CHAPTER 6
Talking and listening
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Good listening • speech and understanding • conversation and relationships • confusion and dementia • language and speech difficulties

What is communication?
What can make communication difficult for an elderly person?
What can be done to make communication easier?

These questions all use the term communication. It is often said that someone is a good communicator when they can talk well and interest their listeners. But there are two sides to good communication: being able to make the meaning clear, and being able to listen and understand what is being said.

In working with elderly people it is often listening which is by far the most important part of good communication. Listening can be done well or badly: think of how annoying it can be when someone does not appear to be listening to what is being said. To be a good listener it is important that your conversational partner can see that you are attending.

For most people, good communication is a very important part of their lives. For many elderly people it is particularly important because they have limited mobility and are restricted in their activities. For example, the frail elderly person, the person with arthritis, the person who has difficulty walking after a stroke – talking and listening are vital ingredients in their everyday lives.

How can people be good communicators and good listeners?

Of course good communication does not mean just speaking clearly. It means using an appropriate tone of voice, making eye contact with the listener, perhaps using gesture to emphasise a particular point, perhaps altering body position to show someone that you are talking to them rather than someone else. In other words most people, including elderly people, listen with their eyes as well as their ears.

Some elderly people have hearing difficulties or cannot see well. Communicating with them requires the same set of good communication skills but with a different emphasis.

An elderly person with hearing difficulties will be much more reliant on their eyes when listening. They will only know when someone is speaking to them
because that person is facing them. They may be able to lip read and so need to be able to see the person’s face well, in good light.

They need to see normal speech to be able to lip read. This comment may seem strange but when someone is shouting they distort their normal speech. Not only is lip reading then more difficult but, if the person listening can hear something, it is much more difficult to understand and it can even be painful to the ears.

In much the same way the elderly person who has poor sight needs alerting to the fact that someone is talking to them, rather than anyone else. It often helps to call their name or to touch their arm so that they are alerted and ready to listen. But even someone who cannot see is helped by the same good communication skills. Tone of voice becomes very important but, because they are relying on their ears, it is also important to face them so that your speech can be heard clearly.

Do elderly people speak and understand in a different way from younger people?

The answer to this question is, probably not. Some research has been carried out which shows that elderly people hesitate and pause more when they speak. Elderly people themselves say that they sometimes find it difficult to remember a particular word, often a name. But everyone has this same difficulty from time to time.

Sometimes elderly people do not understand what is being said to them, but they usually have no difficulty when something is repeated. Part of this difficulty may be hearing loss, but part of it is due to psychomotor slowing. Psychomotor slowing is the slowing down of thought and the following action. Elderly people may be somewhat slower at understanding what is said to them than younger people.

One of the few changes which definitely does occur with age is a change in voice quality. Given a choice between an elderly and younger person speaking, it is usually easy to tell who is older. In elderly men the voice often becomes higher and in elderly women it sometimes becomes lower.

Of course elderly people do have difficulty communicating at times. Illness, fatigue and anxiety all make talking and understanding more difficult for an elderly person. An elderly person with bronchitis, for example, or in pain with arthritis may find communicating more difficult temporarily.

Do people speak differently to an elderly person?

Yes, they can do. Most people adopt different tones of voice depending on who they are talking to. People may sound very different when they are speaking on the telephone.

People often speak very differently to small babies and dogs. They make their voice higher, they speak more slowly and their voice often has a different rhythm. Researchers call this “motherese” because mothers of small children use it a great deal. Some research has shown that people use the same sort of voice when talking to elderly people.

This is not a good idea. It may be very irritating to some elderly people. To make sure that you are not using motherese, make a tape recording of yourself and your colleagues when you are talking to elderly people, and then listen.

What helps good communication in a residential home?

It is very easy for communication to go wrong between the carer and resident in a home, but it is also quite easy to put it right. One of the delicate balances in looking after someone is the relationship between the resident’s needs and the carer’s time and interest. Good communication needs some time and a genuine interest between
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the people who are having the conversa-
tion.

It is quite easy to have low expectations about how elderly people communicate. It is also quite easy to forget that they may have a great deal to contribute to a conversa-
tion. As well as asking the elderly person how they are, encourage them to ask how
you are. Ask for their opinions about the weather, politics, sport, the newspaper or
Television and give them yours.

This is real communication and it is quite unlike the passive communication which sometimes can happen. Real commu-
nication includes the kind of teasing and telling jokes which is natural between
friends.

Most human beings like change. Change stimulates conversation. Going for a walk, meeting a new person or old friend or
changing activities can all start a conversa-
tion.

What about television? Television can be an excellent activity but it needs to be
watched actively. It is much better to turn on the television for a particular pro-
grame and then turn it off at the end. Television requires concentration and, if
it is left on all day, it becomes just another
noise. It is easier to listen to music, but make sure it is appropriate for that age
group.

Language

Before considering specific problems that the elderly may have in communicating, a
brief description of the constituents of
language may be useful.

