Overcoming Communication Predicaments in Later Life

Ellen Bouchard Ryan

All too often communication problems of older adults are presumed to be solely due to age-related losses. The Communication Predicament of Aging model highlights how negative stereotypes create communication predicaments for older adults, and other related models portray how health professionals and older adults themselves can minimize the social construction of excess disability among older adults. In particular, health professionals can seek to treat older adults as individuals while monitoring automatic social reactions to speak to them in terms of their age and disability. Several of our person perception studies show how hiding a hearing problem may lead to evaluations of lower competence and how assertiveness can work for older adults with hearing or vision impairments. Writing is a special kind of selective assertiveness which can empower older adults, especially those with difficulty in conversation. Audiologists and other health workers can also make a positive impact by fostering selective assertiveness among their clients.

Communication Predicaments

Cross-Cultural Aging Stereotypes

Comparisons of stereotypes of older adults in the East (e.g., Japan, South Korea, Hong Kong) and the West (e.g., North America, Australia, New Zealand) have shown unexpected similarity, with more variation among countries in Asia than between East and West. Older adults are viewed as lower in vitality and competence and considered to be more dependent and in poorer health than middle aged and younger adults. Young adults have particularly unfavorable views of older adults. Even though old age is viewed as more benevolent, helpful, wise, and trustworthy than younger ages, interactions with older adults can be dominated by age stereotypes of dependency and incompetence. As adults with hearing impairment presume when they avoid going for that first hearing assessment or using that first hearing aid, memory and hearing difficulties are associated with older age (Harwood, 2007; Kite, Stockdale, Whitley, & Johnson, 2005; Nelson, 2002, 2005; Williams & Nussbaum, 2001).

Stereotypes of the old in the USA (with similar patterns elsewhere) include positive prototypes such as Golden Ager and Perfect Grandparent while negative prototypes include severely impaired, despondent, shrew/curmudgeon, and recluse. The positive prototypes are more associated with younger and healthier individuals. Those with visible disabilities or in nursing homes are linked to the more negative prototypes (Hummert, Garstka, Ryan, & Bonnesen, 2004).

Self-stereotyping by older adults is also a problem. Priming studies show that the performance of older adults decreases with priming of negative stereotypes and improves with positive stereotypes (Hummert et al., 2004 Levy, 2003; Nelson 2005). In a well-controlled prospective study, older adults holding negative age stereotypes, especially related to physical appearance, showed more decline in hearing after 3 years (Levy, Slade, & Gill, 2006).

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Intergenerational communication is expected to be more problematic than intragenerational communication. This is especially true for non-family elders where first impressions weigh heavily. The one intergenerational situation which engenders particular closeness with young people is communicating with grandparents (Harwood, 2007; Williams & Nussbaum, 2001).

Models for Communication with Older Adults

Communication Predicaments of Aging Model

The social impact of negative age stereotypes on communication and identity has been conceptualized within the Communication Predicament of Aging Model (Ryan, Giles, Bartolucci, & Henwood, 1986). See figure 1.
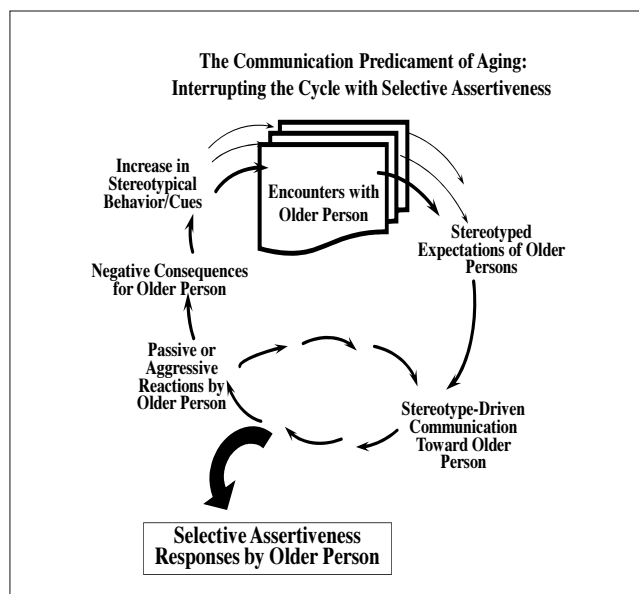
Figure 1. The Communication Predicament of Aging: Interrupting the Cycle with Selective Assertiveness.

