Emerging scholar article

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'My darling' – elderspeak of nurses to acute hospitalised older adults: An integrative review

Abstract

Introduction: As the population ages, older adults will become a larger special interest group requiring perioperative care. It is therefore vital that we provide an appropriate environment for our older adult perioperative and acute care patients to feel comfortable and safe. Ageism may be defined as a prejudice by one group toward another age group, and the way that many patients are spoken to in health care (elderspeak) would be defined as an 'interpersonal ageist practice'. Interpersonal ageism in the form of elderspeak is rife in the nursing care of older adults in all areas of health care and has adverse effects in most instances, particularly in those with a cognitive impairment who exhibit greater rejection of care behaviours in response. This integrative literature review explores the concept of elderspeak and its theoretical underpinnings and will provide some recommendations for mitigation of this practice in the future care of our older patients.

Review methods: A comprehensive literature search was conducted using CINAHL, EBSCO and Scopus databases. Search terms used included 'aged', 'elderspeak', 'infantilising communication' and 'patronising communication'. Boolean operators, wildcards, subject headings, keywords and the 'cite forward' function in Scopus were used to filter articles and ensure more contemporary research was not omitted.

Discussion: Born out of ageism, elderspeak manifests in well-meaning but misdirected communication overaccommodations in intergenerational interactions. These patronising overaccommodations are often received negatively by cognitively impaired older patients leading to rejection of care and subsequent difficulty in meeting the medical and psychological needs of these patients. This review highlights the frequency with which this practice occurs, the impact upon patients, theoretical underpinnings of the concept and interventions shown to both reduce the use of elderspeak by nurses and rejection of care behaviours by cognitively impaired older patients.

Conclusion: Though reports are mixed as to whether elderspeak is a harmful or helpful practice, most literature condemns the practice as an ageist act that leads to adverse effects in patients, particularly those with a cognitive impairment. Educational interventions have shown substantial promise in reducing ageist attitudes and elderspeak in nursing staff internationally but to strengthen confidence, research in the Australian setting would be required.

Keywords: elderspeak, ageism, intergenerational communication, nursing practice, cognitive impairment

Introduction

Our population is aging, thus older adults – those more than 65 years old – will become a larger special interest group requiring specialised perioperative care. Also, as new medical innovations extend life expectancy and the baby boomer generation ages, the issue of ageism and its adverse sequalae have become a worldwide concern[1].

Ageism is a relatively recent concept and has been defined, by Pulitzer Prize winning gerontologist Robert Butler[2], as 'prejudice by one group toward other age groups.' Expanding on this definition, Butler introduced the concept of stereotyping, whereby cognitive structures guide inferences and behaviour towards a certain group of people[3].

DOI: 10.26550/2209-1092.1407

There is a litany of ways ageism towards older adults manifests in the healthcare setting, including clinical deprioritisation and exclusion from medical trials[4]. However, this paper will focus on the interpersonal ageist practice of elderspeak. The aim of this integrative review is to explore elderspeak, as a manifestation of interpersonal ageism in the nursing care of acute hospitalised older adults, and to address the question 'What is elderspeak, where did it come from and what can we do about it?'

Schnabel et al.[5] characterise the practice of elderspeak as linguistic and paralinguistic adjustments made by the speaker (usually younger) to accommodate for stereotypical perceived communication needs in the older adult hearer. These adjustments can include exaggerated prosody or melodic aspects of speech, juvenile lexical choices or 'baby talk', simplified sentence structure and inappropriate use of terms of endearment or diminutives[1].

The impact of elderspeak on the patient is fiercely debated but the bulk of the literature condemns its use, particularly in the care of the cognitively impaired older adult where elderspeak is associated with more likely and more severe rejection of care behaviours[6,7]. There is an unfortunate paucity in contemporary Australian literature on this phenomenon in the acute hospital setting; as a result, this review explores mostly international literature and includes research based in residential care facilities.

Methods

This integrative review was guided by Whittemore and Knafl's method for integrative reviews[8] and answered the question 'What is elderspeak, where did it come from and what can we do about it?'