Communication is made up of many parts. Before communication there needs to be a thought or idea. That thought or
idea then needs words which are arranged into an appropriate order for what is to be
said. Then the arranged words are spoken. The muscles of the face, tongue and larynx
move in a co-ordinated manner to pro-
duce speech. The larynx produces the
sound while the tongue and facial muscles
shape it into speech. Communication can
go wrong at any of these points.

What specific problems can affect commu-
nication?

• Confusion
• Dementia
• Language problems
• Speech production problems

Confusion

Confusion arises due to alteration in a
person’s mental state. This alteration is
often variable; the person may be disorientated in time and place (perhaps insisting
that he is in another place) and may fail to
recognise familiar faces or surroundings.

He or she may say a mixture of quite
sensible and very odd things or take off-
ence through failing to understand what
has been said. Confusion is commonly
associated with illness such as urinary tract
infection, changes in medication and life
events such as entering a residential home.

When communicating with a confused
person, it is helpful to provide information
about the here and now, to assist in orient-
ting the person to the present. It is advisable to confine speech to the essentials
that need to be understood. Understanding will be helped by clear informative
speech produced in short sentences, al-
lowing time between sentences for under-
standing the meaning.

Repetition may be needed to clarify the
meaning. Normal voice and expression
should be used and it is helpful to face the
listener since understanding is aided by
the additional information gained from
the speaker’s facial expression and ges-
tures.

Particular effort to help re-orientation
is needed when confusion recedes. The person will need to be reassured about where he is and what is happening to him. Discussion of this and daily activities and pastimes will be beneficial.

**Dementia**

Unfortunately, for some elderly people, confusion represents an early sign of an underlying dementia – a general intellectual impairment (see Chapter 15). Brain mechanisms for speech are eventually disrupted by the loss of brain cells. As well as confusion, early signs of dementia are short term and recent memory loss and a general slowing up, with difficulty in carrying out activities of daily living as the disease progresses.

There are a number of specific changes in speech and language abilities which occur in most people with dementia. In the early stage speech is fluent, words are spoken normally, comprehension remains intact. However, difficulty in thinking of words can occur. This is often seen as a “tip of the tongue” state when someone can’t think of the right word although they know it. Even at an early stage communication is affected by short term memory loss, which means that the person may well not remember what they have just done.

As the disease progresses, naming becomes more impaired. The fluency of speech increases so that speech becomes rambling and fragmented. Here is an example from an eighty-two year old lady with a two-year history of dementia, describing a picture of a busy high street. She has been widowed for twenty years:

“Two ladies, baker, somebody leading a little baby. I had a little baby. I don’t see much of my husband now. She turned around and looked at me. Supermarket”.

Understanding becomes moderately impaired and problems with reading and writing occur.

In the later stages of dementia the person becomes non-fluent, speaking only occasional words. Sometimes a word may be repeated many times. Some people also produce echo-speech, repeating what has been said to them. By this stage the person has severe problems with understanding and is probably only able to understand a few conversational points. Reading and writing become impossible for them.

It is obviously difficult to communicate with a person suffering from advanced dementia. However, the early and middle stages can last for many years, and during this time effective communication can be achieved. There are five basic points to consider in order to assist communication with someone who is suffering from dementia:

1. Do not assume that any aspects of meaning which are not specified will be understood. For example, you may talk about the next meal and be very well aware that this must be breakfast because it is 7 am and the elderly person is just getting up. But you must make this clear, perhaps by using the word “breakfast”.
2. Be very direct – cut out unnecessary details.
3. Keep the content direct. For example, the remark “I imagine its like flying” would be very difficult for a dementia sufferer to understand.
4. Do not assume that the person remembers – he or she is likely not to, even though what you refer to may be a daily event.
5. Try to give additional facial and gestural clues.

Although communication with a person suffering from dementia may be difficult it is important that these people are encouraged to talk, discuss and remember. With a little extra effort on the part of the listener it is usually possible to understand what the person is saying, to extend their topics of conversation and to communicate effectively. This helps the
confused person to stay in contact with daily activities and surroundings. It also makes caring for the person far more rewarding, as a relationship between staff and elderly residents is primarily maintained through their communication.

Language problems

Damage to certain areas of the brain can cause an adult to have an acquired language disorder, called dysphasia: the ability to understand and express meaning through words is disrupted. This may affect speech, reading and writing. The most common cause of this would be a stroke affecting the left side of the brain.

The exact effect of such an injury on speech and language ability will vary from one individual to another depending upon their injury, their previous education, work and experiences, their personality and their present communication needs relating to their environment.

Recovery can occur after such an injury although previous levels of language ability are not always achieved. Many of the residents entering elderly persons homes may have had their dysphasia for many years so that further recovery cannot be expected. But where someone becomes dysphasic in the residential home some degree of recovery would be expected.

Dysphasic adults may have non-fluent speech: they have difficulty producing sentences, or even words in severe cases.

For example, they might say “walk”, where “I went for a walk” would be expected, or “ki” to mean cat.