Conversations based on negative stereotypes of aging such as dependence, poor health, and incompetence tend to incorporate modifications that limit the older person's opportunity for satisfying communication. Age and disability cues setting off predicaments can be derived from information provided by others (e.g., age on patient lists), physical traits (e.g., wrinkles, white hair or stooped back), assistive devices (e.g., hearing aid or walker), behaviors (e.g. asking for repetition or forget-

ting), and settings (e.g., senior centre, nursing home). The negative feedback cycle of age-adapted communication implicitly constrains opportunities to display competence, reinforces age-stereotypical behaviors, and limits satisfaction. Age-adapted modifications in conversation shape either passive or aggressive reactions which further contribute to the negative cycle. Frequent exposure to stereotype-based communication can undermine older adults' opportunities for rewarding social participation and lead to social withdrawal, helplessness, lowered self-esteem, and becoming older in appearance and behavior. The long-term impact on older recipients can be reflected in their own stereotype-reinforcing communication behaviors: painful self-disclosure, age excuses, repetitive verbal behavior, and off-topic verbosity (Coupland et al.,1988; Hummert et al., 2004; Ryan, Bieman-Copland, Kwong See, Ellis, & Anas, 2002).

Patronizing communication (also known as age-adapted speech or elderspeak) can be characterized as automatically modified speech in talk with older adults based on generalized low expectations associated with age and age-related disabilities. Such communication can be overly controlling, superficial, non-listening, or involve talking for or about the old person present. Overly nurturing communication (despite its friendly overtones and even intention) is also dismissive of the individuality and competence of the person. Secondary baby talk (the strongest form of patronizing communication) employs the same tone of voice (high pitch and exaggerated variations in pitch and stress) as talk addressed to infants or small children. Patronizing nonverbal features include pat on the head, wink to others, hands on hips, and raised eyebrows. Language features include overly familiar forms of address (e.g., dearie or sweetie, nicknames), simplified vocabulary and grammar, repetitions, interruptions, exaggerated praise, and narrow topic management (e.g., focus on the past, health). Moreover, avoidance of talk based on stereotypes of incompetence and "nothing in common" may be the most pervasive form of patronizing behavior.

Even though health professional or family users of patronizing styles are rated as less competent than counterparts using adult speech, there is some evidence that older recipients of patronizing speech or overhelping are "blamed" in the sense that they are rated as less competent. There is further evidence for acceptance of negative age stereotypes and patronizing styles by older adults in nursing home and hospital settings where cues of dependence are more salient than in community settings. Also, the age-adapted speech used in nursing

homes is more linked to characteristics of the speaker than to the recipients – that is, some staff use secondary baby talk with most residents and some do not use it. Interestingly, there are variations in the sources of patronizing speech for older adults in community versus nursing home settings. Compared with friends, same-age family members, younger family members, and familiar service workers, community residing older adults in O'Connor & St. Pierre (2004) reported only receiving patronizing speech from unfamiliar service workers. However, nursing home residents received patronizing speech from all speaker types. Thus, it is clear that there are detrimental effects of receiving patronizing speech frequently and that this is more likely to occur for the more frail and vulnerable older person (Hummert et al 2004).

Communication Enhancement Model for Health Providers

The Communication Enhancement Model was developed as a framework for communication interventions intended to reverse the operation of the negative feedback Predicament loop (Ryan, Meredith, MacLean, & Orange, 1995). This framework, shown in figure 2, emerged from a consideration of health promotion strategies that focus on the roles of self-care, mutual aid, and social support. The communication encounter with an older person is part of a positive feedback loop. This positive cycle can be achieved through a person-centered, as opposed to category-based, approach to communication with older individuals. This approach requires not only a consideration of the individual characteristics of an older conversational partner at the beginning of an interaction, but also a constant reassessment of the interaction as it progresses. If the partners engage in appropriate adaptations, the enhancement model sees positive outcomes for both parties in terms of empowerment, increased competence, satisfaction, health, and effective communication.

