COMMUNICATION PROBLEMS IN ELDERLY PEOPLE

Practical Approaches to Management

Rosemary Gravell

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Volume 17

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Routledge
Taylor & Francis Group
LONDON AND NEW YORK

First published in 1988 by Croom Helm Ltd

This edition first published in 2024
by Routledge
4 Park Square, Milton Park, Abingdon, Oxon OX14 4RN

and by Routledge
605 Third Avenue, New York, NY 10158

Routledge is an imprint of the Taylor & Francis Group, an informa business

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

ISBN: 978-1-032-67433-9 (Set)
ISBN: 978-1-032-68797-1 (Volume 17) (hbk)
ISBN: 978-1-032-68808-4 (Volume 17) (pbk)
ISBN: 978-1-032-68805-3 (Volume 17) (ebk)

DOI: 10.4324/9781032688053

Publisher's Note
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CROOM HELM
London & Sydney

Croom Helm Ltd, Provident House,
Burrell Row, Beckenham, Kent BR3 1AT
Croom Helm Australia, 44–50 Waterloo Road,
North Ryde, 2113, New South Wales

British Library Cataloguing in Publication Data

Gravell, Rosemary
Communication problems in elderly people:
practical approaches to management. —
(Therapy in practice).
1. Geriatrics 2. Communicative disorders
I. Title II. Series
618.97'6855 RC952.5

ISBN 0–7099–4634–1

Printed and bound in Great Britain by Mackays of Chatham Ltd, Kent

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In memory of
my father, John R. Moon

Acknowledgements

I would like to thank Jenny Sheridan and Sue Stevens for their invaluable advice and support; Marjorie Moon and Lyn Gregory for their secretarial skills; and Chris Griffin for the artwork.

Foreword

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The profession of speech-language pathology and audiology devotes itself to the enrichment of communicative skills and opportunities for a wide variety of individuals from infancy to old age. The concept that we have a significant service to offer elderly people, in particular, has only been realised in the past ten to fifteen years. Recently, there has been an awakening to the changes that occur with age in speech physiology, cognition, speech and language processes, and auditory functioning. This has led to an increase in research in these areas and to innovative ways of meeting the communication needs of older people in the community and in long-term care settings. Communication disorders specialists in Great Britain, the United States and Canada meet on a common ground when they devote their research and clinical efforts to better understanding the role of communication for elderly people, the changes that occur with aging, specialised diagnostic methods, and efficient and effective service delivery programmes.

Elderly individuals with communication problems present unique challenges. These challenges stem from the characteristics of elderly people themselves, the stereotypes society has created about the aged, and our own reluctance at times to work with the most severely handicapped, the multiply-impaired, those with progressive disorders, those who are dying, and those who may not visibly appreciate our efforts. It is only by understanding the aging process itself and its relationship to communication, that we can better identify the communication needs of this group and plan appropriate intervention.

Furthermore, communication disorders specialists have also begun to realise that 'remediating' the communication problems of elderly patients without working with significant others in the patient's environment may be futile, inefficient, and inappropriate. Clinical research has clearly indicated that the physical and psychosocial environment of the elderly patient

impacts on the patient's motivation to communicate and to carry over improved skills to activities of daily living. The burden to improve communication must be *shared* by the elderly person *and* his or her primary communication partners. Older persons need not only adequate cognitive, speech, language and hearing skills but also ample opportunities to communicate with partners of their choice in stimulating activities. Thus, communication disorders specialists cannot end their treatment at the therapy door but must invite significant others including family, other rehabilitation staff, medical personnel, social service, other patients, volunteers and friends to be a part of the communication therapy process.

This book meets a special need in our growing literature on elderly people and their communication needs. First, it is written by a practitioner, a clinician who works with older people. The perspective taken in this text thus reflects her extensive experience with such people, their care givers, and other rehabilitation specialists. Second, the book reflects a team approach to intervention with elderly clients. Effective intervention is defined from a wholistic and realistic viewpoint. Third, the text integrates the existing literature in the area without being overbearing. The information is synthesised in a coherent, practical way, leading the reader to a better understanding of the problems of working with elderly people and hence more effective ways of service delivery. Finally, the text has an international flavour in that it reflects the author's knowledge of the current state of clinical geriatric intervention in both Great Britain and the United States. Few books offer this valuable integration of two knowledge bases.