Sometimes errors are made. These may involve changing sounds – “tat” for “bat” – or use of an incorrect word – “dog” for “cat”, “sugar” for “salt”.

Other dysphasics may have fluent speech but difficulty in finding the right words. For example, “That’s a, oh yes, it’s a, you know, cut, cut with it, fork no knife.”

In other cases, although speech is fluent, it is not correctly structured so that little meaning is expressed.

A person’s understanding of language can also be disrupted by dysphasia but not necessarily in the same way as their expressive speech. Thus a person who is only able to utter the occasional word may have very good understanding, while someone with fluent speech may have great difficulty in comprehending other people’s speech. Reading and writing are usually affected in the same way as speech, but occasionally someone is able to write down what they can’t say. On the other hand in some cases, reading and writing can be much more severely affected than expressive speech.

Where possible a speech therapist can be asked to give details of a dysphasic person’s speech and language abilities, and to give advice on the most effective ways of achieving communication. Staff can also observe a dysphasic patient and note the difficulties that they have in communicating and what helps them to achieve this. In addition the following general guidelines are helpful to remember when speaking to a dysphasic person.

1. Slow down
2. Remove distractions, eg TV.
3. Break any speech into stages. For example:
   - “It’s getting cold, isn’t it?”
   - “Are you cold?”
   - “Do you want a jumper?”
4. Try and understand the person. Asking questions which only need a yes/no answer may help to give you clues. For example “Is it red?”
5. Maintain contact with the person while they struggle to speak: look towards them, look interested and wait patiently.
6. Give the person time.
7. Commiserate with the person if he gets upset or frustrated.
8. The person is not stupid — speaking loudly and very slowly does not help. Use
normal voice and expression.
9. Ask the person’s opinion.
10. Use gesture – “Would you like a cup of tea?” – point to the tea pot while speaking.
11. Remember that speech is a great effort so try to break up interviews etc. Do not expect a dysphasic person to talk for too long and watch for signs of fatigue.

Speech production problems

Another form of acquired speech problem is called dysarthria. This is a disorder of speech production with no disruption in comprehension or reading and writing skills (unless other physical problems such as poor eyesight cause these). In dysarthria the nerve supply to the muscles is disrupted so that speech production is difficult. There are a number of forms of dysarthria, the main ones being:

1. Flaccid dysarthria – where the muscles are weak and floppy. The person may have a very quiet voice making them difficult to hear, and their speech may sound slurred.
2. Spastic dysarthria – where the muscles are very stiff making movement difficult. Speech is therefore very jerky with sudden changes in loudness.
3. Parkinsonian dysarthria – here the muscles are stiff and uncoordinated due to Parkinson’s disease. This can cause the person’s speech to speed up, and the speech is often difficult to hear at the end of a sentence.

Dysarthria can be caused by a number of diseases which affect the brain or central nervous system including strokes, Parkinson’s disease, motor neurone disease, multiple sclerosis and several infections or viral diseases.

However, the most common cause of a motor speech problem is ill-fitting dentures or no dentures at all. This makes speech production difficult and results in speech that can be difficult for the listener to understand.

A person with dysarthria can understand language fully and has no problem in thinking what to say or in formulating a sentence in his head but has a physical difficulty in speaking the words because the speech muscles are not working normally. In some cases very little speech can be achieved, or the speech is unintelligible. It is often the case that people in everyday contact with a dysarthric speaker can “tune in” to their speech and understand them very well. Some dysarthrics are able to use writing or a communication aid such as a pointing chart or an electronic device to augment or be a substitute for speech.

Feeding difficulties

Many dysarthric people and some dysphasics have difficulty with feeding. Many of the muscles used for speaking are also used for eating. Problems can occur with getting food into the mouth, holding it in the mouth, chewing, moving food to the back of the mouth, swallowing and control of saliva. Expert advice from a doctor or speech therapist should be gained if the resident appears to choke on food or drink or reports that food is sticking in his or her throat.

There are a number of ways in which eating and drinking can be assisted:
1. Ensure that dentures are worn and are correctly fitted.
2. Posture – ensure that the resident is sitting up and that the head is slightly flexed forward. Food or drink should never be “poured down the throat” while the head is back. This is likely to cause choking.
3. Give food in small amounts using a normal fork if possible. Give food in single textures per mouthful, ie give meat, or potato, or vegetable. Mixed textures are more likely to cause choking.
4. Encourage chewing and allow enough
Communicating with a person suffering from dementia may be difficult, but it is important to encourage them to talk, discuss and remember.

5. Ensure that the patient has swallowed the food before giving another mouthful.
6. Mixed texture goods, such as soup with pieces of food in it, and dry crumbling foods such as peanuts, crisps, dry biscuits etc, should be avoided where a person has difficulty swallowing.
7. Try to make mealtimes calm and relaxed, and food interesting and tasty, to increase motivation where feeding is slow or difficult. Keeping food hot will also help where feeding is very slow.

Drinking thin liquids such as water and tea is often more of a problem than taking solids. Again posture, taking small amounts and giving enough time to achieve a swallow are important.