The success of a dyadic interaction between care provider and an older client is seen to depend on multiple environmental influences well beyond the interaction itself. One can improve the chances for a satisfactory encounter by dealing with some of those environmental factors (e.g., average time allowed per encounter, institutional philosophy, sound and lighting conditions, training level of personnel, financial issues). The key to an initial encounter is to assess cues about the older client in an individualized, contextualized man-
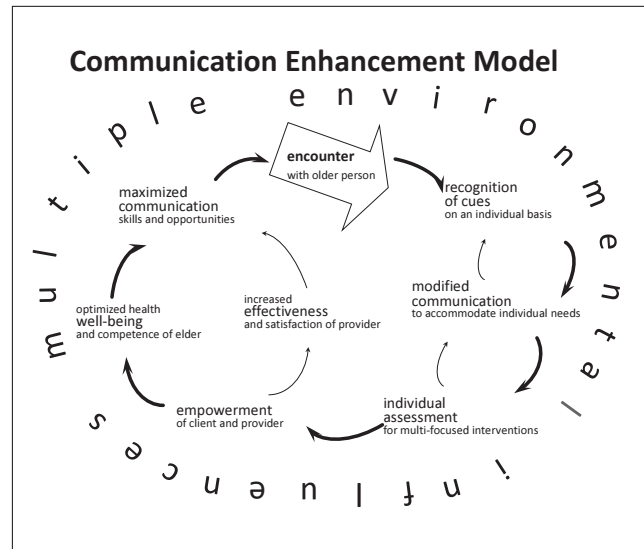
Figure 2. Communication Enhancement Model (reprinted with permission from Ryan, Meredith, MacLean, & Orange, 1995).

ner. If some communication modification appears needed because of limited English as a second language or a hearing impairment, for example, adult-focused modifications are attempted while feedback regarding their appropriateness is sought. The provider is well aware of the tendency to overgeneralize impairments and to overdo communication modifications in response to particular communication difficulties and is constantly monitoring the mode of communication as well as the content. The assessment and development of a treatment plan for the client are as individualized as possible and as collaborative with the client as feasible. The care provider attempts to empower the client, to help them identify the issues and participate in their resolution. The strengths of the client are an important part of the assessment and treatment planned; the client's sense of control is thereby supported. The client experiences enhanced competence, health, and control.

The provider has a high probability of achieving a satisfactory encounter, and the treatment plan has a better chance of success. With repeated exposure, the client grows in the ability to collaborate with the provider in seeking his or her own health and both client and provider may become more able to influence environmental constraints on healthy communication.

Much research is needed to address how communication partners of all ages can enact this model which empowers both the older adult and the social partner. For instance, a scenario study showed that long term

care staff who used personhood-based language were rated more positively than staff who used directive language with nursing home residents with dementia and, more importantly, that the residents were also rated more positively in the personhood scenarios even though their responses in both personhood and directive scenarios were identical (Savundranayagam, Ryan, Anas, & Orange 2007). Carefully simplified language, suggested by the elegant experiments of Kemper and Harden (1999) as an effective language modification, strengthened those effects by showing staff as less patronizing, and residents as more competent. These findings suggest that appropriate changes in staff communication benefit both staff and residents.

The work of the late Margaret Baltes and colleagues in the USA and in Germany highlighted the dependence-reward script in nursing homes whereby social interactions with staff were achieved largely by needing help. Attempts to feed, dress, or groom oneself were largely ignored. Getting used to living in longterm care may be largely a matter of getting used to these social contingencies and hence taking on the passive, needy pattern of a patient. Their intervention research demonstrated that institutional staff could increase their social rewards for independent behaviors and thereby effect some return of competence on the part of patients (Baltes, Neumann & Zank, 1994).

The research program of Kristine Williams also supports the Communication Enhancement Model. Williams and her colleagues (Williams, 2006; Williams, Kemper, & Hummert, 2003, 2004) developed a brief intervention that informed long term care staff of the importance of socialization for older adults. The intervention focused on communication barriers specific to the longterm care context, and the positive and negative aspects of elderspeak. Using actual and simulated videotaped staff-resident interactions, participants were able to identify aspects of elderspeak in their own interactions and those of others; and to reenact selected interactions using more effective communication strategies. Participating staff members gained knowledge about their own communication patterns, especially their use of elderspeak. They also used fewer psycholinguistic features of elderspeak (e.g., diminutives, shortened statements, and simplistic vocabulary) after training. Further work could establish the extent to which such an intervention could positively affect the residents as well, especially in terms of social engagement.