Different types of scholarly literature, using different methodologies including qualitative, quantitative and mixed methods research, were selected for their ability to answer the question posed. A comprehensive search strategy for this integrative review involved the use of Boolean operators, wildcards, subject headings and keywords across several nursing and health science databases including CINAHL, EBSCO and Scopus. MeSH (Medical Subject Headings) were used for 'aged' but the remaining search terms including 'elderspeak', 'infantilising communication' and 'patronising communication' were left as keywords as no subject heading existed for these. The first search was conducted in CINAHL using 'Aged AND (Elderspeak OR infantilising communication OR infantilizing communication OR patronising communication OR patronizing communication)' yielding 27 results.

No age limit was used to capture germinal literature as well as to allow citing forward of older papers. Selected articles were included if published in the English language. Exclusion criteria included literature published in a language other than English and research without an explicit nursing focus. Though the acute hospital nursing care of older adults is the focus of this integrative review, some studies involving nursing homes were included to add context and to strengthen areas where there is a scarcity of acute hospital-based studies. Australian literature was sought in the primary instance, though due to topic paucity international literature was included if originating from a location with a similar healthcare and ageism landscape to Australia.

Quality appraisal

Literature found using the above search strategy was appraised with the 6S Pyramid, developed by Dicenso, Bayley and Haynes[9]. Preference was given to literature towards the top of the 6S Pyramid as these are highly synthesised and have an excellent methodological quality. Following this process, the EQUATOR (Enhancing the QUAlity and Transparency Of health Research) network checklists for each study type were used to further appraise and critique the literature.

Results

Using the above search strategy, and after reviewing and excluding ineligible papers, a total of 11 primary research articles were deemed eligible for inclusion in this integrative review – four quantitative studies, four qualitative studies, two mixed-method studies and one cluster randomised control trial. In addition, due to the scarcity of primary articles, nine reviews and one piece of grey literature were also included. Geographically, the primary literature originated from the United States of America (4), the United Kingdom (2), Germany (1), Australia (1), Austria (1), Norway (1) and South Korea (1).

Discussion

Discussion surrounding this topic will be presented under the following three themes that emerged from the literature: 'features, frequency and forces of elderspeak in nursing', 'origins of elderspeak and ageism – theoretical underpinnings and attitudes towards the hospitalised older adult in nursing' and 'future implications and strategies to mitigate elderspeak in the nursing care of the hospitalised older adult'.

Features, frequency and forces of elderspeak in nursing

Elderspeak is an infantilising type of speech register that occurs within intergenerational communication, undermining meaningful conversation, suggesting an intimate parent–child relationship and reinforcing power differentials already pervasive in health care[5]. First coined by Cohen and Faulkner[10], elderspeak presents as a number of linguistic and paralinguistic adjustments to speaking in a misdirected and ageist attempt to accommodate to the perceived needs of the older adult hearer[3,5]. These can include overly juvenile expressions, exaggerated prosody, terms of endearment or diminutives inappropriate to the situation (e.g. 'lovely'), collective pronoun substitution (e.g. 'our' instead of 'your') and tag questions (e.g. 'you're ready for your surgery now, aren't you?'). The use of elderspeak not only impacts the quality of the person-centred interaction but can also increase the likelihood of others perceiving older adults as incompetent or dependent[3].

Perhaps contributing to the already rife culture of paternalism in institutional settings, elderspeak is a common phenomenon in the nursing care of older adults[5]. Emphasising how frequently elderspeak is used in health care, a quantitative study (n = 114) by Schnabel et al.[5], in which interactions were observed across acute geriatric and acute general medicine wards in Germany, found that tag questions, collective pronoun

substitutions and baby talk were used by nurses at least once in the majority of interactions with patients. Testing this assertion, Shaw et al.[6] conducted a cross-sectional quantitative study observing care interactions between 56 nurses and 16 hospitalised patients living with dementia (PLWD). This study showed that, when accounting for all communication states across the ten hours and 47 minutes of cumulative care, elderspeak was used 11.7 per cent (SD = 10.4%) of the time[6]. Although this study had a small sample size, Shaw et al.[11] demonstrated that this effect is reproducible in their recent mixed-methods study that replicated care encounters in a simulation environment with ten of the 56 nurses from the earlier study, finding that the frequency of elderspeak was comparable to the naturalistic setting.

