

INTRODUCTION

“Elderspeak” (or “baby talk”) is a kind of speech characterized by speaking slower and/or louder, using simplified sentences, a patronizing tone etc., when talking to an elderly individual. It is not without consequences for older people: they can feel powerless and experience lower self-esteem¹.

Mains: (1) to analyze if more characteristic of elderspeak is observed when participants have to explain a treatment to older patients in comparison to younger ones; (2) to observe if elderspeak is linked to aging view: our hypothesis is that participants with a negative aging view will speak with more characteristics of elderspeak.

METHODOLOGY

Participants: 20 physicians and 20 students in medicine.

Methodology: They have to record a podcast where they explain hormone therapy to a fictional patient, (40 vs 70 years old) suffering from a breast cancer. Their aging view is measured by two scales (the FSA-R and the Aging Semantic Differential). We analyzed several measures of speech, as verbal fluency, grammatical complexity, semantic content and vocal analysis.

References:

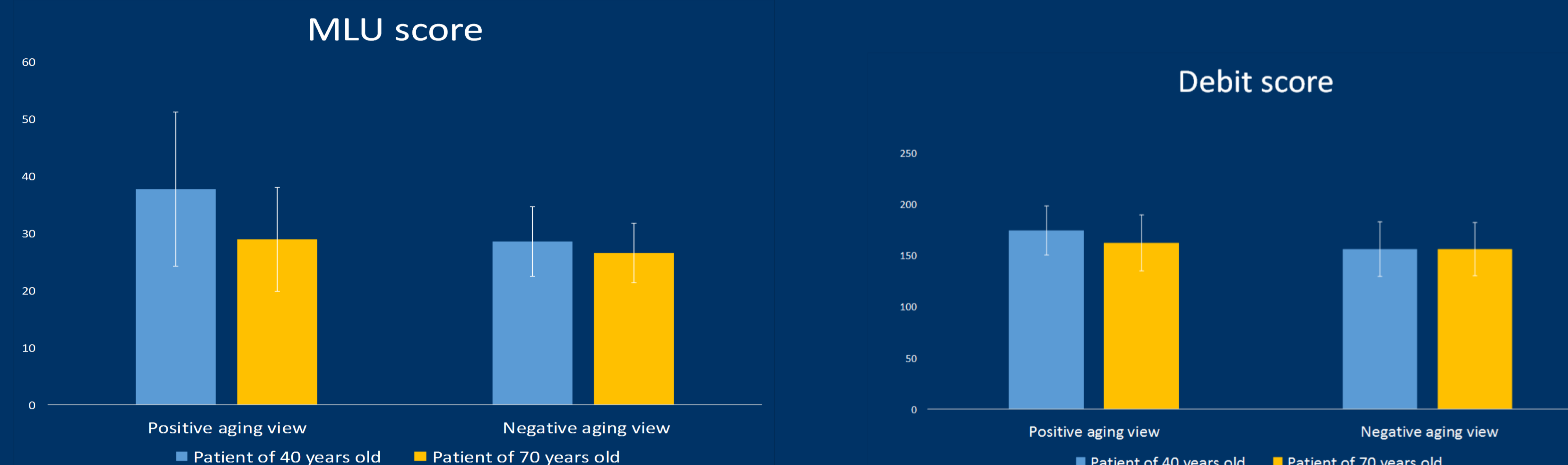
1. Ryan & Butler (1996). Health Commun, 8, 191-7. 2. Kemper & Harden (1999). Psychol Aging, 14, 656-670.

RESULTS

Linguistic measures: The number of words is smaller ($p = .048$), the mean length of utterance (MLU) is shorter ($p = .003$), the debit is slower ($p = .027$) and there is more repetitions ($p = .003$) when participants talk to older patients in comparison to younger ones. By contrast, the number of utterances is the same ($p = .23$), there is no difference concerning grammatical complexity ($p = .44$), lexical diversity ($p = .57$) and the highest, lowest and mean pitch (all $p > .06$).

Content analyses: When they talk to an older patient, in comparison to a younger patient, participants evoked less side effects ($p < .001$) and more accurately they avoid more frequently or minimize consequences of sexuality issues ($p < .001$) and skin dryness ($p = .047$).

Link with aging view: The reduction of length of utterances and of debit was observed for older patients when participants have a positive aging view (respectively, $p < .001$ and $p < .01$) but are the same for both patients (40 and 70-years old) when they have a negative aging view ($p > .21$). Moreover, the MLU and the debit are the same for older patients, whatever participants' aging view ($p > .28$) but MLU is shorter and debit is slower for younger patients when participants have a negative aging view ($p < .01$).



CONCLUSION

Participants with a negative aging view seem to consider a 40 year-old patient already “old” and so already adapt their speech. This adaptation is still presents when they have a positive aging view but only for a 70-year-old patient, which can lead us to talk about “benevolent ageism”: participants speak slower and reduced their sentences in expecting to enhance speech comprehension. However, previous studies has shown that such adjustments have negative consequences for elderly: it brings negative self-assessments of communicative competence².