As you read this book, ask yourself how important communication is to you now at this point in your personal and professional life. Then project yourself into the future when you, too, will be elderly. Can you imagine the changes that will occur, some positive, many negative? What will being able to communicate mean to you then? It is likely that being able to communicate effectively and meaningfully will be an important part of your life. Our communication lives, twenty, thirty or more years from now, are being sown in the philosophy we create today in our society, our institutions, and our teaching programmes. The more attention we can devote today to improving the communication of elderly people will be reaped in our own lives tomorrow.

1

The Aging Process

Aging is the developmental process that extends throughout life, from 'womb to tomb'. Thus, a person aged twenty will have different abilities, skills and experiences from those he will possess when he is fifty years old, and these in turn will differ from those at eighty years old. Aging causes differences, not deficits, for disease and disorder are not inevitable correlates of old age.

Such a difference can be seen in the communication skills that an individual demonstrates at different points in his life. Aging leads to changes in language comprehension, expression and use, in speech and voice. These changes are more pronounced in the later years of life, and therefore there will be particular demands placed upon the speech therapist who works with an elderly population. These demands will extend from assessment, through planning and management, and must be met if therapy is to be effective.

However, having stated that changes occur with age, and that these changes require a specialised approach, it is not necessarily chronological age that determines the need for special treatment. The overuse and overgeneralisation of chronological age as the criterion for being 'elderly' has contributed enormously to the myths of aging and the negative stereotype which attaches to the status of being old. So which elderly people do require this specialised approach?

It is not difficult to find statistics relating to the huge increase in that proportion of the population aged 65 or over. The US Health Affairs, for example, reported an increase from 5.4 per cent of the population being over 65 years old in 1930 to 11.3 per cent in 1980, and went on to predict that by 2030 there will

be 18.3 per cent of the population in this age bracket. Such 'were, are and will be' figures are frequently used in attempts to stimulate a response from Health and Social Services planners. Ouslander and Beck (1982) found that over 65-year-olds in the United States, while forming 11 per cent of the population, used 30 per cent of annual health care costs, 30 per cent of acute beds, and 25 per cent of prescription drugs.

However, the value of such statistics is debatable because they are based on this arbitrary cut-off point of chronological age. While this may be necessary in some instances, such as distribution of pensions and benefits, in many cases it has led to enormous overgeneralisation of facts relating to older members of society. Researchers who have looked at such statistics in more depth have demonstrated this. Roos, Shapiro and Roos (1984), for example, looked at the proportion of hospital days used by over 65-year-olds, and found it was indeed high. However, closer study revealed that 42 per cent of this age group had not been admitted, and that a huge 20 per cent of total hospital days were used by a mere 2 per cent of the so-called elderly people. They also stated that it is a myth that over 65s take up more family practitioner time, and suggest that the elderly population are less often referred on for specialist advice.

What is perhaps most significant in the statistics is that it is the 'old old' whose numbers are increasing most rapidly, as the result of improved medical and social care. In the *British Medical Journal* (April 1985) it was suggested that the total over 65 group will alter little in the next 25 years, but that the 65 to 74-year-old group will decrease, and the 75 to 84-year-old group will rise by 7 per cent, with a phenomenal increase of 34 per cent in the over 85-year-olds. Some claim that the term 'elderly' is usually used, in health care, to refer to the over 75-year-olds, but many researchers continue to use the 65-year-old cut-off point.

However, clinicians seem intuitively to recognise that the term 'elderly' is best applied, not as a result of an arbitrary chronological criterion, but to refer to those who might be described as 'physiologically aged'. Thus the alert 75-year-old who requires no more medical or social care than a 'normal' 45-year-old is not seen by most clinicians as being elderly. The 'physiologically aged', meanwhile, may be viewed clinically as those who suffer from one or more of the mental, physical

or socioeconomic conditions that are more likely to occur, and to create problems, in older people. As individuals age the risk that they will experience certain illnesses (for example, depression, dementia, cerebrovascular accident) increases, and the associated likelihood that they will suffer from multiple pathologies grows. These age-linked conditions create very particular management problems.