Unsurprisingly, Schnabel et al.[5] found that when caring for patients with a functional impairment nurses are more likely to use diminutives, simplified syntax, slower speech patterns and simplified lexicon. Though their sample is not nursing specific, Cassidy and Ojeda's[12] quantitative descriptive study supports the assertion of Schnabel et al. that functional impairment may lead to inaccurate assumptions about a person's mental agency, manifesting in elderspeak. Cassidy and Ojeda[12] observed that individuals attribute lower mental agency to older adults living in nursing homes than those residing independently (n = 179, p < 0.001).

Although Schnabel et al.[5] observed that decreased functional status was a greater predictor of elderspeak than cognitive status (p = 0.001), they noted that the use of elderspeak may be particularly harmful to those with a cognitive impairment. This can be further explained by Shaw et al.[6] who argued that elderspeak, as a depersonalising communication practice, is in direct contravention of person-centred care. The type of interpersonal care that respects individuality and selfhood is especially vital for those with declining cognition who, according to Kitwood[13] in his seminal work on person-centred dementia care, often rely on reassurance from others to uphold their sense of self. It is therefore not surprising that elderspeak elicits a negative response from the older adult hearer and is associated with an increase in neuropsychiatric symptoms, rejection of care and poorer treatment outcomes in patients with a cognitive impairment[5,6].

As a type of reactive aggression, rejection of care occurs in patients with a cognitive impairment and involves the patient actively or passively opposing the medically necessary efforts of the caregiver[6]. Of the observed care encounters in the, albeit small, cross-sectional quantitative study by Shaw et al.[6], rejection of care was exhibited in 48.9 per cent of care encounters between hospitalised patients living with dementia and nurses (n = 16 and n = 56, respectively). It was calculated that, when excluding other confounders, a ten per cent reduction in the amount of elderspeak used by nursing staff accounted for a 77 per cent reduction in probability of rejection of care (OR = 0.23, CI = 0.03-0.68) and a 16 per cent reduction in severity of rejection of care (e^{β} = 0.84, 95%; CI = 0.73, 0.96)[6].

Williams et al.[7] reported similar results in their quantitative study of elderspeak in nursing homes. Following an educational intervention, it was observed with statistical significance (p < 0.001) that every percentage point decrease in elderspeak was linked to a 0.43 per cent reduction in resistance to or rejection of care[7]. However, these results must be viewed with some caution as this study and education program was in a nursing home so might have limited generalisability in the acute hospital setting. Nonetheless, these statistically significant findings suggest that reducing the practice of elderspeak results in a decrease in frequency and severity of resistance to care in PLWD in residential care.

In contrast, in their qualitative study of PLWD (n = 43) Bridgstock et al.[14] observed that terms of endearment, regarded as a form of elderspeak[15], aided in communication with PLWD. Bridgstock et al.[14] hypothesise that terms of endearment mitigate communication with PLWD in certain contexts where there might be a threat of loss of face. Politeness Theory[16] argues that conversational partners in any interaction work together to maintain face, including using accommodating speech. For example, Bridgstock et al.[14] reported that terms of endearment were successfully used on two occasions where a healthcare practitioner asked for clarification from a PLWD when their statement was misheard. Requesting clarification may draw attention to lack of shared understanding between the PLWD and the healthcare practitioner and threaten a loss of face[14] but on these occasions terms of endearment were used to successfully maintain face during the conversation. However, Bridgstock et al.[14] conceded that on some occasions in the study, particularly when the PLWD was receiving an unwanted but medically necessary intervention, terms of endearment did not aid communication, and one participant rejected the endearment 'sweetheart' outright. Though elderspeak has the potential to foster cooperation between PLWD and healthcare practitioners in some contexts, the potential adverse effects of a blanket approach to this depersonalising speech pattern may not justify the alleged benefits. This should be a key consideration for future experimental research, particularly in the acute hospital setting.