Selective Assertiveness Model for Older Adults

Communication dilemmas frequently arise for older adults in health care encounters and elsewhere. How should they respond to infantilization, premature interruptions, comments about them in their presence, inadequate explanations due to the assumption they wish to rely on authority for decisions, being kept waiting due to the assumption they have nothing better to do, and the "what can you expect at your age" messages?

Figure 1 incorporates the option for older adults to interrupt the communication predicament cycle by choosing to respond with selective assertiveness (Ryan, Bajorek, Beaman, & Anas, 2005a). Normally, the social pressure of the predicament cycle leads an older adult to react – most of the time passively and then in exasperation aggressively. Both of these reactions feed into the negative feedback loop, reinforcing age stereotypes. See also Doty, 1987; Paterson, 2000; Taylor & Epstein, 1999; Twenge, 2001; Wilson, & Gallois,1993.

Selective Assertiveness points to the opportunity to choose alternatively to respond calmly, with confidence and clear language, to state one's needs for information or help or to refuse a request or to register a complaint. Assertive speakers communicate clearly while taking responsible control over meeting their goals without passively deferring to others or aggressively imposing on them (e.g., an older adult firmly requesting a follow-up doctor's appointment). In line with Socioemotional Selectivity Theory, speakers make choices about important, realistic goals to fit the circumstances (Carstensen, Isaacowitz, & Charles, 1999). Selectively assertive communication is characterized by straightforward messages, relaxed gestures, and calm and confident emotional responses. The assertive speaker is tactful: aware of the social context and the other person's perspective, knows when to be direct or indirect, and acknowledges the communication partner's positive behaviors when appropriate Older adults with age-related impairments can use these skills selectively for self-advocacy and also for group advocacy (Hickson & Worrall, 2003; Orr & Rogers, 2003; Ryan et al., 2005a).

The older person with selective assertiveness skills can decide when to ignore patronizing behavior and when to confront it. This person is making choices, including resisting the impact of the Communication Predicament cycle by reframing so that the problem belongs to the other person not oneself. When the short-

term and long-term benefits outweigh the potential risks, the older person can proceed with an assertive response matched to the situation. Some older people are naturally skilled in this arena. However, many older people, especially those with impairments who are often in vulnerable one-down situations, could use training and role-modeling exercises to empower them. Orr and Rogers (2003), for example, have developed an effective community training program in self-advocacy for older adults with visual impairment.

First Impressions Research on Communication with Older Adults with Hearing or Visual Impairments

People with hearing or visual impairments are expected to be dependent, less capable, and all alike. Encounters with older adults with age-related sensory loss can exacerbate the already prevalent fears associated with aging within our society. People unfamiliar with sensory impairments exhibit uncertainty about how to interact with a person with hearing or visual impairment – how to avoid staring, what accommodations would be useful, when and how to offer help. Particular communication challenges experienced by individuals with disability include the social pressure and risks of disclosing information about one's impairments, managing help (avoiding overhelp while recruiting needed help), and gaining access to required information (Braithwaite & Thompson, 2000; Goffman, 1963).

Three of our person perception studies are presented here to illustrate how presentation of carefully controlled scenarios can be used to weigh the impact of different types of descriptive and behavioral information on first impressions of older individuals with or without sensory impairments.

Hiding Hearing Impairment Can Be Risky

The impact of communication predicaments based on stereotype-based talk underscores the importance of understanding how age and disability information guides the formation of "disabling" first impressions. In the domain of age research as well as other stereotype work (e.g. about gender, race, nationality), information about two negatively valued group memberships or traits can lead to double jeopardy or a leveling effect (Fiske & Taylor, 1991; Palmore, 1999). In the communication domain, some evidence for double jeopardy has been found in person perception studies. In particular,

older speakers were not accorded the approval received by young speakers for faster, more effective performance (Ryan & Laurie, 1990; Stewart & Ryan, 1982).