Speech therapists are as much at fault as other professionals in making generalisations about elderly people, and in neglecting properly to consider the needs of the physiologically aged. Assessment materials and techniques are used as they would be with any adult, and rarely is consideration given to the inherent difficulties in generalising about this older group. Therapy is offered to those alert enough to respond to traditional approaches, but there is little attention paid to the needs of those who are unable to respond to this form of intervention. They, and their carers, are frequently left to cope with the communication difficulty.

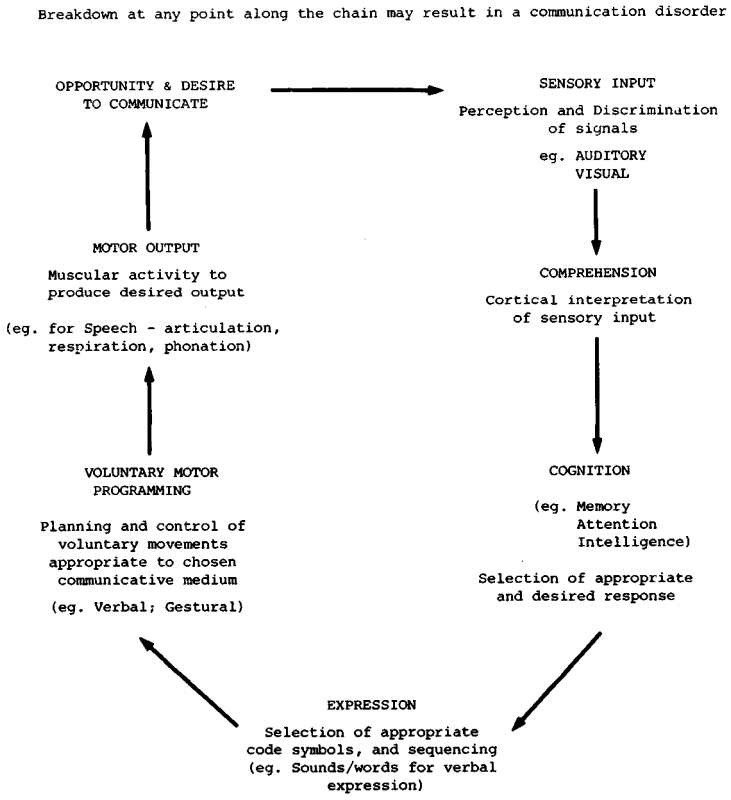
Any clinician working with an older population needs a baseline upon which to base clinical judgements; that is, a knowledge of the aging process and how it impinges upon their field of expertise. As Rowe (1985) points out 'Just as children are not merely young versions of adults, the elderly are not simply old adults'.

THE AGING PROCESS

A brief outline of physiological, cognitive, psychological and social changes related to the aging process, and which affect communication, will be given. There are numerous texts which offer a fuller description of such changes, but it is hoped that this short discussion will provide a basis from which practical management decisions may be made.

Effective communication is the transmission of a message between sender and receiver. It requires an individual to have functioning sensori-perceptual, language, cognitive and motor skills, although it is not essential that the medium is auditory-verbal; and also to have adequate opportunity and reason to communicate. Figure 1.1 describes the communication chain and it can be seen how changes in such abilities as hearing and memory will indirectly or directly affect the efficient operation of the communication act.

Figure 1.1: Communication chain



The study of most aspects of the aging process has historically been via cross-sectional design, that is comparing older and younger subjects at one time. This has led to results which are possibly not a function of age *per se*, but of cohort differences. Recognition of this methodological failing led to the introduction of longitudinal studies, which look at one individual at two or more points in time. Again, however, there are flaws, in that results may be due to specific circumstances at the time of testing, and in any case cannot be generalised without reservation to other cohorts. Denney (1981) stresses the need to be aware of such problems in interpreting data relating to the

effects of age, and this proviso must apply to some of the research mentioned in the following pages. Indeed Weiss (1971) felt that attempting to study aging was so fraught with difficulties that it 'would make strong men weep'.

Physiological changes

There are age-related changes within most bodily systems, but physiological changes are not related in an absolute way to chronological aging. In the physiological sense some people age faster or more slowly than others, but in all individuals eventually systems such as the respiratory and cardiovascular will show signs of aging. The respiratory system, which is of course crucial to speech production, is affected by changes in the curvature of the vertebral column, and increased rigidity of the thorax. Reduced pulmonary function results from a decrease in elasticity and power, and anatomical changes in the joints and muscles will further affect functioning. Diseases of the respiratory system (such as bronchitis and pneumonia) are very common in older people.