Origins of elderspeak and ageism – theoretical underpinnings and attitudes towards the hospitalised older adult in nursing

It is widely accepted in theoretical and germinal literature on ageing that implicit ageism underpins the often well-intentioned practice of elderspeak within the healthcare setting[15]. As theorised by Butler[2], ageism manifests in stereotypes which guide inferences about the way individuals from different groups may act. Discrimination is the physical manifestation of stereotyping, and describes behaviours guided by inappropriate inferences about another group of people[3]. The World Health Organization's landmark 'Global report on ageism'[3] poses that, in the case of the older adult, stereotypes can be either negative (e.g. older adults are frail and incompetent) or positive (e.g. older adults are friendly and cute) but are similarly inaccurate and potentially harmful.

Ageist attitudes can be understood through the lens of Terror Management Theory[17] which posits that the presence of older adults prompts a human existential awareness of the inevitability

of death and aging, and this awareness generates anxiety, negative reactions and an aversion to older adults[1]. The existential threat posed by older adults and the ensuing ageism, complements Allport's Intergroup Threat Theory[18] where a perceived threat from another group motivates discrimination. In the case of ageism, the threat posed to the worldview that prioritises youth and vitality caused by the presence of older adults may explain discriminatory feelings and behaviours towards this group[19]. In their concept analysis, Hammouri et al.[1] draw these theories together to define ageism in the nursing context as 'any kind of stereotype, prejudice or discrimination against or to the benefit of older adult patients that is implicitly or explicitly practiced by the nurse and leads to actual or perceived (direct or indirect) decrease in the quality of health care provided'.

The attitudes that nurses have towards the care of older adults, was highlighted by Higgins et al.[20] in their qualitative descriptive study of nurses' attitudes towards older patients within acute medical and surgical wards in an Australian teaching hospital. Though dated and having a small sample size (n = 9), pervasive themes emerged of stereotyping, marginalising and oppressing older patients[20]. This aligns with an international cross-sectional qualitative study by Lampersberger et al.[21] that shows some nurses have a tendency to label patients as having a dementia if they require more care or take a prolonged time to do something. Indeed, Schnabel et al.[5] reported a statistically significant correlation between negativity of age stereotypes and higher use of collective pronoun substitution ($p = 0.029$) and tag questions ($p = 0.037$).

The Communication Predicament of Aging (CPA) model developed by Ryan et al.[22] is derived from the Communication Accommodation Theory whereby a speaker will alter the content and delivery of their speech based on the needs of their conversational partner to facilitate comprehension[15]. In contrast to the Communication Accommodation Theory, the CPA model poses that implicit ageism in the speaker can place emphasis on age- or disability-related visual cues in the hearer, leading the speaker to overaccommodate their speech with an older adult[22]. This overaccommodation is an attempt to facilitate comprehension in the older adult hearer and results in elderspeak using oversimplified, exaggerated or juvenile speech patterns[15]. Contrary to the often positive intentions of the speaker, elderspeak is frequently perceived negatively by the older adult, limiting the quality of the interaction and any future interactions[15].

Building upon the CPA model was the model of Patronising Talk which suggests that elderspeak exists on a care–control continuum[23]. This model poses that elderspeak contains both caring and controlling dimensions, whereby requests can be conveyed with an appearance of caring[23]. Shaw and Gordon[15] speculate that this balance between care and control is particularly relevant in the healthcare setting where rapport must be established while maintaining some degree of control over medical interventions. Bridgstock et al.[14] theorise that elderspeak is a form of mitigation, where speech is modified to reduce the negative effects of the speech content. For example, the harshness of medical instructions can be softened with the use of diminutives or collective pronoun substitution[14]. Thus, elderspeak is the manifestation of implicit ageist attitudes and, though well-intentioned, is generally perceived negatively by the older adult, particularly those with a cognitive impairment who exhibit responsive rejection of care behaviours[1,3].