Ryan, Anas, and Vuckovich (2007) employed the person perception paradigm to examine age-related disability biases about hearing impairment (Pichora-Fuller & Carson, 2001; Strawbridge, Wallhagen, Shema, & Kaplan, 2000). Young adults gave first impressions of four younger or older target persons, with or without hearing impairment, who did or did not exhibit communication difficulty in a conversation. The target persons were hospital volunteers involved in various social conversations. Across four hospital settings, a brief introduction either mentioned the volunteer's gradual loss of hearing and use of a hearing aid or not, and a brief conversational script incorporated a misunderstanding on the part of the volunteer or not. Participants evaluated the volunteers on how well they expected the target to perform on several anticipated cognitive performance measures (sentence repetition, visual memory for objects and printed names, visuo-spatial, written vocabulary, and wisdom). In addition, on a social distance scale, participants assessed the likelihood with which they would interact with the target at three levels appropriate to the volunteer context: moderate (e.g., invite home), casual (e.g., offer a ride) and distant (e.g., say hello in passing). In line with age stereotypes, older targets were rated lower on visual memory and visuospatial skill but higher on wisdom. Targets with normal hearing and communication difficulty were rated as least competent on the cognitive tasks and most socially distant. Furthermore, the lowest wisdom scores were anticipated for normally hearing young targets exhibiting communication problems. The findings showed that adults, young or old, were judged less severely for communication difficulties if known to use a hearing aid. In this experimental situation, hearing loss and use of a hearing aid figured very little in first impressions where communication performance was directly portrayed, except as a reason for communication difficulty. These findings could help those counseling older adults with hearing loss since "faking it" can lead to serious interpersonal problems.

Selective Assertiveness Can Pay off Richly

A number of studies have examined the risks and benefits of assertiveness by older adults (Hummert et al., 2004). Early studies established that assertive responses in communication dilemmas within community

settings were rated as less polite but the speakers were rated as more competent. Within the nursing home, direct assertiveness was not seen as a competent role for residents. For that setting, a more indirect assertive response (declining an inappropriate request with humor) was effective.

Ryan, Anas, and Friedman (2006) examined assertiveness as an option for older adults confronted with a problematic health care conversation. Within a health care encounter, unsatisfactory communication can result in inadequate diagnosis, inappropriate treatment, insufficient information, and reduced compliance with life style, exercise, and medication prescriptions. Three clinical scenarios with a problematic conversation were developed: being ignored by a physician, unable to follow a message delivered too quickly by a pharmacist, or misunderstanding a physiotherapist's message because of noise.

Older and younger participants evaluated scenarios in which senior client targets with or without hearing loss employed either assertive, passive, or aggressive responses. As predicted, assertive seniors were evaluated as most competent and likely to be satisfied with future encounters. Hearing loss made no difference in evaluations of the three response styles, thereby indicating that older speakers with hearing loss can be just as successful with assertive strategies as others. Further research in which part of the assertive response involves mention of hearing impairment in a clear matter-of-fact way might well show special benefits of assertiveness to seniors with hearing impairments.

Compared to older participants, young participants gave equivalent ratings for assertiveness but viewed the senior's passive response especially positively and the aggressive response especially negatively. This finding shows that young people expect the old to behave passively, and while accepting assertive behavior, they are not tolerant of missteps over the boundary into aggressiveness. Thus, it is clear that seniors have to be more careful of their assertive speech style among young people.

Knowing how to match one's assertive options to the setting and situation is a key ingredient to successful communication. Building from this study then, the second assertiveness study (Ryan, Anas, & Mays, 2008) examines the impact of these two features upon evaluations of assertiveness.

Patronizing speech has been evaluated differently in community settings as compared to the hospital or long term care setting. In the one relevant assertiveness study, more assertive responses were offered to patronizing advice given to an old person in a community setting than in the hospital. The greater hierarchical structure in the institutional environment can be expected to limit the opportunities for assertiveness. Furthermore, one would expect that serious situations create a context where assertiveness is more acceptable. From the point of view of politeness theory, the weight of an assertive request is increased by a hierarchical environment and moderated by situational features indicating specific reasons for the request (Hummert et al., 2004).

