swallowing problems, and clinical management approaches.

Key Points

This chapter addressed common questions, myths, and biases about aging. Several factors that contribute to the heterogeneity of the aging population were discussed. An overview of the topics and organization of the book was provided. Key points in this chapter included the following:

• Personal perspectives on aging may affect interactions with the elderly.
• Culture and personal experiences influence perceptions of older people.
• Cognitive abilities change, but older people are motivated to learn new information and skills. Dementia is not part of normal aging.
• Most older people report that they are in good health. They also experience fewer negative emotions.
• The majority of older people live at home and above the poverty level.
• Effective communication with older people does not require loud, slow, simple speech.
• There is no simple or agreed-upon definition of old.

References