Future implications and strategies to mitigate elderspeak in the nursing care of the hospitalised older adult

In order to mitigate the harmful effects of ageism, which underpin the practice of elderspeak, the World Health Organization recommends a multifactorial approach involving education, research to increase the evidence-base, intergenerational interventions, policy and law[3]. In this review, only the first two strategies will be discussed – education and increasing the evidence-base.

Williams et al.[7] demonstrated a marked and sustained decrease in elderspeak and resistance to care in cognitively impaired residents in their cluster randomised control trial involving 29 staff and 27 PLWD following an educational Changing Talk (CHAT) intervention for nursing home staff. This involved training sessions, improving staff awareness of the negative effects of elderspeak and supervised practice in effective communication strategies[7]. While the results of this study are promising, the trial was in a nursing home, had a small sample size and involved staff who were predominantly white and female; therefore, the results cannot be directly generalised to the acute hospital setting. Replication of this study in the Australian hospital setting with a more diverse sample would help strengthen confidence in the CHAT intervention as a strategy to reduce elderspeak and resistance to care in patients with cognitive impairment.

Similarly, a mixed-methods study in South Korea by Kang et al.[24] (n = 48) found that education had a positive result on acute care nursing staff knowledge and attitudes towards cognitive impaired older adults. As previously mentioned, collective pronoun substitution and tag questions have been found to increase with negative age stereotyping. Kang et al.[24] reported an improvement in nursing staff attitudes towards cognitively impaired older adults following the education program which suggests a possible simultaneous but untested reduction in elderspeak.

The cross-sectional nature of many studies investigating ageism and elderspeak, makes it difficult to ascertain causality of ageist attitudes, impacts of ageism and mitigating strategies. Randomised control trials would be more effective for assessing causation[25] and could be carried out in the Australian, acute hospital setting. This would strengthen the previous international research findings related to elderspeak, the impact of ageist practices and the efficacy of mitigating strategies. Local research studies would also inform steps toward the cessation of this ageist practice in Australia.

Conclusion

This integrative review has defined and explained the concept of elderspeak in nursing, discussed origins of elderspeak and ageism, revealed the frequency with which this practice occurs and looked at future implications and mitigating strategies.

The conclusions drawn in the available literature on this topic are mixed but,

in general, the overaccommodation in speech frequently employed by nurses caring for the elderly is viewed as a harmful interpersonal ageist practice affecting older adult patients in the acute hospital setting.

While often well-intentioned, the practice of elderspeak emerges from ageist attitudes that attribute reduced mental agency to older adults. This is a harmful and inaccurate generalisation that is largely given a negative reception and may compromise patient care, particularly in those with a cognitive impairment like dementia who require greater personalised care that recognises and upholds selfhood. International educational initiatives have shown that through improving nurses' attitudes towards cognitively impaired older adults, elderspeak and resistance to care are reduced in this cohort.

However, there is a paucity of contemporary Australian research on this topic. It is therefore a recommendation of this integrative review that research within the Australian acute hospital setting be conducted on not only the practice of elderspeak but also the use of international nursing education initiatives as a potential mitigating strategy for ageist attitudes, elderspeak and resistance to care in patients with a cognitive impairment.

As our population ages, and more older Australians will require surgery, this research will be vital to ensure we can provide an appropriate environment for our older adult perioperative and acute care patients to feel comfortable and safe.

Conflict of interest and funding statement

The authors have declared no competing interests with respect to the research, authorship and publication of this article.

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Acknowledgement

This paper was submitted to the University of Tasmania as part fulfilment of subject CNA803, Advanced Clinical Nursing Practice, for the Master of Clinical Nursing (Primary Health). The author sincerely wishes to thank Dr Paula Foran, unit coordinator, for her guidance throughout the master's course and work in preparing this paper for publication.

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