Ryan et al. (2008) assessed the impact of two contextual manipulations on evaluations of disability-related assertive responses by older adults with visual impairment. Young and older adults evaluated visually impaired older women targets presented in brief written conversational scenarios where they responded either passively or assertively to the lack of requested assistance with reading needed information.

The conversation took place in either a community or a hospital setting. In the community, help was requested with reading a petition at the hairdresser's protesting the construction of an apartment building or with reading the ingredients on a food package in the grocery store. In the hospital, the target requested help from a pharmacist to read product information or help from a nurse to complete a visitor information form. Care was taken to create hospital situations not involving direct health care. The conversations ended with the target responding passively or assertively to the lack of forthcoming help from the conversational partner. Two versions of each vignette were created by varying the seriousness of the request (e.g., for the food package – watching one's weight vs. allergy to peanuts).

Assertiveness was positively evaluated on selected measures, allowing for the usual ratings of assertiveness as less polite than passivity. Compared to passive speakers, assertive speakers were seen as more competent, more capable in handling their situation, and more likely to attain their goals in future encounters. We did find that context matters for assertiveness as predicted. The assertiveness advantage (i.e., the difference between ratings for assertive and passive responses) was greater in the community setting than in the hospital. There was also a greater assertiveness advantage in situations with serious consequences. Even though the two hospital situations differed less in rated seriousness than those in the community, no triple interactions occurred for the evaluative data. The analysis of expected help confirmed

the assertiveness advantage in meeting the needs of the visually impaired target speaker.

These findings suggest specific ways in which older adults might be encouraged to respond more effectively by carefully choosing features of assertiveness to match the demands of problematic situations. Carefully stating one's reasons for repeating a request (without escalation of emotion) can be an effective route to success, especially when the reasons are serious. All too often older adults contribute to unsuccessful health care encounters and other situations by giving up ahead of time and not providing the specific information which would gain the service provider's attention. The institutional setting data do not imply that seniors should not be assertive in hospital settings. Not only is there an assertive benefit in this setting, but the assertive benefit is especially strong in serious situations. Rather, older adults need to know that they must attend more specifically to when and how to be assertive in less inviting hierarchical settings.

Writing as Selective Assertiveness

Writing is a means of communication that provides many benefits over oral conversation. People slowed by old age and/or impaired by sensory or cognitive losses can develop their thoughts without having to deal with the real-time requirements of conversation and the unpredictability of conversational partners' behavior. Writing offers an increased level of control and empowerment, as well as more time and greater flexibility for constructing messages (Ryan, 2006).

Writing to Supplement Oral Communication

By writing in advance, one can prepare for important conversations and maintain better control over assertive oral communication, managing the tightrope between appearing passive, on the one hand, or aggressive, on the other hand. Journaling about upcoming conversations (e.g., visit to the doctor or sorting out a problem during a family meeting) allows the writer to work through negative emotions safely, to create and follow through various scenarios about what might happen, to practice the wording for a specific request or complaint, and to develop the confident calm with which to present these words. Sharing writing with a confidante offers further opportunity to develop an assertive strategy or even to decide that this battle is not the one to choose.

In addition to writing as a preparation strategy, written lists or documents can support conversations. It is easier to stick to the point, with a list or agenda. Taking a list to the doctor's appointment is the most frequently offered suggestion. But one can go farther. If the doctor regularly ignores the list, the patient can bring a larger list, look at the list, or even gently hold the list up to break eye contact with the doctor. These nonverbal gestures communicate more indirectly than words that the patient's concerns are to be addressed. An agenda for a family meeting is a way for an older adult to ensure that their perspective is not ignored and that all their considerations are aired (Ryan et al., 2005a).

The use of writing can be especially advantageous to older adults experiencing difficulty with conversation, including those with hearing impairments. We have worked with older people with early and moderate dementia in creating Conversational Remembering Boxes (Hagens, Beaman, & Ryan, 2005). These could work very well for persons with hearing impairment who could follow conversations with visitors more readily if the conversations centered on familiar themes. The idea is to choose a box (e.g., a hat box from the old days or a fishing tackle box) and then place items within to prompt short or long conversations. These include photographs, pictures, audio or video tapes, small objects, writings, and a journal. The most important writings are those with the person's own words (either written directly or recorded by another person). This could be easily done by older persons with hearing impairment once they are given suitable prompts.