Sensori-perceptual changes

Sensory changes have been studied in some depth, and it appears that there are both peripheral effects and alterations in central processing. All the special senses — vision, hearing, taste, olfaction and touch — are affected in that there appears to be a lowering of sensitivity. This may be a function of over-cautious responding within a test situation which elevates thresholds.

Visual changes. These include alterations in the cornea, lens and media, and there is a much greater risk of ocular diseases such as cataract and glaucoma. This may impair the older person's ability to utilise non-verbal clues in communication, and specifically to use vision to compensate for decreased auditory acuity. Chapter 5 considers this aspect of aging in greater depth.

Hearing. This has been the focus of much research in the field of

gerontology. At the same time, it has frequently been neglected in terms of rehabilitation and management. There appear to be regular alterations in the structures of the inner ear, such as increased stiffness of the basilar membrane, increased viscosity in the tissues of the ear, physical changes in the tectorial membrane and hair cells, and in the endolymph.

These changes may contribute to the condition known as presbyacusis, which is a decrease in hearing acuity particularly marked in the higher frequencies, and which therefore leads to a distorted speech signal input. Other pathologies not uncommon in older populations include tinnitus, noise-induced losses and otosclerosis.

The quality of the auditory signal becomes more crucial to older ears, with less ability to cope with distorted signals. Hearing loss, of whatever aetiology, will often affect the person in the role of the speaker, as well as listener, as the important auditory feed-back loop for monitoring speech will be less efficient. Furthermore, hearing loss — which will be discussed in more detail in Chapter 5 — can have profound effects upon the individual's general behaviour and response to treatment.

Perception may be defined as the way in which the central nervous system makes use of the incoming sensory information. It seems likely that there are alterations in the CNS that limit the capacity to integrate input from several sources, and thus to make processing decisions. Response rigidity and a reduced ability to alter initial perceptions — perhaps as a result of decreased efficiency of sensory feedback mechanisms — will also affect perceptual abilities. Other factors may include problems with concentration and cerebration. A useful summary of sensori-perceptual aging is offered by Corso (1971) among others.

Psychomotor changes

It appears from the literature that reaction time to sensory stimuli is increased, not as a result of muscular changes, but because of changes in central mechanisms (such as diminished arousal levels) and in psychological factors (for example, caution in responding). The stereotyped view of older people with slowed movements and reduced ability is due not to the aging process as such, but to some overgeneralisation of the

incidence of physical complaints and disorders. Such conditions as arthritis and rheumatism are far from uncommon in the older population.

Cognitive changes

Various academics have attempted, from the sea of available data, to create models of cognitive development. Among them is Schaie, who in 1977–78 proposed stages of Acquisition, Achievement, Responsibility, Executive functioning and — in old age — of Reintegration. He saw this final stage as more pragmatic and functional, with greater influence exerted by motivational and attitudinal variables, and a subconscious rejection of redundant and irrelevant information. It may thus be that changes in cognitive functioning that occur with age are in fact beneficial, and represent more adaptive ways of coping with alterations in life situation.

Memory. This is not a unitary phenomenon, as can be seen in Figure 1.2, but is a term to represent various types or levels. Smith and Fullerton (1981) reviewed the experimental evidence relating to iconic (visual), echoic (auditory) or haptic (movement) memory (that is, immediate recall, as in auditory digit repetition tasks) and found it to be shortened in older subjects, but that this had little, if any, functional relevance. Short-term memory is the name given to the system (or set of interlinked systems) which allows storage of information on a temporary basis. This, despite conflicting results, does not on balance appear to be limited in capacity as a result of aging, but response time is increased, and in addition the rate of scanning (that is, 'looking'; through the temporary information store), does seem to decrease with age (Madden and Nebes, 1980). Both these factors may have complicated research in this area. Certainly Smith and Fullerton (1981) felt that there was no empirical evidence to suggest short-term memory is more vulnerable in aged people.

Differences do occur in recall from episodic memory. It appears that aging affects the acquisition of new information for storage in memory, either because of a less efficient use of encoding strategies, or as a result of retrieval problems. There also seems to be evidence for an age-related difference in