The box is a living container. As it is used, more ideas develop for contents and especially for writing more segments of one's life story. After a nephew brings a favorite item for the box to remind the aunt of their long ago trip together, one of them can write out their reminiscences in the journal. Thus, an older person with problems hearing unfamiliar voices can prepare for conversations with a Conversational Remembering Box. In this way, selective assertiveness begins well before the visitors arrive. Building such boxes could be the focus of several meetings of hard-of-hearing support groups. In these groups participants might also be guided in the writing of group poetry on themes such as "where we're from" or "the color red" or "outings to the country in whooping cough times." Such poems can be great conversation starters as visitors try to guess which parts of the poem were contributed by the host (Hagens et al., 2005; Hagens, Cosentino, & Ryan, 2006).

Writing to Chronicle, Educate and Advocate

Writing one's life story or memoirs about segments of one's life is a prime example of selective assertiveness. The person takes control of their own story, outside the conversational shaping that occurs in social contexts. In contrast to storytelling during conversation, one does not need an attentive, appreciative audience for writing. Writing for the ideal reader empowers a person to dig deep for their own authentic story.

Over the past 7 years, we have been analyzing memoirs by writers with various forms of disability – vision, hearing, physical, cognitive, emotional disorders (Ryan, 2006; Ryan & Bannister, 2009). We have tried to capture the ways in which writers with dementia (diagnoses of probably Alzheimer's disease) cope with specific reading and writing impairments associated with their condition (Ryan, Spykerman, & Anas, 2005b). We have documented the process of empowerment through writing experienced by authors with dementia (Ryan, Bannister, & Anas, 2009). As you can imagine, the excess social disability associated with a dementia-related diagnosis is extreme as family and friends begin to treat individuals only in terms of stereotypes of cognitive impairment. They portray with amazing authority how this social diminishment feels from the inside. They direct their writing to family caregivers and professionals and also to others with this diagnosis to describe their symptoms but even more to speak out powerfully about their continuing personhood and diverse competencies, including insight and ability to adapt. Thus, some older adults can come to grips with acquired disability in later life through writing and can provide leadership on behalf of others in similar situations.

In Conclusion

From this article, there are three main conclusions relevant to audiologists working with older adults with hearing impairment.

Older adults experience communication predicaments. These are likely to be exacerbated by hearing difficulties and the stigma associated with hearing aid use. Health professionals can use the Communication Enhancement Model as a guide to empower their older clients within their own assessment and training sessions. They must be on guard for the automatic patronizing reactions to old age and disability socially shaped within our society and learn to monitor their communication style – seeking feedback from clients. Most tip lists for talking with older adults include some demeaning behaviors that might be needed in an individual situation but certainly not for the majority of older adults – e.g. speak simply and slowly. When asked for such a list, I have offered one word – Listen. If the professional focuses on the older individual, listening and observing, then a natural appropriate conversational style is likely to follow.

Health professionals can facilitate effective communication for their older clients by fostering selective assertiveness. One can help them to pay particular attention to how they express assertiveness in hierarchical contexts such as hospital and doctor-patient situations and to be sure calmly to state the reasons for their request or refusal, more than once if need be. They can help them through role play with difficult situations calling for assertiveness such as dealing with the health and social care system, dealing with unwanted advice or overly controlling behaviors, seeking to be talked to directly when with a younger companion, meeting new people, or making other types of requests.

Finally, audiologists and other health professionals can support older persons to use writing as selective assertiveness. Encouraging older adults with acquired hearing impairment to write in a journal for themselves can assist them in finding their inner voice. The writing for the self can help them find positive meaning in age-related changes including hearing loss, express their emotions, convert emotion and images to words and story, adjust goals and activities in line with their impairment, see themselves in a wider context, identify lessons learned, and find the humor in their story. Older adults can be helped to use written preparation for difficult conversations so that they can achieve their goals more readily. Finally, those inclined can be supported as they find their social voice and write their memoirs (about aging and hearing loss or perhaps more broadly) to help others with the same impairments, to pass along lessons learned, to educate health providers, and/or to advocate for social changes which would improve the life opportunities for older people with hearing loss.

Acknowledgements

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